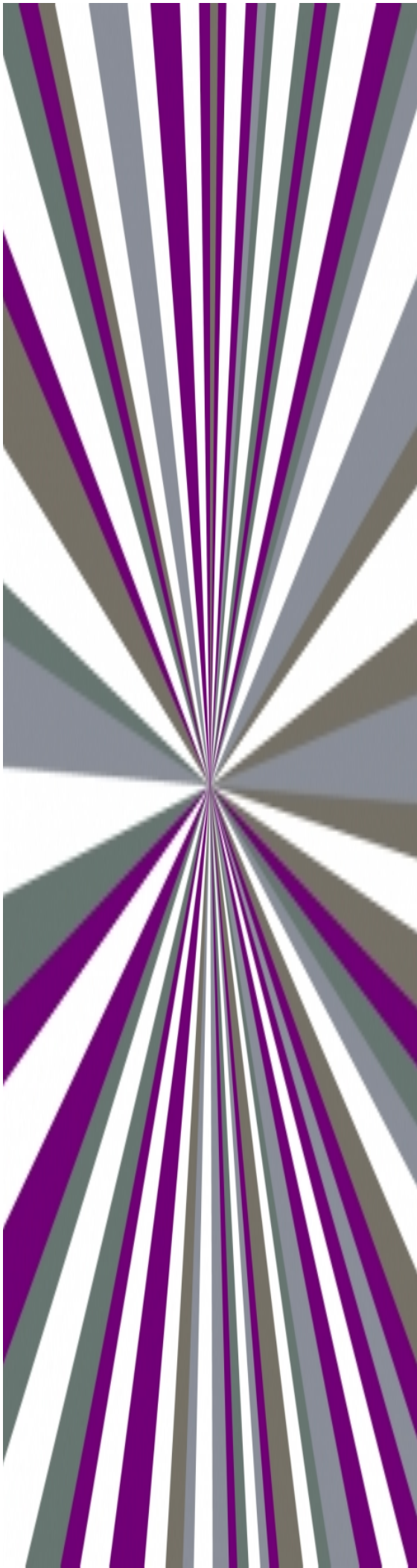
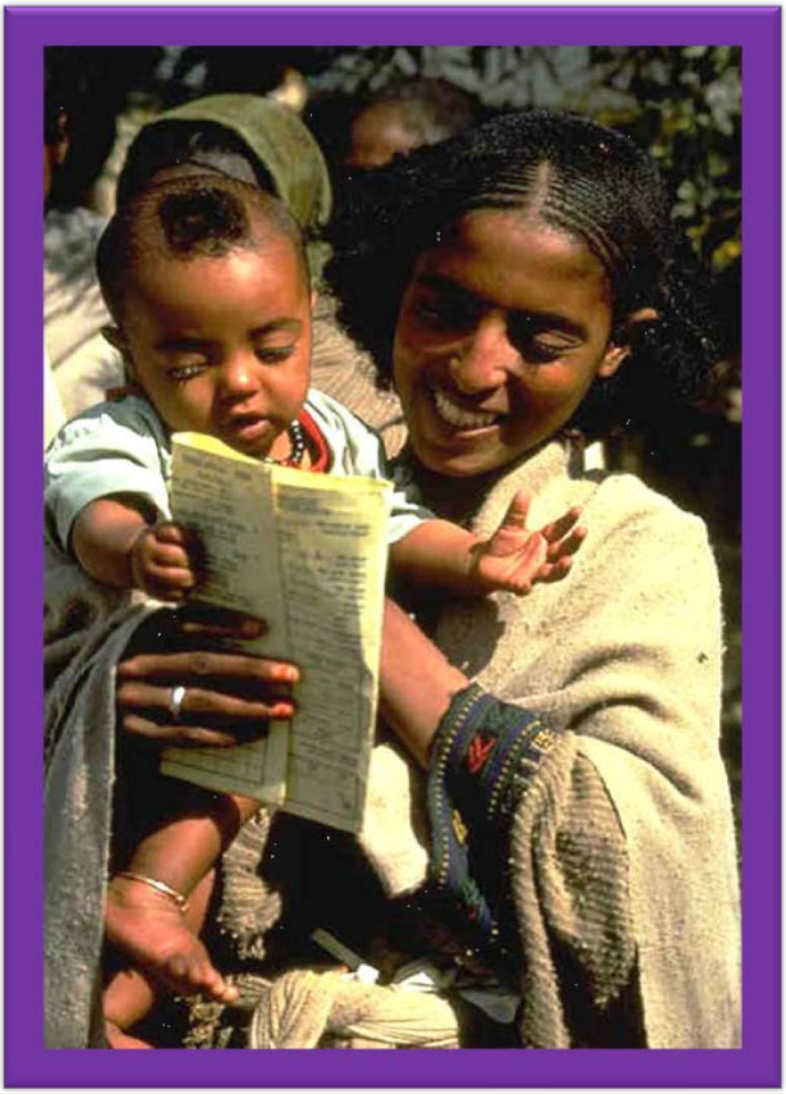
HEALTH SECTOR GENDER TRAINING MANUAL

FACILITATORS' GUIDE



FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA
MINISTRY OF HEALTH
DECEMBER 2013

Strongerhealthsystems,Greateroutcomes.




Tigray
Afar
Amhara
Benishangul-
Gumaz
Dire Dawa
Addis Ababa
Harari
Gambela
Somali
Southern Nations,
Nationalities,
and Peoples
Oromia

FACILITATORS' GUIDE

The facilitators' guide of the gender trainingmanual for the health sector is a comprehensive guide to conduct a six day course. This guide consists of seven modules and different sessions. Eachmodule contains module descriptions, session learning objectives, session durations, icebreakers, exercises, note for the facilitators, and attachments/handouts. The guide also includes two sections. The first is parts on creating an atmosphere conducive for learning and the second is on action planning, course evaluation, and summary.In addition to this, each module has a module evaluation sheet.

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

TABLE OF CONTENTS

FIGURES

TABLES

LIST OF ACRONYMS

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

APPROVAL STATEMENT OF THE MINISTRY

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

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

DrWendemagegnEnbialeYeshaneh

Human Resources Development & Administration Directorate

Federal Ministry of Health, Ethiopia

PREFACE

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

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

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

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

KeseteberhanAdmasu (Dr.)

Minister,
Federal Ministry of Health

[1] These terms reference the concepts used by the Interagency Gender Working Group (IGWG)—see definitions of these terms in Annex 1 and Module 3

INTRODUCTION

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

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

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

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

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

Objectives of the Gender Training Manual

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

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

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

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

Specifically, the training is designed to allow participants to:

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

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

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

Justification for a Gender Training Manual

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

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

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

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

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

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

Facilitator Qualification and Requirement

Facilitators should fulfill the following criteria.

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

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

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

Target Audience of the Manual

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

Organization of the Facilitators' Guide

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

Creating an Atmosphere Conducive to Learning: *Creates a conducive learning environment for participants' to develop mutual trust and respect*

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

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

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

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

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

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

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

***Action Planning, Course Evaluation and Closing:**Seeks to enable participants translate the training into action.*

CREATING AN ATMOSPHERE CONDUCIVE TO LEARNING

CREATING AN ATMOSPHERE CONDUCIVE TO LEARNING

Session duration: 2 hours and 45 minutes

Description

An environment conducive to learning is critical to gender training. A working relationship is crucial in any training where participants come from different disciplines, backgrounds, ethnicities, religions, and regions. In particular for gender training, because both genders are socialized in different cultures, it is necessary to create an atmosphere of mutual trust and respect as both men and women challenge the status quo and confront their own biases. Most people are a little unsure about themselves, especially in a group of strangers. If left to themselves, most people will stick to the group they already know which can slow down teambuilding.

To address the issues above, this part of the training manual provides opportunities for facilitators to create an environment that promotes learning.The session includes addressing administrative and logistic issues, leveling expectations, and building a good team spirit and instilling confidence. If there is an opportunity to invite an inspiring guest speaker to open the workshop, this can set the stage for teambuilding. The guest speaker can emphasize the role of gender training, the challenges health workforce have in mainstreaming gender, and the positive health outcomes that can be gained from such an effort.

The session helps to address adversarial relationships and stereotypes among men and women participants. It allows both genders to reflect on their own socialization and behaviors, and helps them confront a cultural context in which gender inequality exists.

Session objectives

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

- Get to know other participants and facilitators.
- Share expectations and fears with the group.
- Identify the progressive structure of the module and overall workshop objective.
- Establish ground rules to maximize learning and sharing throughout the

workshop.

- Create a supportive environment for discussing norms, values, and behaviors both men and women share regarding gender.
- Get clarifications related to workshop logistics.

Activity 1: Introducing your other half

30 minutes

Materials:*Illustrated introduction cards (Figure 1) and scissor*

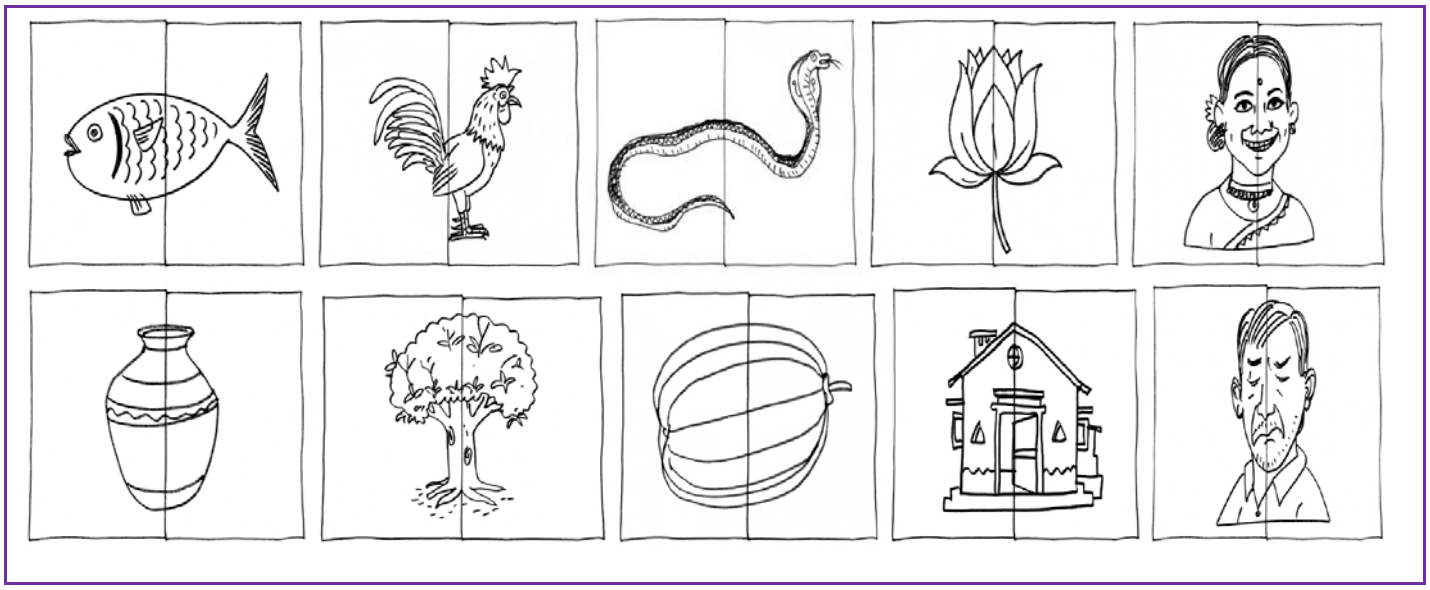
Direction

Step 1-The facilitator or the host welcomes everyone and introduces himself/herself.
Step 2-Ask the participants to stand and form a circle.
Step 3- Handout the illustrated cards found in figure 1 by splitting each picture in two.
Step 4-Make sure each person gets one-half of a picture.
Step 5- Ask participants to find the person with the other half of their illustrated card, and introduce themselves to their partner by sharing key information such as name, position, one positive thing about themselves.
Step 6- Allow five minutes for discussion in pairs, and then ask each pair to introduce their partner to the rest of the group.

Note for the facilitators

Before the workshop, take some time to set up the room by arranging participants' seats and posting welcome greetings for participants to see when they enter the room. The greeting can be indicated in multiple languages, especially local languages.

Figure 1: Illustrated pictures for introduction



Activity 2: Set expectations

30 minutes

Materials:*Marker, meta cards, masking tape, and flipchart paper*

Direction

Step 1-Ask participants to write expectations and fears on separate meta cards.

Step 2-Allow participants to read out and post it on the wall according to various categories of needs such as the need for knowledge, skills, attitudes and fears expressed.

Step 3- Facilitate thecomparisonofexpectations against the course outline. In doing so, identify what needs to be clarified or adjusted to so that expectations are met and fears are resolved.

Step 4-Leave the expectations and fear on the wall, so that participants would see whether they have met their expectations or not as the training proceeds.

- At the end of each module, ask participants to take out the metacards and see if their expectations were met and their fears addressed.

Step 5-Let participants know if their expectations cannot be met within the training time schedule.

Note for the facilitators

Whenever people attend training, they have certain expectations (needs) and also feel

some threats (fears) concerning the outcome. Hence the facilitators must encourage participants to express their expectations and fears concerning the training at the outset of the course. Based on the threat expressed, appropriate solutions can be recommended to meet the training objectives effectively.Many issues will arise that cannot be covered during any given section of the modules or workshop. To address these, pin a blank flipchart on a separate space and use it to highlight important issues that will be covered later. This can be called the "parking lot."

Activity 3: Set ground rules /Learning contract

20 minutes

Materials:*Flipchart paper and stand, marker, and masking tape*

Direction

Step 1- Encourage participants to come up with basic ground rules for the training.
Step 2- Ask participants to write possible ground rules on the flipchart.
Step 3- Allow participants to reach on consensus.
Step 4- Ask participants to identify sanctions for those who break rules and norms and seeks consensus.
Step 5-Post the ground rules in a wall that is visible to all participants.

Note to the facilitator:

In order to effectively meet training objectives, some ground rules have to be established by which everyone is governed during the training session.

Activity 4: Identify management teams /Learning support team

20 minutes

Materials:*Flipchart paper and stand, marker, and masking tape*

Direction

Steps 1- Ask the participants to form daily training management teams.

Step 2-Explain to the teams the terms of reference he/she will be using, e.g., daily evaluations, recapitulation, maintaining order in the class, the importance of time-keeping, periodic energizers, and expressing appreciation.

Step 3-Allow the teams members to choose their leader, draw duties, and post it on the class wall.

Step 4-After the daily evaluation has been completed by the teams, the facilitators and team leaders meet to discuss the feedback and draw some basic lessons to use in the next session.

Step 5- Establish the process as an ongoing activity that is conducted daily and proceedings are included in the training report at end of the training.

Note for the facilitators

Facilitators need to have a mechanism in place at the end of each day to gauge the perception of the trainees with regard to the training. One such tool used for purpose is the management team. The teams offer an opportunity for participants to give their feedback regarding the progress of the course. The outcome of the daily evaluation can be used to improve their performance.

Activity 5: Overview of the module and workshop outline

20 minutes

Materials:*Course outline or training schedule*

Direction

Step 1- Introduce the objective of the overall workshop.

Step 2- Highlight the modules of the workshop, which seeks to increase awareness and build the skills of the health workforce to mainstream gender using: a gender analysis; a gender audit; gender-responsive budgeting; and gender-responsive actions.

Activity 6: Test participants' confidence

30 minutes

Materials:*Printed copy ofpre-training confidence tests*

Direction

Step 1- Give out a printed copy of the pre-training confidence test to all participants (Table 1).

Step 2- Ask participants to fill out the test as per the instruction.

Step 3-Collect the test and summarize it to identify participants' confidence regarding knowledge of the core learning agendas.

Table 1: Pre-training confidence test

Introduction

Please indicate your level of knowledge, skills, attitude and practice with respect to the areas listed in the first column by putting an "X" mark in the appropriate box. This will help facilitators to identify participants' level of understanding before the beginning of the training.

Issues/Areas	Level of knowledge, skills, attitude and practice				
	Low → High				
	1	2	3	4	5
Gender concepts and terminologies					
Gender as a social determinants of healthin Ethiopia					
Gender mainstreaming					
Gender analysis					
Gender audit					
Gender budgeting					
Gender and the health workforce in Ethiopia					

Note for the facilitators

Confidence tests assist the facilitator to conduct a baseline on the skills and knowledge of the participants and adjust the workshop content and materials to suit the learning needs of the participants. It also enables the facilitators to understand the immediate improvement in

the knowledge, skills, and attitudes of participants.

Activity 7: Conduct dailyevaluation

15 minutes

Materials:*Meta cards, masking tape, marker, and daily mood barometer (table 2)*

Direction

Step 1- Use a daily mood-barometer as the last activity before official closure of the daily program.

Step 2-Draw faces that show happiness, sadness and in between using three different metacards and post it on the wall.

Step 3- Put small boxes below the facesso that participants can put their daily evaluation (Table 2).

Step 4- Provide participants with pieces of meta cards and encourage them to write if they are happy, sad, or in between. This is to be conducted at the end of each training day.

Step 5- Tell participants to write what they are happy or sad about so that the facilitators can improve the training based on the feedback.

Step 6-Remind participants the importance of keeping a daily journal since they will use this as a reference during action planning phase.

Table 2: Sample daily mood barometer

Happy **Average** **Sad**

Note for the facilitators

The evaluation of the training has to be an important ingredient of the training session. At the end of each day facilitators needs to measure the perception of the trainees with regard to the training. Getting continuous feedback is important to keep in touch with the group. Do not take negative feedback as a personal offence but as a challenge to improve the situation for all by looking for the best solution.

MODULE 1

MODULE 1: GENDER CONCEPTS AND TERMINOLOGIES

Description

Moduleone consists oftwo sessions. The first session is on gender-related concepts and terminologies. This session will establish a common understanding of gender concepts so that participants are fully aware of the proceeding modules and sessions of the training manual. The second session is on policies and conventions related to gender. This session gives an overview of the major national laws and legislation, and as the major conventions that the country has committed to as a signatory.

Session 1: Gender Concepts and Terminologies

Session duration:4hoursand 25 minutes

Session objective

At the end of this session, participants will be able to:
- Explain the distinction between sex and gender.
- Define gender equity and equality.
- Describe other common concepts and terminologies of gender.

Activity 1: Matching game on gender concepts

40 minutes

Materials:*Set of A4 papers containing terms, another set of A4 papers containing corresponding gender definitions, masking tape, and attachment 1.1*

Direction

Step 1-Distribute the two sets of A4 papers with the selected gender terminologies and their definitions among the participants.

Step 2- Ask each person to look for the person bearing the paper that matches his/her term of definition.

Step 3-Ask participants to tape on the wall or spread on the floor the matched definitions and terminologies.

Step 4-Ask participants to review and explain the matches.
- For mismatched terms, allow them to shift the papers and correct their matches as necessary.

Step 5-Go through the terms together with the participants and explain the terms and definitions.

Activity2: The gender game

30 minutes

Materials: *LCD projector*

Direction

Step 1-Display table 3 in using LCD projector.

Step 2-Ask participants to categorize each statements as gender or sex. Tell them to give explanation as to why they categorized it under gender or sex.

Step 3- Summarize the exercise by relating the statements with gender roles and responsibilities using attachment 1.1

Table 3: Statements clarifying concept of gender and sex[4]

No	Statements	Category		Justification/ Reason
		Gender	Sex	
1.	Women do more of the housework than their spouse			
2.	Women can breastfeed			
3.	Men can only bottle feed			
4.	Nursing is often seen as a woman's job, although many men enter the position			
5.	Women can menstruate men cannot			
6.	The most important role for a man is to be the breadwinner/head of the family			
7.	Only men can produce sperm for reproduction			
8.	Girls should be gentle, boys should be tough			
9.	Men's voices change with puberty			

Note for the facilitators

Statements in number 2, 4, 6, and 8 refer to sex. This is because the statements are directly linked to biological and physiological factors. On the other hand, statements in number 1, 3, 5, and 7 are directly linked to gender. This is because the statements are indication of gender roles, norm and relation.

Activity 3: Brainstorming exercise on assumptions related to gender and health and/or development

30 minutes

Materials: *Flipchart paper and stand, LCD projector, marker, andattachment 1.2*

[4] http://www.medicalnewstoday.com/articles/232363.php

Direction

Step 1- Ask participants to be in pairs and discuss some of their assumptions about gender in relation to health and/or development.
Step 2- Allow participants to share their views to the plenary.
Step 3- Capture the points on a flipchart.
Step 4- Summarize the discussion using the handout in attachment 1.2.

Activity4: Clarifying the concept of equity and equality

30 minutes

Materials: *LCD projector, marker, andattachment 1.3*

Direction

Step 1- Ask participants to be in group of three and refer the cartoon and story in attachment 1.3.
Step 2- Ask participants to reflect on their views using the following question:
- Does equal opportunity bring equality of outcomes?

Step 3- Summarize the exercise using attachment 1.3.

Activity 5: Exercise on empowerment

30 minutes

Materials:*Attachment 1.4, LCD projector, flipchart paper and stand, and marker*

Direction

Step 1- Ask participants to refer to attachment 1.1 for gender concepts and terminologies and see the definition of empowerment. Further explain the concept using handout in attachment 1.4.

Step 2- Divide participants into four groups and ask them to provide examples of empowerment at each of the following levels that result in positive health outcomes.

- Inform participants to refer to table 4 found in the participants' guide.

Step 3- Ask the leaders of the four groups to present their findings.

Step 4- Summarize the exercise using the handout in attachment 1.4.

- While doing the exercise, if the participants have not identified income as one ingredient for empowering women, then suggest that one of the most critical needs for women is a lack of income.
- Then present the pie chart displayed in attachment 1.4 and ask participants to explore the meaning from a women's empowerment perspective in the Ethiopian context**.**

Table 4: Women's empowerment measures for positive health outcomes

Levels	Examples of women empowerment actions/programs for positive health outcomes
Individual level: What kind of actions can women as individuals take to empower themselves?	
Family/household level: What can the family do to empower women and in the household?	
Community level: What kind of actions can the community take to empower women?	
State/government level: What is the role of the state or the government to empower women?	

Attachment 1.1: Gender Concepts and Terminologies

Terms	Definitions
Sex	The different biological and physiological characteristics of males and females, such as reproductive organs, chromosomes, hormones, etc.
Gender	Refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men.
Gender norms	Refer to beliefs about women and men, boys and girls that are passed from generation to generation through the process of socialization.
Gender roles	Refers to what males and females are expected to do (in the household, community and workplace) in a given society.

Terms	Definitions
	E.g. o Women are disproportionately responsible for child care due to their biological roles. As a result, men are often excluded from prenatal and antenatal care, counseling and services. o Women's gender roles and responsibilities for preparing food in many contexts expose them to indoor air pollution at higher rates than men resulting in severe respiratory disorders, and even mortality, for women and children.
Gender relations	Refers to social relations between and among women and men that are based on gender norms and roles.
Gender stereotypes	Images, beliefs, attitudes or assumptions about certain groups of women and men. Stereotypes are usually negative and based on assumed gender norms, roles and relations. E.g. o Women's biological responsibility for children, often results in the exclusion of men from ante and prenatal care responsibilities. o Health providers assume that family planning is a woman's responsibility, resulting in limited services for men to protect their own and partner's health.
Access to resources	The availability of a resource that includes several components such as geographic or physical accessibility, financial and social accessibility. E.g. o Lack of access to disposable income can prevent women from using available health care facilities that exist in the community.
Control over resources	The ability to decide when, how and who can use a resource. E.g. o Gender roles, norms, relations and stereotypes determine expectations for women and men, as well as their control over resources. For example, Women spend most of their productive years caring for children, the ill, elderly and disabled with no or low pay, or in the informal sector. This type of work excludes them from the pensions and benefits provided by formal employers.
Practical gender needs	Needs defined by women (or men) that respond to immediate necessities such as adequate living conditions, water provision, health care,food, housing, and income. It can be addressed by provision of specific inputs such as food, hand pump s, clinics, etc.
Strategic gender needs	Needs identified through an analysis of gender inequality and its impact on women and men of different groups. Addressing strategic gender needs challenges predominant gender systems such as the

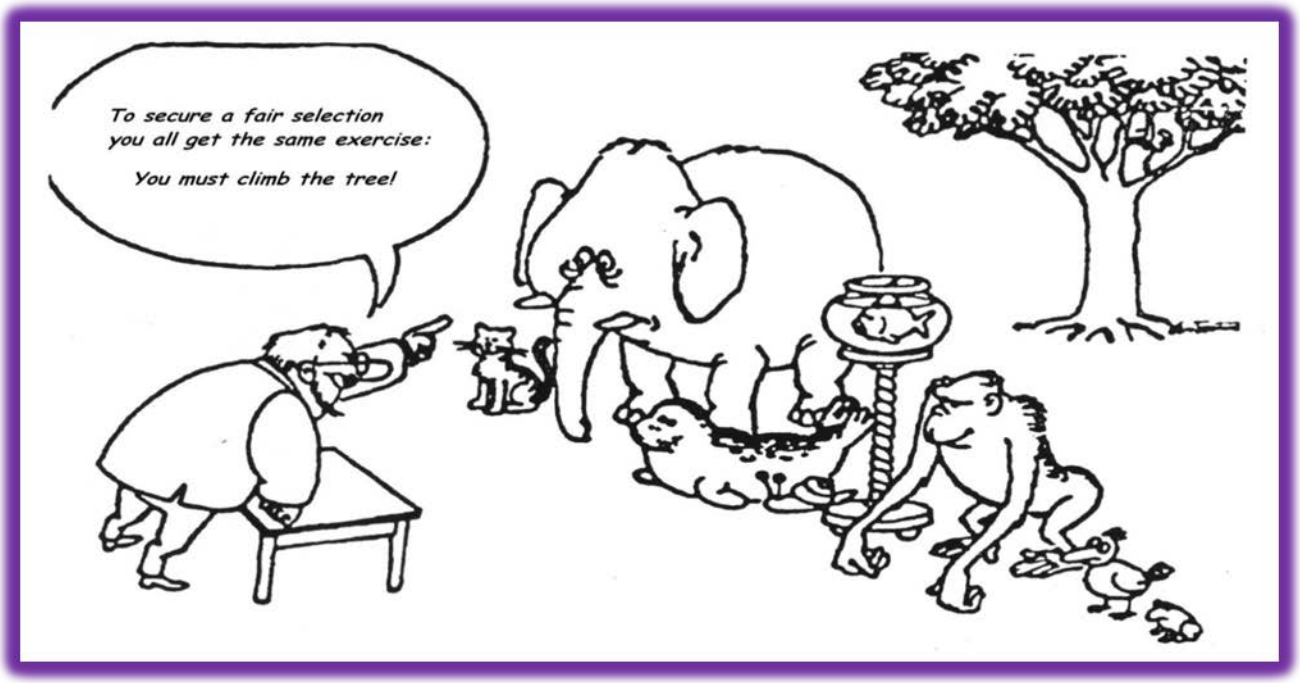
Terms	Definitions
	gender-based division of labor. This relate to lack of resources and education, vulnerability to poverty and violence, etc. It can be addressed by consciousness-raising, increasing self-confidence, education, strengthening women's organizations, political mobilization, etc.
Gender mainstreaming	The process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated.
Gender equity	Refers to the process of being fair to women and men.
Gender Equality	Refers to the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources.
Empowerment	Empowerment is a multidimensional social process that enables people to gain control over their lives.

Attachment 1.2: Gender-Related Assumptions

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

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

Attachment 1.3: Clarifying the Concepts of Gender Equity and Equality



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

The story of the fox and the crane

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

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

Even though all animals in the cartoon have the same opportunity to respond to the test (equality), it is unfair because they do not all have the same capacity to climb the tree (inequity). In the story, both friends had an equal opportunity for nourishment, but each time one of them could not take advantage of this opportunity because of their physiological difference or the ways their mouths are shaped. Hence, the development challenge in every case is to identify barriers to the opportunities that exist, and custom design the adjusted interventions that will lead to equality of outcome.

Gender in health is defined as :	o Women and men's health status and determinants. o Gender-based hurdles in access to health services and resources. o Impact of health policies and programs. o Distribution and remuneration of health labor. o Participation in health policy and decision-making.
Gender equity in health means:	In health status: o It means that women and men have equal opportunities to enjoy good health, without becoming ill or dying through causes that are unjust and avoidable. o It does not mean equal rates of mortality or morbidity for women and men. In access/use: o It means differential distribution and access to resources (technological/financial/human) according to need. In financing of care: o It means women and men contribute according to their economic capacity, not their need or use of services. In participation in health production: o It means just distribution of responsibilities and power. o It is also placing value on non-remunerated health work.
Gender equality in health means:	o Gender equality in health means that women and men have equal conditions to realize their full rights and potential to be healthy, contribute to health development and benefit from the results. o Achieving gender equality will require specific measures designed to support groups of women and men with limited access to such goods and resources.

Source: Adapted from Gender mainstreaming for health managers: a practical approach, participant note, World Health Organization (2011).

Attachment 1.4: The Empowerment of Women at Different Levels

Empowerment refers to a multidimensional social, economic and political process that enables people to gain control over their lives.

- It is an aspect that focuses on putting power in the hands of men and women of all groups.
- It is a means to address aspects of gender-based discrimination.
- It tries to achieve a more equal society.
- It seeks to address unequal power relations and to increase individual and group capacity.

With respect to women's health, empowerment has often meant, for example, increasing education opportunities and access to relevant information to enable women to make informed decisions about their health, improve self-esteem and equip them with communication and negotiation skills.

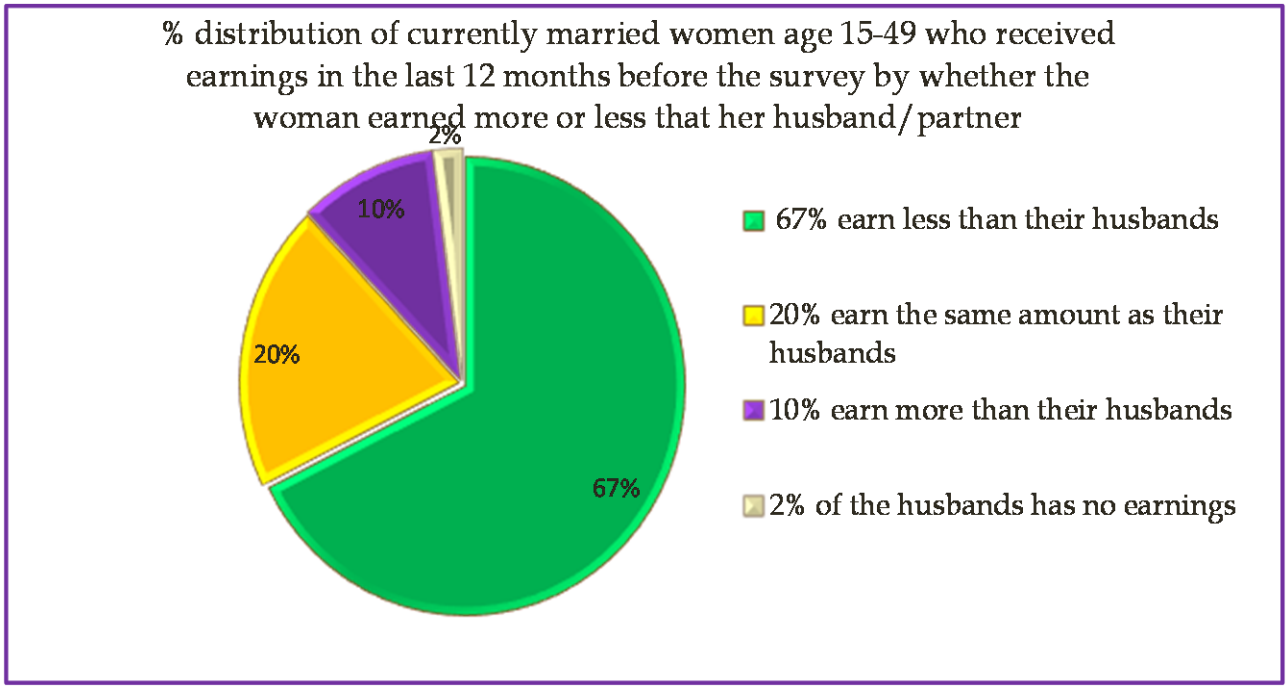
Table 5: Women empowerment at various levels

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

or the government to empower women?	implementation (e.g. property right). o Existence of active women's movements and institutions. o Existence of gender policy. o Use of media and media monitoring strategy from gender perspective.

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

Figure 2: Comparing women's and partner's earnings



Source: Ethiopia Demographics and Health Survey, 2011

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

Session duration:4 hours

Session objectives:

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

- Identify different national legislations and international conventions related to gender equality and women empowerment.
- Describe the gender focus of the policies for use and reference.
- Use the policies as a justification for the need of gender mainstreaming.

Activity 1: Brainstorming exercise on the Ethiopian constitution

25 minutes

Materials:*Flipchart paper and stand, marker, masking tape, LCD Projector, and attachment 1.1*

Direction

Step 1-Ask participants how many of them are aware of the different legal policy frameworks relevant for gender equality.

Step 2-Then ask participants to discuss in pairs the gender-related provisions of the Ethiopian constitution.

Step 3-Let participants reflect on the output of their discussion and capture their response on a flipchart.

Step 4-Summarize the brainstorming exercise by presenting attachment 1.1 using a PowerPoint slide or flipchart.

Activity 2: Brainstorming exercise on family law, labor law, and penal /criminal code

40 minutes

Materials:*Flipchart paper and stand, marker, masking tape, LCD Projector, and attachment 1.2*

Direction

Step 1- Ask participants to be in groups of three and brainstorm the gender focus of the three laws.
Step 2-Then ask participants to identify the new amendments made in these three laws.
Step 3- Capture participants' response on a flipchart.
Step 4- Summarize the exercise by providing the information given in attachment 1.2 using a PowerPoint slide or flipchart.

Activity 3: Brainstorming exercise on women's policy

25 minutes

Materials:*Flipchart paper and stand, marker, masking tape, LCD Projector, and attachment 1.3*

Direction

Step 1-Ask participants discuss on the objectives and identify priority areas for the women's policy in Ethiopia.
Step 2-Capture participants answer on flipchart.
Step 3- Wrap up the exercise by presenting handout on attachment 1.3 using a PowerPoint slide or flipchart.

Activity 4: Exercise on key policies

40 minutes

Materials:*Flipchart paper and stand, marker, masking tape, LCD Projector, and attachment 1.4*

Direction

Step 1- Ask participants to organize themselves into five groups, and discuss on the gender focus of the education, reproductive health, cultural, health and environmental policies.
Step 2- Regardless of the existence and guarantees of the constitutions and other key laws discussed above, women continue to suffer from GBV and other violations of rights.

- Ask participants why women continue to suffer, and what can be done to reverse the situation.

Step 3- Ask them to present their group output to the plenary.
Step 4- Summarize the exercise by presenting the handout in attachment 1.4.

Activity 5: Brainstorming exercise on international conventions

55 minutes

Materials:*Flipchart paper and stand, marker, masking tape, LCD Projector, attachment 1.5, and module evaluation sheet*

Direction

Step 1- Ask participants form four groups and discuss the contents of CEDAW, ICPD, BPFA, and the MDGsfrom a gender perspective.
Step 2- Allow participants to present the group output to the plenary.
Step 3-Then summarize the exercise by presenting the handout in attachment 1.5 using PowerPoint slides or a flipchart.
Step 4-Assess participants understanding of the module using the module evaluation sheet.

Attachment 1.1: Ethiopian Constitution and Its Gender Provisions

The constitution of Ethiopia is an integral part of the law of the land. It ensures that all fundamental rights granted are to be interpreted in conformity with the principles of the signed international conventions and declarations. Article 35 of the Ethiopian constitution focuses on the rights of women. The focus area of the article is summarized as follows in Table 6.

Table 6:Gender focus of the Ethiopian constitution

Area of focus	Issues covered
Employment	o Women shall have a right to equality in employment, promotion, pay, and the transfer of pension entitlement.
Health	o To prevent harm arising from pregnancy and childbirth, and in order to safeguard their health, women have the right of access to family planning education, information, and capacity. o Women have the right to maternity leave with full pay. The duration of maternity leave shall be determined by law, taking into account the nature of the work, the health of the mother, and the well-being of the child and family. Maternity leave may, in accordance with the provision of the law, include prenatal leave with full pay.
Customary practices	o The state shall enforce the right of women to eliminate the influences of harmful customs and laws, and practices that oppress or cause bodily or mental harm to women are prohibited.
Affirmative action	o The historical legacy of inequality and discrimination suffered by women in Ethiopia is taken into account, and in order to remedy this legacy women are entitled to affirmative measures. The purpose of such measures is stated.
Asset/property	o Women have the right to acquire, administer, control, use, and transfer property. In particular, they have equal rights with men with respect to the use, transfer, administration and control of land. They shall enjoy equal treatment in the inheritance of property. o Women have equal rights with men in marriage as prescribed by the constitution.
Decision-making	o Women have the right to full consultation in the formulation of national development policies, the designing and execution of projects, and in the case of projects affecting the interests of women. o Women shall enjoy the rights and protections provided by the constitution, and have equal rights with men.

Attachment 1.2: Family Law, Labor Law, and Penal /Criminal Code

Ethiopian family law, labor law and criminal (penal) code are other key laws that address gender to ensure the protection of women. The gender focus of these regulations is summarized as follows in the table 7.

Table 7:Gender focus of family law, labor law and criminal (penal) code

Revised Family Code	Criminal (Penal) Code	Labor Law
o The revised family law contains most important women and child rights protection issues. o Changes have been made in federal and regional family laws and revised age at marriage, divorce procedures, equality during and after marriage, custody of children and rights to matrimonial properties. o For example, the law: • Raised the marriage age for girls from 15 to 18, making it equals with that ofboys • Validates marriages concluded by consent. • Gave women right to use and control land	o The penal code has been revised to ensure safeguards for women and to penalize perpetrators. o For the first time HTPs such as FGM, abduction, early marriage, rape, harassments are punishable by law. o The revised criminal code increased number of years of imprisonment of criminals of rape and abduction.	o The labor law explicitly states that there is equal employment opportunity for all citizens irrespective of sex. o The revised Federal Civil Servants proclamation No. 515/2007 ensured women'sconstitutional rights to affirmative action concerning recruitment, promotion, deployment, and creation of sexual violence free working environment.

Attachment 1.3: Policy on Women[5]

The national policy on Ethiopian women was formulated in 1993 by what was then referred to as the Women's Affairs Office (WAO) with the objectives of:

- Creating and facilitating conditions for equality between men and women;
- Creating conditions to make rural women beneficiaries of social services like education and health; and
- Eliminating stereotypes and discriminatory perception and practices that constrain the equality of women.

The structures of the national machinery to address gender equality and equity issues were clearly laid down in the policy. Ministry of Women's Affairs (MOWA) had selected seven priority areas of the women policy and developed National Action Plan on Gender Equality (NAP-GE).These priority areas are:

1. Poverty and economic empowerment of women and girls
2. Education and training of women and girls
3. Reproductive rights, health and HIV and AIDS
4. Human rights and violence against women and girls
5. Empowering women in decision making
6. Women and the environment
7. Institutional mechanisms for the advancement of women

Although no budget estimate has been given for the various activities included in the NAP-GE, the plan has been integrated into the five-year (2005-2010) poverty reduction strategy paper known as A Plan for Accelerated and Sustained Development to End Poverty (PASDEP)[6]. Gender is currently treated as a development issue under the Growth and Transformation Plan (GTP) [7]that runs from 2010 to 2015.

[5] A new policy on women is being drafted but is not available at the time of the preparation of the manual.
[6] PASDEP is Ethiopia's overall strategy for development from 2005-2010.
[7] GTP is Ethiopia's ambitious five year plan developed to carry forward the important strategic directions pursued in PASDEP.

Attachment 1.4: Summary of Key Policies

Education Policy	Reproductive Health (RH) Policy	Health Policy	Environmental Policy	Cultural Policy
o **One of the specific objectives is to** introduce a system of education that would rectify the misconceptions and misunderstandings regarding the roles and benefits of female education in development. o Indicates that the design and development of curriculums and books should give special attention to gender issues. o States that equal or special attention should be given to female teachers when selecting, training, and advancing their careers. o Indicates the need for financial support to raise the participation women in education. o A number of initiatives have been taken to implement the policy. For example, currently female teachers are selected with a smaller grade point average (GPA) than male teachers, and this has increased the number of female teachers in elementary schools. o Has specified strategies to ensure that women receive vocational guidance at all institutions of education, have access to the same curricula as men, and are free to choose their field of study.	o Addresses the social and cultural determinants of women's reproductive health, fertility and family planning, maternal and newborn health, HIV and AIDS, RH of young people, and reproductive organ cancers. o Seeks to strengthen the legal frameworks that protect and advance women's RH rights; prioritizing the attainment of age of marriage; increase educational attainment; reduce the acceptability of all forms of FGM; and eliminate HTPs. o Aims to reduce unwanted pregnancies and enable individuals to achieve their desired family size, increase access to and utilization of quality FP services, and to delegate the service delivery to the lowest level possiblewithout compromising safety or quality of care. o Seeks to empower women, men, families, and communities to recognize pregnancy-related risks, ensuring access to a core package of maternal and neonatal health services. o Responds to young women's heightened vulnerability to sexual violence and non-consensual sex. o Addresses HIV infection among reproductive age groups and improves the quality of life of those living with the disease.	o Serves as a foundation for the development of the country's health related strategies. o Emphasizes decentralization of the health care system to ensure accessibility to all segments of the population. o The policy gives special attention to the health needs of the family particularly women and children. o The policy on women's health focus on: o -Adequate maternal health care and referral facilities for high risk pregnancies, o -Intensifies family planning for the optimal health of the mother, child and family, o -Inculcates principles of appropriate maternal nutrition, optimization of access and utilization, o -Identifies and discourages harmful traditional practices while encouraging their beneficial aspects, and o –Encourages paternal involvement in family health.	o Improves and enhances the health and quality of life of all Ethiopians. o Promotes sustainable social and economic development through sound management of resources. o Finds substitutes for fuel wood. o Highlights the need to involve water resource users, particularly women, in planning, design, implementation and follow-up local water policies, programs and projects. o Highlights the need to increase the number of women extension agents in the field of natural resource and environmental management. o Has a separate section on social and gender issues focusing on the need for formal and informal training on environmental and resource management.	o Indicates that cultural behaviors, practices, and attitudes that support and promote stereotypes and prejudices against women should be slowly eliminated, and conditions can be created to promote gender equality. o Elaborates the unfavorable situation of women, and emphasizes the need for a change that ensures women's active participation in all cultural activities. o Guarantees women equal rights to various benefits, such as recognition and decision-making power in the various traditional celebrations and institutions, elimination of HTPs, and promotion of cultural practices that promote women's welfare.

Attachment 1.5 Summary of Key International Conventions and Mandates

Convention for the Elimination of All Forms of Discrimination against Women (CEDAW), 1979	International Conference on Population and Development (ICPD), 1994	Beijing Platform for Action (BPFA), 1995	Millennium Development Goals (MDGs), 1990-2015
o Ethiopia ratified CEDAW on 10 September 1981. Ethiopia has been reporting on the progress made in the implementation of CEDAW. o Defines what constitutes discrimination against women and establishes an agenda for national action to end such discrimination. o Commits states to incorporate the principle of equality of men and women into their legal systems. o Abolishes all discriminatory laws, and adopt those that prohibit discrimination against women. o Specifically mentions actions to be undertaken so that women enjoy equal rights in the areas of education, health, and employment.	o Ethiopia ratified ICPD on 31 May 1994. o Endorses a new strategy which emphasizes the numerous linkages between population and development, and focuses on meeting the needs of individual women and men rather than achieving demographic targets. o Empowers women and provides them with more choices through expanded access to education and health services, and promotes skill development and employment. o Advocates for making family planning universally available by 2015. o Includes goals with regard to universal education; further reduction of infant, child and maternal mortality levels; and access to reproductive and sexual health services including family planning.	o Since the fourth world conference on women in 1995, Ethiopia committed to implementation of BPFA. o Deals with twelve criticalareas of concern: poverty, education, health, violence, armed conflict, the economy, power and decision-making,institutional mechanisms, human rights, the media, the environment, and the girl child. o TheBeijing+5 review session held in 2000 in New York reaffirmed the importance of gender mainstreamingin all areas and at all levels. o Identified areas that required special actions: education,social services and health including sexual and RH, HIV, and AIDS pandemic, burdenof poverty on women, violence against women and girls, and the development of effective and accessible national machineries for the advancement of women.	o Ethiopia is one of the signatories for the implementation of the MDGs. o Although all the goals of the MDGs are relevant for women; Goal 3, 4, and 5 are particularly gender-specific and lie at the core of women's health and development: o Goal 3-promote gender equality and empower women o Goal 4-reduce child mortality o Goal 5-improve maternal health

Module 1 Evaluation Sheet

	Aspects I liked most	Aspects I liked least	New things I learnt	Suggestion for improvement
Content				
Methodology				
Facilitation				

Module 1 References

Federal Democratic Republic of Ethiopia (1991).*The National Population Policy of Ethiopia.*

Federal Democratic Republic of Ethiopia (1994).*Constitution of the Federal Democratic Republic of Ethiopia.*

Federal Democratic Republic of Ethiopia (2000).*The revised family code: federal negaritgazetta of the Federal Democratic Republic of Ethiopia*. Issue No.1/2000. Proclamation No. 213/2000. Addis Ababa.

Federal Democratic Republic of Ethiopia.(1994). *Education and training policy.* Addis Ababa.

Federal Democratic Republic of Ethiopia.(1997). *Cultural policy.*

Federal Ministry of Health (2006).*National reproductive health strategy 2006-2015*.

Federal Ministry of Labour and Social Affairs (1996).*Developmental social welfare policy*. Addis Ababa

http://mapsof.net/uploads/static-maps/ethiopia_regions_english.png

Ministry of Agriculture (2010).*Handout on introduction to gender and development for Ethiopian TVET system*.Rural Development and Capacity Building Project.Alage

World Health Organization (2011).*Gender mainstreaming for health managers: a practical approach.Participant note.*

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

MODULE 2

MODULE 2: GENDER ASA SOCIAL DETERMINANT OF HEALTH IN ETHIOPIA

Description

Module two will provide an analysis of women's biological vulnerabilities and the major socio-cultural, economic, and political factors that affect them. Their biological roles as mothers and primary agents of socialization are superimposed on their roles as family caretakers and health providers. Women are therefore central to the development of the nation and the achievement of the MDGs.

The module has five sessions dealing with:

- Session one will identify the situation of Ethiopian women.
- Session twowill use a life cycle approach for understanding the challenges women face in health and nutrition during the different stages of their lives.
- Session three will analyze data to discuss how the socio-cultural and economic determinants of health affect health outcomes. The data on topics of (early marriage, FGM, fertility, and maternal mortality) will be analyzed to provide the necessary empirical evidence to demonstrate the link.
- Session four focuses on gender-based violence and discusses the ecological framework to better understand gender-based violence, shows data on the prevalence of the issue and its health effects.
- Session five deals with gender and mental health looking at factors affecting mental health, gender differences in mental health, and interventions for promoting women's and men's mental health.

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

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

Session 1: Situations of Women in Ethiopia

Session duration:40 minutes

Session objective

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

- Explain the multiple roles and responsibilities of women in Ethiopia.

Activity 1: Brainstorming exercise on the situation of women in Ethiopia

30minutes

Materials:*Figure 3, LCD Projector, and attachment 1.1*

Direction

Step 1- Ask participants to refer figure 3 and brainstorm on what each picture says about the situation of women in Ethiopia.

Step 2-Summarize the discussion by using the handout in attachment 1.1.



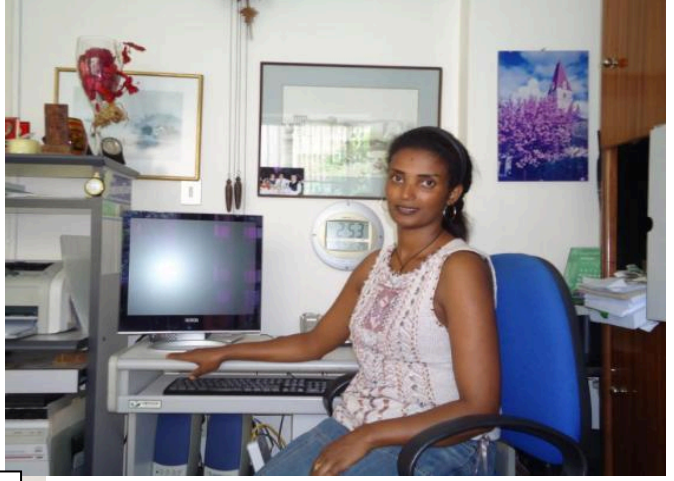


Figure 3: Ethiopian women engaged in various tasks





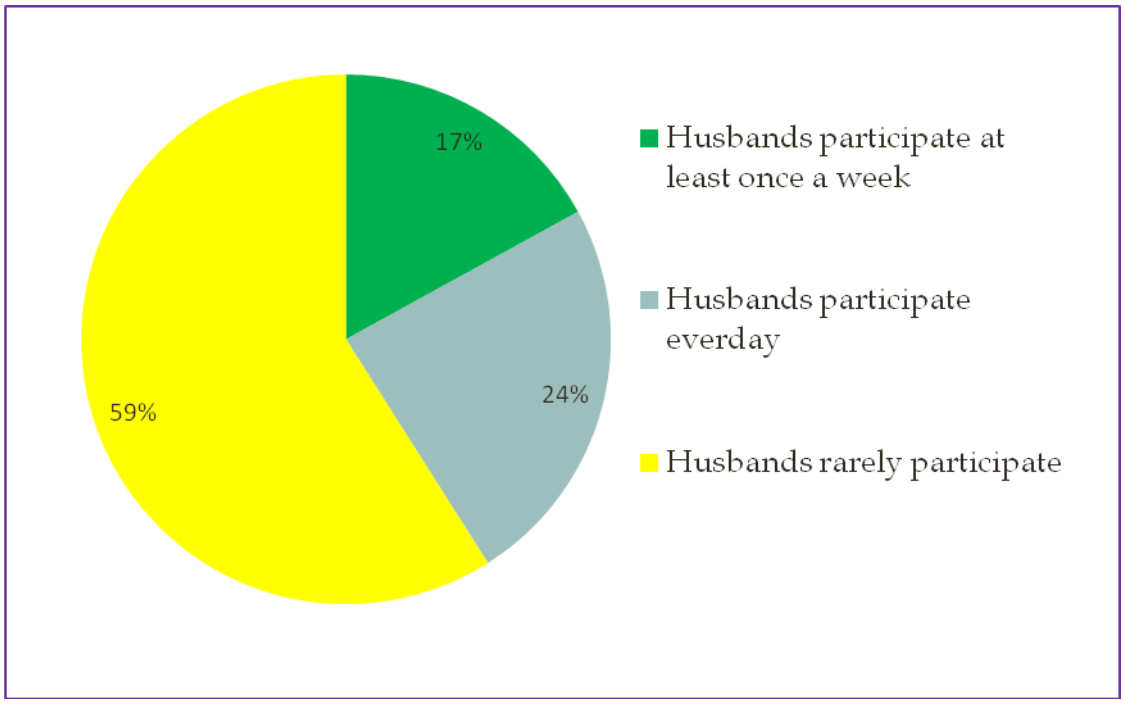


Attachment 1.1: Situation of Women in Ethiopia

Women have triple roles since they engage in productive, reproductive, and community-related work. In doing so, they disproportionately carry the burden of these tasks. Overall the 2011 Ethiopia Demographics and Health Survey (EDHS)data indicates these disparities. For example:

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

Figure 4: Response of married women on husbands' participation in household chores



Source: Ethiopia Demographics and Health Survey, 2011

Session 2: The Life-Cycle Approach

Session duration: 45 minutes

Session objectives

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

- Apply life-cycle approach to identify the different health challenges that women face.
- Describe the biological vulnerabilities and the socio-cultural and economic aspects which affect the lives of women from infancy to old age.
- Demonstratethe skill of analyzing life-time health problems which affect women.

Activity 1: Exercise on life-cycle approach

25 minutes

Materials:*Table 8, flipchart paper and stand, marker, masking tape, attachment 1.1, and LCD Projector*

Direction

Step 1-Divide participants into four groups.

Step 2-Ask participants to identify and list health and nutritional factors that affect women and girls at different ages using life-cycle approach using flipchart papers/LCD(using table 8).

Step 3-Ask participants to report on the group output.

- Ask participants to give examples while identifying the health and nutritional problems.

Step 4-Summarize the exercise by presenting the life-cycle chart in attachment 1.1.

Table 8:Health and nutritional problems affecting women at various stages of ages

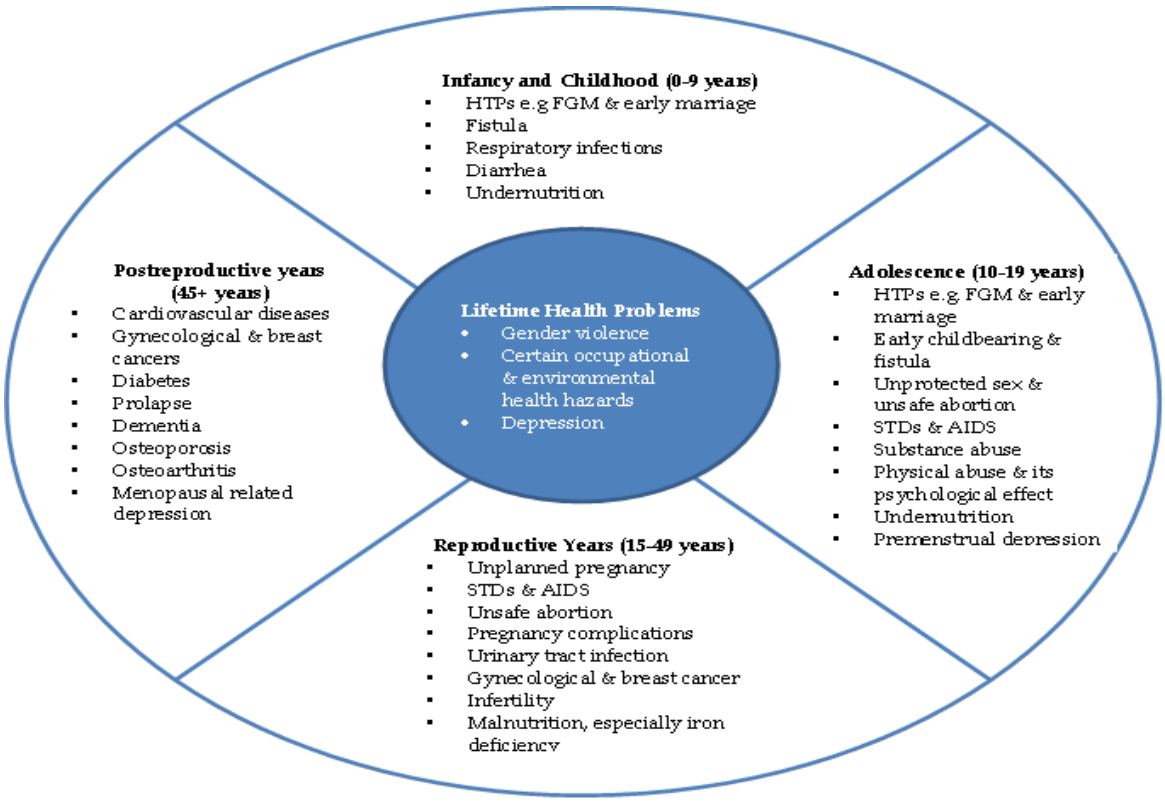
Stage	Health and nutritional problems affecting women and girls
Infancy to childhood (0-9)	
Adolescence (10-19)	
Reproductive Years (15-49)	
Post Reproductive Years (45+)	

Attachment 1.1: The Life-Cycle Approach

Over the years, women's health needs have been addressed through maternal and child health programmes. With new knowledge and changing perspectives, women's health is now being viewed holistically-as a continuum of care that starts before birth and progresses cumulatively through childhood and adolescence to adulthood and old age. The life-cycle approach extends beyond women's reproductive role to encompass women's health at every stage and in every aspect of their lives. Through this approach, other health issues affecting women that were previously overlooked have become more apparent.

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

Figure 5: Health and nutritionalproblems affecting women during their life-cycle



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

Session 3: What Does The Data Show?

Description

One of the sources of information for this session is theDemographicand Health Survey (DHS) which was released in 2011.The primary objectives of the 2011 EDHS are to provide up-to-date information for planning,policy formulation, monitoring, and evaluation of population and health programmes in the country.Using this source of data and other empirical information, the following sessions interprets data to link gender with health.

Session duration:4hours

Session objective

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

- Demonstrate the skill of gender and health-related data interpretation.
- Identifyhow issues of early marriage, FGM, fertility, maternal mortality, and malaria affect women's health.

Early Marriage

Activity 1: Exercise on health data interpretation

30 minutes

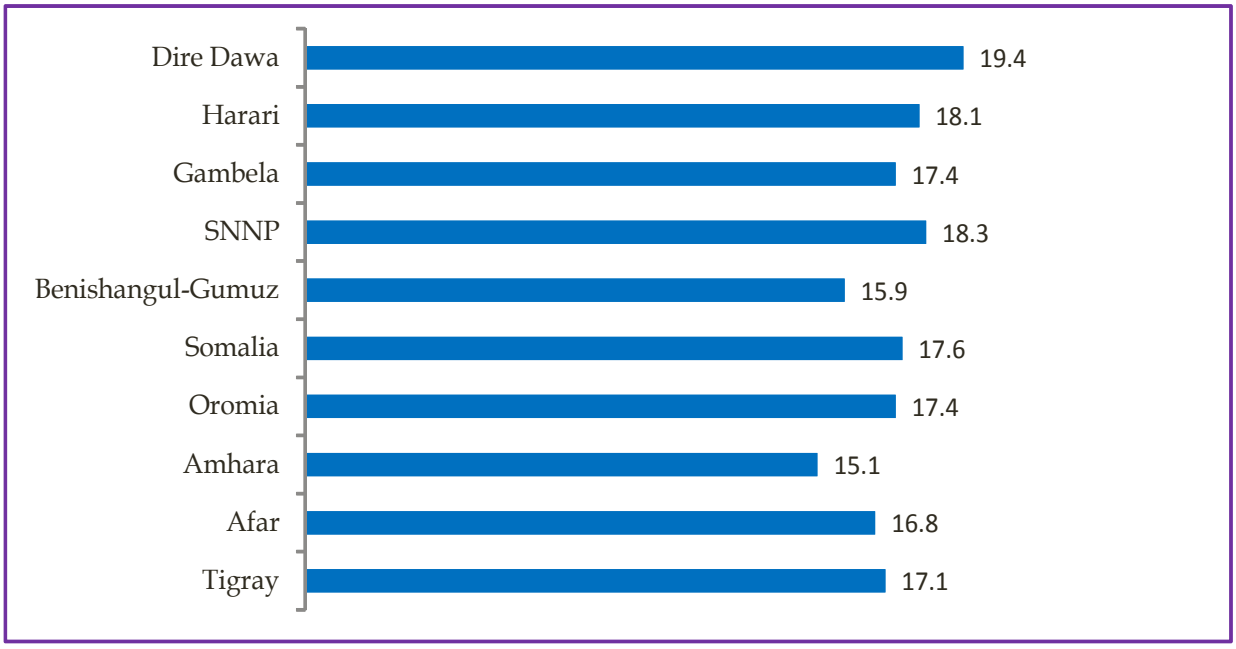
Materials:*Figure 6, flipchart paper and stand, marker, LCD Projector, and attachment 1.1*

Direction

Step 1-Ask participants to refer figure 6and come up with conclusions about what the data shows.

Step 2-Summarize the exercise by presenting the points in attachment 1.1.

Figure 6: Median age at first marriage among women aged 20 - 49by region



Source: Ethiopian Demographic and Health Survey, 2011.

Female Genital Mutilation (FGM)

Activity 2: Exercise on FGM

1 hour

Materials:*Figure 7 and 8, FGM case study, flipchart paper and stand, marker, LCD Projector, and attachment 1.2*

Direction

Step 1- Ask participants to be in groups.
Step 2-Ask participants to interpret figure 7 and 8, and discuss the immediate and long term health risks of FGM.
Step 3-Then ask participants to discuss on FGM case study and present their views.
Step 4-Summarize the exercise using the points in attachment 1.2 using power point slides or flipchart.

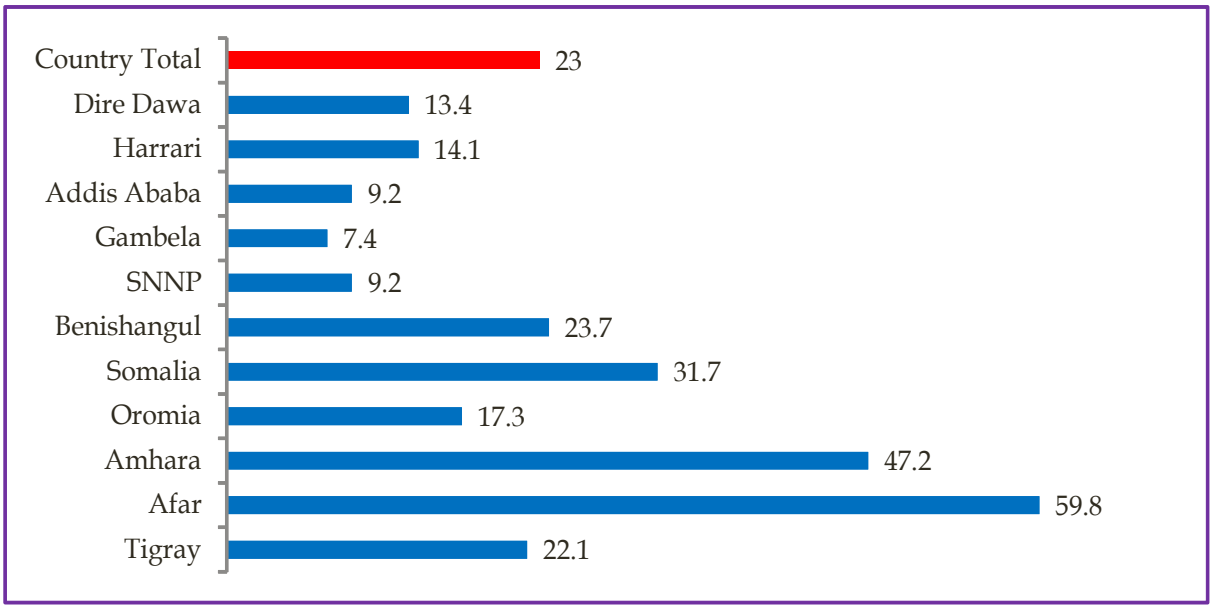
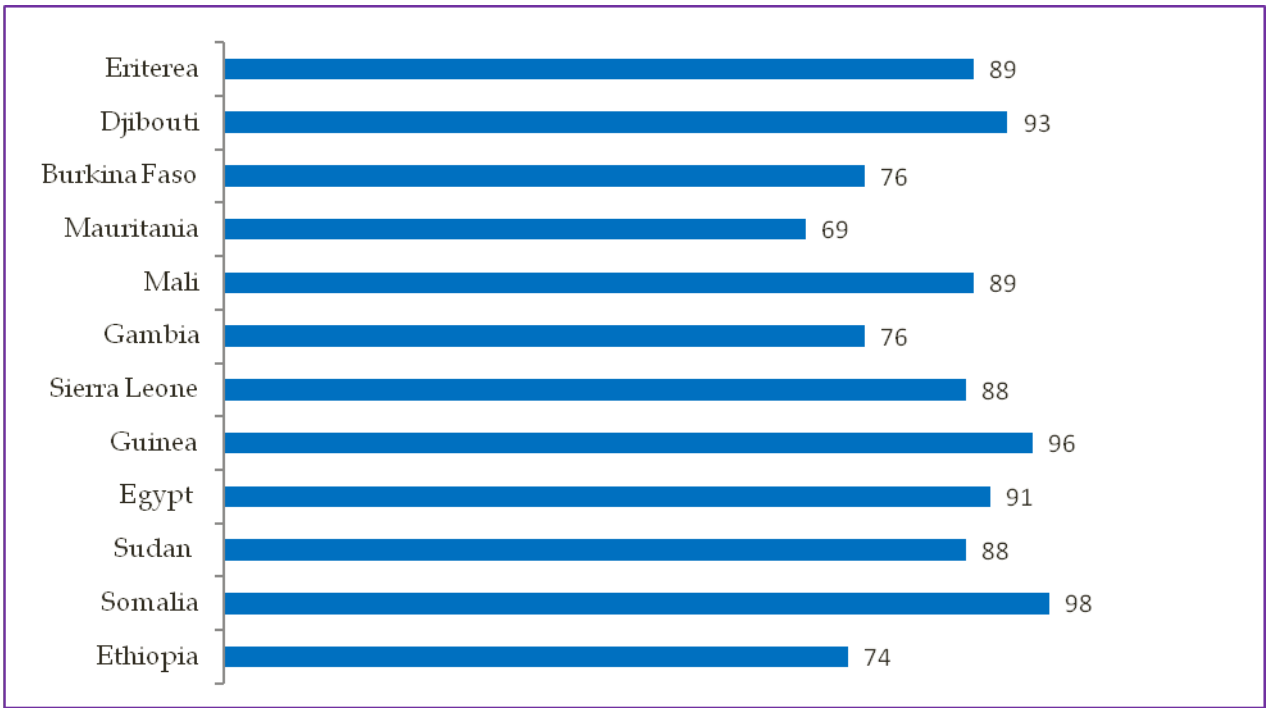


Figure 7: FGMfor children 0-14 years by region by percent

Source: Ethiopian welfare monitoring survey 2011. Central StatisticalAgency

Figure 8: Percentage of girls and women aged 15-49 who have undergone FGM/C, by country



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

Case study: Female Genital Mutilation/Female Genital Cutting

I have undergone FGM when I was 15 years old. I was told I had to get circumcised because my religion requires it. I couldn't refuse. I got married when I was 20 years old. I did not get to choose my husband. It was for my parents to decide the man I was going to marry. I got pregnant right after my marriage. Then the night of my labour came…it was very difficult and painful…There was no hospital nearby and transportation was inaccessible so I had to stay home and bear the pain of labour for two and half days. Finally my family carried me to the hospital. But it was too late for my baby, it was lifeless. In the process, I was damaged from the labour and developed fistula. I had urinary incontinence and was embarrassed from the awful smell. I was lucky thought, for I was among many women who had got support to get medical treatment. After three months of stay at the Addis Ababa Hamlin Fistula Hospital, I have recovered and I am looking forward to go back to my family.

Points for discussions:

1. What do you do if you were the victim?
2. What is your reaction if you are health care provider?
3. What should be done to stop the practice of FGMby*Woreda*/Regional health bureau head?
4. What do you expect from others?

Source: Adapted from Reference Manual on Harmful Traditional Practices. Prepare for use by health care providers. USAID, SIDA, Pathfinder

Note for the facilitators

Suggest the following points under each category.

Victim:

- Seek medical and legal attention.
- Teach and advocate for the eradication of the practice.

Health care provider:

- Provide medical care and psychological support.
- Ensure the victim attends postnatal care.

***Woreda*/Region health bureau head:**

- Include FGM as criteria in women development army and health extension workers teaching package and report checklist.
- Mainstream FGM issue in the Health Development Army community conversation.

Others:

- Work with media to enhance awareness.

- Work with religious leaders to advocate for issue.
- Work with community based organizations (idir, etc) to address the issue.

Fertility

Activity 3:Brainstorming exercise on fertility trend

30 minutes

Materials:*Figure 9, flipchart paper and stand, marker, LCD Projector, and attachment 1.3*

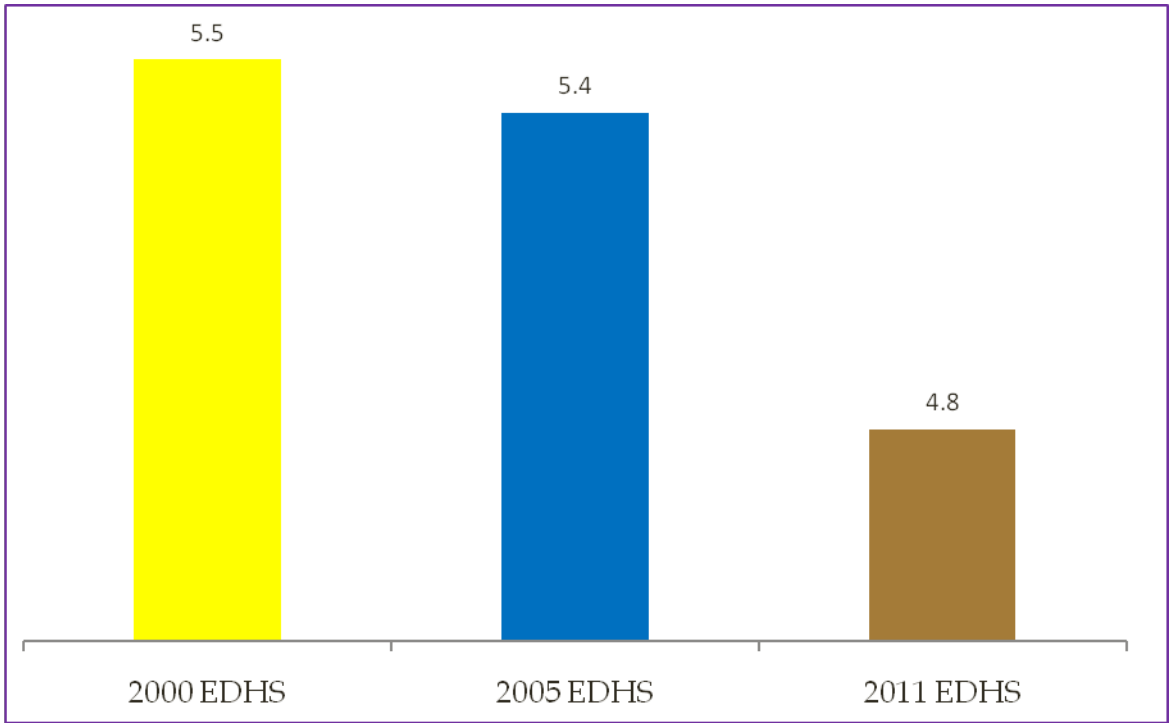
Direction

Step 1- Ask participants to refer figure 9 on the participant guide.

Step 2- Ask participants to brainstorm on what would change these averages or ask them to identify the major determinants of fertility.

Step 3-Summarize the exercise by referring to the handout in attachment 1.3 using a PowerPoint slide or flipchart.

Figure 9: Trend in Total Fertility Rate (TFR): births per woman



Note: Age specific fertility rates are per 1,000 women; rates for the 2005 EDHS

Source: Ethiopia Demographics and Health Survey, 2011.

Maternal Mortality

Activity 4: Exercise on causes maternal mortality

30 minutes

Materials:*Flipchart paper and stand, marker, LCD Projector, and attachment 1.4*

Direction

Step 1- Ask participants to be in groups and list some of the reasons why the maternal mortality rate is so high in Ethiopia (676 per 1000 live births), and why women do not use health services during pregnancy and delivery.

- Ask participants how and whether the health service is responding to the situation.
- Ask participants the percentage of pregnant women who deliver through hospitals, health centers, or trained assistants.

Step 2-Capture participants' responses on a flipchart.

Step 3- Summarize participants' responses by presenting the notein attachment 1.4 using a PowerPoint slide or flipchart.

Activity 5: Exercise on policy on maternal mortality

30 minutes

Materials:*Flipchart paper and stand, marker, LCD Projector, and attachment 1.4*

Direction

Step 1- Ask participants to identify the policies and actions taken by the government to reduce maternal mortality and list them on a flipchart.

Step 2-Summarize their answer using the description given in attachment 1.4 using a PowerPoint slide or flipchart.

Activity 6: Case analysis on maternal mortality

30 minutes

Materials:*Flipchart paper and stand, case story, marker, LCD Projector, and attachment 1.4*

Direction

Step 1- Ask participants to read the case study entitled, "No woman should die while giving birth."

Step 2- Then ask participants to discuss in pairs what health care providers/health institutions can do to increase the number of pregnant women vising health centers.

- Remind participants to come up with solutions that are practical and can be done at their level.

Step 3- Let participants report on the activity.

Case story: no woman should die while giving birth

In Ethiopia, a lack of awareness of the importance of skilled hospital deliveries, cultural beliefs and transport challenges in rural areas are causing a high number of deaths during childbirth. Mothers who did not attend health facilities while giving birth do not see the benefit of delivering in health facilities or abstain from going there by giving culture and beliefs as their reason. Many women prefer delivering at home in the company of known and trusted relatives and friends, where customs and traditions can be observed. Even though communities are aware of the dangers around childbirth, contingencies for potential complications are rarely discussed or made, such that most families hope or pray that things will turn out well. When things go wrong, precious time is lost in finding resources and human power to assist in the transfer to a health facility. In this process expectant mothers are exposed for maternity related death. Besides death, women and girls who miss out on skilled healthcare during delivery end up suffering other complications, including obstetric fistula.

The fact that majority of women did not appreciate the value of institutional delivery calls for a concerted effort to increase skilled birth attendance and postnatal care. To address this problem, health workers in Tigray region of Mehoni*Woreda* have designed a creative way of attracting pregnant mothers to health posts/clinics/hospitals so that they can have pre and post-natal care. These staff members are committed to the motto of "no mother should die while giving birth". With this inspiration, the health workers creatively tried to improve the situation in the health centers by identifying some of the factors that prevent expectant mothers from visiting health centers. One of the reasons they identified was the unique smell/odor of health centers/hospitals.

The health workers wanted to change the odor of health posts substituting a smell well known to the women. They have started to organize coffee ceremonies with all of the familiar components such as grass spread on the ground and incense. Porridge, a traditional food for pregnant mothers,is also being prepared and served to them. This has been reported to increase the number of pregnant women attending pre and post-natal care in the hospital as they have started to feel at home with the welcoming and accommodating environment that the health workers created.

If we want to meet our goal to reduce maternal mortality, we should be creative and address factors that prevent women from coming to health centers. What other innovative, simple but practical things can be done at the health centers and government level?

Source:FM 98.1 Morning Broadcast, 2013

Note for the facilitators

Suggestions to increase the number of pregnant women visiting health centers are:

- Establishment and functioning of maternity waiting homes within hospitals.
- Organize culture sensitive delivery practice.
- Use the existing 1-5 HDA structure to help women deliver in health centers.
- Consistent use of modern and traditional ambulance for such cases.
- Strength functional accountability mechanism to enhance professionalism and avoid negligence by health care providers.

Attachment 1.1: Early Marriage

- Early marriage is one of the cultural practices contributing to the low social and health status of women.
- The average age of first marriage for women in Ethiopia is 16, which is one of the lowest in the world.
- Men are encouraged to marry much later, at an average age of 23. This age gap between husband and wife contributes to significant power disparities at the household level.
- Confined to domestic duties from an early age, young women often experience significant psychosocial problems related to their lost mobility and inability to pursue educational or vocational opportunities.
- Almost half of all early marriages end in divorce or separation, with the newly separated woman often migrating to urban areas in search of work .There, many turn to commercial sex, significantly increasing their reproductive and sexual health risks.
- Reproductive health risks are also high for girls who remain married, as pregnancy-related complications are substantially higher in physically immature women.
- The most common health related consequences early marriages are: early and unwanted pregnancy, early child bearing, low baby's birth weight, prolonged labor,

obstructed labor, fistula, physical trauma (genital), and vulnerability to HIV infection.

Attachment 1.2: Female Genital Mutilation

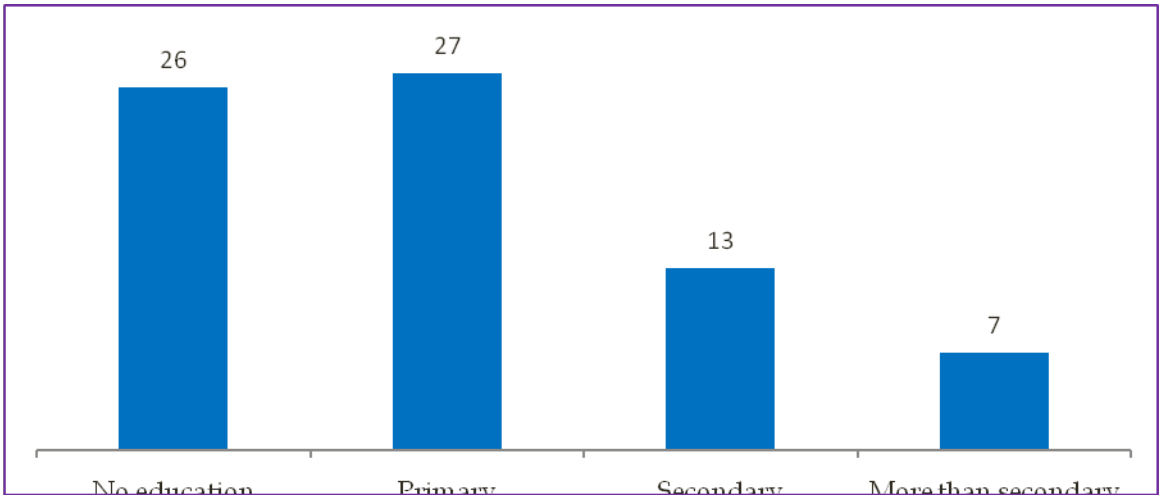
- Female Genital Mutilation is a harmful tradition being practiced all over the country.
- It is the cutting away parts of the female external genital for cultural and religious reasons.
- According to WHO FGM is classified into different types such as: Type I, II, III and IV.
- The practice results in complications depending on the expertise of the operator and the environment within which the operation takes place.
- The immediate health risk of FGM includes: pain and shock, bleeding, urine retention, infection, injury to neighbor organs, bone fracture following heavy pressure applied to the struggling girl, and death.
- The long term complication includes: gynecological complications, heavy scarring, labial fusion, cyst, hematocolpos (accumulation of menstrual blood caused by closure of the vaginal opening by scar tissue), painful menstruation, psychological complication, recurrent urinary tract infection, HIV and AIDS, fistula, and obstructed labor.

Attachment 1.3: Fertility

According to EDHS, 2011:

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

Figure 10: Unmet need for family planning by educational level: Percentage of married women age 15-49 with an unmet need for family planning



Source: Ethiopia Demographics and Health Survey, 2011

Attachment 1.4: Maternal Mortality

The maternal mortality ratio (MMR) in Ethiopia is very high. There are 676 maternal deaths for every 100,000 births. This compares with an average of 290 per 100,000 births in developing countries, and 14 per 100,000 in developed countries.[8]MDG 5 is committed to improvingmaternal health with a target of reducing MMR by three-quarters over the period 1990-2015, the data over the past five years shows no change.

Table 9:Status of maternal mortality in Ethiopia

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

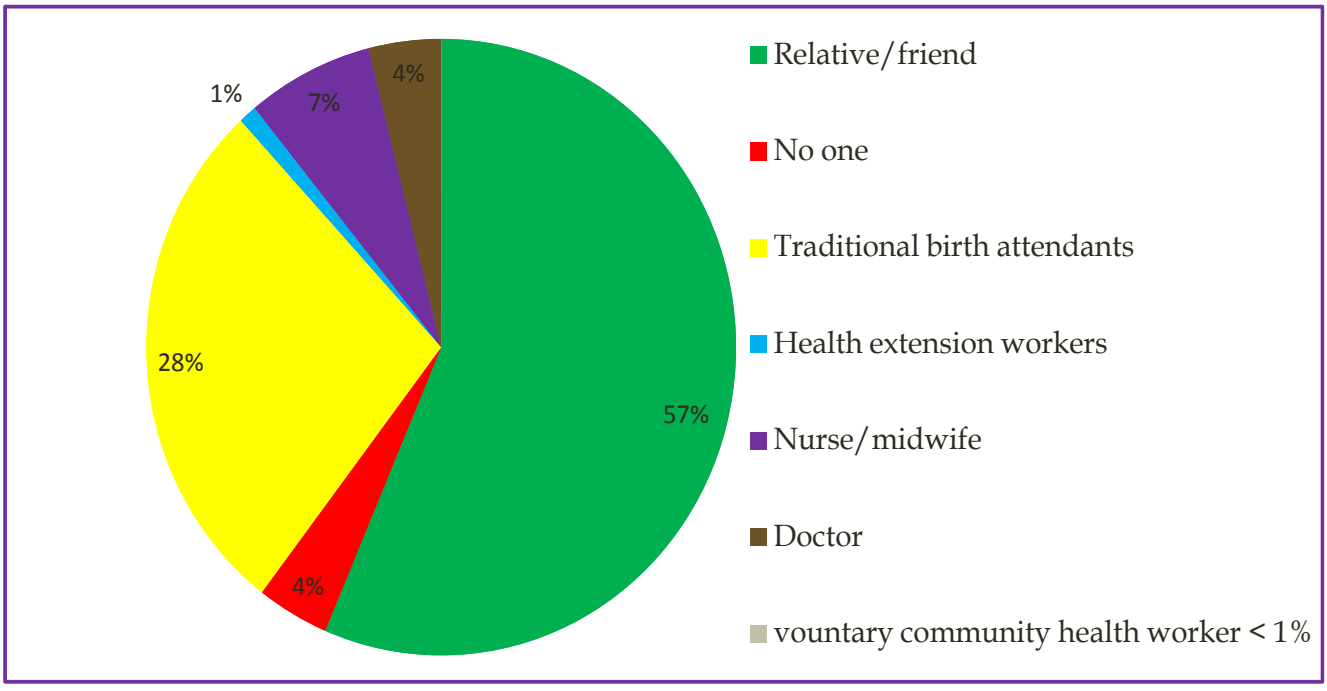
Source: Ethiopia Demographics and Health Survey, 2011

[8] World Health Organization

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

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

Figure 11:Assistance during delivery: percent distribution of births in the 5 years before the survey



Note: 10% of births were assisted by a skilled provider (4% Doctor and 7% nurse or midwife). All the figures have been rounded.

Source: Ethiopia Demographics and Health Survey, 2011

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

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

Session 4: Gender-Based Violence

Session duration: 2hours and 20 minutes

Session objectives

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

- Define gender-based violence (GBV).
- Identify the different forms of gender based-violence associated with partner/ husbands.
- Identify the prevalence of gender-based violence in Ethiopia.
- Describe the health risks of gender-based violence on women.

Activity 1: Brainstorming exercise on gender-based violence

25 minutes

Materials:*Flipchart paper and stand, marker, LCD Projector, and attachment 1.1*

Direction

Step 1-Ask participants to define gender-based violence and identify the various forms.
Step 2-Ask participants to discuss the health risks of GBV on women.
Step 3-Summarize the discussion by presenting the point inattachment 1.1 using PowerPoint slide or flipchart.

Activity 2: Exercise on factors contributing to GBV

40 minutes

Materials:*Flipchart paper and stand, marker, figure 12 and 13, LCD Projector, and attachments 1.1*

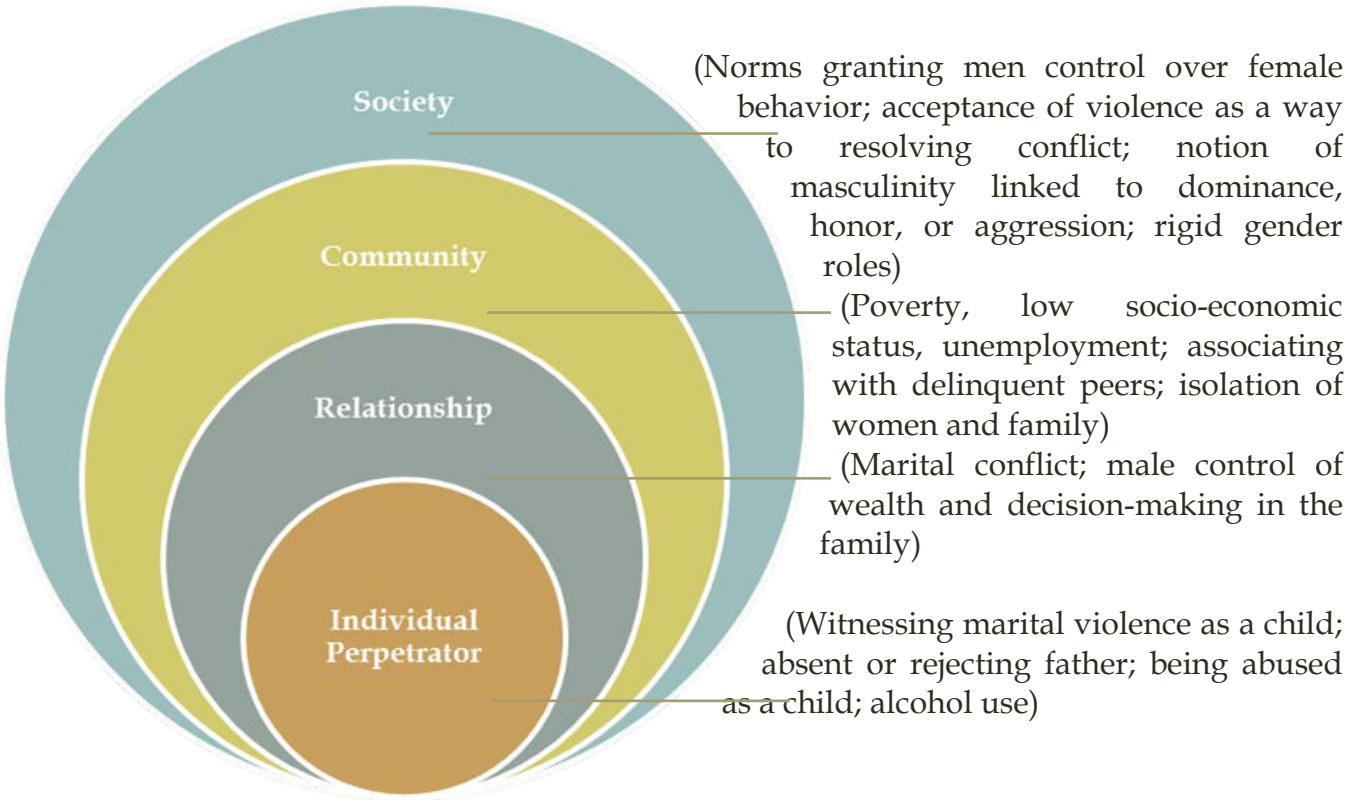
Direction

Step 1-Ask participants to be in pairs and discuss the factors that contribute to GBV.
Step 2-Ask participants toreflect on factors while the facilitator captures the key factors on a flipchart.
Step 3- Thenpresentfigure 12 to the participants using a PowerPoint slide/flipchart and ask them to discuss the model.

- During the discussion, help participants identify reasons why husbands abuse their partners, and capture their responses on flipchart.

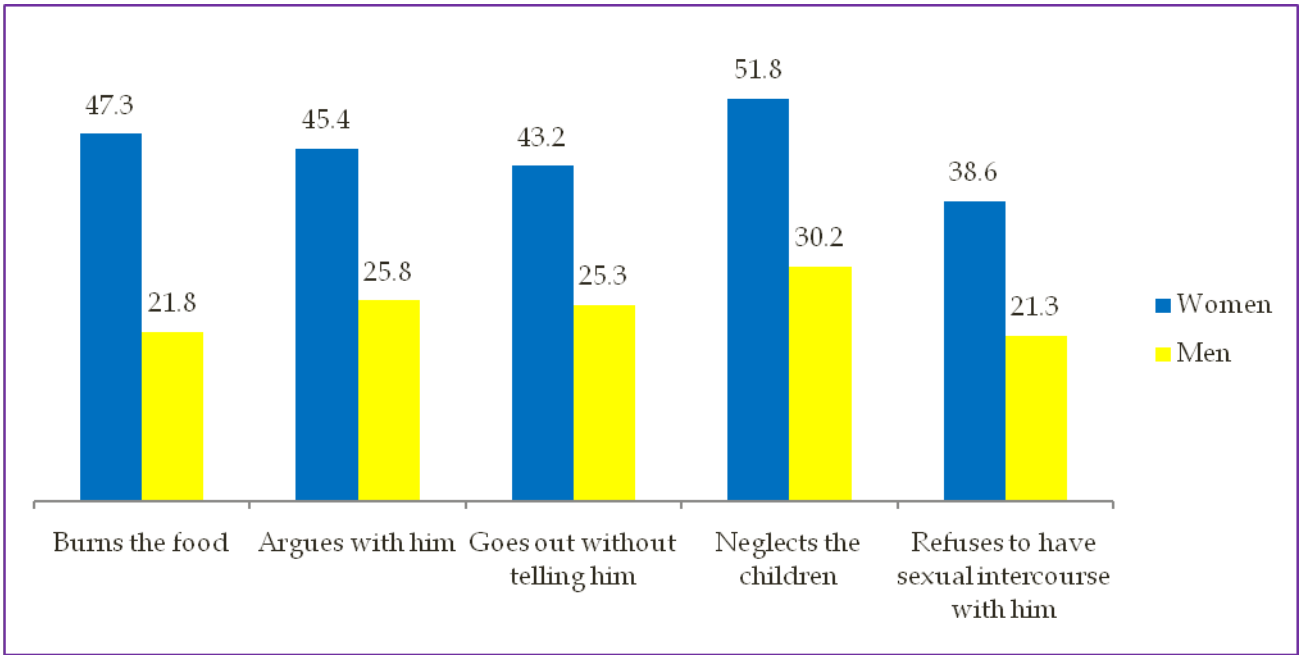
Step 4-Then present figure 13 on the attitudes of women and men regarding wife-beating using a PowerPoint slide or flipchart.
Step 5-Based on Figure 13, ask participants to analyze the differences in attitudes between men and women.
Step 6-Summarize the exercise by presenting the handout in attachment 1.1 using a PowerPoint slide or flipchart.

Figure 12: Ecological model of factors associated with partner abuse



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

Figure 13: Attitude of women and men towards wife beating: husband is justified in hitting or beating his wife if she:



Source: Ethiopia Demographics and Health Survey 2011

Activity 3: Exercise on women's awareness on laws against GBV

25 minutes

Materials:*Flipchart paper and stand, marker, LCD Projector, and table 10*

Direction

Step 1-Askparticipants to refer table 10 in their guide.
Step 2-Then ask participants to reflect on women's awareness of laws against GBV
Step 3- Askparticipants to identify what the government has done to prevent and address GBV.

Activity 4: Exercise on the case study of gender-based violence

Time: 25 minutes
Materials:Flipchart paper and stand, marker, GBV case study, and LCD Projector

Direction

Step 1- Ask participants to read the GBV case study found in their guide and discuss in groups.
Step 2-Let participants reflect on their view.
Step 3- Summarize the discussion using the points in attachment 1.1.

Case study: Gender-Based Violence

Violence against women is a significant public health problem, as well as a fundamental violation of women's human rights. Most of these abuses are perpetrated by very close, intimately related people, often the husband. In Ethiopia gender-based violence occurs under the pretext of tradition and culture and thus overlooked by the society. It appears to be accepted as a normal aspect of life, and the existing laws and policies have done little to address the matter. Sexual abuse, rape, marriage by abduction, early marriage, FGM, sexual harassment and intimidation at work, in education institutions, in police station and judiciary system, are common forms of violence faced by women in Ethiopia today. Ethiopia has one of the highest reports in the world of physical assault by male partners.

Regardless of the existence of the national laws (such as the constitution, revised family code, criminal code) and international conventions that Ethiopia is signatory (CEDAW and Beijing Declaration), public authorities have maintained a deafening silence on the subject of gender-based violence. Consequently, tolerance remains in legal, policing and medical policies and practices. Where there have been significant legislative innovations and policies, these have not been implemented, nor has their implementation even budgeted for.

Point for discussion:

- What action points do you recommend to improve the implementation of these important laws that Ethiopia designed to fight gender-based violence that is being witnessed every day?

Source: Adapted from National committee for Traditional Practices in Ethiopia, 2008, page 59

Attachment 1.1: Gender-Based Violence

- The 1993 Declaration on the Elimination of Violence against Women, the UN General Assembly defined the issue as "any act of gender-based violence that results in, or is likely sexual or psychological harm or suffering for women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life."
- Gender-based violence continues to be a significant and serious human rights and public health issue. Although GBV is acknowledged as a fundamental violation of human rights and a constraint to development, it is endemic throughout Ethiopia.
- GBV is a violence that involves men and women, in which women and girls are disproportionately affected from all cultures and socio-economic backgrounds. Women and girls tend to comprise the majority of GBV victims as itis derived from gender norms,roles,and unequal power relations between women and men.
- GBV takes many forms such as rape, domestic violence, sexual violence, emotional and psychological abuse, trafficking for forced labor or prostitution, sexual exploitation, sexual harassment, harmful traditional practices (e.g. female genital mutilation, early marriages, multiple marriage and forced marriage) and discriminatory practices based on gender.
- According to WHO GBV report of 2013, women who are physically or sexually abused by their partners' reports higher rates of health problems. For example, they are more likely to have low-birth-weight baby;unwantedpregnancy,abortion, infertility and gynecological problems; acquire HIV& STIs; experience mental health problems such as depression, anxiety or suicide; disability.
- Ethiopia has issued a relatively large amount of gender-friendly legislation and policies. These include the national women's policy, family and penal code, and other legislative as well as judicial acts. Despite the presence of these important policies and efforts exerted by civil society organizations, women in Ethiopia remain highly vulnerable and continue to suffer from violence and denial of their rights in one form or another. One of the reasons associated with this is lack of awareness of women towards policies againstGBV which is evident in table 10.

Table 10: Knowledge of the laws in Ethiopia against domestic violence

Percentage of women age 15-49 who know that there is a law in Ethiopia against wife beating	
Background characteristics	**% of women who know that there is a law against wife beating**
Age	
15-19	47.3
20-24	49.7
25-29	48.2
30-34	48.4
35-39	50.2
40-44	53.0
45-49	48.8
Residence	
Urban	61.7
Rural	44.9
Total	48.9

Source: Ethiopian Demographic and Health Survey, 2011

Additional reasons for husbands abusing their partners:

- In some communities, women are regarded as the property of their husbands and are accorded an "inferior" status.
- There is a perception that women "deserve" punishment because they are defined as minors and are seen to require corrective action.
- In poor households and where women have no control over income and are dependent on their spouses, they are more likely to be abused.
- Abuse of alcohol has been associated with partner abuse.
- Abuse can be due to traditional practices that continue even when there are laws against them such as early marriage, abduction, FGM, etc.
- A lack of awareness exists among men and/or women regarding the rights of women.
- Expectations exist in the community that women should be submissive and tolerate abuse.
- A lack of confidence in and/or a weak legal system may allow or even encourage this behavior.

Session 5: Gender and Mental Health

Session duration:1 hour and 40 minutes

Session objectives

At the end of this session, participants will be able to:
- Define mental health.
- Explain the relationship between gender inequality and mental disorder
- Identify strategies to promote mental health for men and women.

Activity 1: Brainstorming exercise for understandingmental health

20 minutes

Materials: *Flipchart paper and stand, marker, sticky-note, attachment 1.1, and LCD Projector*

Direction

Step 1-Give each participant a sticky note and ask themto write one thing that comes to their mind when mental health is mentioned and post it on the flipchart.

Step 2- Give short presentation about mental health using attachment 1.1.

Activity 2: Factors affecting mental health

30 minutes

Materials: *Flipchart paper and stand, attachment 1.2, LCD Projector, marker, and Sisay' s case*

Direction

Step 1- Ask participants to pair up and discuss on factors that contribute to the development of mental disorder for few minutes.

Step 2- Ask participants to referSisay'scasein their guide and identify factors that are responsible for her mental health disorder worsening and reoccurrence.

Step 3-Allow participants to share output of their discussions.

Step 4- Wrap up the discussion by explaining factors affecting mental using the handout on attachment 1.2.

Case study: A woman with mental disorder

Sisay is a woman with a mental health problem. Since Sisay did not get proper attention and care from her families, she started her living in the streets where she was raped and became pregnant as a result. After a while, when she went back to her families, they brought her to Amanuel specialized mental hospital.

In the hospital, Sisay was diagnosed for HIV positive, and her child died during delivery. Sisay's condition got worse due to her burdened situation, and it was a must for her to stay in the hospital to recover. During her stay in the hospital, no family member has come to see how she is doing.

Sisay's mental health condition has showed improvement after she was taken care of in the hospital. Hence, the hospital informed her families to take out of the hospital. However, her families confirmed that they have no daughter by the name of Sisay. Even if the hospital consistently attempted to reach Sisay's family via telephone, they were not able to reach them as the phone was switched off. The hospital took the next step, and went to Sisay's parents via vehicle and negotiated with them to take in their daughter.

Within days after Sisay reunited with her families, her mental health disorder reoccurred and she went out to the streets again. Sometimes she goes to the hospital and spends her day. Even if Sisay's mental health was showing progress after being treated, her situation relapsed due to lack of family understanding and support, the traumatic rape experience, the consequent HIV infection, death of her child, lack of suitable living space, and in ability to consistently take her treatment at the hospital**.**

Note: The real name of the woman in the story has changed for ethical reason.

Source: Amanuelspecialized mental hospital, gender office, 2013

Activity 3: Exercise on the relationship between gender and mental health


25 minutes

Materials:*Markers, LCD Projector, and attachment 1.3*

Direction

Step 1- Ask participants to be in pairs.
Step 2- Ask participants tobrainstormifgender affects mental health for men and women differently.
Step 3- Invite each pair of participants to share idea to the plenary.
Step 4- Conclude the discussion by presenting the handout on gender differences in mental health (Attachment 1.3)

Activity 4: Exercise on mental health interventions


25 minutes

Materials: *Flipchart paper and stand, marker, LCD Projector, attachment 1.4, and module evaluation sheet*

Direction

Step 1-Ask participants to identify interventions to promote mental health of women and men.
Step 2-Capture participants' response on a flipchart.
Step 3-Summarize the discussion by presenting the handout on attachment 1.4.
Step 4-Evaluate the module throughmodule evaluation sheet.

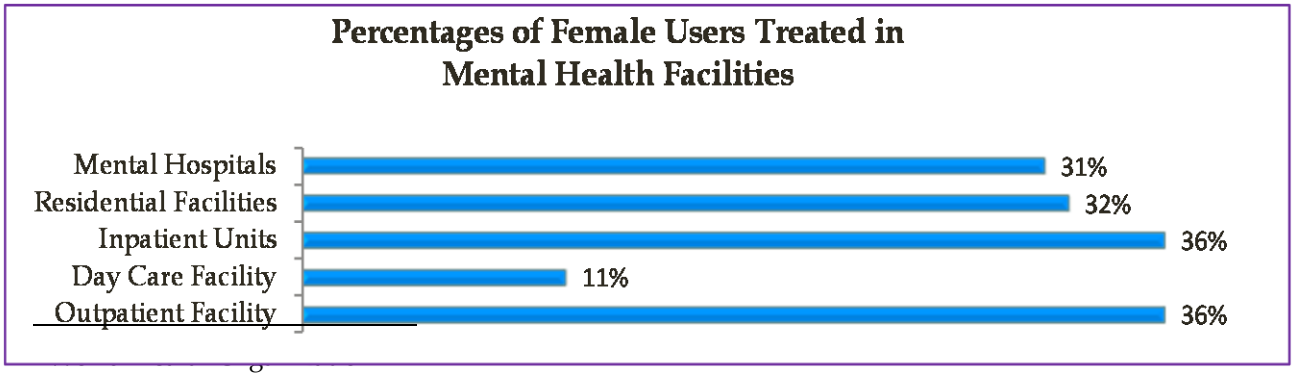
Attachment 1.1: Understanding Mental Health

Mental health is a state of well-being in which the individual realizes his or her own abilities; can cope with the normal stresses of life; can work productively and fruitfully; and is able to make a contribution to his or her community. The conditions ranges from more common problems such as excessive fear and worry (anxiety) or unusually sad mood (depression), to more severe behavioral problems such as suspiciousness, violence, nervousness and other unusual behaviors (psychosis)[9].

A mental disorder can be a brief episode or it may be a long-term persistent condition. Communities often have false beliefs about mental disorders, including what they are, what causes them, and how to respond to a person experiencing a mental disorder. Consequently, many people with mental disorders experience stigma and discrimination that results in delays in seeking appropriate help for the problem; distress for the affected person and their family; and ongoing social and economic exclusion for the affected person and their family.

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

According to the 2006 WHO-AIMS report, approximately 1.7% of Ethiopia's health expenditure for 2004 was spent on mental health. The country has 53 psychiatric outpatient facilities, 6 inpatient facilities and one mental hospital. However, majority of users of mental health facilities are males, and mental health services are a limited for women, children and people who do not live in the city. For instance, out of 1235 patients in Amanuel mental hospital only 31% of patients treated were female.



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

Attachment 1.2: Factors Affecting Mental Health

There is rarely one single cause of a mental disorder. Most mental disorders are caused by a combination of factors including[10]:

- Stressful life events/social factors e.g. gender discrimination, family conflicts, unemployment, stressful work conditions, death of a loved one, infertility, having a baby, sexual or physical violence, poverty which is associated with low levels of education, poor housing, and low income.
- Biological factors e.g. genetics, brain injury, chemical imbalance in the brain, chronic medical problems such as heart or kidney failure, and medication.
- Individual psychological factors e.g. poor self-esteem and negative thinking.
- Adverse life experiences during childhood e.g. abuse, emotional neglect, social exclusion, early death of parents or other traumatic experiences, drug and alcohol abuse.

Attachment 1.3: Gender Differences in Mental Health

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

A better way to understand women's health involves looking at a woman's life comprehensively. Throughout their life cycles, women experience tremendous mental health burdens created by poor social and environmental circumstances such as:

- Gender discrimination (e.g. Preference for male children to keep male line and inheritances in patrilineal society),
- Physical and sexual violence,
- Lack of access to appropriate physical and mental health care and nutrition,
- Low education and high rates of illiteracy,
- Low income, insecure job conditions and unpaid labor,
- Multiple roles and the burden of being the family caretaker,
- Difficult family and marital relationships,
- Low quality housing and dangerous neighborhoods,

[10] Adapted from, an introduction to mental health: facilitator's manual for training community health workers in India. 2009

- Limited opportunities for power and decision making , and
- Migration and displacement

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

Attachment1.4: Interventions for Promoting Women's and Men's Mental Health

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

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

Specific ways to promote mental health include:

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

Module 2EvaluationSheet

	Aspects I liked most	Aspects I liked least	New things I learnt	Suggestion for improvement
Content				
Methodology				
Facilitation				

Module 2 References

_____ (2003).*Adolescent and youth reproductive health HEAT module*.From http://www.stopvaw.org.

_____ (2009).*An introduction to mental health: facilitator's manual for training community health workers in India*. University of Melbourne

Central Statistics Agency and ICF International (2012).*Ethiopia demographics and health survey 2011*. Addis Ababa Ethiopia.

Dawit A., Eshetu W., Masresha G., Misganaw B., &Atsinaf M. (2005).*Module on harmful traditional practices.*Awassa College.

MIS (2012).*Ethiopia National Malaria Indicator Survey 2011*.The Ethiopian Health and Nutrition Research Institute and Partners.

Patel V. (2003).*Where there is no psychiatrist. A mental health care manual*.London, Royal Collage of Psychiatrists

USAID, SIDA, Pathfinder&JSI.*Referencemanual on harmful traditional practices: prepared for use by health care providers.*

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

WHO (2006).*Assessment Instrument for Mental Health Systems report on mental health system in Ethiopia.* Addis Ababa, Ethiopia.

WHO (2010).*World Health Organization factsheet on mental health.*

WHO (2013).*Global and regional estimates on violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.*

World Bank (1994).*A new agenda for women's health and nutrition.*

Yayehyirad K., Fesseha H. &Amare D. (2008). *Ethiopia harmful traditional practices.*(2nded.). Addis Ababa.

MODULE 3

MODULE 3: GENDER MAINSTREAMING

Description

Module three provides an overview of the concept of gender mainstreaming, identifies techniques, tools and steps of the process. It consists of three sessions designed to provide participants a basis to better understand the subsequent modules on gender analysis and gender audit.

Session 1: Understanding Mainstreaming

Session duration:1hour

Session objectives

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

- Describe the concept of gender mainstreaming.
- Identify the tools and techniques of gender mainstreaming
- Identify the steps and process of gender integration
- Describe the importance of gender mainstreaming as mechanism for promoting gender equality in the health sector.

Activity 1: Brainstorming exercise on gender mainstreaming

40 minutes

Materials:*LCD Projector, flipchart paper and stand, marker, and attachment 1.1*

Direction

Step 1- Ask participants to organize themselves into three groups.
Step 2- Instruct each group to take one of the issues described below for discussion:

- Why gender mainstreaming is essential for the health sector.

- Prerequisites for successful gender mainstreaming.
- Challenges of gender mainstreaming.

Step 3-Let participants present to the plenary.

Step 4-Summarize the discussion referring to the handout on understanding gender mainstreaming using a Power Point slide or flipchart (Attachment 1.1).

Attachment 1.1: Understanding Gender Mainstreaming

In July 1997, the United Nations Economic and Social Council (ECOSOC) defined the concept of gender mainstreaming as follows:

"Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making the concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres, so that women and men benefit equally, and inequality is not perpetuated. The ultimate goal of mainstreaming is to achieve gender equality"[11]

The mainstreaming definition has two components: programmatic (operational) and institutional gender mainstreaming.

Programmatic (operational) gender mainstreamingsystematically applies gender analysis methods to health problems to better understand how gender norms, roles andrelations affect the health of women and men across the life course.

Institutional gender mainstreamingexamines how organizations function: policy development and governance, agenda-setting,administrative functions and overall system-related issues. It includes organizational procedures and mechanisms such as staffing, functions or governance such as recruitment and staff benefitspolicies(e.g. establishing work-life balance;sex parity and gender balance in staffing;equal opportunities for upward mobility; andmechanisms for the equal participation of male and female staff in decision-making procedures).

Gender mainstreaming for the health sector is very significant for the following reasons:

- It indicates how health problems affect women and men of all ages and groups differently;

[11]World Health Organization (2011).Gender mainstreaming for health managers: a practical approach.Participant note.

- It uses women's empowerment and women-specific conditions to address historic and current wrongs women and girls face;
- It examines how gender norms, roles and relations influence male behavior and health outcomes and how these shape the role of men in promoting gender equality;
- It adopts a broad equity approach to look at issues of age, socioeconomic status, ethnic diversity, autonomy, empowerment, sexuality, etc. that may lead to inequities;
- It provides evidence to enable appropriate, effective and efficient health planning, policy-making and service delivery.
- It is essential for securing human rights and social justice for women as well as men in the health sector.
- It can reveal a need for changes in goals, strategies and actions to ensure that both women and men influence, participate in, and benefit from health systems.
- It can lead to changes in organizations—structures, procedures and cultures—to create organizational environments which are conducive to the promotion of gender equality.
- It calls for transforming the public health agenda, including the participation of women and men in defining and implementing public health priorities and activities. This will ensure that their needs are subsequently met.
- It addresses programme issues, such as how certain diseases or health problems may affect women and men differently, and the process of how institutions are organized to deliver programmes and services in accordance with the principles of gender equality.

Prerequisites for a successful gender mainstreamingin healthsectorare:

- Political will;
- Gender equality policy framework or separate gender equality policies;
- Structures and mechanisms to support gender issues and enforce commitments to gender equality (including "gender machinery"[12]);
- Civil society engagement, along with gender expertise in civil society;
- Availability of sex-disaggregated data
- Knowledge of gender relation and current research on gender equality;
- Accountability and evaluation frameworks;
- Necessary funds and human resources;
- The participation of women in political and public life and decision-making; and
- The involvement of both women and men.

Challenges of gender mainstreaming at all levels include:

[12] Refers to the formal government structures assigned to promote gender equality and/or improve the status and rights of women.

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

Session 2: Tools and Techniques of Gender Mainstreaming

Session duration:1 hour

Session objective

At the end of this session, participants will be able to:
- Identify the various techniques and tools that are used for gender mainstreaming.

Activity 1: Brainstorming exercise on gender mainstreaming tools/techniques

40 minutes

Materials:*LCD Projector, sticky-notes,flipchart paper and stand, marker, and attachment 1.1*

Direction

Step 1-Distribute sticky-notes of different colors to participants.
Step 2- Ask each participant to write one gender mainstreaming tool/technique in one sticky-note paper and post it on flipchart paper.
Step 3-Summarize the exercise by presenting the handout in attachment 1.1 using Power Point slide or flipchart.

Attachment 1.1: Tools and Techniques of Gender Mainstreaming

Prior to describing the various techniques and tools available, it is useful to clarify the terms used and the way in which they relate to each other. In this context, techniques and tools are defined as groups or types of means to put the gender mainstreaming strategy into practice, i.e. (re)organize, improve, develop and evaluate policy process in order to incorporate a gender equality perspective. The techniques and tools are separated into three main sets: analytical, educational, consultative, and participatory.

Table 11: Summary of gender mainstreaming techniques and tools

Analytical techniques and tools are:	o Includes those delivering information necessary for the development of policies and those which can be used in the policy process itself. o Gender analysis, gender audit, checklists and statistics split up by sex o Surveys and forecasts regarding gender relations o Cost-benefit analyses from a gender perspective, guidelines and terms of reference o Research in gender studies and gender impact assessment o Monitoring, comprising regular reporting and meetings
Educational techniques and tools are:	o Contain awareness-raising and transfer of knowledge o Awareness-raising and training courses o Follow-up action via post-training follow-ups, meeting or mentoring o Special experts joining a unit for some time/flying or mobile experts o Manuals/handbooks (to be used during and after the training) or booklets and leaflets for the general public o Educational material for use in schools
Consultative and participatory techniques and tools are:	o Makes gender equality experts and other experts work together o Think tanks, working or steering groups o Participation of both sexes in decision-making o Conferences, seminars, aimed at informing the public and those concerned by the policies o Hearings (to help people participate in the policy-making process)

Session 3: Gender Integration Processes

Session duration:1hour and 30 minutes

Session objectives

At the end of this session participants will be able to:

- Explain the components of gender integration scale or continuum.
- Identify gender integration steps.

Activity 1: Exercise on gender integration continuum

40 minutes

Materials:*LCD Projector, flipchart paper and stand, marker, figure 14, and attachment 1.1*

Direction

Step 1-Ask participants to form groups of five.
Step 2-Ask each group to explain one component of gender integration referring tofigure 14 displayed using LCD projector.
Step 3- Let the group representatives present the output of their discussion.
Step 4-Wrap up the exercise by presenting the handoutgiven in attachment 1.1 using a Power Point slide or flipchart.

Activity 2: Exercise on gender integrationsteps

50 minutes

Materials: *LCD Projector, flipchart paper and stand, marker, figure 15,role-play, annex 4, attachment 1.2, and module evaluation*

Direction

Step 1-Ask participants to form groups of five and tell them to identify the steps of gender mainstreaming in programs.
- Give participants 15 minutes to work out the first question.

Step 2-Then ask participant to refer figure 15in their guide and check if their responses are in line with diagram.

Step 3-Ask participants to read the role-play scenario below and volunteers to work on it.

Step 4-Ask the volunteers to perform the role-play and tell the rest of participants to take note of the role-play.

Steps 5- Congratulate volunteers and ask the rest of participants to give feedback and additional viewpoints.

Step 6- Summarize the exercise by using the checklist in attachment 1.2.

Step 7-Ask participants to refer the FMOH gender mainstreaming guideline checklist (annex 4) for further information on how to mainstreaming gender.

Step 8-Then evaluate participants understanding of the module using the evaluation sheet.

Role-Play Scenario

The Federal Ministry of Health has been engaged in constructing, upgrading equipping health facilities as major activity of its health sector development plan. In line with this, the ministry has further plans for new health facility constructions, expansions, rehabilitation, and furnishing. Accordingly, a meeting was organized where key stakeholders including the gender directorate were invited to provide their inputs on how to construct better health facilities that address the need of women and the disabled.

The problem: most health facilities constructed both in urban and rural areas is neither gender-sensitive nor easily accessible for the disabled.

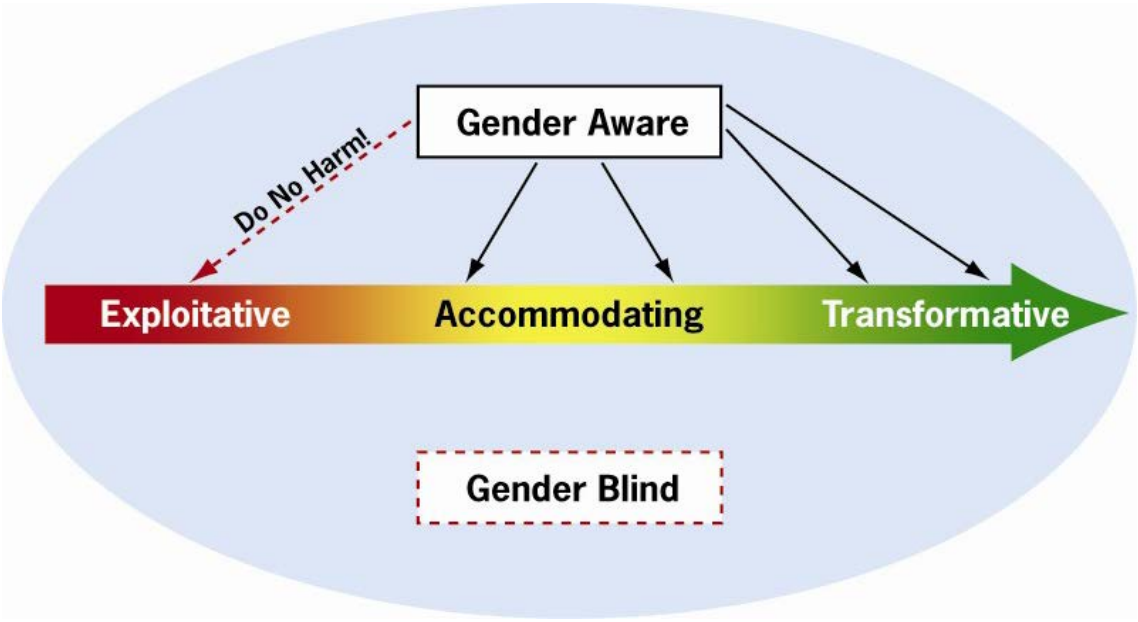
Based on the roles listed below and suggest points to make the health facilities gender and disability – sensitive:

1. *Woreda* health office head
2. Ministry gender officer/director
3. Engineer
4. Plan and policy officer
5. Resource mobilization officer
6. Community representative

Attachment 1.1: Gender IntegrationContinuum/Scale

The gender integration continuum is a tool implementers can use to integrate gender into their programs/policies. The Interagency Working Group on Gender (IGWG) has developed the gender integration conceptual framework to guide various projects on how to integrate gender. This framework categorizes approaches by how theytreat gender norms and inequities in the design, implementation, and evaluation of program/policy. As depicted in figure 14, the gender integration continuum graphic, the circle depicts a specific program environment.

Figure 14: Gender integration continuum/scale



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

Table 12: Summary of gender integration continuum/scale

Gender Blind	o Refers to the absence of any proactive consideration of the larger gender environment and specific gender roles affecting program/policy beneficiaries.
Gender Aware	o Refers to the explicit recognition of local gender differences, norms, and relations and their importance to health outcomes in program/policy design, implementation and evaluation.

Gender Exploitative	o Refers to approaches to program/policy design, implementation, and evaluation that take advantage of existing gender inequalities, behaviors, and stereotypes in pursuit of health and demographic outcomes. o It supports unequal power in the relations between women and men, and potentially deepens existing inequalities.
Gender Accommodating	o Refers to approaches to project design, implementation, and evaluation that adjust to or compensate for gender differences, norms, and inequalities. o It does not deliberately challenge unequal relations of power or address underlying structures that perpetuate gender inequalities.
Gender Transformative	o Refers to approaches that explicitly engage women and men to examine, question, and change institutions and norms that reinforce gender inequalities. o It helps to achieve both health and gender equality objectives.

Awareness of the gender context is often a result of a pre-program/policy gender analysis. Gender aware contexts allow program staff to consciously address gender constraints and opportunities, and plan their gender objectives.Hence, program/policy planners and managers should follow two gender integration principles in pursuit of health outcomes:

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

Attachment 1.2: Gender Integration Steps

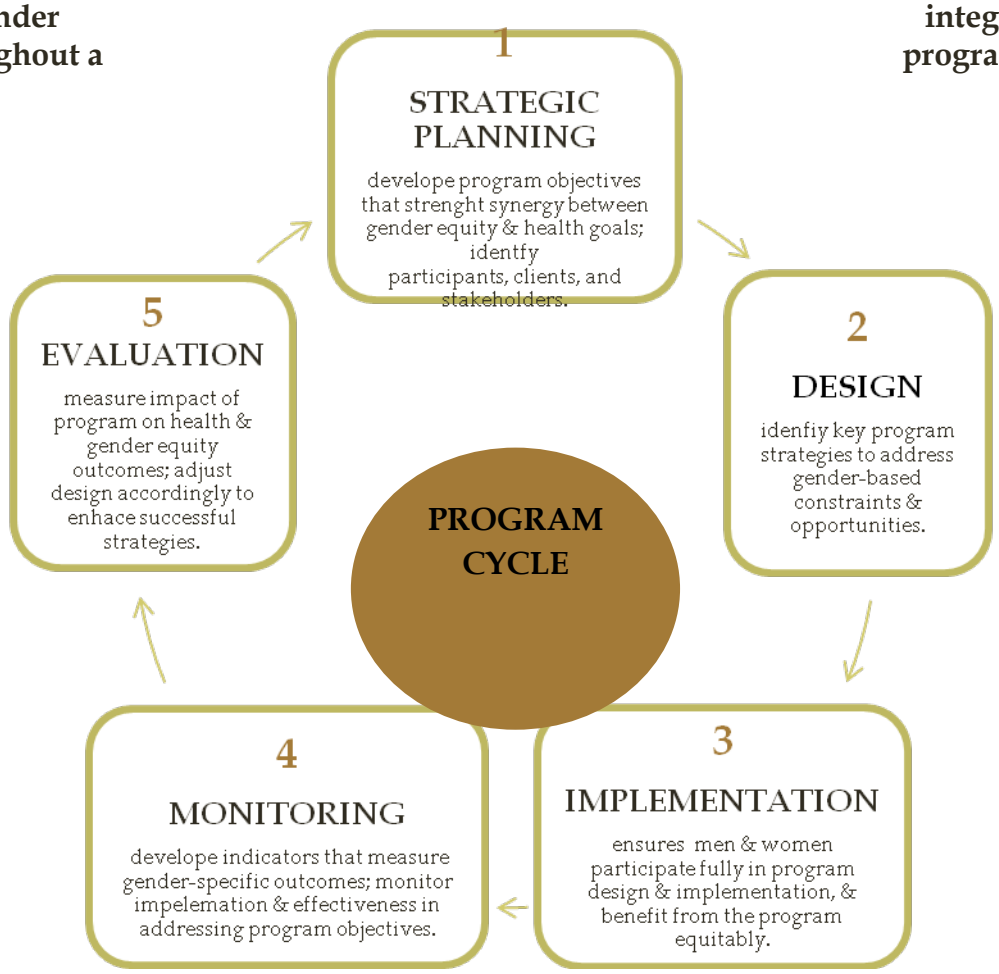
Incorporating a gender perspective in programs involves a series of steps that are sequential. Gender analysis is the foundation of gender integration as it informs gender at each stage of the program cycle. Hence, agender-integrated program is flexible, receptive to feedback on progress and problems, and responsive to changes.

Steps to gender-integrated programs are:

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

2. **Design:**provides an opportunity to address gender through the design program approaches, interventions, and activities of the programs to support achievements of health and gender equity objectives. Program design should take into account the findings of a gender analysis.
3. **Implementation:** implementation strategies are essential opportunities for promoting gender equity and gender equality. It ensures that men, women, girls and boys participate fully in program design and implementation, and that they benefit from the program equitably.
4. **Monitoring**: develop indicators to measure gender-specific outcomes, especially the alleviation of gender-based constraints and application of opportunities; collect baseline data to impact indicators and regularly monitor process indicators
5. **Evaluation**: collect end-line data and analyze differences between baseline and end-line to assess the effectiveness of program elements designed to address gender issues. Re-examine gender analysis, identify any constraints not anticipated at the beginning, and adjust design and activities based on monitoring and evaluation results.

Figure 15: Strategic steps for integration gender throughout a program cycle



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

Table 13: Examples of gender mainstreaming checklist in public health infrastructure

There are a number of gender issues relevant across all infrastructure sectors. Planners and decision makers must know and understand these if they are to respond to the needs, interests and priorities of both women and men. Some of the key gender issues include:

- Different roles and responsibilities of women and men, leading to different needs and preferences of women and men for the infrastructures.
- Differences in access to(use, affordability and availability) and control of (income) health infrastructure facilities and services.
- Differences in women's and men's participation and decision-making process of construction, operation and maintenance of health facilities.

Hence, health infrastructure projects have consider a number of gender issues displayed below

- Does the construction company have personnel with gender awareness? / Is the gender officer of the *Woreda* and the Ministry involved in the health facility project design?
- Has the project consulted women or women organizations operating in the areas on the design, location, and maintenance of the infrastructure?
- Do the infrastructure agencies have capacity to plan, design, implement and monitor programs/project in order to address concerns and issues of women?
- Do women give inputs to the design and operation of the infrastructure?/ Have both women's and men's needs been considered in the design of the project/program?
- Will the project provide opportunities for women to be employed in the construction or operation and maintenance of the public health infrastructure?/Does the construction of the health facility give equal employment opportunity?
- Will the infrastructure be accessible to women and men living in poverty (in terms of cost of travel to and from the location of the health facility anduser fee or cost of the health facility)?
- Is the health facility/building design convenient for pregnant women and disable persons.
- Does the project design have separate safe and environment-friendly toilets for women and men?
- Is the toilet facility child-friendly with accessories that can help for sanitary pads change, etc.

- Is the location of maternity-ward carefully selected to address the needs of pregnant women?

Source: Adapted from checklist for gender mainstreaming in the infrastructure sector. African Development Bank Group. January 2009.

Module 3Evaluation Sheet

	Aspects I liked most	Aspects I liked least	New things I learnt	Suggestion for improvement
Content				
Methodology				
Facilitation				

Module 3 References

African Development Bank Groups (2009).*Checklist for gender mainstreaming in the infrastructure sector.*

Council of Europe (1998).*Gender mainstreaming: conceptual framework, methodology and presentation of good practices.Final report of activities of the group of specialists on mainstreaming*. Strasbourg.

FHI 360 (2012).*Gender integration framework: how to integrate gender in every aspect of our work.*

McBride, Dorothy, & Mazur A. (2011).*Gender machineries worldwide*. World development report 2012.

Ministry of Women, Children and Youth Affairs.*Gender training manual and modules package.*

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

USAID and IGWG (2009).*A manual for integrating gender into reproductive health and HIV programs: from commitment to action* (2nd ed.).

World Health Organization (2011).*Gender mainstreaming for health managers: a practical approach.*

MODULE 4

MODULE 4: GENDER ANALYSIS

Description

Module four is designed to strengthen the capacity of health workers to conduct gender analysis so that gender issues are reflected in policy, programs, and activities of the health sector. It consists of three sessions on understanding gender analysis, the frameworks and tools used in conducting a gender analysis, and gender-sensitive monitoring and evaluation.

Session 1: Understanding Gender Analysis

Session duration: 1hour and 10 minutes

Session objectives

At the end of this session participants will be able to:
- Explain the concept gender analysis
- Clarify the importance of gender analysis to public health

Activity 1: Brainstorming exercise to understand gender analysis

30 minutes

Material: *Flipchart paper and stand, LCD Projector, marker, and attachment 1.1*

Direction

Step 1- Ask participants to define gender analysis.
Step 2- Ask participants why a gender analysis is important to ensure good health and health outcomes.

Step 3-List the definitions and the reasons on a flipchart paper.
Step 4-Wrap up the brainstorming exercise by referring to the handout in attachment 1.1 using PowerPoint slides or a flipchart.

Attachment 1.1: Understanding Gender Analysis

Definition:

- It is a process that assesses the differential impact of proposed and/or existing policies, programs and legislation on women and men.
- It identifies, assesses and informs actions to address inequality that stems from: gender norms, roles and relations; unequal power relations between and among men and women; and the interaction of contextual factors with gender, such as ethnicity, education or employment status.
- It is a methodology for collecting and processing information about gender. It provides disaggregated data by sex and an understanding of the social construction of gender roles and how labor is divided and valued.
- It is one of the core gender mainstreaming tools that generates and processes information needed for health planning and programming. It includes critical questions that dig for information where it is often not easily found.

What does gender analysis in health do?

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

Why is gender analysis important in health?

- It contributes to the understanding of differential health risk factors; exposures and manifestation of disease; difference in severity and frequency of disease; responses of the culture and society to health problems.
- Ithighlights differences in access to: health care and resources; information; transportation; communication and services; and decision-making processes.

How can gender analysis increase health sector effectiveness?

- It ensures the right to health of different groups of men and women
- It identifies practical and strategic gender needs in health

- It recognizes and reduces the constraints women and girls face in protecting and promoting their health
- It considers and addresses how male gender norms, roles and relations may harm the health of men and boys
- It reduces inappropriate and ineffective services, programmes or policies that ignore the realities of women's and men's health needs and life conditions
- It identifies and reduces gender bias in the health system
- It develops and implements gender-responsive policies, laws, programmesand services
- It improves health information, documentation and use

Session 2: Gender Analysis Frameworks and Tool: Gender Analysis Matrix

Session duration: 3hours and 25 minutes

Session objectives

At the end of this session participants will be able to:

- Identify the different types of gender analysis frameworks and tools.
- Describe the components of gender analysis matrix.
- Conduct gender analysis using gender analysis matrix to analyze a health problem or issue.

Activity 1: Exercise ongender analysis frameworks and tools

25 minutes

Material: *Flipchart paper and stand, LCD Projector, marker, sticky-notes, and attachment 1.1*

Direction

Step 1- Distribute sticky-notes to participants and ask them to write different types of gender analysis tools and stick it on flipchart.

Step 2-After they have completed, discuss on the different types of gender analysis tools.

- Then inform participants that gender analysis matrix will be used for the health sector.

Step 3-Wrap up the discussion by presenting the handout on gender analysis frameworks and tools (Attachment 1.1)

Activity 2: Activity on gender analysis matrix

30 minutes

Material: *Flipchart paper and stand, LCD Projector, marker, table 14, and attachment 1.2*

Direction

Step 1- Have a brief discussion on gender analysis and health. While doing so,

- Emphasize that conducting a gender analysis in health refers to examining how gender inequality affects the health and wellbeing of men and women.
- Inform participants that a health gender analysis examines the interaction of biological and socio-cultural factors and their influence on health outcomes and services.
- Highlight how gender inequality negatively affects the health of women and girls.
- Discuss that health risks and problems among men and boys as a result of gender norms in roles and relations.

Step 2- Then ask participants to explain what health risks and vulnerabilities, ability to access and use health services, and health outcomes mean.

- Remind participants to use table 14 for their discussion.

Step 3-Capture participants' response on a flipchart and summarize the exercise by presenting the handout in attachment 1.2 (table 14)using PowerPoint slides or a flipchart.

Table 14: Gender analysis matrix for analyzing a health issue or problem

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

outcomes/ Consequences of healthproblems (economicand social, including attitudinal)			

Activity 3: Exercise on gender analysis of HIV/AIDS using gender analysis matrix

1 hour

Material: *Flipchart paper and stand, LCD Projector, marker, annex 2, table 14, and attachment 1.3*

Direction

Step 1-Ask participants to organize into three large groups to discuss and fill out table 14 using HIV and AIDS as a health problem.

- Remind participants to use table 14 for the exercise.
- Inform participants to refer annex 2 to see resources that need to be considered during gender analysis.

Step 2-Let participants present on the group output.

Step 3-Summarize the exercise by presentingtable14 (Attachment 1.3) in a PowerPoint presentation or flipchart.

Attachment 1.1: Gender Analysis Frameworks and Tools

There are different frameworks for undertaking gender analysis. Since no single framework provides an appropriate way to address all development problems; it is important to select one or a combination of methods. There are five most commonly used gender analysis frameworks. These are:

Table 15: Summary of gender analysis frameworks

	Harvard Analytical Framework/ Gender Role Framework	The Moser/ Triple Role/ Gender Planning Framework	Women's Equality and Empowerment/LONGWE Framework	Social Relations Approach Framework	Capacities and Vulnerabilities Analysis (CVA) Framework
Comment:	One of the first frameworks for gender analysis used by USAID.	Emphasis on setting up gender planning as a type of planning in its own right.	A framework that attempts to measure what women's empowerment means in practice.	-Socialist feminist background thinking. -Aims to enable women to be agents of their own development.	Developed to be used for humanitarian interventions and disaster preparedness.
Based on:	-An efficiency approach, an economic case for allocating resources to women and men. -Focuses only on roles, not relations between the sexes.	Equity, equality and women's empowerment.	Critically assesses how development interventions support women's empowerment.	Analyzes inequalities in distribution of resources, responsibilities and power-people's relationships to institutions.	The concept that people have strengths/capacities and weaknesses/vulnerabilities.
Key components:	-Activity profile of women and men -Access and control profile	-Examine women's triple role. -Identify practical and strategic gender needs. -Examine categories of WID and GAD policy approaches.	Levels of women equality and empowerment: -control -participation -concretization -access -welfare	Concept of social relations and institutional analysis.	Disaster needs are addressed by providing short-term interventions, whereas vulnerabilities require strategic long-term development.
Tools:	Activity profile, access and control profile, project cycle analysis, and gender analysis matrix.	-Gender/triple role identification. -Gender need assessment (practical and strategic needs)	-Levels of equality (control, participation, concretization, access, welfare, etc) -Levels of recognition of women's issues (negative, positive, blind, neutral)	Concepts rather than tools are used in the framework.	-Categories of capacities and vulnerabilities (physical/material, social/organizational, motivational/attitudinal) -Sex-disaggregated data.
Origin:	1985, Overholt, Anderson, Austin Cloud	1980, Moser, UK	1994, Longwe, Zambia, used by UNICEF	1994, Kabeer and Sussex, UK	1990s, Sen and Nussmaum

Source: Adapted from http://www-secure.ifrc.org/dmis/response/humanresources/Gender_seb_Version/Tools... 10/10/2013

Attachment 1.2: Gender Analysis Matrix

Gender analysis helps to clarify the differences between men and women in how they live, what they do, their access to control over resources, which they interact with, and the nature of these interactions and relations. Gender analysis of a health problem brings to light the ways in which these differences interact with biological differences to affect women's and men's health status, their access to and interaction with the health care system, and the social and economic consequences of ill-health. These should be analyzed in relation to health risks and vulnerability, ability to access health services, health seeking behavior, preventive and treatment options, responses to treatment and rehabilitation, experience with health services and health providers, health outcomes, and consequences of the health issue or problem.

The three main gender factors that affect the health of men and women are: biological differences, gender roles and norms, and access and control over resources.

- Gender factors interact with biological differences between men and women and have an impact on their health status.
- Women and men may be exposed to differential risks of contracting a health problem because of gender roles and norms, or because of gender-based division of labor.
- Women often have more limited access to resources than men, and resources are necessary for good health.
- Even when women have access to adequate resources, they may not have the power and authority to make decisions. This increases their vulnerability.

Table 16: Gender analysis matrix used to analyze a health issue or problem

Health issues or problems	Lenses of gender analysis		
	How do biological and physiological differences between sexes influence men and women	**How do gender norms/values affect men and women, boys and girls**	**How do access to and control over resources influence men's and women's**
Health risks and vulnerability	o Risk can mean a probability, i.e., the risk of getting AIDS from an infected needle. o Risk can mean a factor that raises the probability of an adverse outcome that is exposure: Increased risk of STI's following sexual violence against women. o Risk can mean consequences. A boy who experiences violence in the family could himself become a violent person. o Risk can mean a potential adversity or threat, i.e., gender norms and		

	roles that undermine pregnant women to seek health care increases the risk of maternal and infant mortality. o Vulnerability refers to factors that put an individual at increased risk. For example, although both women and men can be affected negatively by "gender," women's disadvantaged social, economic, and political status further undermines their ability to protect and promote their own physical, emotional and mental health, including their effective use of health information and services.
Ability to access and use health services	Women's and men's access to and use of health facilities are influenced by: o Distance to a health facility, hours of operation, cost of services, and time involved. o Community knowledge of available health services. o How treatment options are communicated by providers. o Perceived quality of care. o Knowledge and recognition of issues requiring care. o Perceived severity with health services. o Available options. o Stigma associated with health conditions. o Interference with daily tasks. o Absence of a culturally sensitive approach.
Health outcomes /Consequences of health problems (e.g., social, economic, attitudinal)	The burden of a health problem and its outcome on an individual and family influenced d by: o Monetary costs o Duration of health problems o Stigma

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

Attachment 1.3: Gender Analysis Matrix for Analyzing HIV and AIDS

Figure 16: HIV prevalence for women and men by age, EDHS 2011

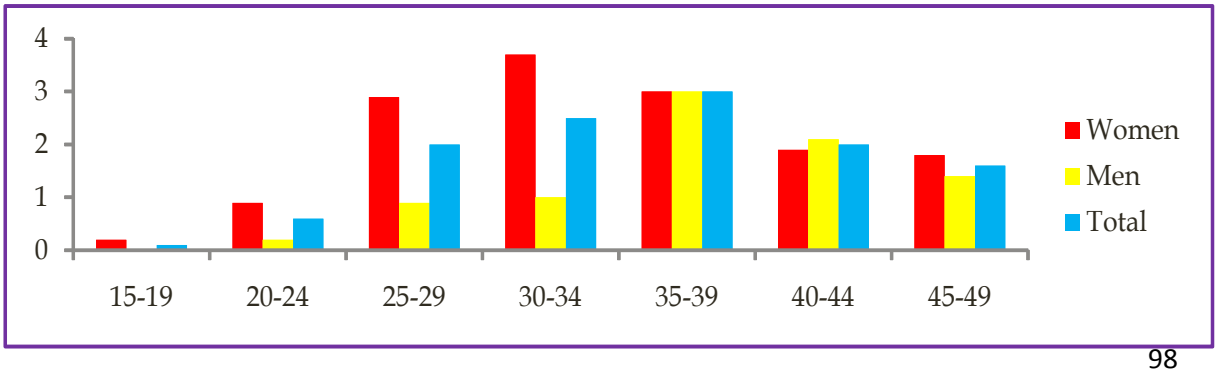


Table 17: Gender analysis matrix for analyzing HIV and AIDS

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

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

Session 3: Gender –Sensitive Monitoring and Evaluation for Health Programming

Session duration: 2 hours and 45 minutes

Session objectives

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

- Describe the concepts and the need forgender-sensitive monitoring and evaluation.
- Explain what sex-disaggregated data and its importance in designing, implementing and evaluating health programs.
- Demonstrate the skill of developing gender-sensitive indicators.

Activity 1: What is monitoring and evaluation and why do we need to do it?

25 minutes

Materials: *Flipchart paper and stand, marker, LCD Projector, and attachment 1.1*

Direction

Step 1- Draw a table with two columns on a flipchart paper, and write monitoring in the first column and evaluation in the second.

Step 2- Ask volunteer participants to write words that comes to their mind about monitoring and evaluation

Step 3- Ask participants why they need to monitor and evaluate

Step 4- Wrap up the discussion by explaining the concepts using handout on attachment 1.1

Activity 2: Gender-sensitive/responsive monitoring and evaluation for health sector

25 minutes

Materials:*Flipchart paper and stand, marker, LCD Projector, and attachment 1.2*

Direction

Step 1- Divide participants into five groups.
Step 2- Ask participants to brainstorm on gender-sensitive/responsive monitoring and evaluation and why we need it in the health sector.
Step 3- Ask participants to share the output of their discussion.
Step 4- Wrap up the discussion by presenting the handout on gender-sensitive/monitoring and evaluation (Attachment 1.2)

Activity 3: What makes a gender-sensitive indicator?

25 minutes

Materials:*Flipchart paper and stand, marker, LCD Projector, and figure 17 and table 18 (attachment 1.3)*

Direction

Step 1- Ask participants to be in pairs.
- Using figure 17 and table 18, ask participants tobrainstorm on what makes a gender-sensitive indicator.

Step 2- Allow participants to share their ideas.
Step 3- Wrap up the discussion by presenting the handout on designing gender-sensitive/monitoring and evaluation (Attachment 1.3)

Attachment 1.1: Defining Monitoring and Evaluation

Monitoring is routine collection and analysis of and reporting on information about the performance of the work in a programme or project, comparison of the performance with the programme or project plans, and connected discussions about proposals for any corrective action.

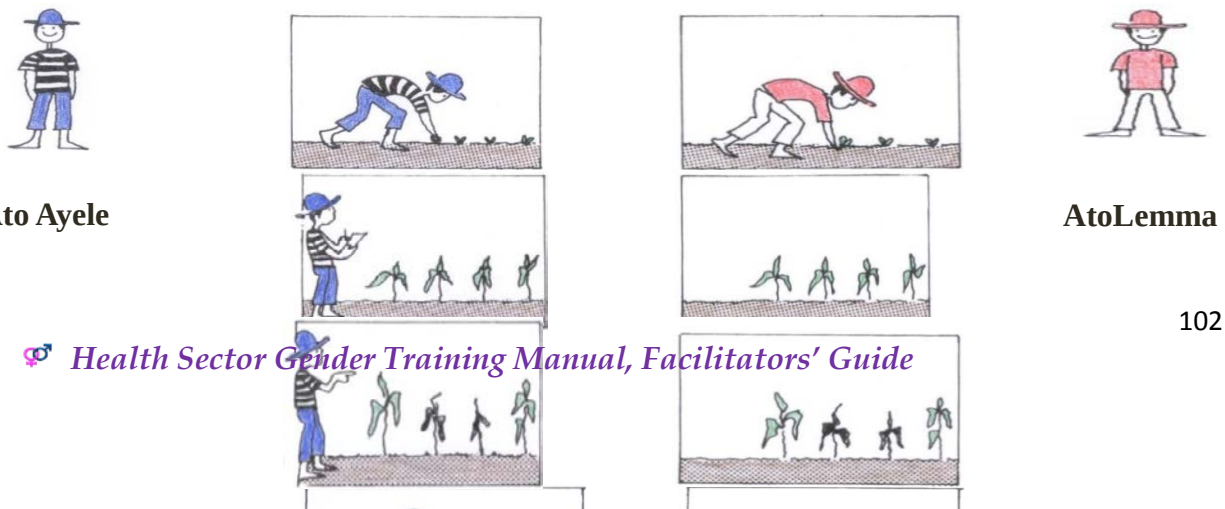
Evaluation is an objective and systematic assessment of processes and outcomes related tothe undertaking and implementation of an activity, project or programme.

Table 18: Links between monitoring and evaluation

Monitoring	
ntly,ona permanent basis.	Takesplacelessfrequently, various stages.
	Assessment
videinformationforreprogrammingtoimproveoutcomes	Improve effectiveness, imp valueformoney,futureprog
s, work plans(operationalimplementation)	Effectiveness,relevance,imp
rts,registers,administrativedatabases,fieldobservations	Scientific,rigorousresearch
system,fieldobservationreports,progressreports,rapidassessment,programreviewmeetings	Samesourcesusedformonit basedsurveys,vitalregistrat
tsspreadacrossimplementationperiod	Episodic,oftenfocusedatth

Source:AdaptedfromGlobal Fund (2011). Monitoring and evaluation toolkit: HIV, tuberculosis, malaria, and health and community system strengthening. 4th edition

Figure 17: Justification for conducting monitoring and evaluation



Attachment 1.2: Gender-Sensitive/Responsive Monitoring and Evaluation for Health Sector

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

Gender-sensitive monitoring and evaluation provides a framework to successfully integrate gender into health-related activities, assess their progress and impact. Gender-sensitive/responsive monitoring and evaluation achieves the following:

- Showsthe extent and the impacttowhich a project/programme/ policy has on addressingthe different needs of men and women.
- Improves project performance during implementation, through mid-term evaluations, and develops lessons for future projects.
- Measures how the program's outputs have affected/benefited women and men.
- Uses gender-sensitive indicators and data categorized by sex, age, ethnicity, etc.

Attachment 1.3: Designing Gender-Sensitive Monitoring and Evaluation

Indicators are defined as "*statistical series, and all other forms of evidence that enable us to assess where we stand and where we are going with respect to values and goals, and to evaluate specific programs and determine their impact*." Indicators are the building blocks of an

effective monitoring and evaluation system, but they are highly context specific and uniquely representative of a particular program or project. A gender-sensitive indicator, therefore, can be defined as "*an indicator that captures gender-related changes in society or in the context being dealt over time*".

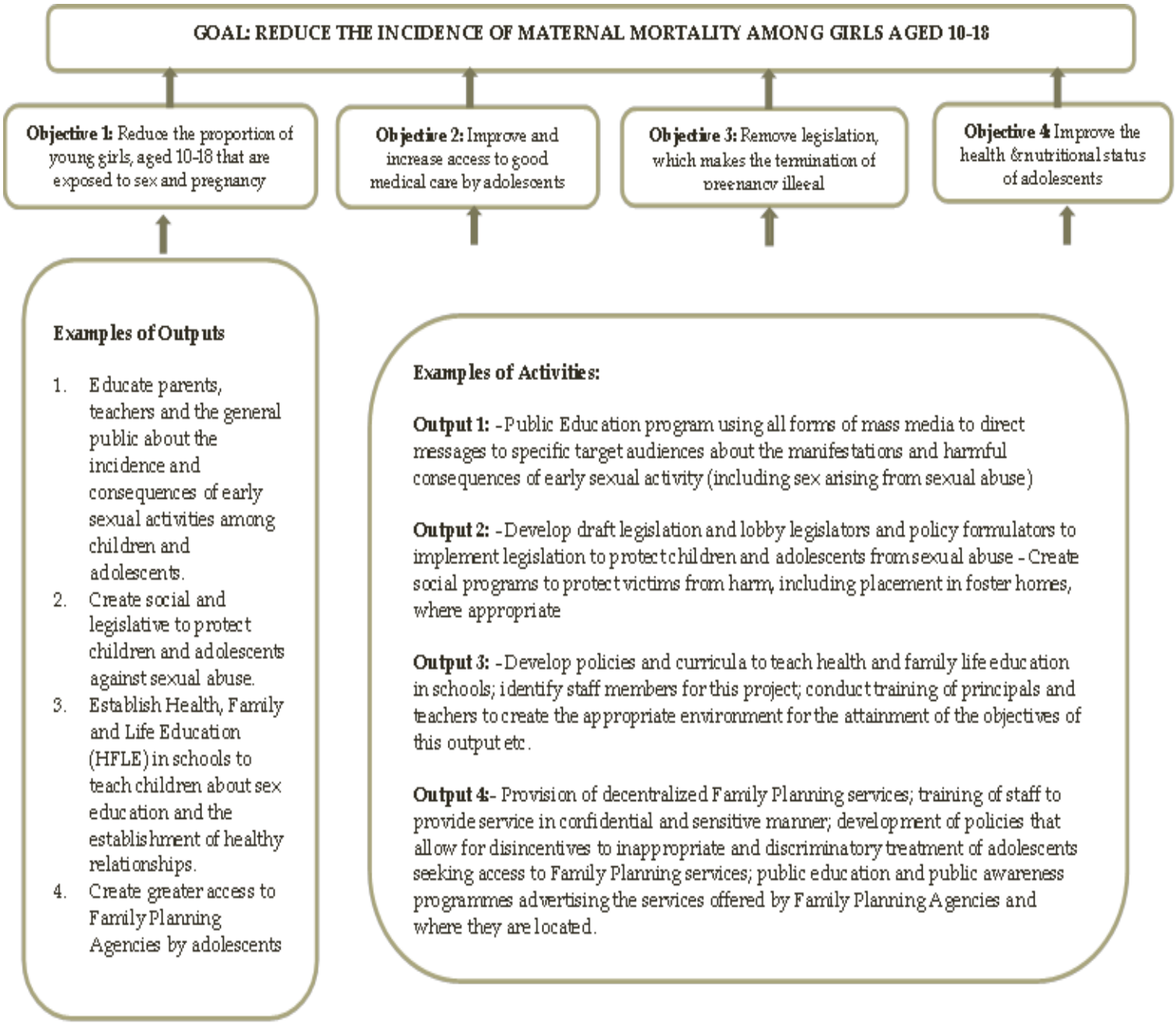
In order to measure how well a health project or programme has scored in its gender targets and if its results relating to gender equality have been achieved, indicators must be gender-sensitive. In order to make a monitoring and evaluation system gender-sensitive, the following methodologies should be integrated:

1. Gender analysis: A gender analysis isnecessaryin order to monitor and assess how an intervention affects women, men, gender relations and gender equality thereby determining what the starting point is. A gender analysis, therefore, has to form part of every baseline study.

2. Disaggregation of various stakeholder groups: Data should be collected in a disaggregated manner by gender, ethnicity, age etc.

3. Mixed methods approach(qualitative and quantitative): Gender issues are so linked to cultural values, social attitudes and perceptions that measuring them must mean using a variety of indicators engendering both quantitative and qualitative information.

Figure 18: Gender-sensitive monitoring and evaluation for maternal mortality project



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

Table 19: Maternal mortality reduction project log frame

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

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

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

Table 20: Key questions to consider for monitoring and evaluation of a project/program

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

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

Module 4Evaluation Sheet

	Aspects I liked most	Aspects I liked least	New things I learnt	Suggestion for improvement
Content				
Methodology				
Facilitation				

Module 4 References

Global Fund (2011).*Monitoring and evaluation toolkit: HIV, tuberculosis, malaria, and health and community system strengthening*. 4th edition.

Hunt, J. (200)4.*Introduction to gender analysis concepts and steps*, Development Bulletin, no. 64, pp. 100-106.

IIRR-Ethiopia (2004).*Gender in leadership and decision-making Manual*.CIDA.

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

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

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

UNDP (2001).*Gender in Development Programme: Gender Analysis*.

World Health Organization (2011).*Gender mainstreaming for health managers: a practical approach.*

MODULE 5

MODULE 5: GENDER AUDIT

Description

Module five provides an overview on how to conduct a gender audit. It is specifically included in the manual to develop participants' knowledge and skills about the gender audit process and analysis. Ultimately, participants will be equipped to assess and address the status of gender equality in their work and the health sector at large.Themodule has two sessions that give an understanding of what a gender audit is; demonstrate the steps used in conducting a gender audit process; and make use of gender audit tools.

Session 1: Understanding Gender Audit

Session duration:50 minutes

Session objectives

At the end of this session participants will be able to:
- Explainthe concept and purpose ofgenderaudit.
- Identify gender audit process and tool.
- Relate gender audit with gender mainstreaming and gender equality within the health sector.

Activity 1: Brainstorming exercise on gender audit

30 minutes

Material:*Flipchart paper and stand, marker,attachment 1.1, and LCD Projector*

Direction

Step 1- Ask participants to brainstorm on the following points:
- What is a gender audit?
- Why is gender audits needed for the health sector or any organization?
- Who conducts gender audit and when is it conducted?
- What are the outputs of a gender audit process?

Step 2-Summarize the exercise by presenting the handout on attachment 1.1referring using a PowerPoint slide or flipchart.

Attachment 1.1: Understanding Gender Audit

A gender audit is an assessment tool and process for organizations to use in identifying staff perceptions of how gender issues are addressed in their programming portfolio and internal organizational processes.[13] It is alsoa self-assessment methodology that focuses on improving the organization's performance with respect to gender equality and women's empowerment. In doing so, it employs a participatory method that encourages interaction, involves all stakeholders, and uses SWOT as well as documentary analysis in order to triangulate the information gathered through gender audit questionnaire.

The purpose of gender audit is to evaluate:

- The gender-responsiveness of the health sector's culture.
- How well that the health sector is integrating a gender perspective into its work.
- The audit recommendations aim to assist the health sector to become more gender responsive.

Accordingly the gender audit process provides the following outputs:

- A reflection of the status of gender equality within the health sector
- A baseline for collective discussions and analysis
- A participatory process that builds organizational ownership for the health sector gender equity initiative.
- A detailed action plan.

Who conducts gender audit:

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

When to conduct gender audit:

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

Gender audit methodology:

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

[13] From the gender audit: questionnaires handbook. Commission on the Advancement of Women.InterAction. 2003.

Session 2: Gender Audit Tool and Process

Session duration:2hoursand15 minutes

Session objectives

At the end of this session participants will be able to:

- Describe the four pillars of genderaudit framework.
- Explain the stages/steps of gender audit process.
- Identify the components of gender audit questionnaire.
- Develop the skill of conducting gender audit.

Activity 1: Exercise on gender audit framework and stages/steps

30 minutes

Material:*Flipchart paper and stand, marker,attachment 1.1, and LCD Projector*

Direction

Step 1-Divide the participants into two large groups

Step 2- Ask the first group to identify the four pillars of a gender audit framework and discuss gender issues that are embedded in each of the pillars.

- They can give examples of the existing gender equity environment in their organization using the pillars

Step 3-Ask the second group to discuss and point out stages/steps of a gender audit process.

Step 4-Let the groups present their findings to the plenary.

Step 5-Wind up the exercise by presenting handout in attachment 1.1using power point slides or flipchart.

Activity 2: Brainstorming exercise on gender audit tool

25 minutes

Material:*Flipchart paper and stand, marker,attachment 1.2,annex 3, and LCD Projector*

Direction

Step 1- Ask participants to pair with the person sitting on their right and brainstorm answers to the following questions:
- In the gender audit questionnaire, what are the five areas of programming and six areas of organizational processes
- What type of sampling strategy do you think a gender audit employs?

Step 2- Ask participants to reflect on their discussion.
Step 3-Wind up the discussion by presenting attachment 1.2 using PowerPoint slide or flipchart.

Activity 3: Case study exercise on human resources

30 minutes

Material:*Flipchart paper and stand, marker,case study, LCD Projector, module evaluation sheet*

Direction

Step 1-Ask participants to refer to the case study in their guide.
Step 2- Invite one of the participants to read the case study on human resources.
Step 3- Ask participants to be in pairs and discuss what could be done to assist women in similar situations assume leadership and manage their family life as well.
- Remind participants to come up with solutions that are practical and can be done at the federal ministry, agencies, hospitals and regional health bureau.

Step 4-Let participants report on the activity.
Step 5-Wrap-up the discussion by focusing on the need for flexible and accommodating working culture that recognizes the triple role of women.
Step 6-Evaluate participants understanding of the module using the module evaluation form.

Case study: work-life balance

This is a case story of lady who turned-down an important position that she has been nominated for. The 42 years old lady had her first degree in Medicine and second degree in Public Health. She is a mother of three and married to a business man who rarely gives her hand in the house related matters. The lady is hired at a federal ministry and is well recognized for quality of work, commitment, hard work, and rich experience. Recognizing this, the organization that she works for nominated her for a much higher position with better salary, benefit and exposure for self-development.

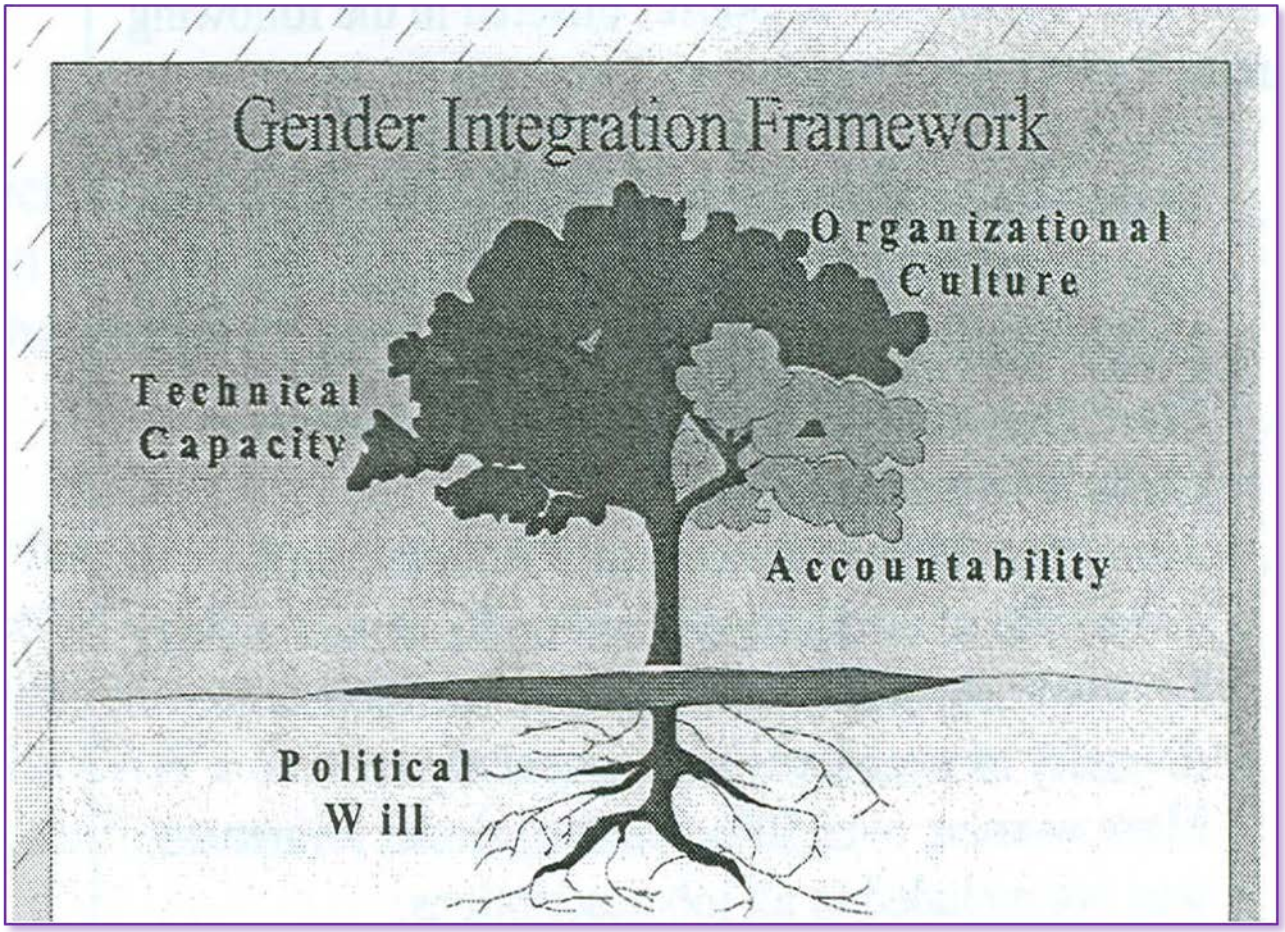
The lady turned-dawn the offer saying the new position would only give her little time to attend to her family need. After this incident the staff of the organization started to say that women turn away their face when given with the leadership opportunity.

Source: Taken from a spoken true story in a given Federal Ministry

Attachment 1.1: Gender Audit Framework and Stages/steps

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

Figure 19: Commission on the advancement of women, gender audit framework, 1998

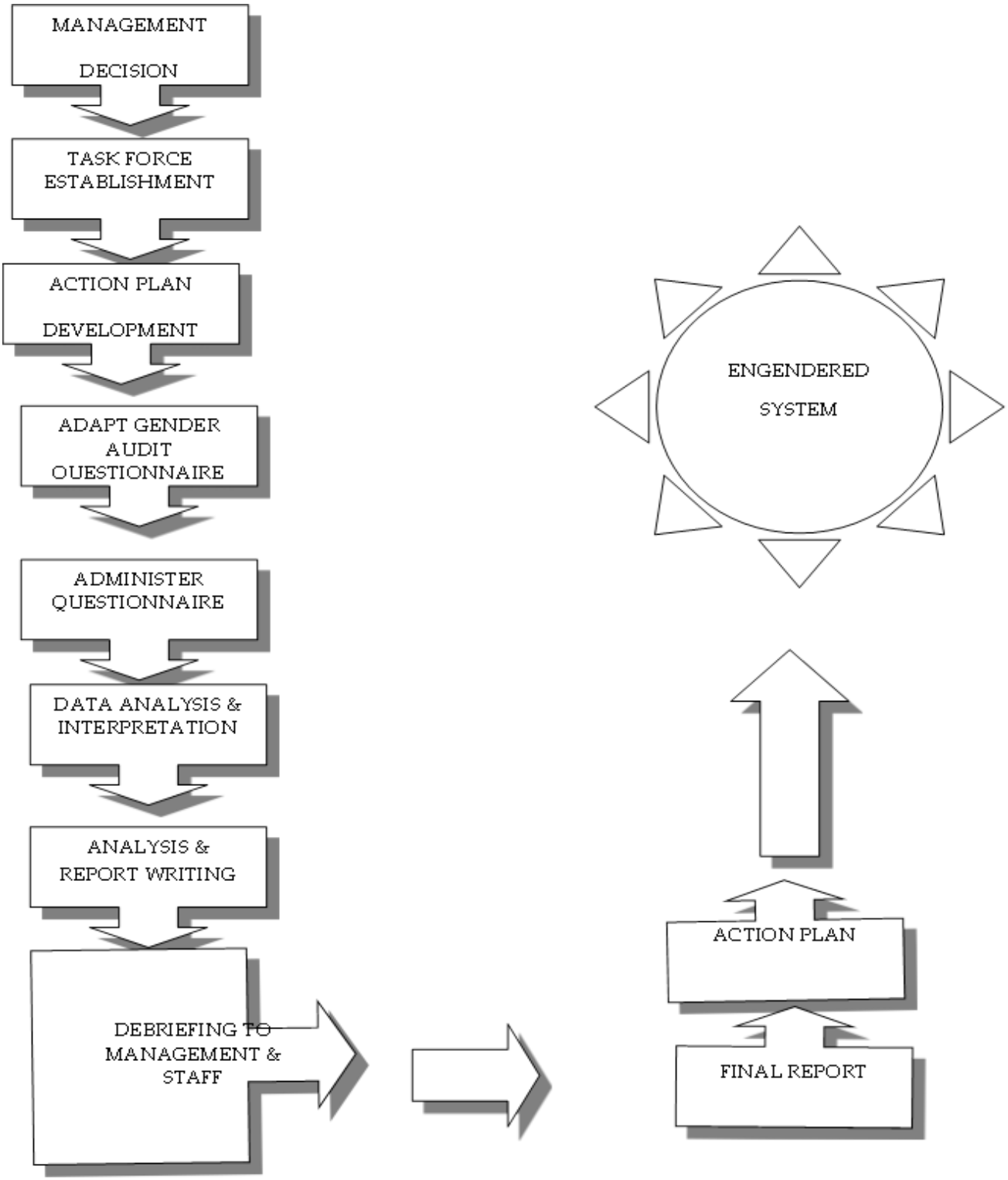


- **Political will** becomes evident when top-level leadership publicly support gender integration, commit staff time and financial resources, and institute needed policies and procedures.
- These conditions lead to a favorable **organizational culture,** which involves progress toward a gender-balanced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

A gender audit is a two-stage process. The first stage is the gender audit questionnaire. The second stage is the discussion, analysis, and planning phase. The gender audit process includes detail stages such as:

- Preparing for the gender audit process (e.g. getting political buy-in from senior managers and organizing a meeting)
- Conducting the gender audit
- Analyzing the gender audit questionnaire
- Presenting the gender audit questionnaire result
- Using the gender audit result for action planning

Figure 20: Gender audit steps/stages



Attachment 1.2: Gender Audit Questionnaire

The gender audit questionnaire focuses on five areas of programming and six areas of organizational processes:

Table 21: Gender audit questionnaire programing sub-section

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

Table 22: Gender audit questionnaire organization sub-section

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

Sampling strategies: depending on the size of the organization, the CAW recommends the following sampling strategies. For small to medium organizations (less than 100 staff), all staff should complete the questionnaire. For medium to large organizations, a representative sample of at least 25-30% inclusive of a proportional number of respondents from each unit or department, including overseas offices, should be taken. Organizations with a large number of non-program staff may wish to administer the program section of the questionnaire exclusively to program staff if there are clear indications that program support staff members are completely unfamiliar with the organization's overseas program.

Module 5Evaluation Sheet

	Aspects I liked most	Aspects I liked least	New things I learnt	Suggestion for improvement
Content				
Methodology				
Facilitation				

Module 5 References

♂ *Health Sector Gender Training Manual, Facilitators' Guide*

ILO (2007).*A manual for gender audit facilitators: The ILO participatory gender audit methodology.* Geneva

T. Morris,P. (2003). *The gender audit: Questionnaires handbook*. Commission on the Advancement of Women.InterAction.Washington DC.

T. Morris,P. (1999). *The gender audit: A Process for organizational self-assessment and action planning*. Commission on the Advancement of Women.InterAction.

MODULE 6

MODULE 6: GENDER BUDGETING

Description

Modulesix is prepared with the aim of introducing the concept and approach of gender budgeting for health workforce. The module consists of two sessions that are believed to strengthen what the gender directorate of the federal ministry of health does in this regard and replicate the practice to its federal agencies, hospitals and regional health bureaus.

Session 1: Understanding Gender Budgeting

Session duration:40minutes

Session objective

At the end of this module, participants will be able to:

- Explain the meaning of gender budgeting.
- Describe the advantaged of gender budgeting.

Activity 1: Brainstorming exercise on gender budgeting

20 minutes

Materials:*Flipchart paper and stand, marker, LCD Projector, and attachment 1.1*

Direction

Step 1-Ask participants to brainstorm on the meaning of and the advantages of gender budgeting.

Step 2-Put their ideas on a flipchart.

Step 3-Summarize the exercise by presenting the handout on understanding gender budget(Attachment 1.1) using Power Point slides or flipchart.

Attachment 1.1: Understanding Gender Budgeting

Gender budgeting is an application of gender mainstreaming in the budgetary process. It means a gender-based assessment of budgets, incorporating a gender perspective at all levels of the budgetary process, and restructuring revenues and expenditures in order to promote gender equality.

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

A gender-responsive budgeting process aims at producing gender-responsive budgets. These budgets (which are synonymous with gender-sensitive budgets, gender budgets and women's budgets) are not separate ones for women, but rather government budgets that are planned, approved, executed, monitored and audited in a gender-sensitive way.

Hence, a gender-responsive budget:

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

Advantages of gender responsive budgeting include:

- Monitor the achievement of policy goals e.g. MDGs
- Alleviating poverty more effectively.
- Enhancing economic efficiency.
- Achieving gender equity/equality
- Advancement towards the realization of women's right.
- Achieving good governance.
- Enhancing accountability and transparency.

Session 2: Approaches and Tool for Conducting Gender Budgeting

Session duration: 1 hour and 55 minutes

Session objectives

At the end of this session participants will be able to:

- Examine the key approaches and tool for conducting a gender budgeting.
- Identify the need for gender budgeting in the health sector at the federal and regional level.
- Advocates for the allocation of gender budgeting in the health sector.

Activity 1: Exercise on categorization/classification of genderbudget

25 minutes

Materials:*Flipchart paper and stand, marker, LCD Projector, masking tape, attachment 1.1 and 1.2*

Direction

Step 1- Ask participants to identify the two major categorization/classification of gender budget

Step 2- Then ask participants to separate into three groups and ask them to come up with health-related examples for the three gender budget categories.

- Examples for women/gender specific expenditure:
- Examples for equal opportunities in the public service:
- Example of general or mainstream expenditures:

Step 3- Make sure each group works on one category only.

Step 4-Ask participants to present their findings to the plenary.

Step 5- Summarize the discussion by presenting the handout on attachment 1.1and 1.2 using a PowerPoint slide or flipchart.

Attachment 1.1: Approaches and Tools for Conducting Gender Budgeting

There are a number of approaches that are used by different countries to create gender-responsive budgets.

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

The three-way categorization: it divides the budget into three specific types of expenditures. These categories are:

i. **Women or gender specific expenditures:** are expenditures in the budget that specifically target groups of girls and women addressing a particular gender issue. They are an example of affirmative expenditure.
ii. **Equal opportunities expenditures in the public service**: are allocations to equal employment opportunities (e.g. training and mentoring programs for women public servants and the review of job description to remove gender bias).
iii. **General or mainstream expenditures:** are expenditures that are not gender-specific but are analyzed for their gender impact. This budget category is the biggest and accounts for 99% of the funding (e.g. funding for increased water coverage).

Table 23: Summary of gender budget expenditure

Examples for women/gender specific expenditures:	Examples for equal opportunities expenditures in the public service:	Example of general or mainstream expenditures:
o Women's health programs (e.g. reducing maternal mortality, setting up maternity wards) o Drugs for reproductive health o Special education initiatives for girls (e.g. family planning,	o Program that promote the equal representation of women in management and decision-making. o Equitable pay and conditions for women public servants. o Review of job	o Includes money for clinics, water and sanitation. o General question that needs to be raised under this category are: • Does the budget, minus the above two types of

Examples for women/gender specific expenditures:	Examples for equal opportunities expenditures in the public service:	Example of general or mainstream expenditures:
reproductive health, early childhood and nutrition) o Employment policy initiatives for women o Initiatives to address violence against women o Economic empowerment for women o Scholarships for women o Capacity building for health workers targeting women o Research on women and men health	descriptions to reflect equal employment opportunity principles and remove gender bias. o Number of men and women in positions with gender knowledge or specialization. o Provision of child-care facilities o Parental and maternal leave provisions	expenditure, reflect gender equity and equality objectives? o Specific sample questions that needs to be raised under this category are: • Who are the users of health services? • Who benefits from expenditures on tertiary education?

The five-step approach:itinvolves five steps in conducting a gender budget analysis from a gender perspective and comprises the following stages:

- **Carry gender situation analysis:** involves identifying gender issues in a sector or society.
- **Carry policy analysis:** establish whether the policy addresses the gendered situation identified in step 1.
- **Carry budget analysis**: find out whether there are enough resources to implement the policy.
- **Budget monitoring:** see whether the money was spent as planned, what was delivered and to whom.
- **Budget assessment:** assess whether policy implementation has changed the gendered situation identified in step 1.

Attachment 1.2: Gender Budgeting Steps/Stages

Gender budgeting is not a one-time activity; it is a process that helps to identify gender issues in our society and at the same time assist in incorporating gender issues in budgets. It has three major steps/stages:

Step1: identifying gender issues

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

Step 2: engendering policies/programs

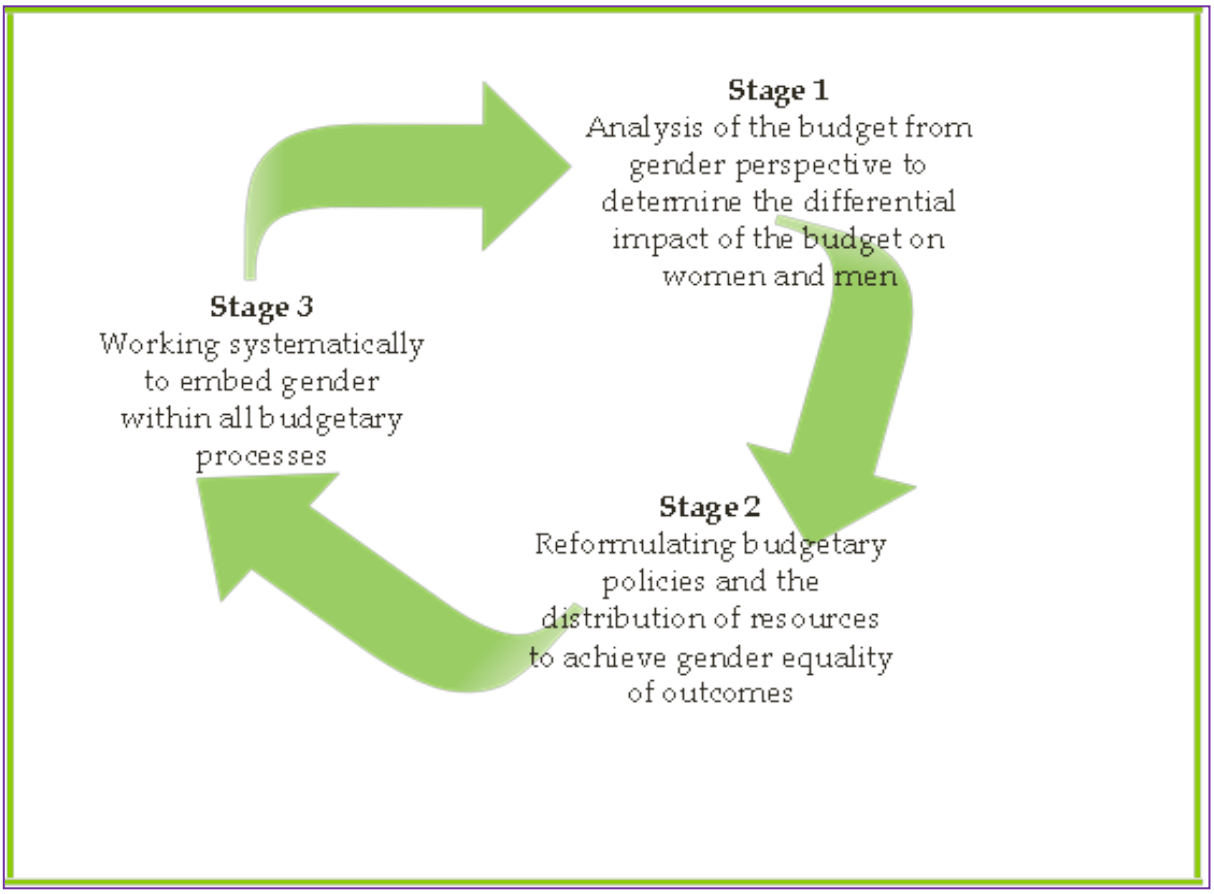
- This step determine whether the policy/program designed to address particular problems in a country/organization has explicitly or implicitly tackled gender issues identified in step 1. The policy/program might also reinforce or remove gender inequalities.
- A gender- aware policy/program appraisal involves the development of an analysis which reflects an understanding of the policy's/program's gendered implications by:
  - Identifying the implicit and explicit gender issues and policy/program objectives
  - Identifying the accompanying resource allocation
  - Assessing whether the policy/program will continue or change existing gender inequalities between women and men and patterns of gender relations.

Step 3: Engendering budgets

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

- Mainstream expenditures

Figure 21: Stages of gender budgeting



Source: Gender budgeting: practical implementation handbook, 2009

Checklist for a gender-sensitive budget:

- Is there any gender-specific expenditure in the budget?
- Was the budget process gender-sensitive or participatory?
- Who benefits from the money allocated?
- Use of sex-disaggregated data
- Administrative vs development/service delivery expenditures
- How much budget for the gender machinery?

Module 6 evaluation

	Aspects I liked most	Aspects I liked least	New things I learnt	Suggestion for improvement
Content				
Methodology				
Facilitation				

Module 6 References

MoFED and UNWOMEN (2012). *National gender responsive budgeting guidelines: Mainstreaming gender in the program budget process.*

MoFED, UNICEF and British Council.*Guidelines for mainstreaming gender in the budget process.*

Quinn, S. (2009). *Gender budgeting: practical implementation handbook.* Council of Europe

Schneider, K. (2006) *Manual for training on gender responsive budgeting*. GTZ

MODULE 7

MODULE 7: GENDER AND THE HEALTH WORKFORCE IN ETHIOPIA

Description

As part of gender mainstreaming it is important to understand how the health force operates in Ethiopia and what the challenges are. Hence, this module discusses the position of women in the health workforce of Ethiopia.

Module duration:1hour

Moduleobjectives

At the end of this module participants will be able to:

- Describe how the workforce is organized, and the challenges women face as health care providers.
- Identify the role women play in leadership, management, and governing positions in the health workforce.
- Suggest practical recommendations to address gender discrimination in human resources for health.

Activity 1: Brainstorming exercise on position of women in the health workforce

20 minutes

Materials:*Flipchart paper and stand, marker, LCD Projector, and table 24*

Direction

Step 1- Ask participant to be in pairs and brainstorm using table 24.
Step 2-Ask participants to reflect upon what they understand from the data.
Step 3- To improve the situation, ask participants to suggest what can be done at the family, community, schools, universities, FMOE and FMOH levels?
Step 4-Summarize the exercise by using the note for the facilitator using a PowerPoint Slides or flipchart.

Table 24: Distribution of health professionals by gender (2009)

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

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

Note for the facilitators

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

Individual initiatives to address gender imbalance

- It is important for women to embrace initiatives personally that will help promote their career advancement.
- Women need to take responsibility for their career paths in order to overcome the many obstacles that exist in the country/ministry, as well as the barriers that women often put upon themselves.
- Women have various natural qualities and talents such as changing risks into opportunities and connecting or networking positively with others. This in turn will help them to advance their career.
- Women need to be confident and role-model for others.

Organizational initiatives to address gender imbalance

- FMOH need to realize that women are a valuable resource in the search for talent to lead into the future.
- Hence, there is a need to address the cultural workplace issues by developing more opportunities for female leaders, creating more flexible work schedules, creating leadership development programs, organizing mentoring programs, and forming women networks/associations. Keeping work-family life balance is critical.
- FMOH, FMOE and universities need to work hand-in-hand to create competent female high school students and inspire them by creating experience sharing events.

Activity 2: Exercise on recommendation to address gender discrimination

30 minutes

Materials:*Flipchart paper and stand, marker, LCD Projector, attachment 1.1 (table 25 and figure 22), and module evaluation sheet*

Direction

Step 1-Divide the participants into three groups.

Step 2- Ask them to discuss on the different interventions they envision for women at each of the following three levels:

- Policy and planning: how to strengthen human resources policies and planning to promote gender policy.
- Workforce development: how to decrease segregation in education, training and work
- Workplace support: how to create a supportive, fair, and safe work environment

Step 3-Summarize participants' answers by presenting attachment 1.1 (table 25 and figure 22) using a Power Point slide or flipchart.

Step 4-Evaluate the participants' understanding of the module using the module evaluation sheet.

Attachment 1.1: Practical Recommendations to Address Gender Discrimination in Human Resources

The framework displayed belowdemonstrates the challenges women face in the health system starts from the entry level and moves up as they go into leadership, management and governance positions. At each of these levels, interventions are identified to increase the numbers of women in leadership management and governance, as well as those that will make them more effective in their roles. Gender-based interventions, however, are necessary to support and advance women workers at all levels in the health system.

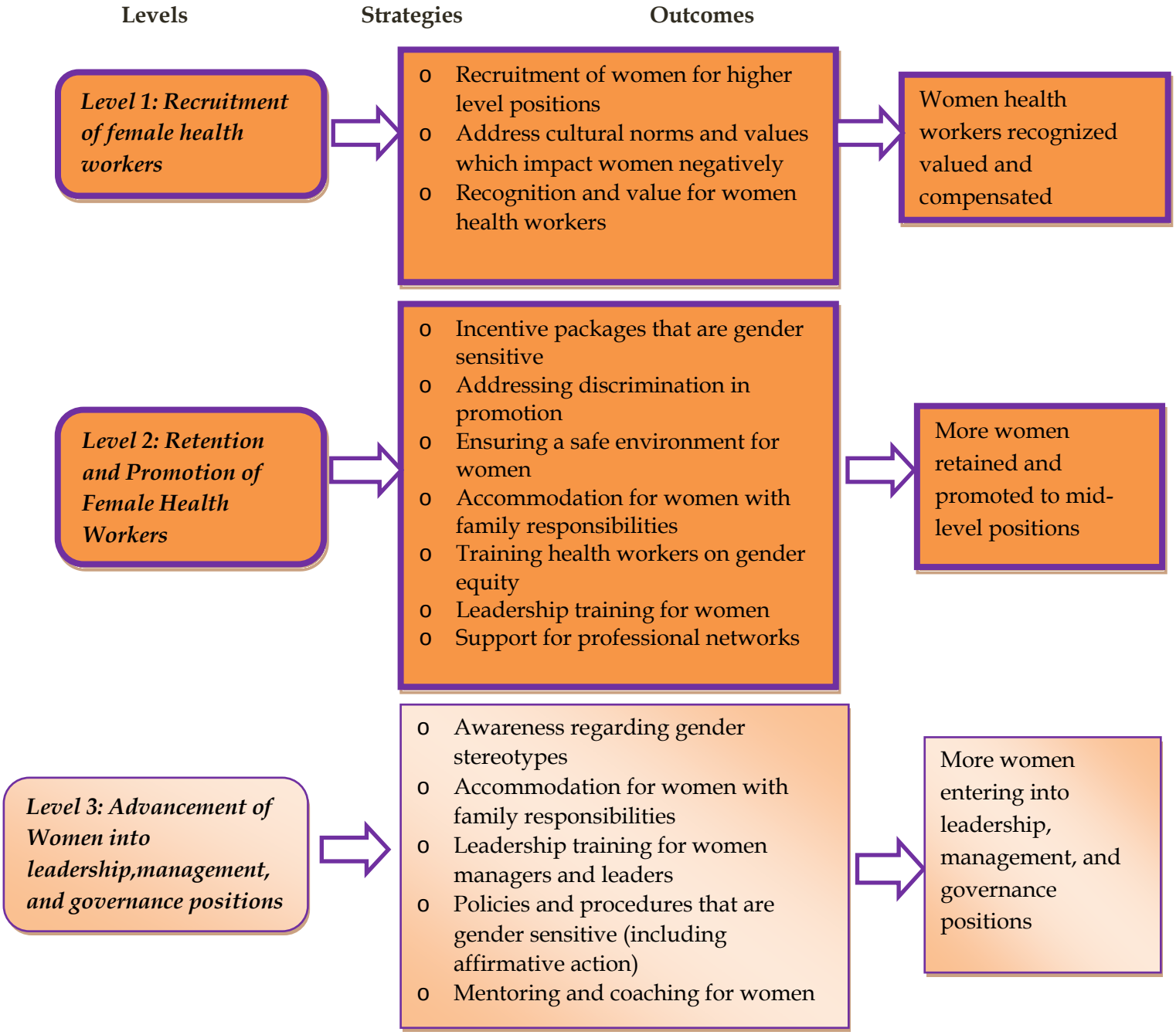
These interventions correspond roughly to women in the lowest and informal levels of the health force, women in low- and mid-level positions in the health force, and women in leadership, management and governance positions, respectively.

Table 25: Gender and HRH recommendations to address gender discrimination

Policy and Planning: Strengthen HRH policies and planning to promote gender policy	Workforce Development: Increase gender integration anddecrease segregation in education training and work	Workplace Support: Create supportive, fair and safe work environments
o Identify gender discrimination in HR policy and workforce planning through workforceassessments that routinely gather information on gender discrimination at work, and onwomen's status relative to men's in policy and law o Design human resources information systems(HRIS) to provide sex-disaggregated data for HR policy and planning, including identification of discrimination in pay, promotion or training o Translate international and national commitments to gender equality into national equal opportunity policies and laws o Promote policies that responds to flexibility in scheduling hours, pregnancy benefits and parental leave o Create standardized protections and resources for volunteer health workers (e.g. financial incentives, health insurance/care, pensions) o Address violence and discrimination, and at the same time develop HR policies and programs that ensure the safety and security of women at work o Involve women in HR policy and strategy decision-making processes on an equal basis with men	o Eliminate gender stereotypes incurricula that may serve as barriers to women's and men's entry into nontraditional health occupations or task-sharing o Promote equality in educational recruitment, targeting boys'/men's entry into "female" health occupations and girls'/women's entry into "male" health occupations o Provide social support toboys and men who choosenontraditional health occupations o Create"bridging programs" to help girls meet entry requirements for medical schools o Eliminate policies andpractices that exclude girlsand women from schooling ifthey become pregnant o Ensure that women areequally represented inmanagement and leadershipskills training o Strengthen associations asempowermentandleadership mechanisms forfemale health workers o Add gender equality and gender-based violence content to school curricula to raise awareness of gender and health	o Promote gender-aware humanresources management (HRM) policiestoeffectively support both femaleand male health workers inequitable work environments o Conduct "gender audits" ofworkplace policies and practices o Develop and enforce equalopportunity employment policies to eliminate discrimination on thebasis of marriage, pregnancy andfamily responsibilities o Promote equal remuneration and equal opportunity for careeradvancement o Implement health personnel training on workplace violence and gender discrimination o Develop and enforce zero tolerancecodes of conduct for sexual harassment o Develop employee assistanceprograms that offer free familyplanning, voluntary counseling and testing, prevention of mother to child transmission services, post exposure prophylaxis, counseling, child care and response to gender-based violence o Make changes in the physicalwork settings or in housing toimprove security; provide vehiclesto enhance health workers'mobility

Source: Adapted from Conceptual and Practical Foundations of Gender and Human Resources for Health

Figure 22: Gender-based intervention in the health workforce at different levels



Module 7 Evaluation Sheet

	Aspects I liked most	Aspects I liked least	New things I learnt	Suggestion for improvement
Content				
Methodology				
Facilitation				

Module 7 References

Federal Ministry of Health (2001).*Health sector development plan III annual performance report.*

Federal Ministry of Health (2009*). Health and health related indicators*. Policy Plan and Finance General Directorate.

Newman C. (2009). *Conceptual and practical foundations of gender and human resources for health.*USAID and the Capacity Building Project.

World Bank (2012).*The health workforce in Ethiopia: Addressing the remaining challenges*. Washington DC.

ACTION PLANNING, COURSE EVALUATION AND CLOSING

ACTION PLANNING, COURSE EVALUATION AND CLOSING

Session 1: Action Planning

Description

In this session participants are guided on how to develop an action plan for implementation in their respective places of work. They learn to develop a realistic, concrete and doable action plan that considers the inputs from other participants and the facilitators. In other words, participants will learn to develop a SMART[14] action plan.

Session duration:2 hours

Session objective

At the end of this session participants will be able to:
- Identify major components of a gender action plan.
- Develop SMART action plans for their respective workplaces, using what they have learned from this course.
- Translate knowledge and skill gained so far in to practice.

Activity 1: preparation for the action plan

1 hour

Materials: *Printed copy of the action planning template*

Direction

Step 1- Introduce the session by explaining the following points:
- Learning needs to be translated into an action plan.
- The action plan guides participants on what to do when they return to the realities of their work places. In other words, it is a map of their expectations, what they have learned, and how they will apply the knowledge, attitudes, and skills gained.

[14] SMART refers to specific, measurable, appropriate, realistic and time bound.

Step 2-Remind participants to refer to their daily journal to get ideas for the action planning.

Step 3-Present the following guidelines for action planning:

- Timeframe can be divided into short-term (3-6 months) or long-term (1 year).
- Begin with your reflections.
- Build on your organization's existing programs.
- Identify a critical need of your organization or community.
- Develop plan that is doable and realistic–something that is within your sphere of responsibility and financial resources.
- Make simple and practical assumptions.

Step 4- Ask participants to form into groups (based on their organization or region).

Step 5- Distribute the action plan template (table 26) andexplain the format that the action plans should follow.

Step 6- Explain that the groups have 40 minutes to embark on the action planning processandthat their plans will be presented to the plenary for critiquing and feedback.

- Informthem that any of the facilitators are available for consultation as needed.

Activity 2: Presentation of the action plan and enriching

1 hour

Materials: *Printed copy of action planning template*

Direction

Step 1- Invite each participant/group representative to present the action plan.

Step 2- Invite other participants to critique the plans and ask the group to take note of the feedback to further refine the plans.

Step 3- Conclude the presentations by thanking each group for its participation.

Step 4- Give the participants the opportunity to revise their action plans, incorporating thecomments and suggestions from the participants and facilitators.

- Remind them to submitto the facilitators a final copy of their action plans.

Step 5-Collect and document the final copy of the action plan for future reference and follow-up.

Table 26: Action planning template

Background information

_____

Purpose and objectives of the proposed action:

_____

Time frame: _____

What to do?	How do you do? /Strategies/Methods	Stakeholders	What are the outputs/outcomes?	Budget Source	Potential obstacles to the proposed action, and ways to deal with them

Name of participants:

_____

_____

_____

Name of the organization, department and region

_____

_____

Session 2: Course Evaluation and Closing

Description

The successful closure of any training event involves evaluation of the learning that has taken place, a celebration of the successful completion of the course and a bridge to practice at the organizational and community level. This session seeks to achieve these throughtrainingcourse evaluation and official closure.

Session duration:1 hour and 30 minutes

Session objective

At the end of this module participants will be able to:

- Conduct the course evaluation and closing.

Activity 1: Test participants' post-training confidence

30 minutes

Materials: *Printed copy of post-training confidence test*

Direction

Step 1- Give out post-training confidence test to participants and let them determine their level of understanding of each module.

Step 2-Collect the test and summarizes it to identify participants' confidence regarding knowledge of the core learning agendas.

Table 27: Post-training confidence test

Introduction

Please indicate your level of knowledge, skills, attitudes, and practices with respect to the areas listed in the first column by putting an "X" mark in the appropriate box. This will help facilitators learn how far participants understood the core learning areas of the gender workshop.

Issues/Areas	Level of knowledge, skills, attitude and practice				
	Low ⟷ High				
	1	2	3	4	5
Gender concepts and terminologies					
Gender as a social determinant of health in Ethiopia					
Gender mainstreaming					
Gender analysis					
Gender audit					
Gender budgeting					
Gender and the health workforce in Ethiopia					

Activity 2: Conduct Course Evaluation

30 minutes

Materials: *Printed copy of course evaluation sheet*

Direction

Step 1- Distribute the copies of the course evaluation sheets to the participants.
Step 2- Explain the key components and completion procedure.
Step 3- Give the participants 30 minutes to complete the forms.
Step 4- Ask participants to return the completed form upon completion.
Step 5- Ask the participants to review their expectations and identify if there are any that have not been met.

Step 6- Take note of those expectations which have not been met and their relevance to the course content. Find the most appropriate way to help the participant/s.

Step 7- Conclude this activity by thanking participants for their feedback and committing to use that information to improve future courses. Also explain that the feedback will also be incorporated into the training report.

Table 28: Course Evaluation Sheet

Introduction

Please take few minutes to provide your reflection about the contents, approaches and processes of the training.

Issues/Areas	**Level of knowledge, skills, attitude and practice**				
	Low ⟷ **High**				
	1	**2**	**3**	**4**	**5**
Meeting your initial expectations					
Overall impressions					
Relevance of the course contents					
Level of participations					
Level of time management					
Level of experience shared among participants					
Level of facilitations					
Overall methodology used					

1. Training aspects you liked most?

_____

_____

_____.

2. Training aspects that you liked least?

_____

_____

_____.

3. New things you learnt from the training?

_____

_____

_____.

4. Suggestion or recommendation for future improvement.

_____

_____

_____.

Activity 3: Conduct closing program

30 minutes

Materials: *Certificate, and soft or hard copy of the course manual*

Direction

Step 1- Invite two representatives of the participants (a lady and a man), facilitators, course organizers and invited local authority representative to make the closing remarks.

Step 2-Facilitate the certificate award process in the following manner:

- Ask the participants to pick a certificate at random (not their own). Explain that they will each come to the front, call out the name on the certificate they are holding and award the certificate of their colleagues.
- Ask the participant seated at one end to start the process and the others would follow in that order until all have received their certificates.
- The facilitators will assist by awarding each participant with the hard or soft copy of the manual

Step 3- Close the workshop by reminding the participants that they now have the powerand tools to go and share their skills to their colleagues and community to mainstream gender and contribute to the equality of men and women.

Step 4- Emphasize that the participants should feel free to consult the facilitators' and/or each otherand to share lessons as they mainstream gender in their day-to-day work.

Step 5- Wish the participants well and encourage them to keep in touch. (This assumesthat the list of contacts has been distributed earlier).

ANNEXES

Annex 1: Glossary of Gender-Related Terminologies and Concepts

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

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

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

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

Terms	Definitions
	relations; 2) unequal power relations between and among groups of men and women, and 3) the interaction of contextual factors with gender such as ethnicity, education or employment status.
Gender analysis in health	Examines how biological and sociocultural factors interact to influence health behavior, outcomes and services. It also uncovers how gender inequality affects health and well-being.
Gender based division of labor	Refers to where, how and under what conditions women and men work (for or without pay) based on gender norms and roles.
Gender blind	Ignores gender norms, roles and relations and very often reinforces gender-based discrimination. By ignoring differences in opportunities and resource allocation for women and men, such policies are often assumed to be "fair" as they claim to treat everyone the same.
Gender responsive	A policy or programme that considers gender norms, roles and inequality with measures taken to actively reduce their harmful effects.
Gender sensitive	Indicates gender awareness, although no remedial action is developed.
Gender-based discrimination	Any distinction, exclusion or restriction (such as unfair or unequal treatment) made based on gender norms, roles and relations that prevents women and men of different groups and ages from enjoying their human rights. It perpetuates gender inequality by legitimizing stereotypes about men and women of different ages and groups.
Health and social outcomes and consequences	Health and social outcomes and consequences refer to *what happens* when a person becomes sick. The consequences of a health problem often cause economic and social changes for both the sick individual and their *social network*. This social network can include family or household members, friends and broader community members. Health outcomes relate to recovery, disability or death from a health problem. Gender considerations often influence how these outcomes influence a family or individual.

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

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

Annex 3: Gender Audit Questionnaire

I. PROGRAMMING

A. Program Planning and Design

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

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

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

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

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

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

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

B. Program Implementation

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

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

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

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

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

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

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

C. Technical Expertise

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

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

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

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

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

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

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

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

D. Monitoring and Evaluation

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

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

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

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

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

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

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

7. The organization programs/projects collect gender disaggregated data in the following areas:

Material well-being	[ ] YES	[ ] NO	[ ] Don't Know
Access to resources	[ ] YES	[ ] NO	[ ] Don't Know
Access to training	[ ] YES	[ ] NO	[ ] Don't Know
Participation in decision-making	[ ] YES	[ ] NO	[ ] Don't Know
Self-respect/legal status	[ ] YES	[ ] NO	[ ] Don't Know
Control over benefits	[ ] YES	[ ] NO	[ ] Don't Know
Control over resources	[ ] YES	[ ] NO	[ ] Don't Know
Participation in the public sector	[ ] YES	[ ] NO	[ ] Don't Know
Beneficiaries view of the project's benefit to their lives	[ ] YES	[ ] NO	[ ] Don't Know

E. Partner Organizations

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

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

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

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

4. What are some of the obstacles to incorporating gender analysis in program/project planning, implementation and evaluation in the organization? Please tick all that apply.
   - [ ] organization size
   - [ ] staff size
   - [ ] office culture/environment
   - [ ] local culture
   - [ ] lack of financial resources for gender programming
   - [ ] lack of staff training on gender
   - [ ] lack of gender analysis tools
   - [ ] lack of support from senior management
   - [ ] low organizational priority for gender issues
   - [ ] other, please specify below:

   _____

II ORGANIZATION

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

A. Gender policy

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

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

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

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

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

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

B. Staffing

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

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

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

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

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

5. Does management show respect for diversity in work and management styles between women and men in the organization?

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

C. Human Resources

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

1.Is there a written equal opportunity policy in the organization?

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

2. Are there flexible work arrangements in the organization?

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

3. Is there a maternity and paternity leave policy in the organization?

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

4. Is there a childcare and dependent care leave policy in the organization?

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

5. Is gender awareness included in all job descriptions in the organization?

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

6. Is gender awareness included in the organization staff performance & development review criteria?

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

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

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

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

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

9. The organization promotes teamwork, involving both men and women as equal partners
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

10. Management is committed to promoting female representation at senior levels of the organization.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

11. There has been a gradual increase of gender expertise among staff members in the organization.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ]Strongly Disagree

12. Good performance in the field of gender is rewarded in the organization.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

D. Advocacy, Lobbying and Communications

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

1. Are the organization advocacy and lobbying campaigns/ initiatives planned and informed by a gender perspective?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

2. Are the organization advocacy and lobbying policies and plans influenced and advised by women's organizations, networks and gender experts?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

3. Is gender incorporated in the organization communications, fund-raising and media strategies?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

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

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

E. Financial Resources

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

1. Does the organization budget adequate financial resources to support its gender integration work?
[ ] Not at all [ ] to a limited extent
[ ] to a moderate extent [ ] to a great extent
[ ] to the fullest extent [ ] do not know

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

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

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

F. Organizational Culture

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

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

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

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

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

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

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

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

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

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

10. Men in the organization think that the organization is women friendly
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

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

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

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

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

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

16. It is unfair to promote women more than men in the organization field programs/ projects.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

17. In the organization males have a much easier time establishing personal and professional networks within the organization than do females.
[ ] Strongly Agree [ ] Agree [ ] No opinion
[ ] Disagree [ ] Strongly Disagree

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

_____

_____

Annex 4: Supervisory Checklist to Monitor Institutional Gender Mainstreaming

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

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

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

Annex 5: Training Schedule

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

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

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

Annex 6: Pre/post test questions

Instruction: Choose the best answer and circle the letter of your choice.

1. One of the following doesn't indicates the difference between Gender and Sex
   A. Gender is social construction while sex is natural
   B. Sex roles are universal while Gender roles vary from place to place and over time period
   C. Gender roles can be modified while sex is not
   D. None of the above
2. Which one of the following is not example of Gender?
   A. Women have long working hours at house hold level
   B. Men are considered heads of the family
   C. Men shows physical and behavioral changes at puberty stage
   D. All of the above
3. Which one of the following is correct statement?
   A. Education and Income can change women status
   B. Laws and proclamation to change status of women may not yield result in the absence of change in norms values and customs of the community
   C. Men are sole contributors of GBV
   D. All except C
4. What is the median age at first marriage in Ethiopia?
   A. 15
   B. 18
   C. 16
   D. 17
5. One of the following is common Harmful Traditional Practice related to Gender, in Ethiopia?
   A. Female Genital cutting
   B. Early marriage
   C. Abduction
   D. All of the above
6. Which one of the following is health hazard of Female Genital Cutting?
   A. Problems during labor and delivery
   B. Cyst
   C. Hematocolapos
   D. All
7. One of the following is among the different measures taken by the Government of Ethiopia to reduce maternal death.
   A. Free ANC and delivery services to pregnant women

B. Abortion care implementation manual
C. Deployment of HEWs
D. All of the above

8. Which one of the following is true about Gender mainstreaming?
   A. Gender mainstreaming is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programs
   B. Gender mainstreaming should be done in all areas and at all levels in society
   C. It helps ensure that human rights of all people, women and men, girls or boys are protected, promoted and respected
   D. All of the above
9. What is the benefit of Gender mainstreaming in health?
   A. Increases service uptake
   B. Promote Gender equity
   C. Helps to design strategies to reach both men and women with health services
   D. All of the above
10. Which one of the following is a challenge in Gender mainstreaming?
   A. Limited institutional capacity
   B. Fear of stigma
   C. Lack of time
   D. All of the above
11. Which one of the following is false about Gender continuum?
   A. Gender exploitative approaches, take advantage of rigid gender norms and existing imbalances in power to achieve the health program objectives
   B. Gender aware programs/policies are expected to be designed with gender accommodating or transformative intentions Gender transformation is deliberate process to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health as well as gender equity objectives
   C. A gender accommodating approach may be considered a missed opportunity because it does not deliberately contribute to increased gender equity, nor does it address the underlying structures and norms that perpetuate gender inequities
   D. All
12. Which one of the following is not true about Gender audit?
   A. It shows the extent to which the health sector is considering issues of men and women
   B. Gender audit has to be done regularly every two years in each institution
   C. Gender audit reports can be considered for future planning and discussion on ender sensitive programming
   D. None of the above
13. Which of the following statement is correct about gender equity and gender equality?
   A. The terms gender equity and gender equality are often used interchangeably

B. Gender equity refers to an approach where measures are put in place to compensate for the historical and social disadvantages that prevent women and men from operating on a level playing field while Gender equality refers to a relational status between women and men
C. Gender equity is a means to achieving gender equality
D. All are correct statements

14. What is Gender Analysis?
    A. Gender analysis is a process of collecting and analyzing sex disaggregated information in order to understand gender differences
    B. Gender analysis is head count of men and women in an organization
    C. Gender analysis is to increase number of women in an organization
    D. All of the above
15. What is the benefit of Gender analysis?
    A. Helps to design and implement development projects in a way that will close gender inequality gaps so that both women and men benefit from development and are equitably empowered
    B. Helps to understand how gender roles, responsibilities and inequalities affect the project's effectiveness and the sustainability of its results
    C. Both A and B
    D. All of the above

Annex 7: Pre/post-test Answer Key

1. One of the following doesn't indicates the difference between Gender and Sex
   A. Gender is social construction while sex is natural
   B. Sex roles are universal while Gender roles vary from place to place and over time period
   C. Gender roles can be modified while sex is not
   D. None of the above
2. Which one of the following is not example of Gender?
   A. Women have long working hours at house hold level
   B. Men are considered heads of the family
   C. Men shows physical and behavioral changes at puberty stage
   D. All of the above
3. Which one of the following is correct statement?
   A. Education and Income can change women status
   B. Laws and proclamation to change status of women may not yield result in the absence of change in norms values and customs of the community
   C. Men are sole contributors of GBV
   D. All except C
4. What is the median age at first marriage in Ethiopia?
   A. 15
   B. 18
   C. 16
   D. 17
5. One of the following is common Harmful Traditional Practice related to Gender, in Ethiopia?
   A. Female Genital cutting
   B. Early marriage
   C. Abduction
   D. All of the above
6. Which one of the following is health hazard of Female Genital Cutting?
   A. Problems during labor and delivery
   B. Cyst
   C. Hematocolapos
   D. All
7. One of the following is among the different measures taken by the Government of Ethiopia to reduce maternal death.
   A. Free ANC and delivery services to pregnant women
   B. Abortion care implementation manual

C. Deployment of HEWs

D. All of the above

8. Which one of the following is true about Gender mainstreaming?
   A. Gender mainstreaming is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programs
   B. Gender mainstreaming should be done in all areas and at all levels in society
   C. It helps ensure that human rights of all people, women and men, girls or boys are protected, promoted and respected
   D. All of the above
9. What is the benefit of Gender mainstreaming in health?
   A. Increases service uptake
   B. Promote Gender equity
   C. Helps to design strategies to reach both men and women with health services
   D. All of the above
10. Which one of the following is a challenge in Gender mainstreaming?
   A. Limited institutional capacity
   B. Fear of stigma
   C. Lack of time
   D. All of the above
11. Which one of the following is false about Gender continuum?
   A. Gender exploitative approaches, take advantage of rigid gender norms and existing imbalances in power to achieve the health program objectives
   B. Gender aware programs/policies are expected to be designed with gender accommodating or transformative intentions Gender transformation is deliberate process to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health as well as gender equity objectives
   C. A gender accommodating approach may be considered a missed opportunity because it does not deliberately contribute to increased gender equity, nor does it address the underlying structures and norms that perpetuate gender inequities
   D. All
12. Which one of the following is not true about Gender audit?
   A. It shows the extent to which the health sector is considering issues of men and women
   B. Gender audit has to be done regularly every two years in each institution
   C. Gender audit reports can be considered for future planning and discussion on ender sensitive programming
   D. None of the above
13. Which of the following statement is correct about gender equity and gender equality?
   A. The terms gender equity and gender equality are often used interchangeably
   B. Gender equity refers to an approach where measures are put in place to compensate for the historical and social disadvantages that prevent women and men from

operating on a level playing field while Gender equality refers to a relational status between women and men

C. Gender equity is a means to achieving gender equality

D. All are correct statements

14. What is Gender Analysis?
    - **A. Gender analysis is a process of collecting and analyzing sex disaggregated information in order to understand gender differences**
    - B. Gender analysis is head count of men and women in an organization
    - C. Gender analysis is to increase number of women in an organization
    - D. All of the above
15. What is the benefit of Gender analysis?
    - A. Helps to design and implement development projects in a way that will close gender inequality gaps so that both women and men benefit from development and are equitably empowered
    - B. Helps to understand how gender roles, responsibilities and inequalities affect the project's effectiveness and the sustainability of its results
    - **C. Both A and B**
    - D. All of the above

Acknowledgment

This gender training manual for the health sector is drafted for use with Women and Youth Affairs Directorate of the Federal Ministry of Health, under the development of USAID supported Leadership, Management and Governance (LMG) Project of Management Sciences for Health (MSH). LMG project provided the finance and technical assistance for the manual preparation. To this end, the Women and Youth Affairs Directorate of FMOH wishes to acknowledge and thank LMG project and all the contributors of the manual.

The Directorate would like to express its sincere appreciation to Dr. BelkisWoldeGiorgis, Gender and Capacity Building Senior Advisor at LMG home office, and Seble Daniel, Gender Advisor at LMG Ethiopia, for drafting the manual.

The Directorate would like to extend its gratitude to the following individuals for providing their priceless input during the consultative workshop of the manual:

- AlemayehuBogale, Ahmed Mohammed, AlemtsehayBerhie, Behredin Mohammed (Dr.), ElfineshBekele (Sr.), HailuDawo, Hailu G/Michael, and Michael Mesfin from the different directorates of FMOH.
- Alemtsehay Data, AshenafiWoldu and Tesfanesh Goa, DejytnuMulaw and Lulu Bekana (Dr.), KirubelZewdie, Nuria Yusuf and TadesseNigatu, LeulKebede (Sr.) and ZewdneshWolde (Sr.), TewabechTefera, TewedajMersha (Sr.) and ZelekeBiadglegn from FMHACA, ALERT Center, Amanuel Specialized Hospital, PFSA, EHNRI, St. Paul Millennium Medical College, HAPCO, and St. Peter Hospital respectively.
- Tesfayenesh Lemma, MinyamirYitayih, ZinashDirese and GirumnehNigussie; and Ahmed Mohammed from MOWCYA and MOFED respectively.
- DerejeAyele, FikirMelese (Dr.), Helen Amdemichael, HeranAbebe, and TsehayGette from MSH/LMG, WHO, Future Groups/HPP, IFHP/Pathfinder International, and UNFPA respectively.

The Directorate also would like to thank the following individuals for their valuable contribution during the pre-test training of the manual:

- AlmazAbera, FatumoBidiye , Merka Peter, MisrakGulma, NediDiribsa, SewnetGeleta, TsehayWorkalemahu, Tangut Demas, and YazachewGetaneh from nine regional health bureaus and two administrative town health bureaus.
- AmsaleEshetu, KetemaTafesse (Dr.), Weyinishet Belay (Sr.), and WubnatBirarafromFMOH, ALERT Center, Amanuel Specialized Hospital, and FMHACA respectively.

The Directorate especially would like to thank and appreciate FitsumGirma (Dr.) and RehimaShikur from the Human Resource Directorate of FMOH for their guidance to keep the standards of FMOH National In-Service Training Guide, and to make the manual take its current shape.

W/o YamerotAndualem

Director