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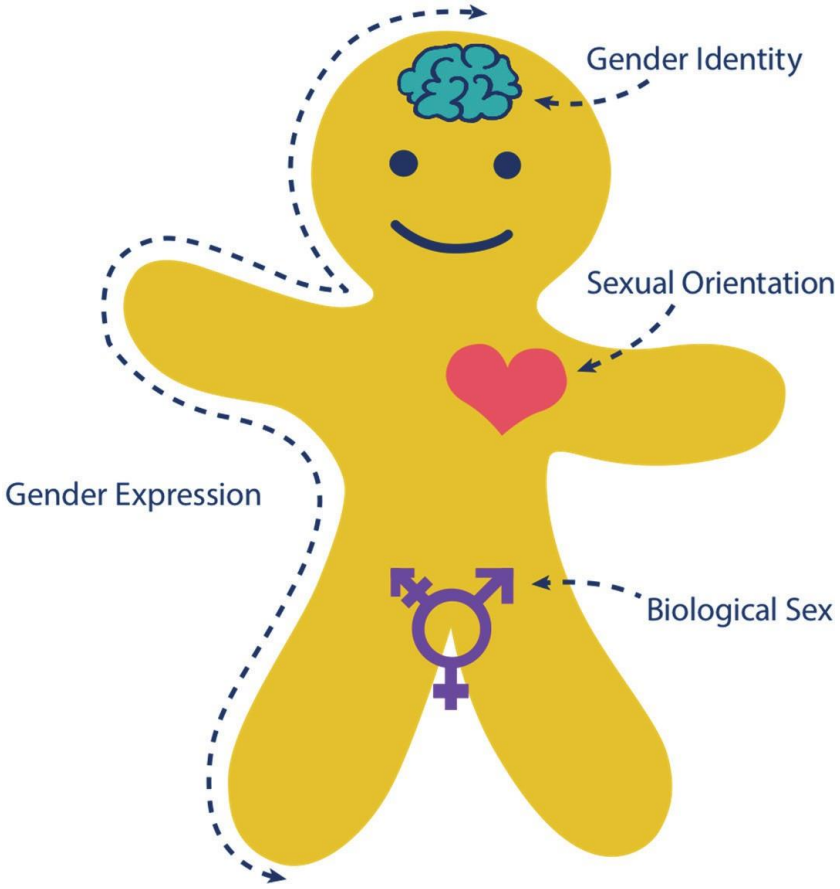
Gender 101

Facilitator guide for virtual delivery

December 2022



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Jhpiego is a nonprofit global leader in the creation and delivery of transformative health care solutions that save lives.

In partnership with national governments, health experts and local communities, we build health providers' skills, and we develop systems that save lives now and guarantee healthier futures for women and their families. Our aim is revolutionizing health care for the planet's most disadvantaged people.

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Brown's Wharf
1615 Thames Street
Baltimore, Maryland 21231-3492, USA
www.jhpiego.org

Foreword

Jhpiego recognizes the critical role organizations implementing health and development programs and their staff can play in promoting gender equity. Research from the private sector, which has now been adapted by recommendations for the public and nonprofit sector, indicates that three key foundations for optimizing performance of an organization are: 1) a diverse and representative workforce, 2) an inclusive and equitable culture, and 3) a flexible and empowering workplace. Thus, Jhpiego's Gender Strategy 2.0, launched in 2020, has a key pillar of gender mainstreaming in organizational culture. More specifically, the objective of this pillar states that, "Jhpiego will model the gender sensitivity and equality that it aims to achieve by integrating gender into its culture and staff attitudes and behavior." This curriculum is one of various tools and approaches to support gender equity among staff attitudes and behavior. Its focus to is help staff identify and reflect on their own gender biases and discriminatory actions that may influence how they approach their work while also providing the basic knowledge and vocabulary for gender-sensitive and transformative programming. Jhpiego's Gender101 curriculum is designed around participatory approaches to engage participants and stimulate reflection and discussion as well as learning. This virtual adaptation strives to duplicate this participatory model in a virtual space.

Acknowledgements

Development of the original 2018 Jhpiego Gender 101 training curricula was led by Maimouna Toliver with support from Myra Betron. Several sessions were adapted from the Interagency Gender Working Group gender training sessions. The virtual edition was developed with instructional design support from TechChange and guidance from Elizabeth Arlotti-Parish. Special thanks to Susi Wyss and Celine Gomes for editing and formatting support.

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Abbreviations

ANC	antenatal care
APA	American Psychological Association
BMC	BioMed Central
CARE	Cooperative for Assistance and Relief Everywhere
CDCS	Country Development Cooperation Strategies
DHS	Demographic and Health Survey
FGC	Female Genital Cutting
FP	Family Planning
GBV	Gender-Based Violence
ICRW	International Center for Research in Women
IEC	Information, Education, and Communication
IGWG	Interagency Gender Working Group
IOM	Institute of Medicine
IPV	intimate partner violence
IUD	intrauterine device
JICA	Japan International Cooperation Agency
JSI	John Snow, Inc.
LGBTI	Lesbian, Gay, Bisexual, Transgender, and Intersex
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
MCE	Maternity Centers of Excellence
MCHIP	Maternal and Child Health Integrated Program
MENA	Middle East and North Africa
MER	Monitoring, Evaluation, and Research
MoH	Ministry of Health
MOPHP	Ministry of Public Health and Population
MSM	Men who have Sex with Men
NGO	Nongovernmental Organization
NLIS	Nutrition Landscape Information System
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technology in Health
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PNC	Postnatal Care
PTR	Program and Technical Review
PWID	People Who Inject Drugs
RCH	Reproductive and Child Health
SBCC	Social Behavior Change Communication
SDP	Service Delivery Point
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAWG	Violence Against Women and Girls
VCT	Voluntary Counseling and Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

Facilitator guidance

Target Audience

The sessions in this manual are geared toward Jhpiego staff of all genders. The manual aims to provide participants with a basic understanding of gender and its impacts on health service delivery and sexual and reproductive health outcomes. Sessions from the manual may also be used with Jhpiego- supported health care workers to build their capacity to offer gender-sensitive services.

Content of the manual

This manual includes 14 sessions collectively focused on the following topics:

Gender Concepts

1. Gender Terms and Definitions

Gender Socialization

1. Gender-Focused Icebreaker
2. Power Walk
3. Power and Gender
4. Vote with Your Feet
5. Act Like a Woman, Act Like a Man
6. Gender Determinants of Health
7. What is Violence?
8. Violence in Daily Life
9. Circles of Influence

Gender Programming

1. Gender Equality Continuum
2. Introduction to Gender Analysis
3. Technical Standards for Jhpiego Gender and Gender-Based Violence Programming
4. Gender-Sensitive, Respectful Service Delivery

How to use the manual

The sessions in the manual may be facilitated in a variety of ways depending on time and resources available. Several sample agendas are provided at the end of this guidance. Regardless of how you organize the sessions, the following guidance must be observed to ensure participant learning and minimize harm:

- The “Gender Terms and Definitions” session is mandatory and must always be included.
- The “Violence in Daily Life” session should never be facilitated as a standalone session, and must always be preceded by either the “‘What Is Violence?” session or the “Circles of Influence” session. In addition, this session should only be facilitated as part of a broader workshop to allow for trust

building within the group, and to ensure participants have had the time to reflect on social norms and their own personal perceptions.

Session format

Each session is formatted as follows:

- Learning objectives of the session
- Time required for the session
- Materials needed for the session
- Advance preparation the facilitator will need to complete before leading a session
- Steps for leading the session
- Facilitator notes and Technology notes on the session process and important points to be made during the session
- Participant handouts that may be given out during or at the end of the session
- Facilitator resources needed to lead the session

Learning objectives

- The learning objectives are what participants should learn as a result of completing the session. It is a good idea to begin each session by telling participants about its learning objectives. This helps participants to understand why they are doing the session and what they can hope to get out of it.

Time

- Time indicates how long the session should take. Depending on various factors, such as the number of participants, the time for completing each session could vary. It is important to work at the pace of the participants. It is also important to remember that any agenda for a workshop is usually a full one. Taking too long with one session may mean you do not have time to complete others. Try to stick to the time suggested.

Materials needed

- These are the materials you will need for each session. You will need to prepare some of them before the workshop begins. Materials may include collaborative Jamboards, Google Documents, or Zoom polls. All materials may be created by facilitators using a free account, and they may be accessed by participants without an account. Additional guidance regarding materials is provided below.

Advance preparation

- This section will inform you about any preparations you should make before conducting the session.

Facilitator notes

- These notes will help you to facilitate the session better. They point out important aspects of the process, as well as background information and tips to help you prepare for the session. Make sure to read these notes before you begin.

Technology Notes

- These notes include important logistical information related to technology. They include alternative

options for managing some of the technological logistics, recommendations for troubleshooting common issues, or other relevant guidance. Make sure to read these notes before you begin.

Introduction

- This section provides the facilitator with an opening statement for the session. You are free to create your own opening statement.

Steps

- These are the steps you should follow to facilitate the session effectively. The steps should be followed in the order in which they appear. You should also remain mindful of the time allotted for each step. Note the **"Technology Action"** steps, which provide specific guidance for anything that needs to be completed related to technology.

Closing

- This section highlights the key points that participants should retain from the session. It may be helpful to refer to these key points while you are facilitating group discussions. You can also use them to sum up the discussion at the end of the session.

Participant handouts

- Some sessions include handouts. These appear at the end of the session. The handouts include information for participants to take away with them or for you to review with them. Handouts should be emailed to participants prior to the session for their reference.

Facilitator resources

- This is additional information for the facilitator to review while preparing a session. Not all sessions include facilitator resources.

Role of the facilitator

Leading this workshop is a great opportunity to share awareness, inspiration, healing, and empowerment with others. As workshop leader, your job will be to:

- Help participants feel welcome, valued, and safe
- Encourage respectful listening and dialogue
- Facilitate workshop sessions

What **is not** expected of you as a facilitator:

- You are not expected to be an expert on all of the issues that might arise in this workshop. No one person can know it all.
- You are not expected to have the answer to every question that might arise. If you do not know the answer, say so! Someone in the group may have an answer, or the group may come up with an answer together.
- You are not expected to do everything perfectly. You will make mistakes. Use these mistakes as learning opportunities. (It is important for the group to see you acknowledge and work through mistakes, awkwardness, and difficulty. It is an essential part of learning!)

- You are not expected to be responsible for each participant's learning and change. This is not something you can control; each member is responsible for himself or herself.

What **is** expected of you as a facilitator:

- **You are expected to guide participants through this workshop.** Sometimes, this means actively steering the group's conversation, and sometimes this means stepping back and letting the group members develop their own ideas.
- **You are expected to help every member of the group feel welcome, safe, and respected.** Everyone should have a chance to share their ideas, experiences, and opinions.
- **You are expected to provide gentle guidance, support, and encouragement** to individuals and to the group as a whole, particularly when things get difficult.
- **You are expected to keep the larger picture in mind.** Remember the goals of the workshop and bring the group back to those goals when necessary.
- **You are expected to model gender equality**—with your co-facilitator, group members, and everyone with whom you come into contact during the workshop.

Facilitation guidelines

- **Keep the end in mind.** Know what you are doing and why you are doing it. Be sure that participants are clear about the purpose and goals of the workshop and of each session.
- **Be flexible.** Be prepared to adapt or skip a session to meet the specific needs of a group or situation. Reassure participants that it is okay to leave some of the sessions and discussions unfinished. This is a lifelong process, and participants can continue to meet as a group or individually to talk, learn, and plan together.
- **Encourage participation.** Ask the group questions and encourage participants to ask questions. Show appreciation for all comments (even if you disagree with them).
- **Pay attention to who speaks and who does not.** Ask people to be mindful of sharing speaking time in the group. You may need to ask people who speak up often to hold their thoughts to create space for people who have not yet spoken.
- **Help the group learn and practice dialogue skills.** Listen to each participant with respect and compassion rather than criticism. Explain that differences in experiences and opinions are an opportunity for learning, not judgment.
- **Encourage participants to engage and talk about their emotions.** The deepest, most effective learning involves both the mind and the heart.
- Everything that happens is a learning experience, especially situations that seem challenging. Remind participants that you are learning from each other and with each other all of the time.
- **Use yourself and your experiences as examples.** Trust the value of your experience and perspective. The workshop is a learning experience for you too. Share with the group what you are learning.

Benefits of working with a co-facilitator

A co-facilitator equally shares the responsibility of leading and facilitating the workshop. You are encouraged to use two facilitators for this workshop because:

- You can share the responsibility for the workshop. (It is hard work!)

- You will have someone to help keep track of the important tasks and details of the workshop and each session, **including technological logistics and responsibilities** (find more information about technological roles below).
- It brings an additional perspective on gender and another set of life experiences and wisdom into the large group.
- It can provide participants with an excellent model of cooperation, connection, and gender equity when things are going well. It can also provide an excellent model of dialogue and conflict resolution when things are challenging.
- Your co-facilitator can help you check your perceptions about what is happening in the group, help you to think about and address group dynamics, and give you feedback on your facilitation.
- It provides a mix of facilitation styles and personalities, helping to keep the energy fresh and engaging.
- Each facilitator can learn something from the skills and perspectives of the other.
- **If the training is conducted virtually, it is always helpful to have a second, technology-focused facilitator, to support the technological management of the session. This is particularly true for the following sessions: Chapter 4, Chapter 11, and Chapter 13.**

Co-facilitation preparation

- The relationship between co-facilitators has a big impact on the workshop. It is important that you meet with your co-facilitator at least twice before the workshop to get to know each other, review the workshop sessions, and work out the details of your workshop plan.
- Talk with each other about your experiences as participants in previous workshops: What was most valuable to you? What seemed most effective for others in the group? What did you notice about the facilitation? Was there anything that you did not like?
- If you have worked together as co-facilitators before, talk about the last time you facilitated together: What went well? What was challenging? What would you do differently? How can you improve the experience for workshop participants?
- Carefully review the objectives of the workshop, as well as the objectives for each session.
- Review the session descriptions. Discuss their potential challenges, how to avoid these challenges, and how to deal with them if they occur.
- Discuss contingency plans for each day. Despite our best efforts, things do not always go as we plan. What sessions can you shorten or skip if you run out of time?
- Set times during the day for the two of you to check in with each other.
- Talk specifically about how you will manage the beginning and ending of the workshop.
- Review the “Managing Conflict” section and talk about effective ways for managing conflict that you have observed.

Virtual Delivery-specific Preparation Tips

- Set up a “backchannel” for you and your co-facilitator to communicate during the session. Backchannels provide a means of communication for just you and the co-facilitator to easily check in on timing, questions, and any other concerns. Consider setting up a Microsoft Teams or Skype group, or start a facilitators’ group chat on Whatsapp.

- Decide who will serve as lead facilitator and who will serve as the technological facilitator for each session. Review the additional notes below on the difference between these two roles, and confirm that the recommended break-down of responsibilities will also work for you and your co-facilitator.

Co-facilitation during the workshop

- Be open to thoughts, feedback, and help from your co-facilitator. Your co-facilitator may notice something happening during the workshop that you missed. If you feel stuck or unsure about something, ask your co-facilitator for their thoughts. In addition, when you are leading, make a habit of asking your co-facilitator for input or if they have anything to add.
- Take time during and after the workshop to check in with your co-facilitator. This will give both of you the opportunity to check your perceptions, give and receive feedback, and strategize about what happens next.
- When your co-facilitator is leading a session, pay attention to the time. It is very easy to lose track of time, particularly when there is a great conversation or significant learning happening. Helping your co-facilitator to pay attention to time will enable both of you to balance the immediate needs of the group with the objectives of the workshop. Use the backchannel to send timing reminders when needed.

Virtual Delivery-specific Live Workshop Tips

- Keep your chosen backchannel up on your computer/phone throughout the session. It's always a good idea to have your backchannel on your phone as well as your computer, if possible, so you can communicate about any technological/internet issues during the live session.
- When your co-facilitator is leading, scan participant videos and the Zoom chat to get a sense of what is happening in the group. If you see people sharing questions or comments in the chat, consider whether the question/comment is one that should be brought up verbally for the whole group, or whether you can effectively respond in the chat so that your co-facilitator can continue to stay focused on the content. Send a message to your co- facilitator using your backchannel if you think something is happening that needs immediate attention.
- Use the guidelines below to help divvy up roles during the live session. In general, it is always recommended that one person take on the role of "Lead Facilitator", while another individual takes on the role of "Technological Facilitator". Each facilitator guide explicitly calls out "technology actions" that should be completed during the session; each of those activities should be managed by the Technological Facilitator if possible, so that the Lead Facilitator can focus on the content. Find an overview of the responsibilities of each role below.

Lead Facilitator	Technological Facilitator
• Give directions for and/or demonstrating activities • Call on participants to answer or ask questions • Track collaborative documents during small group work to help structure a more meaningful debrief • Summarize and synthesize participant ideas	• Let people in from the waiting room • Post relevant links in the chat • Respond to queries related to technology (e.g., *why isn't my microphone working?*) • Manage breakout rooms (including creating breakout rooms, sending people to breakout rooms, and sending broadcast messages) • Share their screen (when relevant) • Launch and manage polls • Start and pause the recording if it is being used

Personal preparation

As a facilitator preparing to do gender work, you will need to consider your own thoughts and feelings and how they may affect your role as a facilitator. For example, you may feel uncomfortable talking openly about certain topics (e.g., masturbation or other aspects of sexuality). You may also have strong feelings about certain topics (e.g., homosexuality). These feelings may make it hard to facilitate an open or frank discussion. You may also be reminded of painful experiences from your past. Being reminded of these experiences may make it hard to talk about certain topics.

To help women and men discuss these issues as openly as possible, you must first make time to think about your own thoughts, feelings, and experiences. This could involve:

- Meeting with a colleague to discuss your thoughts and feelings about the gender work you will be doing: talk about what you are nervous and unsure about, discuss any issues that make you uncomfortable and why, and make a plan for how you will deal with this discomfort.
- Making time during a team meeting to have the same discussions with your peers. If possible, bring in a skilled outside facilitator to help team members with this discussion.
- Choosing someone you trust and whom you think will listen to you and support you (colleague, friend, family member). Tell this person about the past experiences you are concerned about, how you think they may affect your work, and how you would like to be supported in dealing with your memories of them. Make a plan for how to get this support. If you think you cannot get the support you need or that the memories of the experiences are too strong and painful, remember that you have the choice not to do this work.

Video Conferencing Norms

To situate participants to participate actively and collaboratively in the workshop, consider reminding the group of certain “norms” that you ask everyone adhere to in order to make this a space one in which all participants can effectively gather and learn. In addition to general workshop norms (e.g., “One person, one mic” or “Be curious, open, and respectful”), consider sharing a set of norms that are specific to virtual delivery. You may want to adapt the list below to fit the specific context and needs of your participants.

- Use your video camera to convey presence. Try to keep your video camera on as much as possible, if you’re able and comfortable.
- Embrace the craziness in your background. Things happen!
- Get up and take breaks as you need them.
- Use the hand-raise function to indicate when you would like to speak or share questions/comments in the chat.
- Keep yourself on mute unless you're speaking.
- Keep your view in Gallery Mode when in small groups.
- Make sure your name in the video conferencing platform is your actual name.

Active listening

Active listening is a basic skill for facilitating group discussions. It means helping people feel that they are being understood as well as heard. Active listening encourages people to share their experiences, thoughts, and feelings more openly. It shows participants that their ideas are valuable and important when it comes to solving their problems.

Active listening involves:

- Using body language to show interest and understanding. In most cultures, this will include nodding your head and looking at the video of the person speaking.
- Showing interest and understanding to reflect what is being said. In some communities, such direct eye contact may not be appropriate until the people speaking and listening have established some trust.
- Listening not only to what is said, but also to how it is said, by paying attention to the speaker's body language.
- Asking questions of the person who is speaking to show that you want to understand.
- Summing up the discussions to check that what was said was understood. Ask for feedback.

Be nonjudgmental

Remember that information should be provided in nonauthoritarian, nonjudgmental, and neutral ways. You should never impose your feelings on the participants.

Effective questioning

Being able to ask effective questions is also a core facilitator skill. Effective questions help facilitators identify issues, get facts clear, and draw out differing views on an issue. Skillful effective questioning also challenges assumptions, shows you are really listening, and demonstrates that the opinions and knowledge of the group are valuable. Effective questioning also increases participation in group discussions and encourages problem-solving.

Ways to achieve effective questioning include:

- Asking open-ended questions: Why? What? When? Where? Who? How?
- Asking probing questions. Follow up with questions that delve deeper into the issue or problem.
- Asking clarifying questions by rewording a previous question.
- Discovering personal points of view by asking how people feel, not just what they know.

Facilitating group discussions

There is no single best way to facilitate a group discussion. Different facilitators have different styles. Different groups have different needs. But the following are some common aspects of good group facilitation:

- **Set the rules.** It is important to create "ground rules" that the group agrees to follow. Establish ground rules regarding respect, listening, confidentiality, and participation.
- **Involve everyone.** Helping all group members to take part in the discussion is an important part of group facilitation. This involves paying attention to who is dominating discussions and who is not contributing. Try to involve members who are not participating by asking them a direct question. However, remember that people have different reasons for being quiet. They may be thinking deeply! If a participant is very talkative, you can ask them to allow others to take part in the discussion and then ask the others to react to what that person is saying.
- **Encourage honesty and openness.** Encourage participants to be honest and open. They should not be afraid to discuss sensitive issues. Encourage participants to honestly express what they think and feel, rather than say what they think the facilitator(s) or other participants want to hear.

- **Keep the group on track.** It is important to help the group stay focused on the issues being discussed. If it seems as if the discussion is going off the subject, remind the group of the objectives for the session and get them back on track.

Virtual Delivery-specific Group Discussion Tips

- **Ask your small groups to elect a "spokesperson" before they return to the main room.** Ask each group to select one individual from their group who will share key findings and takeaways from their small group discussion. Having groups select a spokesperson will prevent long silences during the debrief and ensure a more organized, balanced final debrief.
- **Ask participants to respond in the chat.** If participants aren't eager to share over live video/audio, remind them they can share their ideas and responses in the chat. Once you have a couple of people who have responded in the chat, you can call on a few of those individuals to elaborate on their ideas.
- **Embrace silence, engage wait-time.** Embrace the silence! During this time, people are reflecting on the question and gathering their thoughts. Silence leads to a more enriched conversation because the initial thoughts have already been captured and reviewed. If you feel like some prompting is required, try: "What's missing?" or "Where is your thinking now compared to when you first started?" But make sure you wait at least five seconds (count in your head) before following up with additional questions or calling on participants randomly.
- **Capitalize on nonverbal techniques.** Encourage participants to use the reaction or chat feature to indicate agreement, ask questions, and/or share related resources from their personal work experiences from which the rest of the team might benefit.

Dealing with difficult people

People often take on certain roles within groups. Some of these roles can interfere with the learning of the workshop. Facilitating a group discussion may mean dealing with people who are negative or disruptive or who continue to interrupt the discussion. Reminding the group of the ground rules and asking everyone to be responsible for maintaining them is a good way to deal with difficult people. If someone is always complaining, you can ask for specifics, address the complaint, or refer the complaint to the group. If a participant is disruptive, you can involve the group by having members ask the difficult person to help, rather than hinder, the group, or you can deal with the individual apart from the group.

Managing conflict

- Know the difference between disagreement and conflict: disagreement is healthy and can lead to better understanding; conflict is not healthy and distracts from learning objectives. Disagreement is not always a bad thing: It can be productive and is a normal part of group development.
- When disagreement occurs, do not rush to interrupt if it is happening in a respectful way.
- Reassure the group that disagreement is an important part of the workshop and that it can create a learning and healing experience for everyone.
- Encourage the group to use "I" statements, describing their own individual feelings, rather than "you" statements that criticize or judge others.
- Tell the group that disagreements do not always have to be resolved. **Learning to allow each other our differences can be even more important than getting everyone to agree.**
- If the disagreement is becoming a problem, the following strategies can help deescalate:
    - Review the group guidelines and talk about the importance of working together.

- Give the group a 5-minute break so that you can confer with your co-facilitator.

- After managing the disagreement, ask the group for examples of what they saw done or what they found helpful. Also, ask if there is anything unresolved about the disagreement. Write the answers to these two questions on two pieces of flipchart paper titled “Helpful” and “Unresolved.” It can also be helpful to check in with key individuals during breaks to learn how they feel about the disagreement.

Advance preparation

Practice using the technology

- Don’t join the session planning on learning how to manage various technological logistics during the live session. You should go into the session feeling comfortable with each described technology action in the session. Take some time to read through the “Guidance on Virtual Tools” below, and practice as much as possible before the session. (Perhaps recruit a few colleagues or friends to join your Zoom room so you can practice making breakout rooms, broadcasting messages, or using Zoom annotations!)

Read the manual

- Read through the manual before you begin a workshop. Read through each session once more before you facilitate it. If you are confused or concerned about any of the information in the manual, ask another facilitator about it.

Prepare materials

- Prepare all collaborative virtual materials ahead of time. Make sure you have an easily accessible list of links that can be readily posted in the chat when the time comes. You may also need to double-check that all links are editable by all viewers, and not restricted to users with an account.

Find out about support services

- For some participants, a gender workshop may bring up painful memories, such as childhood sexual abuse. Some participants may have experienced violence during their adult lives, and some may still be experiencing violence. It is important that facilitators identify available support services and are able to refer participants if needed.

As participants arrive

- Welcome each participant enthusiastically.
- Keep your video on in order to encourage others to do the same. Create a culture of “videos on” from the beginning.
- Try to have some kind of activity for participants to do as they log on. Consider sharing a Zoom poll, posting a fun icebreaker prompt and Jamboard to go along with it, or encouraging conversations in the chat.
- Keep an eye out for participants whose internet connection seems weak (e.g., they keep dropping the call or don’t have their video on) or who are having trouble with other aspects of the technology. Troubleshoot using the “Troubleshooting Guidance” below.

Troubleshooting guidance

Troubleshooting unstable internet connections

If you or a participant experience a poor internet connection during the workshop, try some of the troubleshooting tips below:

- Bring your computer or mobile device closer to the WiFi router or access point in your home or office
- Connect directly to the WiFi router through an ethernet cable
- Restart your router and computer device
- Close other applications that are currently open on your computer
- Disable HD options
- Turn off your video
- Use a call-in number for audio connection

Troubleshooting audio issues

- **First, check the audio settings.** Whoever is having issues should check their audio settings from within their video conferencing platform and ensure they have connected the correct audio system. If you're using Zoom, the participant should click "Join Audio" to review their settings. If they have multiple audio options to choose from (for example, headphones and system audio), have the participant try a different speaker and microphone. You can also have them "Test Speaker & Microphone".

- **Use a call-in number.** If a participant is still unable to connect their audio, have them call in using a call-in number. In general, try to keep call-in information on-hand at all times; you never know when audio issues might become a problem for someone, or even for yourself! Paying Zoom users may use this link to access call-in information for participants outside of the U.S.

Final Thoughts

Relax. Breathe. Stay in the moment. Connect with your co-facilitator. As much as possible, connect with each person in the virtual space. Feel and acknowledge emotions and energy—your own and the group's. **Trust that you can and will be a good facilitator**, that the group will learn and connect, and that the experience will be valuable for everyone!

Sources

Adapted from EngenderHealth. 2015. Training on Gender and Sexual and Reproductive Health: Facilitation Manual. New York, NY: EngenderHealth.
Adapted from The ACQUIRE Project/EngenderHealth and Promundo. 2008. *Engaging Boys and Men in Gender Transformation: The Group Education Manual*. The ACQUIRE Project/EngenderHealth and Promundo: New York, NY, and Rio de Janeiro, Brazil.

Annex 1: Guidance on Virtual Tools

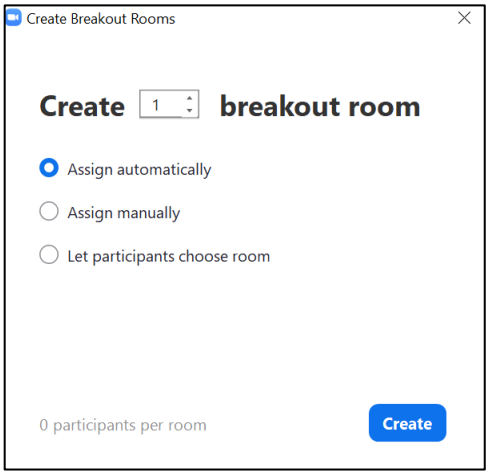
The content below was last updated June 2021. Please note that platforms update regularly, and consequently some of the technological guidance may be out of date by the time you use this Facilitator Guide. Prior to any live session, test all technologies to ensure a smooth workshop.

Zoom

Zoom Breakout Rooms

Creating Breakout Rooms

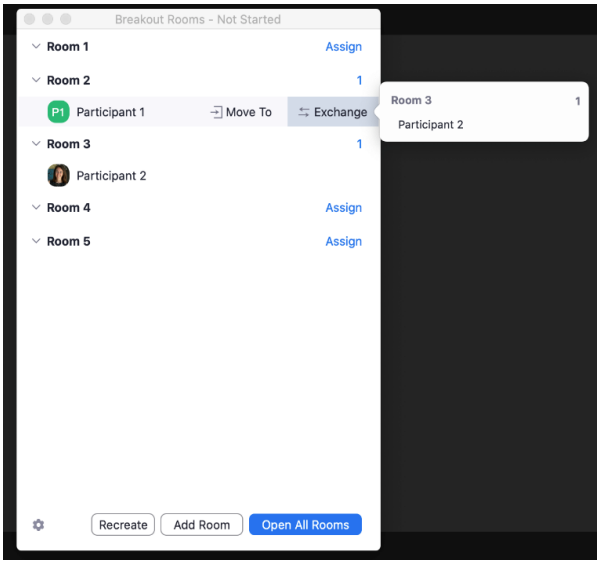
- From within the Zoom meeting, find the "Breakout Rooms" button at the bottom of your Zoom screen. Note that you may need to click "More" in order to find the "Breakout Rooms" button.
- Select the number of breakout rooms that you will need.
- You will be able to select from three options:
    - **"Assign Automatically"**: If this option is selected, all participants except the host will be randomly assigned to a breakout room. Participants will be distributed equally amongst the rooms.
    - **"Assign Manually"**: If this option is selected, no participants will be added to breakout rooms until you add each individual manually.
    - **"Let participants choose room"**: If this option is selected, participants will be able to select which room they would like to join. They will also be able to move between breakout rooms. Note that you can also allow participants to select their own breakout room after this initial step.



- After selecting from the options above, click "Create". (Note that you will still have an opportunity to add additional breakout rooms later if needed.)

Assigning Participants to Breakout Rooms

- To add participants to a breakout room, click where it says "Assign" next to each room number.
- To move participants from one room to another, hover over their name and then click "Move to". You will be able to select which room you would like to move the participant to.
- To exchange one participant with another, hover over one participant's name and select "Exchange"; you will then have an option to select the other individual with whom you would like to exchange them.
- To remove participants from breakout rooms entirely (e.g., in the case that you have automatically assigned all participants but want

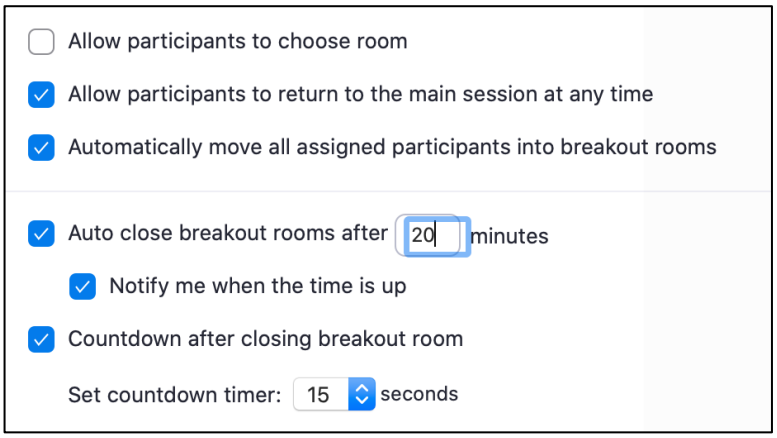


to keep facilitators in the main room), click “Assign”. Then, unselect the name of the individual whom you would like to keep in the main room. They will no longer be assigned to a breakout room.

- Hover over a room’s name to rename it or delete it.

Adjusting the Breakout Room Settings

- Click the gear icon in the bottom left-hand corner of the breakout room window in order to edit the settings for the breakout rooms. ***Note that you will need to adjust these settings almost every time you create/re-create breakout rooms.***
- The options you may select from, as well as a brief description of each, are as follows:
  - **“Allow participants to choose room”**: In general, this should be unselected.
  - **“Allow participants to return to the main session at any time”**: When this is selected, participants may leave their breakout room and return to the main room if needed. In general, it’s recommended that this remains selected so that participants with questions or concerns can return to the main room and check in with a facilitator.



  - **“Automatically move all assigned participants into breakout rooms”**: When this is selected, participants are moved to breakout rooms without them having to do anything; when it is unselected, they have to click “Join Breakout Room” in order to be taken to their room. It is recommended that this remains selected to avoid situations when participants do not move to their breakout rooms in a timely fashion.
  - **“Auto close breakout rooms after __ minutes”**: When this is selected, participants and facilitators will see a countdown clock letting everyone know how much time remains in the breakout rooms. *Note that the number selected here **cannot** be changed or adjusted once you have opened the breakout rooms.* In general, we recommend keeping this selected and noting the time participants have in breakout rooms so that all parties know how much time remains.
    - You may still close breakout rooms before the timer is up.
    - You may keep breakout rooms open longer than the time allotted **only if “Notify me when time is up”** is selected. For that reason, we recommend keeping that option selected so you may extend the time in breakouts if needed.
- **“Countdown after closing breakout room”**: This setting allows you to choose how long participants have to return to the main room after you click “Close Breakout Rooms”. When workshop time is limited, it is highly recommended that participants be given 15 seconds (or no more than 30 seconds) to return to the main room in order to keep to time.

Broadcast a Message

- Once breakout rooms are open, the only option for communicating with participants (besides joining their breakout room) is through Broadcast Messages.

- Note that chats sent in one Zoom room will only be seen by those in that room, and will not be viewable when someone returns to or joins that room. For example, if you send a Zoom chat message to other facilitators in the main room while all participants are in breakout rooms, participants will not see that Zoom chat.

- To send a broadcast message, open the Breakout Rooms window.
- Click “Broadcast Message to All”.
- Type your message and click “Broadcast”.
  - Note that the individual who sends the broadcast message will not see it; however, all other participants should see it at the top of their Zoom screen within a blue or green box.

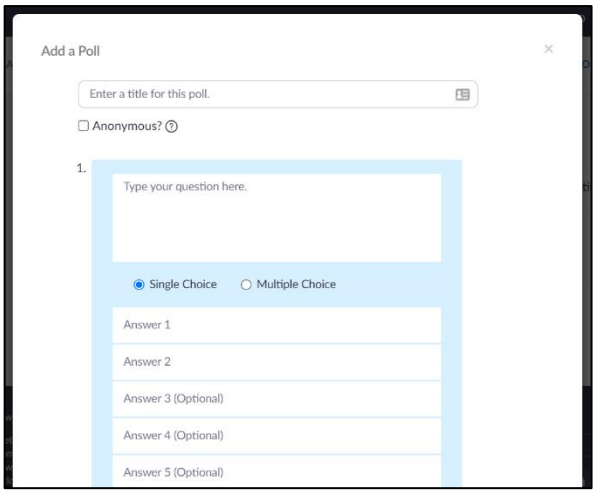
Zoom Polling

Adding Zoom Polls

Follow the steps below prior to your Zoom workshop in order to add polls.

- Go to Zoom.us/meeting.
- Find the scheduled meeting through which you will host your workshop and click on the title to edit its settings.
- Scroll to the bottom of the page; where it says “Poll”, click “Add”.

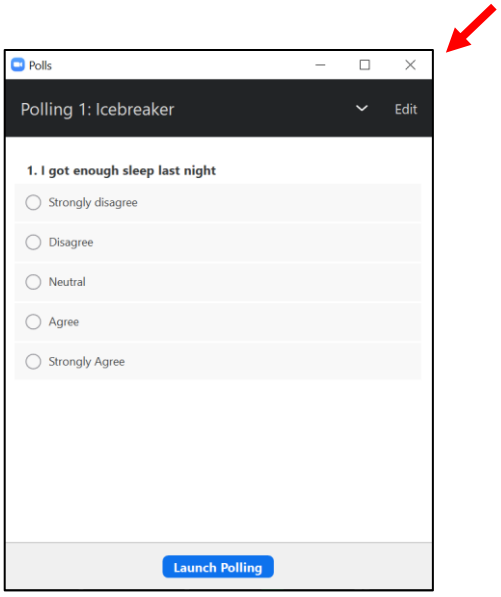
- Enter a title for your poll, your question, and your answer choices.
  - If your respondents should be allowed to select **more than one response** (e.g., for questions that request that people select “all that apply”), change the poll type from “Single Choice” to “Multiple Choice”.



- Note two ways to add multiple polls:
  1. Click “Add a Question” at the bottom of the polling window to add a question that viewers will have to respond to **at the same time as the question above.**
  2. Click “Save” to save your first poll. Scroll back down the meeting information page to where it says “Poll”, and again click “Add”. You will be invited to add another poll that viewers will respond to **separately from other questions.**
- After you’ve finished adding your polls at Zoom.us, there’s nothing else you need to do before the workshop.

Launching Zoom Polls

Follow the steps below to launch your Zoom polls during the Zoom meeting.



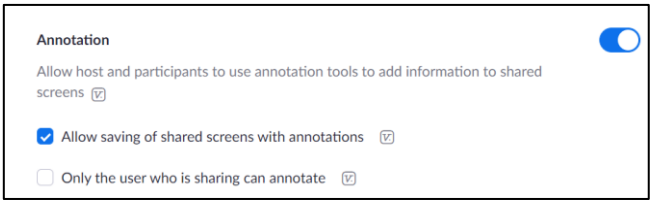
- Click “Polls” at the bottom of the Zoom screen; if you don’t immediately see the “Polls” option, find the “More” option (three dots) and look for Polls there.
- If you have multiple polls, you should select the correct poll by clicking the white down arrow at the top of the polling box (within the black box sharing the poll title). *See the red arrow in the image to the right.*
- To launch the poll, click the blue “Launch Poll” button.
- Click “End Polling” to prevent additional participants from responding.
- Click “Share the Results” to allow all attendees to view the results of the poll. Note that poll results will be anonymous.

Zoom Annotations

Enabling Zoom Annotations

Check to make sure your Zoom annotations are enabled prior to facilitating a workshop that utilizes annotations.

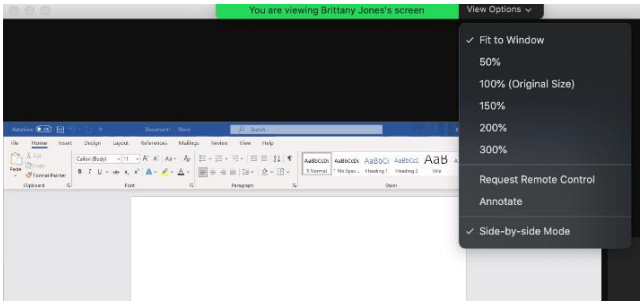
- Go to https://zoom.us/profile/setting
- Scroll down to the “In Meeting (Basic)” settings.
- Look for “Annotation”; make sure the slider to the right of “Annotation” is blue, which means it is turned on (see image to right). If it is grey, click on it and it will turn blue.



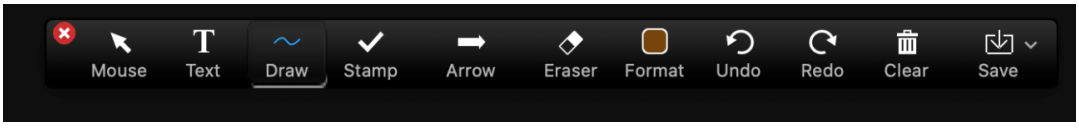
- Select whether or not anyone may save the shared screen with annotations, or only the user who is sharing their screen.

Using Zoom Annotations

*To use Zoom Annotations during a meeting, **each participant** will need to follow these steps:*



- Find the green bar at the top of the Zoom window where it says, “You are viewing [Name’s] screen.”
- Next to the green bar, click “View Options” and then “Annotate”.
- Use any of the annotation tools available at the top of the screen (see image below) to contribute to the annotations on the shared screen.



Zoom Spotlights

Zoom's spotlighting feature allows hosts and co-hosts to showcase up to 9 participants as the primary active speakers for all participants, such that these participants take up the majority of a participant's Zoom window, while other videos are displayed as small thumbnails. This feature may be used to spotlight participants in a group who are all presenting, and whom others should consequently be able to view all together.

- Find one of the individuals whom you would like to spotlight and click the blue button with three dots at the top right-hand corner of their video.
- From the options, select "Spotlight for Everyone".
- To add additional spotlights, again find an individual's video and click the blue button with three dots; this time, click "Add Spotlight" from the options.

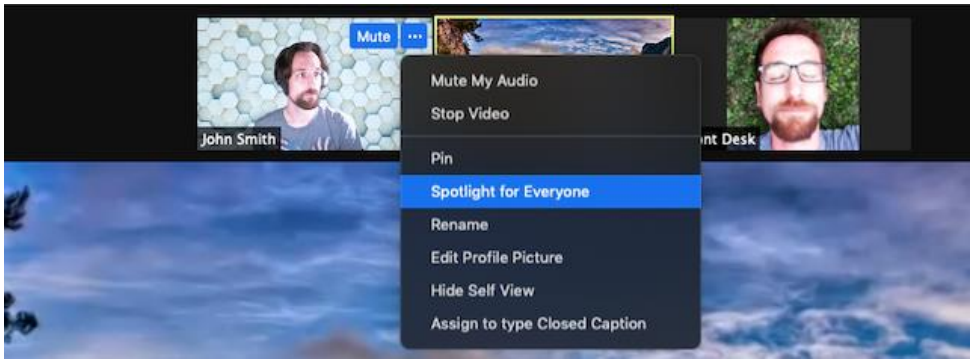


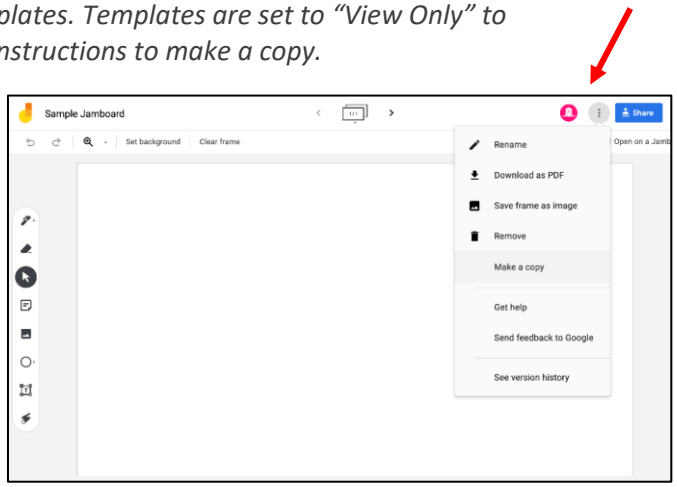
Image source: Zoom

- To cancel a spotlight, click the blue button with three dots in the right-hand corner of a speaker's video and select "Remove Spotlight".
- If only one speaker is spotlighted, you can find the "Remove Spotlight" option in the upper-left corner of the speaker's video.

Jamboard

Making copies of Jamboards

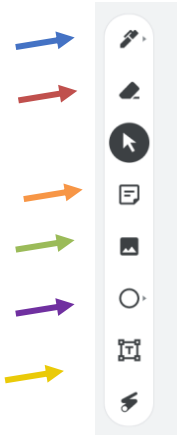
*Please **do not** make edits to the Jamboard Templates. Templates are set to "View Only" to prevent accidental edits. Instead, follow these instructions to make a copy.*



- Click the row of three vertical dots at the top of the screen next to "Share". *See the red arrow in the image to the right.*
- Select "Make a Copy" from the drop-down menu.
- Name your new Jamboard.
- Select a folder in your Google Drive where you would like your Jamboard to be stored.
- Start editing your Jamboard! You may also wish to make additional copies for multiple groups; you can do so following the same instructions.

Editing Jamboards

Jamboards allow users the following functionalities:



- Select the pen (blue arrow) to draw lines or images.
- Select the eraser (red arrow) to erase something you've drawn.
- Select the sticky note icon (orange arrow) to add sticky notes.
- Select the image icon (green arrow) to upload images or add images from Google image search.
- Select the circle icon (purple arrow) to add simple shapes.
- Select the text box (yellow arrow) to add text to your Jamboard.

If you need to add content to your Jamboard that others should not be able to move or edit, consider designing the content on another platform (such as Google Slides), saving it as an image, and then uploading it as a background to your Jamboard. Many of the Gender 101 training Jamboards utilize backgrounds to prevent participants from editing/altering frameworks.

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Saving lives. Improving health.
Transforming futures.

Chapter 1: Gender terms and definitions

Gendor 101 training materials

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Chapter 1: Gender terms and definitions

Learning objectives

By the end of this session, participants will be able to:

- Distinguish between gender and sex
- Distinguish between gender equity and gender equality
- Explain the concepts of gender identity, gender expression, and sexual orientation

Time needed

1 hour 35 minutes

Materials needed

- Six Jamboards (one per group)
  - See "Advance Preparation" below for additional notes on preparing each Jamboard
- Polling software (integrated into Zoom)
- Participant Handout: Gender Terms and Definitions I
- Participant Handout: Gender Terms and Definitions II
- Participant Handout: The Genderbread Person
- Participant Handout: Diversity in Human Sexuality Fact Sheet
- Facilitator Resource: PowerPoint on Gender Terms and Definitions
- Facilitator Resource: Myths and Realities about Sexual Orientation and Gender Identity

Facilitator note: Sexual orientation can be an extremely sensitive topic, and it is important that the facilitator be accepting and comfortable discussing it. It may be helpful to first identify common myths and stereotypes about sexual orientation that exist in the local context in order to address them during the session. If the facilitator is not comfortable discussing sex and sexual orientation generally, or if they are unable to address the topic in a respectful and nonjudgmental manner, then they should not facilitate the second portion of this session.

Advance preparation

1. Email a copy of each Participant Handout to participants.
2. Save a copy of the PowerPoint on **Gender Terms and Definitions** to your computer, and practice presenting the PowerPoint beforehand to ensure you have a good understanding of the various concepts.
3. Create one copy of each of the six Jamboards linked below.
   - Group 1: Sex and Gender
   - Group 2: Gender Equality and Gender Equity
   - Group 3: Women's Empowerment and Agency
   - Group 4: Male Engagement

- Group 5: Gender Roles and Gender Stereotypes
- Group 6: Gender-Based Violence and Violence against Women

Then, prepare links to each Jamboard. The links should be readily available to easily copy and paste into the Zoom Chat. The format for the text that is copied and pasted should be as follows:

- Group 1: [link to Jamboard]
- Group 2: [link to Jamboard]
- Group 3: [link to Jamboard]
- Etc.

4. Log into Zoom.us and add the following poll to your Zoom meeting (review the Technical Facilitator Guidance for more information on adding polls to a Zoom meeting).

   Question: Do you believe the statement is true or false?

   Answer Choice (single choice):

   - True
   - False

> **Facilitator note:** The concepts discussed in this session are foundational to understanding gender and are important for participants to understand before moving on to more advanced sessions. The facilitator should regularly check in with participants by asking if they have any questions related to the concepts discussed or if they need any points clarified.
>
> **Facilitator note:** Before starting the session, the facilitator should point out to participants the sensitive nature of the subject matter, and re-emphasize the importance of confidentiality (what is said inside the room, stays inside the room), respect for others' opinions, and the right to pass (if a participant is uncomfortable with the topic, they may choose not to take an active part in the session).

Steps

Introduction (5 minutes)

Open the activity by explaining to participants that they will spend some time familiarizing themselves with some key foundational terminology related to gender and sexuality.

Foundational gender concepts: Activity (30 minutes)

1. Technology Action: At any time after participants begin to join the meeting, you may begin creating breakout rooms for the "Foundation Gender Concepts" activity.
   - 6 groups (randomly distributed participants)
   - Check "Breakout rooms automatically close after"
     - 10 minutes
   - Check "Notify me when time is up"
   - Countdown after closing breakout room: 30 seconds

2. Explain that participants will be divided into 6 groups. Each group will be assigned one or two concepts to define as a team, and they will be able to take notes as a group on a Jamboard. Explain that they will have 10 minutes to come up with a definition for each assigned concept.
3. Technology Action: Screen share a sample Jamboard and demo how one would do each of the activities described below.
    - Show the group how to add a sticky note to the sample of the Jamboard: click on the sticky note icon, write a word/phrase, click save, and then click anywhere on the Jamboard to go back to the main Jamboard and move your sticky note to the center of the board.
    - Continue adding words and phrases (one word or phrase per sticky note) that make up the assigned concept.
4. Technology Action: Copy and paste into the chat links to each Jamboard. Jamboards should be clearly labeled Group 1, Group 2, etc. See example below.
    - Example:
        - Group 1: [Link to Jamboard]
        - Group 2: [Link to Jamboard]
        - Group 3: [Link to Jamboard]
        - Group 4: [Link to Jamboard]
5. Explain that you have shared links to each group's Jamboard in the Zoom chat. Explain that, as they are being moved to a breakout room, participants will see on their screen to which numbered room they are being moved. Once they are in their breakout rooms, their room number will appear at the top of the Zoom screen. Their breakout room number will represent their group number and should be used to know which Jamboard to open.
6. Explain that, before returning to the main room, each small group should elect a "spokesperson" who can verbally present their Jamboard to the rest of the larger group.
7. Make sure participants understand the instructions. Remind them that they should use the "Ask for Help" button if they have questions for a facilitator while in their breakout room. (Spend no more than 5 minutes on steps 1 to 7).

Technology Note: For many participants, this will be the first time that they have worked on Jamboard. It is important that the facilitator slowly but succinctly demonstrates how to use Jamboard and confirms that participants feel comfortable using it once they go to their breakout rooms. Consider joining breakout rooms soon after they have been opened to check in with each group and confirm that at least one person in each group is comfortable using Jamboard.

8. **Technology Action:** Open the breakout rooms.
9. **Technology Action:** Open each Jamboard on a different tab in your computer. Regularly review each Jamboard to ensure that at least one participant has opened the board and, eventually, that groups have started adding sticky notes. Join any group where no one is on the Jamboard after 30-40 seconds, or where no one has written anything after a couple of minutes.

Technology Note: Anonymous circles at the top right corner of the Jamboard will indicate whether or not participants have opened the Jamboard.

10. **Technology Action:** Send a broadcast message reminding participants when they have 1 minute left. In the broadcast message, remind participants to select a spokesperson if they haven't already. After approximately 10 minutes, close the breakout rooms.
11. **Technology Action:** Screen share Group 1's Jamboard.
12. Invite the spokesperson from Group 1 to read the group's definition to the larger group. Then, ask the larger group to share their thoughts about the definition. (Is the definition accurate? Is the definition complete? How might the definition be improved?) Spend no more than 1 minute discussing the group's definition.
13. Repeat step 12 for the group's second concept/definition (if applicable).
14. Repeat steps 11 to 13 for the remaining groups.

Optional Adaptation

If you are either limited on time or want to focus on only a few of the terms, consider employing the following adaptation as an alternative to the Jamboards.

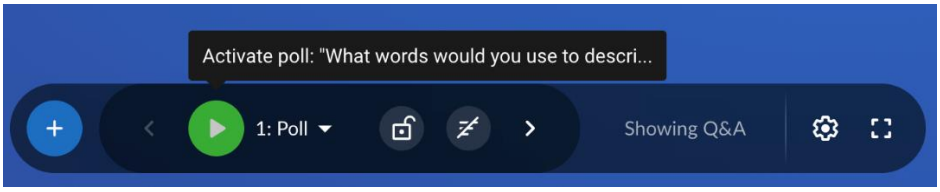
Advanced Preparation

- Select up to 3 words from the following list that are most relevant to your audience.
  - Sex
  - Gender
  - Gender Equality
  - Gender Equity
  - Women's Empowerment
  - Women's Agency
  - Male Engagement
  - Gender Roles
  - Gender Stereotypes
  - Gender-Based Violence
  - Violence Against Women
- Follow these instructions to create your word cloud. Note that facilitators may use Slido or Mentimeter to implement the activity. Slido is recommended for any facilitator that would like to use the word cloud option but does not have a paid Slido or Mentimeter account. All following instructions will assume that the facilitator does not have a paid account for either Slido or Mentimeter, and is using the free version of Slido.
  - Go to Slido.com and create an account or sign in.
  - Click "New Slido". Name your Slido event and be sure that the start/end date fall within the time/date of your live workshop *(note that there are no consequences for having the Slido start/end a few days before/after your workshop, as long as you workshop date falls within the Slido event dates).*
    - Consider changing the event code to something more relevant to your audience/easy to remember.
  - Click "Schedule Slido".
  - Under "Create your polls", select "Word Cloud". Add the following question:
    - What words would you use to describe "[First selected term]"?
    - Click save.

- Create two additional word clouds (select “Create Poll” to add new word clouds) for the other selected terms:
  - What words would you use to describe “[Second selected term]”?
  - What words would you use to describe “[Third selected term]”?

Steps (15 minutes)

1. Explain that, as a group, we’re going to begin familiarizing ourselves with key gender terminology by “crowd-sourcing” some initial definitions to some of the most important terms. (Spend no more than 2 minutes introducing the activity).
2. **Technology Action:** On Slido.com, open up your first event from the Events page. Click the green “Present” button at the top right-hand corner of the screen. Once you are presenting, note that you will need to click the green “play” button (“Activate poll”) from the toolbar at the bottom of the screen to show the poll and allow participants to respond.



3. **Technology Action:** Share your screen and present the first word cloud question, which asks participants to share words that they think of when they hear the first selected term.
4. Explain that participants may either use their phone to scan the QR code and respond to the prompt, or they may go to Slido.com and add the code shown on the screen.
5. Once you have a robust word cloud, pause and ask participants to consider the words in the word cloud and reflect:
   - Are these words here accurately representing the concept?
   - Is there anything still missing?
6. Facilitate a brief group discussion. (Spend no more than 4 minutes on steps 2 to 6).
7. Repeat steps 2-6 for each of the remaining concepts/terms.

Foundational gender concepts (5 minutes)

1. Remind participants that they can access the **Participant Handout: Gender Terms and Definitions I** in their emails to reference later.
2. **Technology Action: Screen-share the PowerPoint Gender Terms and Definitions.**
3. Present the formal definitions in the first half of the **PowerPoint Gender Terms and Definitions**. Allow participants 2 minutes to ask questions and/or make comments.

Facilitator note: When discussing the concepts of gender equity and gender equality, emphasize the following points:

- The goal of **gender equality** is not for women and men, girls and boys, to become the same. Rather, the goal is to ensure that women and men have the same chances to access and benefit from social, economic, and political resources (e.g., have the same opportunities to vote, to be educated, etc.)
- The goal of **gender equity** moves beyond equality in all aspects. Gender equity seeks to ensure that conditions will not prevent equal participation in health promotion activities. It recognizes, for example, that women and men may have different needs, preferences, and interests, some due to biological differences (such as pregnancy) and others due to gender constraints, such as inadequate investment in girls' education or restrictions on their mobility. Achieving equality of opportunity (e.g., gender equality) may require treating women and men differently and/or separately. (For example, an organization may adopt a positive discrimination policy during recruitment to increase women's representation due to gender roles or constraints, such as burden of household care).
- Gender equality differs from gender equity in that gender equity is about how public services meet different population needs, as well as historical inequalities that have mitigated opportunities. Gender equality is about making sure that everyone has the same opportunity to use those services.
- The level playing field and equity/equality trees are useful illustrations of these concepts. In the first illustration, three people are given the same size boxes despite their different heights, and only the tallest of the three can reach the apple on the tree. This illustration displays inequality in outcomes (reaching an apple on the tree) because the boxes are not tailored to the capacities of the individuals (their differing heights). In the second illustration, boxes are equitably distributed and are tailored to the capacities of the individuals (the shortest person has the tallest box), and therefore there is equality since all three people can reach the apples.

Sexual and gender identities (40 minutes)

1. Explain that the group will spend time exploring some additional important concepts related to how we identify with the norms surrounding our gender, as well as norms related to sexual expression.
2. Acknowledge that some participants may have strong beliefs about sexual orientation. State that you will respect every participant's right to their opinion; however, sexual orientation is important to discuss because it is a human rights issue and also an important part of every individual's sexuality.

Facilitator note: It is helpful to remind participants of Article 1 of the Universal Declaration of Human Rights, which states, "All human beings are born free and equal in dignity and rights." The United Nations Human Rights Council interpreted this as, "All people, including lesbian, gay, bisexual and transgender (LGBT) persons, are entitled to enjoy the protections provided for by international human rights law, including in respect of rights to life, security of person and privacy, the right to be free from torture, arbitrary arrest and detention, the right to be free from discrimination, and the right to freedom of expression, association and peaceful assembly" (November 17, 2011; http://www.ohchr.org/Documents/Issues/Discrimination/A.HRC.19.41_English.pdf).

3. Explain that you will read a series of statements aloud, and that for each statement you will ask participants to respond to an anonymous Zoom poll indicating whether they believe the statement to be true or false. (Spend no more than 2 minutes on steps 1 to 3).
4. Refer to **Facilitator Resource: Myths and Realities about Sexual Orientation and Gender Identity**, and read the first statement to the group.
5. **Technology Action: Launch the poll. Give participants 30 to 45 seconds to respond, and then close the poll once all or most participants have responded. Share the results of the poll.**
6. Invite a few participants to briefly explain how they answered and why. Allow 1–2 minutes of discussion and then provide the correct answer.
7. **Technology Action:** Re-launch the poll.
8. Repeat step 4-7 for the remaining statements, spending no more than 3 minutes on each.

Technology Note: You will be informed that "Re-launching the poll will clear existing polling results. Do you want to continue?" Select "Continue".

If you would prefer to have all results of the poll saved, you may create separate polls for each statement. Note that this will need to be completed prior to the start of the session.

9. Before moving on, explain that many of the statements reviewed are myths that use judgment and fear to maintain rigid ideas about women, men, and "acceptable" sexual desire and behavior. Indicate that an important dimension of the stigma, discrimination, and/or violence that lesbian, gay, bisexual, transgender, queer, and intersex (also known as LGBTQI) individuals experience is related to the fact that they deviate from dominant, normative gender norms in their sexual behavior and in other ways (e.g., gender expression).

Facilitator note: The term "queer" may not be commonly used in the communities where your participants are from. If that's the case, you can provide the definition of queer, but you do not need to use the term throughout the training:

The "Q" in LGBTQI represents "queer," which is an umbrella term to describe individuals who don't identify as heterosexual or who have a non-normative gender identity. It can also be used as a political affiliation. Because it has historically been used in a derogatory manner, not all members of the LGBTQ community embrace or use the term. Often, "queer" and LGBTQ are used interchangeably.

Source: *A Guide to Gender: The Social Justice Advocate's Handbook*, 2nd ed., by Sam Killermann, 2017.

10. Technology Action: Share your screen to show the PowerPoint Gender Terms and Definitions, "Gender and Sexual Diversity".
11. After you have read all of the statements, review the second part of the PowerPoint Gender Terms and Definitions, "Gender and Sexual Diversity." Refer to the discussion points included beneath each slide during the presentation. (Spend no more than 20 minutes on this step).

Facilitator note: Discussions about sexual identity can be uncomfortable for some participants, as sexual identity is not often discussed. This discomfort is exactly what this session aims to explore. It can be helpful to relate perceptions about homosexuality to those around race. In many contexts, it was considered unnatural and/or even illegal for people of different races to have sex, marry, have children, etc., but this has changed over time.

12. Next, remind participants that they can review these terms through the Participant Handout: Gender Terms and Definitions II, Participant Handout: The Genderbread Person, and Participant Handout: Diversity in Human Sexuality Fact Sheet, which was emailed ahead of time to each participant.

Group discussion (10 minutes)

1. Facilitate a 10-minute group discussion using the following questions:
    - What is something that you learned in this session about gender or sexuality?

> **Facilitator note:** Be prepared to deal with religious arguments that claim homosexuality is a sin, and that the Bible and/or the Koran say so. Be careful not to enter into arguments against religious doctrine. Do point out, however, that the tenets of both Christianity and Islam (as well as most other religions) also teach love, respect, and care for all. As a facilitator, you may then ask the following question of the group: "What does it mean on a practical level to love, respect, and care for those in the LGBTI community?"

    - What questions do you still have about the concepts we discussed today?
    - How do these concepts relate to your work?
        - Probe: How can understanding these concepts help you with your work?
    - What expressions of gender identity does society tend to find more acceptable? Which are considered unacceptable? What about sexual orientation?
    - How do gender norms shape our attitudes about what is considered "acceptable" and "unacceptable" sexual behavior?
        - Probe: If a woman is known to have sex with multiple partners, how is she perceived in your society and culture? How do gender norms impact that perception?

Closing (5 minutes)

End the session by emphasizing the diversity of humans' experiences of gender and sexuality. Explain that while concepts and definitions are helpful for understanding and articulating people's experiences, our experiences and identities cannot (and should not) be limited to mere concepts. We all have the right to define who we are independent of social rules and expectations.

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Participant handout: Gender terms and definitions I

Sex refers to biologically defined and genetically acquired differences between males and females, according to their physiology and reproductive capabilities or potentialities. It is universal and mostly unchanging, without surgery.

Gender refers to a socially constructed set of economic, social, and political roles, responsibilities, rights, entitlements obligations, associated with being female and male, as well as the power relations between and among women and men, boys and girls. Ones' gender identity may or may not correlate with ones' sex assigned at birth. The definition and expectations of what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures, over time, and throughout the life course; they also often intersect with other factors such as race, class, age and sexual orientation.

Gender equity is the process of being fair to women and men. To ensure fairness, measures must be taken to compensate for historical and social disadvantages that prevent women and men from operating on a level playing field.

Gender equality is the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources.

Gender integration refers to strategies applied in program assessment, design, implementation, and evaluation to account for gender norms and compensate for gender-based inequalities.

Gender mainstreaming is the process of incorporating a gender perspective into policies, strategies, programs, project activities, and administrative functions, as well as into an organization's institutional culture.

Gender roles are the behaviors, tasks, and responsibilities that are considered appropriate for women and men as a result of sociocultural norms and beliefs. Gender roles are usually learned in childhood. Gender roles change over time as a result of social and/or political change.

Gender stereotypes are ideas that people have on masculinity and femininity: what men and women of all generations should be like and are capable of doing. (For example, girls are allowed to cry whereas boys are expected to be brave and not cry).

Agency is a person's capacity to set and act on goals. It often entails bargaining, negotiation, and resistance. (Adapted from Naila Kabeer's [1999] definition of agency).

Empowerment refers to the expansion of people's capacity to make and act upon decisions (agency) and to transform those decisions into desired outcomes, affecting all aspects of their lives, including health. It entails overcoming socioeconomic and other power inequalities in a context where this ability was previously denied. Programmatic interventions often focus specifically on empowering women, because of the inequalities in their socioeconomic status. (Adapted from definitions of empowerment by Naila Kabeer [1999] and Ruth Alsop and Nina Heinsohn [2005]).

Male engagement refers to the involvement of men and boys across life phases in family planning, sexual and reproductive health, maternal and child health, and HIV programs as a) clients/users; b) supportive partners; and c) agents of change to improve health and gender equality outcomes, actively address power dynamics, and transform harmful masculinities. Engaging men and boys also includes

broader efforts to promote equality with respect to sexual relations, caregiving, fatherhood, division of labor, and ending gender-based violence (GBV).

Gender-based violence, in the broadest terms, is violence that is directed at individuals based on their biological sex, gender identity, or perceived adherence to culturally defined expectations of what it means to be a woman and man, girl and boy. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private. GBV is rooted in economic, social, and political inequalities between men and women. Although women and girls are the primary victims of GBV because of their subordinate position, men and boys also may be victims of violence when it is perpetrated to uphold or reinforce dominant forms of masculinities (i.e., socially determined roles, expectations, and behaviors associated with being a man or a boy).

Violence against women and girls (VAWG) involves any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women or girls, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life (Arango et al. 2014). VAWG against someone with whom the perpetrator is in an intimate relationship is referred to as intimate partner violence (IPV).

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Participant handout: Gender terms and definitions II

Sexual orientation refers to an individual's physical and/or emotional attraction to the same and/or opposite sex. A person's sexual orientation is distinct from the individual's gender identity and expression. Heterosexuality is attraction to the opposite sex. Homosexuality is attraction to the same sex. Bisexuality is attraction to both sexes.

Gender norms are the culturally defined roles, responsibilities, rights, entitlements, and obligations associated with being female and male, as well as the power relations between and among women and men, boys and girls.

Gender identity refers to one's innermost concept of self as male, female, a blend of both, or neither—how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.

Gender expression refers to the external translation of one's gender identity, usually expressed through behavior, clothing, haircut, or voice, and may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine.

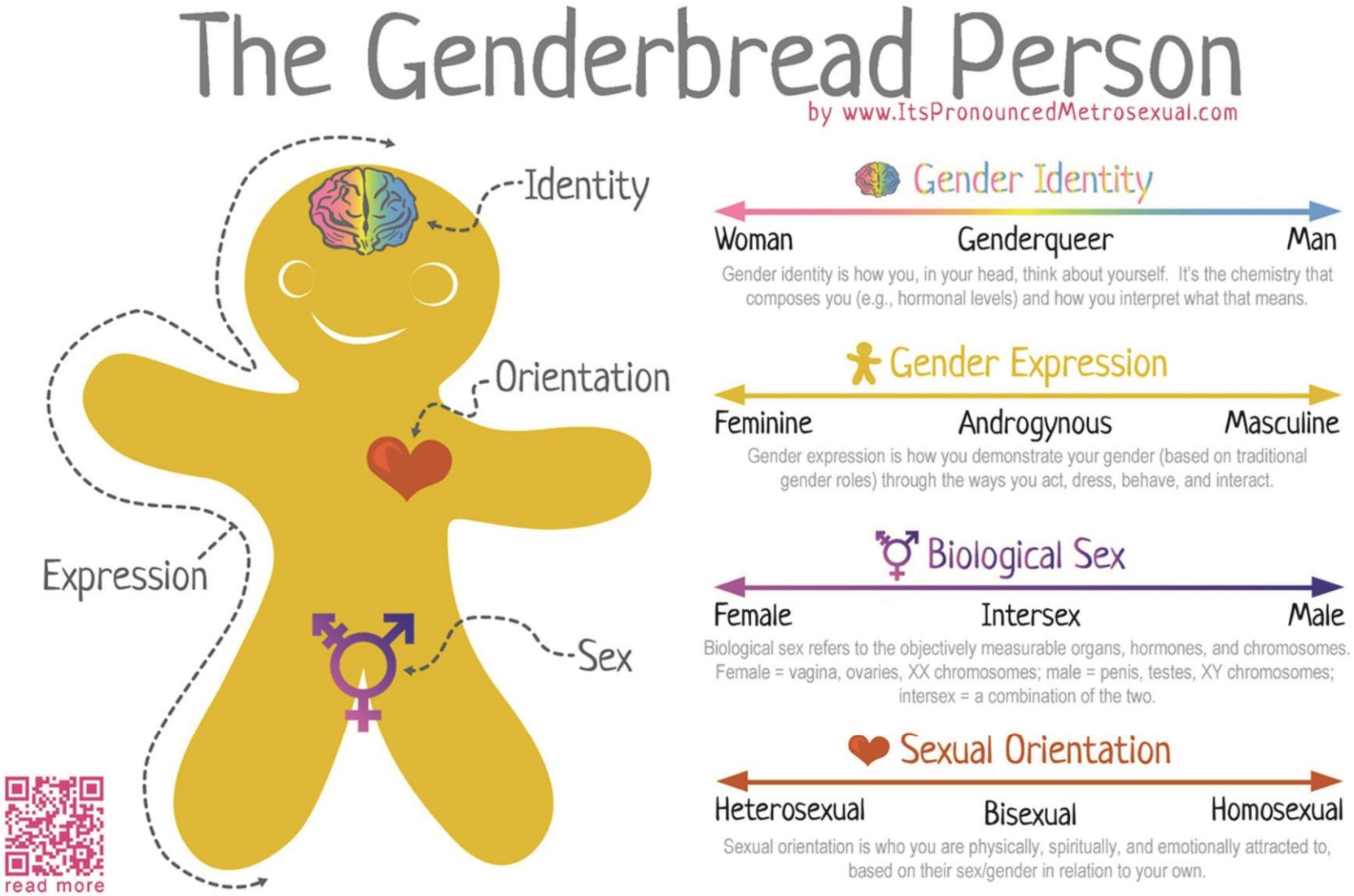
Homophobia is the fear and hatred of, or discomfort with, people who are attracted to members of the same sex.

Heterosexism is the presumption that everyone is heterosexual and/or the belief that heterosexual people are naturally superior to homosexual and bisexual people.

Transgender is an umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.

Participant handout: The Genderbread Person

Source: https://www.genderbread.org/



Participant handout: Diversity in human sexuality fact sheet

(*Adapted from* Diversity in Human Sexuality: Implications for Policy in Africa, Academy of Science of South Africa, May 2015)

What is the evidence that biological factors contribute to diversity in sexual orientation and gender identity?

- Contemporary science does not support that sexuality is a simple binary of hetero/homosexual (Feinstein et al. 2014; Seto 2012).
- Variations in sexual identities and orientations has always been part of a normal society (Greenberg 1988; Cantu et al. 1999; Halperin 2000; Herdt 1996, 1997; Roscoe and Murray 1997).
- There is substantial biological evidence for the diversity of human sexualities and for sexual orientations in particular. Studies have found significant linkage between male sexual orientation and regions of the X chromosome (Mustanski et al. 2005; Sanders et al. 2014).
- Sociobehavioral research demonstrates unequivocally that both heterosexual and homosexual men and women lack a sense of choice in terms of their sexual attraction (Quinsey 2003; Herek et al. 2010; Savin-Williams and Vrangalova 2013; Worthington et al. 2002; Diamond 2012; Diamond 1995; Dillon et al. 2011; Farr et al. 2014; Savin-Williams 2014).

Does upbringing and socialization explain the diversity of sexual orientations and gender identities?

- There is very little evidence that sexual orientation is directly correlated to family upbringing (Beckstead 2012; Isay 2009; Peplau and Garnets 2000; Rosario and Schrimshaw 2014; Royal College of Psychiatrists 2010).

Is there any evidence for same-sex orientation being "acquired" through contact with others?

- There is no evidence that sexual orientation can be acquired through contact with lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons. There is substantial evidence that tolerance of same-sex orientation benefits LGBTI persons and positively impacts public health, civil society, and long-term economic growth in societies across the spectrum of economic development (Florida 2014; Badgett et al. 2014).
- Peer pressure among young people has not been shown to influence same-sex activity or the development of same-sex sexual or bisexual orientations (Brakefield 2014).
- Same-sex parents are no more likely to produce homosexual children than are heterosexual parents (Bailey et al. 1995; Gartrell et al. 2011; Golombok and Tasker 1996).
- Homosexual parents are not any less fit or able as parents than heterosexual parents. Children of homosexual parents do not experience disparities in mental health or social adjustment (Herek 2006).

What evidence is there that any form of therapy or "treatment" can change sexual orientation?

- There is no evidence that same-sex orientation can be changed through "conversion" or "reparative" therapy. Same-sex attraction is not inherently pathological or an illness. There are documented dangers of this kind of therapy and it is therefore not medically ethical (Haldeman 2002; IOM 2011; APA 2009; PAHO 2009; Nel 2014).

What evidence is there that same-sex orientations pose a threat of harm to vulnerable populations such as children?

- There are no credible studies showing that people with same-sex orientation are more likely to abuse children than heterosexual offenders (Barth et al. 2013; Stoltenborgh et al. 2011). Almost all abusers of children are heterosexual men, many of whom are male relatives of these children.
- There is no evidence that men with same-sex attraction or men who have sex with men (MSM) are responsible for the high rates of childhood sexual abuse in African countries or in other countries (Barth et al. 2013; Roberts et al. 2013; Stoltenborgh et al. 2011).

What are the public health consequences of criminalizing same-sex sexual orientations?

- There is abundant evidence that more repressive environments increase minority stress and negatively influence LGBTI health. LGBTI individuals are often unable to freely access health facilities and health information, primarily due to stigma and discrimination. Most LGBTI populations in Africa also face a higher threat of physical violence than heterosexual populations (Denton 2012; Goldbach et al. 2014; Pascoe and Smart Richman 2009; IOM 2011; Schmitt et al. 2014; Berlan et al. 2010; Burton et al. 2013; Poteat et al. 2014; United Nations High Commissioner for Human Rights 2010; Lee 2014).
- There is overwhelming evidence that this has a direct impact on the general population's health, particularly in terms of HIV/AIDS, TB, and other sexually transmitted infection reduction efforts
- (Beyrer 2014; Goldbach et al. 2014; Smith et al. 2009; Baral et al. 2014, Berlan et al. 2010; Johns et al. 2013; Ryan et al. 2010; Schneeberger et al. 2014; Semugoma et al. 2012a; Semugoma et al. 2012b; Reddy et al. 2009; Beyrer et al. 2010; Singh 2013).

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Facilitator resource: Myths and realities about sexual orientation and gender identity

(Adapted from Interagency Gender Working Group (IGWG). 2010. IGWG Gender, Sexuality and HIV Training Module. Washington, DC: IGWG. Pages 55–58*).*

Sex between two men is, by definition, risky.

FALSE—Variance in gender identities, sexual behaviors, and sexual orientations is not inherently harmful. Sexual orientation does not itself determine risk. People's sexual exposure to HIV varies according to patterns of sexual behavior, condom use, other sexual risk-reduction practices, and overall HIV prevalence among sexual partners. People's ability to negotiate safer sex, safer drug use, and access to HIV treatment and care can be influenced by poverty, social and gender inequality, drug use, and other social or structural factors. In other words, various factors make up risk and sex between two men, and it does not necessarily result in greater risk than heterosexual sex. Sex between two men can involve various methods for risk reduction, such as condom use and lubricants, which may ultimately be less risky, for example, than someone having heterosexual intercourse with many individuals without using condoms.

Lesbians have little need for HIV prevention, treatment, or care.

FALSE—Sexual and reproductive health programs and providers have traditionally excluded lesbians because they may not have contraceptive needs and because sexual transmission of HIV between lesbians is relatively low; however, providers should not make assumptions about HIV vulnerability based on sexual orientation alone. Although the risk of sexual transmission of HIV between two women is very low, lesbians nevertheless face risks for HIV. Research shows that many lesbians also have male partners. As women in society, lesbians may be vulnerable to HIV through rape (especially in contexts where sexual violence is used as a "punishment" or "cure" for homosexuality). Lesbians are also at risk for HIV and other sexually transmitted infections (STIs) through the sharing of sex objects. Finally, just like people of any other sexual orientation, lesbians could be vulnerable to HIV transmission through injection drug use.Lesbians should have full access to the same range of reproductive health care as any other woman, including information about sexual and reproductive health, STI and HIV counseling and testing, pap tests, breast exams, and fertility services.

Sex between two men can be motivated by love, sexual pleasure, and/or economic exchange.

TRUE—The same things that motivate sex between a man and a woman motivate men to have sex with other men. The reasons may include love and companionship, sexual pleasure, and as a way of earning money in exchange for sex.

Bisexual people are just sex addicts who will have sex with anyone.

FALSE—Bisexual is the term for people who have affection and sexual attraction toward people of either sex. This does not imply that bisexuals are more likely than anyone else to have multiple partners or to be less "choosy" about sexual partners.

You can spot a homosexual by the way they look or act. "Feminine" men or "masculine" women are usually gay.

FALSE—Gender identity and gender expression do not determine sexual orientation or vice versa. Ideas that link the two are rooted in *stereotypes* meant to preserve rigid distinctions between men and women; that is, by accusing those who diverge from gender norms of being homosexual. Remember: although Lesbian, gay, bisexual, transgender, and intersex (LGBTI) communities sometimes accept or

promote gender deviance more than "mainstream" society, almost everyone acts or looks in some way different from the expectations of their sex. Likewise, there is a range of sexual orientation, and many people experience sexual orientation as fluid, or changing over the life course.

Men who have sex with men (MSM) engage in the same sexual practices as other couples.

TRUE—MSM use many of the same sexual practices as heterosexual couples, including kissing, masturbation, touching, anal sex, and oral sex. These activities are not restricted to sex between a man and woman or MSM, but are commonly practiced by both groups. Some of us, for example, assume that all MSM practice anal sex, but in fact, many do not and there are many heterosexual couples who practice anal sex.

Homosexuality is a new phenomenon brought to my region by Westerners.

FALSE—Although homosexuality is more visible in some contexts than others, same-sex intimate behavior is relatively common, having been found in almost every known culture of the world. Further, historians have documented that colonization in many areas altered pre-existing attitudes toward homosexuality, introducing extreme *homophobia* (rather than homosexuality) by naming, categorizing, and even criminalizing same-sex practices and intimacies. Others argue that the invention of the term MSM by the development field similarly collapsed diverse experiences into a singular category of "other"—especially separating MSM in the global South from gay (white) men in the North. Around the world, visibility and acceptance of homosexuality is slowly growing.

Sex between two men is, by definition, coercive.

FALSE—Consensual sex between adults takes many forms, including sex with people of the same and other sexes/genders. So, too, does sexual coercion. Coercion is characterized by a lack of consent, regardless of the sex/gender of those involved.

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Chapter 2: Gender-focused icebreaker

Gendor 101 training materials

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Jhpiego is a nonprofit global leader in the creation and delivery of transformative health care solutions that save lives.

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Chapter 2: Gender-focused icebreaker

Learning objectives

To allow participants to get to know one another by sharing their personal stories

Time needed

30 minutes

Materials needed

- One copy of the Gender Ice-Breaker Jamboard template

Facilitator note: This exercise may be used as an abbreviated version of the session "Act Like a Man, Act Like a Woman" when time is limited. However, it does not include discussion on the links between gender roles and health.

Steps

Introduction (5 minutes)

Start by explaining that the activity is intended to help create a friendly and trusting atmosphere for the workshop through sharing their personal stories. Point out that this activity is also useful for initiating personal reflection on gender and its influence in our lives.

Getting to know one another (20 minutes)

1. Technology Action: At any point after participants arrive, you may begin to prepare breakout rooms:
    - Groups of 2 (randomly distributed participants)
    - Check "Breakout rooms automatically close after"
        - 4 minutes
    - Check "Notify me when time is up"
    - Countdown after closing breakout room: 30 seconds
2. Explain that, in just a minute, participants will take turns in paired breakout rooms introducing themselves and answering a question. Explain that each person will have 2 minutes to introduce themselves (e.g., their name, where they are from, and the program/project they work on) and to answer the following question:
    - When did you first become aware that there are certain things you are allowed and not allowed to do as a woman/man?

Facilitator Note: If workshop participants already have a good level of gender awareness and understanding, use the following question instead: "Describe some things you do in your personal life to step outside of traditional gender roles."

3. Technology Action: Post the following in the Zoom chat for participants to reference in their breakout rooms:
    - When did you first become aware that there are certain things you are allowed and not allowed to do as a woman/man?

4. Explain that after 2 minutes you will send a broadcast message instructing participants to stop and switch so the person who was speaking becomes the listener.
    - Remind participants that the broadcast message will show up in a small box in the top center of their Zoom screen. If they miss the broadcast message, they can also check the countdown timer that will be at the top right-hand corner of their screen.
5. Ask participants if they have any questions and clarify any misunderstandings. (Spend no more than 5 minutes on steps 1 to 4).
6. **Technology Action: Open the breakout rooms.**
7. **Technology Action: After 2 minutes have passed, send a broadcast message reminding participants to switch so the person who is speaking becomes the listener.**
8. **Technology Action: After 4 minutes, close the breakout rooms.**
9. Ask each person to introduce her/his partner and to relate the stories or issues that she/he talked about. Allow no more than 2 minutes per pair.
10. On a blank Jamboard, add two slides: one with "Male" at the top and one with "Female". As participants share, list the different gender roles, norms, expectations, or constraints participants share as being male or female, respectively.
11. **Technology Action: Screen share the Jamboard on which you've been taking notes.**
12. At the end of the introductions, briefly explain that these gender roles, norms, expectations, and constraints are boxes that society imposes on us due to gender. We can call them the "man box" and "woman box." You may refer to this throughout the training for quick reference to gender roles, norms, expectations, and constraints.

Facilitator note: It is important to ask each participant for permission to share their story with the group.

Optional Adaptation

If all of your participants will be joining from their homes, take advantage of their virtual environments and adjust the prompt. Ask each participant to find a physical object that they believe represents either:

- What is acceptable to do/be as a man or woman in their culture.
- A time when they stepped out of their traditional gender role.

Then, while in small groups, have each participant share that objective with their partner. (Note that if someone has no object nearby to share, they may think of an object and then describe it to their partner).

Additional considerations:

- This exercise may require that each participant have approximately 1 additional minute to share their object (bringing the total time in breakout rooms to 6 minutes).
- Consider emailing participants prior to the live session and asking them to come ready with their object in order to save time. Otherwise, give no more than 2 minutes for participants to find their object and bring it to their work area.

Closing (5 minutes)

End the activity by thanking everyone for their openness and for sharing their stories. State that the personal experiences shared help to illustrate the profound influence of gender norms in shaping our social identities.

Source

- Cooperative for Assistance and Relief Everywhere (CARE), and International Center for Research in Women
- (ICRW). 2007. *ISOFI Toolkit: Tools for Learning and Action on gender and sexuality*. PLA Exercise 3. Atlanta,
- GA: CARE and ICRW. Copyright © 2007 Cooperative for Assistance and Relief Everywhere, Inc. (CARE) and International Center for Research on Women (ICRW). Used by permission.

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Chapter 3: Power walk

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Chapter 3: Power walk

Learning objectives

By the end of this session, participants will be able to describe how gender and sexual identities impact access to health services across different populations

Time needed

45 minutes

Materials needed

- One copy of one of the following Powerwalk Jamboard templates (see the **Technology Note** below)
  - Option 1: 10 sticky notes per slide
  - Option 2: 17 sticky notes per slide
- Facilitator Resource: Character Profiles
- Facilitator Resource: Power Walk Statements I: Gender Inequalities in Health Services
- Facilitator Resource: Power Walk Statements II: Gender Inequalities in the Community

Technology Note: In order to participate in this activity, each participant will need their own sticky note on the Jamboard. While the Option 1 Jamboard provides only 10 sticky notes, it allows participants greater movement on the Jamboard and facilitators may consequently read more statements (up to 9 or 10 statements). The Option 2 Jamboard, in contrast, provides 17 sticky notes, and consequently allows for more participants. However, facilitators will only be able to read up to 6 or 7 statements. Facilitators should consider which option is preferable for their context.

If there are more participants than Jamboard sticky notes, select enough participants to fill the sticky notes, and ask the others to observe the activity.

The activity notes below assume facilitators are using the Option 1 Jamboard; some directions (i.e., the direction in which participants should move their sticky notes) will need to be adapted if facilitators elect to use the Option 2 Jamboard.

Advance preparation

1. Refer to **Facilitator Resource: Character Profiles** and select enough character profiles for each participant (one profile per participant) and/or enough character profiles for each sticky note. (Participants who observe the session will not need a character profile).
2. Review the **Facilitator Resource: Power Walk Statements I: Gender Inequalities in Health Services** and **Facilitator Resource: Power Walk Statements II: Gender Inequalities in the Community**. Prioritize the 7 to 12 statements that you would like to use during this activity.
3. (**Optional** – See Step 1 under "Power walking" below for an alternative means of distributing character profiles). Send a private email to each participant with their character profile. *Make sure that each character profile that is distributed to participants is **numbered**, and that each participant receives a different number.*

4. Make a copy of your preferred Jamboard Template (Option 1 or Option 2). As necessary, delete sticky notes so that the number of sticky notes reflects the number of participants.

Facilitator note: The purpose of this activity is to allow participants to experience the ways in which gender and other health determinants interact. Participants will represent a range of characters to demonstrate varying experiences of vulnerabilities and privileges with respect to health behavior and interactions with the health system. It is important, therefore, to select character profiles that will have maximum impact. Make sure to select profiles that are relevant to the social and cultural context.

Facilitator note: Regardless of the number of participants present, make sure to always include the character of the heterosexual man with a wife and two children.

Steps

Introduction (1 minute)

Explain to participants that they will spend some time reflecting on the links between social norms and sexual and reproductive health outcomes. State that this activity is intended to provide them with greater insight into the ways a person's social position influences their capacity to exercise their sexual and reproductive rights.

Power walking (22 minutes)

1. *[If you have not already emailed participants a description of their character profile]* As participants arrive to the meeting, send each participant a **private message through the Zoom chat** with their assigned character profile. *Make sure that each character profile that is distributed to participants is numbered, and that each participant receives a different number. Numbers should be reflective of the numbered sticky notes on the Jamboard.*

Facilitator Note: It is not necessary to distribute the characters based on participants' sex. Male participants may receive female character descriptions, and female participants may receive male character descriptions.

Facilitator note: Because the Jamboard limits the number of participants on a single board, you may consider inviting some participants to just listen and watch. This can be helpful in the case that you have participants who are accessing the meeting from their phone or have extremely low bandwidth. Screen share the Jamboard throughout the exercise so they can watch the activity. Additionally, encourage them to reflect silently on each statement as it is read.

2. Explain to participants that they have each received a character profile through the Zoom chat/in their email. Confirm that all participants have indeed received their character profile, and that their profile came with a number. Participants who did not receive a character profile should raise their hand. (Re)Send them their character profile in a private Zoom chat message.
3. During the exercise, each participant will represent the character they were assigned. Explain that you will read a series of statements with which participants can either "agree" or "disagree." Their answer will depend on the character they represent—that is, they will answer based on how they believe their character would answer.

4. (Optional) Explain that, in person, this exercise would normally take place with the group standing in a single line. As a facilitator would read statements, participants would take one step forward if their character would be likely to agree with the statement; if their character would be likely to disagree with the statement, they would take one step backwards.
5. Explain that we'll be completing a version of this activity, adapted for the virtual space.
6. Next, one by one, ask each participant to unmute and read their character profile aloud to the group. If they cannot unmute, ask them to put their profile description in the chat and the facilitator will read it out loud. As participants share their character profiles, answer any questions they may have about their character.

Facilitator note: Some participants may feel uncomfortable representing characters who do not conform to dominant gender and/or sexuality norms (e.g., transgender and gay characters). It is important to emphasize that this is only an exercise and explain that this activity is intended to explore precisely the types of feelings people may have about non-normative sexual and gender identities.

Facilitator note: Some male participants may feel uncomfortable representing a female character. The facilitator should be sensitive to reactions of discomfort expressed by male participants and, when appropriate, remind them of any previous discussions about gender roles. The facilitator should also encourage the men to reflect on their reactions. If absolutely necessary, male participants who are not comfortable representing a female character may be given a male character description.

7. **Technology Action:** Screen share the Jamboard on which participants will move their sticky notes.
8. **Provide the following instructions:** "On this Jamboard, you'll notice we have a grid. On the grid are a series of sticky notes, each with a number. In just a minute, I'll post a link to this Jamboard in the Zoom chat so that you can all access it. Once you are on the Jamboard, you will want to locate the number from your character profile. You will use the sticky note with your number during this activity."
9. "As I read each statement, you're going to take one of the following actions: If you believe your character would agree with the statement, you're going to move the sticky note to the right on the board (towards the yellow). If you believe character would disagree with the statement, you're going to move your sticky note to the left on the board (towards the pink)."

Facilitator note: The colors within the Jamboard template are currently structured such that as participants move "back", their sticky note begins to disappear into the background—mirroring the ways in which those with less privilege/power often are unseen within the larger society.

Facilitator note: If the Option 2 Jamboard is being used for this exercise, participants will get the following movement instructions: "If you believe your character would agree with the statement, you're going to move the sticky note up on the board (towards the yellow). If you believe character would disagree with the statement, you're going to move your sticky note down on the board (towards the pink)."

10. **Technology Action:** Post a link in the Zoom chat to the Jamboard.

11. Ask participants to open the Jamboard. Confirm with participants that everyone has been able to access the board. Have all participants try moving their sticky note to the right or left. (Spend no more than 7 minutes on steps 1 to 11).

> **Technology Note:** If participants are having any problem moving their sticky note, explain that participants should move their cursor over the sticky note such that their cursor switches to an icon with four arrows (see image to right). This cursor will allow them to move the sticky note.
>
> 

12. Refer to **Facilitator Resource: Power Walk Statements I and/or II** and read the first statement aloud. After you have read the statement, allow participants a few seconds to decide on their answer and move their sticky note accordingly. Then, read the next statement aloud. (Spend no more than 15 minutes on this step; you may not be able read all statements)

> **Facilitator note:** Depending on the focus you desire for the exercise and time available, you may choose to read the statements that focus on health services, on the broader community gender norms and roles, or a mix of both. A mix of both is recommended.

13. After you have read your final statement, pause. Ask participants to look at the Jamboard and notice how sticky notes have moved across the slide. Instruct participants to take a moment to reflect on their own sticky note's position and the positions of others.
14. Ask participants to close or minimize the Jamboard and re-open the Zoom meeting, so they can see others' videos.
15. **Technology Action:** Continue to screen-share the Jamboard so participants can reflect on where character profiles ended up on the grid. You may want request that participants re-share their number and character profile; alternatively, post all the numbered character profiles in the chat for participants to reference.
16. **Technology Action:** Stop sharing your screen so that everyone can return to Gallery View for the closing discussion.

Group discussion (20 minutes)

1. Next, facilitate a 20-minute group discussion using the following questions and the important discussion points related to each statement in **Facilitator Resource: Power Walk Statements**:
    - How did you feel about portraying your character?
    - Who tended to move to the right (into the yellow) the most during the exercise? Why?
    - Who tended to move to the left (into the pink) during the exercise? Why?
    - How did you feel at the end when you saw your sticky note in relation to others?
    - How did expectations about acceptable/normal female and male behavior affect how people moved? For which questions?
    - How did expectations about proper/normal sexual behavior affect how people moved?
        - In relation to which questions?
    - What benefits do more equal gender roles bring to men's lives? Women's lives?
    - What does this exercise tell us about the impact of social expectations on individuals' health?
    - What does all of this mean for our sexual and reproductive health (SRH) programming?

Facilitator note: During the group discussion, it may be necessary for participants to briefly remind others of their character profile.

Closing (2 minutes)

1. End the activity by making the following points:
    - Gender and sexual norms reinforce each other. Together, gender and social norms enforce power inequalities. The traits most highly valued in society are masculine, heterosexual, white (or the dominant ethnic/racial group in a given context), and financially secure. This reinforces a hierarchy of relations (men over women, more "masculine" men over less "masculine" men, and adult men over younger men). Gender and sexual norms determine which sexual practices are valued or are stigmatized and punished by society, who has the power to make decisions about sex, and whose sexual pleasure and well-being is most important.
    - Gender roles and inequalities drive who has power and who is at greater risk of violence.
        - In general, women typically have less power than men.
    - Social norms that dictate that women should be subservient to men can limit women's access to SRH services and contraception. In some contexts, providers may even refuse to provide women with contraception without the male partner's consent.
    - Social norms dictate acceptable and unacceptable sexual behaviors/practices. "Acceptable" sex is penile-vaginal intercourse, while other sexual practices are often stigmatized and/or discouraged.
    - Social norms also dictate that sex is supposed to occur within the institution of marriage or within stable partnerships. Having multiple sexual partners, having sex before marriage, or paying for sex are generally stigmatized (and in many instances, criminalized). Unmarried and/or young women and men may be discouraged (or prohibited) from accessing SRH centers to obtain contraceptive methods.
    - Social norms that dictate what constitutes "normal" sexual behaviors for women and men also inform the delivery of SRH services, ultimately limiting women's and men's access to SRH services as well as access to services by socially marginalized populations (e.g., transgender, gay, lesbian, bisexual, and intersex persons; men who have sex with men; women who have sex with women; etc.). As such, these individuals cannot exercise their sexual and reproductive rights and ensure their SRH.

Sources

- EngenderHealth. 2015. *Training on Gender and SRH: Facilitation Manual*. New York, NY: EngenderHealth.
- Interagency Gender Working Group (IGWG). 2010. *IGWG Gender, Sexuality and HIV Training Module*.
- Washington, DC: IGWG. http://www.healthpolicyinitiative.com/Publications/Documents/1408_1_IGWG_GSHIV_Module_Oct_20 10_acc.pdf.
- Michau L. 2008. *The SASA! Activist Kit for Preventing Violence against Women and HIV*. Kampala, Uganda: Raising Voices. http://raisingvoices.org/sasa/download-sasa/.

Facilitator resource: Character profiles

Male sex worker
Female sex worker
Transgender woman (born as male sex, but self-identifies as a woman)
Transgender man (born as female sex, but self-identifies as a man)
Single woman living with HIV
Married man living with HIV
Gay man (a man who is sexually, romantically, and spiritually attracted to other men)
Gay woman (a woman who is sexually, romantically, and spiritually attracted to other women)
Man who has sex with women and men (a man who engages in sexual activity with men and women but who does not self-identify as gay or bisexual)
Poor woman who often trades sex for basic necessities
15-year-old girl married to a 45-year-old man
Male religious leader who is sexually active
Married woman who is a victim of domestic violence
Male adolescent who has HIV
Unmarried, 50-year-old heterosexual man who is sexually active
Sexually active single adolescent girl
Sexually active single adolescent boy
Heterosexual man with a wife and two children
Married woman with no children
Sexually active, 20-year-old unmarried woman with three young children
Policeman who frequently pays for sex

Facilitator resource: Power walk statements I: Gender inequities in health services

1. I feel respected by health care workers.

   Important points for the group discussion:

   - Many gay and transgender people are not respected by health care workers when they go for services because in many countries around the world, being gay and/or transgender is socially unacceptable and, in some cases, illegal. Although health care workers are supposed to suspend personal judgment and treat the individual, many allow their personal beliefs to interfere with service provision, which may result in their exhibition of discriminatory behaviors and attitudes toward gay and transgender clients. As a result of this discrimination in health facilities, many gay and transgender individuals may not seek out health services even when they really need them. This has serious implications in terms of their sexual and reproductive health (SRH) outcomes.
   - Many of the other characters might also face judgment and discrimination from health care workers because they are seen as not complying with dominant norms regarding acceptable female and male sexual behavior (e.g., male and female sex workers, single woman with HIV, poor woman who often trades sex for basic necessities, unmarried sexually active woman, sexually active adolescents, boy with HIV, and married woman with no children).

2. I can consult health services when and if I need to.

   Important points for the group discussion:

   - Given the stigma and discrimination faced by many gay and transgender individuals, most may not feel that they can access health services. This discrimination may also limit their ability to speak openly about their health concerns, thereby further limiting the quality of the service provided.
   - Similarly, some of the other characters may also feel unable to consult health services when they need to because they fear stigma and judgment from providers (e.g., female and male sex workers, boy with HIV, single woman with HIV, unmarried woman who is sexually active, etc.). Some other characters may be unable to consult services altogether because they lack the financial means (e.g., poor woman who often trades sex for basic necessities), or because their mobility and decision-making power may be restricted by others (e.g., married woman who is a victim of domestic violence, 15-year-old girl married to a 45-year-old man, sexually active single adolescents).

3. I can easily find a health facility able to address my particular health needs.

   Important points for the group discussion:

   - Given widespread discrimination against non-normative gender and sexual identities, most health facility staff do not possess the required sensitivity, skills, and knowledge required to provide equitable and respectful services to gay and transgender clients.
   - Female victims of domestic violence may not be able to easily access health facilities equipped to address the specific needs (medical, psychosocial) of gender-based violence (GBV) survivors. Similarly, the young characters might also find it challenging to access health services adapted to their needs.

4. It would be easy for me to find relevant information about my sexual health in local health facilities.

   Important points for the group discussion:

   - Given widespread discrimination against non-normative gender and sexual identities, most health facility staff do not possess the required sensitivity, skills, and knowledge to provide equitable and respectful services to gay and transgender clients.
   - Similarly, the young characters might find it challenging to access health services adapted to their needs.

5. I can openly discuss my sexual practices and concerns with a provider.

   Important points for the group discussion:

   - Due to widespread stigma and fear of non-normative gender and sexual identities, many gay and transgender individuals may not feel that they can access health services at will because of the discrimination they are likely to experience from insensitive and ignorant health workers. This discrimination may also limit their ability to speak openly about their health concerns, thereby further limiting the quality of the service being provided.
   - Young clients may also find it challenging to openly discuss their sexual practices with providers because not only are many providers ill-equipped to provide youth-sensitive services, but many also have their own personal judgments about youth and sexuality.

6. I can insist on condom use during sex.

   Important points for the group discussion:

   - Gender norms in many cultural contexts tend to make it more challenging for women (compared to men) to negotiate the conditions of sex. Gender and sexuality norms are interlinked. Social norms that dictate that women should be submissive to men and that men should dominate women contribute to the challenge women face in being able to decide when, where, how, if, and with whom to have sex.

7. I am allowed to be treated by a health care worker of the opposite sex.

   Important points for the group discussion:

   - Depending on the sociocultural context, it may not be socially (or legally) acceptable for clients to be treated by providers of the opposite sex.

8. I can visit a health facility without asking permission from any family members.

   Important points for the group discussion:

   - Depending on the sociocultural context, it may not be socially (or legally) acceptable for women, in particular, to leave the house unaccompanied. Women's limited mobility has implications in terms of their ability to make decisions about their SRH (e.g., ability to access family planning services).
   - Young people may also be limited in terms of their ability to seek health services without parental consent.

9. My sexual practices are respected and accepted by the broader community.

   Important points for the group discussion:

   - In many countries around the world, non-heterosexual sex is not acceptable because it does not conform to practices that are considered socially acceptable. It is important to note that the perpetuation of dominant norms of masculinity and femininity depends upon the enforcement

of specific sexual norms. Dominant masculinity is defined in direct opposition to femininity. This opposition rests on the rationale that masculinity is superior to femininity. Common stereotypes of gay men as feminine therefore challenge the notion of dominant masculinity that society attempts to uphold. Homophobia sustains dominant masculinity since its main goal is to censor in men any expression of feminine characteristics (e.g., tenderness, sensitivity, gentleness, and caring), thereby reinforcing male stereotypes like aggression, physical strength, and dominance.

- Society may judge the sexual practices of many of the other characters as unacceptable because they do not fit within the norms of acceptable sexual practices for women and men (e.g., transgender woman and man, sex workers, poor woman who often trades sex for basic necessities, unmarried sexually active woman, sexually active adolescents, married woman with no children, sexually active single woman with children).

Facilitator resource: Power walk statements II: Gender inequalities in the community

1. I was raised in a community where the majority of police, government workers, and politicians were of my gender.
2. I have been in a situation where a teacher has promised me better school results in exchange for sexual favors.
3. I have never been sexually harassed or disrespected.
4. Most doctors, lawyers, professors, and other “professionals” are the same sex as me.
5. People of my gender generally do not fear violence in their relationship or homes.
6. People of my sex can beat a partner and others generally accept this behavior.
7. Scientists have never considered my sex as inferior.
8. People of my sex often pay for sexual favors.
9. I have never been discouraged from pursuing activities of my choice because of my sex.
10. I generally do not fear being attacked if I walk home alone after dark.
11. I generally am not expected to take part in household chores and childcare responsibilities.
12. I have never worried about being called a prostitute.
13. I do not rely on my partner to pay for my clothes and food.
14. I have never been offered presents for sexual favors.
15. I have never worried about how to dress to keep myself safe.
16. It is generally accepted for people of my sex to have different partners.
17. My religious leaders are the same sex as me.
18. I have never feared being raped.
19. My sex is the one who usually makes the decisions about household expenditures.

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Chapter 4: Power and gender

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Chapter 4: Power and gender

Learning objectives

By the end of this session, participants will be able to:

- Describe the different forms of power
- Describe how power imbalances limit people's ability to exercise their rights

Time needed

1 hour 7 minutes

Materials needed

- Participant Handout: Co-host Privileges
- Participant Handout: Expressions of Power
- Participant Handout: Questions for Discussion *(Only applicable to **Option 2**)*
- World cloud through Slido or Mentimeter
    - See "Advance Preparation" below for additional notes on preparing the word cloud.

Advance preparation

1. Email a copy of the Participant Handout: Expressions of Power to all participants.
2. Refer to the Participant Handout: Expressions of Power and create a simple slide with the four expressions of power and their definition. (Do not include the examples).
3. Create a word cloud following the instructions below. *[Note: The instructions that follow describe how one would use the free version of Slido. Facilitators may also create the word cloud using Mentimeter.]*
    - Go to Slido.com and create an account or sign in.
    - Click "New Slido". Name your Slido event and be sure that the start/end date fall within the time/date of your live workshop *(Note: There are no consequences for having the Slido start/end a few days before/after your workshop, as long as you workshop date falls within the Slido event dates).*
        - Consider changing the event code to something more relevant to your audience/easy to remember.
    - Click "Schedule Slido".
    - Under "Create your polls", select "Word Cloud." Add the following question: What is power?
    - Click "Save."
4. Review the two options for completing "The New Planet" activity below, and determine which of the two options you will implement, based on your session objectives and the characteristics of your participants.
5. **[If you will be implementing Option 2 below]** Confirm that file transfer is enabled for your Zoom meeting. *Learn more about enabling file transfer here.*

6. Identify individuals (approximately 1/5 of your total group) who generally have strong internet access and learn new technologies quickly. Prior to the meeting, send each individual an email that reads as follows:

"I'm looking forward to seeing you soon at another Gender 101 session! In our upcoming session, we'll be completing a highly interactive activity, and I need help from a few tech-savvy participants. So this is just a quick note to let you know that I may (or may not, depending on how the activity works out!) give you a few extra responsibilities during the session. Specifically, you'll be provided with "co-host" privileges. This means you'll be able to mute people, turn off videos, and rename other participants. If you don't know how to do any of those three actions already, please check out the attached document to see how! Feel free to keep the attached document handy during the session. Don't hesitate to reach out with any questions, and I look forward to seeing you soon!"

*Attach the **Participant Handout: Co-Host Privileges** document to the email.*

Technology note: It is highly recommended that facilitators recruit an additional individual to support them with the technical logistics of this session.

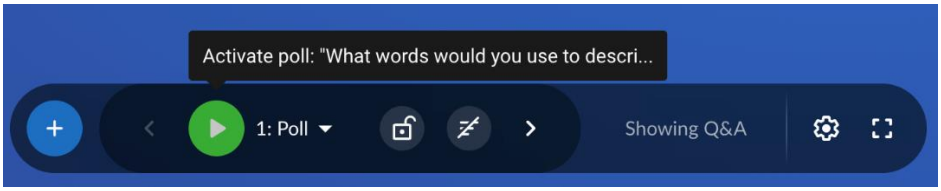
Steps

Introduction (1 minute)

Open the activity by explaining that when working to promote gender equality, it is important to be aware of the power we exercise as individuals, and how we can use our power to empower others in a way that encourages them to make choices for themselves. State that during this activity, participants will spend some time exploring the concept of power.

Defining power (20 minutes)

1. **Technology Action:** On Slido.com, open up your event from the Events page. Click the green "Present" button at the top right-hand corner of the screen. Once you are presenting, note that you will need to click the green "play" button ("Activate poll") from the toolbar at the bottom of the screen to show the poll and allow participants to respond.



2. **Technology Action:** Share your screen showing the question, "What is power?"
3. **Technology Action:** Copy the link and participation code into the chat. This is slido.com and a number code that starts with "#".
4. Invite participants to respond to the question by clicking on the link and entering the code when prompted. They can then add words to the word cloud that they would use to describe power. As time allows, invite a few participants to unmute and share more about the words they added to the word cloud. (Spend no more than 4 minutes on this step).
5. Spend another 6 to 7 minutes discussing the following questions (invite participants to unmute and answer verbally):

- What are some examples of people or groups who have power? How do you know they are powerful?
- Is power only control over others? What are other types of power?

6. State that some people define power as "the capacity to bring about change." Power takes many forms, comes from various sources, and is measured in many ways. Power can be considered "positive" or "negative" depending on one's perspective.
7. **Technology Action:** Screen share a slide deck with the four types of power and their definition.
8. Review each expression of power one by one. Refer to **Participant Handout: Expressions of Power** for examples of each type of power.
9. After you have walked participants through each expression of power, explain that power is just power; it is not necessarily good or bad, although it can be used both constructively and destructively. Remind participants that they can access information about each expression of power through the handout that was emailed to them prior to this session.
10. Next, explain to participants that they will spend some time reflecting on power imbalance. Explain that understanding power imbalance is fundamental to understanding gender inequality. (Spend no more than 10 minutes on steps 5–10).

The New Planet (45 minutes)

Note that there are two options for facilitating this activity. While both achieve similar goals, the two activities involve slightly different considerations, and facilitators should determine which option will work most effectively for their participants.

Facilitators should consider **Option A** if:

- They are hoping to provide participants with opportunities to get to know many of the other group members.
- Their participants generally have a strong internet connection.

Facilitators should consider **Option B** if:

- They want to provide participants with opportunities to further reflect on gender norms, power, and privilege.
- Their participants generally have a weak internet connection.

Option A:

1. Technology Action: As participants arrive, begin to create breakout rooms. You should have enough breakout rooms to allow for groups of 3, or up to 4, in each breakout room. You may assign participants to a random room. TO ENSURE ROOMS ARE CORRECTLY SET-UP, CLICK OPTIONS AND SELECT "Allow participants to choose room." This will allow participants to move between breakout rooms.
    - Groups of 3 (randomly distributed participants)
    - Uncheck "Breakout rooms automatically close after"
    - Countdown after closing breakout room: 15 seconds
    - Check "Allow participants to choose room"

2. Explain to participants that in this part of the activity they will all become citizens of a new planet. Explain that on this planet there are special laws and that the inhabitants of the new planet always respect the laws. State that you will read the first law.

Law number one

Welcome to all noble citizens of our new planet! You are a planet of happy, friendly people, always eager to meet someone new, always ready to tell them something about yourself. As citizens of this planet, you have a right to four things:

- You have a right to physical safety, which protects you from being physically hurt.
- You have a right to respect from others, which protects you from people treating you unkindly or discriminating against you.
- You have a right to the opportunity to make your own decisions, which protects you from people who prevent you from having money or property or access to information.
- You have a right to control over your sexuality, which protects you from people forcing you into marriage, sex, commercial sex work, or any type of unwanted sexual activity.

3. **Technology Action:** To support visual learners, paste the following list of rights in the chat:

   Rights: *Physical safety; Respect from others; Opportunity to make your own decisions; Control over your sexuality*

4. Explain that, in addition to respecting the laws, the inhabitants of this new planet do one thing all the time: they greet each other.
5. Tell participants that they will use self-selected Zoom breakout rooms in order to greet as many people as possible. Self-selected breakout rooms allow participants to move between breakout rooms.
6. Explain that, in just a minute, you will open the breakout rooms. Everyone will be automatically placed in a room. Once in a room, participants can move between rooms by doing the following:
   - Find the “Breakout Room” button on the bottom of their Zoom screen. It will likely be near or next to “Reactions”. They may have to click “More” in order to find it.
   - Click the blue “Join” button to the far right of the room name.
   - Note that they will be able to see who else is in a Zoom room by reviewing the list of names under the Room name/number.
7. As they’re moving between rooms, participants should keep the following in mind:
   - There should never be more than 3 people in any breakout room.
   - Participants may join a room that already has 3 people; however, one person will need to move to a new breakout room when that happens.
   - Participants should not join rooms that already have 4 people in them.
8. Explain that you will share these rules in the Zoom chat so everyone remembers.
9. **Technology Action:** Copy and paste the following into the Zoom chat:
   - *There should never be more than 3 people in any breakout room.*
   - *Participants may join a room that already has 3 people; however, one person will need to move to a new breakout room when that happens.*

- *Participants should not join rooms that already have 4 people in them.*

10. Explain that, as participants move between rooms, they should introduce themselves in each room. Each time participants introduce themselves, they should share something new about themselves. Participants should stay in a breakout room until at least one other person has introduced themselves; then, they may move to a new breakout room. (Spend no more than 7 minutes on steps 1 to 10).
11. **Technology Action:** Open the breakout rooms.
12. **Technology Action:** After approximately 4-5 minutes, close the breakout rooms and bring everyone back to the main room. Do not change or adjust any settings on the Zoom breakout rooms.
13. Explain that you will now read the second law of the new planet.

Law number two

To all noble citizens of our new planet, the whole of our population will now be divided into two parts. Many of your will now become "Squares", while the rest of you will become "Circles". Circles will be indicated by the designation of "co-host". We will now give co-host privileges to all Circles.

14. Technology Action: After you have read the second law, assign as co-hosts up to 1/5 of your participant group. *(These people should be identified and emailed ahead of time; see the "Advance Preparation" section).*
15. Explain that participants will now continue greeting each other. (Spend no more than 3 minutes on steps 13 to 15).
16. **Technology Action:** Re-open breakout rooms.
17. **Technology Action:** After approximately 4-5 minutes, close the breakout rooms and bring everyone back to the main room. Do not change or adjust any settings on the Zoom breakout rooms.
18. Explain that you will read the third and final law.

Law number three

To all noble citizens of our new planet, times have changed. We now officially declare that Circles have more power than Squares. The third law stipulates that, whenever a Circle enters a breakout room, the Square who is speaking at the time may have a right taken away from them. The rights to be taken away are as follows (and in this order):

- Respect from others: You will lose your name, and be re-named to just your initials
- Physical safety: If your video is on, it will be turned off
- Opportunity to make your own decisions: You will be stuck in a breakout room and not allowed to move to a new breakout room
- Control over your sexuality: Your microphone will be muted and you will not be able to communicate with others in the group

Even though Squares know of this risk, they must continue moving between breakout rooms and greeting the other citizens of the planet. With their co-host privileges, Circles may rename the other participants, turn their video off, and finally mute them when required to do so. However, Circles may only move to a new breakout room once everyone in their breakout room, or up to 3 people, have introduced themselves. Circles should also continue introducing themselves.

19. **Technology Action:** Copy and paste the following into the Zoom Chat:

    Whenever a Circle enters a room while a Square is talking, one of the following rights will be taken away from the Square that is talking (in this order):

    - *Respect from others: You will lose your name, and be re-named to just your initials*
    - *Physical safety: If your video is on, it will be turned off*
    - *Opportunity to make your own decisions: You will be stuck in a breakout room and not allowed to move to a new breakout room*
    - *Control over your sexuality: Your microphone will be muted and you will not be able to communicate with others in the group*

    Circles may only move to a new breakout room once everyone in their breakout room, or up to 3 people, have introduced themselves.

20. Explain that participants will now go back to greeting each other. (Spend no more than 3 minutes on steps 18 to 20).
21. **Technology Action:** Re-open breakout rooms.
22. **Technology Action:** After approximately 7-8 minutes, close the breakout rooms.
23. Facilitate a 15-minute group discussion using the following questions:
    - How did you feel when you learned you would have four rights?
    - How did you feel when you were divided into Circles and Squares?
    - Squares, how did you feel when the Circles were given more power? How did you feel being at risk of having your rights taken away at any time? How did it affect your behavior?
    - What happens when society gives one group more power than another?
    - Is it fair or just for society to give some people more power?
    - Who is usually given more power in society?
    - How do imbalances of power between women and men affect women's lives?

Option B:

1. **Technology Action:** As participants arrive, create breakout rooms. You should have at least one person in each room whom you will give co-host privileges to. *(These people should be identified and emailed ahead of time; see the "Advance Preparation" section).*
    - Groups of 4-5 participants
    - Uncheck "Breakout rooms automatically close after"
    - Countdown after closing breakout room: 15 seconds
2. Explain to participants that, during this session's activity, they will reflect further in small groups about some of the concepts and topics that they have either already talked about, or will be talking about in future sessions. They will also have an opportunity to learn more about a few of the other participants in this workshop.
3. Explain that each group will be given a list of questions. Each group member will respond to each question; the group should not move onto a new question before each person has responded. That said, participants are not required to provide an extensive answer or explanation if they do not feel sufficiently comfortable. But participants are encouraged to take time to reflect on and respond to

each question. The first person to respond to each question should first read the question out loud. The group should rotate who reads the question out loud and answers first.

4. Explain that participants **are not expected to answer all the questions.** Rather, they'll answer as many as they get to, but the goal is to have engaging conversations with their colleagues and learn more about one another's perspectives/experiences, not to answer every single question.
5. **Technology Action:** In the chat, upload and send the Participant Handout: Questions for Discussion.
6. Explain that these conversations will not be taking place on "Earth." Instead, they will take place on a new planet. All participants are now citizens of this new planet. Explain that on this planet there are special laws and that the inhabitants of the new planet always respect the laws. State that you will read the first law.

Law number one

Welcome to all noble citizens of our new planet! You are a planet of happy, friendly people, always eager to meet someone new, always ready to tell them something about yourself. As citizens of this planet, you have a right to four things:

- You have a right to **physical safety**, which protects you from being physically hurt.
- You have a right to **respect from others**, which protects you from people treating you unkindly or discriminating against you.
- You have a right to the **opportunity to make your own decisions**, which protects you from people who prevent you from having money or property or access to information.
- You have a right to **control over your sexuality**, which protects you from people forcing you into marriage, sex, commercial sex work, or any type of unwanted sexual activity

7. Technology Action: To support visual learners, paste the following list of rights in the chat:

   Rights: *Physical safety; Respect from others; Opportunity to make your own decisions; Control over your sexuality*

8. Ask if anyone has any questions before you open the breakout rooms. Remind participants that they should use the "Ask for Help" button when in their breakout room if they have any questions for the facilitator. (Spend no more than 5 minutes on steps 1 to 7).
9. **Technology Action:** Open breakout rooms.
10. **Technology Action:** After approximately 4 to 5 minutes, close the breakout rooms and bring everyone back to the main room. Do not change or adjust any settings on the Zoom breakout rooms.
11. Explain that you will now read the second law of the new planet.

Law number two

To all noble citizens of our new planet, the whole of our population will now be divided into two parts. Many of your will now become "Squares", while the rest of you will become "Circles". Circles will be indicated by the designation of "co-host". We will now give co-host privileges to all Circles.

12. **Technology Action:** After you have read the second law, assign one member from each group to be a co-host. *(These people should be identified and emailed ahead of time; see the "Advance Preparation" section).*
13. Explain that participants will now return to their rooms in order to continue answering questions. (Spend no more than 3 minutes on steps 10 to 12).

14. **Technology Action:** Open breakout rooms.
15. **Technology Action:** After approximately 4 to 5 minutes, close the breakout rooms and bring everyone back to the main room. Do not change or adjust any settings on the Zoom breakout rooms.
16. Explain that you will read the third and final law.

Law number three

To all noble citizens of our new planet, times have changed. We now officially declare that Circles have more power than Squares. The third law stipulates that, whenever a broadcast message is sent, if a Square is speaking, then a Circle may take one of their rights away. The rights to be taken away are as follows (and in this order):

- Respect from others: You will lose your name, and be re-named to just your initials
- Physical safety: If your video is on, it will be turned off
- Opportunity to make your own decisions: You will not be allowed to send messages over the chat
- Control over your sexuality: Your microphone will be muted and you will not be able to communicate with others in the group

Even though Squares know of this risk, they must continue answering each of the questions when it is their turn and must not rush through their answers. With their co-host privileges, Circles may rename the other participants, turn their video off, and finally mute them when required to do so.

17. Technology Action: Copy and paste the following into the Zoom Chat:

    Whenever a broadcast message is sent, if a Square is talking, then a Circle will be table to take away one of the following rights from the Square that is talking (in this order):

    - Respect from others: You will lose your name, and be re-named to just your initials
    - Physical safety: If your video is on, it will be turned off
    - Opportunity to make your own decisions: You will not be allowed to send messages over the chat
    - Control over your sexuality: Your microphone will be muted and you will not be able to communicate with others in the group

18. **Technology Action:** Re-open breakout rooms.
19. **Technology Action:** At irregular intervals, send broadcast messages. (Aim to send at least 7-10 messages).
    - While there is no requirement for what facilitators should send over these broadcast messages, we recommend something simple and repetitive such as “This is an announcement” or “If a Square is speaking, a Circle should now take one of their rights away”.
20. **Technology Action:** Close the breakout rooms after 7-8 minutes.
21. Facilitate a 15-minute group discussion using the following questions:
    - How did you feel when you learned you would have four rights?
    - How did you feel when you were divided into Circles and Squares?

- Squares, how did you feel when the Circles were given more power? How did you feel being at risk of having your rights taken away at any time? How did it affect your behavior?
- What happens when society gives one group more power than another?
- Is it fair or just for society to give some people more power?
- Who is usually given more power in society?
- How do imbalances of power between women and men affect women's lives?

Closing (1 minute)

Close the session by reminding participants that how power is used determines whether it is good or bad, constructive or destructive. As we saw in the second part of the activity, power imbalances can restrict individuals' ability to exercise their rights. Power imbalances sustain gender inequality. In many societies around the world, men are more valued than women and, as such, are granted more power than women. Power imbalances between women and men can lead to violence against women, as men attempt to maintain their position of power through the use of force. Power imbalances in relationships also increase women's risk for HIV and other sexually transmitted infections. To achieve gender equality, there must be a balance of power, and this is only possible with commitment, support, and action from both women and men.

Sources

- Burden A, Fordham W, Hwang T, Pinto M, Welsh P. 2013. *Gender Equity and Diversity Module Five: Engaging Men and Boys for Gender Equality*. Activity 18. Atlanta, GA: Cooperative for Assistance and Relief Everywhere (CARE).
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- Influencing attitudes module. Section 2.1:B. Kampala, Uganda: Raising Voices, 7–11. http://raisingvoices.

  org/wp-content/uploads/2013/03/downloads/Sasa/SASA_Activist_Kit/AWARENESS/Training/Awareness.Training.InfAttitudesModule.pdf.

Participant Handout: Co-Host Privileges

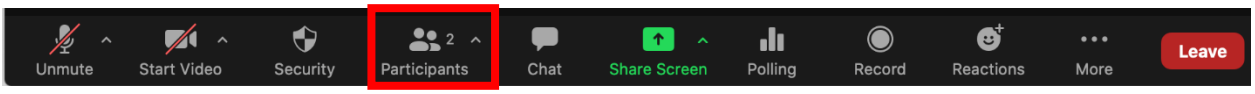
Individuals who are made co-hosts on a Zoom meeting have access to a number of additional controls. These controls include:

- Renaming participants
- Muting participants
- Turning off a participant's video

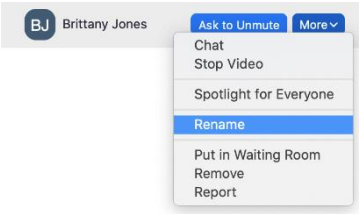
Review the following notes to learn more about how to access the co-host controls.

Renaming a Participant

At the bottom of your Zoom screen, click "Participants".



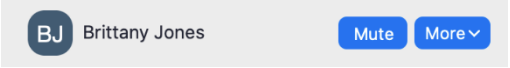
The list of participants will open on the right side of your Zoom screen. Hover over an individual's name and select "More". Then, select "Rename."



A new window will open up. In that window, edit the individual's display name and click "Ok".

Muting a Participant

As above, click "Participants" at the bottom of your Zoom screen.



Hover over a participant's name. Click "Mute".

Turning off a Participant's Video

As above, click "Participants" at the bottom of your Zoom screen.

Hover over a person's name. Click "Stop Video".

Participant handout: Questions for Discussion

Activity Reminders

Each group member should respond to each question; the group should not move onto a new question before each person has responded. That said, participants are not required to provide an extensive answer or explanation if they do not feel sufficiently comfortable. But participants are encouraged to take time to reflect on and respond to each question. The group is not expected to respond to every question.

The first person to respond to each question should first read the question out loud. The group should rotate who first responds to a question.

Questions

1. Introduce yourself, including your name, location, what you do for work.
2. Share one thing that brings you joy.
3. What is one thing you've learned so far in the Gender 101 training?
4. What is one aspect of your work that consistently excites you?
5. What is one gender norm that you wish was different?
6. Re-imagine the gender norm you just shared. What do you *wish* the norm was?
7. What is something or someone that has recently inspired you?
8. When were you first aware that gender mattered?
9. When you were in school, what is one way that you noticed teachers treating boys and girls differently?
10. Think back on the shows you watched and/or books you read as a child. Were boys or girls most often the main character?
11. If you could pick up a new skill in an instant, what would it be?
12. Of all the communities you've been a part of (work, school, religious institution, etc.), which one do you think has made the greatest impact on your life?
13. What is one way your life may be different if you were born of the opposite sex?
14. Think back on your childhood. How were you expected to behave because of your gender?
15. Describe one time when someone you knew did not confirm to gender norms. Without naming names, what did that individual do?
16. Think back on television shows or advertisements that you've watched recently. Share one example in which gender norms were reinforced through a show, movie, or advertisement.
17. What is one way in which you have benefited from adhering to gender expectations/roles?
18. If you could know the absolute and total truth to any question, what question would you ask?
19. What is one thing you're really looking forward to?
20. Do you think the movies targeted for today's children are more or less gender stereotypic than the movies you watched as a child? Why or why not?
21. What is one way that you have contributed to gender stereotypes?

22. Share one time you did not behave according to gender expectations. What were the consequences?
23. What's one thing that you do or have done that would surprise most people?
24. What is one way the world may be different is men and women were treated equally?
25. Think back on television shows or advertisements that you've watched recently. Share one example in which gender norms were challenged through a show, movie, or advertisement.
26. If you could change one thing about the world, what would you change?
27. What is one thing that you would like to be remembered for?

Participant handout: Expressions of power

Power OVER

The power to dominate others. Power is seen as an external control over something or someone. The source of this power is **authority**. *Examples: parents' authority over children, supervisors' authority over supervisees.*

Power WITH

The power of mutual support, solidarity, and collaboration. This power comes when groups work together toward a common goal. The source of this power is **other human beings**. *Examples: people who support and assist a leader, groups who use collective action to achieve a goal, a person's sense of identity or belonging.*

Power TO

The power that comes from the capacity to accomplish something. The source of this power is one's **knowledge, education, skills, or talent**. *Examples: education, talent, knowledge of a certain thing or of how to do a certain thing.*

Power WITHIN

The power of internal beliefs, attitudes, and habits. This has to do with a person's sense of self-worth and self-knowledge. The source of this power may be **self-confidence, faith, ideology, or a sense of mission**. *Example: a person's ability to stand up for what they believe.*

Source

Burden A, Fordham W, Hwang T, Pinto M, Welsh P. 2013. *Gender Equity and Diversity Module Five: Engaging Men and Boys for Gender Equality*. Cooperative for Assistance and Relief Everywhere (CARE); 72, Figure 1. Reused under Creative Commons license at https://creativecommons.org/licenses/by-ncsa/3.0/legalcode with some formatting changes.

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Chapter 5: Vote with your feet

Gendor 101 training materials

Jhpiego is a nonprofit global leader in the creation and delivery of transformative health care solutions that save lives.

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Chapter 5: Vote with your feet

Learning objectives

By the end of this session, participants will be able to:

- Analyze their personal perceptions about gender differences, roles, and inequalities

Time needed

35 minutes

Materials needed

- Zoom Annotations ***or*** polling software (integrated into Zoom)
    - Note the **Alternative Set up and Execution** should you prefer to use polling over Zoom annotations
- Facilitator Resource: Statements on Gender Roles
- Facilitator Resource: Dealing with Difficult Situations
- Powerpoint slide: Chapter 5V_Vote with your feet_Agree Disagree

Advance preparation

1. Select five statements from Facilitator Resource: Statements on Gender Roles.
2. Save a copy of the powerpoint slide "Chapter 5V_Vote with your feet_Agree Disagree" to your computer.
3. Check to ensure that Zoom annotations is enabled for your Zoom meetings. *(Review the Technical Facilitator Guidance for more information on enabling annotations).*

Steps

Introduction (5 minutes)

1. Explain to participants that this activity is designed to give them a general understanding of their own and each other's values and attitudes about gender. It aims to challenge some of their current thinking about gender issues and help them clarify how they feel about certain issues. Remind participants that everyone has a right to their own opinion, and everyone's opinions should be respected.
2. Explain that when this activity is done in person, people move across the room depending on whether they agree or disagree with the statement that is read, so they actually vote with their feet (hence the name of the session). But this version has been adapted for a virtual setting.

Values Clarification (23 minutes)

1. Explain to participants that you will read a series of five statements. Each participant will need to decide (on their own) whether they disagree or agree with each statement.
2. Explain that you will read each statement aloud twice. Additionally, you will present an image with two circles: One will say "Agree" in the center, and one will say "Disagree".

3. **Tehnology Action:** Around this time, begin presenting the "Agree Disagree" slide for participants to view. *Make sure you are in full-screen mode.*
4. Explain that, after you read each statement, you will invite participants to "stamp" within either the "agree" circle or the "disagree" circle, depending on whether they agree or disagree with the statement. Participants will be able to stamp the screen using Zoom's annotation feature.
5. Explain that after they have voted, you will call on a few participants to share their opinions.
6. Tell participants that they cannot remain neutral. They must select either "agree" or "disagree".
7. Explain that we will try the Zoom annotations feature together now.
8. Provide the following instructions regarding how to use Zoom's annotation feature:

   "There are two steps required in order to access the Zoom annotation feature. First, find the green bar at the top of your screen that says 'You are viewing [name's] screen.' You may need to move your cursor in order to see this. Next to the green bar, it will say 'View Options'. Click on 'View Options'. Then click 'Annotate'. You will now be able to annotate on the screen. Everyone will be able to see what you write or add. We're going to use the 'Stamp' feature. Find where it says 'Stamp' near the top of your screen. Then, select the 'Star'. Now, you can click anywhere on the screen in order to add a star. Let's practice with the following statement: 'I got enough sleep last night.' Use the stamp feature to share whether you agree or disagree with that statement."
9. Once everyone has practiced and is comfortable using the Zoom annotations feature, continue with the activity. (Spend no more than 4 minutes on steps 1 to 9).
10. Refer to **Facilitator Resource: Statements on Gender Roles** and read the first statement you pre-identified aloud.
11. Invite participants to stamp within either the "agree" or "disagree" circle.

Facilitator Note: If all participants agree on any of the statements, play the role of "devil's advocate" by asking, "Why would someone have responded with [agree/disagree]?" (i.e., What values would they have that would influence that response?).

Facilitator Note: Some participants may say that they don't know whether they agree or disagree and don't want to respond. If this happens, ask these participants to talk more about their reactions to the statement. Then encourage them to choose a response. If they still don't want to, they can refrain from participating in this poll.

Facilitator Note: During facilitation, you may address topics that are sensitive and challenging to discuss. You will likely have to deal with participants who make statements that are not in line with the views and values of the program or the organization. These could include sexist, homophobic, or racist remarks or opinions. Everyone has a right to their opinion, but they do not have a right to oppress others with their harmful views. **Refer to Facilitator Resource: Dealing with Difficult Situations** for suggestions on how to address harmful participant views.

12. Ask for two to three volunteers from each group to explain their opinion to the group. (Spend no more than 3 to 4 minutes on steps 10 to 12).
    - Facilitator's notes are included under some of the statements in the **Facilitator Resource: Statements on Gender Roles**. These notes include helpful talking points and supporting or clarifying information for the facilitator after participants have had the chance to explain their opinions to the group. However, for most of these statements, there is no clear "right" or "wrong" answer, and it is important to make that clear to the group.

Facilitator note: Sometimes, it can be challenging to identify participants for conversations, especially as the Zoom annotations produce anonymous responses and we can't watch and interpret body language. Consider the following facilitation techniques for managing the brief debrief on each question:

1. Ask all users who responded "agree" to raise their hand using Zoom's raise hand feature. These participants will all be raised to the top of your participant list. Then, call on a few participants to share why they responded as they did. Ask everyone to lower their hand. Do the same with participants who responded "disagree".
    - If necessary to explain to participants how to access the "raise hand" feature, you may use the following language: "You can access the 'raise hand' feature on Zoom by click on the 'Reactions' button on the bottom of your Zoom screen. If you don't immediately see the 'Reactions' button, look for the icon with three dots, titled 'More'. Click that and select 'Reactions'. Then, click 'Raise Hand'. You will need to return to the 'Reactions' button to lower your hand."
    - Consider asking the most popular group, based on annotation responses, to raise their hands and respond first.
2. Invite any participant who selected "agree" to raise their hand if they would like to talk more about why they selected the answer they did. Then, ask the same of participants who said "disagree".
3. Randomly call on participants to share how they responded and why.

13. **Technology Action:** Click "Clear" within your Zoom annotations window in order to clear all responses and begin with a new question.
14. Repeat steps 10-13 for the remaining statements.

Alternative Set-up and Execution for "Vote with your Feet"

Consider the following set-up for voting if you are uncertain whether your participants will feel comfortable using Zoom annotations, which will likely be a new tool for many. You may also select this set-up if you as the facilitator would feel more comfortable using Zoom polling than Zoom annotations.

Advance Preparation

1. Log into Zoom.us and add the following poll to your Zoom meeting (review the Technical Facilitator Guidance for more information on adding polls to a Zoom meeting).

   Question: Select whether you agree or disagree with the provided statement.

Answer Choices (single choice):

- Agree
- Disagree

Technology Note: Facilitators who feel comfortable using Slido, Mentimeter, or an alternative third-party polling software may choose to you that polling software in place of Zoom's polling software.

Values Clarification (23 minutes)

1. Explain to participants that you will read a series of five statements. Each participant will need to decide (on their own) whether they disagree or agree with each statement.
2. Explain that you will read each statement aloud twice. Then, you will launch a Zoom poll. Participants should respond to the Zoom poll, selecting whether they agree or disagree with the statement. Remind participants that all responses to the Zoom poll are anonymous.
3. Explain that after they have voted, you will call on a few participants to share their opinions.
4. Tell participants that they cannot remain neutral. They must select either "agree" or "disagree".
5. Next, refer to **Facilitator Resource: Statements on Gender Roles** and read the first statement you pre-identified aloud.
6. **Technology Action:** Launch the poll. After most or all participants have responded, close the poll and share the results so that all participants can see the distribution of responses.

Facilitator note: If all participants agree on any of the statements, play the role of "devil's advocate" by asking, "Why would someone have responded with [agree/disagree]?" (i.e., What values would they have that would influence that response?).

Facilitator note: Some participants may say that they don't know whether they agree or disagree and don't want to respond. If this happens, ask these participants to talk more about their reactions to the statement. Then encourage them to choose a response. If they still don't want to, they can refrain from participating in this poll.

Facilitator note: During facilitation, you may address topics that are sensitive and challenging to discuss. You will likely have to deal with participants who make statements that are not in line with the views and values of the program or the organization. These could include sexist, homophobic, or racist remarks or opinions. Everyone has a right to their opinion, but they do not have a right to oppress others with their harmful views. Refer to **Facilitator Resource: Dealing with Difficult Situations** for suggestions on how to address harmful participant views.

7. Ask for two to three volunteers from each group ("agree" or "disagree") to explain their opinion. (Spend no more than 3 to 4 minutes on Steps 5 to 7). Facilitator's notes are included under some of the statements in the **Facilitator Resource: Statements on Gender Roles**. These notes include helpful talking points and supporting or clarifying information for the facilitator after participants have had the chance to explain their opinions to the group. However, for most of these statements, there is no clear "right" or "wrong" answer, and it is important to make that clear to the group.

Facilitator note: Sometimes, it can be challenging to identify participants for conversations, especially as the Zoom polling results produce anonymous responses and we can't watch and interpret body language. Consider the following facilitation techniques for managing the brief debrief on each poll:

- Ask all users who responded "agree" to raise their hand using Zoom's raise hand feature. These participants will all be raised to the top of your participant list. Then, call on a few participants to share why they responded as they did. Ask everyone to lower their hand. Do the same with participants who responded "disagree".
    - If necessary to explain to participants how to access the "raise hand" feature, you may use the following language: "You can access the 'raise hand' feature on Zoom by click on the 'Reactions' button on the bottom of your Zoom screen. If you don't immediately see the 'Reactions' button, look for the icon with three dots, titled 'More'. Click that and select 'Reactions'. Then, click 'Raise Hand'. You will need to return to the 'Reactions' button to lower your hand."
    - Consider asking the most popular group, based on polling responses, to raise their hands and respond first.
- Invite any participant who selected "agree" to raise their hand if they would like to talk more about why they selected the answer they did. Then, ask the same of participants who said "disagree".
- Randomly call on participants to share how they responded and why.

8. **Technology Action:** Stop sharing the results of the poll.
9. Read the next statement twice.
10. **Technology Action:** Click the blue "Re-launch Polling" button on the Zoom poll in order to allow participants to respond to the next statement.

Technology Note: You will be informed that "Re-launching the poll will clear existing polling results. Do you want to continue?" Select "Continue".

If you would prefer to have all results of the poll saved, you may create five separate polls (one for each statement). If you have already selected your five statements while you are creating the Zoom polls, you made add each statement to the Zoom poll question. Note that this will need to be completed prior to the start of the session.

11. Repeat steps 5–10 for the remaining statements.

Group discussion (10 minutes)

1. Next, facilitate a 10-minute discussion using the following questions:
    - What statements, if any, did you have strong opinions or not-so-strong opinions about? Why?
    - Did some of the opinions of other participants surprise you? Why or why not?
    - How do you think people's attitudes about some of the statements might affect the way they deal with women and men in their lives?
    - How did it feel to talk about an opinion that was different from that of some of the other participants?

Closing (1 minute)

1. End the activity by emphasizing the importance of thinking about our personal attitudes toward gender, and continuing to challenge our own values and beliefs about gender. State that although it is important to respect other people's attitudes about gender, it is also important to challenge them if their attitudes and values can be harmful to themselves and to others.
2. Make the following final points:
    - Even though we may be familiar with gender and the importance of gender-sensitive programming, some questions are still difficult to address.
    - Our own experiences with, and beliefs about, gender can have an impact on how we view and understand our projects/programs.
    - We need to keep all of these challenges in mind as we ask staff and project/program participants to address gender issues.

Sources

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- World Health Organization. 2017. HIV/AIDS Fact Sheet: Transmission.
- http://www.who.int/mediacentre/factsheets/fs360/en/.
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Facilitator resource: Statements on gender roles

Statements on gender roles

Facilitator note: When discussing the various statements under this category, you may want to raise the following points:

- Men are generally perceived to have more privileges in society—for example, being favored for educational and economic opportunities. However, men can also have many burdens. Likewise, women face many social pressures.
- Although individuals are born female or male, they undergo a socialization process whereby they learn to conform to social and cultural expectations regarding how women and men should behave, dress, speak, think, etc. Gender roles are learned/acquired and are not biological/innate.
- The goal of gender equality is not for women and men, girls and boys, to become the same. The goal of gender equality is to ensure that women and men have the same chances to access and benefit from social, economic, and political resources (e.g., have the same opportunities to vote, to be educated etc.).

- A woman's place is in the home.
- The most important thing a woman can do is have babies and care for them.
- A man is only valued for his ability to make money and provide for his family.
- A man is more of a man once he has fathered a child.
- Women are naturally better parents than men.
- Men will feel threatened if too many women are in leadership roles.
- For women to succeed in the workplace, special benefits and dispensations must be made available to them.

Facilitator note: Women may be equally capable in the workplace in terms of skills and abilities and should not necessarily be given special advantages over men. However, women may need special considerations for things like leave for childbearing, flexible schedules for childcare, space for breastfeeding and breast pumping, or special considerations (for example, for office setting or travel, or safety and security).

- The burden of accommodating women's needs in the workplace is too costly.
- Gender-equitable relationships should be the goal of a family planning/reproductive health (FP/RH) program.
- Female-controlled contraceptive methods perpetuate gender inequality in sexual relationships (because responsibility for contraceptive protection remains on women).

Facilitator note: In some societies where women typically have little decision-making over family planning use, a female-controlled contraceptive method can help a woman gain more control over her body and family planning. However, in some instances or societies, female-controlled methods may simply continue the norm and burden that women alone are responsible for family planning.

- It is fair and appropriate to expect service providers to mitigate power dynamics between a couple seeking services.

Statements on men and reproductive health

Facilitator note: Keep in mind the following points related to some of the statements under this category:

- All sex must be consensual, meaning that both partners must freely agree to participate in a particular sexual activity. Just because two people are in an intimate relationship (including marriage) does not mean that rape cannot occur.
- Women's and men's sexual and reproductive health (SRH) is relational—a female partner's SRH is dependent upon her male partner's SRH and vice versa. In heterosexual intimate relationships, women are often unable to negotiate the conditions of sex, or make decisions about their own health because they tend to lack power in the relationship. It is therefore important to meaningfully involve men as partners in SRH and reproductive, maternal, newborn, and child health (RMNCH) promotion efforts as a means of contributing to more joint decision-making and shared responsibility (e.g., for childcare) among couples.
- Men are also impacted by sexually transmitted infections (STIs), HIV, and pregnancy (even if indirectly). Social norms, however, tend to discourage health-seeking behavior among men and boys as any call for help by a male is seen as a sign of weakness. Most SRH and RMNCH service sites also tend to target their messaging and services toward women; consequently, SRH and RMNCH are seen as exclusively concerning women. As a result, men become further and further disengaged from their roles as parents and partners. Health programs can encourage more male involvement in SRH and RMNCH efforts by supporting health facilities to offer male and couple-friendly services.

- Increasing men's participation in family planning and reproductive health programs will only further increase men's power over women.
- Family planning will always be a more important issue to a woman than to a man because she is the one who can get pregnant.
- Men are more concerned about STIs than women are.
- Clinics should concentrate on serving older, married men because adolescent males are highly unlikely to seek clinical services.

Facilitator note**:** Interventions must be carefully designed and monitored to ensure that men's power over women does not increase further. However, involvement of men alone does not necessarily mean their power will increase. The goal is to achieve joint decision-making through promotion of joint dialogue and communication between couples.

- Men are uncomfortable going to a female-oriented health facility or being treated by a female clinician.
- In today's world, a boy child is more valued than a girl child.
- A woman can do any kind of work a man can do.
- Family planning is a woman's responsibility.
- A man is only a real man if he has fathered a child.

- It is normal for a man to look after the children and cook.
- A man has the right to have sex with his wife even if she does not want to.
- It is easier to be a man than a woman in today's world.
- A man should compromise sexual pleasure for contraception or health.

Statements on HIV/AIDS

Facilitator note: Keep in mind the following points related to some of the statements in this category:

- Variance in gender identities, sexual behaviors, and sexual orientations is not inherently harmful. Sexual orientation does not itself determine risk. People's sexual exposure to HIV varies according to patterns of sexual behavior, condom use, other sexual risk-reduction practices, and overall HIV prevalence among sexual partners.
- Stigma and fear can make it difficult for gay and bisexual people, lesbians, transgender people, and men who have sex with men (MSMs) to access sexual health information and services, putting them at greater risk for HIV and AIDS. It is important to work to dispel harmful myths around sexuality, and promote respect for the rights of women and men to express their sexual orientation, free from discrimination.
- HIV can be transmitted through the exchange of a variety of body fluids from infected individuals, such as blood, breastmilk, semen, and vaginal secretions. HIV cannot be transmitted through ordinary day-to-day contact such as kissing, hugging, shaking hands, or sharing personal objects, food, or water.

- An HIV-positive woman should avoid getting pregnant if at all possible.

Facilitator note: Mother-to-child HIV transmission rates in the absence of any intervention ranges from 15%–45%. However, this rate can be reduced to 5% with effective interventions during pregnancy, labor, delivery, and breastfeeding. Interventions typically include antiretroviral treatment for the mother and a short course of antiretroviral drugs for her baby.

- Gender-equitable relationships should be the goal of an HIV/AIDS program.

Facilitator note: Different kinds of HIV/AIDS programs and interventions are tailored to specific populations (e.g., voluntary medical male circumcision for boys and men). Ideally, all HIV/AIDS programs should be gender sensitive, and ideally gender transformative; however, gender-equitable relationships may not always be a main program goal of an HIV/AIDS program. The health goals of most HIV/AIDS programs are around prevention and increasing testing, treatment, and viral suppression. A gender outcome may be gender-equitable relationships. Gender-equitable relationships may also be a secondary goal of a program, or even along a pathway to a health goal.

- HIV behavior change efforts would have greater success if they addressed sexual pleasure.
- MSM are more vulnerable to HIV because, in most countries, they cannot marry.

Facilitator note: The research does not make evident that not being able to marry increases risk; however, MSM who are in multiple concurrent relationships, just as anyone else in multiple concurrent partnerships, are at higher risk for HIV. Likewise, unprotected sex, whether inside or outside marriage, can carry with it some level of risk.

- A more "sex-positive" sociocultural environment—meaning an environment that promotes greater acceptance of sexuality and sexual desires—would decrease HIV risk and vulnerability.

Facilitator note: A "sex-positive" environment could certainly contribute to decreased HIV risk and vulnerability, especially if sex involving populations that are often stigmatized (e.g., MSM and transgender individuals) is accepted in the community. In more conservative societies or in societies where acceptance of sexuality is limited, people from stigmatized populations are often unable to access services without experiencing discrimination. Therefore, they may choose not to seek services at all, which may increase their HIV risk and vulnerability even further.

- In a generalized epidemic, it is important for HIV programs to focus on transgender people because they are driving the spread of the disease.

Facilitator note: A *generalized epidemic* is firmly established in the general population. HIV prevalence in generalized epidemics usually is greater than 1% among pregnant women attending antenatal clinics. A *concentrated epidemic* has spread rapidly in one or more populations and is not as well established in the general population. It is possible that in a setting with a generalized epidemic, certain subpopulations such as transgender people have higher HIV prevalence. However, in generalized epidemics, the heterosexual population also sustains the epidemic.

Statements on gender and sexuality

Facilitator note: Keep in mind the following points related to some of the statements in this category:

- Unfortunately, in many cultures, men and women receive different messages about sexuality. Men's sexuality is seen as impulsive and uncontrollable, whereas women's sexuality is seen as passive and controllable. These contrasting messages often have negative implications for how men and women relate to each other in intimate and sexual relationships.
- Both men and women have sexual desires and can feel sexual excitement. This excitement depends on biological as well as social and psychological factors.
- Messages about sexuality, regardless of the source, communicate different attitudes and expectations.
- Often messages, whether from parents, peers, religious institutions, or the media, communicate traditional gender norms and stereotypes regarding sexuality (e.g., it is not "normal" to have anal sex; sex should only happen when both parties are married, etc.).
- When sexual rights are not respected, both women and men are more vulnerable to STIs and HIV and AIDS. It follows, therefore, that respecting sexual rights, as well as other rights, creates a more secure society for everyone.
- Despite the fact that homosexuality is more visible in some contexts than others, same-sex intimate behavior is relatively common, having been found in almost every known culture of the world. Further, historians have documented that colonization in many areas altered pre-existing attitudes toward homosexuality, introducing extreme homophobia (rather than homosexuality) by naming, categorizing, and even criminalizing same-sex practices and intimacies.
- Although we do not know precisely what determines a person's sexual orientation, we do know that it is formed early in life, is not chosen by the person, and cannot be changed, although some may hide it because of social taboos and homophobia.

- Men are more concerned about sexual performance than women.
- Sexual pleasure is more important to men than to women.

Facilitator note: Sexual pleasure is just as important to women as it is to men. Society often focuses on men's sexual pleasure, but women's sexual pleasure is equally as important.

- These days, it's okay for a girl/woman to initiate sex.
- Oral sex is more intimate than intercourse.
- People who have multiple sexual partners concurrently are irresponsible.

Facilitator note: Some people who have multiple sexual partners concurrently did not choose to have multiple partners. Additionally, having multiple sexual partners concurrently is condoned in some religions or cultures.

- It is empowering for a woman to use her sexuality as a bargaining tool (e.g., by offering or withholding sex with her partner or another person).
- A sex worker is a victim.

Facilitator note: Often, women or men choose to sell sex for pleasure, money, goods, or services. People who sell sex come from many different backgrounds and may choose sex work for a range of reasons. A sex worker may be poor and not have the education or training for another type of career. A sex worker may have a middle-class background, college education, and no apparent financial need to engage in sex work. Some sex workers enjoy their work and some may not.

- People in same-sex relationships have equal rights in my community.
- The ability to express one's sexuality and sexual diversity freely is key to contributing fully to society.
- A woman should have sex only with someone she loves.
- A man should have sex only with someone he loves.
- Sex is more important to men than to women.
- A woman should be a virgin at the time of marriage.
- It is okay for a man to have sex outside of marriage if his wife does not know about it.

Statements on gender-based violence

Facilitator note: Keep in mind the following points related to some of the statements in this category:

- No person deserves to be beaten, no matter what they have done. Regardless of the circumstances, violence cannot and should not be justified.
- When there is violence in a relationship between men and women, generally the violence the man commits is more severe. When women use violence, it is generally in response to a partner's violence, and in many cases, their partners react with more violence.
- A violent person is not out of control. Even men who say they lose control when they hurt their partners do not use violence in every situation, nor with every person. They are selectively violent—in other words, their violence is a choice.

- Those who mistreat others do not feel any more rage than other people, but they use their rage as an excuse and a justification for their behavior, against people who have less power than they do.

- Women are just as likely to support wife beating as men. Or, women are just as likely to perpetrate violence as men are.

Facilitator note: Based on demographic and health surveys in various countries, women are often just as likely or more likely to believe wife beating is justified. Women are influenced by the same social and gender norms that make violence acceptable, but their beliefs do not mean that they deserve it or are asking for it. Some studies have found that women use violence in relationships as well, sometimes as much as men. However, in surveys on intimate partner violence that have asked how often, how harsh, and is it in response to violence they experience, men come out more clearly as aggressors. In terms of general violence in society, men are overwhelmingly more likely to be the perpetrators.

- A man has the right to hit a woman.

Facilitator note: Violence is never justified. Everyone has a right to live free of violence.

- In certain circumstances, women provoke violent behavior.

Facilitator note: First, women are never to blame for experiencing intimate partner violence at the hands of their partner. Women may in some cases initiate violence; however, violence is not acceptable from either males or females and should be deescalated.

- Gender-based violence (GBV) is too culturally sensitive an issue to be addressed in reproductive health projects.

Facilitator note: GBV is linked to ill reproductive health outcomes and should absolutely be addressed in reproductive health projects, if there are resources to do so in an adequate manner that complies with World Health Organization clinical guidelines and evidence-based practices. GBV has been linked to STIs, vaginal bleeding and infection, fibroids, decreased sexual desire, genital irritation, pain on intercourse, chronic pelvic pain, and urinary tract infections. GBV during pregnancy has been associated with low birthweight. Some studies have shown associations between abuse during pregnancy and infant outcomes including preterm delivery, fetal distress, antepartum hemorrhage and pre-eclampsia.

- Men sometimes have a good reason to use violence against their partners.

Facilitator note: It is never acceptable for men to use violence against their partners. Women may in some cases initiate violence, but violence is not acceptable from either males or females and should be deescalated.

Statements on safe motherhood

- Increasing men's participation in antenatal care will only further increase men's control over women's fertility and health.

Facilitator note: Interventions must be carefully designed and monitored to ensure that there are no further increases of men's power over women. However, involvement of men alone does not necessarily mean their power will increase. The goal is to achieve joint decision-making and partner support through promotion of joint dialogue and communication between couples.

- Safe motherhood will always be a more important issue to a woman than to a man because she is the one who will give birth and care for the baby.
- Many health workers are uncomfortable counseling men on safe motherhood issues.
- Men are uncomfortable going to a female-oriented health facility.

Facilitator resource: Dealing with difficult situations

During facilitation, the facilitator may address many topics that are sensitive and difficult to discuss. The facilitator will likely have to deal with participants who make statements that are not in line with the program's views and values. These could include sexist, homophobic, or racist remarks or opinions. Everyone has a right to their opinion, but they do not have a right to oppress others with their views.

For example, a participant might say, "If a woman gets raped, it is because she asked for it. The man who raped her is not to blame." It is important that facilitators challenge such opinions and offer a viewpoint that reflects the program's philosophy. This can be difficult, but it is essential in helping participants work toward positive change. The following process is one suggestion for dealing with such a situation:

Step 1: Ask for clarification

"I appreciate you sharing your opinion with us. Can you tell us why you feel that way?"

Step 2: Seek an alternative opinion

"Thank you. So at least one person feels that way, but others do not. What do the rest of you think? Who here has a different opinion?"

Step 3: If an alternative opinion is not offered, provide one

"I know that a lot of people completely disagree with that statement. Most men and women I know feel that the only person to blame for a rape is the rapist. Every individual has the responsibility to respect another person's right to say 'no.'"

Step 4: Offer facts that support a different point of view

"The facts are clear. The law states that every individual has a right to say no to sexual activity. Regardless of what a woman wears or does, she has a right not to be raped. The rapist is the only person to be blamed."

Note that even after the facilitator takes these four steps to address the difficult statement, it is unlikely that the participant will openly change his or her opinion. However, by challenging the statement, the facilitator has provided an alternative point of view that the participant will be more likely to consider and, it is hoped, adopt later.

Source

EngenderHealth. 2015. *Training on Gender and SRH: Facilitation Manual*. New York, NY: EngenderHealth; 123

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Chapter 6: Act like a woman/act like a man

Gendor 101 training materials

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Chapter 6: Act like a woman/act like a man

Learning objectives

By the end of this session, participants will be able to:

- Describe the differences between rules of behavior that society applies to women and men
- Discuss the impacts of social gender rules on the lives of women and men

Time needed

60 minutes

Materials needed

- Jamboard "Act Like a Man" and "Act Like a Woman" copies
  - One Jamboard per group
  - Template for "Act Like a Woman" groups
  - Template for "Act Like a Man" groups
- One blank Jamboard with two empty frames

Advance preparation

- Make one Jamboard copy per group. Remember that the templates will be different depending on whether groups are focusing on what it means to be a man or what it means to be a woman.
  - It is recommended that each Jamboard is labeled with a group number.
  - Prepare links to each Jamboard and have them available to easily copy and paste into the Zoom Chat. The format for the text that is copied and pasted should be as follows:
    - Group 1: [link to Jamboard]
    - Group 2: [link to Jamboard]
    - Group 3: [link to Jamboard]
    - Etc.
- Make one Jamboard with two empty frames (to be used to record participants' ideas during the two 10-minute group discussions following debriefs on the small group work)

Steps

Introduction (1 minutes)

Explain to participants that this activity is intended to deepen their understanding and awareness of the different social rules/expectations applied to women and men, the ways in which they may unwittingly perpetuate some of these rules/expectations, and the positive and harmful impacts of these rules/expectations on their lives.

Facilitator Note: This activity is a good way to understand perceptions of gender norms. Remember that these perceptions may also be affected by class, race, ethnicity, gender identity, sexual orientation, and other differences. It is also important to remember that gender norms are changing in many countries. It is getting easier in some places for women and men to step outside their "boxes."

Man box, woman box, and hegemonic masculinity and femininity (58 minutes)

1. Technology Action: As participants arrive, begin to create the breakout rooms for the activity. Each group should consist of individuals of the same gender. You will need to have one Jamboard per group, and it should say at the top either "Act Like a Man" or "Act like a Woman."
    - Groups of 4-5 (single-gender groups)
    - Check "Breakout rooms automatically close after"
        - 10 minutes
    - Check "Notify me when time is up"
    - Countdown after closing breakout room: 15 seconds

Facilitator Note: If participation numbers allow, the "Act Like a Woman" template should be used by all-female groups, and the "Act Like a Man" template should be used by all-male groups. If numbers do not allow, a single gender group can be asked to take on the role of the opposite gender and respond using the opposite-gender template. There should be at least one "Act Like a Woman" group and one "Act Like a Man" group. If there are enough participants for two groups of women and two groups of men, it can be interesting to have one group of women and one group of men complete each template, to compare the perceptions of the different genders.

2. Ask the male participants if they have ever been told to "act like a man." Ask for a few volunteers to share some experiences in which someone has said this or something similar to them. Ask:
    - Why did the person say this?
    - How did it make you feel?
3. Next, ask the female participants if they have ever been told to "act like a woman." Ask for a few volunteers to share some experiences in which someone has said this or something similar to them. Ask:
    - Why did the person say this?
    - How did it make you feel?
4. Tell participants that they will now spend some time looking more closely at these two phrases. Explain that by studying them, we can begin to see how society can make it difficult to be either female or male. (Spend no more than 5 minutes on steps 1–4.)
5. Explain that the group will now be divided into breakout rooms of 4 to 5 people. Each breakout room will include members of the same gender.
6. Explain that each group will be provided with a Jamboard on which to take notes. On their Jamboard, they should brainstorm ideas/examples of either what it means to "act like a man" or "act like a woman". Their Jamboard will indicate which gender they will review as a group.

7. **Technology Action:** Copy and paste into the chat links to each Jamboard. Jamboards should be clearly labeled Group 1, Group 2, etc. (see example below). Make sure that the linked Jamboards are distributed appropriately between all-male and all-female groups (see Facilitator Note above for more information on distributing "Act Like a Man" and "Act Like a Woman" among the groups).
    - Example:
        - Group 1: [Link to Jamboard]
        - Group 2: [Link to Jamboard]
        - Group 3: [Link to Jamboard]
8. Explain to participants that, as they are being moved to a breakout room, they will see on their screen to which numbered room they are being moved. Once they are in their breakout rooms, their room number will be at the top of the Zoom screen. Their breakout room number will represent their group number, and should be used to know which Jamboard to open.
9. **Technology Action:** Screen share a sample Jamboard, and demonstrate how to use the Jamboard as you explain the following.
10. Explain to participants how to use the Jamboard. Once they click on the link, they will be brought to a collaborative space (similar to a whiteboard), where they can add text, images, shapes, and sticky notes. For the purposes of this activity, they will be primarily using sticky notes. They should use **one sticky note** for each idea. To add a sticky note, hover over the white box with text that is accessible on the toolbar to the left side of the board. If you hover over it, it will say "Sticky note". Click the icon. On the window that opens, type your idea. Then click, "Save". Finally, click anywhere on the Jamboard (outside of the sticky note window) to close the sticky note window and continue manipulating the Jamboard.
11. Responses on the Jamboard will be anonymous as long as participants are not signed into a Google account.
12. Remind groups that they should select one person before coming back to the main room who will be the "spokesperson" for the small group. The spokesperson will present the Jamboard verbally to the rest of the larger group.
13. Remind participants that they should use the "Ask for Help" button once in their breakout room if they need help from a facilitator.
14. Ask if anyone has any clarifying questions before you move the group into breakout rooms. (Spend no more than 5 minutes on steps 5 to 14.)
15. **Technology Action:** Open the breakout rooms.
16. **Technology Action:** Open all Jamboards on your computer (each in its own tab). Watch each Jamboard. If you notice certain groups not adding any content to their Jamboard, join that group to see if they have any questions.
17. **Technology Action:** Send broadcast messages to remind the groups when they have 5 minutes, 3 minutes, and 1 minute left.
18. **Technology Action:** Close the breakout rooms after approximately 10 minutes.
19. **Technology Action:** Share your screen and show each group's Jamboard as they present.
20. Once each group has returned, invite the spokesperson from each group to talk about what they added to their Jamboard. Begin with an all-male "Act Like a Man" group. Follow with any other all-male "Act Like a Man" groups, asking if they have anything to add that has not been presented. If

there is an all-female “Act Like a Man” group, ask them to present next, and draw attention to any areas where the female group’s perceptions about acting like a man differ from the male group’s.

21. Once each “Act Like a Man” group has presented, explain that the lists that were constructed of the “male characteristics” constitute what can be referred to as the “man box” because the characteristics act as rules intended to confine men and boys to a specific definition of masculinity (Spend no more than 5 minutes on steps 19 to 21).
22. Next, facilitate a 10-minute discussion using the following questions and record some of the participants’ answers on a blank Jamboard frame:
    - What are the benefits to men and boys of living inside this box? What are the potential harms to men and boys?
    - In what ways could men’s and boys’ adherence to the rules of the “man box” impact the lives of women and girls?
    - Can men and boys live outside the box? Is it possible for them to challenge and change the rules?
    - What consequences do men and boys face in stepping out of the box?
    - When is it acceptable for men and boys to step out of the box?
23. Invite the spokesperson from an all-female “Act Like a Woman” group to present their Jamboard. Follow with any other all-female “Act Like a Woman” groups, asking if they have anything to add that has not been presented. If there is an all-male “Act Like a Woman” group, ask them to present next, and draw attention to any areas where the male group’s perceptions about acting like a woman differ from the female group’s.
24. **Technology Action:** Share your screen and show each group’s Jamboard as they present.
25. Once each “Act Like a Woman” group has presented, explain that the lists that were constructed of the “female characteristics” constitute what can be referred to as the “woman box”. (Spend no more than 5 minutes on steps 23 to 25).
26. Next, facilitate a 10-minute group discussion using the following questions and record some of the participants’ answers on a blank Jamboard frame:
    - What are the benefits to women and girls of living inside this box? What are the potential harms to women and girls?
    - In what ways could women’s and girls’ adherence to the rules of the “woman box” impact the lives of men and boys?
    - Can women and girls live outside the box? Is it possible for them to challenge and change these rules?
    - What consequences do women and girls face in stepping outside of the box?
    - When is it acceptable for women and girls to step outside the box?
27. Next, introduce the concepts of hegemonic masculinity and hegemonic femininity by explaining the following points (spend no more than 3 minutes on this step):
    - The characteristics listed in the “man box” and the “woman box” are forms of hegemonic masculinity and hegemonic femininity, respectively.
    - Hegemonic masculinity/femininity is the social pressure to conform to a singular predominant idea of “what it means to be a woman or a man” in one’s culture. Hegemonic masculinity and hegemonic femininity are valued more than other expressions of masculinity and femininity.

They are also often defined in opposition to one another; for men to remain dominant, women must be submissive and subordinate.

28. Before closing, allow participants 5–8 minutes to ask questions and/or make comments.

Closing (1 minute)

End the activity by stating that throughout their lives, men and women receive messages from family, media, and society about how they should act as men and women, and how they should relate to other men and women. As we have seen, many of these differences are constructed by society and are not part of our nature or biological makeup. Many of these expectations are completely fine and help us enjoy our identities as either a man or a woman. However, we all have the ability to identify unhealthy messages as well as the right to keep them from limiting our full potential as human beings. There are many ways to be a woman or a man. As we become more aware of the ways in which some gender stereotypes can negatively impact our lives and our communities, we can begin to think constructively about how to challenge them and promote more positive gender roles and relations. Therefore, we are all free to create our own "man box" and "woman box."

Sources

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- EngenderHealth. 2008. *Engaging Men and Boys in Gender Transformation: The Group Education Manual*. Session 1.3. New York, NY: EngenderHealth.
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Chapter 7: Gender determinants of health

Gendor 101 training materials

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Chapter 7: Gender determinants of health

Learning objectives

By the end of this session, participants will:

- Understand gender as it relates to health outcomes of women, men, and children
- Understand the impact of gender in relation to the health workforce

Time needed

53 minutes *(up to 63 minutes with optional adaptations)*

Materials needed

- PowerPoint: 14 Gender Determinants of Health

Advance preparation

1. Save a copy of the PowerPoint **"Chapter 7V_Gender Determinants of Health"** to your computer, and practice presenting the PowerPoint beforehand to ensure you have a good understanding of the various concepts.

Facilitator Note: This session assumes that participants have a basic understanding of gender concepts. Ideally, this session will come after **Gender Terms and Definitions**.

2. Review the **Optional Intro Activity** and **Optional Adaptation** and consider whether you would like to implement either option; review their advanced preparation for more information.

Steps

Introduction (1 minute)

Explain that in this session, participants will learn about the gender determinants of health. This PowerPoint provides a thorough introduction to how gender impacts health outcomes of women, men, and children. Explain that throughout the presentation, participants should be thinking about how the concepts introduced in this presentation relate to their work.

Optional Intro Activity
If you have a small group, additional time, and would like an activity to help jump start conversations about the topic, consider implementing the optional activity below.

Time Needed
10 minutes

Advanced Preparation

1. Log into your Mentimeter or Slido account *(note that a paid account is **not required**).* Add the following **ranking question** and answer choices.
   - Question type: Ranking
   - Question: Review each topic area below. Then, prioritize the topic areas in which you believe gender plays the most significant role in health outcomes.

- Answers:
  - Maternal mortality and morbidity
  - Maternal and child health
  - Women's status (including intra-household bargaining)
  - HIV and other sexually transmitted diseases
  - Family planning
  - GBV and unintended pregnancy
  - Malaria
  - Women in the global health workforce

Steps:

1. **Technology Action:** Share your screen, showing the Mentimeter/Slido poll prepared prior to the session.
2. Invite participants to respond to the poll using the QR code or numeric code. (Spend no more than 5 minutes on steps 1-2).
3. Facilitate a discussion (no more than 5 minutes) regarding why/how participants prioritized the different topic areas.

Facilitator Note: The upcoming presentation will ultimately reveal to participants how *each topic area* is affected by gender, including how gender affects outcomes. Recognize that some participants might try to explain why a specific topic area is not largely impacted by gender; you may need to play some light devil's advocate in those situations through prompting, reflective questions as a response to a particular participant's ideas. Transition to the "Gender determinants of health" presentation by explaining that, in fact, each of the topic areas is affected by gender, and the group will now spend the remainder of the session exploring how gender impacts outcomes in each topic area.

Gender determinants of health (30 minutes)

1. **Technology Action:** Screen share the PowerPoint on Gender Determinants of Health.
2. Refer to the discussion points included beneath each slide during the presentation.

Small group discussion (20 minutes)

1. **Technology Action:** At any point during the session, you may begin creating the breakout groups for the small group discussion.
   - Groups of 3 (randomly distributed participants)
   - Check "Breakout rooms automatically close after"
     - 9 minutes
   - Check "Notify me when time is up"
   - Countdown after closing breakout room: 30 seconds
2. Explain that participants will now be put into small groups to briefly discuss their reflections and take-aways from the presentation.
3. Explain that, in their small groups, participants will answer three questions, briefly summarized as "What? So What? Now What?" Each participant will respond to all 3 questions, and each participant will have up to 3 minutes to respond. If the group finishes early, they may take time to react or

respond to what another participant shared. Specifically, participants will respond to these three questions:

- What is the most important piece of information they gained?
- Why does that information matter?
- What are they going to change in their work as a result of this understanding?

4. **Technology Action:** Post the following into the Zoom Chat:
   - What is the most important piece of information they gained?
   - Why does that information matter?
   - What are they going to change in their work as a result of this understanding?
5. Invite participants to all spend one minute silently reflecting on the question now before you open the breakout rooms. Let participants know that you've shared the questions in the Zoom chat for reference. Pause one minute to let participants reflect on their answers to the questions.
6. Remind participants that they should use the "Ask for Help" button if they have a question for a facilitator while in their breakout rooms. Confirm that everyone understands the instructions. (Spend no more than 4 minutes on steps 2-5).
7. **Technology Action:** Open the breakout rooms.
8. **Technology Action:** Send a broadcast message when groups have 3 minutes and then 1 minute left.
9. **Technology Action:** Close the breakout rooms.
10. Facilitate a brief group discussion, asking if anyone would like to share what they discussed in their breakout rooms. Consider inviting all participants to share their "so what" in the Zoom chat, and read them out loud as participants post. (Spend no more than 7 minutes on this discussion).

Closing (2 minutes)

End the session by explaining that we've learned through this lesson the many ways in which gender influences health outcomes. Gender inequality is a barrier to the success of health programs, contributes to maternal mortality and morbidity, exacerbates poor maternal and child health, and contributes to early marriage and gender-based violence. Rigid norms around masculinity and stigma from failure to adhere to these norms contribute to men's morbidity and mortality related to HIV. Gender inequality also affects human resources for health in pre-service and in-service, and the health workforce. Women dominate in nursing and nonphysician medical roles, and are underrepresented in health management positions.

Optional Adaptation

*Consider the optional adaptation below **only if** you are working with a group of participants who are all from a single project and are consequently focusing on a single health area (e.g., Malaria) AND the participants already have some experience analyzing gender in their programming.*

Time Needed
60 minutes

Advanced Preparation

1. Create five copies of this Jamboard template, or one Jamboard per group (assuming 4-5 participants per group).

- Consider updating the language (i.e., “this topic area”) to reflect your topic of focus.
- Prepare a list of your Jamboards and their links to ensure you can easily copy and paste the information into the Zoom chat during the live session. Example:
  - Group 1: [link to Jamboard]
  - Group 2: [link to Jamboard]
  - Group 3: [link to Jamboard]
  - Group 4: [link to Jamboard]

Steps:

1. **Technology Action:** At any point during the session, you may begin creating the breakout groups for the small group discussion.
   - Groups of 4-5 (randomly distributed participants)
   - Check “Breakout rooms automatically close after”
     - 20 minutes
   - Check “Notify me when time is up”
   - Countdown after closing breakout room: 30 seconds
2. Explain that in this session, participants will learn about the gender determinants of health. Because all participants in this group work within a shared health area, that health area will be the focus of today’s conversation. Through small group work, and then a larger group discussion, participants will participate in a thorough introduction to how gender impacts health outcomes of women, men, and children.
3. Explain that participants will be put into groups of 4-5. In their small groups, participants will reflect on the following three questions:
   - What gender norms might impact and/or be present within [topic area]?
   - How does gender inequality affect health outcomes within [topic area]?
   - What are some of the resulting health outcomes?
4. Each group will have 20 minutes to discuss each question. Groups will take notes within a Jamboard, within which there is one frame for each of the questions.
5. **Technology Action:** Screen share a sample Jamboard and demo the activities below as you describe each.
6. Explain that participants should use the sticky notes to add ideas to their Jamboard. To add a sticky note, participants should click the small white box with text within the toolbar to the left of the screen; after typing their note, click “Save”, and then click out anywhere outside of the sticky note box to return to the main Jamboard.
7. Participants should respond to each of the three questions. To move between frames, participants should click the arrows at the top center of the screen (< >).
8. **Technology Action:** Copy and paste into the chat links to each Jamboard. Materials should be clearly labeled Group 1, Group 2, etc. (see example below).

- Example:
  - Group 1: [Link to Jamboard]
  - Group 2: [Link to Jamboard]
  - Group 3: [Link to Jamboard]
  - Group 4: [Link to Jamboard]

9. Explain that you have just shared links to the Jamboard on which groups will take notes in the chat. Explain that, as they are being moved to a breakout room, participants will see on their screen to which numbered room they are being moved. Once they are in their breakout rooms, their room number will appear at the top of the Zoom screen. Their breakout room number will represent their group number and should be used to know which Jamboard to open.
10. Let the group know that they will have 20 minutes to complete this task. Ask groups to take the last few minutes to elect a spokesperson who can share their group work with the larger group.
11. Make sure participants understand the instructions. Remind them that they should use the "Ask for Help" button if they have questions for a facilitator while in their breakout room. (Spend no more than 5 minutes on steps 1-11).
12. **Technology Action:** Open the breakout rooms.
13. Open each Jamboard on a different tab in your computer. Regularly review each Jamboard to ensure that at least one participant has opened the board and, eventually, that groups have added sticky notes/text. Join any groups where no one is on the document after 30-40 seconds, or where no sticky notes/text have been added a few minutes.

    Technology Note: Anonymous circles at the top right corner of the Jamboard will indicate whether or not participants have opened the document.

14. **Technology Action:** Send a broadcast message reminding participants when they have 5 minutes and 1 minute left. Additionally, remind groups to select a spokesperson.
15. **Technology Action:** After approximately 20 minutes, close the breakout rooms.
16. **Technology Action:** Screen share Group 1's Jamboard.
17. Ask the spokesperson from Group 1 to explain key elements of their discussion and Jamboard. The spokesperson should present for no more than 3 minutes.
18. Invite other participants to ask clarifying questions or share comments. (Spend no more than 2 minutes on questions/comments from other participants).
19. Repeat steps 16-18 for the remaining groups.
20. Use the talking points from the PowerPoint on Gender Determinants of Health to fill in gaps that participants have not already covered. *Note that this option does not otherwise require use of the PowerPoint.*
21. Facilitate a brief full group discussion (no more than 10 minutes) wrapping up key ideas from today's session using the following two questions:
    - Have gender norms been a challenge to your work?
    - What do you think you can do to address gender in your programs?

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Chapter 8: Gender equality continuum

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Chapter 8: Gender equality continuum

Learning objectives

By the end of this session, participants will be able to:

- Distinguish between gender-blind, gender-exploitative, gender-accommodating, and gender-transformative programs
- Describe the features of a gender-transformative program

Time needed

1 hour 30 minutes

Materials needed

- Four copies of this Jamboard template
  - See "Advanced preparation" below for additional notes about preparing Jamboard copies
- Participant Handout: Levels of the Gender Equality Continuum
- Facilitator Resource: Moving Toward Gender-Transformative Programming PowerPoint
- Facilitator Resource: Gender Equality Continuum Case Studies
- Facilitator Resource: Additional Gender Equality Continuum Case Studies by Technical Area
- Facilitator Resource: Gender Equality Continuum Case Studies—Answers
- Facilitator Resource: Additional Gender Equality Continuum Case Studies by Technical Area—Answers

Advance preparation

1. Email copies of the Participant Handout: Levels of the Gender Equality Continuum to participants.
2. Make one copy of the Jamboard template for each of the four groups.
   - Review the **Facilitator Resource: Gender Equality Continuum Case Studies** and select the case studies that are most relevant to your group.
   - Copy and paste one case study onto each frame of the four Jamboards (there are two frames per Jamboard, and there should be different case studies on each frame). You should replace the example case studies that are currently on the Jamboard frames.
   - As you are adding case studies to each Jamboard, make sure that *two of the groups* have *one case study in common* (all other case studies should be unique to each group). Additionally, each Jamboard should include case studies corresponding to two different categories of the gender equality continuum.
   - Label each Jamboard "Group 1", "Group 2", etc.
   - Prepare a list of your Jamboards and their links to ensure you can easily copy and paste the information into the Zoom chat during the live session. Example:
     - Group 1: [link to Jamboard]
     - Group 2: [link to Jamboard]

    - Group 3: [link to Jamboard]
    - Group 4: [link to Jamboard]
3. Save a copy of the **Moving Toward Gender-Transformative Programming PowerPoint** to your laptop and practice presenting before the session to ensure that you fully understand the various concepts.
4. Review the two options for facilitating a discussion around case study examples (see "The gender equality continuum") and decide which option you will implement during the session.
5. [If you will be implementing **Option 1: Zoom Annotations** below] You will use slides 17 and 20 of the **Moving Toward Gender-Transformative Programming PowerPoint** for the plenary exercise.
6. [If you will be implementing **Option 2: Zoom Polling** below] Log into Zoom.us and add the following poll to your Zoom meeting *(review the Technical Facilitator Guidance for more information on adding polls to a Zoom meeting).*
    - Question: Where would you place the case study along the Gender Continuum?
    - Answer Choices (single choice):
        - Blind
        - Exploitative
        - Accommodating
        - Transformative
7. [If you will be implementing **Option 1: Zoom Annotations** below] Check to ensure that Zoom annotations is enabled for your Zoom meetings. *(Review the Technical Facilitator Guidance for more information on enabling annotations).*

Steps

Introduction (5 minutes)

Facilitator note: The Facilitator Resource: Additional Gender Equality Continuum Case Studies by Technical Area includes case studies based on the following technical areas: agriculture; education; environment; family planning/reproductive health/HIV/gender-based violence (FP/RH/HIV/GBV); health policy; key populations; male health; maternal, newborn, and child health (MNCH); water, sanitation, and health (WASH); and youth. These scenarios are available for you to incorporate into the activity if you find them useful. The answers for these case studies can be found in the Facilitator Resource: Additional Gender Equality Continuum Case Studies by Technical Area—Answers.

1. **Technology Action:** At any point after participants arrive, you may begin to prepare breakout rooms for the "Applying the gender equality continuum" activity.
    - 4 groups (randomly distributed participants)
    - Check "Breakout rooms automatically close after"
        - 5 minutes
    - Check "Notify me when time is up"
    - Countdown after closing breakout room: 30 seconds

2. Explain to participants that they will spend some time exploring how gender can affect the outcome of a project by becoming familiar with a conceptual framework known as the *gender equality continuum*. The Interagency Gender Working Group (IGWG) designed the continuum as a guide to various projects on how to integrate gender. This framework categorizes projects/programs based on how they treat gender norms and inequities in their design, implementation, and monitoring and evaluation.

The gender equality continuum (25 minutes)

1. **Technology Action:** Screenshare the Moving Toward Gender-Transformative Programming PowerPoint
2. Use the facilitator discussion points under each slide to explain the various levels of the continuum. Present slides 1 through 14. (Spend no more than 15 minutes on this step).
3. When you get to slide 15, explain that the group will discuss two project examples. Ask for a participant to read the first example aloud.

> **Facilitator Note:** For steps 4-8, select from one of the following options. Consider with which option you are most comfortable, as well as which option will best engage your specific participants.

Option 1: Zoom Annotations

1. Next, explain that each participant will have an opportunity to share where they think the project falls along the continuum. Display a simple slide showing the gender equality continuum. Explain that participants will share where they think the case study falls by using Zoom's annotation feature.
2. Explain how to use Zoom's annotation feature using the following language:
3. "There are two steps required in order to access the Zoom annotation feature. First, find the green bar at the top of your screen that says 'You are viewing [name's] screen.' You may need to move your cursor in order to see this. Next to the green bar, it will say 'View Options'. Click on 'View Options'. Then click 'Annotate'. You will now be able to annotate on the screen. Everyone will be able to see what you write or add. We're going to use the 'Stamp' feature. Find where it says 'Stamp' near the top of your screen. Then, select the 'Star'. Now, you can click anywhere on the screen in order to add a star."
4. Ask everyone to stamp the section of the gender equality continuum where they would place the case study. Then, invite a few participants to share where they placed the case study and why. Finally, explain the answer and allow participants to ask questions. (Spend no more than 5 minutes on the first example). Clear the annotations from the screen by clicking the icon of a trashcan.
5. Repeat step 6 for the next example. (Spend no more than 5 minutes on the second example)
6. Before moving on to the next part of the activity, allow participants to ask any lingering questions. Remind participants that they can access the **Participant Handout: Levels of the Gender Equality Continuum** from their email after this session if they'd like to review anything discussed.

Option 2: Zoom Polling

1. Next, explain that each participant will have an opportunity to share where they think the project falls along the continuum.
2. **Technology Action:** Launch your Zoom poll. Give participants 30 to 45 seconds to respond, and then close the poll once all or most participants have responded. Share the results of the poll.

3. Invite a few participants to share how they responded and why. Finally, explain the answer and allow participants to ask questions. (Spend no more than 5 minutes on the first example)
4. Repeat steps 5 to 6 for the next example. (Spend no more than 5 minutes on the second example)

> **Technology Note:** You will be informed that "Re-launching the poll will clear existing polling results. Do you want to continue?" Select "Continue".
>
> If you would prefer to have all results of the poll saved, you may create two separate polls (one for each case study). Note that this will need to be completed prior to the start of the session.

5. Before moving on to the next part of the activity, allow participants to ask any lingering questions. Remind participants that they can access the **Participant Handout: Levels of the Gender Equality Continuum** from their email after this session if they'd like to review anything discussed.

Applying the gender equality continuum (55 minutes)

1. Tell participants that in the next part of the session they will have a chance to look at more program/project examples and place them along the continuum.
2. Explain that participants will be divided into four breakout groups, and that each breakout group will receive two case studies. The case studies will be written on a Jamboard; each case study will be on a separate frame.
3. **Technology Action:** Screen share a sample Jamboard to show the group as you explain the following.

   Each group will have 5 minutes to read their case studies and decide (as a group) where each of the examples fall along the continuum. Once the group has reached a consensus, one individual should drag and drop the star onto the correct spot along the continuum. Remind participants that some projects may not fit squarely under one category but may instead fall somewhere along the continuum. Remind participants that, to move to the next frame with the second case study, they should click the black arrow (>) at the top of the screen.

> **Technology Note:** If participants are having any problem moving their star icon, explain that participants should move their cursor over the star such that their cursor switches to an icon with four arrows (see image to right). This cursor will allow them to move the star.
>
> 

4. Explain that you will share in the chat links to each group's Jamboard. Explain that, as they are being moved to a breakout room, participants will see on their screen to which numbered room they are being moved. Once they are in their breakout rooms, their room number will appear at the top of the Zoom screen. Their breakout room number will represent their group number, and should thus be used to know which Jamboard to open.
5. **Technology Action:** Copy and paste into the chat links to each Jamboard. Jamboards should be clearly labeled Group 1, Group 2, etc. (see example below).
   - Example:
     - Group 1: [Link to Jamboard]
     - Group 2: [Link to Jamboard]
     - Group 3: [Link to Jamboard]
     - Group 4: [Link to Jamboard]

6. Make sure participants understand the instructions. Remind them that they should use the "Ask for Help" button if they have questions for a facilitator while in their breakout room. (Spend no more than 5 minutes on steps 1 to 7).
7. **Technology Action:** Open the breakout rooms.
8. **Technology Action:** Open each Jamboard on a different tab in your computer. Regularly review each Jamboard to ensure that at least one participant has opened the board and, eventually, that groups have dragged and dropped their star onto a location along the continuum. Join any groups where no one is on the Jamboard after 30-40 seconds, or where no star has been moved after 3-4 minutes.

> **Technology Note:** Anonymous circles at the top right corner of the Jamboard will indicate whether or not participants have opened the Jamboard.

9. **Technology Action:** Send a broadcast message reminding participants when they have 1 minute left. After approximately 5 minutes, close the breakout rooms.
10. **Technology Action:** Share your screen and show the first group's Jamboard.
11. Ask for a spokesperson from Group 1 to explain their group's work. Ask the representative to read the first case study assigned to their group, and then to explain why the group placed the example where they did. Next, ask the other workshop participants if they agree with the placement and if not, where they think it should go. Allow for some discussion and debate before offering the answer (refer to **Facilitator Resource: Gender Equality Continuum Case Studies—Answers**). Then, ask the same group representative to read the second case study assigned to their group, and follow the same process used for the group's first case study.
12. Repeat step 12 for the remaining case studies. (Spend no more than 4 minutes on each case study).

> **Facilitator note:** For the two groups that had one case study in common, after one of the groups has explained its placement, ask the other group if it placed the example in the same category and if not, why.
>
> **Facilitator note:** In most cases, there is no "correct" answer for these examples, as participants' interpretation of the project's intention or design will inevitably be influenced by their cultural/social realities. Encourage diversity in this exercise, letting people explain their placements and any assumptions they made to arrive at their decision.

Closing (5 minutes)

1. End the session by reminding participants of the following points:
    - Projects/programs will not necessarily fall neatly under one level of the continuum. For example, a project/program may include both accommodating and transformative elements.
    - Although the continuum focuses on gender integration in the design phase, it can also be used to monitor and evaluate gender and health outcomes with the understanding that sometimes programs lead to unintended consequences. For example, an accommodating approach may contribute to a transformative outcome even if that was not the intended objective; conversely, a transformative approach may produce a reaction that, at least temporarily, exacerbates gender inequities.
    - Projects/programs must follow two gender-integration principles:
        - Under no circumstances should programs/policies adopt an exploitative approach since one of the fundamental principles of development is to "do no harm."

- The overall objective of gender integration is to move toward gender-transformative programs/policies, thus gradually challenging existing gender inequities and promoting positive changes in gender roles, norms, and power dynamics.

Sources

- Population Reference Bureau. 2009. A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action, 2nd ed. Washington, DC: Population Reference Bureau; 9–17.
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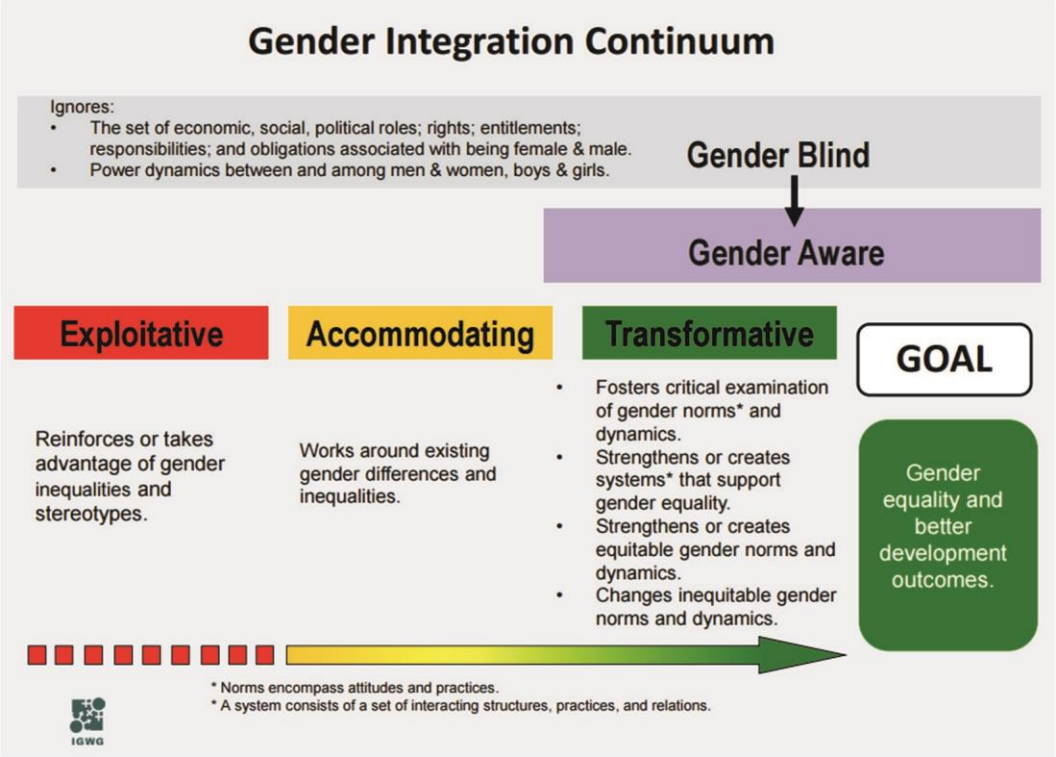
Participant handout: Levels of the gender equality continuum



Source: IGWG, https:/www.igwg.org/about-igwg

The graphic depicts a specific program environment. The gender equality continuum is a tool for designers and implementers to use in planning how to integrate gender into their programs.

- **Gender-blind** programs do not consider the gender norms that characterize the social environment and the ways in which they might affect program/project participants. Gender-blind programs/policies do not consider how gender norms and unequal power relations affect the achievement of project objectives, or how the project objectives might impact gender norms and unequal power relationships.
- **Gender-aware** programs are designed to take advantage of existing gender norms and power relations, accommodate them, or transform them. Programs may have multiple components that fall at various points along the continuum. The ultimate goal of development programs is to achieve health outcomes while transforming gender norms to achieve greater equality between women and men. The part of the arrow related to "transformative" is green to signal that it is okay to proceed. It then extends indefinitely toward greater equality (beyond the arrow). Gender-aware programs can be categorized as:
    - Gender exploitative (taking advantage of existing harmful gender norms)
    - Gender accommodating (working around harmful gender norms without striving to challenge or change them), or
    - Gender transformative (actively addressing harmful gender norms and working to change them).
- **Gender-exploitative** programs (on the left of the continuum) take advantage of rigid gender norms and existing power imbalances to achieve their objectives. Although using a gender-exploitative approach may seem expeditious in the short run, it is unlikely to contribute to sustainable results

and can, in the long run, result in harmful consequences and undermine the program's intended objective. Under no circumstances should programs take advantage of existing gender inequalities in pursuit of health outcomes ("Do no harm!").

- **Gender-accommodating** programs (in the middle of the continuum) acknowledge the role of gender norms and inequities and seek to develop actions that adjust to and often compensate for them. Although such projects do not actively seek to change these norms and inequities, they strive to limit their harmful impacts on gender relations. A gender-accommodating program may be considered a missed opportunity because it does not deliberately contribute to increased gender equity, nor does it address the underlying social, political, and economic factors that perpetuate gender inequities. However, in social and cultural contexts where gender norms remain a highly sensitive issue, gender-accommodating approaches often provide a sensible first step to gender integration because they strive to ensure that all project participants can equally benefit from the project's efforts. As unequal power relations and harmful gender norms are recognized and addressed through programs, a gradual shift toward challenging gender inequities may take place.
- **Gender-transformative** programs (at the right end of the continuum) actively strive to examine, question, and change harmful gender norms and power imbalances between women and men as a means of achieving positive health outcomes as well as gender equity. Gender-transformative approaches encourage critical awareness among men and women of gender roles and norms; promote women's social, economic, and political positioning; challenge the unequal distribution of resources and allocation of duties between women and men; and/or address the power relationships between women and others in the community, such as service providers and traditional leaders.

The gender-equality continuum, in brief:

- Blind: Projects that do not take gender into account at all.
- Aware: Projects that acknowledge the role of gender norms and develop actions to adjust to them rather than challenge and transform them.
- Exploitative: Projects that reinforce or take advantage of gender inequalities.
- Accommodating: Projects that work around existing gender norms and inequalities and do not seek to challenge or change them.
- Transformative: Projects that seek to transform gender norms to achieve positive health outcomes and gender equality.

Facilitator resource: Gender equality continuum case studies

Case study 1: Strengthening PLHIV networks in the Asia-Pacific region

A project in the Asia-Pacific region sought to strengthen the organizational capacity of networks for people living with HIV (PLHIV). To help foster organizational development, the project supported the development of a detailed, user-friendly manual with concrete step-by-step guidance on how to carry out a self-assessment of organizational strengths and weaknesses, with resource materials and activities to strengthen areas identified as challenges. PLHIV regional network members led development of the manual and serve as a technical assistance resource to country-level organizations as they seek to implement network strengthening**.** Women members of the PLHIV networks complained that the manual did not take into account the special needs of women living with HIV.

Case study 2: Preventing malaria in Nigeria

A malaria prevention program in Nigeria sought to increase the use of bed nets in a poor, rural area. Due to budget constraints, the program was only able to provide one net per family. Community health workers emphasized the dangers of malaria during pregnancy and encouraged families to prioritize pregnant mothers to use the nets. However, because men are the main breadwinners in many Nigerian families, the families agreed to prioritize male heads of household and sons to sleep under the nets to ensure that they would not miss work or forego crucial earnings due to being sick with malaria.

Case study 3: Female condom promotion in South Africa

A pilot program was designed to increase the acceptability and use of female condoms in South Africa. Historically, female condoms were promoted to women. The program designed its strategies around findings from preliminary research that showed that men's interest in any contraceptive method was likely to be based on maintaining control over their partners' sexuality. Program strategies were also based on evidence that men are preponderantly concerned with retaining control over the means of protection against HIV and sexually transmitted infections. The program therefore decided to promote the female condom to men through male peer promoters. This involved: (1) demonstrating to men the use of the female condom; (2) explaining to men that self-protection and sexual pleasure are compatible with the use of the female condom, especially when compared to currently available barrier alternatives; and (3) giving female condoms to the men to use with their female partners.

Case study 4: Condom social marketing in Guatemala

The goal of a condom social marketing campaign in Guatemala was to increase condom sales for HIV, sexually transmitted infections, and pregnancy prevention. The campaign capitalized on social and cultural values that focus on male virility, sexual conquest, and control. It depicted macho men having multiple female sex partners, with slogans referencing different color condoms and saying on Monday it's yellow for Yolanda, on Tuesday it's red for Ruby, on Wednesday it's blue for Beatriz, etc.

Case study 5: Female genital cutting prevention program in Kenya

A female genital cutting (FGC) intervention in Kenya sought to reduce the incidence of harmful cutting. Project staff realized that creating a law to prohibit the practice would not address the cultural and social motivations of the community, and would likely result in driving the practice "underground." Instead, the project hired a medical anthropologist to work with the community.
Through qualitative interviews with groups of women, men, and religious leaders, the project sought to understand the meaning and functions that the ritual provides to the community. They determined that the ritual is a rite of passage for girls to enter adulthood. Together with community members, the project staff adapted the FGC ritual by eliminating the harmful cutting but keeping the "healthy" cultural

elements, such as seclusion of girls, dance, storytelling, gift giving, health, hygiene, and sexual education, emphasizing a woman's role with her partner. As a result, a new rite-of-passage ritual was created for girls called "circumcision with words," which has become accepted by the entire community.

Case study 6: Gender-based violence prevention in Burundi

A community-based outreach program in Burundi sought to reduce gender-based violence (GBV) and its resulting health complications, including HIV. Recognizing that adolescent girls and young women are at particular risk of experiencing GBV, the program planners used a peer-based prevention model to empower young women and adolescent girls to protect themselves from GBV. It focused on educating participants about the prevalence and health consequences of GBV, as well as their right to live free of violence. Some topics included safety planning for women whose male partners are violent, peaceful conflict-resolution skills, and where to seek GBV services for physical, sexual, emotional, and financial abuse.

Case study 7: Sexual enrichment for married couples in Mozambique

An HIV prevention project in Mozambique sought to promote safer sex among married couples by tackling one of the reasons that husbands were having sex outside of their marriages: they were bored with their sex lives at home. Preliminary research showed that men justified extra-marital sex by complaining that their wives would not agree to sexual experimentation, especially with regard to sex positions. Women, on the other hand, reported that, "I am never asked what I like in sex, if I like sex, and if I even want sex, so why should I do anything that gives him pleasure?" To transform these gendered expectations that pose as challenges, the project promoted greater dialogue among couples about their sexual desires. The project successfully advocated with local temples and mosques by explaining to religiously affiliated participants the importance of talking more openly about sex and helping them understand that open dialogue among married couples about sex and pleasure is not a threat to culture, religion, or people's sensibilities. Religious leaders supported the project, teaching couples about better sex by getting women and men to talk openly about what they like and do not like about sex in group and couple settings.

Case study 8: Mass media to reach youth on reproductive health in Nicaragua

A Nicaraguan nongovernmental organization produced a popular TV soap opera (*telenovela*) to introduce a range of social and health issues (e.g., pregnancy, HIV prevention, gender-based violence, and discrimination against the physically disabled) into public debate. Since the soap opera was particularly popular with youth, it presented the opportunity to address and challenge traditional gender roles. One storyline followed a young couple as they fell in love, and through their discussions about intimacy, contraception, and sexually transmitted infections. The male character in the couple was sensitive and caring toward his female partner, and they engaged in open communication about sexuality and family planning. In another episode, the young woman was raped. The telenovela then dealt with the aftermath of sexual violence, including women's legal rights in Nicaragua, and the effect of rape on intimacy.

Case study 9: Tackling gender barriers to keep midwives in school in Ethiopia

In Ethiopia, gender inequalities result in low participation and success of women in education. The few women that join higher education institutions generally have lower academic performance and higher forced withdrawal than men. Gender barriers include poor academic performance, pregnancy, adjustment challenges, lack of orientation, low self-confidence, and financial constraints.

Jhpiego, through the USAID-funded Strengthening Human Resources for Health Project, implemented a project to reduce gender disparities in midwifery pre-service education. The project has supported health education institutions to establish gender offices, trained gender counselors to conduct life skills training for female students, provided orientation and academic counseling services to female students, and supported female students to adapt to college life. The project also supported gender offices to recognize high-performing female students, establish sexual harassment policies, and provide scholarships to female students in need. The gender offices have also served as a space where female students receive mentorship and social/financial support, thereby minimizing dropout rates and improving academic performance. For example, female students receive counseling so they do not leave school when they get pregnant.

Case study 10: Community-based delivery of long-acting methods of contraception in Ethiopia

The ministry of health (MoH) in Ethiopia wants to address the unmet need for contraception by expanding access to long-acting methods, including the implant (Implanon/Jadelle). To meet this need, the MoH is training community health extension workers, who already go door-to-door addressing a range of health issues (for example, water and sanitation, HIV, immunization, and family planning) to offer Implanon. Community health workers are being trained to provide information on Implanon (as part of their family planning counseling), screen women for medical eligibility criteria, and provide Implanon (in addition to condoms and contraceptive pills).

Case study 11: HIV/AIDS prevention in Thailand

This HIV/AIDS prevention project provided education, negotiation skills, and free condoms to commercial sex workers (CSWs) in Thailand. Although knowledge and skills among CSWs increased, actual condom use remained low. After further discussions with the CSWs, project managers realized that CSWs weren't successful in using condoms because they did not have the power to insist on condom use with their clients. The project then shifted its approach and enlisted brothel owners as proponents of a "100% condom -use policy." Brothel owners, who did have power and authority, were able to insist that all clients use condoms. Since the vast majority of brothels in the project region participated in the project, it resulted in significant increases in safe- sex practices.

Case Study 12: Social marketing campaign in Tanzania

A social marketing campaign in Tanzania had a similar goal: to increase condom sales. Project designers realized that in Tanzania, only a small percentage of condom sales were to women. Training indicated that women were having a hard time initiating condom use. Therefore, one of its posters explicitly showed a woman at a bar talking to a male partner and insisting that he use a condom.

Case Study 13: Supply chain system in Country X

Recognizing that contraceptive stock-outs are a significant problem in delivering high-quality and reliable services, the ministry of health (MoH) in Country X redoubled its efforts to improve its supply chain system. This involved a thorough assessment to better quantify and forecast commodity needs at the central, regional, and service delivery point (SDP) levels. An electronic Logistics Management and Information System (eLMIS) was developed to capture more detailed information about the procurement, shipping, and issuing of commodities. The MoH agreed to hire more supply chain staff, and additional training was provided to all personnel in order to roll out the new system. But the MoH did not consider gender factors affecting staff training— for example, rolling out the training without checking current composition of staff, and which times, locations, and format are optimal depending on the sex/gender make up of their eLMIS staff. There was no gender analysis of demand for commodities and patterns of stock-outs (for example, are emergency contraceptive or other methods that women can use clandestinely readily available).

Facilitator resource: Additional gender equality continuum case studies by technical area

Family planning/reproductive health/HIV/gender-based violence (FP/RH/HIV/GBV)

FP/RH/HIV/GBV scenario #1

Staff in an HIV clinic in Chile carried out a situational assessment to better understand the reproductive health priorities of HIV-positive women at their clinic. One of the primary issues HIV-positive women expressed was their desire to control their fertility so they could choose whether and when they wanted to become pregnant. However, women reported that a major barrier continues to be the ability to use condoms or other forms of birth control that might be discovered by their partners, as many of their partners are opposed to both. Male partners may even take the suggestion of using such methods as a sign of infidelity and grounds to beat a woman, they said. Based on the information they collected, clinic staff decided to offer only Depo-Provera shots (longer-acting injectables) to all women, and de-emphasize (and reduce their supplies of) any other types of sexually transmitted infection (STI) or pregnancy-prevention methods.

FP/RH/HIV/GBV scenario #2

In rural Egypt, women tend to follow strict cultural rules related to modesty and seclusion that substantially restrict their physical mobility outside the home. This, coupled with limited control over resources and decision-making, has affected women's ability to access family planning services. To address these challenges, the local health district trained female community health workers to bring reproductive health services to women's doorsteps. These health workers visit women in their homes, providing counseling, information, and access to certain methods of contraception.

FP/RH/HIV/GBV scenario #3

A community-based intervention in South Africa combined a microfinance program with a gender and HIV curriculum. Its goals were to reduce HIV vulnerability and gender-based violence (GBV), promote women's empowerment, improve family well-being, and raise awareness about HIV. In the project, groups of five women guaranteed each other's loans, meeting every two weeks to discuss business plans, repay loans, and apply for additional credit. In addition, the groups took part in a participatory learning and action program with sessions on relationships, communication, cultural beliefs, GBV, HIV prevention, critical thinking, and leadership. The microfinance groups elected leaders to participate in additional training on community mobilization. These leaders went on to organize dozens of community events to raise awareness on GBV and HIV.

FP/RH/HIV/GBV scenario #4

In Country Q and elsewhere, family planning clinics will offer female clients a choice of "hidden" contraceptive methods, such as Depo-Provera shots, Norplant, or an IUD, if the woman expresses fear that her husband does not support her use of contraception even though she expresses her desire to limit or space births. Some women may fear violence if their partner finds oral contraceptive pills in the house or if they suggest use of a condom. Clinicians will assure women that the IUD and Norplant are basically invisible, and that their partner is unlikely to realize that they are receiving Depo-Provera shots at well baby clinic visits.

FP/RH/HIV/GBV scenario #5

During regular business hours, public sector family planning clinics in urban Uganda are often busy, with many clients congregating and waiting to be seen by providers. To take advantage of this captive

audience, a clinic developed short videos that run on a continuous loop, providing details about available contraceptive methods. The information shared includes basic details on how the methods are administered, their health advantages, and possible side effects.

Health policy

Health policy scenario #1

A local council and an NGO teamed up to build a public library in a mid-size, highly dispersed town with a third of its population living in nearby neighborhoods not easily accessible by local transport. From the outset, the library aimed to work with young people—both males and females—as part of the community's efforts to improve secondary education. After great deliberation and effort, a local philanthropist living abroad agreed to donate land at the lively center of town, facing the local cafes and billiard halls that attract young and middle-aged men. A stipulation of the donation was that the philanthropist's male cousin, an expert librarian, would manage the library. The library charged a small annual membership fee, limited the number of borrowed books to three at a time, and required that the books be returned or renewed after 1 week. After young women visiting the library complained they were being harassed by the men smoking and playing billiards across the street, the librarian opened a new rear entrance for women and designated a section of the library for women's use only.

Health policy scenario #2

A study found that a requirement for overseas training for medical career progression created an obstacle for female doctors who were not able to leave husbands and family at that period in their lives. In the survey, female doctors described an assumption in the upper ranks of the medical establishment that women did not want, or were not able, to advance their careers because of family responsibilities, which resulted in pervasive discrimination against women in promotions and scholarship awards for overseas study. The study found that nearly half of the graduates were not taking postgraduate training, mainly because of the pressures of family responsibilities. These graduates also believed they were discriminated against through common stereotypes of female doctors as "inefficient" and lacking motivation because they were more likely to work part-time or take career breaks. The study also identified that adequate housing and security were the primary concerns for women doctors moving to rural areas, not salary incentives. Ultimately, female graduates had a high "rate of exit" from medicine.

Health policy scenario #3

Seclusion of girls and women is considered a sign of female respectability; respectability also requires that women travel in the company of a male family member. At the same time, women serve as community-level paramedical staff, in recognition of their frequently greater acceptability to local clients and their ties to the community. Anecdotal evidence suggests that the cultural expectation of female respectability constrains the full range of community outreach activities and supervisory performance expected from trained community midwives. For example, female supervisors are required to return home before nightfall. Recently, the government enacted directive measures to address the problems of getting health staff to work in rural areas. In the face of cultural difficulties in recruiting women, they established a system of compulsory health service for women.

Health policy scenario #4

In Country Q, community-based NGOs sought to gain inheritance and property rights for women. To do so, these groups conducted an analysis to identify which processes—at the level of cultural norms, implementation and decision-making structures, and written laws— presented barriers to women

accessing their rights, and developed an advocacy strategy based on this analysis. In particular, the analysis identified key barriers such as cultural norms that "women who love don't talk about money and property" and structural barriers where local land boards were physically far from women and also institutionally unfriendly (very male dominated). The advocacy strategy thus decided to focus on lobbying traditional decision-making structures led by traditional male authorities, such as councils of elders, to increase their awareness and support for women's property rights, and have them in turn issue decrees to support women's rights and raise the issue of women's inheritance and property rights with local land boards. In the first 6 months after the advocacy was initiated, 20 women were able to reclaim their property.

Health policy scenario #5

A project in Region Q sought to strengthen the organizational capacity of networks for people living with HIV (PLHIV). To help foster organizational development, the project supported the construction of a detailed, user-friendly manual with concrete step-by-step guidance on how to carry out a self-assessment of organizational strengths and weaknesses, and resource materials and activities to strengthen areas identified as challenges. PLHIV regional network members led development of the manual, and serve as a technical assistance resource to country-level organizations as they seek to strengthen networks of PLHIV.

Health policy scenario #6

Health Workers for Change addresses gender biases in health workers' personal, organizational, and professional lives through reflective- and action-oriented training using participatory methods developed under the leadership of the Women's Health Project in Country Q. These courses address gender relations as well as race, class, and other axes of discrimination. Health workers go through a process of value clarification and self-reflection about how their organization and work mirrors their society more broadly. They are encouraged to put themselves in the shoes of others and thus develop empathy for the role of other actors in the health system. Actions devised through the training arise from analyzing health workers' own context and experience base. Within their organizations, health workers that participated in the program were able to make changes within their direct power and influence, but were not able to make wide-ranging institutional changes that were much more difficult to implement.

Health policy scenario #7

In Country Q, a community health worker program relied exclusively on female staff members in ways that reinforced the beliefs that only women can provide maternal health advice. The program also failed to challenge prevailing beliefs that excused men from taking responsibility for childcare, failed to sanction forms of male sexuality that increased sexually transmitted infection risk among their wives, and failed to question norms around domestic violence that inhibited women from talking to male health workers in their homes.

Health policy scenario #8

A program in Country Q provided support to community-based female health workers. They were allowed to assume broader roles than the simple health care tasks they were originally charged with and thus became trusted confidants and respected advocates for their fellow community members. Their work was explicitly and frequently recognized by professional health care workers and strengthened by the formation of their own peer support group. Functioning referral systems supported them. They were

acknowledged by their communities of origin. Managers were sympathetic to their concerns and responded by listening and providing infrastructural support when possible. Lastly, these workers received continuous training and regular supervision. The strategic support the female communitybased workers received greatly sustained their work and permitted the flexibility to adapt their work to suit community needs.

Health policy scenario #9

In Country Q, female community-based volunteers were very successful in making contraceptive methods widely available throughout the country. Although their work was highly regarded by village leaders as well as the general population, it was perceived as an extension of their roles as caregivers. Women's work as family planning volunteers did not significantly increase their decision-making roles within their households or access to education or paid work.

Health policy scenario #10

In Country Q, a new strategy sought to reform traditional gender norms that constrained health workers' efforts in service delivery and assuming tasks for which they were trained, but were prevented from performing by doctors. The strategy entailed subtly redefining the meaning of *purdah* (seclusion) for female staff and the communities in which they worked. *Purdah* was reinterpreted as:

"An emphasis on the external and physical criteria of seclusion to an internalized, moral code of conduct. Observance of inner purdah does not require physical seclusion; rather it manifests itself through politeness in interpersonal behavior, religious orthodoxy, modesty in dress and language, and, above all, through strictly professional behavior and attitudes toward men. As long as this moral code of conduct is followed, the health workers argued, purdah was not broken."

After gaining the initial approval of village elites, female health workers were able to expand their duties to include providing medicines and injections. Gradually, they became known as "little doctors" linked to "big doctors" through effective referral systems. When male senior staff visited their female colleagues for supervision in the field, they treated them with respect rather than reprimanding them in public. Over time, female health workers assumed increasingly influential and respected roles in the villages where they worked, often giving advice to villagers regarding important decisions or resolving local disputes.

Key populations

Key populations scenario #1

Project managers in Country Q have seen an uptick in arrests of men who have sex with men (MSM) in public spaces. In response, they prepare personal safety workshops for MSM. In the workshops, the facilitators tell the MSM participants, "If you're worried about your safety, try being less 'obvious,'" and they ask participants to come up with strategies to look and act more masculine.

Key populations scenario #2

A project in Country Q develops support groups for transgender people to talk about the violence they face. Through partners, the project offers gender-affirming services (such as hormone therapy) as well as HIV prevention, care, and treatment. It also provides referrals and accompaniment to legal assistance for individuals who have been discriminated against or have experienced violence.

Key populations scenario #3

A program that provides HIV services to female sex workers in drop-in centers recently launched an outreach campaign with the message that "sex workers take care of themselves because they are the backbone of their families and communities." The drop-in center provides space for the children of sex workers, and the first question on the new client form is, "What services do your children need?"

Key populations scenario #4

A program to support people who inject drugs (PWID) offers clean needles, HIV testing, and condoms to PWID. Its outreach workers are all men, as a situation analysis showed that 95% of PWID are men. Outreach workers wear shirts with an image of two men running across a finish line and a message that says, "You are a valuable member of society."

Key populations scenario #5

Men who have sex with men (MSM) face such severe stigma and discrimination in health settings that they find it difficult to access sexual health services, including sexually transmitted infection (STI) and HIV counseling, testing, and treatment. An organization working on HIV prevention and mitigation established a pilot program to work with MSM. The group focused on *kothis*—biological males who adopt feminine behaviors and attributes, including normatively feminine sexual roles. The project established a place where they could meet and support one another, providing information on health care and other resources, training local health care providers on how to provide services to *kothis* in a sensitive manner, and organizing medical visits at the meeting space itself. In focusing on *kothis*, staff decided not to work with penetrators, whose numbers are much larger and who do not publicly acknowledge having sex with men. They also decided to focus only on commercial sex workers and on sexual activity occurring in public spaces.

Male health

Male health scenario #1

To increase contraceptive use and male involvement, a family planning project initiated a communication campaign promoting the importance of men's participation in family planning decisionmaking. Messages relied on sports images and metaphors, such as "Play the game right. Once you are in control, it's easy to be a winner" and "It is your choice." The campaign increased the use of contraceptive methods. When evaluating impact, the project asked male respondents who should ideally be responsible for making family planning decisions—them, their partners, or both members of the couple. The evaluation found that, "Whereas men were far more likely to believe that they should take an active role in family planning matters after the campaign, they did not necessarily accept the concepts of joint decision-making. Men apparently misinterpreted the campaign messages to mean that family planning decisions should be made by men alone."

Male health scenario #2

A reproductive health project in an indigenous community wanted to encourage men to become involved in family planning and be more supportive of their wife's or partner's choices. Gender-based violence is an issue in this community, and women sometimes fear that their use of contraception will result in their partner becoming violent toward them. Project planners were also concerned about increasing rates of sexually transmitted infections (STIs) in the area, as the men have been migrating to a nearby mining town for work, returning with infections, and spreading them to their partners in the village.

The project introduced a pilot effort to address these issues. It offered an STI clinic one day each week for men in the local women's clinic. Some of the project designers thought that by bringing men into the women's clinic for services, they would become more comfortable in the clinic, start to feel a sense of belonging, and so be more likely to accompany their partners to the clinic for services, where they could be brought into discussions on family planning, safe motherhood, domestic violence, and other related issues.

Male health scenario #3

A participatory group intervention was piloted in Mumbai with young men ages 16 to 24. Data indicate that almost half of new HIV infections in India occur in young men under age 30. Other data suggest that most boys are socialized into a sense of masculinity characterized by male dominance in sexual and other relationships, and that these norms may promote poor sexual health and risk-taking for young men and their partners. Adapting an intervention (Program H) from Brazil, a behavior change intervention sought to stimulate critical thinking about gender norms. Exposure to the program resulted in a decline in reported violence against any sexual partner and increased condom use. A social marketing campaign is also under way, with the tag line, "Real men have the right attitude."

Maternal, newborn, and child health (MNCH)

MNCH scenario #1

To decrease markedly high rates of maternal mortality in Country Q, a US-based organization initiated a project to reduce disease and death associated with postpartum hemorrhage, particularly among young mothers. The project included community-level interventions to raise awareness among traditional birth attendants, young women, and mothers-in-law about the markers for postpartum hemorrhaging that should trigger an emergency response. During the project's midterm evaluation, community members reported that recognizing the warning signs of distress was not enough to prompt action for mothers who delivered at home. The decision to seek medical care for a new mother in distress was influenced by many factors, including the availability of household resources, the power distribution in the household, and the relative status of the new mother in the household vis-à-vis her in-laws.

The organization subsequently amended the project to establish a community fund to cover the costs of emergency transportation for women experiencing postpartum hemorrhage and other forms of distress.

MNCH scenario #2

In Country Q, a donor project works to strengthen and create more efficient systems, structures, and interventions to reduce maternal mortality in three rural communities. Project interventions focus on the four major causes of maternal mortality and address conditions that lead women to delay seeking lifesaving treatment for emergency obstetric complications. The project trains facility- and community based health workers, including traditional birth attendants, in improved maternal health care practices. One of the interventions includes sensitizing male traditional village leaders in this Muslim region, in recognition of their influence over community norms and behaviors. The leaders are encouraged to promote quick action from household members and neighbors when someone suspects that a laboring woman is having emergency obstetric complications, emphasizing that the baby's life may be at stake.

MNCH scenario #3

A child survival project in Country Q, aiming to reduce disease and death rates among children and women of reproductive age, focused on using indigenous knowledge and cultural resources to increase and improve communication and health-seeking behavior during pregnancy. Research showed that one of the most important obstacles to women's maternal health care-seeking behaviors was the absence of discussion about pregnancy between husbands and wives, as well as with other household members. The women in this area felt that they could not take advantage of maternal services because they could not initiate conversations with their husbands or solicit their consent and financial support as the heads of household. The project staff asked a *griot* to compose a song to educate people about maternal health care, along with promoting the *pendelu* (a traditional article of women's clothing) as a symbol of pregnancy and couple communication. This campaign dramatically increased the level of communication between wives and husbands concerning maternal health. Additionally, the campaign resulted in more positive attitudes and behaviors related to pregnancy at the household level, including husbands supporting their wives by reducing their workloads, improving their nutrition, and urging them to seek medical attention and maternal health services.

MNCH scenario #4

A group of HIV-positive mothers of small children organized to become advocates for prevention of mother-to-child transmission of HIV (PMTCT) and for HIV-positive mothers. The group encourages women to attend prenatal clinics, where they can access PMTCT services if they are HIV-positive. The group also educates HIV-positive mothers in their communities in life skills, PMTCT, infant care, and human rights. They use song, dance, and drama, as well as appearances on television and radio, where

they share their experiences as HIV-positive mothers and call for a reduction in stigma and discrimination. The peer educators also increase women's access to income by training HIV-positive mothers in personal financial management and income generation by tailoring, farming, and selling handicrafts. Finally, the group partners with HIV-positive men's networks to encourage men to value fatherhood and to become involved in PMTCT.

MNCH scenario #5

The Government of India began integrating HIV into the National Rural Health Mission in April 2008. The government issued a circular to district reproductive and child health (RCH) officers asking whether they were willing to work on HIV and to report cases of HIV-positive women who came for antenatal care (ANC). One intervention developed subsequently is working to improve ANC quality for HIV-positive women by addressing gender and quality of care issues —for example, special spousal counseling exists for women in ANC who test positive for HIV. The husband is encouraged to come in for a variety of tests, and the program reports his HIV status to him first. They also put HIV-positive women in contact with a lawyers' network and NGOs in the area working with people living with HIV. The program also introduces the woman and the health care worker to the obstetrician who will attend her labor and birth. This doctor gives the woman her fourth and extra ANC checkup in the third trimester and registers her name on the books to receive Nevirapine prophylaxis when she goes into labor to prevent mother-to -child transmission.

MNCH scenario #6

A multipronged program to improve maternal and child health in several Delhi slums works on diarrheal case management, increasing institutional births, and increasing immunization, among other things. The program conducts community outreach through the formation of women's groups focused on health, and has also provided some limited access to credit. Although the program targets women of reproductive age and children, it also reaches out to men as decision-makers. The program runs local TV ads for services, encouraging men to support their partners in taking children for prevention and treatment, and directing messages at men and women. The program reaches out to religious leaders and men at mosques on the need to take their wives for services.

Water, sanitation, and health (WASH)

WASH scenario #1

Government data showed high incidence rates of diarrhea and other intestinal infections among schoolaged children in several rural provinces in the country. In response to this public health problem, and in an effort to increase the number of days children spend in the classroom (and decrease the number they spend at home being sick), several communities were selected for a behavior change campaign. The campaign aimed to raise awareness of handwashing as a highly effective means of reducing such illnesses and introduced a simple protocol for handwashing by all household members. The campaign targeted women with messages encouraging them to be "good mothers" and "take proper care of their families" by strictly enforcing the handwashing protocol for everyone in their homes. Some messages implied that if a child is sick, it means the mother is not "doing her job well." Follow-up studies showed the messages were effective, with a high rate of adoption of the new handwashing protocol and a subsequent reduction in intestinal diseases among school-age children.

WASH scenario #2

The Central American Hand Washing Institute aimed to reduce disease and death among children under age 5 through a communication campaign promoting proper handwashing with soap to prevent diarrheal disease. Four soap companies launched handwashing promotion campaigns that included radio and television advertisements; posters and fliers; school, municipal, and health center programs; distribution of soap samples; promotional events; and print advertisements. The basic approach was to present a mother as the caretaker of the family and to describe or illustrate the three critical times for handwashing: before cooking or preparing food; before feeding a child or eating; and after defecation, cleaning a baby, or changing a diaper. The promotion also emphasized essential aspects of handwashing technique: use water and soap, rub one's hands together at least three times, and dry hands hygienically.

WASH scenario #3

A WASH program in a rural area of Country Z increased the number of water sources in a community, and decreased the average distance and amount of time that community members had to travel to the water source. A final project evaluation found, as expected, that women were the main beneficiaries of these changes. Given that obtaining household water was a women's role, women experienced the greatest reductions in time burden. The final evaluation also found a surprising result: Women in several focus group discussions reported that the increased access to water sources had decreased household conflict, including violent conflict and beatings from their husbands. The women explained that previously the longer distances they traveled to water sources would sometimes require them to be out after dark; in these cases, their husbands would often accuse women of infidelity, and at times beat them. Now that women spend less time away from home and are returning before dark, they do not face the same conflict and accusations from their husbands.

Youth related

Youth scenario #1

A project for youth at risk of participating in gangs created an activity and training center to provide attractive alternatives to life in the streets for adolescents. The center was open to both young men and women, although the primary focus was intended to be young men, who were presumed to be the greatest threat to the community. To the operator's distress, young women were the center's principal clientele. The young women, who were not attending school because they had become pregnant, often arrived with their babies and toddlers. The center offered them an alternative to the isolation of their homes, a chance to let their children play with others, and stimulating classes and access to computers. The center director noted that the presence of young children deterred young men from coming to the center. In response, the director established a schedule of times when children were allowed to come to the center with either their mother or father (or both) and other times when no children were allowed. Classes were offered during the "no children" hours, under the assumption that without children present more young men would show up and there would be fewer distractions for class participants (both women and men). Class offerings included job skills training, parenting, healthy gender relations, and conflict management.

Youth scenario #2

A project sought to involve young people in the care and support of people living with HIV (PLHIV). This project carried out formative research to assess young people's interest and to explore the gender dimensions of care. The assessment explored what caregiving tasks male and female youth feel more comfortable with and are able to provide, as well as what tasks PLHIV themselves would prefer a male

or female youth provide. Based on this research, the project adopted an approach that incorporates preferred tasks for young women and young men.

Youth scenario #3

Health project staff were concerned about rising sexually transmitted infection STI and pregnancy rates among youth. Unable to convince the predominantly Roman Catholic public school system to incorporate a reproductive health and HIV curriculum in the high schools, the program staff decided to instead recruit volunteer peer educators to conduct *charlas*, informal discussion groups. Peer educators ran afterschool neighborhood youth *charlas* in mixed-sex groups to discuss issues related to dating, relationships, reproductive health, contraception (including condoms), and STI/HIV testing. They also provided information on where participants could access contraceptives (including condoms) and STI/HIV testing.

Youth scenario #4

An NGO produced a popular television soap opera (a *telenovela*) to introduce a range of social and health issues into public debate, such as pregnancy prevention, HIV, gender-based violence, and discrimination against the physically disabled. Since the soap opera was particularly popular with youth, it presented an opportunity to address and challenge traditional gender roles. A storyline in the telenovela followed a young couple as they fell in love and through their discussions about intimacy, contraception, and sexually transmitted infections. The male character in the couple was sensitive and caring toward his female partner, and they engaged in open communication about sexuality and family planning. In another episode, the young woman was raped. The telenovela then dealt with the aftermath of sexual violence, including its effects on intimacy and women's legal rights. Using mass media, this program presented alternative gender role models, and raised awareness and public discussion about gender and reproductive health.

Youth scenario #5

A program in Country N challenges traditional boys' and girls' roles. It works with 10- to 14-year-old boys and girls, bringing them together at child clubs for participatory workshops 1 hour per week for 8 weeks.

Sessions explore young people's hopes, dreams, and ideas about gender equality, power, and fairness. They identify small actions that brothers can take to promote respect and empower girls in their homes. Results of the initial program show boys are making small changes in their own behavior—helping their sisters and mothers with household chores; advocating for their sisters' education and against early marriage; and encouraging family members, friends, and neighbors to do the same. Compared with those who did not participate, more girls in the program-intervention group state that their brothers and other boys in their communities are making small changes toward gender equality. Parents also report that their sons now help their daughters with schoolwork and chores, and that their households are more peaceful as a result.

Facilitator resource: Gender equality continuum case studies—answers

#	Case study	Category	Explanation
1	A project in the Asia-Pacific region sought to strengthen the organizational capacity of networks for people living with HIV (PLHIV). To help foster organizational development, the project supported the development of a detailed, userfriendly manual with concrete step-by-step guidance on how to carry out a self-assessment of organizational strengths and weaknesses, with resource materials and activities to strengthen any areas identified as challenges. PLHIV regional network members led development of the manual and served as a technical assistance resource to country-level organizations as they sought to implement network strengthening. Women members of the PLHIV networks complained that the manual did not take into account the special needs of women living with HIV.	**Blind**	Although the project ensured the participation of its target audience in the manual's development, the manual itself did not take into account specific challenges faced by women living with HIV. As a result, the project ignored the important needs of a significant portion of its target audience, and it may also have compromised its potential for impact.
2	A malaria prevention program in Nigeria sought to increase the use of bed nets in a poor, rural area. Due to budget constraints, the program was only able to provide one net per family. Community health workers emphasized the dangers of malaria during pregnancy, and encouraged families to prioritize pregnant mothers to use the nets. However, because men are the main breadwinners in many Nigerian families, the families agreed to prioritize male heads of household and sons to sleep under the nets, to ensure that they would not miss work or forego crucial earnings due to being sick with malaria.	**Blind**	The project failed to account for gender norms (leaving it up to families to make the decision on their own) and in so doing may have significantly undermined its objectives by failing to address the important health needs of pregnant mothers. Additionally, the project may have contributed to a larger health issue resulting from the contraction of malaria during pregnancy.
3	A pilot program was designed to increase the acceptability and use of female condoms in South Africa. Historically, female condoms were promoted to women. The program designed its strategies around findings from preliminary research that showed that men's interest in any contraceptive method was likely to be based on maintaining control over their partners' sexuality. Program strategies were also based on evidence that men are preponderantly concerned with retaining control over the means of protection against HIV and sexually transmitted infections (STIs). The program therefore decided to promote the female condom to men through male peer promoters. This involved: (1) demonstrating to men the use of the female condom; (2) explaining to men that self-protection and sexual pleasure are compatible with the use of the female condom, especially when compared to currently available barrier alternatives; and (3) giving female condoms to the men to use with their female partners.	**Exploitative**	This program had an explicit intention of empowering men to use a technology that was developed to give women more control over decisions about contraception and protection from STIs and HIV. It exploited dominant norms supporting men's power over sexual and reproductive decisions to achieve a health outcome, and it reinforced men's control over the means of protection. Although some may interpret this project as accommodating rather than exploitative, because it engaged men around the use of a method ostensibly controlled by women, it ended up shifting that control to men.
4	The goal of a condom social marketing campaign in Guatemala was to increase condom sales for HIV, STIs, and pregnancy prevention. The campaign capitalized on social and	**Exploitative**	The campaign capitalized on social and cultural values supporting men's virility, sexual conquest, and

#	Case study	Category	Explanation
	cultural values that focus on male virility, sexual conquest, and control. It depicted macho men having multiple female sex partners, with slogans referencing different color condoms and saying on Monday it's yellow for Yolanda, on Tuesday it' s red for Ruby, on Wednesday it's blue for Beatriz, etc.		control. It reinforced the expectation/stereotype that "macho" men have multiple female sexual partners. It also contradicted other health efforts to promote safer sex practices through partner reduction.
5	A female genital cutting (FGC) intervention in Kenya sought to reduce the incidence of harmful cutting. Project staff realized that creating a law to prohibit the practice would not address the cultural and social motivations of the community, and would likely result in driving the practice "underground." Instead, the project hired a medical anthropologist to work with the community. Through qualitative interviews with groups of women, men, and religious leaders, the project sought to understand the meaning and functions that the ritual provides to the community. They determined that the ritual is a rite of passage for girls to enter adulthood. Together with community members, the project staff adapted the FGC ritual by eliminating the harmful cutting but keeping the "healthy" cultural elements, such as seclusion of girls, dance, storytelling, gift giving, health, hygiene, and sexual education, emphasizing a woman's role with her partner. As a result, a new rite-of-passage ritual was created for girls called "circumcision with words," which has become accepted by the entire community.	**Accommodating to transformative**	This is an example of a project that does not fall neatly on the continuum. Indeed, the project is accommodating but also includes some elements that make it somewhat transformative. Although the project contributed to the elimination of a harmful cultural practice through community engagement, it did not challenge the gender norms underpinning the practice and that revolved around the social control of women's/girls' sexuality (e.g., importance of female virginity), and the promotion and protection of traditional/reproductive roles for women (i.e., being wives, being mothers). To become truly transformative, the project would need to engage communities in challenging dominant norms of femininity so as to shift women's social positioning. However, given the highly sensitive and controversial nature of FGC, the project may be considered slightly transformative in the sense that it began challenging the idea that girls' transition to womanhood requires a measure to physically preserve their virginity.
6	A community-based outreach program in Burundi sought to reduce gender-based violence (GBV) and its resulting health complications, including HIV. Recognizing that adolescent girls and young women are at particular risk of experiencing GBV, the program planners used a peer-based prevention model to empower young women and adolescent girls to protect themselves from GBV. It focused on educating participants about the prevalence and health consequences of GBV, as well as their right to live free of violence. Topics included safety planning for women whose male partners are violent, peaceful conflict-resolution skills, and where to seek GBV services for physical, sexual, emotional, and financial abuse.	**Accommodating to transformative**	The program is mostly accommodating but also includes some transformative aspects. On one hand, the program focused on restoring power to women by equipping them with the information and skills needed to reduce their vulnerability to violence. On the other hand, the program may have perpetuated the dominant social perception of women as helpless victims. The program also placed all of the responsibility for violence prevention on women, and did not include any strategies to engage men in violence prevention, or provide space for men to reflect on dominant gender norms condoning violence against women.

#	Case study	Category	Explanation
7	An HIV prevention project in Mozambique sought to promote safer sex among married couples by tackling one of the reasons that husbands were having sex outside of their marriages: they were bored with their sex lives at home. Preliminary research showed that men justified extra-marital sex by complaining that their wives would not agree to sexual experimentation, especially with regard to sex positions. Women, on the other hand, reported that, "I am never asked what I like in sex, if I like sex, and if I even want sex, so why should I do anything that gives him pleasure?" To transform these gendered expectations that pose as challenges, the project promoted greater dialogue among couples about their sexual desires. The project successfully advocated with local temples and mosques by explaining to religiously affiliated participants the importance of talking more openly about sex and helping them understand that open dialogue among married couples about sex and pleasure is not a threat to culture, religion, or people's sensibilities. Religious leaders supported the project, teaching couples about better sex by getting women and men to talk openly about what they like and do not like about sex in group and couple settings.	**Transformative**	The project challenged the dominant social norm that sex should not be discussed, and especially that men and women should not discuss sex and sexual pleasure. The project also contributed to greater equity in intimate relationships by encouraging women and men to engage in dialogue about sex. This has the potential to contribute to greater joint decision-making about other reproductive and sexual matters.
8	A Nicaraguan NGO produced a popular TV soap opera (*telenovela*) to introduce a range of social and health issues (e.g., pregnancy, HIV prevention, GBV, and discrimination against the physically disabled) into public debate. Since the soap opera was particularly popular with youth, it presented the opportunity to address and challenge traditional gender roles. One storyline followed a young couple as they fell in love, and through their discussions about intimacy, contraception, and STIs. The male character in the couple was sensitive and caring toward his female partner, and they engaged in open communication about sexuality and family planning. In another episode, the young woman was raped. The telenovela then dealt with the aftermath of sexual violence, including women's legal rights in Nicaragua, and the effect of rape on intimacy.	**Transformative**	The soap opera drew attention to the importance of equity in intimate relationships, and challenged the idea that partners should not discuss issues related to sex and reproduction. The use of a sensitive, respectful, and caring male partner also challenged dominant norms of masculinity.
9	In Ethiopia, gender inequalities result in low participation and success of women in education. The few women that join higher education institutions generally have lower academic performance and higher forced withdrawal than men. Gender barriers include poor academic performance, pregnancy, adjustment challenges, lack of orientation, low self-confidence, and financial constraints. Jhpiego, through the USAID-funded Strengthening Human Resources for Health Project, implemented a project to reduce gender disparity in midwifery pre-service education. The project has supported health education institutions to establish gender offices, trained gender counselors to conduct life skills training for female students, provided	**Transformative**	The project contributed to creating an enabling environment within teaching institutions aimed at ensuring the academic success of female students. The project also addressed systemlevel barriers hindering women's access to, and successful completion of, midwifery training. The project's efforts to promote women's equal access to midwifery pre-service education may potentially contribute to transforming the face of the health care

#	Case study	Category	Explanation
	orientation and academic counseling services to female students, and supported female students to adapt to college life. The project also supported gender offices to recognize the best-performing female students, establish sexual harassment policies, and provide scholarships to female students in need. The gender offices have also served as a space where female students receive mentorship and social/financial support, as a means of minimizing dropout rates and improving female students' academic performance (e.g., female students receive counseling so they do not leave school when they get pregnant).		workforce in Ethiopia by increasing the availability of competent female health care workers.
10	The ministry of health (MoH) in Ethiopia wants to address the unmet need for contraception by expanding access to long-acting methods, including the implant (Implanon/Jadelle). To meet this need, the MoH is training community health extension workers, who already go door-to-door addressing a range of health issues (for example, water and sanitation, HIV, immunization, and family planning) to offer Implanon. Community health workers are being trained to provide information on Implanon (as part of their family planning counseling), screen women for medical eligibility criteria, and provide Implanon (in addition to condoms and contraceptive pills).	**Accommodating**	Implant information, screening, and provision are added to a program that takes into account an existing gender norm that women may spend a majority of their time working at home and therefore may be best reached with health services and information through community health extension workers who go door-to-door.
11	This HIV/AIDS prevention project provided education, negotiation skills, and free condoms to commercial sex workers (CSWs) in Thailand. Although knowledge and skills among CSWs increased, actual condom use remained low. After further discussions with the CSWs, project managers realized that CSWs weren't successful in using condoms because they did not have the power to insist on condom use with their clients. The project then shifted its approach and enlisted brothel owners as proponents of a "100% condom use policy." Brothel owners, who did have power and authority, were able to insist that all clients use condoms. Since the vast majority of brothels in the project region participated in the project, it resulted in significant increases in safer sex practices.	**Accommodating**	The project did not attempt to transform gender norms and power imbalances, but instead utilized the existing power imbalance that brothel owners have over CSWs and their clients, and enlisted them to insist that all clients use condoms.
12	A social marketing campaign in Tanzania had a similar goal: to increase condom sales. Project designers realized that in Tanzania, only a small percentage of condom sales were to women. Training indicated that women were having a hard time initiating condom use. Therefore, one of its posters explicitly showed a woman at a bar talking to a male partner and insisting that he use a condom.	**Accommodating/ transformative**	On one hand, this campaign challenged gender norms by explicitly showing a woman talking to a male partner about condom use. By showing a women *insisting* that the man use a condom, the campaign challenges norms that women cannot speak up and negotiate condom use. On the other hand, simply showing images modeling women negotiating condom use does not necessarily build a woman's skills to do so or address the power dynamics in a relationship that inhibit a woman from doing so. The

#	Case study	Category	Explanation
			campaign could be more transformative by also engaging men and woman in communication and negotiation around condom use.
13	Recognizing that contraceptive stock-outs are a significant problem in delivering high-quality and reliable services, the MoH in Country X redoubled its efforts to improve its supply chain system. This involved a thorough assessment to better quantify and forecast commodity needs at the central, regional, and service delivery point (SDP) levels. An electronic Logistics Management and Information System (eLMIS) was developed to capture more detailed information about the procurement, shipping, and issuing of commodities. The MoH agreed to hire more supply chain staff, and provided additional training to all personnel in order to roll out the new system. But the MoH did not consider gender factors affecting staff training —for example, rolling out the training without checking current composition of staff, and which times, locations, and format are optimal depending on the sex/gender make up of their eLMIS staff. There was no gender analysis of demand for commodities and patterns of stock-outs (for example, are emergency contraceptive or other methods that women can use clandestinely readily available).	**Blind**	This project is gender blind because it did not conduct a gender analysis or leverage existing information on gender in context to inform project activities. The project did not consider how gender may affect staff training, and how stock-outs may differ based on gender-related factors.

Facilitator Resource: Additional Gender Equality Continuum Case Studies by Technical Area—Answers

#	Case study	Category	Explanation
FP/RH/HIV/GBV Scenarios			
F1	Staff in an HIV clinic in Chile carried out a situational assessment to better understand the reproductive health priorities of HIV-positive women at their clinic. One of the primary issues HIV-positive women expressed was their desire to control their fertility so they could choose whether and when they wanted to become pregnant. However, women reported that a major barrier continues to be the ability to use condoms or other forms of birth control that might be discovered by their partners, as many of their partners are opposed to both. Male partners may even take the suggestion of using such methods as a sign of infidelity and grounds to beat a woman, they said. Based on the information they collected, clinic staff decided to offer only Depo-Provera shots (longeracting injectables) to all women, and de-emphasize (and reduce their supplies of) any other types of STIs or pregnancy-prevention methods.	**Accommodating**	The program has identified that male partners are often opposed to birth control or condoms and see these as signs of infidelity and grounds for beating a woman. Instead of seeking to change these male norms and unequal gender relations, the HIV clinic staff chose to emphasize a more clandestine method of family planning and de-emphasize other methods that may be more easily detected by male partners.
F2	In rural Egypt, women tend to follow strict cultural rules related to modesty and seclusion that substantially restrict their physical mobility outside the home. This, coupled with limited control over resources and decision-making, has affected women's ability to access family planning services. To address these challenges, the local health district has trained female community health workers to bring reproductive health services to women's doorsteps. These health workers visit women in their homes, providing counseling, information, and access to certain methods of contraception.	**Accommodating**	Rather than changing gender-based norms, practices, and inequalities in rural Egyptian communities that prohibit women's mobility and access to resources, the health district brought female community health volunteers to women's homes to offer them contraception.
F3	A community-based intervention in South Africa combined a microfinance program with a gender and HIV curriculum. Its goals were to reduce HIV vulnerability and GBV, promote women's empowerment, improve family well-being, and raise awareness about HIV. In the project, groups of five women guaranteed each other's loans, meeting every two weeks to discuss business plans, repay loans, and apply for additional credit. In addition, the groups took part in a participatory learning and action program with sessions on relationships, communication, cultural beliefs, GBV, HIV prevention, critical thinking, and leadership. The microfinance groups elected leaders to participate in additional training on community mobilization. These leaders went on to organize dozens of community events to raise awareness on GBV and HIV.	**Transformative**	This intervention intentionally transformed gender inequalities by increasing women's access to economic resources and leadership while seeking to promote more equitable relationships through education and skills-building on communication and GBV and also mobilizing participants to then lead awareness events on GBV and HIV.
FP/RH/HIV/GBV Scenarios			
F4	In Country Q and elsewhere, family planning clinics will offer female clients a choice of "hidden" contraceptive methods, such as Depo-Provera shots, Norplant, or an IUD, if	**Accommodating**	The program identified that male partners are often opposed to birth control or condoms and see these as

#	Case study	Category	Explanation
	the woman expresses fear that her husband does not support her use of contraception even though she expresses her desire to limit or space births. Some women may fear violence if their partner finds oral contraceptive pills in the house or if they suggest use of a condom. Clinicians will assure women that the IUD and Norplant are basically invisible, and that their partners are unlikely to realize that they are receiving Depo-Provera shots at well baby clinic visits.		signs of infidelity and grounds for beating a woman. Instead of seeking to change these male norms and unequal gender relations, the HIV clinic staff chose to emphasize a more clandestine method of family planning and de-emphasize other methods that may be more easily detected by male partners.
F5	During regular business hours, public sector family planning clinics in urban Uganda are often busy, with many clients congregating and waiting to be seen by providers. To take advantage of this captive audience, a clinic developed short videos that run on a continuous loop, providing details about available contraceptive methods. The information shared includes basic details on how the methods are administered, their health advantages, and possible side effects.	**Blind**	Based on the information provided, the clinic has not taken into consideration gender norms, practices, or inequalities (e.g., whether men or women are more likely to see the information, whether there will be resistance to the methods based on gender norms or related barriers) that may impact the program's intended outcome.
Health Policy Scenarios			
H1	A local council and an NGO teamed up to build a public library in a midsize, highly dispersed town with a third of its population living in nearby neighborhoods not easily accessible by local transport. From the outset, the library aimed to work with young people—both males and females—as part of the community's efforts to improve secondary education. After great deliberation and effort, a local philanthropist living abroad agreed to donate land at the lively center of town, facing the local cafes and billiard halls that attract young and middle-aged men. A stipulation of the donation was that the philanthropist's male cousin, an expert librarian, would manage the library. The library charged a small annual membership fee, limited the number of borrowed books to three at a time, and required that the books be returned or renewed after 1 week. After young women visiting the library complained they were being harassed by the men smoking and playing billiards across the street, the librarian opened a new rear entrance for women and designated a section of the library for women's use only.	**Blind then accommodating**	At the outset, the library was not located in a place that took into consideration the threats and unwelcoming environment to women. However, after women complained, the librarian accommodated these concerns and opened a rear entrance. However, he did not institute any practices that aimed to prevent harassment, for example, by changing underlying gender norms that support harassment of women.
H2	A study found that a requirement for overseas training for medical career progression created an obstacle for female doctors who were not able to leave husbands and family at that period in their lives. In the survey, female doctors described an assumption in the upper ranks of the medical establishment that women did not want, or were not able, to advance their careers because of family responsibilities, which resulted in pervasive discrimination against women in promotions and scholarship awards for overseas study. The study found that nearly half of the graduates were not	**Blind**	The training program did not consider the gender constraints that female doctors face due to family responsibilities and burden of care on women as well as concerns around housing and security for doctors moving to rural areas. As a result, women tended to drop out of medical training programs at higher rates.

#	Case study	Category	Explanation
	taking postgraduate training, mainly because of the pressures of family responsibilities. These graduates also believed they were discriminated against through common stereotypes of female doctors as "inefficient" and lacking motivation because they were more likely to work part-time or take career breaks. The study also identified that adequate housing and security were the primary concerns for women doctors moving to rural areas, not salary incentives. Ultimately, female graduates had a high "rate of exit" from medicine.		
H3	Seclusion of girls and women is considered a sign of female respectability; respectability also requires that women travel in the company of a male family member. At the same time, women serve as community-level paramedical staff, in recognition of their frequently greater acceptability to local clients and their ties to the community. Anecdotal evidence suggests that the cultural expectation of female respectability constrains the full range of community outreach activities and supervisory performance expected from trained community midwives. For example, female supervisors are required to return home before nightfall. Recently, the government enacted directive measures to address the problems of getting health staff to work in rural areas. In the face of cultural difficulties in recruiting women, they established a system of compulsory health service for women.	**Exploitative**	Recognizing that females are more accepted as community-level paramedical staff, the government required health service for women. Yet women were difficult to recruit because of gender-based norms and expectations that dictate, for example, that respectable women are not out after nightfall. Without seeking to change the gender norms and stigma around women's mobility in the evening and instead exploiting the expected role of women as caregivers, the government increased potential discrimination and risk for women.
H4	In Country Q, community-based NGOs sought to gain inheritance and property rights for women. To do so, these groups conducted an analysis to identify which processes—at the level of cultural norms, implementation and decision-making structures, and written laws— presented barriers to women accessing their rights, and developed an advocacy strategy based on this analysis. In particular, the analysis identified key barriers such as cultural norms that "women who love don't talk about money and property" and structural barriers where local land boards were physically far from women and institutionally unfriendly (very male dominated). The advocacy strategy thus decided to focus on lobbying traditional decision-making structures led by traditional male authorities, such as councils of elders, to increase their awareness and support for women's property rights, and have them in turn issue decrees to support women's rights and raise the issue of women's inheritance and property rights with local land boards. In the first 6 months after the advocacy was initiated, 20 women were able to reclaim their property.	**Accommodating/ transformative**	The advocacy strategy focused on increasing support for women's property rights within traditional male dominated decision-making structures. Therefore, although the gender norm of women not having property rights was questioned and transformed, the advocacy efforts were still directed at men as the decision-makers. The program did not transform male norms and attempt to promote decision-making structures inclusive of women.
H5	A project in Region Q sought to strengthen the organizational capacity of networks for people living with HIV (PLHIV). To help foster organizational development, the project supported the construction of a detailed, user-friendly manual with concrete step-by-step guidance on how to carry out a self-assessment of organizational strengths and	**Blind**	Per the description, the project did not consider gender in the design of the manual to provide guidance on special considerations for women vs. men.

#	Case study	Category	Explanation
	weaknesses, and resource materials and activities to strengthen areas identified as challenges. PLHIV regional network members led development of the manual, and serve as a technical assistance resource to country-level organizations as they seek to strengthen networks of PLHIV.		
H6	Health Workers for Change addresses gender biases in health workers' personal, organizational, and professional lives through reflective- and action-oriented training using participatory methods developed under the leadership of the Women's Health Project in Country Q. These courses address gender relations as well as race, class, and other axes of discrimination. Health workers go through a process of value clarification and self-reflection about how their organization and work mirrors their society more broadly. They are encouraged to put themselves in the shoes of others and thus develop empathy for the role of other actors in the health system. Actions devised through the training arise from analyzing health workers' own context and experience base. Within their organizations, health workers that participated in the program were able to make changes within their direct power and influence, but were not able to make wide-ranging institutional changes that were much more difficult to implement.	**Transformative**	The workshops intentional ly sought to facilitate reflection on gender relations and biases in participants to then precipitate change in their facilities. Although participants had limited influence, the workshop transformed gender and power dynamics at the relational level for health workers.
H7	In Country Q, a community health worker program relied exclusively on female staff members in ways that reinforced the beliefs that only women can provide maternal health advice. The program also failed to challenge prevailing beliefs that excused men from taking responsibility for childcare, failed to sanction forms of male sexuality that increased STI risk among their wives, and failed to question norms around domestic violence that inhibited women from talking to male health workers in their homes.	**Accommodating**	The program did not challenge or change gendered beliefs, but it also did not actively reinforce them.
H8	A program in Country Q provided support to community-based female health workers. They were allowed to assume broader roles than the simple health care tasks they were originally charged with and thus became trusted confidants and respected advocates for their fellow community members. Their work was explicitly and frequently recognized by professional health care workers and strengthened by the formation of their own peer support group. Functioning referral systems supported them. They were acknowledged by their communities of origin. Managers were sympathetic to their concerns and responded by listening and providing infrastructural support when possible. Lastly, these workers received continuous training and regular supervision. The strategic support the female communitybased workers received greatly sustained their work and permitted the flexibility to adapt their work to suit community needs.	**Blind but possibly transformative**	On one hand, the program did not actively identify or address gender constraints or inequalities that community-based female health workers may face (e.g., possible harassment, balancing other care work, overall discrimination against women). However, the program may have been empowering for females who otherwise may have received little acknowledgment, mobility, or respect in their communities.

#	Case study	Category	Explanation
H9	In Country Q, female community-based volunteers were very successful in making contraceptive methods widely available throughout the country. Although their work was highly regarded by village leaders as well as the general population, it was perceived as an extension of their roles as caregivers. Women's work as family planning volunteers did not significantly increase their decision-making roles within their households or access to education or paid work.	**Exploitative**	The program could be considered exploitative because it recognized women's ability to access other women to offer family planning services and reinforced the perception of women as caregivers.
H10	In Country Q, a new strategy sought to reform traditional gender norms that constrained health workers' efforts in service delivery and assuming tasks for which they were trained, but prevented from performing by doctors. The strategy entailed subtly redefining the meaning of *purdah* (seclusion) for female staff and the communities in which they worked. *Purdah* was reinterpreted as: "An emphasis on the external and physical criteria of seclusion to an internalized, moral code of conduct. Observance of inner purdah does not require physical seclusion; rather it manifests itself through politeness in interpersonal behavior, religious orthodoxy, modesty in dress and language, and, above all, through strictly professional behavior and attitudes toward men. As long as this moral code of conduct is followed, the health workers argued, purdah was not broken." After gaining the initial approval of village elites, female health workers were able to expand their duties to include providing medicines and injections. Gradually, they became known as "little doctors" linked to "big doctors" through effective referral systems. When male senior staff visited their female colleagues for supervision in the field, they treated them with respect rather than reprimanding them in public. Over time, female health workers assumed increasingly influential and respected roles in the villages where they worked, often giving advice to villagers regarding important decisions or resolving local disputes.	**Accommodating/ transformative**	Although women no longer needed to remain secluded, something transformative, the norms of modesty, politeness, and moral code of conduct for women were still maintained.
Key Populations Scenarios			
K1	Project managers in Country Q have seen an uptick in arrests of men who have sex with men (MSM) in public spaces. In response, they prepare personal safety workshops for MSM. In the workshops, the facilitators tell the MSM participants, "If you're worried about your safety, try being less 'obvious,'" and they ask participants to come up with strategies to look and act more masculine.	**Exploitative**	The project is reinforcing traditional gender roles and gender as a binary—i.e., male or female.
K2	A project in Country Q develops support groups for transgender people to talk about the violence they face. Through partners, the project offers gender-affirming services (such as hormone therapy) as well as HIV prevention, care, and treatment. It also	**Transformative**	The project is providing a space for transgender people to talk about violence they face due to gender-

#	Case study	Category	Explanation
	provides referrals and accompaniment to legal assistance for individuals who have been discriminated against or have experienced violence.		based discrimination, as well as to access legal resources to take action against it.
K3	A program that provides HIV services to female sex workers in drop-in centers recently launched an outreach campaign with the message that "sex workers take care of themselves because they are the backbone of their families and communities." The drop-in center provides space for the children of sex workers, and the first question on the new client form is, "What services do your children need?"	**Blind and exploitative**	The program did not consider gender in its design or messaging. It did not consider whether women's main concern was about being caretakers or their children and reinforced the stereotype that women should be concerned first and foremost about their children.
K4	A program to support people who inject drugs (PWID) offers clean needles, HIV testing, and condoms to PWID. Its outreach workers are all men, as a situation analysis showed that 95% of PWID are men. Outreach workers wear shirts with an image of two men running across a finish line and a message that says, "You are a valuable member of society."	**Accommodating**	The program considered the gender of most PWID, i.e., men, and targeted empowering messages just to men.
K5	MSM face such severe stigma and discrimination in health settings that they find it difficult to access sexual health services, including STI and HIV counseling, testing, and treatment. An organization working on HIV prevention and mitigation established a pilot program to work with MSM. The group focused on *kothis*—biological males who adopt feminine behaviors and attributes, including normatively feminine sexual roles. The project established a place where they could meet and support one another, providing information on health care and other resources, training local health care providers on how to provide services to *kothis* in a sensitive manner, and organizing medical visits at the meeting space itself. In focusing on *kothis*, staff decided not to work with penetrators whose numbers are much larger and who do not publicly acknowledge having sex with men. They also decided to focus only on commercial sex workers and on sexual activity occurring in public spaces.	**Accommodating/ transformative**	The organization sensitized health providers on working with a nontraditional gender group, *kothis*. Although it did not work with all high-risk individuals or *kothis*, particularly those that do not publicly disclose as such, the organization still sought to transform attitudes of health workers. It could have been more transformative by working with all *kothis* and the broader society to increase acceptance of *kothis*.
Male Health Scenarios			
M1	To increase contraceptive use and male involvement, a family planning project initiated a communication campaign promoting the importance of men's participation in family planning decision-making. Messages relied on sports images and metaphors, such as "Play the game right. Once you are in control, it's easy to be a winner" and "It is your choice." The campaign increased the use of contraceptive methods. When evaluating impact, the project asked male respondents who should ideally be responsible for making family planning decisions—them, their partners, or both members of the couple. The evaluation found that, "Whereas men were far more likely to believe that they should take an active role in family planning matters after the campaign, they did not necessarily accept the concepts of joint decision-making.	**Exploitative**	The project capitalized on men's desire to be in control and the winner to dominate decision-making around family planning.

#	Case study	Category	Explanation
	Men apparently misinterpreted the campaign messages to mean that family planning decisions should be made by men alone."		
M2	A reproductive health project in an indigenous community wanted to encourage men to become involved in family planning and be more supportive of their wife's or partner's choices. GBV is an issue in this community, and women sometimes fear that their use of contraception will result in their partner becoming violent toward them. Project planners were also concerned about increasing rates of STIs in the area, as the men have been migrating to a nearby mining town for work, returning with infections, and spreading them to their partners in the village. The project introduced a pilot effort to address these issues. It offered an STI clinic one day each week for men in the local women's clinic. Some of the project designers thought that by bringing men into the women's clinic for services, they would become more comfortable in the clinic, start to feel a sense of belonging there, and so be more likely to accompany their partners to the clinic for services, where they could be brought into discussions on family planning, safe motherhood, domestic violence, and other related issues.	**Blind**	Although the program acknowledged the need to engage men in family planning and STI services, it did not consult women and men on whether bringing men into a women's clinic was desirable or comfortable for both men and women.
M3	A participatory, group intervention was piloted in Mumbai with young men ages 16 to 24. Data indicate that almost half of new HIV infections in India occur in young men under age 30. Other data suggest that most boys are socialized into a sense of masculinity characterized by male dominance in sexual and other relationships—and that these norms may promote poor sexual health and risk-taking for young men and their partners. Adapting an intervention (Program H) from Brazil, a behavior change intervention sought to stimulate critical thinking about gender norms. Exposure to the program resulted in a decline in reported violence against any sexual partner and increased condom use. A social marketing campaign is also underway, with the tag line, "Real men have the right attitude."	**Transformative**	The intervention intentionally sought to reduce male dominance in relationship by changing gender norms to reduce violence and sexual risk-taking.
MNCH Scenarios			
MN1	To decrease markedly high rates of maternal mortality in Country Q, a US based organization initiated a project to reduce disease and death associated with postpartum hemorrhage, particularly among young mothers. The project included community-level interventions to raise awareness among traditional birth attendants, young women, and mothers-in-law about the markers for postpartum hemorrhaging that should trigger an emergency response. During the project's midterm evaluation, community members reported that recognizing the warning signs of distress was not enough to prompt action for mothers who delivered at home. The decision to seek	**Accommodating**	The organization's ultimate intervention of establishing a community fund to cover costs of emergency transport for women experiencing postpartum hemorrhage does not address women's lack of control over household resources, lack of decision-making power, and poor status in the household.

#	Case study	Category	Explanation
	medical care for a new mother in distress was influenced by many factors, including the availability of household resources, the power distribution in the household, and the relative status of the new mother in the household vis-à-vis her in-laws. The organization subsequently amended the project to establish a community fund to cover the costs of emergency transportation for women experiencing postpartum hemorrhage and other forms of distress.		
MN2	In Country Q, a donor project works to strengthen and create more efficient systems, structures, and interventions to reduce maternal mortality in three rural communities. Project interventions focus on the four major causes of maternal mortality and address conditions that lead women to delay seeking lifesaving treatment for emergency obstetric complications. The project trains facility- and community-based health workers, including traditional birth attendants, in improved maternal health care practices. One of the interventions includes sensitizing male traditional village leaders in this Muslim region, in recognition of their influence over community norms and behaviors. The leaders are encouraged to promote quick action from household members and neighbors when someone suspects that a laboring woman is having emergency obstetric complications, emphasizing that the baby's life may be at stake.	**Accommodating**	The project recognizes the power and influence of male leaders in the community but does not seek to promote greater gender equality, which would allow women to take action for themselves when they have obstetric complications.
MN3	A child survival project in Country Q, aiming to reduce disease and death rates among children and women of reproductive age, focused on using indigenous knowledge and cultural resources to increase and improve communication and health-seeking behavior during pregnancy. Research showed that one of the most important obstacles to women's maternal health care-seeking behaviors was the absence of discussion about pregnancy between husbands and wives, as well as with other household members. The women in this area felt that they could not take advantage of maternal services because they could not initiate conversations with their husbands or solicit their consent and financial support as the heads of household. The project staff asked a *griot* to compose a song to educate people about maternal health care, along with promoting the *pendelu* (a traditional article of women's clothing) as a symbol of pregnancy and couple communication. This campaign dramatically increased the level of communication between wives and husbands concerning maternal health. Additionally, the campaign resulted in more positive attitudes and behaviors related to pregnancy at the household level, including husbands supporting their wives by reducing their workloads, improving their nutrition, and urging them to seek medical attention and maternal health services.	**Transformative**	The program changed gender dynamics in couples' relationships by promoting communication between husbands and wives around maternal health, while promoting gender equity in access to resources and household care and increasing male support for women during pregnancy.

#	Case study	Category	Explanation
MN4	A group of HIV-positive mothers of small children organized to become advocates for prevention of mother-to-child transmission of HIV (PMTCT) and for HIV-positive mothers. The group encourages women to attend prenatal clinics, where they can access PMTCT services if they are HIV-positive. The group also educates HIV-positive mothers in their communities in life skills, PMTCT, infant care, and human rights. They use song, dance, and drama, as well as appearances on television and radio where they share their experiences as HIV-positive mothers and call for a reduction in stigma and discrimination. The peer educators also increase women's access to income by training HIV-positive mothers in personal financial management and income generation by tailoring, farming, and selling handicrafts. Finally, the group partners with HIV-positive men's networks to encourage men to value fatherhood and to become involved in PMTCT.	**Transformative**	The group promotes gender equality by giving women skills that can generate income, while also encouraging men to play a greater role in parenting.
MN5	The Government of India began integrating HIV into the National Rural Health Mission in April 2008. The government issued a circular to district reproductive and child health (RCH) officers asking whether they were willing to work on HIV and to report cases of HIV-positive women who came for antenatal care (ANC). One intervention developed subsequently is working to improve ANC quality for HIV-positive women by addressing gender and quality of care issues. For example, special spousal counseling exists for women in ANC who test positive for HIV. The husband is encouraged to come in for a variety of tests, and the program reports his HIV status to him first. They also put HIV-positive women in contact with a lawyers' network and NGOs in the area working with people living with HIV. The program also introduces the woman and the health care worker to the obstetrician who will attend her labor and birth. This doctor gives the woman her fourth and extra ANC checkup in the third trimester and registers her name on the books to receive Nevirapine prophylaxis when she goes into labor to prevent mother- to-child transmission.	**Accommodating**	The services do not transform gender norms and relations but rather promote respectful, nondiscriminatory services and facilitate a woman's access to other services she may need. Men are encouraged to come in for tests, which does not necessarily change gender dynamics or relations in the couple.
MN6	A multipronged program to improve maternal and child health in several Delhi slums works on diarrheal case management, increasing institutional births, and increasing immunization, among other things. The program conducts community outreach through the formation of women's groups focused on health, and has also provided some limited access to credit. Although the program targets women of reproductive age and children, it also reaches out to men as decision-makers. The program runs local TV ads for services, encouraging men to support their partners in taking children for prevention and treatment, and directing messages at men and women. The program reaches out to religious leaders and men at mosques on the need to take their wives for services.	**Accommodating/ transformative**	Aspects of this program, such as women's groups, which have proven to be empowering for women by increasing social capital and agency, may be transformative. However, the program targets men as decision-makers and does not seek to transform male norms to be more equitable or promote joint decision-making.

#	Case study	Category	Explanation
WASH Scenarios			
W1	Government data showed high incidence rates of diarrhea and other intestinal infections among school-age children in several rural provinces in their country. In response to this public health problem, and in an effort to increase the number of days children spend in the classroom (and decrease the number they spend at home being sick), several communities were selected for a behavior change campaign. The campaign aimed to raise awareness of handwashing as a highly effective means of reducing such illnesses and introduced a simple protocol for handwashing by all household members. The campaign targeted women with messages encouraging them to be "good mothers" and "take proper care of their families" by strictly enforcing the handwashing protocol for everyone in their homes. Some messages implied that if a child is sick, it means the mother is not "doing her job well." Follow-up studies showed the messages were effective, with a high rate of adoption of the new handwashing protocol and a subsequent reduction in intestinal diseases among school-age children.	**Exploitative**	The campaign reinforced gender norms of expectations that women are caretakers of their families and that they are not doing their job if their child is sick, all in the name of increasing handwashing and reducing disease.
W2	The Central American Hand Washing Institute aimed to reduce disease and death among children under age 5 through a communication campaign promoting proper handwashing with soap to prevent diarrheal disease. Four soap companies launched handwashing promotion campaigns that included radio and television advertisements; posters and fliers; school, municipal, and health center programs; distribution of soap samples; promotional events; and print advertisements. The basic approach was to present a mother as the caretaker of the family and to describe or illustrate the three critical times for handwashing: before cooking or preparing food; before feeding a child or eating; and after defecation, cleaning a baby, or changing a diaper. The promotion also emphasized essential aspects of handwashing technique: use water and soap, rub one's hands together at least three times, and dry them hygienically.	**Accommodating**	The campaigns presented women in their traditional role as caretaker of the family and did not identify a role for men in the caretaking activities.

#	Case study	Category	Explanation
W3	A WASH program in a rural area of Country Z increased the number of water sources in a community, and decreased the average distance and amount of time that community members had to travel to the water source. A final project evaluation found, as expected, that women were the main beneficiaries of these changes. Given that obtaining household water was a women's role, women experienced the greatest reductions in time burden. The final evaluation also found a surprising result: Women in several focus group discussions reported that the increased access to water sources had decreased household conflict, including violent conflict and beatings from their husbands. The women explained that previously the longer distances they traveled to water sources would sometimes require them to be out after dark; in these cases, their husbands would often accuse women of infidelity, and at times beat them. Now that women spend less time away from home and are returning before dark, they do not face the same conflict and accusations from their husbands.	**Blind**	It is not clear whether the program did a gender analysis to understand gender constraints, opportunities, barriers, or possible consequences of the intervention in terms of the status of men and women. Although women were expected beneficiaries, the program did not intentionally take gender into account in the program design as explained. In some ways, the program was gender transformative (i.e., reduced conflict and beatings and increased time availability). On the other hand, the program did not intentionally seek to change norms and relationship dynamics to reduce suspicion of infidelity for being out after dark or the practice of violence by husbands.
Youth Scenarios			
Y1	A project for youth at risk of participating in gangs created an activity and training center to provide attractive alternatives to life in the streets for adolescents. The center was open to both young men and women, although the primary focus was intended to be young men, who were presumed to be the greatest threat to the community. To the operator's distress, young women were the center's principal clientele. The young women, who were not attending school because they had become pregnant, often arrived with their babies and toddlers. The center offered them an alternative to the isolation of their homes, a chance to let their children play with others, and stimulating classes and access to computers. The center director noted that the presence of young children deterred young men from going to the center. In response, the director established a schedule of times when children were allowed to come to the center with either their mother or father (or both) and other times when no children were allowed. Classes were offered during the "no children" hours, under the assumption that without children present more young men would show up and there would be fewer distractions for class participants (both women and men). Class offerings included job skills training, parenting, healthy gender relations, and conflict management.	**Accommodating and transformative**	On one hand, the project accommodated the male norms and preference of not wanting to be around children and leaving childcare to mothers. On the other hand, the project offered classes in parenting, gender relations, and conflict management, which aim to promote gender equality.
Y2	A project sought to involve young people in the care and support of people living with HIV (PLHIV). This project carried out formative research to assess young people's interest and explore the gender dimensions of care. The assessment explored what caregiving tasks male and female youth feel more comfortable with and able to	**Accommodating**	The project accommodated gender-based preferences and roles related to caregiving tasks.

#	Case study	Category	Explanation
	provide, as well as what tasks PLHIV themselves would prefer a male or female youth provide. Based on this research, the project adopted an approach that incorporates preferred tasks for young women and young men.		
Y3	Health project staff were concerned about rising STI and pregnancy rates among youth. Unable to convince the predominantly Roman Catholic public school system to incorporate a reproductive health and HIV curriculum in the high schools, the program staff decided to instead recruit volunteer peer educators to conduct charlas, or informal discussion groups. Peer educators ran afterschool neighborhood youth charlas in mixed-sex groups to discuss issues related to dating, relationships, reproductive health, contraception (including condoms), and STI/HIV testing. They also provided information on where participants could access contraceptives (including condoms) and STI/HIV testing.	**Blind**	The project did not consider gender-based preferences of whether discussions should be run in mixed-sex groups or other gender norms or dynamics to inform the intervention.
Y4	An NGO produced a popular television soap opera (a telenovela) to introduce a range of social and health issues into public debate, such as pregnancy prevention, HIV, GBV, and discrimination against the physically disabled. Since the soap opera was particularly popular with youth, it presented an opportunity to address and challenge traditional gender roles. A storyline in the telenovela followed a young couple as they fell in love and through their discussions about intimacy, contraception, and STIs. The male character in the couple was sensitive and caring toward his female partner, and they engaged in open communication about sexuality and family planning. In another episode, the young woman was raped. The telenovela then dealt with the aftermath of sexual violence, including its effects on intimacy and women's legal rights. Using mass media, this program presented alternative gender role models, and raised awareness and public discussion about gender and reproductive health.	**Transformative**	The soap opera challenged traditional gender roles through reflection of sexual violence, women's legal rights, and couples relationships, especially as they relates to reproductive health.

#	Case study	Category	Explanation
Y5	A program in Country N challenges traditional boys' and girls' roles. It works with 10- to 14-year-old boys and girls, bringing them together at child clubs for participatory workshops 1 hour per week for 8 weeks. Sessions explore young people's hopes, dreams, and ideas about gender equality, power, and fairness. They identify small actions that brothers can take to promote respect and empower girls in their homes. Results of the initial program show boys are making small changes in their own behavior—helping their sisters and mothers with household chores; advocating for their sisters' education and against early marriage; and encouraging family members, friends, and neighbors to do the same. Compared with those who did not participate, more girls in the program intervention group state that their brothers and other boys in their communities are making small changes toward gender equality. Parents also report that their sons now help their daughters with schoolwork and chores, and that their households are more peaceful as a result.	**Transformative**	The program encouraged boys' participation in traditionally female roles and facilitated exploration of ideas around gender equality, power, and fairness.

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Chapter 9: Introduction to gender analysis

Gendor 101 training materials

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Jhpiego is a nonprofit global leader in the creation and delivery of transformative health care solutions that save lives.

In partnership with national governments, health experts and local communities, we build health providers' skills, and we develop systems that save lives now and guarantee healthier futures for women and their families. Our aim is revolutionizing health care for the planet's most disadvantaged people.

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Chapter 9: Introduction to gender analysis

Learning objectives

By the end of this session, participants will be able to:

- Explain the importance of a gender analysis
- Describe the four domains of Jhpiego's Gender Analysis Framework
- Apply Jhpiego's Gender Analysis Framework to identify gender constraints and opportunities

Time needed

2 hours 55 minutes

Materials needed

- Why Did Mrs. X Die Jamboard Template
- Jamboard template for "Discussion on applying gender analysis and integration"
- Four copies of this Jamboard template OR four copies of this Google document template. The Google document template can also be found in the Gender101V folder, and uploaded by the facilitator. [The facilitator should select ahead of time which template (Jamboard or Google document) will work more effectively for their participants and prepare copies accordingly.]
- Participant Handout: Gender Analysis and Integration Table - Blank
- Participant Handout: Preventing Mother-to-Child Transmission of HIV in Country Z
- Participant Handout: MCHIP Yemen
- Participant Handout: Gender Analysis Framework
- Facilitator Resource: Introduction to Gender Analysis and Integration into Health Programs PowerPoint
- Facilitator Resource: Gender Analysis and Integration Table – Completed
- "Why Did Mrs. X Die?" video

Advance preparation

1. Email copies of each participant handout to participants. Request that all participants read the Participant Handout: Preventing Mother-to-Child Transmission of HIV in Country Z prior to the live session.
2. **OPTIONAL** In the same email, send a link to the video, "Why Did Mrs. X Die?" and ask each participant to watch the video prior to coming to the live session.
    - Link to "Why Did Mrs. X Die?": https://www.youtube.com/watch?v=WNb9pNymuwQ (with French subtitles).
    - Alternatively, watch the video with participants during the live session.
3. Save a copy of the **Introduction to Gender Analysis PowerPoint** to your laptop, and practice the presentation beforehand to ensure you have a good understanding of the concepts.
4. Make a copy of the Why Did Mrs. X Die Jamboard Template

5. **OPTIONAL:** To integrate additional interactivity into the presentation, you may ask participants to respond to the questions below during the presentation at the designated slide. [Note that it is not required that you ask participants *every* question. Consider which are most pertinent to your group of participants.] While Zoom chat questions do not require additional preparation, Zoom Chat questions **may be adapted into a question on Mentimeter or Slido if the facilitator has a paid Mentimeter or Slido account.** It is only recommended that facilitators with paid accounts who are comfortable using Mentimeter/Slido use one of these two platforms to ask the following questions.
    - **Slide 13 [Zoom chat question]** (Ask prior to showing the bulleted list of assets):
        - What are some examples of types of assets or resources that we might want to identify and analyze in our gender analysis?
    - **Slide 14 [Zoom chat question]** (Ask prior to showing the bulleted list of participatory activities):
        - What are some types of activities that one may (or may not) participate in that we would want to identify and analyze in our gender analysis?
    - **Slide 16 [Zoom chat question]** (Ask prior to showing the bulleted list of rights):
        - What are some examples of legal rights or statuses that we would want to identify and analyze in our gender analysis?
    - **Slide 17 [Zoom chat question]** (Ask prior to showing the bulleted list of decisions):
        - What are some examples of actions or decisions that one may have power over—or lack power over?
6. Make one copy of this Jamboard template to use as part of the group discussion during "Discussion on applying gender analysis and integration".
7. Make four copies of **either** this Jamboard template OR four copies of this Google document template. Label each document for groups 1 – 4. Additionally, add each group's respective domain to the template, so groups know which domain they will be reviewing.
    - Prepare links to each Jamboard or Google Document and have them available to easily copy and paste into the Zoom Chat. The format for the text that is copied and pasted should be as follows:
        - Group 1: [link to Jamboard/Document]
        - Group 2: [link to Jamboard/Document]
        - Group 3: [link to Jamboard/Document]
        - Group 4: [link to Jamboard/Document]

Steps

Introduction (1 minute)

Start the session by explaining that there is overwhelming evidence pointing to gender as a health determinant. Increasingly, development and health programs are striving to take gender into account as a means of increasing their impact. Addressing gender effectively requires understanding dominant gender norms in a given sociocultural context and their influence on women's and men's health. A gender analysis is fundamental to identifying and understanding gender norms and power relations.

Understanding gender analysis (40 minutes)

1. Explain that you will begin with a presentation on gender analysis. Instruct participants to hold their questions until the end of the presentation.
2. **Technology Action:** Screen share the presentation on gender analysis.
3. Talk through each slide using the facilitator discussion points detailed under each slide. Spend no more than 30 minutes presenting.

OPTIONAL Interactivity Additions

Consider integrating the following questions into the slide deck in order to increase interactivity. Note that each question will add 1 to 2 minutes to the overall presentation time.

Note that "Zoom Chat Question" refers to open-ended questions where participants are encouraged to respond in the chat. There are no technical requirements for Zoom chat questions.

- **Slide 13 [Zoom chat question]** (Ask prior to showing the bulleted list of assets):
  - What are some examples of types of assets or resources that we might want to identify and analyze in our gender analysis?
- **Slide 14 [Zoom chat question]** (Ask prior to showing the bulleted list of participatory activities):
  - What are some types of activities that one may (or may not) participate in that we would want to identify and analyze in our gender analysis?
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  - What are some examples of legal rights or statuses that we would want to identify and analyze in our gender analysis?
- **Slide 17 [Zoom chat question]** (Ask prior to showing the bulleted list of decisions):
  - What are some examples of actions or decisions that one may have power over—or lack power over?

4. Next, allow participants 10 minutes to ask questions and/or make comments.

Why did Mrs. X die? (13 minutes)

1. Explain that identifying and understanding the social determinants of sexual and reproductive health (SRH) is fundamental for achieving positive health outcomes. By moving beyond the identification of immediate contributors to poor health outcomes toward the identification of underlying causes, our programs can become more effective. Gender analysis allows us to uncover underlying causes of poor health outcomes and design more impactful interventions.
2. Explain to participants that the group will now discuss the short film that all participants were asked to watch prior to coming to the live session, "Why Did Mrs. X Die".
3. Ask one participant to briefly (under 1 minute) summarize the video.

Facilitator Note: If you did not request that participants watch the video ahead of the session, take 10 minutes to watch the video with the group now.

When sharing your screen to show the video, be sure to click "Optimize for video clip" and "share sound". Link to "Why Did Mrs. X Die?": https://www.youtube.com/watch?v=WNb9pNymuwQ (with French subtitles).

4. Explain that we will now use the video to consider how our programs address, or fail to address, various dimensions related to gender.
5. **Technology Action:** Screen share the first frame of the Why Did Mrs. X Die? Jamboard.
6. Explain that the group will consider the role that programming plays in two environments: first, the hospital, and second, the home/village. Ask for a few volunteers to share challenges/problems that programs generally do address at the hospital in order to reduce maternal mortality. Encourage them to think back on the video and some of the problems that the hospital addressed in order to reduce mortality rates.
7. **Technology Action:** Add sticky notes with participants' ideas as they share.
8. Then, ask participants to again think back on the video and share some of the problems/challenges that programming did not address at the hospital, but that ultimately affected the outcome of Mrs. X. (Spend no more than 5 minutes on steps 6-8).
9. **Technology Action:** Add sticky notes with participants' ideas as they share.
10. **Technology Action:** Move to the second frame of the Jamboard.
11. Repeat steps 6-9 for the second frame ("In the Home/Village").

Discussion on applying gender analysis and integration (40 minutes)

Facilitator note: If you are short on time, you may choose to simply use the "Why Did Mrs. X Die?"' video to complete a 15–20 minute domain-specific mapping of the gender issues as a group. To do so, you will need to refer to Participant Handout: Gender Analysis Framework and write the titles of the four domains on four separate frames of a Jamboard (one frame per domain), which you will then screen share for the group as you take notes.

Start with the first domain: Explain the domain by referring to the definition and examples provided in Participant Handout: Gender Analysis Framework. Next, ask participants to list some of the gender issues raised in the video that are relevant to the domain in question. Repeat this process for the three remaining domains. After you have completed mapping all four domains, you may move to the fifth part of the session (Small Group Work on Gender Analysis and Integration).

Note that by skipping to the fourth part of the session (Plenary on Applying Gender Analysis and Integration), participants will miss the detailed explanations for each of the components of Gender Analysis and Integration Table. You will, therefore, need to set aside a bit of time to explain the tables before participants move into the small group work.

1. Next, explain to the group that they will spend some time practicing gender analysis and integration using case studies.
2. Tell participants that they will complete a quick gender analysis as a group using a case study.
3. Ask participants to raise their hand if they read the case study prior to the prior to the session. Based on how many participants have/have not read the case study, provide a few minutes for participants to read the case study now. Alternatively, ask one participant to provide a brief (under 1 minute) description of the case study, and suggest that any participants who did not read the case study prior the session read it quickly now.
    - If necessary to explain to participants how to access the "raise hand" feature, you may use the following language: "You can access the 'raise hand' feature on Zoom by click on the 'Reactions' button on the bottom of your Zoom screen. If you don't immediately see the 'Reactions' button,

look for the icon with three dots, titled 'More'. Click that and select 'Reactions'. Then, click 'Raise Hand'. You will need to return to the 'Reactions' button to lower your hand."

4. **Technology Action:** In the chat, upload the Participant Handout: Preventing Mother-to-Child Transmission of HIV in Country Z and invite participants to download the case study so they may easily access and refer to it during the discussion. You may also share your screen, showing the case study, for participants to read if they are having trouble downloading and opening the file. Remind participants that this case study has also been sent to them in their email.
5. Remind participants that you have emailed them all a copy of an important handout: Gender Analysis and Integration Table – Blank. Explain that, while they do not need to have the worksheet downloaded onto their computers for today's activity, we will be spending some time answering the questions on this worksheet as a group. Explain that the worksheet was developed to help guide participants through the process of gender analysis and integration, and that they may wish to reference/use this worksheet after the live session to support them with their own gender analysis. Explain that you will walk them through the process using the country context description for Country Z. (Allow no more than 5 minutes for steps 1–5).
6. **Technology Action:** Screen share a copy of the Jamboard template for full group discussion. Share the first frame, with Step 1A ("What are the key gender relations inherent in each domain that affect women and girls, men and boys?")
7. Ask participants to imagine they need to design a prevention of mother-to-child transmission (PMTCT) intervention.
8. Next, walk participants through Step 1A (frame 1 in the Jamboard) using the following guiding notes (spend no more than 2 minutes on this step):
    - Step 1A: Key gender relations
        - Gender relations are the social, economic, and political relationships between women and men that exist in any family, community, society, or workplace. Gender relations influence people's ability to freely decide, influence, control, enforce, and engage in collective actions. We want to understand the different relations that characterize the lives of women and men (in Country Z) and that may (ultimately) inhibit or facilitate their access to resources and opportunities.
        - As mentioned during the presentation, to understand gender relations, a gender analysis will focus on specific aspects (or domains) of women's and men's relations. In this table, we are going to look at women's and men's gender relations in terms of:
            - their "**practices, roles, and participation**" (e.g., practices/activities and roles that are customary/traditional and/or acceptable (and not acceptable) for women and men; differences in women's and men's participation in social life, political life, family, community);
            - their "**access to assets**" (e.g., women's and men's ability to access natural resources, productive assets, income, information, knowledge, social networks);
            - "**institutional laws and policies**" and the ways in which women and men are dissimilarly affected by policies and rules governing institutions, including the health system (e.g., how laws and policies affect women's/girls', men's/boys' access to education, health services, employment opportunities, property ownership); and

        - "**knowledge, beliefs, and perceptions**" (e.g., social and cultural expectations about appropriate behavior, individual expectations about appropriate behavior) about women and men.
    - Power pervades all four domains, and informs who has, can acquire, and can expend assets; who can make decisions about their bodies and their health and that of their children; who can take advantage of opportunities, etc.
    - Power also determines the way women and men are treated by different types of institutions, policies, and laws.

9. After you have explained step 1A, ask participants to refer back to the description of Country Z and agree on one example of a gender relation for each of the four domains. Refer to **Facilitator Resource: Gender Analysis and Integration Table - Complete** for examples.
10. **Technology Action:** As participants agree on the gender relations, write them using sticky notes on the Jamboard under the relevant domain. (Spend no more than 3 minutes on this step).
11. Next, explain Step 1B (frame 2) using the following guiding notes (spend no more than 2 minutes on this step):
    - Step 1B: Potential missing information
        - After having identified key information about gender relations (by domain), we will need to identify any additional/missing information that might help the program to better ascertain the gender barriers that need to be taken into account during program design (to ensure the success of the program). This analysis is also done across the four domains.
12. After explaining step 2B, ask participants to agree on one example of missing/additional information (for each of the four domains) that might be needed to better understand the gender relations and barriers that were just identified in the Country Z case study. Refer to **Facilitator Resource: Gender Analysis and Integration Table - Complete** for examples.
13. **Technology Action:** As participants agree on the missing/additional information, write it on a sticky note on the second Jamboard frame under the relevant domain. (Spend no more than 3 minutes on this step).
14. Next, explain Step 1C (frame 3) using the following discussion points (spend no more than 2 minutes on this step):
    - Step 1C: Gender-based constraints
        - These are gender relations that **inhibit** men's and/or women's access to resources or opportunities of any type. We will need to identify gender-based barriers faced by women and men in Country Z, specifically those barriers that could hinder the success of the project we're designing. This analysis is also done across the four domains.
15. After you've explained step 1C, ask participants to agree on one example of a gender-based constraint for each of the four domains that would be important to take into account during the design of the project. Refer to **Facilitator Resource: Gender Analysis and Integration Table - Complete** for examples.
16. **Technology Action:** As participants agree on the constraints, write them on a sticky note on the third Jamboard frame under the relevant domain. (Spend no more than 3 minutes on this step).
17. Finally, explain step 1D (frame 4) using the following discussion points (spend no more than 2 minutes on this step):
    - Step 1D: Gender-based opportunities

- These are gender relations that **facilitate** men's and/or women's access to resources or opportunities of any type. We will need to identify gender-based opportunities for women and men in Country Z, specifically opportunities that could contribute to the success of the project. This analysis is done across the four domains.

18. After you've reviewed the fourth column, ask the group to agree on one example of a gender-based opportunity for each of the four domains that would be important to take into account during the design of the project. Refer to **Facilitator Resource: Gender Analysis and Integration Table - Complete** for examples.
19. **Technology Action:** As participants agree on opportunities, write them a sticky note on the fourth Jamboard frame under the relevant domain. (Spend no more than 3 minutes on this step).
20. Explain that based on the gender analysis completed in step 1, we can now begin identifying specific subobjectives, activities, and indicators for PMTCT programs.
21. **Technology Action:** Screen share the fifth frame of the Jamboard.
22. Review the various components of Step 2-5 using the following talking points, starting with step 2 (frame 5); (spend no more than 2 minutes on this step):
    - Step 2: Gender-integrated objectives
      - This step is directly linked to step 2 of the program cycle (Strategic Planning), which has to do with developing program objectives that strengthen the synergy between gender equity and health goals; and identifying program participants, clients, and stakeholders.
      - In this step, we need to formulate program objectives to address some of the gender-based opportunities and barriers that were uncovered during the gender analysis. The objectives should relate to a change we would like to see with respect to specific gender-based barriers, and they should leverage identified gender-based opportunities. The objectives should also be formulated by domain.
23. After reviewing step 2, ask the group to agree on one example of a gender-integrated objective for each of the four domains. Refer to **Facilitator Resource: Gender Analysis and Integration Table - Complete** for examples.
24. **Technology Action:** As participants agree on objectives, write them on a sticky note on the fifth frame of the Jamboard under the corresponding domain. (Spend no more than 3 minutes on this step)
25. Next, explain step 3 (frame 6) using the following talking points (spend no more than 2 minutes on this step):
    - Step 3: Activities
      - This step is related to step 3 of the program cycle (Design), and involves identifying key program strategies by domain to address gender-based constraints and opportunities. In this step, we will need to identify activities that could help achieve each of the gender-integrated objectives we've formulated. Activities should also leverage identified gender-based opportunities.
26. After reviewing step 3, ask participants to agree on one activity example per domain for each of the objectives identified. Refer to **Facilitator Resource: Gender Analysis and Integration Table - Complete** for examples.
27. **Technology Action:** As the group agrees on the activities, write them down on a sticky note on the sixth frame of the Jamboard under the appropriate domain. (Spend no more than 3 minutes on this step).

28. Next, explain steps 4-5 (frame 7) using the following talking points (spend no more than 2 minutes on this step):
    - Steps 4 and 5: Indicators
        - These steps also correspond to steps 4 and 5 of the program cycle (monitoring and evaluation). Step 4 has to do with the development of indicators that measure gender-specific outcomes, and monitoring implementation and effectiveness in addressing program objectives. Step 5 involves measuring the program's impact on health and gender equity outcomes, and adjusting program design to enhance successful strategies and mitigate any unintended harmful results. In these steps, we will need to identify indicators that would point to a decrease in, or removal of, the gender barriers our program seeks to address. As with the objectives and the activities, indicators will be formulated across the four domains.
29. After discussing steps 4-5, ask participants for one indicator per domain for each of the objectives identified. Refer to **Facilitator Resource: Gender Analysis and Integration Table - Complete** for examples.
30. **Technology Action:** As participants agree on the indicators, write them down on a sticky note on the seventh frame of the Jamboard under the relevant domain. (Spend no more than 3 minutes on this step).

Small group work on gender analysis and integration (1 hour 20 minutes)

Facilitator Note: If you do not have sufficient time, this activity may be skipped.

1. **Technology Action:** At any time during the session, you may begin to prepare the breakout rooms for this activity.
    - 4 groups (randomly distributed participants)
    - Check "Breakout rooms automatically close after"
        - 30 minutes
    - Check "Notify me when time is up"
    - Countdown after closing breakout room: 30 seconds
2. Tell participants that they will now work in small groups to complete another gender analysis and integration exercise like the one they just completed in the large group.
3. Explain that participants will be divided into four groups, and each group will be assigned the same case study, along with one of the four gender analysis domains. In their small groups they will have 30 minutes to:
    - Read the case study.
    - Complete Steps 1A through 1D (Frames 1-4 on the Jamboard) with information specific to the domain assigned to their group (identify key gender relations, missing information, gender-based constraints, and gender-based opportunities).
    - Complete Steps 2 through 5 (Frame 5-7 on the Jamboard) with information specific to the domain assigned to their group (identify gender-integrated objectives, activities, and indicators).
4. **Technology Action:** Copy and paste into the chat links to each Jamboard/Document. Materials should be clearly labeled Group 1, Group 2, etc. (see example below).

- Example:
  - Group 1: [Link to Jamboard/Document]
  - Group 2: [Link to Jamboard/Document]
  - Group 3: [Link to Jamboard/Document]
  - Group 4: [Link to Jamboard/Document]

5. Explain that each group's Jamboard/Document has their domain listed within the first page/frame.
6. **Technology Action:** If you are using the Jamboard templates, upload a copy of the Participant Handout: MCHIP Yemen and Participant Handout: Gender Analysis Framework.
7. Remind participants that they can also access these documents through their email.

Technology Note: If you are using the Google Document, both handouts have already been added to the template. Let participants know that they should reference both handouts from their group's document.

8. Explain that you have just shared links to the document on which groups will take notes in the chat. Explain that, as they are being moved to a breakout room, participants will see on their screen to which numbered room they are being moved. Once they are in their breakout rooms, their room number will appear at the top of the Zoom screen. Their breakout room number will represent their group number and should be used to know which document to open.
9. Let the group know that they will have 30 minutes to complete this task. Ask groups to take the last few minutes to elect a spokesperson who can share their group work with the larger group.
10. Make sure participants understand the instructions. Remind them that they should use the "Ask for Help" button if they have questions for a facilitator while in their breakout room. (Spend no more than 5 minutes on steps 1–9).
11. **Technology Action:** Open the breakout rooms.
12. **Technology Action:** Open each Jamboard/Google Document on a different tab in your computer. Regularly review each document to ensure that at least one participant has opened the board and, eventually, that groups have added sticky notes/text. Join any groups where no one is on the document after 30-40 seconds, or where no sticky notes/text have been added a few minutes.

Technology Note: Anonymous circles at the top right corner of the Jamboard/Google Document will indicate whether or not participants have opened the document.

13. **Technology Action:** Send a broadcast message reminding participants when they have 5 minutes and 1 minute left. Additionally, remind groups to select a spokesperson.
14. **Technology Action:** After approximately 30 minutes, close the breakout rooms.
15. **Technology Action:** Screen share Group 1's document.
16. Ask for the spokesperson from the first group to present their group responses. (Allow 5 minutes for the presentation).
17. After the first group representative has presented, allow other participants to ask questions and/or comment on the group's work. (Spend no more than 5 minutes on this step).
18. Repeat steps 15–17 for the remaining three groups. The total debrief time should be no more than 40 minutes.

19. After all four groups have presented, facilitate a 5-minute debrief by asking the following questions:
    - What did you think of this framework and exercise? Do you think this is something you can do or work with Monitoring, Evaluation, and Research (MER) staff to do?
    - How will/can you apply this framework to your current project?

Closing (1 minute)

End the activity by stating that a gender analysis allows for the identification of underlying causes of specific health and development issues and as such is key for achieving programmatic impact. During their design and implementation, programs must be mindful not only of the ways in which gender-based constraints and opportunities might influence programs' ability to achieve sustainable results, but also the ways in which programs might impact (intentionally and unintentionally) the participants they are intended to serve.

Sources

- Interagency Gender Working Group (IGWG). n.d. *Introduction to Gender Analysis and Integration*. https://www.igwg.org/training/gender-analysis-and-integration/. Accessed December 21, 2016.
- Population Reference Bureau. 2009. *A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action*, 2nd ed. Washington, DC: Population Reference Bureau.

Participant Handout: Gender Analysis and Integration Table – Blank

(*Adapted from* IGWG. n.d. *Gender Analysis and Integration*. Gender Integration Table 1: Data Collection and Analysis. https://www.igwg.org/wpcontent/uploads/2017/05/GendrIntegrExercisTbl1.pdf).

Program goal and/or overall health objective: _____

Instructions: Conduct a gender analysis of your program by answering the following questions (in the table).

- Be sure to consider these relations in different contexts—individual, partners, family and communities, health care and other institutions, policies.

Step	Gender Analysis Question	Domain	Notes
1.	A. What are the key gender relations inherent in each domain that affect women and girls, men and boys?	Practices and participation	
		Beliefs and perceptions	
		Access to assets	
		Institutions, laws, and policies	
	B. What other potential information is missing but needed about gender relations?	Practices and participation	
		Beliefs and perceptions	
		Access to assets	
		Institutions, laws, and policies	
	C. What are the gender-based constraints to reaching program objectives?	Practices and participation	
		Beliefs and perceptions	
		Access to assets	
		Institutions, laws, and policies	
	D. What are the gender-based opportunities to reaching program objectives?	Practices and participation	
		Beliefs and perceptions	
		Access to assets	
		Institutions, laws, and policies	

2.	What gender-integrated objectives can you include in your strategic planning to address gender-based opportunities or constraints?	Practices and participation	
		Beliefs and perceptions	
		Access to assets	
		Institutions, laws, and policies	
3.	What proposed activities can you design to address gender-based opportunities or constraints?	Practices and participation	
		Beliefs and perceptions	
		Access to assets	
		Institutions, laws, and policies	
4-5	What indicators for monitoring and evaluation will show if (1) the gender-based opportunity has been taken advantage of, or (2) the gender-based constraint has been removed?	Practices and participation	
		Beliefs and perceptions	
		Access to assets	
		Institutions, laws, and policies	

Participant handout: Preventing mother-to child transmission of HIV in Country Z

(*Adapted from* IGWG. 2010. IGWG Gender, Sexuality and HIV Training Module. Case Study: PMTCT Programming in Country Zed. http://www.healthpolicyinitiative.com/Publications/Documents/1408_1_IGWG_GSHIV_Module_Oct_2010_acc.pdf).

Like many countries, Country Z continues to find it difficult to facilitate women's access to PMTCT services. These services include testing to determine HIV status, access to drugs to prevent HIV-positive mothers from transmitting the disease to their children, information on exclusive infant feeding options, health care for infants, family planning, and care and treatment for the woman's own health.

Available background information

The most recent Demographic and Health Survey (DHS) for Country Z reported high utilization (90%) of antenatal care (ANC) by pregnant women, but only 47% delivered at a health facility. Most women completed at least some primary schooling. More than half of the women reported having a partner or husband. Only 40% had access to piped water or electricity. More than half reported no independent income.

Data from the World Health Organization (WHO) Multi-Country Study on Domestic Violence report that for Country Z, 41%–56% of ever-partnered women ages 15–49 had ever experienced physical or sexual violence from an intimate partner, and 17%–25% had experienced severe physical violence. Of the latter group, one-third to one-half had experienced severe physical violence within the past year. Some recent poster campaigns with slogans such as "Test for the Health of the Next Generation" picture a pregnant woman holding a newborn baby. Although ANC use is high, recent focus groups show that women have limited knowledge of specific PMTCT interventions or their availability at the local health clinic. When asked about the importance and availability of specific medicines and recommended exclusive infant feeding practices, women expressed uncertainty about the effect of these recommendations on their pregnancy and the health of the infant.

A number of women expressed the belief that women who are HIV-positive should not have more children. Regarding testing, women were more interested in knowing their HIV status for the purpose of protecting themselves from infection if they tested negative, or for seeking care if they were HIVpositive. Significantly, only 11% identified concern about infecting their child as a primary reason to learn their HIV status.

Gender norms

Women are expected to seek permission from their male partners before testing. They believe that testing without a partner's permission will increase conflict. Men feel free to make their own decisions about whether to test or not and rarely disclose their HIV status to their partners. However, men are reluctant to use testing sites near their communities, fearing lack of confidentiality. Men also believe that by the time a woman is pregnant, it is too late for themselves and their partners to be tested. They argue that a woman who is HIV-positive should not have any more children. If a man is HIV-positive, however, he is unlikely to disclose, and will still desire more children. Men say that access to antiretrovirals (ARVs) to prevent transmission would be a great incentive for them to agree to testing for themselves and their partners, even if ARVs were only provided to mothers and babies.

Both men and women in the community report that health information is supposed to be brought into the family by the man. Women are not regarded as reliable sources of information. Men are viewed as the family decision-makers. Men regard health care providers as legitimate sources of information, yet they generally do not accompany their partners to family planning, ANC, or postnatal care (PNC) visits

and would not be expected to attend the labor or birth of their child. Birth, delivery, and infant care are seen as exclusively the responsibility of women, although men are increasing their involvement in childrearing responsibilities once children become toddlers or older.

Responding to local beliefs

Many people in the community believe that if one parent is HIV-positive, both parents and all children born will be HIV-positive as well. HIV-related stigma in the community remains high and is directed at the person who first tests and discloses his or her status.

Because of antenatal testing, more women than men know their HIV status. It has not been uncommon for women who reveal their HIV-positive status to be abandoned, and many women fear being abused by their male partners. Women do discuss health and relationship issues with other women in the community, and find other women an important source of social support and practical information, especially as related to women's and children's health. However, this information is not brought directly into the household. Health care providers in the public sector have limited time to provide much information and counseling to their clients. Overburdened by the migration of health care staff as well as by absences due to their own and family illnesses, midwives and nurses are stretched too thin to provide even a minimum standard of clinical care.

Participant handout: MCHIP Yemen

MCHIP Yemen (excerpt)

Yemen presents a severely under-resourced and fragmented health system, where political instability and chronic and seasonal food insecurity are linked with poor maternal, infant, and young child nutrition practices. Health services were further deeply affected by the 2011 Yemeni Revolution, and the ongoing instability and uncertainties of the political situation make long-term planning difficult. Within this context, the Government of Yemen's Ministry of Public Health and Population (MOPHP) drafted the Maternal and Child Health Acceleration Plan 2013–2015 to reduce maternal and under-5 mortality. Other ratified policies and strategies include the National Health Policy 2010–2025, the National Newborn Health Strategy, the National Nutrition Strategy, and the Reproductive Health Strategy. Across the cross-cutting and technical areas relevant to health, the needs and opportunities for intervention are considerable.

USAID's global flagship Maternal and Child Health Integrated Program (MCHIP)—primed by Jhpiego and led operationally in Yemen by John Snow, Inc. (JSI), with support from Save the Children, the Program for Appropriate Technology in Health (PATH), and ICF Macro—is uniquely suited to support the Government of Yemen and USAID/Yemen to fully realize one goal: **reduce maternal and neonatal mortality and morbidity as well as rates of childhood illness and malnutrition, particularly stunting and anemia, in the next 5 years.**

MCHIP's Associate Award activities will be based on an integrated approach that spans reproductive, maternal, newborn, and child health and nutrition (RMNCH/Nut) and will be built on five key objectives: 1) foster an enabling environment to increase coverage of high-impact RMNCH/Nut interventions by leveraging and integrating with other sectors; 2) enhance human resource planning and preparedness of the workforce; 3) support staff at the district level to effectively implement and monitor high-impact health and nutrition interventions; 4) increase access to and quality of service delivery points offering high-impact health and nutrition interventions; and 5) improve health and nutrition practices by families, supported by community health workers and other community members. **MCHIP's objectives in Yemen are designed to achieve progress to meet USAID's central results pathways for decreases in maternal and neonatal mortality, infant and child mortality, and improvements in nutrition status and promote resilience by layering, integrating, and sequencing with emergency relief and other USAIDfunded programs to maximize results, reporting on a continuum toward outcomes that lay a foundation toward impact.**

To achieve these goals, MCHIP will work in partnership with the MOPHP to strengthen the existing health system through targeted technical assistance at the district and governorate levels. Consistent with the USAID Mission's vision for its other health and related programs, MCHIP will maximize the strengths of MOPHP partners at governorate levels, and with multiple public, private, and nongovernmental organizations, to improve access to and quality of RMNCH/Nut services. We will address barriers to care-seeking, access, and uptake of optimal health and nutrition behaviors, including gender-related barriers, through the scale-up of proven, evidence-based, high-impact RMNCH/Nut interventions.

In addition, given the sociocultural and geographic challenges of Yemeni society, MCHIP's focus throughout this project will be to support the MOPHP to **improve equity and access to quality health services**. MCHIP will support communities, district health offices, governorate health offices, and other stakeholders to develop innovative solutions to identify and address equity issues specific to the country's cultural context.

Gender: Gender inequalities remain a fundamental constraint to improving health outcomes. Yemen places **last** out of 136 countries ranked according to the World Economic Forum's Global Gender Gap Index, which measures women's economic participation and opportunity, educational attainment, health and survival, and political empowerment (JICA 2009). The low status of women in society is underpinned by gender and cultural norms that devalue women and restrict their freedoms. Poverty exacerbates matters by forcing families to choose whether to invest in a girl child or boy child and whether or not to raise a girl or sell her off to be married. Inequalities are also entrenched within the legal structure: for instance, the personal status law dictates that a woman may not leave the house without the permission of her husband, there is no minimum age of marriage and there are no laws against female genital mutilation or domestic violence (UNICEF 2011, UNFPA 2013).

These norms and practices, often linked to deeply held religious beliefs, affect children and women's health in multiple ways. In particular, they 1) hinder access to and demand for family planning services; 2) undermine the quality of services; and 3) increase various associated causes of health risk, namely early marriage and gender-based violence (GBV). Men generally are the gatekeepers for women's access to health services: they make decisions with respect to health care in general and to family planning (FP) in particular; and they must accompany their partners to the health facilities. Women, on the other hand, have low levels of literacy and formal education, which are correlated with lower levels of awareness and care-seeking behavior. Cultural norms lead women to deliver at home without a skilled birth attendant and those who deliver in a facility leave health facilities within 2 hours of giving birth. In this context, implementation of the World Health Organization's (WHO's) new guidance in Yemen (which includes a postpartum stay of 24 hours and a home visit for all women) has been challenging. Women are discouraged from leaving the home during the first 40 days after childbirth, and in many places male resistance is an obstacle for women to utilize FP services. Similarly, when a child is sick, the decision to seek help outside the household often belongs to the father or to other family members. In addition, women usually have to be accompanied by a male relative (*muharram*) to bring a sick child to a health facility, particularly if the provider is male.

Adolescent pregnancies linked to early marriage remain a widespread phenomenon in Yemen, underpinned by poverty and religious and cultural norms. About 16% of girls ages 15–18 are married in Yemen (World Economic Forum 2013). Early marriage is not only a major development challenge because of its negative impact on girls' education, women's literacy, and women's economic empowerment, it also results in high fertility rates and poorer health outcomes for mother and newborn.

References

- Japan International Cooperation Agency (JICA). 2009. *Yemen: Country Gender Profile*. Final report, 23 March. Washington, DC: JICA.

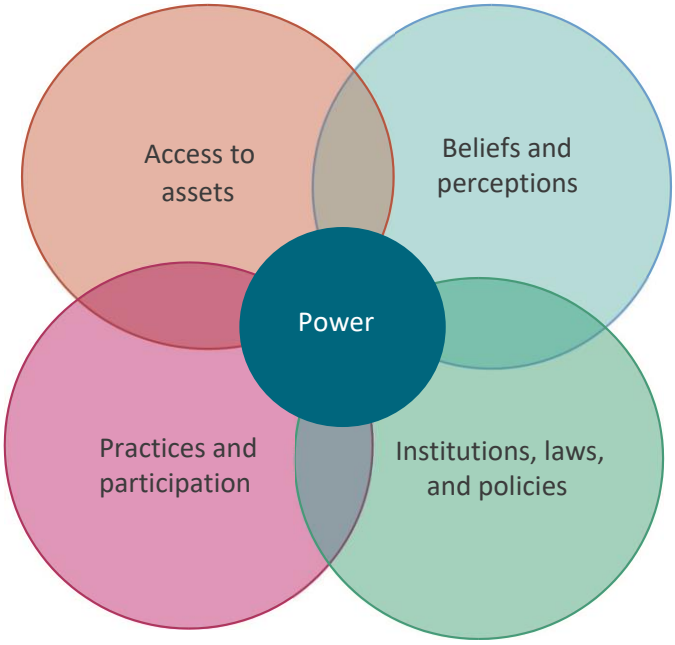
  https://www.jica.go.jp/english/our_work/thematic_issues/gender/background/pdf/e09yem.pdf.

- UNICEF. 2011. *Yemen: MENA Gender Equality Profile*. Washington, DC: UNICEF. https://www.unicef.org/gender/files/Yemen-Gender-Eqaulity-Profile-2011.pdf.

- United Nations Population Fund (UNFPA). 2013. State of the World's Population 2013. New York, NY: UNFPA. https://www.unfpa.org/publications/state-world-population-2013.

- World Economic Forum. 2013. Global Gender Gap Index 2013. http://widgets.weforum.org/gender-gapheat-map/.

Participant handout: Gender analysis framework



Access to assets

This domain of the Gender Analysis Framework refers to how gender relations affect access to the resources necessary for a person to be a productive member of society. It includes both tangible assets (e.g., land, capital, tools) and intangible assets (e.g., knowledge, education, information, employment, benefits).

Beliefs and perceptions

This domain draws from cultural belief systems or norms about what it means to be a woman or a man in a specific society. These beliefs affect women's and men's behavior, dress, participation, and decisionmaking capacity. They may also facilitate or limit women's and men's access to education, services, and economic opportunities.

Practices and participation

The norms that influence women's and men's behavior also structure the type of activities they engage in, as well as their roles and responsibilities. This domain captures information on women's and men's different roles; the timing and place where their activities occur; their capacity to participate in different types of economic, political, and social activities; and their decision-making.

Institutions, laws, and policies

This domain focuses on information about women's and men's formal and informal rights, and how they are dissimilarly affected by policies and rules governing institutions, including the health system. It includes an individual's right to:

- Inherit and own property
- Legal documents (such as identity cards, property titles, and voter registration)

- Reproductive choice
- Lifesaving maternal health care
- Representation
- Due process

Power

The power domain pervades the other four domains of the framework. It refers to an individual's capacity to control resources and to make autonomous and independent decisions free of coercion. Gender norms influence the extent to which individuals can freely decide, influence, control, enforce, engage in collective actions, and exercise decisions about:

- Acquiring and disposing of resources
- Choosing what to believe
- One's own body
- Reproductive choice
- Children
- Occupation
- Affairs of the household, community, municipality, and the state; voting, running for office, and legislating
- Entering into legal contracts
- Moving about and associating with others

Facilitator Resource: Gender Analysis and Integration Table – Completed

(*Adapted from* IGWG. n.d. *Gender Analysis and Integration*. Gender Integration Table 1: Data Collection and Analysis. https://www.igwg.org/wpcontent/uploads/2017/05/GendrIntegrExercisTbl1.pdf)

Program goal and/or overall health objective: **Reduce prevalence of GBV**

Instructions: Conduct a gender analysis of your program by answering the following questions (in the table).

- Be sure to consider these relations in different contexts—individual, partners, family and communities, health care and other institutions, policies.

Step	Gender Analysis Question	Domain	Notes
1.	A. What are the key gender relations inherent in each domain that affect women and girls, men and boys?	Practices and participation	• Men are the decision-makers in the household. • Men serve as the main sources of health information in the household. • Men are the main breadwinners of the family. • Women are responsible for birth, delivery, and caring for the children.
		Beliefs and perceptions	• Men are considered more reliable sources of information than women. • There is a belief that maternal and child health should not concern men. • High rates of GBV indicate some community tolerance of GBV. • Women are believed to be inferior to men. • It seems acceptable for men to abandon their HIV-positive female partners. • HIV stigma is high. • Men's fears surrounding lack of confidentiality limits their use of testing services.
		Access to assets	• Women are able to access ANC services. • Women's use of health facilities for delivery is limited. • Women seem to have limited access to income generation activities/opportunities. (They are highly financially dependent on men). • Men restrict their female partners' access to testing sites. • Women may have limited access to PMTCT services and information. • Most women have access to primary education. • Services for GBV survivors (health, legal, psychological, etc.) may not exist, or people may not know how to access them. Even if there is knowledge about these services, men may prohibit women from accessing them.

Step	Gender Analysis Question	Domain	Notes
		Institutions, laws, and policies	• Men's abandonment of their female partners following disclosure of HIV status may indicate an absence of legal protections for married women and women in domestic partnerships. • There may be no law(s) criminalizing GBV. • Health facilities offering maternal and newborn health services may not be welcoming to men.
	B. What other potential information is missing but needed about gender relations?	Practices and participation	• What are men taught about their familial responsibilities? • Are there any household decisions that are discussed jointly by women and men? • Are there any informal spaces in which men discuss health and relationship issues with other men?
		Beliefs and perceptions	• Do women have knowledge about • available services for GBV survivors (e.g., legal counsel, shelters, psychosocial services)? • Are women who experience GBV stigmatized in the community? • Is GBV discussed?
		Access to assets	• Even though men are not expected to be involved in pregnancy and delivery, do they have any influence over decisions related to where delivery occurs? If, so what role do they play in these decisions? • Are any services available for women who experience violence? • How and where are PMTCT services and information offered? • Are any support services available for individuals who test positive for HIV (e.g., psychosocial services, financial aid services)?
		Institutions, laws, and policies	• Do women have the legal right to any sort of financial support after a marriage/domestic partnership, especially if children are involved? • What are health facility policies regarding men's participation in ANC, delivery, and birth? • Is GBV illegal? Are there legal mechanisms for justice, treatment services, etc., available to women who experience GBV?
	C. What are the gender-based constraints to reaching program objectives?	Practices and participation	• Women do not have much decisionmaking power. • The male is the main source of health information for the family. • Men are not involved during and after pregnancy.
		Beliefs and perceptions	• Social norms may discourage male involvement in maternal and child health. • Community stigma dissuades men and women from getting tested.

Step	Gender Analysis Question	Domain	Notes
			• Fear of violence dissuades women from getting tested. • Women are perceived as unreliable sources of information. • Men tend to mistrust health facilities (e.g., belief that confidentiality is not guaranteed).
		Access to assets	• Women are largely financially dependent on their male partners, which may limit their ability to make decisions independently. • Women's limited access to economic opportunities restricts their ability to make health decisions that would incur financial costs (e.g., funds to travel to the health facility, funds to pay for health services). • Availability of PMTCT services appears limited.
		Institutions, laws, and policies	• Men may not be legally obligated to support children they father with partners to whom they are not married.
	D. What are the gender-based opportunities to reaching program objectives?	Practices and participation	• Women seem to move about with some degree of freedom in the public sphere.
		Beliefs and perceptions	• Men view health providers as reliable sources of information.
		Access to assets	• ANC services seem to be widely available.
		Institutions, laws, and policies	• None are mentioned in the case study.
2.	What gender-integrated objectives can you include in your strategic planning to address gender-based opportunities or constraints?	Practices and participation	• Encourage increased male participation in PMTCT
		Beliefs and perceptions	• Reduce stigma associated with HIV and encourage and support disclosure
		Access to assets	• Expand women's access to a full range of PMTCT interventions
		Institutions, laws, and policies	• Health facilities are strengthened to encourage male participation in maternal and newborn health
3.	What proposed activities can you design to address gender-based opportunities or constraints?	Practices and participation	• Train male peer educators to facilitate reflection sessions with men on the links between gender norms, GBV, and SRH outcomes • Hold education sessions with fathers-to-be and couples on how men can contribute to a healthy pregnancy and delivery • Offer education sessions with men on their role in PMTCT • Encourage men's involvement in couples counseling

Step	Gender Analysis Question	Domain	Notes
		Beliefs and perceptions	• Increase community awareness on stigma and discrimination, the harm they cause, and the benefits of reducing them • Offer awareness campaigns on HIV stigma and discrimination • Facilitate group discussions with women and men on gender norms, GBV, and HIV
		Access to assets	• Train ANC health workers to systematically provide information on the benefits of HIV testing during pregnancy • Strengthen integration of PMTCT services with ANC services • Train peer counselors to provide education and psychosocial support to HIV-positive pregnant women, and follow-up after delivery
		Institutions, laws, and policies	• Support health facilities to develop and operationalize institutional policies that enable men's participation in ANC, labor, and delivery • Train health workers on the provision of malefriendly health services • Train health workers on couples counseling
4-5	What indicators for monitoring and evaluation will show if (1) the gender-based opportunity has been taken advantage of, or (2) the gender-based constraint has been removed?	Practices and participation	• Proportion of women reporting that during their pregnancy their male partner carried out at least one household task traditionally reserved for women • Proportion of women reporting that during the 6 months following delivery, their male partner carried out at least one household task traditionally reserved for women • Proportion of serodiscordant couples (male infected) who report use of a female or male condom at every intercourse occurring during pregnancy • Proportion of serodiscordant couples (male infected) who report use of a female or male condom at every intercourse during 12 month period following delivery
		Beliefs and perceptions	• Proportion of individuals in the intervention area who express tolerant attitudes toward HIV-positive individuals • Proportion of HIV-positive women who report having disclosed their status to their male partner • Proportion of HIV-positive men who report having disclosed their status to their female partner
		Access to assets	• Number of pregnant women who have been tested for HIV • Number of pregnant and breastfeeding women following a PMTCT regimen
		Institutions, laws, and policies	• Percentage of male partners accompanying female partner for ANC visits • Proportion of male partners present during labor and delivery

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Chapter 10: Technical standards for Jhpiego gender and gender-based violence programming

Gendor 101 training materials

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Jhpiego is a nonprofit global leader in the creation and delivery of transformative health care solutions that save lives.

In partnership with national governments, health experts and local communities, we build health providers' skills, and we develop systems that save lives now and guarantee healthier futures for women and their families. Our aim is revolutionizing health care for the planet's most disadvantaged people.

Jhpiego is a Johns Hopkins University affiliate.

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www.jhpiego.org

Chapter 10: Technical standards for Jhpiego gender and gender-based violence programming

Learning objectives

By the end of this session, participants will:

- Understand the gender and gender-based violence (GBV) technical standards that are part of the Program and Technical Review (PTR) for Jhpiego programs

Time needed

50 to 65 minutes

- Timing will be determined based on which of the described options are implemented during the session

Materials needed

- Facilitator Resource: PowerPoint on Gender and Gender-Based Violence Technical Standards
- [If you will be implementing **Option 1: Poll Questions** below] Polling software (integrated into Zoom)
- [If you will be implementing **Option 2: "What's Wrong" Scavenger Hunt** below] Facilitator Resource: "What's Wrong" Scenarios

Advance preparation

1. Save a copy of the **PowerPoint on Gender and Gender-Based Violence Technical Standards** to your computer and practice presenting the PowerPoint to ensure you have a good understanding of the concepts.

> **Facilitator note:** This session is for Jhpiego staff only.

2. Review each of the 3 options for increasing interactivity. Consider which you would like to implement. Note that facilitators may choose to facilitate one of the options or more than one of the options, depending on how much time they have available and what they feel would be most effective for their group of participants.
3. [If you will be implementing Option 1: Poll Questions below] Log into Zoom.us and add the following six polls to your Zoom meeting. Make sure that, when you are adding your poll questions, you add them as six separate polls, and not as one poll with six questions. (Review the Technical Facilitator Guidance for more information on adding polls to a Zoom meeting).
    - Poll 1: Which standard do you expect might be easiest to implement?
    - Answer Choices (single choice):
        - The program has conducted a gender analysis
        - The program has a gender strategy or activities supported with a budget
        - Gender norms-changing activities use evidenced-based curricula over at least a 10-hour interaction

- Program staff have completed Gender and Sexual and Reproductive Health 101
- The program implements standards for gender-sensitive service delivery
- The program conducts research on local gender and culture norms to inform IEC/SBCC
- The program actively seeks to engage men as well as women in the range of health services

- Poll 2: Which standard do you expect might be the most challenging to implement?
- Answer Choices (single choice):
  - The program has conducted a gender analysis
  - The program has a gender strategy or activities supported with a budget
  - Gender norms-changing activities use evidenced-based curricula over at least a 10-hour interaction
  - Program staff have completed Gender and Sexual and Reproductive Health 101
  - The program implements standards for gender-sensitive service delivery
  - The program conducts research on local gender and culture norms to inform IEC/SBCC
  - The program actively seeks to engage men as well as women in the range of health services
- Poll 3: Which standard do you believe is the most important to changing outcomes?
- Answer Choices (single choice):
  - The program has conducted a gender analysis
  - The program has a gender strategy or activities supported with a budget
  - Gender norms-changing activities use evidenced-based curricula over at least a 10-hour interaction
  - Program staff have completed Gender and Sexual and Reproductive Health 101
  - The program implements standards for gender-sensitive service delivery
  - The program conducts research on local gender and culture norms to inform IEC/SBCC
  - The program actively seeks to engage men as well as women in the range of health services
- Poll 4: Which standard do you expect might be easiest to implement?
- Answer Choices (single choice):
  - Adherence to the World Health Organization guidelines
  - Provide a comprehensive response to GBV through either the provision or facilitation of linkages
  - The program ensures and/or advocates for the health and welfare of the patient first before forensic evidence collection
  - The program supports providers to conduct safety planning for survivors
  - The program promotes a basic first-line response to GBV

        - Programs working with community health workers train them to raise awareness about GBV and services available
    - Poll 5: Which standard do you expect might be the most challenging to implement?
    - Answer Choices (single choice):
        - Adherence to the World Health Organization guidelines
        - Provide a comprehensive response to GBV through either the provision or facilitation of linkages
        - The program ensures and/or advocates for the health and welfare of the patient first before forensic evidence collection
        - The program supports providers to conduct safety planning for survivors
        - The program promotes a basic first-line response to GBV
        - Programs working with community health workers train them to raise awareness about GBV and services available
    - Poll 6: Which standard do you believe is the most important to changing outcomes?
    - Answer Choices (single choice):
        - Adherence to the World Health Organization guidelines
        - Provide a comprehensive response to GBV through either the provision or facilitation of linkages
        - The program ensures and/or advocates for the health and welfare of the patient first before forensic evidence collection
        - The program supports providers to conduct safety planning for survivors
        - The program promotes a basic first-line response to GBV
        - Programs working with community health workers train them to raise awareness about GBV and services available
4. [If you will be implementing **Option 2: "What's Wrong" Scavenger Hunt** below] No advanced preparation required.
5. [If you will be implementing **Option 3: Small Group Discussions** below] Select 4 to 5 standards from the list that you believe are particularly important to your participants and their work, and which you believe it would be valuable to discuss further.

Steps

Introduction (1 minute)

1. Explain that in this session, participants will learn about the seven gender and six GBV technical standards that are part of Jhpiego's Program and Technical Review (PTR).

Gender and gender-based violence technical standards (28 minutes minimum; up to 48 minutes)

1. **Technology Action:** Screen share the PowerPoint on Gender and Gender-Based Violence Technical Standards.

2. Refer to the discussion points included beneath each slide during the presentation. You should plan to spend approximately 28 minutes presenting the presentation (not including poll questions/discussions).
3. If you will be implementing Option 1: Poll Questions, refer to the notes below for how to integrate the questions into the presentation.

Facilitator Note: Consider which of the three options for interactivity you would like to implement to support participants' understanding of and reflection on the Jhpiego standards. Note that facilitators may choose to facilitate one of the options or more than one of the options, depending on how much time they have available and what they feel would be most effective for their group of participants.

Option 1: Poll Questions (20 minutes)

Steps:

1. **Pause at slide 13.** Explain that participants will now have an opportunity to further reflect on **the standards for integrating gender into Jhpiego programming** and how they might be applied to a project.
2. Explain that you will show a series of 3 questions, one at a time. Participants will have a chance to respond, and then you will discuss the question and responses with the group. (Spend no more than 1 minute introing the activity).
3. **Technology Action:** Launch the first poll ("Which standard do you expect might be easiest to implement?"). Provide participants with 30 to 45 seconds to respond, and then close the poll.
4. Invite 1-2 participants to share how they voted and why. (Spend no more than 3 minutes on steps 3 to 4).
5. Repeat steps 3 to 4 for the second and third poll questions.
6. Continue presenting the presentation.
7. **Pause again at slide 21.** Explain that participants will now have an opportunity to further reflect on **the standards for gender-based violence programming** and how they might be applied to a project.
8. Explain that you will again show a series of 3 questions. These questions will be the same questions that participants reflected on for the first set of standards. Participants will have a chance to respond, and then you will discuss the question and responses with the group. (Spend no more than 1 minute introing the activity).
9. **Technology Action:** Launch the fourth poll ("Which standard do you expect might be easiest to implement?"). Provide participants with 30 to 45 seconds to respond, and then close the poll.
10. Invite 1-2 participants to share how they voted and why. (Spend no more than 3 minutes on steps 9 to 10).
11. Repeat steps 9 to 10 for the two remaining poll questions.

Activity (35 minutes per option)

Option 2: "What's Wrong" Scavenger Hunt

Steps:

1. **Technology Action:** At any time after participants have arrived at the session, you may begin to create breakout rooms.

- 5 groups (randomly distributed participants)
- Check “Breakout rooms automatically close after”
  - 10 minutes
- Check “Notify me when time is up”
- Countdown after closing breakout room: 30 seconds

2. Explain that participants will now have an opportunity to further reflect on the standards and how they might be applied to a project.
3. Explain that participants will be split into 5 groups. Each group will receive a scenario through the Zoom chat. In each scenario, **one or more technical standards are not being adhered to.** With the other members of their group, participants should answer the following questions:
   - Which standard(s) is/are not being adhered to?
   - What could the project implementers do differently in order to meet the standard?
4. **Technology Action:** Post the two questions into the Zoom chat for participants to reference in their small groups:
   - Which standard(s) is/are not being adhered to?
   - What could the project implementers do differently in order to meet the standard?
5. Explain that, when groups return, a spokesperson should share out the scenario, followed by the group’s responses to the two questions.
6. **Technology Action:** Post the scenarios in the Zoom chat. Make sure each scenario is clearly labeled with each group number. Example:
   - Group 1: Starting out (Gender)
   - Group 2: Training providers on GBV care (GBV)
   - Etc.
7. Call participants’ attention to the scenarios in the Zoom chat. Explain that, as they are being moved to a breakout room, participants will see on their screen to which numbered room they are being moved. Once they are in their breakout rooms, their room number will appear at the top of the Zoom screen. Their breakout room number will represent their group number and should be used to know which scenario to review.
8. Make sure participants understand the instructions. Remind them that they should use the “Ask for Help” button if they have questions for a facilitator while in their breakout room. (Spend no more than 3 minutes on steps 2 to 8).
9. **Technology Action:** Open the breakout rooms.
10. **Technology Action:** Send a broadcast message reminding participants when they have 1 minute left.
11. **Technology Action:** After approximately 10 minutes, close the breakout rooms.
12. Ask the spokesperson from Group 1 to read their scenario and then briefly describe their responses to the two questions. Allow up to 3 minutes for the spokesperson to share, and then up to 2 minutes for any questions/comments from other participants. Ask the other participants if they believe that the group has presented a viable solution for meeting the standard that was previously not being adhered to.
13. Repeat step 12 for the remaining groups.

Option 3: Small Group Discussions

1. **Technology Action:** At any time after participants have arrived to the session, you may begin to create breakout rooms.
    - Groups of 4-5 (randomly distributed participants)
    - Check "Breakout rooms automatically close after"
        - 10 minutes
    - Check "Notify me when time is up"
    - Countdown after closing breakout room: 30 seconds
2. Explain that participants will now have an opportunity to further reflect on the standards and how they might be applied to a project.
3. Explain that participants will be divided into groups of 4 to 5. Each group will be assigned a standard; you will share the assignments in the Zoom chat before opening breakout rooms.

> **Facilitator Note:** Select standards for each group to review prior to the session. Select standards that are particularly important to your participants and their work, as you will not be able to review all. Make sure participants know whether they're looking at a standard for integrating gender or for gender-based violence programming.

4. Explain that, with their group, participants will review their assigned standard and discuss the following:
    - One possible challenge with implementing the provided standard.
    - One important consideration when implementing the provided standard.
    - One possible impact of implementing the standard.
5. **Technology Action:** Post the following statements in the Zoom chat:
    - One possible challenge with implementing the provided standard.
    - One important consideration when implementing the provided standard.
    - One possible impact of implementing the standard.
6. Explain that, before groups return to the main room, they should select a spokesperson who will share with the larger group what their small group answered for each of the three statements.
7. **Technology Action:** Post the group numbers and their assigned standard in the chat. Example:
    - Group 1: [Standard]
    - Group 2: [Standard]
    - Etc.
8. Call participants' attention to the standards in the Zoom chat. Explain that, as they are being moved to a breakout room, participants will see on their screen to which numbered room they are being moved. Once they are in their breakout rooms, their room number will appear at the top of the Zoom screen. Their breakout room number will represent their group number and should be used to know which standard to review.

9. Make sure participants understand the instructions. Remind them that they should use the "Ask for Help" button if they have questions for a facilitator while in their breakout room. (Spend no more than 3 minutes on steps 2 to 9).
10. **Technology Action:** Open the breakout rooms.
11. **Technology Action:** Send a broadcast message reminding participants when they have 1 minute left. After approximately 10 minutes, close the breakout rooms.
12. Invite the spokesperson from group 1 to share their standard and how the group responded to the three questions. Invite others to share questions/comments. (Spend no more than 4 to 5 minutes per group/standard).
13. Repeat step 12 for the remaining groups.

Closing (1 minute)

End the session by explaining that now participants should understand the gender technical standards that are included in Jhpiego's PTR. Explain that participants should strive to improve upon these standards in their programs.

Facilitator resource: What's Wrong

Scenario 1: Starting out (Gender)

County Q is implementing a sexual, reproductive, maternal, neonatal, and child health (SRMNCH) program. The donor has highlighted the need for rapid start up, so the project began activities without conducting any baseline assessment or formative research. The team was not too worried about this because this was the follow-on to another SRMNCH project, though this project is being implemented in new geographic areas, where most of the population is a different ethnic group with different cultural practices than the target population from the original project. The donor has expressed an interest in gender integration, but cut funding for the project's gender advisor position. The country team members have no experience with gender integration, but figure it will come naturally, since they are working with women.

Scenario 2: Increasing ANC uptake (Gender)

At the end of Year 1 of the sexual, reproductive, maternal, neonatal, and child health (SRMNCH) program in Country Q, the donor expressed concern that ANC attendance levels are very low. The donor suggests adding in social and behavior change (SBC) activities, though only provides a very small amount of additional funding. To save costs, the program decides to print copies of posters with information about the benefits of ANC that were used by a previous program five years ago, which was implemented in a different geographic area, where most of the population is a different ethnic group with different cultural practices than the target population from the original project. The project also trains its community health workers to provide information about ANC to community women during their household visits. The program technical director ensures that the donor that once community members have information about the importance of ANC attendance, attendance will increase.

Scenario 3: Training providers on GBV care (GBV)

County Q has asked Jhpiego to train providers and secondary-level health facilities on gender-based violence response, using the country's validated curriculum from 10 years ago. Providers are trained on the importance of convincing a client to provide forensic evidence as soon as she is identified to have experienced GBV, as this will help the perpetrator be brought to justice. During supervisory follow-up after the training, the project found that providers were not providing GBV care because they felt too uncomfortable and they did not have the supplies needed to provide support at their facility level in accordance to the curriculum guidelines.

Scenario 4: First-line support for GBV (GBV)

Given high rates of gender-based violence in project communities, Project X created messaging to raise awareness about GBV and included them in the job aides for Community Health Workers. During supervisory visits, the project found that many CHWs were not including these messages in their talks during household visits because they felt uncomfortable and did not know how to react if a client told them they were experiencing GBV. Other CHWs were more comfortable, and if a client disclosed that she was experiencing GBV she would told to go to the local clinic and the police department.

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Chapter 11: Gender-sensitive, respectful service delivery

Gendor 101 training materials

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Chapter 11: Gender-sensitive, respectful service delivery

Learning objectives

By the end of this session, participants will be able to:

- Describe quality of care through a gendered lens
- Describe standards of respectful care provision
- Identify ways in which their personal perceptions of clients may influence their interactions with them

Time needed

2 hours 5 minutes (minimum)

Materials needed

- Two blank Jamboards
- Facilitator Resource: Role Play Scenarios
- Participant Handout: WHO Quality of Care Framework
- Participant Handout: Jhpiego Gender Service Delivery Standards Facilitation Guide

  (https://jhpiego.sharepoint.com/:b:/s/JhpiegoResources/ER4XijepcZBJj4EM-hbxMXEB8zZIbdeOz0kSU3cBEnFhhQ)
- Participant Handout: Jhpiego Gender Service Delivery Standards

  (https://jhpiego.sharepoint.com/:b:/s/JhpiegoResources/EYOUkWezleNJisDoAi7s2hUB2ydh9OuTA2wDgnyCV982mw)
- Facilitator Resource: PowerPoint on Jhpiego's Global Gender Service Delivery Standards

Advance preparation

1. Email copies of each participant handout to participants.
2. Save a copy of the PowerPoint on Jhpiego's Global Gender Service Delivery Standards to your laptop, and practice presenting.
3. Review the 3 options for reinforcing the standards after the presentation. Select which option you will implement.
4. [If you will be implementing **Option 1: Discussion** or **Option 3: Revised Role Play** below] No advanced preparation.
5. [If you will be implementing **Option 2: Slido/Mentimeter Polls** below] Log into your Mentimeter or Slido account. (Note that it is recommended that facilitators who **do not have a paid account with either Mentimeter or Slido use Slido**; the remaining instructions will assume that facilitators are using a free Slido account. Zoom Polling will not work in this situation as there are 20 standards and Zoom only allows hosts to input up to 10 answer options). Create a new event. Add the three following multiple-choice questions.
   - Question 1: Which standard do you think would be most challenging for health facilities to adopt?

- Answer Choices:
  - [Provide each standard]
- Question 2: Which standard do you believe is most relevant to your program?
- Answer Choices:
  - [Provide each standard]
- Question 3: Which standard do you believe is least relevant to your program?
- Answer Choices:
  - [Provide each standard]

Facilitator Note: It is highly recommended that facilitators recruit an additional individual to support them with the technological logistics of this session, particularly during the role play.

Steps

Introduction (1 minute)

Explain the increasing focus globally and by the World Health Organization (WHO) on the importance of quality and experience of care as central to reproductive, maternal, newborn, and child health. State that the WHO has indicated experience of care as an important domain of its quality of care framework. Likewise, leading agencies have indicated the importance of gender inequality as an issue for accessing quality care.

Introducing the issue of quality of care from a gender lens (8 minutes)

1. **Technology Action:** At any point after participants have joined the meeting, begin creating breakout rooms for the "Role Play" activity.
   - Up to 5 groups (randomly distributed participants)
   - Check "Breakout rooms automatically close after"
     - 15 minutes
   - Check "Notify me when time is up"
   - Countdown after closing breakout room: 30 seconds
2. Lead a quick 3-minute brainstorm with participants around the question: What do you consider to be the key aspects of quality of care?
3. **Technology Action:** Share a link in the chat to a blank Jamboard.
4. Call participants' attention to the link in the chat. Invite participants to add sticky notes to the board in response to the question, "What do you consider to be the key aspects of quality of care?"
5. **Technology Action:** Screen share the Jamboard and demo how to add sticky notes (described below).
   - Click on the sticky note icon within the toolbar to the left of the board, write a word/phrase, click save, and then click anywhere on the Jamboard to go back to the main Jamboard and move your sticky note around or resize it.
6. Invite a few participants to unmute and share verbally what they consider to be a key aspect of quality of care and why. As participants add ideas to the Jamboard, you may also ask who posted a

particularly interesting/pertinent sticky note (because sticky notes are added anonymously, you will need to confirm first who added a particular sticky), and then ask that individual to share more about the idea verbally.

Facilitator Note: As participants record/share their ideas, make sure to probe for elements of the WHO quality of care framework.

Optional Adaptation

Instead of using a Jambaord to collect responses to the question about quality of care, facilitators may use an open ended/open text question from polling software such as Slido or Mentimeter to collect responses from participants. Note that this will require advance preparation on the part of the facilitator. Log into your Slido or Mentimeter account prior to the session and add an open ended/open text question which asks, "What do you consider to be the key aspects of quality of care?" During the session, present the poll and invite participants to contribute their ideas using the numeric code or QR code.

7. **Technology Action:** Screen share the Participant Handout: WHO Quality of Care Framework.
8. Remind participants that they can access this handout from their email. After giving a general overview of the framework, draw participants' attention to the "experience of care" component. Explain that client experience of care is a core aspect of quality of care. It means providing client-centered care. Experience of care encompasses the variety of interactions clients have with the multiple components of the health delivery process (e.g., client ability to communicate needs to providers and health workers, provision of respectful care, etc.)
9. State that, through its programming, Jhpiego seeks to improve quality of care by promoting improved experience of care in addition to improving quality of provision of care. Given our focus on reproductive and maternal health, we need to consider experience of care from a gender perspective. There are various approaches and methods to improving experience of care. A first, important step is to engage health workers in a participatory way to understand the problem and define solutions. Understanding quality of care issues driven by gender inequality is not always so obvious because gender inequality is embedded in sociocultural practices and behaviors. A gender lens is needed to analyze why, and how, women are denied their rights to quality, respectful, and equally accessible care. State that you will begin the analysis using role plays. (Spend no more than 5 minutes on steps 6 to 8).

Role plays (1 hour 10 minutes)

1. Explain that participants will be divided into five groups. Each group will be given a scenario. A facilitator will enter their room soon after opening breakout rooms and will share in the chat the group's scenario.
2. Next, explain that each group will have 15 minutes to read through the scenario they are given, assign each group member one of the characters in the scenario, and prepare to act out their scenario. Tell participants that their role plays must emphasize the gendered aspects of their group's scenario (e.g., gender discrimination, gender stereotypes, gender-discriminatory laws or policies that result in exclusionary or disrespectful behaviors and/or outcomes). Tell participants that they will have up to 5 minutes to perform their role-play in front of the larger group.
3. Explain that, since we're virtual, participants won't be able to act out all aspects of the role play; for example, participants won't be able to move around the room. Consequently, these role plays may be informal and do not need to be perfect; the goal is to convey information about the gendered

aspects of the group's scenario. However, participants should consider how they can make use of Zoom features during their role play; for example, participants may:

- Turn their camera off to imitate leaving a room.
- Mute themselves to have a pretend side-conversation, or to indicate being farther away from other participants who are talking.
- Use any props that they have near-by.
- Change their Zoom background to something representative of the scene.

4. Ask if anyone has any questions. Suggest that participants spend some time introducing themselves to anyone they may not know as they wait for the facilitator to come and share their group's scenario. However, a facilitator will arrive within about the first minute. (Spend no more than 5 minutes on steps 1 to 4).

Facilitator note: If some groups have more participants than the number of characters in the case study they were assigned, they may wish to create additional characters or have the extra group members serve as role play directors as the group practices.

Facilitator note: Some male participants may feel uncomfortable representing a female character. The facilitator should be sensitive to reactions of discomfort expressed by male participants and, when appropriate, remind them of any previous discussions about gender roles. The facilitator should also encourage the men to reflect on their reactions. If absolutely necessary, male participants who are uncomfortable representing a female character may be given a male character description.

Facilitator note: Some participants may feel uncomfortable representing characters who do not conform to dominant gender and/or sexuality norms (e.g., a gay character). It is important to emphasize that this is only an exercise, and explain that the activity is intended to explore precisely the types of feelings people may have about non-normative sexual and gender identities.

5. **Technology Action:** Open the breakout rooms.
6. **Technology Action:** Join each breakout room, one by one. Copy and paste each group's scenario in the chat after you've entered their breakout room.
7. **Technology Action:** Close the breakout rooms after approximately 15 minutes. Make sure that your screen is not being shared as people return to the main room, so that all participants can be seen in gallery view.
8. Explain that each group will present their role plays now, starting with group 1. Explain that each group will be spotlighted so that the rest of the participants will be able to focus on those individuals participating in the role play.
9. **Technology Action:** Begin spotlighting the first group. Hover over the video that you would like to spotlight. Then, click the three blue dots in the top right-hand corner of their video, and select "Spotlight for Everyone". To add a spotlight, hover over an individual's video and click "Add Spotlight".

Technology Note: Consider asking the participants of each group to raise their hand immediately before you begin spotlighting them, or when it is their turn to present. By raising their hand, their videos will all be moved to the top left of your Zoom screen.

10. Instruct the participants in the audience to take note of the following elements during the role-play performance:

- Gender-insensitive, discriminatory and/or disrespectful attitudes and behaviors observed in the role-play.
- Underlying gender norms that may contribute to the gender-discriminatory attitudes observed.

11. Remind the first group that they will have 5 minutes.
12. **Technology Action:** After the first group has performed its role-play, remove the spotlight from each participant (click the three blue dots in the top right-hand corner of their video and select "Remove Spotlight"). Note that participants' view will return to Speaker View.
13. Ask the workshop participants in the audience to share what they observed in terms of gender-discriminatory attitudes and behaviors and the gender norms that might have contributed to these attitudes and behaviors.
14. **Technical Activity:** As participants share their ideas, write them on a second blank Jamboard. Do not share your screen at this time. (You will share the Jamboard notes with participants later in the session).

Facilitator Note: It's recommended that someone other than the lead facilitator take notes on the Jamboard, so that the lead facilitator can focus on the role plays and debrief. A co-facilitator or admin support should play the role of note-taker.

15. After participants from the audience have commented, ask the role players to briefly describe what they had intended to express through their role-play. (Spend no more than 3 minutes on steps 15 to 17).
16. Repeat steps 11 to 17 for the remaining groups.

Facilitator note: During the role play debriefs, participants may point out actions related to general poor communication or lack of support, but make sure to probe for the gender norms and discrimination that lead to such behavior, for example:

- Scenario 1: Acceptance of women's suffering, gender-based violence (GBV)
- Scenario 2: Inability of midwives to challenge senior, male doctors
- Scenario 3: Homophobia and related stigma, men being able to decide on condom use with wife but not male sexual partner
- Scenario 4: Beliefs about masculinity and fertility
- Scenario 5: Gender stereotypes about girls needing to be chaste, judging the girl for being "loose"

17. **Technology Action:** Screen share the Jamboard on which you have been taking notes.
18. Once all five groups have performed their role plays, review all of the gender-discriminatory attitudes/behaviors (and corresponding gender norms) that you listed on the Jamboard. Ask participants if they think there is anything missing and add to the list as needed. (Spend no more than 2 minutes on this step).
19. Before moving to the next section, facilitate a 5 to 10 minute group discussion using the following questions:
    - Were the scenarios realistic?
    - Which forms of gender discrimination occur most often during health service delivery?

- How do your programs currently address some of the forms of gender discrimination illustrated in the role plays?

Presentation on Jhpiego's global standards for gender-sensitive services (45+ minutes)

1. Next, tell the group that Jhpiego's gender unit has developed global standards for gender-sensitive services. Jhpiego programs are expected to work with health facilities to integrate these standards into their quality improvement processes.
2. **Technology Action:** Screen share the PowerPoint on Jhpiego's global standards for gender-sensitive services.
3. Use the discussion points under each slide to discuss the standards. (Spend no more than 30 minutes on this step).
4. After you have presented, allow participants 5 minutes to ask questions and/or make comments.
5. Remind participants that they can access Participant Handout: Jhpiego Gender Service Delivery Standards Facilitation Guide, and Participant Handout: Jhpiego Gender Service Delivery Standards from their email.

Facilitator Note: After the presentation, select between **one of the following** options to reinforce the delivery standards. Consider with which option you are most comfortable, as well as which option will most effectively engage your specific participants. You should also consider how much time you have available.

Option 1: Discussion (10 minutes)

Consider this option if your participants are comfortable participating in full-group discussions over Zoom and you have limited time to reinforce the standards. Note that the exact timing for the discussion may be adjusted based on your needs and the needs of participants.

1. Facilitate a 10-minute group discussion using the following questions:
   - Are there any standards that would be challenging for health facilities to adopt? Which ones? Why?
   - Are some standards less or more relevant to your program? Which ones? Why?
   - What support would you require to advance these standards in your program?

Option 2: Slido/Mentimeter Poll Questions (15 minutes)

Consider this option if your participants find full-group discussions challenging and you would prefer an option that provides some additional prompting to support a more focused discussion.

1. Explain that participants will now have an opportunity to further reflect on each of the standards and how they might be applied to their work.
2. Explain that you will show a series of 3 questions, one at a time. Participants will have a chance to respond, and then you will discuss the question and responses with the group. (Spend no more than 1 minute introing the activity).
3. **Technology Action:** Share your screen showing the first Slido poll question ("Which standard do you think would be most challenging for health facilities to adopt?")
4. Invite participants to either scan the QR code to submit their response, or to go to Slido.com and use the numeric code to respond to the poll.

5. Invite 1 to 2 participants to share how they voted and why. (Spend no more than 5 minutes on each poll).
6. Repeat steps 3 to 5 for the remaining 2 questions.

Option 3: Revised Role Play (60 minutes)

Consider this option if you have a smaller number of participants and want to provide participants with an opportunity to reflect more deeply on how the standards might be integrated and applied to specific health scenarios. Note that this option takes significantly more time than the other options. This activity may be completed in addition to one of the activities above as time allows.

1. Explain that groups will now have an opportunity to revisit their role plays from earlier in the session and begin to consider how they might apply the standards discussed in the presentation to those scenarios.
2. Explain that participants are going to do one more role play. They will have the same scenario that they had previously. However, this time around, instead of acting out the scenario as shared in the original description, each small group will re-imagine the scenario as it might have gone had the health providers adhered to Jhpiego's standards for gender-sensitive services.
3. Note that these can again be highly informal presentations. Additionally, participants are welcome to switch up who plays which character. The most important aspect of this second role play is that the group intentionally incorporates Jhpiego's standards.
4. Explain that participants will again have 15 minutes in their small group to prepare, and then up to 5 minutes to present when they return.
5. Ask if anyone has any questions. (Spend no more than 5 minutes on steps 1 to 5).
6. **Technology Action:** Open the breakout rooms.

> **Technology Note:** As long as you facilitate this activity on the same day as the first role play, there will be no need to re-create breakout rooms, as the settings from the previous breakout room will have been saved and will not need to be updated for this second breakout room activity.
>
> If this activity will be facilitated on a different day (or if you will be required to end and then re-start the Zoom meeting for any reason), you will need to re-create the breakout rooms. In this case, we recommend screenshotting the breakout rooms prior to closing the Zoom meeting so that you have a record of who should be in each room.

7. **Technology Action:** Send a broadcast message when groups have 5 minutes, and then 1 minute left.
8. **Technology Action:** Close the breakout rooms.
9. Explain that each group will present their role plays now, starting with group 1. Explain that each group will be spotlighted so that the rest of the participants will be able to focus on those individuals participating in the role play.
10. **Technology Action:** Begin spotlighting the first group. Hover over the video that you would like to spotlight. Then, click the three blue dots in the top right-hand corner of their video, and select "Spotlight for Everyone". To add a spotlight, hover over an individual's video and click "Add Spotlight".

Technology Note: Consider asking the participants of each group to raise their hand immediately before you begin spotlighting them, or when it is their turn to present. By raising their hand, their videos will all be moved to the top left of your Zoom screen.

11. Ask participants to consider which standards are being intentionally integrated into the new scene as they watch the role play.
12. Remind the first group that they will have 5 minutes.
13. **Technology Action:** After the first group has performed its role-play, remove the spotlight from each participant (click the three blue dots in the top right-hand corner of their video and select "Remove Spotlight"). Note that participants' view will return to Speaker View.
14. Ask the workshop participants in the audience to share which of Jhpiego's standards for gender-sensitive services they observed. Use the following questions to facilitate a brief discussion:
    - What standards did they notice or recognize?
    - How did adhering to these standards affect the scenario?
    - What longer-term outcomes do you suspect these standards might have on the character's (or characters') health and well-being?
15. After participants from the audience have commented, ask the role players to briefly describe what they had intended to express through their role-play. (Spend no more than 3 minutes on steps 14 to 15).
16. Repeat steps 10 to 15 for the remaining groups.

Closing (1 minute)

End the activity by stating that all individuals, regardless of gender, sexual orientation, age, economic status, ethnicity, or other social identifier, have the right to quality, respectful, and accessible care. Delivery of quality care requires health systems to take into account and address gender disparities and other social inequalities.

Sources

- Interagency Gender Working Group (IGWG). n.d. *Introduction to Gender Analysis and Integration*. https://www.igwg.org/training/gender-analysis-and-integration/. Accessed December 21, 2016.
- Population Reference Bureau. 2009. *A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action*, 2nd ed. Washington, DC: Population Reference Bureau.

Facilitator handout: Role Play Scenarios

Scenario 1

You are a new midwife who arrives on duty in the hospital where you work. As you take over duty from the previous midwife, Mary, you are told that one of the women in labor, Siah, is 17 years old, gravida 1 para 0 (G1P0), full term, has reportedly been in labor for 8 hours, and was admitted to the hospital 4 hours ago. You are told that she is uncooperative and difficult to examine because she holds her legs together and cries. You observe the 17-year-old lying on a bed in the labor area with only a sheet covering her. The labor area does not have curtains between beds and you know Mary usually takes the sheet off when examining clients and has been known to force women's legs apart when she doing an exam. She usually communicates little with women in labor except to tell them to "be quiet" or "shut up."

You have asked Mary why she treats the patients so rudely. Mary looks at you with a frown and says, "This is how we are all treated, isn't it? Our husbands hit us all the time. We are all abused. It's our duty as women to suffer, especially while giving birth!"

Mary leaves and you take over the care of Siah. Fortunately, you see that you have only two women in labor at this time.

Scenario 2

You are a midwife who was recently employed in the labor and delivery ward in the county hospital. You have become concerned because you hear from community members that they do not want to go to the hospital in labor because they are treated so poorly. You also observe that:

- On arrival, women are given a bed number and are referred to by that number rather than their name.
- The other midwives make fun of the women, especially those from lower socioeconomic groups.
- The women are given no privacy. There are no curtains separating beds. There are drapes on the ward but there is no attempt to drape women during examinations.
- Women are forced to stay in bed and lie on their backs during labor and birth.
- Women are frequently pushed and shoved if they attempt to sit up or turn over during the birth.
- Women are left alone when their midwife goes out for tea or lunch.

You are quite concerned about the abusive and disrespectful treatment the women receive. You try to raise the issue with your supervisor in charge, a male ob-gyn. He asks why you are worried about such trivial things when women are dying due to hemorrhage and pre-eclampsia.

Scenario 3

John is 30, single, and lives with his parents. He started having sex with men when he was a teenager. He knew that being gay was natural for him, but he was worried his family would find out and make his life miserable. Other gay friends of his had been "discovered" by their parents and their lives had become hell. To avoid this, John got married.

For 1 year, John stayed with his wife without seeing other men. After 1 year, he felt he could no longer wait, so he started having sex with one of his former lovers. Even when he was with his wife, he was thinking about having sex with this man. In the marriage, he insisted on the use of condoms, but in his

sexual relations with his male lover, he found it more difficult to negotiate safer sex. After 2 years of married life, John learned that one of his previous male partners had tested positive for HIV, so he started to worry about his own status. What would people think if he was HIV-positive? Would they find out that he was gay? How would he be treated?

For a while, he avoided getting tested because he was afraid he would be exposed as gay. But he was confused and worried that he might have HIV. Eventually he went to get tested, but the voluntary counseling and testing (VCT) counselor made him feel uncomfortable. She asked a lot of questions about John's sex life, and when John mentioned having had sex with men, she said, "No, you are not one of those! You seem different!" John left the VCT without taking the test and told himself he would never go back.

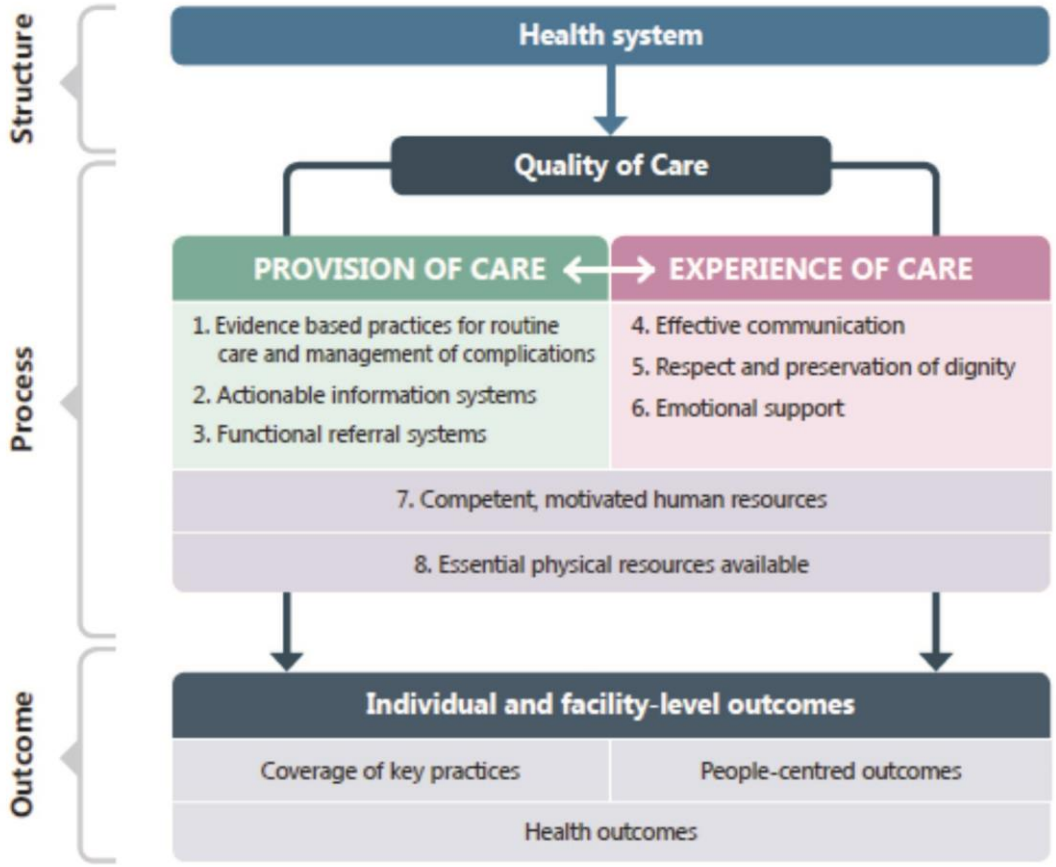
Scenario 4

You are a nurse advising a couple on postpartum family planning. The couple, Michael and Jaughna, have just had their first child, and you are advising them on long-acting reversible contraceptives. Michael and Jaughna have indicated that they prefer not to have any more children. Their parents each had five children, and they do not want to shoulder the same economic or caregiving burden. Michael has heard from a friend that a vasectomy could more permanently prevent pregnancy. But you are shocked when he suggests this. After all, they just have one child. In your society, children are considered God's gift! Fathering many children is an important sign of manhood. You know that vasectomy is a contraceptive method available in some clinics, but it is not a common practice, nor do you think it should be. You continue to explain other long-acting methods even as Michael tries to ask more about vasectomy.

Scenario 5

You are a nurse working in the local dispensary. Layla is a 14-year-old girl who comes to the dispensary with many questions about how to prevent pregnancy. You are surprised and not sure what to say. You tell her that she is too young to be asking such questions. She persists, albeit shyly, and eventually asks about some pills she heard that can prevent pregnancy after having sex. You realize she is talking about emergency contraception and suspect that she may have already had sex. You wonder where her mother is and what kind of mother has let her child become loose like this?!

Participant handout: WHO Quality of Care Framework



Source

Tunçalp Ö, Were WM, MacLennan C, et al. 2015. Quality of care for pregnant women and newborns—the WHO vision. BJOG 122:1045–1049.
http://www.who.int/maternal_child_adolescent/topics/qualityof-care/who-vision-quality-care-for-pregnant-women-and-newborns.pdf?ua=1.

Participant handout: Jhpiego gender service delivery standards facilitation guide

JHPIEGO GENDER SERVICE DELIVERY STANDARDS: **FACILITATION GUIDE**

Introduction

Purpose of This Tool

This tool assesses the quality of facility's provision of gender-sensitive, respectful care. It is designed for health providers, facility managers and central, provincial/regional or district health managers who want to improve the services for which they are directly responsible. It is intended to engage providers in a participatory approach to understand their vision of high quality care, and to apply applicable standards to their country context and facility's context.

These gender standards provide an opportunity for facilities to:

1) Understand and apply the key components of respectful, gender-sensitive care,
2) Measure facilities' progress in a way that allows for comparison across facilities, districts and countries,
3) Identify performance gaps that need to be reduced or eliminated in service delivery, and
4) Create action plans for quality improvement.

The tool:

- Lists key performance standards.
    - Each performance standard has verification criteria with "YES", "NO", and "N/A" (not applicable) answer options.
    - Each verification criteria has a recommended means of verification, as described in the next section.
- Objectively establishes the desired level of performance.
- Measures actual level of performance when applied to a facility.
- Helps identify performance gaps and facility challenges.
- Provides an opportunity to recognize and reward high performing facilities to improve motivation and commitment.

Unlike the traditional format of facility guidelines or assessments, the tool uses a format that allows providers to quickly understand and assess the key elements of gender-sensitive, respectful service delivery, and to identify gaps and challenges. Facility managers and providers can then implement appropriate interventions to address any lack of knowledge and skills, an inadequate enabling environment (including infrastructure, resources and policies), and/or lack of motivation to close these gaps.

The results of the implementation of this tool can provide a baseline assessment and measurement of progress over time. Findings can be used as a mechanism to guide the quality improvement process, inform managerial decisions, and reinforce momentum for change. Measurement also makes it possible to present managers and providers with quantitative targets. Achieving and making sustained progress on these targets has an important motivating effect for those involved in the improvement process.

The tool can be used for several purposes:

- **Self-assessments**: these are conducted by a provider on his or her own work. The provider uses the performance assessment tool as a job aid to verify if s/he is following the recommended standardized steps during the provision of care. These assessments can be performed as frequently as desired or needed.
- **Internal assessments**: are implemented internally by facility staff. These can be in the form of **peer assessments** when facility staff use the assessment tool to mutually assess the work among colleagues, or **internal monitoring assessments** when managers and/or providers use the tool more comprehensively to periodically assess the services being improved every three to four months.
- **External assessments**: are implemented by persons external to the facility. These are usually conducted by central/regional/district level of ministries of health, donors, or implementing partners. They can take the form of **facilitative supervision** when the purpose of the visit is to provide support for identification of performance gaps and interventions, or **verification assessments** when the purpose of the visit is to confirm compliance with recommended standards of care, and to recognize achievements. In case of verification assessments, representatives of the clients and communities being served should be involved in the process in an appropriate way. For instance, there could be a community member on the team conducting the assessment of the facility, or the facility scores or quality improvement plans could be shared with them on a regular basis to increase accountability.
- **Integration into other standards**: The tool can be used as a stand-alone method of assessing a facility's provision of gender-sensitive, respectful care. Alternatively, relevant standards can be integrated into other standards documents and quality assurance processes.

Background on Tool Development

Over the last two decades, Jhpiego has been implementing a practical approach for performance and quality improvement, called Standards-Based Management and Recognition (SBM-R). Working with partner organizations, we have obtained very encouraging results in the achievement of standardized, high-quality health care through the use of a streamlined, step-by-step methodology, the creative management of the process of change, and the joint and active involvement of providers, clients and communities in the improvement process.

Jhpiego has developed a range of SBM-R Standards focusing on health areas including, but not limited to, family planning, antenatal care, and immediate postpartum and post-abortion family planning. In developing these standards for gender-sensitive, respectful care, Jhpiego's existing standards were reviewed, as well as gender standards for health services quality assurance developed by the Futures Group and Jhpiego under the USAID funded Afghanistan Health Services Support Project. We also conducted a literature review of international and national

guidance (listed in the Works Cited section below) on integrating and measuring gender-sensitive health service delivery through a quality of care framework. The standards were informally pilot tested in Nigeria, Rwanda, Tanzania, Ethiopia and Mozambique, and were reviewed by experts and practitioners in maternal and child health, neonatal health, gender, male engagement and family planning. This helped determine the estimated length of time to apply the tool, best means of verification, and edits to improve language, reduce repetition, and revise order and flow of the standards and criteria. They are being implemented in Mozambique, Nigeria and Tanzania.

Example of Implementation of the Standards in Tanzania

Jhpiego Tanzania has adapted and integrated the Gender Service Delivery Standards in assessments and quality improvement processes for their reproductive, maternal, newborn, child, and adolescent health (RMNCAH) and HIV key populations projects.

- The USAID Boresha Afya project led by Jhpiego integrated the standards into a formative health facility assessment to understand the gender-related facility barriers and opportunities to achieving quality RMNCAH services in five project-supported regions in the Lake and Western Zones. The verification for clients were adapted into questions to be used in an assessment with clients in the community.
- The USAID Maternal and Child Survival Program (MCSP), the USAID Boresha Afya project and the Global Affairs Canada-funded Uzazi Salama Rukwa project, integrated the Gender Service Delivery Standards across existing Continuous Quality Improvement standards for various health services (e.g., maternal health, newborn health, family planning) of the Ministry of Health, Community Development, Gender, Elderly and Children. Local teams made adaptations according to their context. For example, the criteria of 30 percent women in leadership in health facilities, was revised to at least 50 percent. The standards are implemented quarterly as part of the quality improvement processes of maternal and newborn care in hospitals, health centers, and dispensaries.
- Under the USAID-funded Sauti Project, the standards were adapted to assess the gender-sensitivity of HIV combination prevention services within the quality improvement/quality assurance (QA/QI) processes for mobile Community-Based HIV Testing and Counselling Plus

(CBHTC+) services on a quarterly basis. The standards were adapted with a focus on key populations including men who have sex with men and female sex workers. The full set of standards are assessed quarterly by Gender Program Officers under the supervision of a Gender Advisor. Four standards were adapted to be indicators for quarterly quality assurance (QA) assessments, which a clinical QA Advisor tracks. These standards were prioritized for their proximate relation to project indicators, including:

- Percent of biomedical providers trained on gender equality and rights using Sauti gender, gender-based violence (GBV) and sexuality training manual
- Percent of beneficiaries and providers interviewed who reported having ever observed or experienced an abuse at the site by anyone
- Percent of clients that receive information about all available contraceptive methods and provide informed consent for method implemented
- Percent of HIV infected beneficiaries offered partner counseling/assisted disclosure and partner HIV testing services (HTS).

Description of the Tool

The tool includes 20 standards, organized in 5 sections as follows:

Section	# Standards	# Verification Criteria	Page #
1. Availability & Accessibility of Services	9	36	1-4
2. Male Engagement and Family Inclusiveness	2	9	5
3. Provider-Client Interaction	4	17	6-7
4. Key Aspects of Cordial and Respectful Relationship (information box - not scored)			7-8
5. Health Care Policies and Facility Management	5	15	8-9
TOTAL	**20**	**77**	

Means of Verification

In each section, we list means of verification that should be used to assess whether or not each verification criterion has been achieved.

There are five means of verification which are indicated a letter C, D, I, R or S. They are defined as follows:

- **C:** Client interviews. These should be conducted in private where the provider or facility manager cannot hear the client. The client should be informed about the purpose of the questions, and assured of the confidentiality of her or his responses;
- **D:** Direct structured observation of physical facilities, administrative or clinic processes. This can include reviewing inventories of material resources (e.g., infrastructure, supplies, medications, written materials);
- **I:** Inquiry through key informant interviews with providers or facility managers. The provider and the team should ask questions and probe when necessary to determine if procedure is performed or the item exists as described in the tool. For particularly sensitive questions, the assessor can pose the question as a hypothetical. For example, for standard 9.2, (No client is asked by providers for fees outside of the approved policy, gifts, favors, bribes or sexual acts in exchange for care) the assessor could ask a question such as ""Have you ever heard of a client having to pay a bribe or exchange a sexual favor in exchange for care in this facility or district?" This allows the provider to state whether or not this practice occurs without laying blame on a particular provider, or implicating her or himself.
- **R:** Review of clinical and administrative records that pertain to the provision health services, such as: registers, job aids, guidelines, protocols and policy documents. A small selection of client charts will be reviewed for completeness of reporting and to observe what types of information are being collected on the forms (e.g., gender and age of perpetrator, type of assault, was emergency contraception provided, was post-exposure prophylaxis provided, etc.) Although personal identifiers may be visible to the assessment team when reviewing charts or GBV registers, personal identifiers or any individual client information should not be collected. This is to protect the safety and confidentiality of all clients.
- **S:** Simulation. For standards that are difficult to assess with the means of verification above, ask the provider what s/he would do in a particular situation. To assess provider-client communication, the assessor can ask the provider about what s/he would do in a hypothetical scenario, or, do a short role-play in which the assessor is a client seeking family planning, and the provider should demonstrate his or her counseling approaches.

Please note that multiple means of verification may be needed to assess some criteria. Where the assessor can choose which of the means of verification should be used to verify whether a criterion is met, there is a comma (,) between each mean listed. If multiple means of verification need to be used together, there is a plus sign (+) between each mean of verification.

For example, for verification criterion 1.5 ("There are a referral system and an up-to-date referral directory in place for clients of any gender or age"), we recommend the means of verification "I + R." This means that the assessor should interview the provider to ask if such a directory exists (using the means of verification **I** for interview) and should ALSO ask to see it (using **R** for records review).

Alternatively, to assess the criterion 2.3 (Each inpatient client has her/his own bed and is not

required to share a bed with another person or use the floor), the assessor can EITHER interview the client (**C**) or directly observe (**D**).

Prompts

Some verification criteria are difficult to ask about. For these, we have included *prompts in italic text* with suggested language to use in the tool. For phrasing the questions to ask about other verification criteria, the assessor should use his or her judgment and appropriate local language. If a response is unclear, the assessor should rephrase the question, repeat back what s/he has understood, and/or probe for further information.

Assessment Process

This tool is not meant to be used as a traditional external assessment, but rather an opportunity for providers and facility managers to learn about and establish their own vision for what high-quality care looks like in their facilities, and to set benchmarks against which to continually measure their progress on quality improvement. Towards that end, we suggest the following process:

1. Identify the Facilities and Stakeholders That Will Participate

The assessor should work with the relevant ministries, donors, communities and/or facility managers to introduce and gain shared ownership over the use of the standards, and to select facilities for use of the tool. The tool can be used for any type of facility (e.g. district hospital, health center or rural outpost), but keep in mind that facilities with fewer resources may have greater challenges in meeting all the standards.

2. Organize a Team

A key task of the assessor is to organize teams for the implementation of the improvement process. Most service delivery processes do not depend on the action of single providers, they are the result of team efforts, therefore, it is important to expand the group of committed people beyond champions. Ask the facility manager to identify a quality assurance team or an individual at the facility who will be responsible for applying the tool, filling out the Scoring Sheet, developing and implementing quality improvement action plans based on the results of the tool, conducting on-going supervision and mentorship to improve quality of services, and reporting scores to relevant stakeholders. It is desirable to work with networks of services rather than isolated services. Working in networks of similar services or facilities, which can exchange experiences and provide mutual support usually favors the achievement of positive changes.

The process emphasizes bottom-up action and client and community involvement. A key purpose of the SBM-R process is to provide local health workers and the clients and communities they serve with practical tools that empower them and increase their control on the health delivery process. Clients and communities are not seen as passive recipients of health activities but as

essential partners in the health care process. To the maximum extent possible, client and community representatives should be part of the improvement teams, plans and activities.

3. Prepare the Team

a) Orient the facility teams on the standards through a one-day or half-day workshop, going through each standard to ensure the teams understand the language, context and means of verification. We suggest beginning the workshop with a participatory, open facilitation exercise in which team members or small groups brainstorm 5-8 key elements of gender-sensitive, respectful care. It is helpful to first present or discuss specific scenarios of the treatment of patients in facilities. These can each be written on a sticky note and presented to the group. Through group discussion, the facilitator or volunteer from the audience can organize the sticky notes with key elements of gender-sensitive care into common categories on a flip chart paper.

   Participants can also conduct a role play of a client-provider interaction or counseling session that displays both positive and negative behaviors in relation to gender-sensitive, respectful care, and then allowing facility teams to discuss on what might be important key elements of gender-sensitive respectful care based on the role play. This may allow for deeper reflection of real life scenarios.

   Suggested agenda:

   - SBM-R approach overview and introduction of standards
   - Setting standards for desired performance- group exercise
   - How to conduct the assessment and the scoring process
   - Role play group exercise
   - Developing and implementing action plans, recognizing progress
   - Timeline

b) Through group discussion, the team should come to agreement on standards they would like to apply in their own facilities. They can add new standards to the tool, or use language from relevant standards in the tool to refine their own standards. The intention of this participatory exercise and inclusion of the team's standards is to promote reflection and inspire ownership around the tool and QI process.
c) Present the checklist tool to participants, explaining the rationale for each, and ask them to choose the standards that are relevant and useful for their country and facility's context. If any of the key elements brainstormed by the group earlier is missing, ask the group to write it into the format of a new standard. Participants are also welcome to revise the language of standards if necessary to better align with local terminology and policies while still keeping the principle of the standard. For example, in Tanzania, the pilot team working on the Maternal and Child Survival Project revised language to cite specific laws and policies for Tanzania in relation to age of consent and gender-based violence guidelines for the health sector.

d) Explain the Scoring Sheet and process (details below) to participants, establish a timetable for conducting the assessment, timeline for reporting facility scores to Jhpiego, and recognition/reward system for facilities that achieve measurable progress over time.

4. Adapt the Tool

Based on workshop feedback, update the tool to reflect these changes, review the tool against relevant national guidelines to ensure it is in compliance (e.g., look up the age at which a child or adolescent is legally permitted to give consent without a parent or guardian), and ensure that all participants are using the same tool to allow comparison across facilities if possible. This can be done through a workshop to orient the QA team on the tool, including providers familiar with RMNCAH service delivery, to review the tool and identify areas that need to be adapted to the local context, policies and procedures.

5. Apply the Tool

The first use of the tool should be conducted by providers *in conjunction with* Jhpiego staff (ideally the Gender Advisor, Gender Focal Point, and/or other technical staff who have been trained on gender, including the quality improvement team at Jhpiego and at the facility). This will ensure that providers understand what each the meaning and purpose of each standard, how to ask about it, and how the means of verification can be used. When conducting the visit,

a) Introduce yourself and explain the objectives of the tool, particularly that it is meant to provide assistance to the providers and not to critique their performance
b) Thank the staff for their participation, allow time for cordial introductions and for staff to tell you about their facility (e.g. when it was established, how many GBV cases they receive each month, and anything else they may like to tell you)
c) Explain that the assessment will last approximately 3 hours and includes time to conduct a tour of the facility, the interviews and records review
d) Identify the staff that typically carries out the activities or procedures for interviewing
e) The assessment tool must be used to guide the observation and interviews
f) Be objective and respectful during the assessment
g) Ask clarifying questions to individuals responsible for these areas if needed
h) Probe to get the precise information, do not assume responses
i) Feedback should not be provided during the assessment and should only be shared afterwards
j) Identify correct sources of information (e.g., administrative forms, statistical records, service records)
k) Ask the person to show documents, equipment, or materials as appropriate

After the first use of the tool, conduct a debriefing meeting with the QA team within the next day to clarify any standards that posed difficulty.

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b) Thank the staff for their participation, allow time for cordial introductions and for staff to tell you about their facility (e.g. when it was established, how many GBV cases they receive each month, and anything else they may like to tell you)
c) Explain that the assessment will last approximately 3 hours and includes time to conduct a tour of the facility, the interviews and records review
d) Identify the staff that typically carries out the activities or procedures for interviewing
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k) Ask the person to show documents, equipment, or materials as appropriate

After the first use of the tool, conduct a debriefing meeting with the QA team within the next day to clarify any standards that posed difficulty.

6. Score the Tool

Facilities will receive a score of either zero, 1 or N/A (not applicable) for each standard, and an overall facility score (out of a highest possible score of 20) for the level of gender-sensitive service delivery. Scores for each standard should be recorded on the tool, noting any comments or missing items. This will be used to identify the facility's gaps and challenges, set goals and create a quarterly or biannual action plan for quality improvement. Once enough facilities are using the tool, the scores can be used to introduce an element of healthy competition between facilities or districts to increase respectful care.

a) Immediately record the information collected to ensure no data are lost.

b) Mark each verification criteria individually as "YES", "NO" or "N/A" (not applicable). Mark "YES" if the procedure is performed or the item exists as it is described. Mark "NO" if the procedure is not performed, if it is performed incorrectly or if a required item does not exist. Mark "N/A" if this verification criterion is not relevant or cannot feasibly be measured.

c) Provide concise justification for any criteria marked "NO" and "N/A" by recording any gaps, issues, or missing items/elements of care in the comments column.

d) Do not leave any verification criteria blank.

e) In the comments column, write down all pertinent comments, in a concise form, highlighting relevant issues and potential causes or challenges in meeting the criteria.

f) Only if all verification criteria are met should a standard receive a score of 1. Do not give a partial score if only some of the verification criteria are met.[1] Instead, be sure to mark in the Comments section what was missing.

g) If any verification criteria are missed, a standard should receive a score of zero.

h) If a verification score is N/A, and all other verification criteria in this standard are met, this standard should still receive a score of 1 **and not zero**.

i) Add the scores for all the standards and record that number on the Scoring Form in the row "TOTAL." Also record any comments, overall strengths and challenges on the Scoring Form.

Example 1:

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	Y	N	N/A	COMMENTS
1. The facility maintains conditions that ensure		3.1 Separate, private rooms are available for confidential client counseling with auditory and visual privacy (cannot be heard or seen	D	☒	☐	☐	

[1] No partial scores are used in order to keep the scoring process as straightforward and easy to calculate as possible.

and safeguard clients' privacy and confidentiality		from outside)					
		3.2 Women in labor and patients undergoing physical examinations have some visual privacy (curtains, screen or wall)	D, I, C	☐	☒	☐	
		3.3 The registration book is not accessible to anyone other than the providers/ facility managers	D + I	☒	☐	☐	
		3.4 Client records are kept confidential and can only be accessed by the client and her/his providers	D + I	☒	☐	☐	
		3.5 Clients of all gender identities and sexual orientations are treated equally with regard to confidentiality (nondisclosure) of health information	C, D	☒	☐	☐	

In the example above, the assessment team notes that all women in labor deliver together in one large room with no privacy, but all of the other criteria are met. **This standard would then be scored zero**.

Example 2:

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	Y	N	N/A	COMMENTS
10. The facility provides a welcoming, male-friendly environment		10.1 Providers encourage and allow women to bring a companion of any gender with them to FP and ANC visits, labor & delivery, and HCT	D	☒	☐	☐	
		10.2 Providers encourage and allow fathers to accompany their children to clinic visits (for immunization, routine examinations, malaria treatment, etc.)	D, I, C	☒	☐	☐	
		10.3 The facility offers services to men, including vasectomy and male condoms	D + I	☒	☐	☐	
		10.4 The facility has conducted demand creation to increase male utilization of services (e.g.	D + I	☐	☐	☒	

		advertising services and conducting outreach in traditionally male-dominated physical spaces such as taxi ranks, bars, sports facilities, etc.)					

In the example above, the assessment team notes that it partners with a community-based organization that conducts demand creation in traditionally male-dominated physical spaces, and so this verification criterion is marked "N/A" for not applicable. Since all the other criteria are met, **this standard is scored with a 1**.

On the Scoring Sheet, the assessor should record the score for each standard, sum these scores, and provide a total overall score for the facility. The assessor should also copy any notes on missing items or important information onto the score sheet.

Development of Action Plans

After every assessment, the facility staff should develop operational plans in order to implement the improvement process. These plans are relatively simple tools that outline what are the gaps and the causes that need to be eliminated, the specific intervention to be conducted, the person(s) in charge, the deadline for the task, and any potential support that may be needed. The identification of the responsible person(s) and the setting of the deadline are extremely important because they allow better follow up of the activities included in the plan. Operational plans should be developed upon analysis of the results of the baseline or follow-up monitoring assessments by teams of facility providers/managers working in the different areas of service provision being improved. The plans should be shared with relevant stakeholders, partners and donors to document progress.

It is important to understand that the process is usually initiated by a small group of committed persons because it is very infrequent to find widespread support for a new improvement initiative. It is, therefore, key to identify committed champions for the initiative and incorporate them in the initial improvement efforts. Providers are encouraged to focus on action and begin with simple interventions (the "low hanging fruit") in order to achieve early results, create momentum for change, and gradually acquire change management skills to address more complex gaps.

Sample Template for Action Plan

Gap/Challenge	Intervention/Action	Person Responsible	Support	Deadline

How Often To Use the Tool

After the first visit with the Jhpiego assessor's assistance, subsequent quarterly or biannual uses should be conducted by a provider(s) or facility manager(s) responsible for quality improvement. Ideally, it will be the same person each time, and s/he will also be responsible for documenting and sharing facility scores with Jhpiego and relevant ministries/donors. This person should compile and analyze facility scores to present to relevant ministries, partners, communities or donors to show which facilities are succeeding, which need greater support, and any trends in key areas of quality improvement across districts or regions. For example, the facility may score low on provider-client communication, indicating that further training is needed in this area.

The Jhpiego assessor should conduct one assessment in partnership with the facility team each subsequent year to ensure consistency in applying the tool and scoring process described above.

How to Track Performance

The scores and action plans should be shared with relevant stakeholders such as district, state and national ministries of health, facility managers, and providers. Key results from implementation of the action plans, gaps and challenges addressed, etc. can also be summarized and shared with clients and communities.

How to Recognize and Reward High Performance

Facilities showing the greatest improvement should be recognized for their achievements by Jhpiego, the MOH or other stakeholders. This could include simple steps such as sharing feedback and praise via email or a phone call. For significant successes, recognition could include a formal letter, presenting providers with a certificate of recognition, a visit to the facility with a key government or MOH official, and/or a brief article in local news media.

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Glossary of Terms

- **First-line support** is the immediate care a GBV survivor should receive upon first contact with the health or criminal justice system. The WHO defines "first-line support" using the acronym **"LIVES"**: **L**istening, **I**nquiring, **V**alidating, **E**nsuring safety, and **S**upport through referrals.
- **Gender** refers to the economic, social, political, and cultural attributes and opportunities associated with being women and men. The social definitions of what it means to be a woman or a man vary among cultures and change over time. Gender is a sociocultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality.
- **Gender-based violence (GBV)** is any form of violence against an individual based on that person's biological sex, gender identity or expression, or perceived adherence to socially-defined expectations of what it means to be a man or woman, boy or girl. The most common forms are sexual assault, intimate partner violence and child abuse, but GBV also includes physical and psychological abuse, threats, coercion, arbitrary deprivation of liberty, and economic deprivation, whether occurring in public or private life. GBV is rooted in gender-related power differences, including social, economic and political inequalities. It is characterized by the use and abuse of physical, emotional, or financial power and control. GBV takes on many forms and can occur across childhood, adolescence, reproductive years, and old age.
- **Gender Identity** refers to a person's internal, deeply felt sense of being a man or woman, or something other or in between, which may or may not correspond with the sex assigned at birth. Because gender identity is internal and personally defined, it is not visible to others.
- **Provider** refers in this tool to health care workers in general, and can include any type or level (physician, nurse, social worker, police officer, midwife, psychologist, et al.) This is because the number and type of providers who deliver services will differ across countries and even across facilities.
- **Sex** refers to the biological differences between males and females. Sex differences are concerned with males' and females' physiology.
- **Transgender** refers collectively to people who challenge strict gender norms by behaving as effeminate men or masculine women, adapting "third gender" roles, or embarking on hormonal and surgical treatment to adjust their bodies to the form of the desired sex. Transgender persons often find that the sex assigned to them at birth does not correspond with the innate sense of gender identity they experience in life. Transgender may include **transsexuals** (people whose physical sex conflicts with their gender identity as a man or a woman); **transvestites** (people who cross-dress for sexual gratification but do not wish to be a person of the other sex); and **intersex persons** (people whose sexual anatomy is neither exclusively male nor exclusively female).

Participant handout: Jhpiego gender service delivery standards

JHPIEGO GENDER SERVICE DELIVERY STANDARDS

Name of Facility _____

Name of Person Completing This Tool _____

Title of Person Completing This Tool _____

Date _____

Please read the Facilitation Guide for instructions on how to use this tool, available at www.jhpiego.org/gender

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION[1]	YES	NO	N/A[2]	COMMENTS
Availability & Accessibility of Services							
1. Services are equally accessible to women, men, adolescent girls and adolescent boys, and other gender identities[3]		1.1. Facility offers emergency services 24 hours a day, including services for obstetric complications, physical trauma, and essential post-GBV care (emergency contraceptives, HIV post-exposure prophylaxis, and first-line support[4]) *Prompt: During what hours are emergency services available? Are the following services available during these hours: post-GBV care including EC, PEP, and GBV first-line support?*	C + I	☐	☐	☐	
		1.2 Facilities offer some evening/weekend hours for routine services for clients (e.g. working mothers/fathers) who cannot attend during typical business hours	C + I	☐	☐	☐	
		1.3 Providers give all clients the full range of information and services they need, regardless of age, marital status, gender identity or socioeconomic status *Prompt: For example, would a married adult woman seeking family planning services receive the same information and services as an unmarried adolescent?*	C, D, S	☐	☐	☐	

[1] Means of Verification are coded in the following format: **C:** interviews with clients; **D:** Direct observation of clinical procedures and physical facilities; **I:** interviews with providers and facility managers; **R:** review of clinical and administrative records, policies and protocols; and **S:** Simulation or role play to demonstrate the interaction or communication. **Choose as appropriate.**

[2] N/A=Not Applicable. If N/A is checked, this verification criterion does not factor into the overall score for the standard. (e.g. if the facility gets an N/A for one verification criteria but meets all the others, this standard should still receive an overall score of 1)

[3] Other gender identities can include: transgender people (people's whose personal gender identity does not correspond with their biological sex), intersex people (people born with both male and female genitalia), agender people (those who do not identify with any gender), et al.

[4] First-line support for GBV includes basic empathetic counseling, documenting violence, conducting safety planning and providing referrals. For more information, please see Jhpiego's GBV Quality Assurance Standards, available at www.jhpiego.org/gender

		1.4 Facility ensures all patients have equal access to care, regardless of sex, gender identity, sexual orientation, marital status, age, disability, race, religion, ethnicity, etc. *Prompt: Have you ever heard of any patient being turned away from the facility due to the ethnic group they were from, because they were unmarried, because they were gay, or for any other reason?*	C, D + I	☐	☐	☐
		1.5 Facility has a referral system and an up-to-date referral directory in place for clients of any gender or age	I + R	☐	☐	☐
2. Facilities' infrastructure accommodates needs of all clients		2.1 Location of health services is accessible to clients of any gender and age *Prompt: How long does it take for clients to travel to the health facility? What means of transportation are available and affordable?*	C	☐	☐	☐
		2.2 Facility has clean restrooms available for clients of any gender with a functioning toilet, water, soap, towels, and privacy	D	☐	☐	☐
		2.3 Facilities offer each inpatient client her/his own bed and no client is required to share a bed with another person or use the floor	C, D	☐	☐	☐
3. The facility maintains conditions that ensure and safeguard clients' privacy and confidentiality		3.1 Facility has separate, private rooms available for confidential client counseling with auditory and visual privacy (cannot be heard or seen from outside)	D	☐	☐	☐
		3.2 Facility offers some privacy (curtains, screen or wall) to women in labor and patients undergoing physical examinations	D, I, C	☐	☐	☐
		3.3 Facility ensures the registration book is not accessible to anyone other than the providers/ facility managers *Prompt: Who has access to this registration book?*	D + I	☐	☐	☐

		3.4 Facility keeps client records confidential and can they only be accessed by the client and her/his providers	D + I	☐	☐	☐	
		3.5 Providers treat clients of all gender identities and sexual orientations equally with regard to confidentiality (nondisclosure) of health information	C, D	☐	☐	☐	
4. Clients' agency, autonomy and well-being are respected regardless of gender		4.1 Except for clients who are dependents or minors,[5] providers do not require a client's spouse, partner or family member to give consent for any services *Prompt: Are there any services that a client needs her spouse's consent to receive?*	C, D, I + S	☐	☐	☐	
		4.2 Providers give female clients about their health directly (e.g. provider does not give information to male spouse, partner or guardian *instead* of to the woman herself) *Prompt: Have you ever seen a provider who gives information about a woman's health to her male partner instead of to her directly?*	C, D, I + S	☐	☐	☐	
		4.3 Facility providers care to all individuals according to the facility's triage system or on a first-come, first-serve basis, regardless of whether the client is accompanied by a spouse, partner or family member *Prompt: How does this facility decide whom to see first? Should a woman who is accompanied by her spouse allowed to skip the line?*	C, D + I	☐	☐	☐	
		4.4 Facility prioritizes patients for care based on urgency of the medical condition, regardless of gender *Prompt: Have you ever heard of a man being seen first, even if a woman is waiting with an equally serious need for care?*	C, D + I	☐	☐	☐	

[5] Each country defines "minor", "child" and "dependent" differently. **Provider should follow national law**, or if none exists, minors can be considered children under the age of 12. "Dependents" refers to children or persons who are under the care of a legal guardian who is legally authorized to give consent on the client's behalf (e.g. a mentally or physically-impaired client who cannot voice consent, or a child who is too young to understand a procedure or its implications).

5. Clients have access to— and receive information about— all available contraceptive methods		5.1 Provider explains the different contraceptive methods available, checks that the client has understood, asks if s/he has a method in mind, and lets the client's needs guide the consultation	C, D, S	☐	☐	☐	
		5.2 Providers are knowledgeable and communicate clearly about services and contraceptive methods available at the facility	C, D, S	☐	☐	☐	
		5.3 Providers allow clients of any gender and age to voluntarily choose any available and appropriate family planning method, including permanent methods such as sterilization, regardless of the number of times a woman has been pregnant or given birth, or client's marital status *Prompt: If a woman requests permanent sterilization, would her marital status or the number of children she already has affect whether or not you fulfil her request?*	C, D, S	☐	☐	☐	
		5.4 Providers respect client's choice of method if available. (If **NOT** available, provider offers an alternate, medically appropriate method, or a referral to a facility that offers client's preferred method)	C, D, S	☐	☐	☐	
		5.5 If a client declines to use a method, provider respects her/his choice and further care is not denied *Prompt: What would you do if a client refuses the method you suggest?*	C, D, S	☐	☐	☐	
		5.6 Unless required by national law, providers do not require any client (except minors or dependents) to seek their spouse, partner or family member's consent to undergo voluntary sterilization[6] *Prompt: Can a woman undergo voluntary sterilization without her spouse's consent?*	C, D, I + S	☐	☐	☐	

[6] Unless required by national law. If the facility is in a country where national law requires spousal consent, check the "N/A" box for "not applicable."

		5.7 Providers never sterilize any client without her or his informed consent	C, D + I	☐	☐	☐	
		5.8 Facility ensures contraceptive commodities, supplies and equipment covering a range of methods, including long acting and emergency contraception, are integrated within the essential medicine supply chain to increase continuous availability	D + R	☐	☐	☐	
6. Clients have access to emergency contraception (EC) regardless of their circumstance, gender or age		6.1 When medically indicated, provider offers any client (or their guardian in the cases of minors and dependents) EC regardless of age, marital status, **AND** without another person's consent *Prompt: if a woman has been sexually assaulted, does she need anyone's consent to obtain emergency contraceptives?*	C, D + I	☐	☐	☐	
		6.2 If client requests EC and it is medically indicated, provider identifies whether the client has been exposed to unprotected sexual intercourse within the last 5 days (120 hours), and if yes, provider offers EC	I + S	☐	☐	☐	
		6.3 Provider asks questions and records responses related to sexual behavior and need for EC in a professional and non-judgmental manner *Prompt: How would you ask the client about why she needs EC and what happened? What would you say if she told you she was drinking and out alone at night?*	C, D, I, S	☐	☐	☐	
7. Clients can choose the gender of their provider		7.1 Facility ensures female and male providers are available at the health facility for clients who prefer a particular gender	C, D + I	☐	☐	☐	
		7.2 Providers inform clients that they can choose the gender of their provider if available	C, D	☐	☐	☐	
		7.3 Facility honors client's preference on the gender of their provider	C, D + I	☐	☐	☐	

8. There are information, education & communication (IEC) materials accessible to clients of all genders		8.1 Facility ensures materials (e.g. posters) are available in high-traffic locations in the facility such as waiting rooms, in the local language(s), and accessible to a low-literacy audience so that clients of any gender can see and understand them	D	☐	☐	☐	
9. No client is denied care because s/he cannot pay fees		9.1 Providers never detain any client due to inability to pay fees	C, D + I	☐	☐	☐	
		9.2 Providers never ask any clients for fees outside of the approved policy, gifts, favors, bribes or sexual acts in exchange for care *Prompt: Have you ever heard of a client being asked to pay a bribe or exchange a sexual favour to receive care, or better quality care?*	C + I	☐	☐	☐	

PERFORMANCE STANDARD	SCORE	VERIFICATIONCRITERIA	MEANS OF VERIFICATION	YES	NO	N/A	COMMENTS
Male Engagement & Family Inclusiveness							
10. The facility provides a welcoming, male and family-friendly		10.1 Providers encourage and allow women to bring a companion of any gender with them to FP, ANC, labor & delivery, HCT	C, D + I	☐	☐	☐	
		10.2 Providers encourage and allow fathers to accompany their children to clinic visits (for immunization, routine examinations, malaria treatment, etc.)	C, D + I	☐	☐	☐	

environment and services		10.3 Facility offers services to men, including vasectomy and male condoms	D + I	☐	☐	☐	
		10.4 Facility conducts demand creation to increase male utilization of services (e.g. advertising services through outreach in traditionally male-dominated physical spaces such as taxi ranks, bars, sports facilities, etc.)	I	☐	☐	☐	
11. Provider offers couples/partner counselling on communication and joint-decision making		11.1 Providers have been specially trained to counsel couples on ANC, Family Planning, PMTCT and HCT, couples communication, joint decision-making on FP and birth planning	I	☐	☐	☐	
		11.2 Facility offers sexual and reproductive health counseling to couples/partners, including skills building on couples'/partners' communication and negotiation	C, D + I	☐	☐	☐	
		11.3 Provider asks client if s/he would like to have a companion present **AND** only invites a companion to be present if the client gives permission	C, D, I, S	☐	☐	☐	
		11.4 Providers educate and engage male partners who may influence health-decision making in the relationship and family, on the importance of supporting female partners to seek care, and seeking care for children	C, D, I, S	☐	☐	☐	
		11.5 Provider emphasizes the importance of *shared* decision-making and emphasizes s/he is not asking men to take control	C, D, I, S	☐	☐	☐	

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	N/A	COMMENTS
Provider-Client Interaction							
12. The provider establishes a cordial and respectful relationship with the client and their companion (if present) **(DETAILS IN THE BOX BELOW)**		12.1 Provider treats the client and her/his companion (if present) respectfully **(DETAILS IN THE BOX BELOW)** *Prompt: Can you name a few key approaches you use to treat a client respectfully, how you communicate with him or her, and ensure how you ensure privacy?*	C, D, S	☐	☐	☐	
		12.2 Provider uses empathetic interpersonal communication skills during the entire visit	C, D, S	☐	☐	☐	
		12.3 Provider assures client of confidentiality	C, D, S	☐	☐	☐	
		12.4 Provider ensures necessary privacy during the visit	C, D, S	☐	☐	☐	
		12.5 Provider explains to the client and companion what s/he is going to do and encourages her/him to ask questions	C, D, S	☐	☐	☐	
		12.6 Provider displays non-stigmatizing, non-judgmental attitude to all clients, including unmarried clients/ adolescents seeking reproductive health services *Prompt: What would you say to an unmarried 15 year-old girl seeking condoms?*	C, D, S	☐	☐	☐	
		12.7 Provider does not leave a client unattended or alone when s/he needs care *Prompt: Have you ever seen or heard of a client in need of care who was left unattended?*	C, D, S	☐	☐	☐	

		12.8 Providers never physically, sexually, verbally or emotionally abuses any client *Prompt: Have you ever heard of a client who was physically, sexually, verbally or emotionally abused by a provider at this facility?*	C, D, S	☐	☐	☐	
13. Provider gives appropriate emotional support for post-abortion care, and post-abortion family planning		13.1 Provider shows compassion and addresses any feelings of denial, guilt, shame, anxiety, fear, depression and loss *Prompt: How would you counsel a woman who has come in for post-abortion care?*	C, D, S	☐	☐	☐	
		13.2 Provider treats post-abortion client in a non-judgmental, respectful and professional manner	C, D, S	☐	☐	☐	
		13.3 If/when client is ready, provider gives information on post-abortion contraceptive options, including long-acting methods and emergency contraception	C, D, S	☐	☐	☐	
14. Providers take into account gender barriers that impact health-seeking and utilization of services		14.1 During ANC, provider asks female clients if they can make the decision about whether to deliver in a facility, and if not, encourages her to bring the decision-maker to her next appointment for counseling *Prompt: Do you ask female clients if they can decide on their own where they will deliver? If they say they cannot, do you encourage them to bring the decision-maker, for example their spouse, for counseling?*	C, D, S	☐	☐	☐	
		14.2 During contraceptive counseling, provider asks female clients if they are able to decide for themselves whether or not to use FP, and if not, encourages her to bring her partner to her next appointment for counseling	C, D, S	☐	☐	☐	

		14.3 Provider asks if she would be at risk of GBV if her partner participates in FP. [If **YES**, the provider offers GBV counseling and care according to national guidelines or Jhpiego GBV Quality Assurance Standards.[7] If **NO,** trained provider is available, a referral is made to nearby GBV services.]	C, D, S	☐	☐	☐	
		14.4 During antiretroviral therapy counseling, provider asks if there are any reasons that would prevent the client from taking HIV medication on schedule or for returning for follow up, including influence from spouse, family or others	C, D, S	☐	☐	☐	
15. Providers address myths or beliefs that impact health-seeking and utilization of services		15.1 During ANC or FP counseling, providers ask clients and their companions if they hold any beliefs that would prevent them from using FP, attending ANC, using a male or female condom, breastfeeding, delivering in a facility, seeking an HIV test, or STI treatment	C, D, S	☐	☐	☐	
		15.2 Providers dispel false beliefs or myths held by clients or companions around the provision of care using scientific facts. (For example, some clients falsely believe contraception and abortion affect the ability to conceive in the future)	C, D, S	☐	☐	☐	

[7] The Jhpiego GBV Quality Assurance Standards are a comprehensive checklist that outlines essential components of high quality post-GBV care. Available at www.Jhpiego.org/gender

Key aspects of a respectful relationship (DETAILS OF STANDARD 15- THIS SECTION IS NOT SCORED)		
Treating the client respectfully • Greet the client cordially (and companion if present) • Introduce him/herself • Call client by his/her name or appropriate title • Show concern and respect client's culture, beliefs and ideas • Displays a non-judgmental attitude and avoids judgmental terms, instead using specific, appropriate clinical and counselling terms	**Interpersonal communication skills** • Encourages client to ask questions and answers them • Listens to client • Maintains eye contact • Uses language and terminology that client understands • Speaks in the language of the client, or offers a translator • Uses open and friendly non-verbal communication expressions (smiling, facing client directly, etc.) • Uses visual-aids during counseling • Allows client to repeat the information to verify comprehension • Checks if the client has understood • Summarizes salient (important) points when necessary • Explains to the client what to expect during the clinic visit • Gives information on return visits and invites client to come back any time for any reason • Facility shows concern for clients who have missed appointments and attempts to follow up, as possible • Providers speak up against disrespectful conduct among other providers such as insults, verbal abuse or scolding of clients; • The facility has in place a policy that encourages positive communication and does not allow harsh or abusive language	**Ensuring privacy during the visits** • Keeps the door and curtains closed • Only people/staff authorized by the client can come into the consultation/examination room or area • The client can undress/dress privately • The client remains covered during examination • If possible, the examination is witnessed by a matron authorized by the client • Provider pays special attention to privacy and confidentiality of clients seeking care for GBV or STIs • Facility and providers accommodate companions for women in labor and other clients, to the extent possible and when requested by client

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICA-TION	YES	NO	N/A	COMMENTS
Health Care Policies & Facility Management							
16. Clients and providers can enjoy an environment free of sexual or other abuse		16.1 Facility has a written zero-tolerance policy or client service charter that expressly prohibits sexual, physical or other abuse of clients and providers	I, R	☐	☐	☐	
		16.2 Providers have received training and are knowledgeable about what constitutes sexual harassment or abuse	I	☐	☐	☐	
		16.3 Facility documents and acts upon any instances of abuse according to facility's policy	C + I	☐	☐	☐	
17. Policies support equal opportunities for providers of all genders for advancement and compensation for comparable work		16.1 Providers, regardless of gender, receive equal pay and benefits for equal work	I, R	☐	☐	☐	
		16.2 Facility has a written non-discrimination policy	R	☐	☐	☐	
		16.3 Facility ensures at least 30% of the facility's leadership team is female or of a non-traditional gender identity	D, I	☐	☐	☐	
		16.4 Providers of any gender have an opportunity to be involved in the facility's planning and policy formulation	I	☐	☐	☐	
		16.5 Regardless of gender, facility ensures that providers of equal seniority and training have equal decision-making and influence *Prompt: Amongst this facility's leadership, do you feel that the most senior men and women have equal decision-making power and influence?*	I	☐	☐	☐	
		16.6 Facility gives providers of any gender equal opportunity to work the same number of hours and shifts, regardless of whether or not they have children	I	☐	☐	☐	
		16.7 Facility ensures providers of any gender have the same opportunities for training, professional development and promotion	I	☐	☐	☐	

18. Providers are trained on gender equality and human rights		18.1 Facility ensures all providers have received training on gender equality and human rights within the past two years	I	☐	☐	☐	
19. A feedback mechanism exists for clients to report their level of satisfaction, or to file complaints		19.1 Facility ensures there is a hotline, suggestion box, exit feedback form, or ombudsperson (an impartial representative) that clients can use to give anonymous and confidential feedback on their experience at the facility	D, R	☐	☐	☐	
		19.2 Provider informs client of the existence of the feedback mechanism(s)	C, D	☐	☐	☐	
20. Health information systems data are regularly used for gender analyses and evaluation to improve gender-equitable service delivery		20.1 Facility disaggregates all relevant data by sex and age	R	☐	☐	☐	
		20.2 Facility analyzes and uses sex and age-disaggregated data to improve and tailor services offered, approaches used, and commodities stocked	I, R	☐	☐	☐	

TOTAL STANDARDS:	20
TOTAL STANDARDS OBSERVED:	
TOTAL STANDARDS ACHIEVED:	

jhpiego
Saving lives. Improving health.
Transforming futures.

Chapter 12: What is violence?

Gendor 101 training materials

Jhpiego is a nonprofit global leader in the creation and delivery of transformative health care solutions that save lives.

In partnership with national governments, health experts and local communities, we build health providers' skills, and we develop systems that save lives now and guarantee healthier futures for women and their families. Our aim is revolutionizing health care for the planet's most disadvantaged people.

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Chapter 12: What is violence?

Learning objectives

By the end of this session, participants will be able to:

- Define the concept of violence
- Define gender-based violence
- List different types of gender-based violence

Time needed

1 hour 30 minutes

Materials needed

- What is Violence? Jamboard template
- Polling software or Annotations (integrated into Zoom)
  - (If using Zoom Annotations) "Violence_No Violence" slide
- Participant Handout: What Is Gender-Based Violence?
- Participant Handout: What Is Sexual Harassment?
- Participant Handout: Myths and Truths about Violence
- Facilitator Resource: Violence Scenarios

Advance preparation

1. Email a copy of the three Participant Handouts to participants.
2. Review the violence scenarios (from Facilitator Resource: Violence Scenarios) and select the 3 to 4 scenarios most relevant to your program and context.
3. Review the myths (from Participant Handout: Myths and Truths about Violence) and select the 5 to 10 statements most relevant to your program and context.
4. [If you will be implementing **Option 1: Zoom Polling** below] Log into Zoom.us and add the following poll to your Zoom meeting (review the Technical Facilitator Guidance for more information on adding polls to a Zoom meeting).

   Question: Select whether the scenario describes a case of violence ("Violence"), does not describe a case of violence ("No Violence"), or whether you are not sure ("Not Sure")

   Answer Choice (single choice):

   - Violence
   - No Violence
   - Not sure

Technology Note: Facilitators who feel comfortable using Slido, Mentimeter, or an alternative third-party polling software may choose to use that polling software in place of Zoom's polling software.

5. [If you will be implementing **Option 2: Zoom Annotations** below], download a copy of the "Violence_No Violence" slide to your computer.

> **Facilitator note:** It is likely that some participants, particularly women, have experienced, or are experiencing, violence in their personal lives. It is important for the facilitator to have information about existing national laws and/or policies related to gender-based violence (GBV) so that they can refer to this information during the activity (including policies around mandatory reporting for health providers, if applicable). Prior to leading this activity, the facilitator should research local support services for GBV survivors, and have contact information for those services available, should any participants request such support.

Steps

> **Technology Note:** While other Gender 101 training sessions may be recorded, sessions on gender-based violence should never be recorded to maintain the confidentiality of participants' experiences.

Introduction (5 minutes)

1. Share with the group that this session will focus on violence. Acknowledge that the topic is challenging, because violence harms many women and men and yet is very common. State that some people in the group, including the facilitators, may have been affected by violence—maybe they witnessed violence with neighbors or family, maybe they experienced it in their own families as a child, maybe they experienced it at some point in their adult lives, etc.
2. Explain that violence is a sensitive topic and that it is important for participants to respect the following group norms as they move through the session:
    - Maintain confidentiality. What is said in the room stays in the room. This session is not being recorded. Gossiping is not tolerated.
    - Everyone has the right to pass. If a participant feels uncomfortable about a particular topic or if they feel uncomfortable about sharing on a particular point, they have the right to pass.
    - Suspend judgment. Everyone has a right to their opinions and beliefs. Try not to judge others, and try to maintain an open mind and hear what others are saying.
    - Respect the opinions and feelings of others. Avoid interrupting others while they are speaking. Do not mock or minimize another person's contribution.
    - Do not speak for others. Only share what you have said. Do not relate what someone else may have said in the context of this group.
    - Practice active listening. Pay attention when others are speaking and try to listen carefully to what they are saying.
3. Explain that given the sensitive nature of the topic, you would like participants to keep in mind the following options during the session:
    - Take care of yourself, and take a break if you need to do so.
    - Anyone who wants additional support on this issue for themselves, a family member, or a friend should feel free to talk to the facilitator after the session to be connected to support resources.
4. Ask the group if they have any questions or concerns.

What does violence mean to us? (30 minutes)

1. **Technology Action:** Screenshare the first frame of the Jamboard and add sticky notes as you discuss the following points.
2. Ask for some volunteers to share with the group what violence means to them. Write the responses on the first frame of the Jamboard template ("What does violence mean to you?"). Examples might include "pain," "control," "suffering," etc.

> **Optional Adaptation**
>
> Instead of requiring that participants unmute and share ideas while you take notes, consider sharing the editable link to the Jamboard in the Zoom chat; invite participants to add responses to the question using sticky notes. Remind participants that, if they choose to add ideas, these ideas will be anonymous. As time allows, ask if anyone would like to share more about what violence means to them by unmuting and sharing verbally with the group.
>
> *Consider the technological capacity and comfort level of participants with Jamboard when determining whether to implement this adaptation.*

3. Next, reveal the second frame of the Jamboard detailing the World Health Organization's (WHO) definition of violence, and ask for a volunteer to read it aloud to the group.
4. Ask participants if they have any questions or comments about the definition.
5. Next, ask participants to provide some examples of the types of violence the WHO definition is referencing. As participants call out their ideas, write them on the third frame of the Jamboard ("Types of Violence"). Elicit examples for the four types of violence (physical, sexual, psychological/emotional, and economic). Spend no more than 10 minutes on steps 1 to 4.
6. After you have identified the four types of violence, review each one individually using the explanation points below (spend no more than 10 minutes on this step):
    - **Physical violence** involves using physical force, such as hitting, slapping, or pushing.
    - **Emotional/psychological violence** is often the most difficult form of violence to identify. It may include humiliating, threatening, insulting, pressuring, or expressing jealousy or possessiveness (e.g., by controlling decisions and activities).
    - **Economic violence** occurs when a person takes control of or limits another's access to individual or family assets, or limits another's ability to earn money (e.g., denying access to money or the means of earning money; denying access to work or school; intentionally withholding necessities such as food, clothing, shelter, medication, or personal hygiene products; stealing from an individual; or forbidding another from maintaining a personal bank account).
    - **Sexual violence** involves pressuring or forcing someone to perform physical sexual acts (from kissing to sex) against their will. It does not matter if there has been prior consenting sexual behavior. That is, an individual can still be forced to perform sexual acts by a person even if they have consented to have sex with that person in the past. Sexual violence can also occur within a marriage—being married does not imply consent for sexual acts.
    - **Sexual harassment** is a form of sexual violence that includes unwelcome sexual advances, requests for sexual favors, and other conduct of a sexual nature. Although people tend to think of sexual harassment as occurring between two individuals with different levels of power (e.g., supervisor to supervisee), this is not always the case. Examples of sexual harassment include unwanted sexual looks or gestures; unwanted pressure for sexual favors; looking a person up

and down; unwanted sexual teasing, jokes, remarks, or questions; and repeatedly asking out a person who is not interested.

7. Remind participants that they have received the **Participant Handout: What Is Sexual Harassment?** via email. Ask participants if they have any questions about the types of violence reviewed so far.

> **Facilitator note:** When discussing the different types of violence, make clear to participants that physical, emotional/psychological, economic, and sexual violence are not necessarily discrete categories. Emotional/psychological violence always exists in tandem with physical, economic, and sexual violence. Likewise, sexual violence necessarily implies physical violence, although *sexual harassment* does not necessarily imply physical violence.

8. **Technology Action:** Screen share a copy of the Participant Handout: What Is Gender-Based Violence?
9. Remind participants that they can also access their handout from their email. Explain that the group will now examine the concept of gender-based violence (GBV). Spend 10 minutes discussing the following points with participants:
    - GBV encompasses a range of physical, sexual, economic, and emotional/psychological violence that can occur in public or in private. GBV is used to reinforce unequal power dynamics based on gender.
    - Examples of GBV **in the family** include battering, marital rape, sexual abuse of children in the household, dowry-related violence, and female genital mutilation.
    - Examples of GBV **within the general community** include rape, sexual violence, sexual harassment and intimidation at work, trafficking, and forced prostitution.
    - Examples of GBV that are **state or institution-sanctioned** include rape as a weapon of war.
    - Women and girls experience GBV more often than other genders because of their subordinate position in many societies. Norms that emphasize men's superior status over women justify men's use of violence against women as a means of maintaining their dominant status.
        - Men can experience GBV when they step outside traditional gender norms or do not express in a masculine enough way.
        - Explain that most violence between men is gendered (because violence is a way to express masculinity) but not necessarily GBV.
    - GBV can lead to serious health consequences including HIV transmission, unintended pregnancies, unsafe abortions, depression, injury, obstetric complications, and death.
    - **Special note on intimate partner violence (IPV):** IPV is actual or threatened physical, sexual, psychological/emotional, and/or economic abuse directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner. Typically, women in heterosexual intimate relationships tend to experience IPV more often than men. Though more rare, IPV can be committed against male partners by female partners.
10. Offer participants an opportunity to ask questions about GBV.
11. Explain that during the second part of the exercise, the group will review a series of case studies to help them reflect on the different meanings and types of violence.

Types of violence (30 minutes)

1. Explain that you will read some scenarios out loud and that each participant will need to decide on their own whether they believe the scenario:
    - Depicts a case of violence.
    - Does not depict a case of violence.

> **Facilitator Note:** For steps 2-6, select from one of the following options. Consider with which option you are most comfortable, as well as which option will best engage your specific participants. Both options are estimated to take approximately the same amount of time.

Option 1: Zoom Polling

2. Explain that participants will be able to select their response from a Zoom poll. They will be able to select from the following options:
    - "Violence", if they believe the scenario describes a case of violence
    - "No Violence", if they believe the scenario does not describe a case of violence
    - "Not Sure", if they are undecided
3. Once participants understand the instructions, refer to Facilitator Resource: Violence Scenarios, and read the first scenario aloud.
4. **Technology Action:** Launch your Zoom poll. Give participants 30 to 45 seconds to respond, and then close the poll once all or most participants have responded. Share the results of the poll.
5. Once you have closed the poll, ask for volunteers to explain their reason for answering as they did. Allow no more than 5 minutes of discussion for each scenario. After discussing a scenario, sum up the discussion using the "Key points" provided at the end of the scenario.

> **Facilitator note:** Sometimes, it can be challenging to identify participants for conversations, especially as the Zoom polling results produce anonymous responses and we can't watch and interpret body language. Consider the following facilitation techniques for managing the brief debrief on each poll:
>
> 1. Invite any participant who selected "Violence" to raise their hand if they would like to talk more about why they selected the answer they did. Then, ask the same of participants who selected "No Violence".
> 2. Randomly call on participants to share how they responded and why.

6. **Technology Action:** Re-launch the poll.
7. Repeat steps 3 to 6 for the remaining scenarios.

> **Technology Note:** You will be informed that "Re-launching the poll will clear existing polling results. Do you want to continue?" Select "Continue".
>
> If you would prefer to have all results of the poll saved, you may create two separate polls (one for each scenario). Note that this will need to be completed prior to the start of the session.

Option 2: Zoom Annotations

1. Explain that each participant will be able to share their opinion using Zoom annotations.

2. **Technology Action:** Screen share the "Violence_No Violence" slide.
3. Explain how to use Zoom's annotation feature using the following language:

   "There are two steps required in order to access the Zoom annotation feature. First, find the green bar at the top of your screen that says, 'You are viewing [name's] screen.' You may need to move your cursor in order to see this. Next to the green bar, it will say 'View Options'. Click on 'View Options'. Then click 'Annotate'. You will now be able to annotate on the screen. Everyone will be able to see what you write or add. We're going to use the 'Stamp' feature. Find where it says 'Stamp' near the top of your screen. Then, select the 'Star'. Now, you can click anywhere on the screen in order to add a star."
4. Once participants understand the instructions, refer to **Facilitator Resource: Violence Scenarios**, and read the first scenario aloud. Ask everyone to add a stamp within the circle that represents their opinion of the scenario.
5. Once each participant has added their stamp, ask for volunteers from each group to explain their reason for stamping where they did. Allow no more than 5 minutes of discussion for each scenario. After discussing a scenario, sum up the discussion using the "Key points" provided at the end of the scenario.
6. **Technology Action:** Clear the annotations by clicking the icon of a trash can.
7. Repeat steps 4 to 6 for the remaining scenarios.

Group discussion (10 minutes)

1. After discussing all of the scenarios, facilitate a 10-minute group discussion using the following questions: How did you feel about portraying your character?
   - Were you surprised that any particular situation was indeed an act of violence? Why?
   - What kinds of violence occur most often in intimate relationships between men and women in your country? What causes this violence? (Examples may include physical, emotional, and/or sexual violence that men use against girlfriends or wives, as well as violence that women use against their boyfriends or husbands)
   - What kinds of violence occur most often outside relationships and families? What causes this violence? (Examples may include physical violence between men, gang- or war-related violence, stranger rape, and emotional violence or stigmatization of certain individuals or groups in the community)
   - Are some acts of violence related to a person's sex? What is the most common type of violence practiced against women? Against men?
   - What are the consequences of violence in relation to sexual and reproductive health?
   - What are the consequences of violence in relation to one's overall health and wellness (mental health, disability, etc.)?

Facilitator note: During the discussion, be sure to point out that men are often socialized to repress their emotions and anger is sometimes one of the few socially acceptable ways for men to express their feelings. Moreover, men are sometimes raised to believe that they have the "right" to expect certain things from women (domestic tasks or sex, for example) and the right to use physical or verbal abuse if women do not provide these things. Violence is a learned behavior, and in that sense, it can be unlearned and prevented.

Myths and truths about violence (14 minutes)

1. Before ending the session, explain to participants that you would like to spend some time discussing common myths about violence.
2. Refer to **Participant Handout: Myths and Truths about Violence.** Read a myth to the group and ask the group why it is a myth. After a few responses, read the reason provided on the handout. Repeat this process for as many myth statements as time allows.
3. Remind participants that they can access the **Participant Handout: Myths and Truths about Violence** through their email.

Alternative Set-up and Execution for "Myths and truths about violence"

Consider the following set-up if you have additional time and would like to provide participants with an opportunity to discuss myths and truths about violence in greater depth in small groups.

Advanced Preparation:

1. Select 5 statements from the **Participant Handout: Myths and Truths about Violence** and label them 1 to 5. Make sure the numbered myths are typed out in a location where you will readily be able to copy and paste the text into the Zoom chat.

Myths and truths about violence (26 minutes)

1. **Technology Action:** At any point during the activity, set up breakout rooms:
    - 5 groups (randomly distributed participants)
    - Check "Breakout rooms automatically close after"
    - 8 minutes
    - Check "Notify me when time is up"
    - Countdown after closing breakout room: 30 seconds
2. Explain to participants that you would like to spend some time discussing common myths about violence.
3. Explain that participants will be split into 5 groups, and that each group will receive a myth to review.
4. Explain that, in their groups, they should read the myth and collectively identify why it is a myth. Then, they should select a spokesperson who will share their group's ideas with the rest of the participants.
5. **Technology Action:** Post in the chat five myths, numbered 1 to 5.
6. Call participants' attention to the myths in the Zoom chat. Explain that, as they are being moved to a breakout room, participants will see on their screen to which numbered room they are being moved. Once they are in their breakout rooms, their room number will appear at the top of the Zoom screen. Their group should review the myth that matches their room number.
7. Make sure participants understand the instructions. Remind them that they should use the "Ask for Help" button if they have questions for a facilitator while in their breakout room. (Spend no more than three minutes on steps 2 to 7)
8. **Technology Action:** Open the breakout rooms.

9. **Technology Action:** Send a broadcast reminder when groups have 2 minutes left.
10. **Technology Action:** After 8 minutes, close the breakout rooms.
11. Invite the spokesperson from group 1 to read their myth to the group and then share why it is a myth. Allow brief questions/comments from other participants. Complement the discussion with the "truth" notes in the handout. Spend no more than 3 minutes discussing each myth.
12. Repeat step 11 with the remaining groups.

Closing (1 minute)

1. End the session by making the following points:
    - In every situation that we discussed, there was some form of violence. Although the violence was clearly evident in some cases, in other cases it was less so.
    - In each case, the person at the receiving end suffered physical pain, emotional pain, economic deprivation, or a combination. Violence is therefore not only causing physical injury.
    - Violence happens all around the world. It is commonly assumed that inflicting violence is a "natural" or "normal" part of being a man. However, violence is a learned behavior, and in that sense, it can be unlearned and prevented.

Sources

- EngenderHealth. 2015. Training on Gender and Sexual and Reproductive Health: Facilitation Manual. New York, NY: EngenderHealth, 45–52.
- EngenderHealth. 2008. Engaging Men and Boys in Gender Transformation: The Group Education Manual. Activity 9.1. New York, NY: EngenderHealth.
- World Health Organization (WHO). 2018. Definition and typology of violence. WHO website. http://www.who.int/violenceprevention/approach/definition/en/.

Participant handout: What is gender-based violence?

(*From* The ACQUIRE Project/EngenderHealth and Promundo. 2008. *Engaging Men and Boys in Gender Transformation: The Group Education Manual*. New York, NY and Rio de Janeiro, Brazil: The ACQUIRE Project/EngenderHealth and Promundo, 306. http://www.acquireproject.org/archive/files/7.0_engage_men_as_partners/7.2_resources/7.2.3_tools/Group_Education_Manual_final.pdf)

In many settings, most laws and policies use "family violence" or "domestic violence" to indicate acts of violence against women and children by an intimate partner, usually a man. However, there has been an increasing shift toward the use of "gender-based violence" (GBV) or "violence against women" to encompass the broad range of acts of violence that women suffer from intimate partners, family members, and other individuals outside the family. These terms also draw focus to the fact that gender dynamics and norms are intricately tied to the use of violence against women (Velzeboer et al. 2003).

Below is a definition of gender-based violence and violence against women based on the United Nations General Assembly Declaration on the Elimination of Violence against Women in 1993:

…any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring **in public or in private life.**

…shall be understood to encompass, but not be limited to the following:

- Physical, sexual, and psychological violence occurring **in the family,** including battering, sexual exploitation, sexual abuse of children in the household, dowry-related violence, marital rape, female genital mutilation, and other traditional practices harmful to women, nonspousal violence, and violence related to exploitation
- Physical, sexual, and psychological violence occurring **within the general community,** including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution
- Physical, sexual, and psychological violence **perpetrated or condoned by the state and by institutions,** wherever it occurs.

For reference, the WHO definition of violence is: "The intentional use of physical force or power, **threatened or actual**, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury death, psychological harm, maldevelopment, or deprivation."

Reference

Velzeboer M, Ellsberg M, Clavel Arcas C, García-Moreno C. 2003. *Violence against Women: The Health Sector Responds*. Washington, DC: Pan American Health Organization (PAHO) and World Health Organization (WHO).

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- Minnesota Advocates for Human Rights. 2003. *What is gender-based violence?* Minneapolis, MN: Advocate for Human Rights. https://www1.umn.edu/humanrts/svaw/advocacy/modelsessions/what_is_GBV.PDF.
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- World Health Organization (WHO) and Pan American Health Organization (PAHO). 2012. *Understanding and Addressing Violence against Women: Intimate Partner Violence*. Geneva, Switzerland: WHO. http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf.

Participant handout: Myths and truths about violence

(*From* Instituto Promundo, Salud y Género, ECOS, Instituto PAPAI, and World Education. n.d. *Working with Young Women: Empowerment, Rights and Health.* Rio de Janeiro, Brazil: Promundo, 43–45).

1. **MYTH:** It is easy for a woman to leave a violent relationship. If a woman remains in a violent relationship, it must be because she enjoys it.
   TRUTH: There are personal, social, cultural, religious, and economic reasons that keep a woman in a relationship, even a violent one. Men who are violent against their partners frequently make it difficult for the women to leave. They may make threats (against the woman or their children), ask for forgiveness, promise not to hurt her again, and/or manipulate the victim into thinking that they themselves are the ones to blame.

2. **MYTH:** When a woman says no to sex it is only because she's ashamed to say yes. "No" can mean maybe or even yes.
   TRUTH: "No" is always no.

3. **MYTH:** Women provoke rape by the way they behave: wearing provocative clothing, getting drunk, hanging out in the street at night, etc.
   TRUTH: No one asks to be sexually victimized. The aggressor is the only one responsible for the crime.

4. **MYTH:** The majority of sexual assaults are committed by strangers.
   TRUTH: The majority of sexual assaults are committed by someone the victim already knows. In fact, a large percentage of rapes occur inside the victim's home or at the home of a friend, neighbor, or acquaintance.

5. **MYTH:** Domestic violence is a private matter within the family. No one else should get involved.
   TRUTH: Domestic violence is a public health and human rights issue; therefore, it is a problem for all of society. With social support, victims of violence can decide to leave a violent relationship.

6. **MYTH:** Women are safer at home. They are at greater risk from strangers or out of the home.
   TRUTH: Contrary to the vision that the family represents a safe refuge, young and adult women are at greater risk of violence in their own homes and at the hands of someone they know.

7. **MYTH:** *Sexual violence does not exist within relationships.*
   TRUTH: Having sex with a woman without her consent is a violation, even if she is a friend, girlfriend, or spouse. Sexual violence is not defined by the type of relationship but by the lack of consent.

8. **MTYH:** *A woman who has previously consented to sexual relations with someone cannot be raped by that person.*
   TRUTH: Any occasion in which a person does not want to have sexual relations but is forced into it is a violation or rape. Accepting kisses and touches does not mean accepting sex. A person can say "NO" to sex at any point, no matter what has happened up to that point.

9. **MYTH:** *Violence is caused by drugs and alcohol.*
   TRUTH: There is no single cause of violence; rather, it is caused by many factors. Drugs and alcohol can increase violent behavior, but many people who use drugs and alcohol are not violent, and many who are violent do not use drugs and alcohol.

10. **MYTH:** *Men are violent by nature*.
    TRUTH: Nearly all researchers of violence agree that although there may be some limited male biological basis for aggressive and risk-taking behavior, the majority of men's violent behavior is explained by social and environmental factors. In sum, boys are not born violent. They are taught to be violent through messages they receive from society and their families. Many men learn to resolve

conflicts and maintain their control over other people by using violence. However, just as violence is learned, it can be unlearned.

11. **MYTH:** The media makes boys violent.
    TRUTH: Some studies have found that viewing violent media images may be associated with carrying out violence, but the causal connection is not entirely clear (Bushman and Anderson 2015). Watching violence on TV or in movies probably does not "cause" boys' violence, but it can reinforce some of boys' beliefs—and our general belief as a society—that men's violence is normal, or even cool.
12. **MYTH:** Violent men are out of control.
    TRUTH: A violent person is generally not out of control. Even men who say they lose control when they hurt their partners do not use violence in every situation, nor with every person. They are selectively violent—in other words, their violence is a choice.
13. **MYTH:** Anger causes violence.
    TRUTH: People who hurt and mistreat others do not necessarily feel more rage than others; rather, they use their rage as an excuse to justify their behavior, against people who have less power than they do.
14. **MYTH:** Violent men are mentally ill.
    TRUTH: Only a small number of men who use violence actually suffer from mental illness. In general, men's use of violence is not associated with mental illness but with gender norms that uphold violence as an acceptable, or "masculine" means of resolving conflicts.
15. **MYTH:** Women commit as much violence against men as men commit against women.
    TRUTH: When there is violence in a relationship between men and women, generally the violence the man commits is more severe. When women utilize violence it is generally in response to a partner's violence, and in many cases, their partners react with more violence.
16. **MYTH:** Violence is a problem among poor people who lack education.
    TRUTH: Violence occurs among all demographic groups, regardless of race, color, class, sexual orientation, occupation, or education.

Reference

Bushman BJ, Anderson CA. 2015. Understanding causality in the effects of media violence. *Am Behav Sci.* 59(14):1807–1821. doi:10.1177/0002764215596554.

Participant handout: What is sexual harassment?

Sexual harassment is a form of violence that includes unwelcome sexual advances, requests for sexual favors, and other conduct of a sexual nature. Although people tend to think of sexual harassment as occurring between two individuals with differing levels of power (e.g., supervisor-supervisee), this is not always the case.

“Unwelcome” is the critical aspect of sexual harassment. “Unwelcome” does not mean “involuntary.” A victim may consent or agree to certain conduct and actively participate in it even though it is offensive and objectionable to them. Sexual harassment is in the eye of the beholder. The way language or behavior makes a person feel is how harassment is defined. In most cases, sexual harassment involves a person using sex to exert power or control over another person, making them feel uncomfortable, threatened or harmed in some way. Sexual harassment is different from sexual assault which occurs when physical, sexual activity is engaged in without the consent of the victim, or when the victim is unable to consent to the activity. Sexual harassment is usually heard about in school or work settings because these are the two main places where sexual harassment is reported. Sexual harassment, however, can occur in other places as well.

Sexual harassment can happen to women, men, transgender persons, intersex persons, and those who are non-gender conforming. Sexual harassment is not limited to sexual orientation.

Sexual harassment includes many things:

VERBAL

- Referring to an adult as a girl, hunk, doll, babe, or honey
- Whistling at someone, cat calls
- Making sexual comments about a person's body
- Making sexual comments or innuendos
- Turning work discussions to sexual topics
- Telling sexual jokes or stories
- Asking about sexual fantasies, preferences, or history
- Asking personal questions about social or sexual life
- Making kissing sounds, howling, and smacking lips
- Making sexual comments about a person's clothing, anatomy, or looks
- Repeatedly asking out a person who is not interested
- Telling lies or spreading rumors about a person's personal sex life

NONVERBAL

- Looking a person up and down (elevator eyes)
- Staring at someone
- Blocking a person's path
- Following the person
- Giving personal gifts

- Displaying sexually suggestive visuals
- Making sexual gestures with hands or through body movements
- Making facial expressions such as winking, throwing kisses, or licking lips

PHYSICAL

- Giving a massage around the neck or shoulders
- Touching the person's clothing, hair, or body
- Hugging, kissing, patting, or stroking
- Touching or rubbing oneself sexually around another person
- Standing close or brushing up against another person

Sources

- EngenderHealth. 2008. Engaging Men and Boys in Gender Transformation: The Group Education Manual. New York, NY: EngenderHealth.
- Women Watch. n.d. What is sexual harassment? http://www.un.org/womenwatch/osagi/pdf/whatissh.pdf. Accessed March 13, 2017.

Facilitator resource: Violence scenarios

Scenario 1

A woman and her boyfriend are in a hotel room together. They start kissing and caressing each other. The boyfriend begins to take off her clothes. She stops him and says that she doesn't want to have sex. He is furious and tells her that he has spent a lot of money on the room and says, "What are my friends going to say?" He pressures her to change her mind. First he tries to be sweet and seductive, then he begins yelling at her in frustration. Finally, he pulls at her forcefully, pushing her down on the bed.

Key points

Even if the woman agreed to go to the motel with her boyfriend, and even if she is kissing him, it does not mean that she wants to have intercourse with him. Her boyfriend is pressuring her to have sex, and despite the fact that she has told him she does not want to have sex with him, the man tries to force her by using physical force. It is clear that the man intends to rape his girlfriend. Everyone has the right to refuse sex for any reason or for no reason at all. A person can choose to refuse sex for any reason and at any point—even if it's during a sexual act. All sex must be consensual, meaning that both partners must freely agree to participate in a particular sexual activity. Just because two people are in an intimate relationship together does not mean that rape cannot occur.

Scenario 2

A 12-year-old boy has just come home with his examination results. He has failed. His parents shout at him; his mother refuses to give him any food that day, while his father threatens to teach him a lesson he will not forget. Would you describe what the parents did to the boy as violence? Why?

Key points

Although the boy's father has threatened physical violence, which will definitely hurt the boy, the mother's behavior can also harm him physically and mentally. Therefore, what the parents did to the boy can be described as violence. It is natural for the parents to be angry at their son's behavior, and they do have a right to scold him and tell him to improve his performance the next time. But "disciplining" their son cannot be an excuse for using physical force or depriving him of basic necessities.

Scenario 3

In a university, and openly gay young man is constantly harassed by his peers who insult and mock him because of his sexual identity.

Key points

Every individual has the right to be treated equally and fairly, regardless of religion, sex, race, caste, ethnicity, and sexual and gender identities. In this case, the young man is being discriminated against because of his sexual identity. This will result in psychological/emotional harm to the young man.

Scenario 4

A woman and her husband work in the same company. The woman has just got a promotion, while the man has not. As a result, he is upset and has stopped talking to his wife; he taunts her in front of his

friends, telling them that she is now “too important” for him. Do you think there is any violence involved in this situation? Why?

Key points

Yes, the husband’s behavior is a form of violence. It will cause emotional and mental harm to the woman. It is his jealousy that is making the man hurt his wife in this manner. Also, most men are brought up to believe that they are “superior” to women; so when his wife does better than him at her job, he probably feels inferior, he feels he is “less of a man.” But the fact is that, like a man, a woman has a right to have a career and to secure a promotion based on her hard work and good performance.

Scenario 5

A well-off couple has employed a 13-year-old girl to work as a domestic helper. The girl is expected to do all the housework, including washing the clothes and vessels, cleaning the house, taking care of the couple’s 2year-old baby, and buying things at the market. She is expected to work 7 days a week. She gets a salary and two meals every day. Do you think there is any violence involved in this situation? Why?

Key points

Yes, this is a form of violence. This is a clear example of child labor. And every case of child labor causes serious mental, emotional, and even physical harm to the child.

The law prohibits child labor. However, this is a common situation in many countries. Children often work in hazardous and extremely harsh conditions. This deprives them not only of basic rights like education, but they also lose out on their childhood. Children are employed because they provide cheap labor; employing a child does not mean that the employer is “helping” the child’s family. Employing an adult in the child’s place would not only put an end to this practice, but it would also reduce the large-scale prevalence of adult unemployment in our country.

Scenario 6

The wife and husband in a couple both have full-time jobs. When the wife returns home at the end of the day, her husband expects her to cook his dinner, help the children with their homework and prepare them for bed, and tidy up the house. Most nights, the husband also expects his wife to have sex with him. The wife is often very tired at the end of the day and needs sufficient rest to wake up early the next day so she can get the children ready for school before she goes to the office. As a result, she often refuses to sex with her husband. On several occasions, however, her husband has forced himself on her in spite of her protestations. Do you think there is any violence involved in this situation? Why?

Key points

Yes, this is a form of violence. The type of violence described is marital rape because the husband has been forcing his wife to have sex against her will. All sexual encounters must be consensual; both partners— whether married or not—must be able to provide their consent free from coercion and violence. When partners are not consenting and are forced or coerced into engaging into sexual practices, it is rape.

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Chapter 13: Violence in daily life

Gendor 101 training materials

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Jhpiego is a nonprofit global leader in the creation and delivery of transformative health care solutions that save lives.

In partnership with national governments, health experts and local communities, we build health providers' skills, and we develop systems that save lives now and guarantee healthier futures for women and their families. Our aim is revolutionizing health care for the planet's most disadvantaged people.

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Chapter 13: Violence in daily life

Learning objectives

By the end of this session, participants will be able to:

- Describe the many ways that men's use of violence limits women's (and men's) lives
- Reflect on the pervasiveness of violence in their personal lives

Facilitator note: This activity should only be completed *after* participants have completed the session titled "What Is Violence?"

Facilitator note: Given the highly sensitive nature of this activity, it is advisable to include this activity as part of a broader gender training during which participants have been able to examine social norms. Do not facilitate this activity as a stand-alone session.

Facilitator note: Some people have strong emotional reactions to this activity. These reactions may include anger, outrage, astonishment, shame, embarrassment, and defensiveness. These may be related to personal experiences of violence at some point in their lives. Female participants may feel frustrated by some men's lack of understanding and/or empathy regarding women's experience of violence. Some women may feel exasperated at having to relive, rehash, and "display" the vulnerability they feel. Some participants may want to share their feelings overtly, which can be very emotional and challenging for the entire group, although the outcome can also be therapeutic and healing. Enough time should be given to enable participants to express themselves (even if it means extending the length of the activity). Do not end the session abruptly for the sake of moving on to the next item in the agenda.

Participants should be encouraged to support one another. As participants share their feelings, let them know that their reactions are normal and appropriate. Remind them that anger can be a powerful motivating force for change. Encourage them to identify ways they can use their anger and outrage to prevent violence and promote gender equity and equality.

Time needed

1 hour 40 minutes

Facilitator note: It is likely that some participants, particularly women, have experienced, or are experiencing, violence in their personal lives. It is important for facilitators to have information about existing national laws and/or policies related to gender-based violence (GBV) to refer to during the activity. Prior to leading this activity, research local support services for survivors of GBV and have contact information for those services available in the event a participant requests such services. It is also important to clarify with your organization any ethical and legal aspects related to dealing with situations that might come up during discussions on violence.

Materials needed

- Violence in Daily Life Jamboard Template: one copy per group

Advance preparation

1. Copy the provided Jamboard template until you have enough for each group, assuming single-gender groups of 5 to 8 participants.
    - Label each Jamboard "Group 1", "Group 2", etc.
    - Prepare a list of your Jamboards and their links to ensure you can easily copy and paste the information into the Zoom chat during the live session. Example:
        - Group 1: [link to Jamboard]
        - Group 2: [link to Jamboard]
        - Group 3: [link to Jamboard]
        - Group 4: [link to Jamboard]

Technology Note: It is highly recommended that facilitators recruit an additional individual to support them with the technical logistics of this session, particularly during the "Sharing our Stories" section.

Steps

Technology Note: While other Gender 101 training sessions may be recorded, sessions on gender-based violence should never be recorded to maintain the confidentiality of participants' experiences.

Introduction (3 minutes)

1. **Technology Action:** At any point after participants arrive, you may begin to prepare breakout rooms for the "Sexual Violence in Daily Life" activity.
    - Groups of 5-8; within each group, all group members should all be the same gender
    - Check "Breakout rooms automatically close after"
        - 20 minutes
    - Check "Notify me when time is up"
    - Countdown after closing breakout room: 30 seconds

Facilitator note: Even if you have a small number of participants and/or a limited number of participants from either sex, maintain single-sex groups. The purpose of this part of the activity is to make evident the significant contrast between women's and men's daily experiences of sexual violence.

2. Open the activity by explaining to participants that they will now move beyond a conceptual understanding of violence to examining the prevalence of violence in individuals' personal lives, as well as the influence of violence on women's and men's lives.
3. Before proceeding further, explain that because the session focuses on a very sensitive topic, it is important for participants to observe the following ground rules:
    - Maintain confidentiality. What is said in the room stays in the room.
    - Everyone has the right to pass. If a participant feels uncomfortable about a particular topic or if they feel uncomfortable about sharing on a particular point, they have the right to pass.

- Suspend judgment. Everyone has a right to their opinions and beliefs. Try not to judge others and try to maintain an open mind and hear what others are saying.
- Show respect for the opinions and feelings of others. Avoid interrupting others while they are speaking. Do not mock or minimize a person's contribution.
- Do not speak for others. Only share what you have said. Do not relate what someone else may have said in the context of this group.
- Practice active listening. Pay attention when others are speaking and try to listen carefully to what they are saying.

4. Explain that given the sensitive nature of the topic, you would like participants to keep in mind the following options during the session:
   - Take care of yourself, and take a break if you need to do so.
   - Participants who wants additional support on this issue for themselves, a family member, or a friend should feel free to talk to the facilitator after the session to be connected to support resources.
5. Ask the group if there are any questions or concerns.

Sexual violence in daily life (50 minutes)

1. Explain that, in just a minute, you will divide participants into same-sex groups. Within each group, participants will have 20 minutes to answer the following questions:
   - What do you do on a daily basis to protect yourself from sexual violence?
   - What do you lack in order to be able to protect yourself from sexual violence?
2. Instruct participants to write their answers to each question on two separate Jamboard frames (one Jamboard per group). The Jamboards have the questions written at the top of each frame.
3. **Technology Action:** Screen share a sample Jamboard and demo the activities below as you describe each.
   - Explain that participants should use the sticky notes to add ideas to their Jamboard. To add a sticky note, participants should click the small white box with text within the toolbar to the left of the screen; after typing their note, click "Save", and then click out anywhere outside of the sticky note box to return to the main Jamboard.
   - Participants should respond to each of the two questions on two separate frames. To move between frames, participants should click the arrows at the top center of the screen (< >).
4. **Technology Action:** Copy and paste into the chat links to each Jamboard. Jamboards should be clearly labeled Group 1, Group 2, etc. (see example below).
   - Example:
     - Group 1: [Link to Jamboard]
     - Group 2: [Link to Jamboard]
     - Group 3: [Link to Jamboard]
     - Group 4: [Link to Jamboard]
5. Explain that you've just shared links to each group's Jamboard in the Zoom chat. Explain that, as they are being moved to a breakout room, participants will see on their screen to which numbered room they are being moved. Once they are in their breakout rooms, their room number will appear

at the top of the Zoom screen. Their breakout room number will represent their group number and should be used to know which Jamboard to open.

6. Make sure that everyone understands the instructions. Remind them that they should use the "Ask for Help" button if they have questions for a facilitator while in their breakout room.
7. **Technology Action:** Open the breakout rooms.
8. **Technology Action:** Open each Jamboard on a different tab in your computer. Regularly review each Jamboard to ensure that at least one participant has opened the board and is adding sticky notes. If you notice any group that has not added sticky notes after some period of time, go in and check on the group to ensure they don't have any questions.

> **Technology Note:** Anonymous circles at the top right corner of the Jamboard will indicate whether or not participants have opened the Jamboard.

9. **Technology Action:** Send a broadcast message reminding participants when they have 5 minutes left and then again when they have 1 minute left.
10. **Technology Action:** After approximately 20 minutes, close the breakout rooms.

> **Facilitator Note:** In steps 11 to 12, participants will have time to review other groups' Jamboard frames. Two options are presented for step 12 to help facilitate this "gallery walk"; please consider with which option you are most comfortable, as well as which option will best engage your specific participants.

11. Explain to participants that they will now have some time to silently read and reflect on each group's Jamboard.

Option 1: Shared Screen

12. **Technology Action:** Share your screen to show group 1's Jamboard. Show each Jamboard frame for 30 to 45 seconds, and then move to the next frame, or to the next group's Jamboard. Consider also re-sharing links to each Jamboard in the chat, in case any participant wants to spend additional time reading another group's sticky notes.

Option 2: Independent Review

13. **Technology Action:** Re-send links to each group's Jamboard in the chat.
    - Ask participants to open each Jamboard on their own computer and spend the next 4 to 5 minutes reading through each group's sticky notes.

> **Technology Note:** Consider sharing your screen to show a 5-minute timer (such as this one here).

14. After participants have had time to read the Jamboards, facilitate a 5-minute debrief. Start with the men and ask: What did you notice about the women's list(s)? Do you have any questions or comments about the women's list(s)?
15. After a few men have shared their observations, ask the women: What did you notice about the men's list(s)? Do you have any questions or comments about the men's list(s)?
16. Next, facilitate a 15-minute group discussion using the following questions:
    - Have the men listed many things pertaining to sexual violence? Why or why not?
    - How does men's use of violence damage men's lives as well as women's?

- (to the men) How much do you already know about the impact of men's use of violence on women's lives? How does it feel to have not known much about it before?
- (to the men) Do you think some men avoid noticing the impact men's use of violence has on women's lives?

Facilitator note: Be sensitive to the fact that some men may not be aware of the level of consciousness women carry on a daily basis to avoid violence.

Facilitator note: While facilitating the discussion, be careful not to push men into feeling blamed and guilty. Rather, try to ease them into recognizing the reality of the situation and committing themselves to greater responsibility in ending other men's use of violence.

Sharing our stories (45 minutes)

1. **Technology Action:** At any time, you may begin to create the first set of breakout rooms for the next activity. Note that there will be three sets of breakout rooms total for this activity, and that each set of breakout rooms should be different. Use the "Assign automatically" feature in order to quickly randomize paired groups with the following settings:
   - Groups of 2 (randomly distributed participants)
   - Check "Breakout rooms automatically close after"
     - 4 minutes
   - Check "Notify me when time is up"
   - Countdown after closing breakout room: 15 seconds

Technology note: If you have an even number of women and men, you may wish to pair the women with other women, and pair the men with other men. While you can still use the "Assign automatically" Zoom feature to quickly make groups, you will need to move some participants between groups to ensure same-gender groups. You can do so quickly by hovering over a user's name, selecting "Exchange", and then selecting the participant with whom you'd like to switch this participant.

Technology note: It is important that participants completing this activity have their video cameras on. If you regularly have large numbers of participants who do not turn their videos on (even during small groups), you may need to consider not implementing this activity. It may also be worthwhile to email participants ahead of the session and ask them to please come prepared to have their videos on for the second half of the session, as they will not be able to participate otherwise.

2. Transition to the next part of the session by explaining to participants that they will spend some more time reflecting on their individual experiences with violence. Tell participants they will complete a listening exercise during which they will reflect on their personal experiences with violence.

Facilitator note: This activity helps to establish a clear understanding of the extent and impact of men's use of violence against women. Be sure to allow sufficient time for group discussion as the discussion may be quite emotional.

Facilitator note: If men are defensive during the discussion, make it clear that you are not accusing anyone in the room of having created a climate of fear. Remind the group that you are trying to show how common and devastating violence against women is for everyone. Be sure to challenge participants who try to deny or reduce the significance of violence, particularly violence against women.

Facilitator note: Be aware that some men may think they need to protect women from violence. If some men in the group say this, remind the group that it is important for women and men need to work together to create a world free from violence. By saying that it is up to men to protect women, we reinforce the stereotype of men as strong and powerful and women as men's property that must be protected from other men.

3. Explain to the group that they will complete three rounds of active listening. During each round, participants will switch partners and spend 4 minutes with this partner discussing their personal experiences with violence. During the partner work, each person will have the opportunity to be both a listener and a speaker.

Facilitator note: Tell participants that they should only share what they are comfortable sharing. Remind participants of the various forms of violence that were discussed during the first session on violence and explain that they can share personal experiences with any of the various forms of violence (e.g., emotional, economic, sexual, physical).

4. Explain that during the partner work, it is important for the listener to truly hear their partner and avoid interrupting with questions. Instruct participants not to take notes while their partner is speaking.

Facilitator note: During this activity, you may notice that it is easier for participants to talk about violence they have suffered outside their homes than violence they have suffered inside their homes, or violence they have used against others. They may not wish to go into detail about these experiences, and it is important that you do not insist they do.

5. Explain that you will put participants into pairs through breakout rooms. Explain that each person will have 2 minutes to answer two questions. Explain that both people in each pair will have the opportunity to answer the questions. Tell participants that if they finish answering the questions before the 2 minutes are up, they should sit quietly until it is time to switch. (Spend no more than 10 minutes on steps 2 to 5.)
6. Read the following questions aloud:
    - Describe an experience where you or someone you know was a witness to violence.
    - How did that experience affect you/them?
7. **Technology Action:** Post the questions in the Zoom chat for participants to easily reference while in their breakout rooms.
8. Explain that you will send a broadcast message when 2 minutes have gone up and the pairs should switch; however, remind participants that they may also reference the timer in the top right-hand corner of their Zoom screen to know how much time has passed.
9. Ask if anyone has any remaining questions before you open the rooms.
10. **Technology Action:** Open the breakout rooms.

11. **Technology Action:** After 2 minutes have passed, send a broadcast message reminding participants to switch roles.
12. **Technology Action:** Close the breakout rooms after 4 minutes.
13. **Technology Action:** Re-create breakout rooms. Note that time will be limited to re-create breakout rooms. As soon as the previous breakout rooms have closed, click "Recreate". Then, again use the "Assign Automatically" feature to quickly make breakout rooms (same number of groups as before). Your previous settings will remain the same and will not need to be updated.

> **Technology note:** If you have an even number of women and men, you may wish to pair the women with other women, and pair the men with other men. While you can still use the "Assign automatically" Zoom feature to quickly make groups, you will need to move some participants between groups to ensure same-gender groups. You can do so quickly by hovering over a user's name, selecting "Exchange", and then selecting the participant with whom you'd like to switch this participant.

14. As the new breakout rooms are being created, remind participants of the guidelines then read the following questions aloud:
    - Describe an experience where you or someone you know was a victim of violence.
    - How did that experience affect you/them?
15. **Technology Action:** Post the questions in the Zoom chat for participants to easily reference while in their breakout rooms.
16. Ask if anyone has any questions before you open the rooms.
17. **Technology Action:** Open the breakout rooms.
18. **Technology Action:** After 2 minutes have passed, send a broadcast message reminding participants to switch roles.
19. **Technology Action:** Close the breakout rooms after 4 minutes.
20. **Technology Action:** Re-create breakout rooms. Note that time will be limited to re-create breakout rooms. As soon as the previous breakout rooms have closed, click "Recreate". Then, again use the "Assign Automatically" feature to quickly make breakout rooms (same number of groups as before). Your previous settings will remain the same and will not need to be updated.

> **Technology note:** If you have an even number of women and men, you may wish to pair the women with other women, and pair the men with other men. While you can still use the "Assign automatically" Zoom feature to quickly make groups, you will need to move some participants between groups to ensure same-gender groups. You can do so quickly by hovering over a user's name, selecting "Exchange", and then selecting the participant with whom you'd like to switch this participant.

21. As the new breakout rooms are being created, remind the group of the guidelines once more and then read the following questions out loud:
    - Describe an experience where you or someone you know was a perpetrator of violence.
    - How did that experience affect you/them?
22. **Technology Action:** Post the questions in the Zoom chat for participants to easily reference while in their breakout rooms.

23. Ask if anyone has any questions before you open the rooms.
24. **Technology Action:** Open the breakout rooms.
25. **Technology Action:** After 2 minutes have passed, send a broadcast message reminding participants to switch roles.
26. **Technology Action:** Close the breakout rooms after 4 minutes.
27. Facilitate a 10-minute debrief by asking if anyone would like to share what they spoke about with their partner. Be sure to emphasize that they are only to share what they said and not what their partner said.

Facilitator note: Before proceeding with the debrief, remind participants of the group's agreement about confidentiality: what is said in the room, stays in the room.

Facilitator note: Do not force participants to share what they spoke about with their partners. Make it clear to participants that they should only share if they feel comfortable doing so. If no one wants to share, you may move on to the group discussion.

28. After participants have shared, thank everyone for being open and vulnerable.
29. Next, facilitate a 10-minute group discussion using the following questions:
    - What is the most common type of violence used against us?
    - What is the most common type of violence we use against others?
    - How do we know if we are really using violence against someone?
    - Where do we learn violence?
    - Is any kind of violence worse than another?

Closing (2 minutes)

End the activity by making the following points:

- Violence and the threat of violence is an everyday fact for women. Because most men do not live with the daily threat of violence, they do not realize the extent of the problem that women face. Men generally do not understand that violence—actual and threatened—is a regular feature of women's daily lives. However, men's lives are also damaged by violence against women. This violence targets their sisters, mothers, daughters, cousins, and colleagues—the women they care about are being harmed by violence every day.
- Social acceptance of violence against women gives men permission to treat women as unequal and makes it harder for men to be vulnerable with their partners, wives, and female friends.
- Violence poses a serious risk to women's sexual and reproductive health. Women in abusive relationships are often unable to negotiate the conditions of sex (e.g., where, when, how, and if sex occurs). Sexual violence makes it impossible for a woman to negotiate condom use and eliminates any element of choice regarding whether to have sex or not. Forced sex also increases women's risk for an unwanted pregnancy, sexually transmitted infections, and HIV.

Source

EngenderHealth. 2015. Training on Gender and Sexual and Reproductive Health: Facilitation Manual. New York, NY: EngenderHealth, 57–60.

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Chapter 14: Circles of influence

Gendor 101 training materials

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Chapter 14: Circles of influence

Learning objectives

By the end of this session, participants will be able to:

- Identify the links between gender inequality and intimate partner violence (IPV)
- Explain why IPV is never justified

> **Facilitator note:** This activity should only be completed *after* participants have completed the "What Is Violence?" session.

Time needed

40 minutes

Materials needed

- Link: Circles of Influence Interactive Image
- Ecological Model Jamboard Template
- Participant Handout: Ecological Model of Intimate Partner Violence
- Facilitator Resource: Ecological Model
- Facilitator Resource: Character Statements

Advance preparation

1. Email copies of the Participant Handout: Ecological Model of Intimate Partner Violence to all participants.
2. In the same email, let participants know that this session includes an interactive activity in which roles are assigned in advance, so it is important to let the facilitator know if they are not able to attend.
3. Consider printing relevant Participant Handouts and Facilitator Resources so you may easily reference them during the session.
4. Make a copy of the Ecological Model Jamboard Template.
5. Type up a list of your participants' names (*not* in Excel/Google Sheets, but somewhere where the text can be easily copied and pasted into the Zoom chat). Number each participant 1 through 30. If you have fewer than 30 participants, do not number participants sequentially up until the number of participants in your group. Instead:
    - Make sure numbers 1 and 2 are assigned.
    - Make sure at least 3 numbers within the following sequences are assigned:
        - 3-8
        - 9-23
        - 24-30

Steps

Introduction (1 minute)

Open the activity by stating that gender-based violence (GBV) occurs within a broad social, cultural, economic, and political environment in which factors that drive GBV operate. Explain to participants that this activity will give them the opportunity to explore the various factors that help perpetuate violence, as well as the various levels from which these factors exert their influence.

Factors that perpetuate violence (38 minutes)

1. **Technology Action:** In the chat, post your list of participant names, with each participant's name clearly labeled with a number (numbers distributed as described in "Advance Preparation").

> **Facilitator note:** As participants log on, review your list of participants and their assigned number, and consider who has actually shown up to the session as compared to whom you expected to show up during the session. If some participants are not in attendance, some changes may need to be made to the list before sharing it in the chat.
>
> - Make sure **numbers 1 and 2** are assigned.
> - Make sure at least **3 numbers** within the following sequences are assigned:
>   - 3-8
>   - 9-23
>   - 24-30

2. Explain to participants that, in just a minute, you're going to post a link in the chat. This link will open up an interactive image; everyone will need to have the image open on their own computer or phone in order to complete the rest of the activity.
3. **Technology Action:** Share your screen showing the circles of influence interactive image.
4. Walk through the interactive image. Call participants' attention to the three circles, on top of which are icons of people, each of whom is identified by a number. Each participant should find their number on this interactive image, as identified in the chat. Then, they should click on that numbered person. When they click on their number, a text box will open. Participants should read that statement silently to themselves, and they should keep the text box open on their computer. Participants should not click on any other numbers/icons.
5. Confirm that everyone has received their number and there are no questions.
6. **Technology Action:** Post a link to the circles of influence interactive image in the chat. Stop sharing your screen.
   https://ds8h8s59z0bwt.cloudfront.net/jhpiego/gender/circles%20of%20influence/v1/story.html
7. Give everyone one minute to open the link on their own computer and open their numbered statement.
8. Explain that, now, you will go around the virtual "room" and ask that each participant read their statement. The participant with number 1 will start, and then the group will continue reading all the statements sequentially up until the last number.
9. Note that some numbers may be missing from the list, so participants may want to look back at the list of participants posted in the Zoom chat and make a note of after which participant they will speak.

10. Ask if anyone has any questions. Then request that the participant labeled number 1 reads their statement. Continue until everyone has read their statement. (Spend no more than 8 minutes on steps 1 to 10.)
11. Next, facilitate a 10-minute debrief using the following questions:
    - Which circle do you think has the most influence on Betty and Benja? Why?
    - Are there any circles that do not have an influence on Betty and Benja? Which ones? Why?
    - What does this exercise tell us about community norms?
    - How can this exercise inform our efforts to reduce violence?
12. Next, ask participants to transform their statements into a positive one such that their character takes action to help Betty and/or Benja. Before participants begin this part of the exercise, explain that the positive statement should be one sentence, or a maximum of two sentences. This should not be treated as a role play. Start with the participant who has number 3. After 3 through 30 have transformed their original statements into positive statements, ask Betty and Benja to transform their original statements into positive statements, taking into consideration all of the new positive statements. Make sure that Benja specifically articulates that he should not perpetrate violence and that violence is never justified. (Spend no more than 6 minutes on this step.)
13. Before moving on, explain that the activity was intended to demonstrate factors at various levels that influence individuals' lives. GBV can be perpetrated and perpetuated by any number of actors—intimate partners, family and community members, and the state. However, these individuals can also play a role in preventing GBV. In fact, all individuals in the community can play a role in preventing GBV. Explain that by representing the three circles around the female and male characters, the group recreated an "ecological model."
14. Technology Action: Screen share the ecological model on the Jamboard template.
15. State that researchers developed this model to show how various factors at the individual, relationship, community, and societal levels cause and allow GBV to happen.
16. Explain each of the levels by using the points below:
    - **Individual level:** the two individuals involved in an intimate relationship (woman and man). Individual-level factors contributing to IPV include personality traits, personal experiences, and history of both the people experiencing violence and the perpetrators (e.g., childhood traumas, acceptance of violence as a means of resolving conflict, alcohol abuse, women's unemployment, etc.).
    - **Relationship level:** close social relationships, most importantly those between intimate partners and within families. Relationship-level factors contributing to IPV include poor communication, inequalities in decision-making, etc.
    - **Community level**: the community context in which social relationships exist, including peer groups, schools, workplaces, and neighborhoods. Community-level factors contributing to IPV include social norms supporting wife-beating, emphasis on family privacy, lack of legal or moral sanctions for violence, etc.
    - **Societal level/macrosocial**: larger societal factors that "create an acceptable climate for violence, reduce inhibitions against violence" (Krug et al. 2002, p. 13). Societal-level factors that contribute to IPV include lack of economic rights and entitlements for women, collectivist versus individual cultural orientation, etc.
17. Explain that women bring to their relationships certain personality traits and many experiences from their childhood and adolescence. They partner with men who likewise bring their own personality

traits and personal histories to the relationship. The couple's relationship has its own dynamics, some of which may increase or decrease the risk of abuse, and the relationship is embedded in a household and neighborhood context that affects the potential for violence. In many low-resource settings, this includes the influence of extended family members who interact with the couple in ways that may either increase or lessen the chances of abuse. In turn, both partners engage with various "communities," including those related to work, friendship networks, faith communities, and governance structures. Finally, these various communities are embedded in a macrosystem, which refers to the cultural, economic, and political systems that inform and structure the organization of behavior at lower levels of the social ecology (e.g., community, relationship, and individual) (Heise 2011).

18. Ask participants for examples of factors that perpetuate GBV at each of the four levels.
19. **Technology Action:** As participants share ideas, write them on the Jamboard diagram in the corresponding circle using sticky notes (refer to Participant Handout: Ecological Model of Intimate Partner Violence for additional examples).
20. Explain that the various factors and levels are linked, and that each level influences the others. Emphasize that understanding GBV requires understanding its underlying causes and contributing factors, as well as the dynamics between the individual and the broader environment (e.g. family, community, society). (Spend no more than 10 minutes on steps 13 to 20.)
21. Before ending the session, allow participants 4 minutes to ask questions and/or make comments.
22. Remind participants that they can access the **Participant Handout: Ecological Model of Intimate Partner Violence** from their email.
23. When closing, emphasize that research is ongoing on the causes and risk factors for intimate partner and sexual violence. However, research done by Lori Heise, who initially coined the ecological model for IPV, shows that countries with the most gender-inequitable, patriarchal norms are prone to higher levels of violence.

Facilitator note: The ecological model can sometimes cause debates over how each factor is categorized and what should be considered a factor or not. If that happens, you may emphasize to participants that the model is only intended to demonstrate the various factors influencing GBV, thereby contributing to the design of effective violence prevention interventions.

Closing (1 minute)

End the activity by stating that although the sociocultural and political environment is important for understanding why GBV occurs, it does not excuse it. People, mostly men, still make a choice when they use violence. They need to be held accountable for their decision to use violence and for the suffering they cause. GBV is never justified.

Sources

Adapted from "Circles of Influence" in Raising Voices. 2009. PREP Module of *The Sasa! Activist Kit* Kampala: Raising Voices.

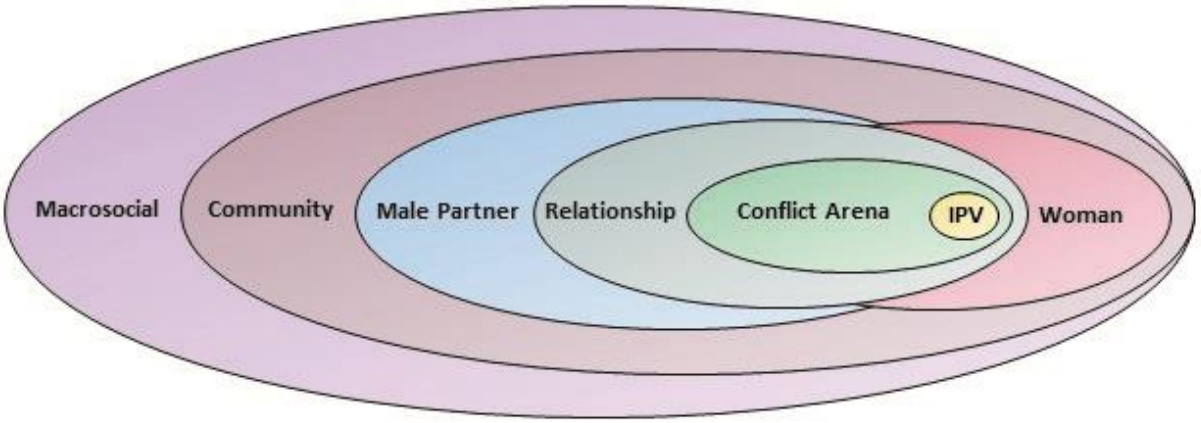
The ACQUIRE Project/EngenderHealth and Promundo. 2008. *Engaging Men and Boys in Gender Transformation: The Group Education Manual.* Session 9.4. New York, NY, and Rio de Jeneiro, Brazil: EngenderHealth and Promundo.

References

- Heise LL. 2011. What Works to Prevent Partner Violence? An Evidence Overview. London, UK: STRIVE.
- Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. 2002. World Report on Violence and Health. Geneva: Switzerland: World Health Organization, 13.

Participant handout: Ecological model of intimate partner violence

(*Source:* Heise LL. 2011. *What Works to Prevent Partner Violence? An Evidence Overview*. Figure 1.2 Revised conceptual framework for partner violence, 8. London, UK: STRIVE. https://www.oecd.org/derec/49872444.pdf)



Gender order
- Lack of economic rights and entitlements for women
- Discriminatory family law
- Composite measures of gender inequality

Cultural factors
- Collectivist versus individual cultural orientation
- Emphasis on women's purity and family honor

Economic factors
- Level of development
- Women's access to formal wage employment

Norms
- Acceptance of wife beating
- Male right to discipline/ control female behavior
- Tolerance of harsh physical punishment of children
- Stigma for divorced or single women
- Norms linking male honor to female purity
- Family privacy

Lack of sanctions
- Lack of legal or moral sanction for violence
- Others do not intervene

Neighborhood
- Community violence
- High unemployment
- Low social capital
- Poverty

Violence in childhood
- Harsh physical punishment
- Witnessing parental violence
- Other childhood traumas
- Psychological dysfunction
- Antisocial behavior
- Adult attachment issues

Attitudes
- Accepting of violence as a means to resolve conflict
- Acceptance of partner violence
- Gender hierarchical or transitional attitudes

Alcohol abuse

Gender role conflict

Delinquent peers

Sociodemographic
- Young
- Low level of education

Interaction
- Inequality in decision-making
- Poor communication
- High relationship conflict

Situational triggers
- Sex/infidelity
- Money/distribution of family resources
- Children or in-laws
- Division of labor
- Male drinking

Patriarchal triggers
- Female challenge to male authority
- Failure to meet gender role expectations
- Assertions of female autonomy

Childhood violence
- Child sexual abuse
- Other childhood traumas
- Witnessing mother being beaten

Attitudes
- Tolerance of wife beating
- Sociodemographic
- Young age (for current violence)
- High education attainment (protective)

Low social support

Factors that operate differently in different settings.
- Women's unemployment
- Participation in credit schemes or other development programs
- Asset ownership

- **Individual level:** the two individuals involved in an intimate relationship (woman and man). Individual-level factors contributing to IPV include the personality traits, personal experiences, and history of both the victims and the perpetrators (e.g., childhood traumas, acceptance of violence as a means of resolving conflict, alcohol abuse, women's unemployment, etc.)
- **Relationship level:** close social relationships, most importantly those between intimate partners and within families. Relationship-level factors contributing to IPV include poor communication, inequality in decision-making, etc.
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- **Societal level/macrosocial**: larger societal factors that "create an acceptable climate for violence, reduce inhibitions against violence" (Krug et al. 2002, p. 13). Societal-level factors that contribute to IPV include lack of economic rights and entitlements for women, collectivist versus individual cultural orientation, etc.

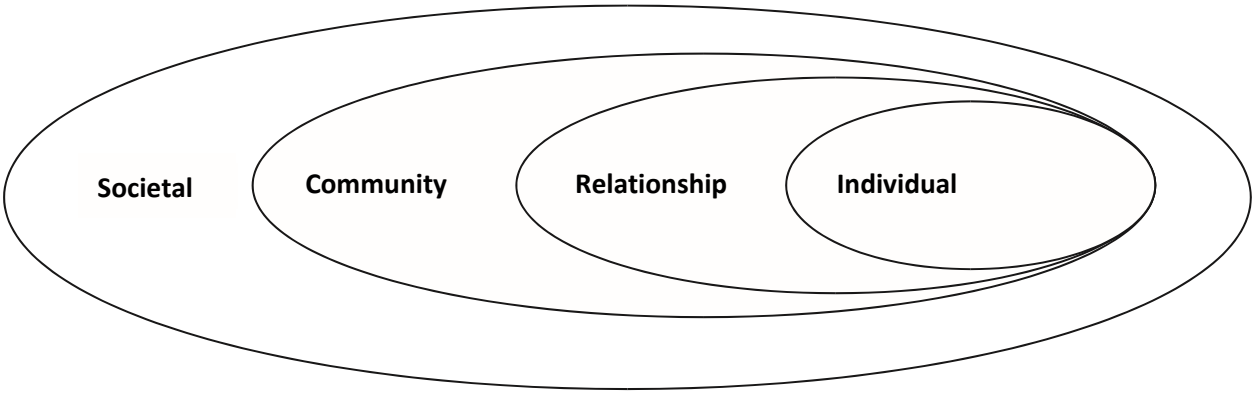
Women bring to their relationships certain personality traits and a host of experiences from their childhood and adolescence. They partner with men who likewise bring personal histories to the relationship. The couple's relationship has its own dynamics, some of which may increase or decrease the risk of abuse, and is embedded in a household and neighborhood context that affects the potential for violence. In many low-resource settings, this includes the influence of extended family members who interact with the couple in ways that may either increase or lessen the chances of abuse. In turn, both partners engage with various "communities," including those related to work, friendship networks, faith, and governance structures. Finally, these various communities are embedded in a macrosystem, which refers to the cultural, economic, and political systems that inform and structure the organization of behavior at lower levels of the social ecology (e.g., community, relationship, and individual) (Heise 2011).

Factors operating at the different levels combine to establish the likelihood of abuse occurring. No single factor is sufficient, or even necessary, for partner violence to occur. There are likely to be different constellations of factors and pathways that may converge to cause abuse under different circumstances. Likewise, the same set of personal history and situational factors (such as abuse in childhood or having too many drinks) may be sufficient to push a particular man toward partner violence in one sociocultural and community setting, but not in another. One can imagine that a man's response to "perceived" provocation may be quite different based on what his expectations are regarding male/female relations; whether his friends, neighbors, and local authorities are likely to find his behavior "acceptable" or shameful; and whether his partner has the social permission and economic means to leave him if he crosses the line (Heise 2011).

References

- Heise LL. 2011. *What Works to Prevent Partner Violence? An Evidence Overview*. London, UK: STRIVE. https://www.oecd.org/derec/49872444.pdf.
- Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. 2002. *World Report on Violence and Health. Geneva: Switzerland*: World Health Organization.

Facilitator resource: Ecological model



Facilitator resource: Character statements

1. My name is Betty. I am married to Benja. We used to be okay, but nowadays Benja shouts at me a lot and even sometimes hits me. It's especially bad when he's been drinking. I fear him and so do my children. But my mother endured the same fate as well.

2. My name is Benja. I am married to Betty. For some time now, things at home have not been so good. My wife annoys me, and I have no choice but to shout at her. Sometimes I even beat her. I guess this is what happens in marriage.

Level: R

3. I am a relative of Benja's. We were raised knowing that men can discipline women. This is how things should be.

Level: R

4. I am a friend of Benja's. We go to the drinking joint together. I see how you drink and then go home angry. But it is normal for men.

Level: R

5. I am a friend of Betty's. You and I discuss everything. My relationship is similar to yours—men are head of the house, and we have to endure.

Level: R

6. I am Betty's mother-in-law. If you didn't disrespect my son so much, he wouldn't hit you. You are to blame for the violence!

Level: R

7. I am Betty's mother. Your father and I care very much for you, but it would be a disgrace to the family if you were to leave your husband. As a woman, it is important to be patient and tolerant.

Level: R

8. I am Benja's brother. After the seeing the way your wife spoke back to you the last time I came to visit, it is no wonder you punish her. My wife would never speak to me that way!

Level: C

9. I am an elder. You respect me and follow my advice. Men have to make all the decisions for a family.

Level: C

10. I am your neighbor. I hear your fights at night but say nothing. It isn't my business.

Level: C

11. I am an adolescent. I keep silent when I see the violence happening. What can I do?

Level: C

12. I am a priest/imam. I keep silent about violence. God/Allah will take care of things.

Level: C

13. I am a health care provider. I take care of your injuries but don't ask anything. It is not my business.

14. **Level: C** 14. I am a food seller. I see her bruises but keep silent.

Level: C

15. I am a police officer. Men sometimes can't avoid using some small violence at home. It is a domestic issue.

Level: C

16. I am a farmer. I think a woman is not equal to a man. A woman should obey her husband.

Level: C

17. I am a taxi driver. I think violence should be used against a woman once in a while. Otherwise women start thinking they can do anything.

Level: C

18. I am a market seller. Women and men are not equal. If a man wants to show that he has more power, then that is a woman's fate.

Level: C

19. I am a local leader. Violence in relationships is a domestic issue. I don't have time for it!

Level: C

20. I am a pharmacist. You buy things from me, and ask for my advice. I think women must be patient and endure.

Level: C

21. I am a teacher. Making jokes about girls is just for fun; it doesn't do any harm.

Level: C

22. I am your doctor. I advise you on many issues but don't see how violence and HIV/AIDS are connected.

Level: C

23. I am a social welfare officer. I see violence in the community but I mostly focus on children, as violence between women and men is pretty normal.

Level: S

24. I am a judge. Sometimes women file cases just for simple violence. I dismiss the cases.

Level: S

25. I am a parliamentarian. There are no laws in my country specifically about domestic violence. That's a private matter!

Level: S

26. I am a donor. I fund AIDS prevention programs in Africa. I only fund ABC programs. They're the best!

Level: S

27. I am a radio announcer. You hear my messages every day. We joke about women and violence. What's the harm?!

Level: S

28. I am a United Nations official. I monitor countries' progress on international conventions, but I don't see the connection between violence against women and HIV/AIDS.

Level: S

29. I am a minister of health. I decide which services are available at the health centers. Women's rights issues don't belong in clinics. We prescribe drugs!

Level: S

30. I am a newspaper editor. I show promiscuous photos of women in my paper, because it sells!
