



**One-Day
Gender Training
Module On RH
For
Female Health Workers**

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GENDER TRAINING
MODULE ON RH
FOR
FEMALE HEALTH WORKERS**

**United Nations Population Fund
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PREFACE

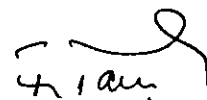
The Training of Trainers (TOT) module on Gender and Reproductive Health (RH) for Female Health Workers (FHWs) intends to give a basic exposure to FHWs on gender issues with a focus on health, especially reproductive health. Formulating this module is in consonance with the ICPD goals with reference to gender equity and equality. It underscores the premise that reproductive right is an integral part of service provision. Many providers, both men and women fail to respond to the practical and strategic needs of women and men without knowing how sex, which is biologically defined, and gender, which is a socio-cultural construct, work to the disadvantage of women in terms of their access to RH/health care. The first few sessions of the module give a conceptual understanding of gender and show how the latter informs reproductive health. The application of these concepts is explained in the subsequent sessions relating to gender-based violence, male participation and practice of gender-sensitive health services and care.

The training methodologies emphasize an interactive, participatory and experiential learning. The modules are formulated with the assumption that the experiences of participants women and men, are the moot learning point on which sensitisation has to be based. It is, therefore, not the novelty of knowledge but the cultururation of the existing knowledge from a gender perspective that gets the prime focus in these modules. The articulation on gender, when trainers provide the training, would then be convincing. Therefore, the training methodology is based on the basic premise that participants are the critical resource and the trainer is a facilitator who creates an environment for learning rather than provide knowledge itself. Any trainer on health with an open mind, with basic human sensitivity and with an ability to communicate effectively has the potential to handle these modules as a gender trainer.

The methodologies and design used in these modules are based on the hands-on experience UNFPA gained while conducting a series of gender training workshops in collaboration with the project partners in the various States in the past one year. Some of the methodologies used by the trainers which were found to be effective during these training workshops have been used in these modules. UNFPA takes this opportunity to acknowledge the contribution made by each of the trainers, especially Mr. Subhash Mendhapurkar, Consultant, in enriching these modules.

The module was prepared at the request of the Governments of Madhya Pradesh and Gujarat, the two IPD States where a formal decision has been taken to extend the 12-day RCH training by one more day. The motivating force behind the requests were some of the senior programme managers of IPD who had exposure to Gender through the two population, RH and development workshops conducted at LBSNAA, Mussoorie, in 2000. These workshops were conducted by UNFPA in collaboration with LBSNAA.

UNFPA wishes to acknowledge the contribution of UNFPA Technical Advisor, Gender, Ms B. Bhamathi, in putting together this module. Any feedback would be most welcome.



Francois M. Farah
UNFPA Representative

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HOW TO USE THE MANUAL

The Manual contains seven sessions. Each session follows the sequence given below.

- **Session Title** This identifies the main topic of the session. This must be shared with the trainees/ instructors at the beginning of the session.
- **Session Objectives** It describes what participants will be able to do by the end of the session in order to demonstrate increased knowledge, improved skills or changed attitudes. Objectives should be written on the flip chart/ blackboard before the sessions. The trainer should start each session by presenting the session objectives and try to re-read the objectives towards the end to enable participants to assess whether these were met.
- **Core Message** These are the suggested core points of discussions. It is expected that discussion around the given points will enable the participants to accomplish session objectives.
- **Expected Outcome** This is indicative of what in terms of basic knowledge that participants should have gained at the end of the session
- **Time** It indicates approximate duration of the sessions. Resource persons are expected adhere to the time allotted for each session and activity/task (where prescribed). Resource persons should try to conclude the session within the given time frame. Incomplete sessions will be of no use.
- **Methodology** It explains the methodology adopted by the trainer to conduct the sessions in a participatory manner.
- **Note to Facilitators** You must study these before conducting the session. They contain additional information, which should be used by the trainer while conducting the session. This could be shared with the trainees.
- **Facilitator's Guidelines** These provide specific instructions to the Instructor/Resource Person. These notes are only for the guidance of the trainers and are not to be shared with the trainees. Therefore, it is very important to read, understand and, if possible, rehearse the session steps before the workshop.

Session Plan

Session Number	Course Contents	Method	Time
Session 1 Concepts of gender and gender stereotypes	Examines the basic concept of gender and clearly differentiates between sex and gender	Gender quiz, interactive discussions	45 minutes
Session 2 Gender roles, access & control and division of labour	<ul style="list-style-type: none"> ➤ Women's work burden ➤ Access and control over resources based on gender ➤ How work roles impact health 	Bar chart game	60 minutes
Session 3 Understanding FHWs roles and tasks	<ul style="list-style-type: none"> ➤ Roles and expectations from FHW 	Circular story telling	45 minutes
Session 4 Understanding the power structure within village and its effects on women	<ul style="list-style-type: none"> ➤ Gender as a component of larger socio-cultural and economic issues ➤ Socio-cultural constraints on women's health 	Film or web game	45 minutes
Session 5 Socio-Cultural determinations of women's health	<ul style="list-style-type: none"> ➤ Concept of RH ➤ Understanding differential health needs of men and women ➤ All RH issues have a gender basis 	Group work, presentation and discussions	45 minutes
Session 6 Reproductive health & gender	<ul style="list-style-type: none"> ➤ Impact of violence on RH ➤ Role of providers in addressing gender-based violence 	Film, discussion	60 minutes
Session 7 Gender-based violence and RH	<ul style="list-style-type: none"> ➤ The importance of male participation in RH ➤ To discuss ways of enhancing male participation in RH programmes 	Role play and discussions	60 minutes
Session 8 Male participation	<ul style="list-style-type: none"> ➤ Understanding applications of gender-sensitive health service ➤ Develop gender-sensitive indicators 	Role play	45 minutes
Evaluation	Questionnaire filled up by participants as feedback	Individual exercise	15 minutes

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NOTE FOR THE TRAINER ON THE DESIGN OF THIS TRAINING MODULE

This Training Module has been designed keeping in mind the following principles

- The principles of adult learning;
- The principles of participatory training.

To succeed with this module, it is essential that the following core principles of training are kept in mind:

- This training module is oriented towards causing attitudinal and behavioural change in one of the core areas of our personal/cultural beliefs and practices, i.e the relationship between men and women. The sessions, therefore, must draw from real-life examples as much as possible.
- This training will challenge many of our conscious and unconscious beliefs and practices and as such has to be held in an environment which is friendly and supportive but is challenging as well. It should allow the participants to feel comfortable to voice deep concerns and, if necessary, try out new patterns of behaviour.
- There must be a total atmosphere of trust between participants and facilitators. It should be publicly mentioned that statements made during the course of this workshop will not be used outside the training room.
- The training will be a joint exploration by both participants and facilitators, and there must be mutual respect for all opinions and points of view. This does not mean that views cannot be challenged. What it does mean is that no views will be held in contempt as inferior or superior, and no one will be laughed at.
- Learning is possible only if the learner is willing. The facilitator will only provide opportunities in which learning can take place. There must be no autocratic control of the learning process by the facilitator. Similarly, the learners must take responsibility for learning, which will include logistics and timings as well.
- Adult learning takes place in the context of the adult's own reality and experiences. Thus, participants must be provided with adequate opportunity to relate their experiences.
- This training module emphasizes the value of equality. All arrangements during the training must also emphasise this. The seating pattern must be non-hierarchical, and the communication must be two-way.
- The Trainer should be conscious of his/her position in the hierarchical system and class, in general, on the basis of which special efforts should be made to generate responses for an inclusive and interactive process. At the end of the training, the trainer and trainee should feel equally empowered.

Some of the core values of participatory training

Respect	Trust
Acceptance	Non-threatening / comfortable environment
Openness	Co-operation and support
Sharing	Mutuality

Note for the facilitator

The facilitator has to always be alive to the fact that the participants are women and if the facilitator is a man he must never devalue their experiences. If the facilitator is a doctor s/he must be aware that this professional hierarchy has the potential of affecting the training process and openness of the participants. Care in the use of language is also essential. FHWs are usually comfortable only in the vernacular. Use songs and games, and also participate in them.

PRE-TRAINING QUESTIONNAIRE

Time: 15 Minutes

Note: The participants are requested to answer the following questions before the workshop. They are requested to provide their answer as per their understanding and experience. The questionnaire must be in the local language. Therefore, please translate before using this.

Name of the participant :

Place of posting :

1. What is the reason behind your taking up this profession?
2. What, according to your field experiences, are the most important health concerns/problems of women in your work area?
 - i) Anaemia
 - ii) RTI/STDs
 - iii) Pregnancy-related
 - iv) Early marriage
 - v) Inaccessibility of health-care services
3. What, according to your understanding and experience, are the main reasons behind these health problems?
 - i) Because they cannot afford health care
 - ii) Because they cannot access health services
 - iii) Because of illiteracy
 - iv) Families are indifferent to women's health needs
4. Do you think women in your area enjoy inferior/superior/equal status to men?
5. In case of any critical problems, whom do you approach for help/consultation?
 - i) Male Health Workers
 - ii) Husband
 - iii) Sarpanch
 - iv) Medical Officer
6. Who do you think respects you most as a professional?
 - i) Medical officer
 - ii) Male Health Workers
 - iii) Sarpanch
 - iv) Husband
 - v) Children

7. Do you think community support could help you to perform better? Narrate any experience of how community has supported you in your work.
8. Caring for children is women's responsibility? Agree/disagree
9. There are more men leaders in society because women lack leadership qualities. Agree/disagree
10. Societal norms for men and women are appropriate. Agree/disagree
11. All diseases (except gynaecological diseases) affect men and women similarly.
Agree/ disagree
12. Men have more knowledge mainly because they have more exposure to the world. Agree/disagree

Facilitator's Guidelines

It is required to have a benchmark on participants' knowledge of gender before the training. It is a useful for undertaking a process documentation of gender training and for any impact evaluations undertaken in future. Please conduct this exercise as soon as possible. It may be given to the participants individually as they come in or as a group, but in no case should the participants consult each other during filling it up. A print-out of this handout must be ready in adequate numbers before the workshop begins.

SESSION I

Time: 30 Minutes

CONCEPTS OF GENDER

- Objective:** To examine the basic concept of gender and the difference between sex and gender and their relationship with health.
- Core message:** Sex is biological, gender is a socio-cultural construct of men and women.
- Expected outcome:** Participants are able to clearly differentiate between sex and gender.
- Methodology:** Photo game- *pehchan*.
Gender quiz
Brainstorming

Materials required - Photographs

STEP I

Divide the participants into four groups and give each group a picture of a two-month-old diaper-clad baby, a five, 12 and 20 years old persons. Use a combination of female and male pictures in the last three categories. Ask the participants to identify the sex of the person shown in the picture and to list out the means by which they do it.

1. Can one identify the sex of a two month-old diaper clad baby?

Definitely not

2. Can one identify the sex of a five year-old child?

Yes, in certain cases.

Characteristics:

- Hair, Clothing, Language, Play activities etc

3. Can one identify the sex of a 12-year-old?

Yes, positively.

Characteristics:

- Hair, Clothing, Language, Voice, Ornaments worn, behaviour

4. Can one identify the sex of a 20-year-old person through observation of day-to-day activities?

Yes, positively.

Characteristics:

- Hair, clothing (culturally imposed covering of breast region with a *duppatta*), language, voice, ornaments (piercing of nose and ear lobes), division of work (outdoor and indoor activities), nutrition (eating last, least and leftovers), *Bindi* & vermillion, change in body language.

STEP II

Form a group of four and share the set of statements below with each group for discussion. Each group is asked to identify and reason out each statement as sex or gender or both (S\G) and then discuss each statement in a plenary.

Sum up by a guided discussion by asking the questions at the end.

- Women are better at caring for children than men (S\G)
- Peanuts should not be eaten by women as these are hot for them (S/G)
- Women are better nurses than men (S\G)
- Women neglect their own health needs (S\G)
- Women breastfeed babies (S\G)
- Men need more nutrition as they undertake heavy work (S/G)
- Male voice breaks at puberty (S\G)
- Men are genetically taller than women (S/G)
- Women menstruate and also undergo menopause (S\G)
- Men are soldiers, because they are brave and can use weapons to fight (S\G)
- Men need to eat deshi ghee as it helps them to produce healthy semen (S/G)
- Men are naturally built up stronger to do more physical work than women (S/G)

Q.1 Did any of the statements surprise you? Why?

Q.2 From the statements given above, can one infer that sex is nature-given and gender is human-made?

STEP III Summing up. Define "gender" based on discussions and use this table to assist in

SEX	GENDER
Biological	Socio-cultural construct
Nature-made	Society-made
Constant	Variable
Individual	Systemic
Non-hierarchical	Hierarchical
Cannot be changed	Difficult, not impossible

Examples of the different properties of sex and gender:

Sex is constant and cannot be changed – Men and women in all parts of the world and across different times have similar biological features. Sex change is possible but it is a deliberate surgical procedure. *Hijras* are not an example of sex change.

Gender is variable and changes – The norms of dress change across regions – and across times. Men wear *salwar kurtas* in some places and women wear it in others, men pierce their ears in some places while women do it in others; women wear their hair long in some places while men wear it long in others. Norms also change over time. Women now wear trousers, which they didn't do twenty years ago.

Gender is systematic – Gender norms are common for all men and women in a particular cultural context. All men and women are expected to behave in a similar manner. The difference between men and women are codified at the level of different systems like law, religion, etc. The sex of a person is an individual attribute, constant and invariable.

Gender is hierarchical and sex is not – Hierarchy refers to values of superiority and inferiority being attached to things/people. Thus, with males and females are different as two sexes, but in terms of gender men are supposed to be superior to women. Thus, men are stronger, braver, are bread-winners, while women are the weaker, the gentler sex, the housewives, and so on.

STEP IV

Ask the participants to go back to their groups and list out the 'Thou shall not do' instructions given to a girl and a boy in the same family. For example, boys are told not to cry because only girls cry. Girls are told not to go out alone at night because they are not safe.

STEP V

Ask each group to make presentation and with each instruction try to generate discussion on the effects of this on health care seeking attitudes of women. List these out on the blackboard. For example, *pardah* denies sunlight and Vitamin D, repeated *vrat* kept by women weakens them, no food or water is given to the mother for three or more days after delivery.

Facilitator's Guidelines:

- Guide discussions and, as far as possible, encourage participants to respond to questions that come up. Step in to facilitate discussion.
- Make the participants speak from the standpoint of their experiences and personal lives.
- Encourage participants to question why small and listed differences should lead to unlimited number of gender differences.
- Try to bring up health issues by showing interactions between biology and gender.

GENDER ROLES, ACCESS & CONTROL AND DIVISION OF LABOUR**Objective:**

- To understand men and women's roles, particularly multiple roles of women.
- The differential access to and control over resources for men and women.

Core message: To understand gender division of labour.

Expected outcome:

- ★ To understand how access and control over resources in meeting health needs are affected by gender roles.
- ★ To understand that the division of labour within the family has two aspects: (1) unpaid labour is credited to women, and (2) certain types of work done repetitively has effects on health.
- ★ FHWs are sensitised towards the limitations imposed on women by traditional division of labour on their health care seeking behaviour.

Methodology: Small group discussion, plenary and role-play

STEP 1

Divide the participants into three groups and give them the question (ask one group to focus on any one set of questions if the time in hand is inadequate)

- ❖ Mention those rights that men have and women don't.
- ❖ Mention those rights women have that men don't.
- ❖ Mention those tasks that men have to do but women don't.
- ❖ Mention those tasks that women have to do but men don't.
- ❖ Mention those qualities and behaviours that men have to have and women don't.
- ❖ Mention those qualities and behaviours that women have to have and men don't.

MEN	WOMEN	MEN	WOMEN
Rights	Rights	Responsibilities	Responsibilities
i.			
ii.			
iii.			
iv.			

Give the groups twenty minutes to discuss- and then ask each group to present their responses to one set of questions. Allow for discussion in the larger group – through questions and clarifications. It may emerge that men have many more rights than women, and women have many more tasks that they have to do that men don't have to. Most of men's tasks are also done by women. Note how the qualities of and behaviours expected of men and women are different.

Explain the difference between men and women using the sex-gender framework. Emphasise how these differences are imbibed right from birth -- explain the process of socialisation.

STEP II

Prepare a set of name cards of men women, each card mentioning the name of a person and the person's age. Distribute these cards to all the participants. Tell the participants that for the duration of this game they will become the persons whose name card they get. Thus, half the participants will become men and the other half women- randomly. Now read out these questions one by one and ask them to think and write down an answer – "Yes" , "No" or "I don't know". They must answer from the point of view the persons whose name card they got.

Questions

1. Have you passed high school (age 20: ST)
2. There is a fair being held near your village. Will you be able to visit the fair? (age 22: Brahmin)
3. You like running. Will you run to your friend's house? (age 15)
4. You have seen a thing at a shop and you like it very much. The thing costs Rs 150 . Will you buy it? (age 40:ST)
5. Are you the owner of your family fields/ house? (age 50: Widow)
6. There is a child who has fallen sick in your home. Will you be asked to look after the child? (age 10: agricultural labourer)
7. Your friend lives 10 km. away. Will you go to visit your friend alone? (age 30)
8. You are very hungry, but no one in your house has eaten till now. Will you start eating? (age 25: Rajput)
9. You have a headache; there is a lot of work left in the fields. Will you take a little rest? (age 40: Marginal Farmer)
10. There is a new government scheme which has come to your village. They are asking for workers. Will you apply for work? (age 35: New Govt. Scheme)
11. You do not like washing utensils. There is a huge pile of utensils lying unwashed. Will you wash these? (age 20s : Working Couple)
12. Do you work for money? Age:30s : Labourer)

Now, ask the participants to identify themselves- who were women? Ask all the women to come to one side and all the men to come to the other side. Now, read out one question and take the responses from one sex group. Note the responses on a chart or board in the manner illustrated below. Note how when the question relates to work in the home it is usually "yes" for women and "no" for men; when it is any thing that the person wants to do, women "don't know" because they have to ask for permission. Also, women even when they like doing something, they cannot do it on their own. The number of "I don't know" answers are usually much less in the case of men because they can take decisions on their own while women have to consult others. It will emerge from the responses that women have a greater workload – at home and outside, but have little access/control over resources (including leisure and time) as well as little decision-making authority.

Sample is worked out as follows:

Q. No.	Men		Don't know	Women		Don't know
	Yes	No		Yes	No	
1	✓				✓	
2	✓				✓	
3	✓				✓	
4						
5						
6		✓		✓		
7						
8						
9						
10						
11						
12						

Circulate Handouts 1-3

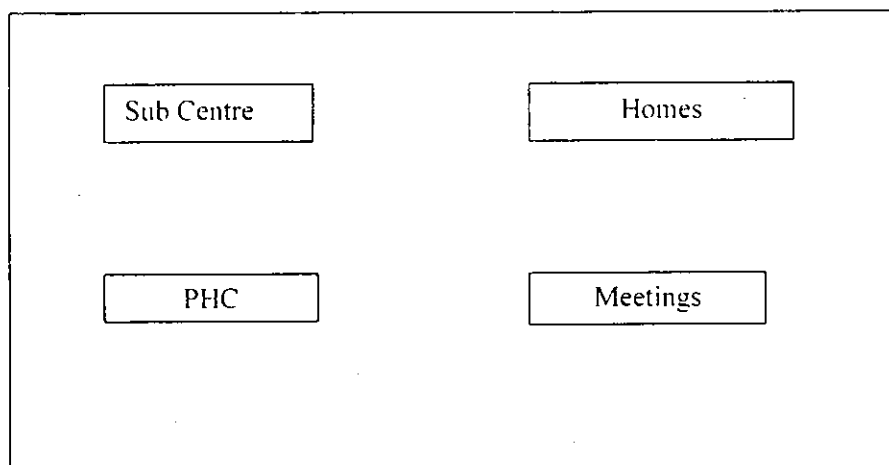
UNDERSTANDING FHW's ROLES AND TASKS

- Objective:** To understand the roles and tasks of FHWs
- Core message:** The multiple work burden of FHWs and the gender roles and expectation from her at home and the work place, especially in the context of Family welfare activities
- Expected outcome:** To lay the basic roles and tasks of FHWs, based on which changes would be discussed in later sessions

Method – Circular story telling

Steps – The participants are sitting around in a circle. Tell the participants that they will now all create a story about the life of an ANM. The story will be prepared by the whole group by adding one line to it. The facilitator starts the story by stating a line like – Rekha is an ANM. And then asks the person next to her/him to continue the story (a line which relates to the tasks and roles of an ANM what she does during the whole day.) And this process continues. As the different participants are relating their one line the facilitator makes a note of all the tasks and roles mentioned on the board/chart paper. At the end of the circle the facilitator reads out the list of tasks and roles mentioned and asks them if any thing is left out. If the answer is many a second round may be started.

Notes on writing the tasks- The different tasks mentioned may be classified according to the place where the ANM conducts them eg. Sub-centre, PHC, home of the client, village public place etc. This classification can be kept in mind while writing the tasks as they are mentioned with different task groups written at different places on the board/chart.



Note for the facilitator – This exercise is useful because it lays down the basic work of the ANM and this can be related to later when the changes in her work is being discussed – what changes may be made, at what place and how.

UNDERSTANDING THE POWER STRUCTURE WITHIN VILLAGE AND ITS EFFECTS ON WOMEN

- Objective:** To sensitise the FHWs towards the class and caste divide between and among women
- Core Message:** All women are not the same – Women are also governed by Caste and Class ideology
- Expected Outcome:** Participants understand that Caste and Class affect women's relationship with other women, so differential approach is required for different groups of women.
- Methodology:** Role Play:

STEP-I

Make two groups of participants and ask them to enact the following two role-plays:

- A Brahmin woman has three daughters. Her husband wants a son. She is weak and has TB. She wants contraceptive support from the FHW without the knowledge of the husband.
- The son of a landlord has sexually violated a woman agricultural labour belonging to SC and she has approached the ANM for support.

STEP-II

The facilitator explains all women are not the same. Each one of us (men and women) is governed by caste and Class ideology – higher the caste (socially), less the freedom for women to explain the violence they face.

Most of the time, the atrocities committed by higher class men on lower class women are either neglected or are not taken seriously by women village functionaries. Why?

Facilitator's Guidelines:

The facilitator should be able to explain that women belonging to socially or economically higher caste/class have more pressure to produce a son than the lower ones.

How does it affect their RH?

Sexual violence committed by higher class male on lower class women – how does it affect their RH?

How the ANM needs to be sensitive towards these, the class and caste issues, so that she can become more effective in providing services.

SOCIO-CULTURAL DETERMINANTS OF WOMEN'S HEALTH

- Objective:** To understand the socio-cultural determinants of women's health.
- Core message:** Gender is part of larger social issues.
- Expected outcome:** Gender analysis of health/RH problems and their socio-cultural specificities.
- Methodology:** Web game

Step I

The Web Game

A case study on socio-cultural determinants of women's health is given to the group. The facilitator reads out a story, stops at different points and asks the participant to identify the cause of the situation mentioned in the case study at that point, giving the following five options:

- Sex
- Gender
- Social and cultural
- Political
- Economic

A strong chord held by the facilitator at the centre is moved to the participant who responds first and the chord is rolled over and fastened to the hands of the respondent. The chord is moved with each question and response, in a complex way, to five corners/themes and this becomes a web. More than one option was possible for each question. At the end of the case study, the facilitator, standing in the middle, points to the area where there is the least and the most grouping of participants. The largest number is usually seen in the "socio-cultural" corner and the smallest in the "sex" corner. Then, the facilitator asks each participant to give one response, which could be an answer/solution/approach to the issue, and then cuts the chord to release each participant.

LAKSHMI'S STORY

Lakshmi belongs to a village in central Tamil Nadu, located about 15 km from the district headquarters. She is 27-years-old and is an agricultural wage labourer belonging to the Scheduled Caste.

Lakshmi grew up in another village. She was the first of four surviving children -- three girls and a boy. Her father had another woman. The family suffered a lot because of this. Lakshmi's mother had to go out to earn. Lakshmi was stopped from attending school after Class-I. She would graze cattle and earn money, and when she was about 10, started working as an agricultural labourer.

When Lakshmi was only 14, she was married off to her uncle's son, Ramu, because there would be no dowry involved. Ramu was 25 and was also an agricultural wage labourer without any property.

When they got married, Ramu told Lakshmi that times had changed, and that they should have only two children. If they had a boy and a girl, she should have an operation. But somehow, Lakshmi never conceived for two years. Her mother-in-law started abusing her.

She conceived when she was 17. Her first pregnancy was very difficult. Her arms and legs and even her face were swollen, and something would cloud her vision. She would also vomit everything she ate, day after day. But she never went to see a doctor. People said this is how it is when one is pregnant. A baby girl was born to her. After the delivery, in a government hospital, all these problems went away.

The second baby was also born in a hospital. But he died in a few days: vomited once in the morning, was taken to hospital immediately but died. The third was a daughter, and she died a few hours after birth. Some doctors said the baby had a heart problem while others said that Lakshmi was very weak. Some others that it was because she had married a close relative. But the baby was very small and only skin and bones. Lakshmi felt heart-broken.

After her third delivery, Lakshmi started having a foul-smelling white discharge frequently. She did not do anything about it, telling herself that this must be because of weakness. Lakshmi started a *vrat*, fasting once a week for a healthy birth the next time. Her fourth baby was born recently, and is a boy. Lakshmi wanted to have a family planning operation, and so did Ramu. But the doctors said that she was too weak, and sent her home. They asked her to come back after her health improved.

Lakshmi is now desperate. She does not want to conceive immediately and wants to make sure that her son survives and grows into a healthy child. But knowing her husband, she thinks abstinence is not feasible. She is afraid that if she refuses, he will take another woman just like Lakshmi's father did. She wants to know if we can help. Can we?

REPRODUCTIVE HEALTH AND GENDER**Objective:**

- To understand the concept of RH and to what extent these services are being provided in the health systems.
- To understand how RH is a gender issue.

Core message: All RH issues have a gender basis.

Expected outcome: Participants are able to analyse gender implications of each component of RH.

Methodology: Role play

Divide the participants into five groups (each group must have a minimum of five participants). Tell them that you are going to give them a women's health-related situation. They have to prepare a play showing the background to the situation. They cannot show an ANM in their play – only incidents that they feel must have happened to the women, based on their understanding of health and social situation and gender discrimination).

- A pregnant woman with three daughters who is also very anaemic,
- A woman who has been married for 6 years but has no children,
- A woman with white discharge and itching in her groin. Her husband usually stays outside but is home nowadays.
- A woman with three daughters and one son. Her husband is "no-good" type,
- An 18-year-old unmarried woman. Her periods have been delayed by two months.

The groups are given 30-45 minutes for preparation – check the stories to see that the discrimination angle has been dealt with and ask each group to rehearse. When the groups are ready, ask them to present their plays one by one. Ask the viewers to note:

- ❖ Manifestations of the disease
- ❖ Social causes/pressures
- ❖ Roles/behaviour of the family
- ❖ Response of self

(write these points on a board or chart paper)

After the presentations of the play, take up one condition at a time and ask for viewers' responses. These can be noted in the following format.

Manifestations of the health condition (Swasthya samasya ka prabhav/asar kya hai)	
Social causes/pressures Kya samajik dabav dikh rahe hai)	
Roles/behaviour of the family (parivar ke logon ka rawaiya)	
Response of self (Swayam ki pratikria)	

Sample is worked out on the topic "A woman with white discharge & itching in her groin. Her husband usually stays outside but is home nowadays".

Manifestations of the health condition (Swasthaya samasya ka prasthuth hota hai)	Pain during intercourse, itching, pelvic inflammation, discharge, sometimes foul-smelling, infertility, repeated abortions, fever, bleeding etc.
Social causes/pressures (Kya samajik dabav dikh rahe hai)	Suppression of truth, speaking in husband tones, blaming the girl than boy
Roles/behaviour of the family (parivar ke logon ka rawaiya)	Indifference, do not want the problem to be known outside family, not seeking medical attention for girl (trivialising), while encouraging boy taking treatment, send the girl to natal/maternal home, tension in marital relations, families do not support nor cooperate in house work
Response of self (Swayam ki pratikria)	Shy, not self-reporting, trauma of not being able to share with anybody, suppression because of domestic responsibilities, poor self-image, does not want to socialise, fear of being deserted, fear of re-marriage

Add to the analysis if there are points which have been left out. Ask the participants, "Do you think the situation is the same for men in terms of all these different parameters?"

Ask the participants whether they have heard the term Reproductive Health? What do they understand by this term, how is it different from family planning? Emphasise that in RH, the woman is at the centre, and we must understand her situation in order to help her.

What is RH?

Reproductive Health is a state of complete physical, mental, and social well-being, and is not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health, therefore, implies that people are able to have satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if and when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant.

.... ICPD, Cairo

Facilitator's Guidelines:

The salient features of the RH approach are the following and these should be compared with FP approach of the past:

- Range of services is more comprehensive in RH approach,
- Includes a rights-based approach,
- Acknowledges the health needs of women,
- Is based on a life cycle approach,
- Is based on the needs of the individual (women),
- Talks of quality services,
- Includes counselling as an essential part of services,

Circulate handouts 4-7

GENDER-BASED VIOLENCE AND RH

Objective: To understand gender-based violence, its impact on RH and the potential roles of providers in addressing it through the health systems.

Core message: Positive role of providers in addressing gender-based violence.

Expected outcome: Establish linkages between RH and gender-based violence in concept and practice.

Methodology: Films and discussions

STEP I

Screen the film *Nasreen O Nasreen*. This film has been made by an NGO in Delhi, called Shakthi Shalini, which supports women in violence through counselling and other services. The film is based on real-life incidents of women who have faced violence irrespective of their class, caste, religion, age, etc.

STEP II

Discuss the film and the facilitator should encourage the participants to speak about their own feelings about the film and narrate any experience of violence against women in their personal / official lives.

Facilitator's Notes: It is necessary to define gender-based violence with the help of participants. To do that, first do a free listing of violence, as follows:

- ❖ Physical/mental torture,
- ❖ Verbal, sexual and physical abuse,
- ❖ Eve-teasing (man to girls/women),
- ❖ Sati,
- ❖ Public insults,
- ❖ Not paying attention to her, confining her,
- ❖ Neglect of her medical nutritional, educational and personal needs,
- ❖ Non-co operative behaviour,
- ❖ Compelled to follow social traditions (Devadasi),
- ❖ Sexual harassment,
- ❖ Extra-marital relations,
- ❖ Divorce without reason/threats of divorce,
- ❖ Comparing,
- ❖ Demanding dowry,
- ❖ Abetting suicide,
- ❖ Not calling wife back from her natal home,
- ❖ Selling one's wife,
- ❖ Forcing wife/daughter into prostitution,
- ❖ Verbal abuse words in the health system),
- ❖ Abandonment and exposure,
- ❖ Coercive sterilisation (case of aquamarine),
- ❖ Unnecessary hysterectomies/c-sections,
- ❖ Induced abortion,
- ❖ Blackmailing with photographs,
- ❖ Unnecessary drugs.

STEP III

Impact of gender-based violence on women's health/RH.

Ask the participants to think of examples linking violence with RH outcomes. Guide the participants and help them to see the connections with one or two examples and then add to the following list. Give it as a handout. Encourage participants to share real-life examples:

- Impact on perinatal health
- Unwanted pregnancy/abortion
- STIs / HIV through consensual sex or by inability to negotiate contraceptive use
- Pelvic problems
- Miscarriage/low birth weight
- Birth of son or daughter helps or harms conjugal relationship (viz. foeticides)
- Violence leads to high-risk pregnancies and adverse pregnancy outcomes
- Infertility leads to violence against women.

Facilitator's guidelines:

- Violence is a human rights issue. All forms of violence should be condemned. But, documented evidence shows that women are subjected to violence by men as violence is a way of maintaining and reinforcing women's subordination.
- Women commit violence against women also, e.g mother-in law's violence against daughter-in law for dowry is common. This is made possible as women use the authority of being the son's mother to enforce their dominance.
- Explain physical and mental health consequences of violence, which is usually not recognised, such as post-traumatic stress, eating disorder, depression, anxiety, sexual dysfunction, low self-esteem, phobias,
- Providers can do their jobs well if they understand how violence and powerlessness affect women's reproductive health and sexual decision-making ability,
- RH care providers are strategically placed to identify victims of violence and connect them with other support services. (medico-legal or medico-social),
- 90 per cent of domestic abuse, with or without visible violence, requires medical, psychological, public health treatment,
- Women are far more likely to reach the health system/ professional first than police, lawyer, media etc.

Circulate handouts 8-11

MALE PARTICIPATION

- Objective:** To highlight the importance of male involvement in RH performance.
- Core message:** RH programmes make positive and substantial gain by involving males.
- Expected outcome:** Participants learn ways of integrating men into RH programmes.
- Methodology:** Role play, guided role play.

STEP I

Define male participation

It means providing an enabling environment for existing and changing needs and concerns of men, depending on gender relations, which would help both men and women in the context of Sexual and Reproductive health (SRH),

Emphasise that equality is the goal and partnership the means to achieve that equality.

STEP II

- Role Play -1.** A Gram Panchayat meeting is going on. A male health worker visits the Panchayat and makes a presentation on his work.
- Role Play -2.** A Gram panchayat meeting is going on. A female health worker visits the Panchayat and makes a presentation on her work.
- Role Play -3.** Guided - A Gram Panchayat meeting is going on. A Male health worker and a female health worker visit the Panchayat and make a joint presentation on their work.

Plenary Session: Discuss the difference between the first two and the third role plays. Initiate a discussion on the various means and steps that can be taken at the family, community and health service levels where male and female, men and women take joint responsibilities to promote partnerships for reproductive health.

COMMITMENT SESSION

Planning for change:

What two steps would you like to take in your personal life so that the gender pressures may be reduced and health status improved (this can be related to others in your family as well as yourself)

What two steps would you like to take in your professional life so that gender pressures may be reduced and women's health status may improve.

Write these steps on a separate piece of paper- do not write your name. Stick these papers on the wall in two sets. Ask some volunteers from the participant group to come and read them out for everyone to hear.

CLARIFYING RELATED CONCEPTS

Some underlying concepts involved in gender training require to be explained for trainers. The trainers would need to explain these when required.

Sex and gender

Sex refers to the biological differences between men and women.

Gender refers to the roles that men and women play and the relations that arise out of these roles.

They are socially constructed, not physically determined.

Access and control

Access is the ability to use a resource

Control is the ability to define and make binding decisions about the use of a resource.

Practical and strategic gender needs

Practical gender needs	Strategic gender needs
Short-term needs	Long-term needs
Needs more easily identifiable	Needs less immediately identifiable
Biological requirements and specific health conditions	Targets inequities in power relationships
Provides health goods and services	Focuses on empowerment processes viz. Self-esteem, creation of awareness
Involves men and women as passive subjects	Involves people as active participants
Improves health conditions	Improves position of women to increase access and control over resources
Gender roles and relations remains constant	Improves balance of power relations between men and women in the use of health resources, through control over internal and external factors that affect ability to protect health

Production, Reproduction

Productive comprises the work done by men and women for payment in cash or kind.

Patriarchy and Matriarchy

They mean male and female domination, respectively, in very simple terms. But there are related terminologies which must be explained to avoid any confusion on the understanding of these terms.

Inheritance of property	Patrilineal Where male inherits	Matrilineal Where female inherits
Residence on marriage	Patrilocal, Where wife lives in husband's home	Matrilocal, Where husband goes to live in wife's home
Decision-making	Patriarchal, Where all decisions rests on males. Women have decision-making to the extent that they accept the rule of patriarchy	Matriarchal, Where all decisions rests on females. But even here they don't control other social institutions

Equity and Equality (*Samata and Samanta*)

EQUITY	EQUALITY
Fair	Equal
Not measurable and quantifiable	Measurable and quantifiable
Subjective and can change with culture, community, society	It is a universal goal
Positive discrimination through reservation	No such concept
Practice	Principle

EVALUATION OF THE TRAINING

Time: 15 minutes

POST-WORKSHOP QUESTIONNAIRE

1. To what extent do you think your expectations of this workshop have been met? Rate on a scale of 1–10 where 1 is "not at all" and 10 is "entirely"
2. What were your three major learnings from this workshop?
3. How do you think this workshop will make you a better service provider?
4. What kind of changes would you like to bring about in you personal and professional behaviour?

Personal

Professional
5. What kind of follow-up support would you need/want for implementing the learning from this workshop (Please be as specific as you can)

6. What in your opinion could be done to make the workshop more effective?
7. Should workshops like these be held on a regular basis? Give reasons for your answer.
8. Caring for children is women's responsibility? Agree/disagree
9. There are more men leaders in society because women lack leadership qualities. Agree/disagree
10. Societal norms for men and women are appropriate. Agree/disagree
11. All diseases (except gynaecological diseases) affect men and women similarly. Agree/ disagree
12. Men have more knowledge mainly because they have more exposure to the world. Agree/disagree
13. Comment on the trainers.

Name of Trainer/s

Co-ordination

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HANDOUT NO: 1

Percent distribution of ever-married women by person who makes specific household decisions, according to residence, India, 1998 – 99.							
Household decision	Respondent only	Husband only	Respondent with husband	Others in household only	Respondent with others in household	Missing	Total percent
URBAN							
What items to cook	71.3	3.5	4.7	10.2	10.5	0.0	100.0
Obtaining health care for herself	35.0	34.2	17.7	7.0	6.2	0.0	100.0
Purchasing jewellery or other major household items	13.3	28.5	35.7	11.1	11.4	0.0	100.0
Going and staying with her parents or siblings	18.0	36.3	28.4	9.0	8.2	0.0	100.0
How the money she earns will be used ¹	57.0	14.2	24.0	1.9	2.8	0.1	100.0
RURAL							
What items to cook	71.1	3.7	4.3	11.6	9.3	0.0	100.0
Obtaining health care for herself	25.7	41.1	16.7	10.0	6.6	0.0	100.0
Purchasing jewellery or other major household items	9.7	35.7	29.2	14.4	11.0	0.0	100.0
Going and staying with her parents or siblings	12.4	41.2	23.9	13.0	9.4	0.1	100.0
How the money she earns will be used ¹	36.5	31.0	25.3	3.5	3.6	0.2	100.0
TOTAL							
What items to cook	71.2	3.6	4.4	11.2	9.6	0.0	100.0
Obtaining health care for herself	28.1	39.3	16.9	9.2	6.5	0.0	100.0
Purchasing jewellery or other major household items	10.7	33.8	30.9	13.5	11.1	0.0	100.0
Going and staying with her parents or siblings	13.9	39.9	25.1	12.1	9.1	0.1	100.0
How the money she earns will be used ¹	41.1	27.2	25.0	3.1	3.4	0.1	100.0
¹ For women earning cash							

Source: NFHS – III, 98-99

HANDOUT NO: 2

TABLE NO. 2

Women's autonomy

Percentage of ever-married women involved in household decision-making, percentage with freedom of movement, and percentage with access to money by selected background characteristics, India, 1998 – 99.

Background characteristic	Percentage not involved in any decision-making	Percentage involved in decision-making on:				Percentage who do not need permission to:		Percentage with access to money	Number of women
		What to cook	Own health care	Purchasing jewellery, etc.	Staying with her parents/siblings	Go to the market	Visit friends/relatives		
Age									
15 – 19	24.4	66.6	38.6	39.8	37.4	13.8	10.2	45.5	8,182
20 – 24	15.4	77.3	45.0	46.1	43.1	22.0	16.6	54.1	16,389
25 – 29	9.4	84.9	49.7	51.5	46.2	28.8	21.1	58.8	17,745
30 – 34	6.1	89.4	53.6	54.8	49.3	34.0	25.1	61.1	15,094
35 – 39	4.8	91.9	56.5	57.7	52.7	37.9	29.8	64.3	13,089
40 – 44	3.7	92.6	59.3	59.3	53.6	43.0	35.1	65.9	10,521
45 – 49	3.9	91.6	60.1	60.3	56.1	45.4	37.5	67.6	8,179
Residence									
Urban	7.1	86.3	58.9	60.4	54.6	46.9	35.0	73.6	23,370
Rural	10.3	84.7	49.0	49.9	45.7	26.1	20.6	54.6	65,829
Education									
Illiterate	9.6	86.1	48.6	49.6	45.1	27.0	21.6	52.8	51,871
Literate, < middle school complete	9.1	85.2	52.5	51.0	49.2	32.6	24.3	61.3	17,270
Middle school complete	11.3	81.6	53.5	54.3	49.7	35.9	25.6	66.6	7,328
High school complete and above	8.1	83.3	61.2	62.0	57.2	46.2	35.0	81.0	12,719
Religion									
Hindu	9.6	85.2	50.8	52.4	48.0	31.8	24.6	59.4	72,903
Muslim	10.7	82.8	50.5	48.1	43.4	23.4	19.0	56.0	11,190
Christian	5.8	88.0	63.0	65.6	61.7	44.6	35.6	68.5	2,263
Sikh	2.4	93.6	74.6	72.5	64.6	46.2	25.6	74.0	1,427
Jain	9.8	84.3	54.7	55.9	47.0	50.9	39.8	74.0	331
Buddhist/Neo-Buddhist	4.6	89.7	57.0	58.7	52.7	56.3	38.7	72.2	676
Other	4.9	89.1	52.8	61.7	58.4	33.3	31.0	60.6	285
No religion	4.2	91.2	64.6	65.4	71.9	41.5	33.8	72.3	44
Caste/tribe									
Scheduled caste	9.1	86.2	49.7	51.8	47.4	31.3	23.7	56.0	16,301
Scheduled tribe	7.6	87.6	49.8	52.9	48.8	30.7	26.2	50.7	7,750
Other backward class	10.2	84.4	51.3	52.5	48.4	34.7	26.6	62.4	29,383
Other	9.3	84.7	53.3	53.3	48.2	29.6	22.7	61.0	34,904
Cash employment									
Working for cash	5.7	89.8	57.0	59.6	54.6	41.4	33.2	64.7	23,391
Working but not for cash	10.2	85.1	46.5	47.1	43.1	26.4	21.4	50.6	11,519
Not worked in past 12 months	10.9	83.1	50.3	50.8	46.3	28.5	21.2	59.3	54,271
Standard of living index									
Low	8.5	87.7	48.5	49.9	45.5	28.5	23.0	52.1	29,033
Medium	10.2	84.3	50.8	51.6	47.2	30.0	22.8	58.1	41,289
High	9.3	82.9	58.4	59.6	54.5	40.1	30.2	75.1	17,845
Total	9.4								

Source: NFHS – III, 98-99

How Burdened is Women's Life!

Weekly average time spent (in hours) on some peculiar activities by sex (All)

Activities	Haryana		Madhya Pradesh		Gujarat		Orissa		Tamil Nadu		Meghalaya		Combined states	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Cooking	0.36	11.37	0.62	14.24	0.38	13.85	0.86	19.28	0.38	14.74	1.06	13.74	0.52	14.93
Cleaning household	0.12	4.37	0.28	4.44	0.16	5.06	0.15	3.72	0.26	4.80	0.35	3.26	0.21	4.55
Cleaning utensils	0.10	4.68	<u>0.13</u>	<u>3.71</u>	0.10	4.28	0.10	2.45	0.06	2.62	0.82	3.90	0.10	3.39
Washing and Mending clothes	0.09	4.02	<u>0.28</u>	2.12	0.11	4.03	0.13	1.05	0.21	2.81	<u>0.37</u>	<u>3.10</u>	0.18	2.71
Shopping	0.39	0.34	0.64	0.31	0.45	1.56	1.03	0.23	0.48	0.50	0.40	0.44	0.59	0.64
Pet care	0.01	0.02	<u>0.08</u>	0.10	—	0.02	0.01	0.04	0.01	0.03	0.02	0.05	0.03	0.04
Care of children	0.18	3.91	0.26	3.23	0.33	3.25	0.53	3.92	0.29	2.36	0.47	4.44	0.32	3.16
Teaching own Children	0.08	0.18	0.14	0.10	0.17	0.33	0.27	0.18	0.11	0.18	<u>0.35</u>	0.29	0.16	0.19
Accompanying Children to places	0.03	0.06	0.23	0.21	0.02	0.04	0.02	0.02	0.05	0.09	0.05	0.23	0.08	0.09
Care of sick and elderly	0.06	0.11	0.02	0.12	0.04	0.16	0.10	0.54	0.01	0.08	0.03	0.19	0.04	0.19
Supervising children	0.12	0.89	0.25	0.96	0.51	1.13	0.24	0.54	0.16	0.45	0.98	1.79	0.28	0.78
Care of guests	0.14	0.04	0.01	0.01	0.04	0.11	0.04	—	0.02	0.02	0.15	0.24	0.03	0.04

Note: 1. The entry '—' in a cell indicates that no corresponding observation was found in the sample.

2. M : Male; F : Female

Source: NFHS – III, 98-99

GENDER ISSUES IN ADOLESCENT YEARS

- For girls, this is the period when numerous restrictions on their mobility begin to operate.
- Both girls and boys do not have access to information on sexual development and sexuality.
- While girls are not encouraged to know about their bodies and about reproduction till they are married, gender norms expect boys to be sexually experienced well before marriage.
- Reproduction-related risks increase because:
 - Trend towards lowering age of menarche,
 - Increasing urbanization and exposure to mass media, making premarital sex more permissible to adolescents,
 - Greater opportunities for premarital sex,
 - Strict segregation of sexes, together with expectations that young men should be sexually experienced, encourages risky sexual behaviour on the part of many young men.
- Lack of information about their bodies creates undue anxiety in boys on matters related to sexuality. For girls, lack of information on menstrual hygiene and beliefs and practices surrounding menstruation are important problems.
- Although exposed to sexual intercourse, access to contraception and MTP is very difficult for unmarried adolescent girls because of provider bias. This puts unmarried adolescents at risk of illegal and unsafe abortions.
- Adolescents are the second largest group to be affected by STDs and HIV/AIDS globally.
- 36% of girls between 13-16 yrs old, and 64% of girls below 19 have already begun childbearing.
- Early pregnancy carries with it higher risks of maternal mortality as well as complications.
- Since girls are not expected to be informed about contraception prior to marriage, and also because of the pressure to bear the first child immediately after marriage, there is near-absence of contraception in the 15-19 age group. This also means that adolescent girls run greater risks related to STIs.

GENDER ISSUES IN ABORTIONS

INDUCED ABORTION

- Induced abortion is sought to terminate unwanted pregnancies resulting from non-use of spacing method of contraception because of lack of information or fear of side-effects, non-consensual sex within or outside marriage, including sexual abuse, contraceptive failure, male abdication of responsibility for prevention of pregnancy, 20 – 25 per cent of maternal deaths in India are estimated to be from septic abortions,
- Illegal abortions may be 11 times as prevalent as MTPs,
- 2nd trimester abortions amongst highest in the world due to sex-selective abortions,
- MRs not generally performed but D&Cs are, which are associated with a greater possibility of complications,
- Access to MTP services limited by cost,
- Few facilities or trained personnel,
- Cumbersome licensing procedures,
- Lack of privacy and confidentiality,
- Providers' attitudes,
- Long waiting time,
- Lack of information,
- Linking MTP to FP acceptance.

ABORTION-RELATED COMPLICATIONS

- Septic abortion,
- Gangrene and tetanus,
- Haemorrhage due to incomplete abortion or injury to internal organs (even D&C can cause damage to the uterine wall),
- Poisoning from abortifacients, resulting in kidney failure,
- Tubal infections which sometimes cause infertility.

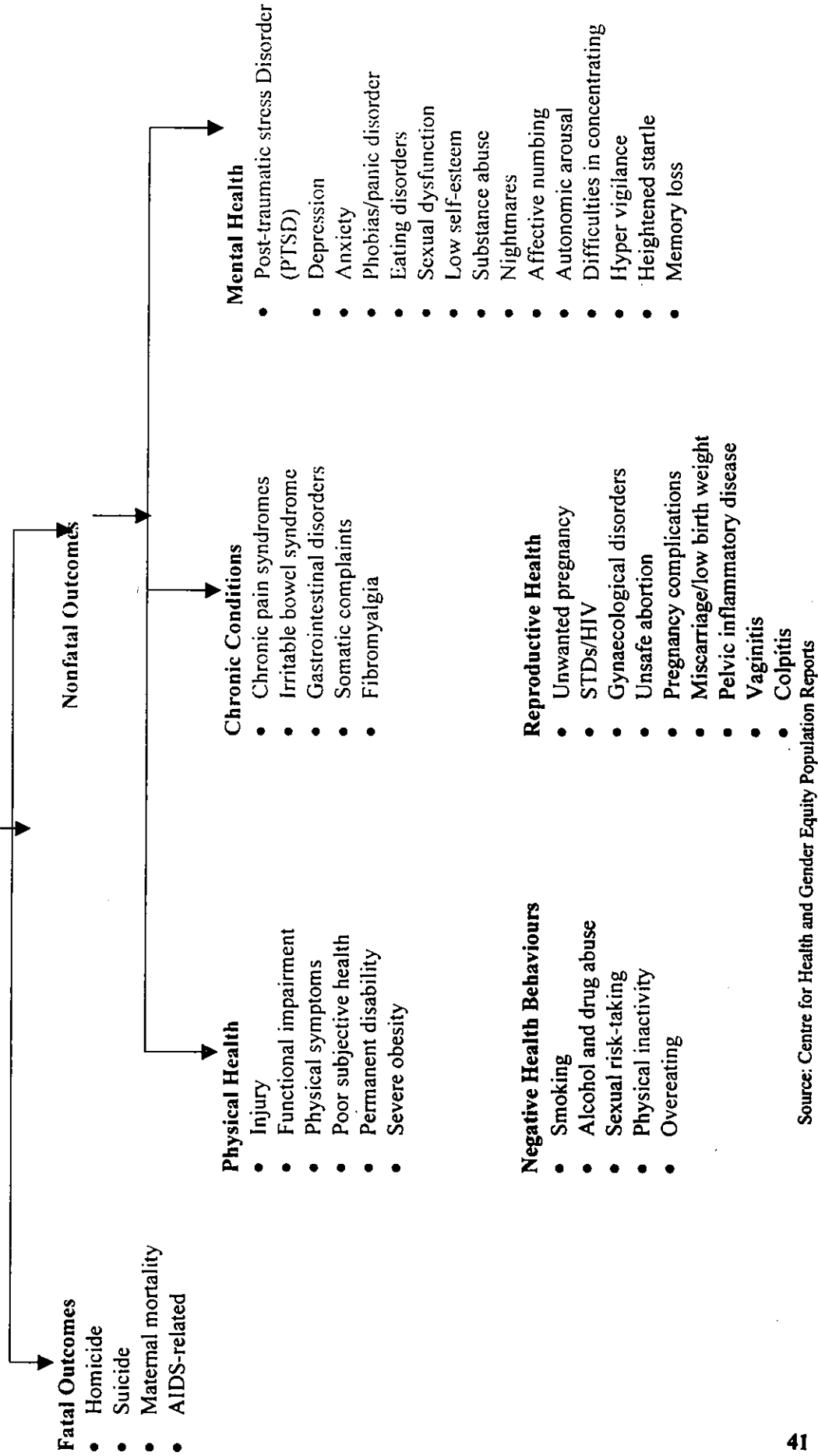
GENDER ISSUES IN CONTRACEPTION

- Contraceptive Prevalence Rate about 41% in 1992-93
- Contraception rarely practised before first birth.
- Reversible methods account for less than 15% of contraceptive use..
- Male methods account for only 15%.
- Share of female sterilisation 76%.
- 19.5% of women 15-49 have unmet need for contraception.
- Health concerns, not having enough options and husband's opposition feature as important reasons for non-use.
- Poor reproductive health and high pregnancy loss deters use of temporary methods.
- Poor quality-of-care an important issue: studies show sterilisation to be associated with tubal inflammation due to upper RTIs.
- Non-availability of a wide enough range of reversible methods to suit varying needs leads to abortion's use for spacing births.
- Lack of male involvement a major problem.
- Women contra-indicated for sterilisation often have few other contraceptive options.
- Predominant reliance on sterilisation poses important challenges in an era of HIV infections: sterilised women cannot insist on condom use by their husbands, posing risk of STIs and HIV.

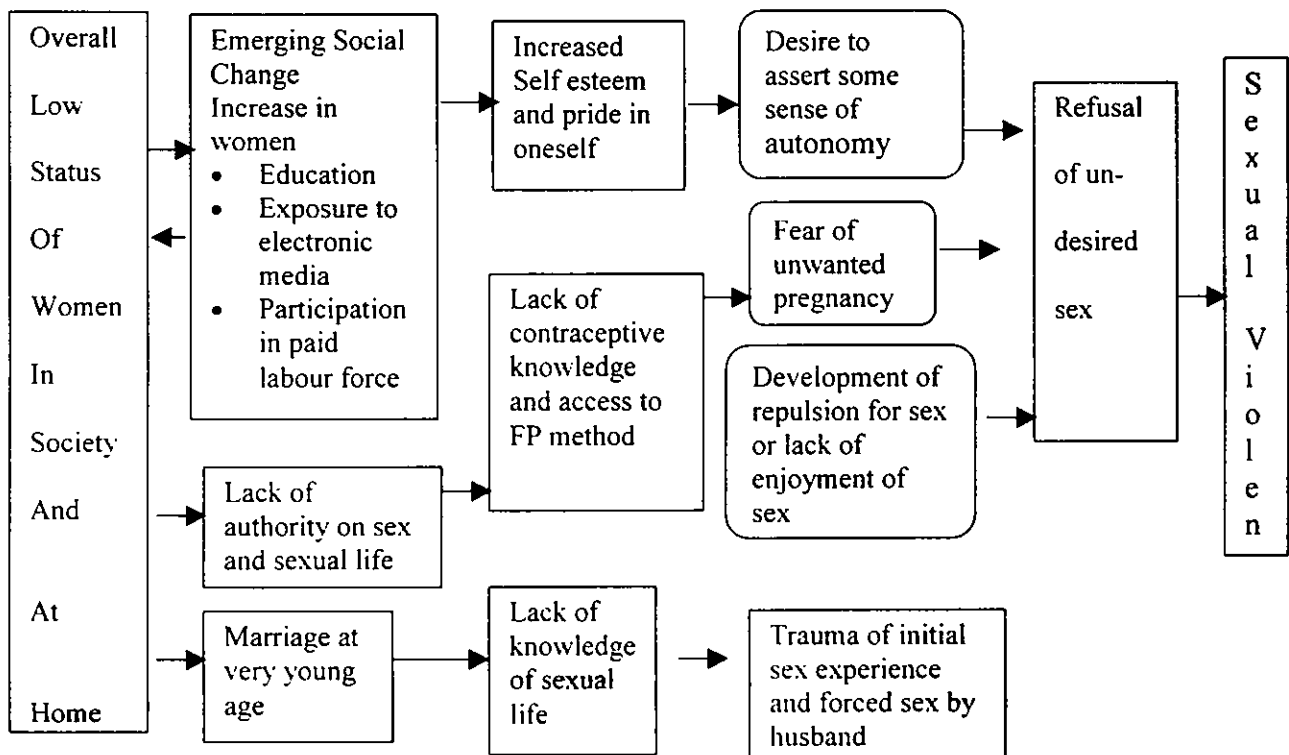
GENDER ISSUES IN HIV AIDS

- ☐ Due to social and sexual subordination, women find it difficult to negotiate and prevent men from practising unsafe sex at home and at workplace.
- ☐ Lack of control over sexuality, in addition to the culture-specific submissiveness, increase chances of infection,
- ☐ Poverty, unemployment, illiteracy and abduction force women in to prostitution, making them more vulnerable to HIV AIDS through unsafe sexual practices,
- ☐ Rape or early exposure to sex through marriage expose women to AIDS,
- ☐ Immature cervix in adolescents and low mucous production in the genital tract of post-menopausal women may cause injury during sexual intercourse, increasing their susceptibility to an HIV infection,
- ☐ Since the infection can be transmitted from mother to child, women undergo trauma of guilt and grief about infecting children,
- ☐ Male condoms are the only means to prevent HIV/AIDS. Many women do not have control and decision-making power on use of contraceptives,
- ☐ Male promiscuity,
- ☐ Women more vulnerable because semen is highly infectious, vaginal mucous membrane more vulnerable,
- ☐ Semen remains in vaginal tract,
- ☐ Age factor - under 18 and post-menopausal stages make women particularly vulnerable,
- ☐ Sexual violence.

Health Outcomes of Violence Against Women



Dynamics of Sexual Violence within Marriage



Source: M.E. Khan et.al. Sexual Violence within marriage, and case study of rural Uttar Pradesh by Cort and Population Council, New Delhi.

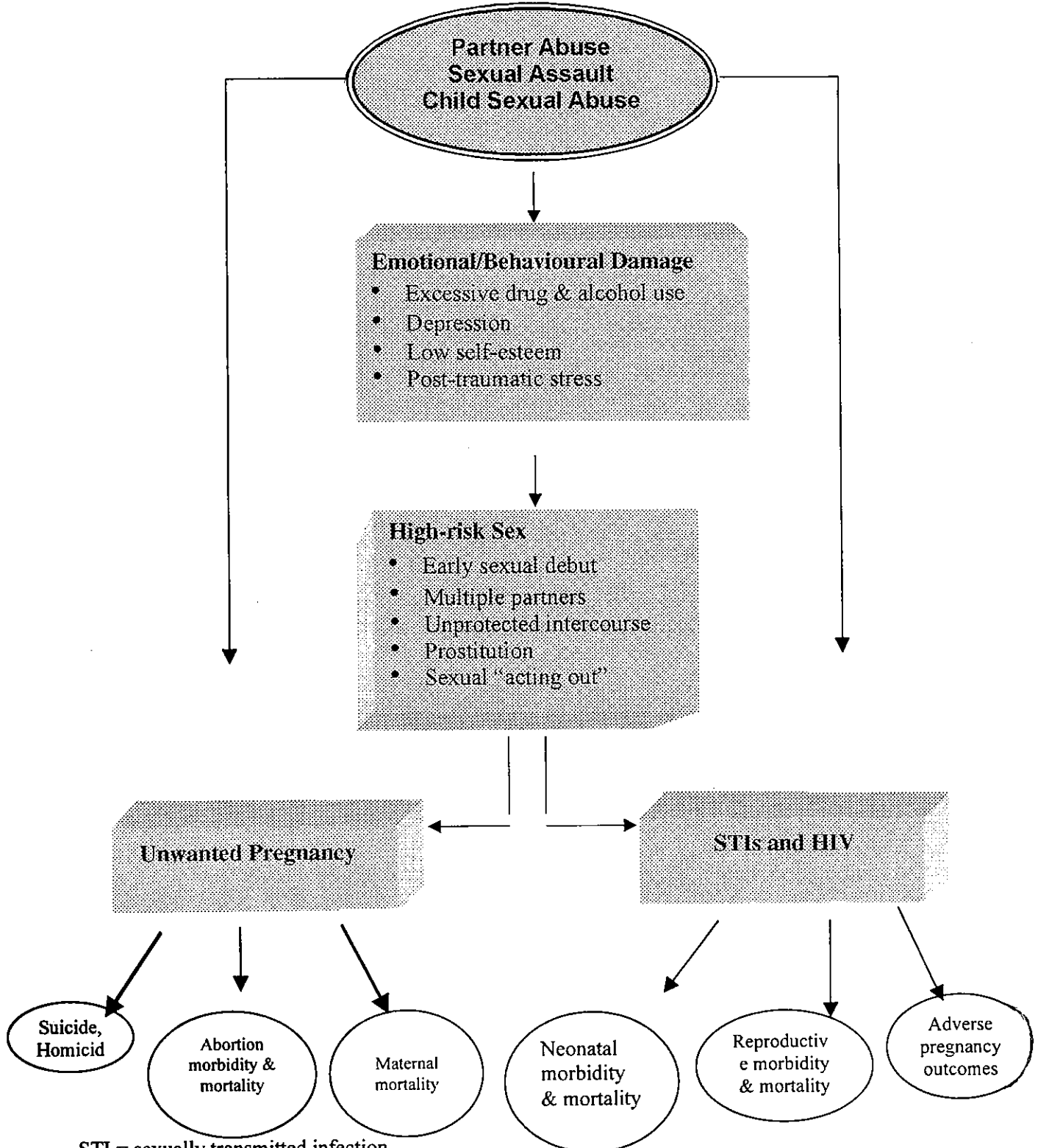
Gender Violence throughout the Life Cycle	
Phase	Type of Violence Present
Prenatal	Sex-selective abortion (China, India, Republic of Korea); battering during pregnancy (emotional and physical effects on the woman; effects on birth outcome); coerced pregnancy (for example, mass rape in war).
Infancy	Female infanticide; emotional and physical abuse; differential access to food and medical care for girl infants.
Adolescence	Child marriage; genital mutilation; sexual abuse by family members and strangers; differential access to food and medical care; child prostitution.
Reproductive	Dating and courtship violence (acid-throwing in Bangladesh; date rape in the United States); economically-coerced sex (African schoolgirls having to take with "sugar daddies" to afford school fees); sexual abuse in the workplace, rape; sexual harassment; forced prostitution; trafficking in women.
Old age	Abuse of women by intimate male partners; marital rape; dowry abuse and murders; partner homicide; psychological abuse; sexual abuse in the workplace; sexual harassment; rape; abuse of women with disabilities. Abuse of widows; elder abuse (in the United States, the only country where these data are now available) elder abuse mostly affects women.

Source: L.*et.al* Violence against women: The Hidden Burden, World Bank Discussion Paper, 1994.

Warning Signs for Health Workers

- A woman who makes an appointment but does not attend.
- A woman with multiple injuries in sites that are usually covered by clothing.
- A woman whose partner comes with her and stays close at hand in order to monitor what is said,
- A woman with evidence of strangulation attempts on the neck or fractures to the upper arms, which may have been caused, when the women tried to defend herself.
- A woman who is excessively shy, embarrassed or anxious, or who is reluctant to provide information about how she was injured,
- A woman or partner with a history of psychiatric such as depression, alcoholism, drug abuse or suicide attempts,
- A woman with a history of "accidents",
- A woman, particularly if pregnant, with injuries to the breasts, genitalia or abdomen.

Violence Against Women: Direct and Indirect Pathways to Unwanted Pregnancy and Sexually Transmitted Infections



STI = sexually transmitted infection

HIV = Human Immuno-deficiency Virus (which causes AIDS)

Source: Adapted from Heise et al. 1995 (211)



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