Module 6

Equity and Gender

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Overview

Social and gender equity is one of the six core principles of Ecohealth identified by Dominique Charron of Canada’s IDRC (2012). Social and gender inequities and inequalities are considered major determinants of health. Nevertheless, they have resisted change, in part because they are deeply embedded in political, cultural, and social processes, which themselves are rooted in deeply-held beliefs. Understandings of power dynamics, relationships and social, economic, and political structures are essential if we seek to intervene to address social and gender equity issues, and improve health outcomes.

Introduction to Ecohealth (Module 2) emphasized the importance of considering the complex interactions among social and ecological factors that support or undermine health. Using Systems Concepts in Ecohealth (Module 4) clarified ways in which framing and perspective can influence which variables are deemed important and how that influences research and action. As you will read, Knowledge to action (Module 8) emphasizes the importance of putting knowledge into practice and linking it to decision and policy making. The Ecohealth principle of gender and social equity takes a firm, value-based perspective and offers a concrete example of an issue that can be used to frame the situation socially. This module aims at introducing critical thinking concerning power relationships, equity, and gender as well as presenting techniques and tools that can help clarify the issues and identify opportunities for change. While many activities in this module are framed in terms of gender, researchers and practitioners may substitute other categories of stakeholders, using similar forms of analysis.
Learning Objective:
Understand the meaning and importance of gender and equity in addressing social and health issues, and reflect on our gender roles.

Learning Objective:
Explain how social and gender inequities result in poorer health outcomes.

Learning Objective:
Reflect upon the roles of power dynamics, structures, and relationships, and describe the way they affect equity and therefore health outcomes.

Advanced Learning Objective:
Explain how social equity and gender analysis can be used to achieve more relevant research that accommodates life patterns, biological differences, needs, and interests of different cultures, genders, generations, and species.

Activity 1A:
Individual work and reflection; discussion

Activity 1B:
Small groups; reflection; discussion

Activity 2:
Lecture; reflection

Activity 3:
Review case study; small group work

Activity 4:
Reflect; brainstorm; share; discuss

Activity 5:
Pairs; small groups; discussion

Appendix II:
Review case study; small group work
Module Aims

1. To develop working definitions for social equity, gender, and power, and understand the need to work towards social and gender equity as one of the principles of Ecohealth.

2. To explore how power relationships, dynamics, and structures play a defining role in equity and gender issues.

3. To understand how working towards social and gender equity leads to health outcomes that are more just and fair.

Why is this topic important?

Ecohealth research and practice need to explicitly consider equity at every step and to integrate it systematically in all interventions. Health inequities research demonstrates quite conclusively that those without a voice, with lower socio-economic status, with diminished access to services and facilities, and so on, have poorer health outcomes. And vice versa. This means that any intervention that seeks to improve the health of individuals in a population must address these inequities. Otherwise the chances are that it will fail. Although Ecohealth practitioners have sometimes been successful at looking at gender and equity issues in the research part of a project, they still struggle to take them into account when it comes to outcomes, long-term interventions, knowledge to action, and policy. As such, there is a need to better address these issues in Ecohealth and continue to develop our understanding and our tools to do so.

This principle of equity does not necessarily imply that we need to eliminate all health differences so that everyone has the same level and quality of health. Rather, we aim to reduce or eliminate those differences that result from factors that are considered to be both avoidable and unfair; to do this requires first identifying and understanding these factors. Equity is therefore concerned with creating equal or balanced opportunities for health, and with bringing health differentials down to the lowest level possible. The unfair conditions impinging on people because of gender, race, ethnicity, economic background, age, language, literacy, political and economic power, religion, and so on, are often stubbornly resistant to change, in part because they often interact in self-reinforcing ways, and have been inadequately considered when interventions are planned.

Since people are embedded in relationships, they form patterns and structures from which power dynamics emerge. It is therefore essential to understand power as a relationship issue and not as something that is owned. Understanding how power and equity are intertwined is a first step in addressing social and gender inequities.
Key Concepts

1. Those who “have” are more likely to be healthier than those who “have not.” Any attempt to improve the lives of people must therefore address this “have/have not” divide related to poverty and socio-economic status.

2. Power dynamics emerge from relationships between people and play a defining role in social and gender equity issues.

3. Addressing social and gender equity helps to build healthy communities and ecosystems, and creates better health and living conditions for all, including non-human beings.

4. Integrating considerations of equity in the design, implementation, evaluation, and communication of projects will improve both the understanding of complex situations, and facilitate more effective, sustainable, fair, and just solutions to health challenges.

5. All inequities reflect relationships and power imbalances. It is the power imbalance in relationships that needs to be addressed; the issue cannot be reduced to focusing only on the vulnerable group without considering the context. For example, gender inequity cannot be reduced to a “women’s issue” or “women’s health.”

Guiding Questions

1. What is equity? Why is it important to address social and gender equity in Ecohealth research?

2. What is gender? What is the difference between sex and gender? How does gender influence health inequities? Why are gender issues often invisible or uncomfortable?

3. How do social and gender inequities relate to poorer health outcomes?

4. How are power relationships between people and/or groups important to Ecohealth?

5. What role do power dynamics play in the different equity issues relevant to our research/practice? How should we address the underlying power within our research/practice context(s)?
Basic Learning Objectives

After completing this module, learners will be able to:

1. Understand the meaning and importance of gender and equity in addressing social and health issues, and to reflect on our gender roles.
2. Be able to explain how social and gender inequities result in poorer health outcomes.
3. Reflect upon the roles of power dynamics, structures and relationships, and describe the way they affect equity and therefore health outcomes.

Advanced Learning Objectives

Learners will be able to:

1. Explain how social equity and gender analysis can be used to achieve more relevant research that accommodates life patterns, biological differences, needs, and interests of different cultures, genders, generations, and species.

Practical Notes

1. Participants need to have a basic pre-requisite understanding about Ecohealth, including transdisciplinarity, participation, and systems thinking. Hence Modules 2, 3, 4 and 5 provide excellent preparation for this module.
2. It is helpful for participants to have had hands-on experience in research or practice in Ecohealth, or working with communities on health or environmental issues.
3. Pre-reading of the Key References is strongly recommended.
4. The module will work best if participants include men and women from different disciplines, cultural and ethnic backgrounds, and age groups; be aware that this will almost certainly create the situations that we seek to redress and that trainers need to be comfortable with such a prognosis (see Notes to Trainers below).
5. The module could be delivered in one half day or extended/integrated into a more in-depth course.
6. More advanced learning objectives may be addressed by using the tools and case studies in the Appendix.
NOTE TO TRAINERS

In all the activities in the course, and especially in this module, careful attention needs to be paid as to who participates actively and who does not, and why this might be so. Is this related to: language skills? Personality type (introverts and extroverts)? Culture? Gender? Do the rules of participation favour some groups (e.g. extroverts, men, women, certain cultural or age groups) over others?

In other words, this module might create the conditions under which some people are “voiced” and some are “voiceless,” for much the same reasons as this module explains. It could be challenging for participants, and for instructors, to be exposed to this, and create difficult interpersonal situations that would ordinarily require trained professionals, like counsellors, to deal with appropriately. Instructors should be aware of this likelihood from the outset. It is possible that you feel that you are not equipped to deal with these outcomes. If so, it is suggested you consider a few options:

- Not delivering the module at all
- Delivering only the theoretical or more straightforward activities in the module (e.g. Activity –)
- Employing the services of a co-instructor who has these facilitation skills.

A useful technique that instructors can adopt is to create “ground rules” to encourage everyone to participate; for instance, you can make a rule that only a person holding a stick (“talking stick”) or other object is allowed to speak, and then only for a specified time. Periodically, trainers should work with the class to review who is participating and who is not and to explore why not. In participatory work, there are various ways to manage groups and minimize the influence of overly-dominant personalities, or involve very shy people, by taking them aside, carefully assigning members to different small groups, etc. Again, seeking professional advice about these matters is the best approach, if you feel you don’t have the experience to deal with the situations that are likely to arise. It is also recommended to allow time, within the course or after class, to encourage participants to reflect on and process the ideas and issues raised during the module.
Background information

According to the World Health Organization, “while inequality implies differences between individuals or population groups, inequity refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust...Not all inequalities are unjust, but all inequities are the product of unjust inequalities. The definitions of just and unjust are subject to various interpretations. The Pan-American Health Organization has interpreted “just” to refer to equal opportunities for individuals and social groups, in terms of granting access to and using the health services, in accordance with the needs of the various groups of a population, regardless of their ability to pay.” (WHO 1999). One might also characterize “justness” in terms of equal opportunities and capacities to access nutritious food, clean water, and meaningful work, as well as treatment, regardless of age, gender, ethnicity, and the like.

Large, measurable, inequalities in health outcomes such as life expectancy, infant mortality, chronic and infectious diseases, exist between different groups in society, and between individuals within households and neighbourhoods. Many of these inequalities reflect unfair or unjust differences in access to food, water, health care, and other known determinants of health. The principle of equity in Ecohealth says that we are concerned with reducing unfair differences in these determinants. For instance, the principle of equity in relation to health care means that health services are accessible on the basis of need rather than who you are, where you are, or how much you can afford to pay.

“Equity in health” puts forward the ideal that everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that none should be disadvantaged from achieving this potential. This ideal, then, is related to the social and natural environments within which people live, and reflected in the ability to access food, water, education, and social opportunities. Equity is therefore concerned with creating equal opportunities for health, and with bringing unequal health differentials down to the lowest level possible. Improving access also implies an outcome goal of improving health status of different groups in society.

There are often unfair conditions affecting the health and well-being of women and other disadvantaged groups, such as specific age groups, people of lower socio-economic status, and indigenous populations, due to multi-faceted socio-economic and cultural patterns. Health services may not recognize the specific and different needs of women and men, girls and boys. Relations between aboriginal and non-aboriginal groups, or between wealthy business owners and poor workers, result in inequitable access to knowledge about, and access to, health services.
In Ecohealth, any response or action will be ineffective and may have unintended, and even negative impacts, if differences in gender roles and responsibilities are not taken into account. A research agenda that examines cultural and socio-economic differences of gender and other forms of equity will help lead to more equitable solutions.

Activities

Activity 1A

**Defining power and equity**

**Learning Objective:**
- To understand the meaning and importance of gender and equity in addressing social and health issues, and to reflect on our gender roles.

**INSTRUCTIONS**

1) **Define:** Ask participants, on their own, to:
   - i) Write down a definition of power according to what they think it is, or have experienced
   - ii) Write down their own definition of equity according to what they think it is, or have experienced
   - iii) Reflect upon, and make notes about how their belonging to a social group (based on gender, ethnicity, language, social class, etc.) places them in terms of equity. Do they have equal possibilities to access resources (material, informational, educational, etc.)?

   **Note for instructor:** This part can be done prior to the session, and be part of a journalling exercise.

2) **Share:** Present the learners with various definitions of power and equity from the literature.

3) **Discuss:** As a group, discuss the various definitions from learners and from the literature.
   - i) Start with power: Discuss recurring and interesting aspects of the definitions and develop a working definition of power. The following questions may be useful for prompting group discussions:
     - Are some power positions “good” and others “bad”? Is power necessary? Is power avoidable?
     - Why is it important to frame power as a relationship issue in Ecohealth? (You may want to refer to the Module as background for this)
     - How is status quo a power position? Does neutrality exist?
ii) Continue with equity: Discuss recurring and interesting aspects of the definition and develop a working definition of equity. The following questions may be useful:

- What does equity mean?
- What are some examples of equity?
- Is equity subjective (can it mean different things in different situations)? How so? Why is this important?
- How are power and equity related?
- What is the difference between equality and equity?

Activity 1B

**Defining gender and sex**

**Learning Objective:**

- To understand the meaning and importance of gender and equity in addressing social and health issues, and to reflect on our gender roles.

**INSTRUCTIONS**

(1) Divide participants into groups of 3-4 persons. Each group uses a flip chart to make five general statements about what “gender” means and applies to, and five statements about the meaning of “sex.” Examples of such statements could be:

- “When we think a man should do certain types of work and women other types of work, this is based on gender roles.”
- “Sex determines the role that men and women can play in biological reproduction.”

*Note for instructor: see the terminology below for definitions that can be used as reference.*

(2) Each group takes turns to report their statements to the class. Ask participants to discuss why their statements reflect sex or gender. The following questions may be useful:

- What are the differences between sex and gender? How are sex and gender related to each other? Can we separate the two?
- The trainer may point out that the statements reflect the beliefs of the participants, which are generally influenced by society, as well as biology. However, society is constantly changing, and the roles and status of women and men are also changing.

(3) Go through the definitions with the participants along with the discussion, feedback and explanations. Then ask the participants to discuss the questions below to round up their understanding of the gender concepts.
• What is the difference between saying “women in development” and talking about “gender in development”? Why is gender a preferable term to women in development?
• Why is gender/sex an important component of Ecohealth research and practice?
• Why is there a need to address gender/sex specifically, as well as social equity in general?

### NOTE TO TRAINERS

Some issues for the trainer to consider in talking with participants about their responses to “women in development” and gender:

The move to gender-equitable development can be summed up as follows:

1. It is an approach to people centred development
2. It is a focus on relations between women and men – not centred only on women
3. It highlights the problem of unequal relations that prevent equitable development and women’s full participation
4. It aims at equitable and sustainable development with men and women sharing decision making and power
5. It seeks to empower disadvantaged women and transform unequal relations and structures rather than just integrating women in existing structures
6. It addresses the practical needs determined by women and men to improve their conditions, strategic needs of women and men and the poor through people centred development (UNDP).
Activity 2

Brief presentation: on the consequences of inequities for health outcomes

Learning Objective:

• To be able to explain how social and gender inequities result in poorer health outcomes.

INSTRUCTIONS

The trainer gives a brief review of the term “Social Equity” and explains how equity influences health and how it persists in social contexts. Of critical importance here is the underpinning concept of social determinants of health – that is, an individual’s health is not just a product of their genes, age or sex. Their health is determined by a range of social and environmental factors. The determinants mean that some people are more likely to be unhealthy than others. This inequality is, in most cases, a societal construction, and reversible; given that we don’t address it effectively it is unjust, and deserves our attention.

The 2008 final report of WHO’s Commission on Social Determinants of Health provides an excellent background document for this, and should be consulted by the trainer before teaching this module. The summary article by Marmot on social determinants of health (Lancet 2005) provides useful background. See Module 6 – Appendix II – Gender Analysis Framework for an online reference to the full report.

Some essential messages for this presentation can be covered by a discussion of Figure 6.1.

Figure 6.1 Multiple Layers of Influence on Health Source: (Whitehead & Dahlgren 1991)
The Figure refers to the multiple layers of influence on health, the so-called “determinants”:

- At the extreme perimeter is the national and regional environment, that sets limits on the social and environmental “infrastructure” available to support health. Opportunities for education, housing, and nutrition are constrained by global and national distribution of wealth.

- Closer to individuals but still largely outside of their control are the conditions in which they live and work. Safe, healthy environments are critical to the level of population health.

- Cultural and social factors are next, reflecting a range of norms and practices that affect health. Consumption patterns are a good example of this. Cultural values, amplified through sophisticated marketing, largely influence the types of food that are available and that we choose to eat; try to find a fast food burger in a wealthy suburb.

Individual behaviours exert a direct influence on health, but as some examples above illustrate, they also are affected by socio-economic factors. Driving a motor vehicle at a dangerous speed may be an immediate cause of injury. However fatigue from having to drive long distances to reach essential services is more likely if you live in rural areas, having a tyre blow-out may be more likely for those with lower paying jobs because of high maintenance costs, or having more passengers may be influenced by the size and closeness of your extended family. Individual level interventions, such as driver education programs, are not going to change any of these determinants.

The recent explorations of the socio-economic, cultural, and environmental determinants of health have occurred alongside increasing concerns about worsening health inequities, despite improvements in overall health. During the last 50 years of the twentieth century the health status of many countries has improved more than ever before. However, when this national-level data is disaggregated, disparities in mortality rates and health outcomes between different groups become apparent. These inequities are not only an issue for developing countries, but also for more developed countries that experience overall good health, such as the Netherlands, Sweden, Denmark, and the USA. For example in the USA although life expectancy for the overall population improved between 1984 and 1989, closer inspection revealed that the increase only applied to the health of white people, while the health of black people actually decreased. This is despite a narrowing of this gap in previous decades when the life expectancy for black people increased more rapidly than for white people. In the USA it is suggested that “race” is a proxy for underlying socio-economic differentials, such as living and working conditions.
Activity 3

Meaning and description of social and gender inequities/inequalities in Ecohealth

Learning Objective:

- To reflect upon the roles of power dynamics, structures and relationships, and describe the way they affect equity and therefore health outcomes.

INSTRUCTIONS

Have the participants read the study by Renaud de Plaen et al (2004). The paddy, the vector and the caregiver: lessons from an ecosystem approach to irrigation and malaria in Northern Côte d'Ivoire. Acta Tropica 89 (2): 135-146. (If you can’t get the original paper, you can find a summary in Health: An Ecosystem Approach by J. Lebel, available from IDRC.)

http://www.idrc.ca/EN/Resources/Publications/Pages/IDRCBookDetails.aspx?PublicationID=338

NOTE: Other case studies can also be used to do this exercise and others in this module.

A case study well known by the trainers (or even better, the case study used in the course) is a good example to use as you are able to dig deeper and offer insights to participants. IDRC’s Ecohealth research in practice, edited by Charron (2012) also offers examples of case studies. Several case studies are summarized in the Appendix for Module 5. If using an alternate case study, some of the questions from the handouts below may need to be adapted.

Using the de Plaen et al. (2004) example:

The study revealed that disease patterns reflected complex dynamics among agricultural practices, gender, access to wealth, access to markets, and cultural expectations.

Question for the exercise:

How would you introduce equitable change into this society, and what are the ethical implications of doing this?

Divide the participants into three groups:

1. Legislative/regulatory issues in relation to social determinants of health
2. Organizational and operational matters
3. Inequities arising from competing demands for finite resources.
Each group works by discussing and explaining problems from the participants’ personal and academic experiences. Provide handouts for the guiding questions for each of the groups.

**Group 1: Legislative/regulatory issues in relation to social determinants of health** (e.g. access to land and markets, to nutritious food, access to medical care, public health services).

**Guiding questions for discussion:**
- What regulations/systems are hampering different stakeholders/groups (e.g. men/women; rural/urban; aboriginal/non-aboriginal; poor/wealthy) from changing the social determinants of health in the community in the case study?
- Who developed the regulations?
- Who is the most affected? Why? How might research in gender and other social inequity contribute to the reduction of social inequities?

**Group 2: Organizational and operational matters**

**Guiding Questions for discussion:**
- Do people in the rural areas receive the same quality health services as people in the urban areas?
- Do different groups (e.g. men/women; rural/urban; aboriginal/non-aboriginal; poor/wealthy) have different access to health care?
- With regard to health care and gender specifically:
  - Are the services distributed more to men than women?
  - Are there more male doctors than female doctors in the rural hospital?
  - Are males better doctors than females? What does better mean?
  - How is the concept of “better” related to the sex of the patients? To religious or cultural beliefs?
  - Will the patients be better served by a doctor who is aware of gender roles?
- What are the organizational and institutional arrangements that maintain differences in access to better nutrition, education, and work?
- Are there organizational arrangements for more equitable (re-) distribution of wealth within communities or within the larger society (e.g. taxation, mutual aid organizations, cooperatives, religious groups)?

**Group 3: Inequities arising from competing demands for finite resources**

**Guiding Questions for discussion:**
- Are health care services and supports equally available for people of different backgrounds, or with special needs related to their physical
or mental condition, and/or age or chronic diseases? Who will mostly access the resources?

- Who controls the food, educational, and livelihood resources?
- When resources are scarce or constrained, are there differences in priorities between men or women, poor/wealthy, aboriginal/non-aboriginal?

(3) Give the participants 30 minutes to discuss in small groups, and share the information of inequity analysis to the other group members. Provide references and cases for further discussions and analysis.

Activity 4
Reflecting on power and equity

Learning Objective:

- To reflect upon the roles of power dynamics, structures and relationships and describe the way they affect equity and therefore health outcomes.

Note: If participants do not have their own research work, this exercise can easily be done using a case study. Case studies are available in Charron (2012) or consider those suggested in other modules, or use a local case study base on the work of local stakeholders/partners/colleagues.

INSTRUCTIONS

- Brainstorm: Using flipchart paper and coloured markers, ask participants to map out (diagram or draw) power, equity, and equality within their own research or work, or based on the case study chosen for this activity. This can be done by identifying the people and social structures involved in their work and diagramming the power relationships among them. Ask them to think about who is concerned, where they are, resource distribution, etc.
- Share: Divide participants into small groups and ask them to share their maps with each other and help each other develop their maps further.
- Discuss: Using examples from participants’ maps, facilitate a broader discussion to address the following questions:
  - How are power relationships between people important to ecosystem approaches to health?
  - What are my own relationships and power dynamics within my research/practice context(s)/studies/hobbies, or in the case study? How should I take these into account?
• How can I identify and address the underlying power relationships within my research/practice context(s), or those in the case study?
• What is the difference between equality and equity? How are these differences related to power?
• What role do power dynamics play in the different equity issues relevant to my research/practice, or those in the case study?
• What roles do desire and emotions play in power dynamics?

Activity 5

*Gender roles and expectations, stereotypes, and influences*

**Learning Objective:**

• To understand the meaning and importance of gender and equity in addressing social and health issues, and to reflect on our gender roles

• To reflect upon the roles of power dynamics, structures and relationships and describe the way they affect equity and therefore health outcomes.

**INSTRUCTIONS**

(1) Divide the participants into pairs. If possible, pair people who don’t know each other very well. Give pairs three minutes to interview each other then, in a group session, everybody introduces his/her neighbour within one minute. Next in the group session, everybody introduces his/her neighbour for another minute. This may have been done in an initial ice-breaker session in the course. If so, go immediately to (2).

(2) If the participants have taken part in the group activities from Module 2, 3 or 4, ask them to reflect back on those sessions, and to comment on who spoke and who didn’t, who took notes, etc, and whether that reflected skills, or power, or both. What activities or behaviours have been gendered?

(3) Divide participants into groups of three. Assign to each group one of the following institutions: family, communities, health care, sciences, religion, law and order, education, military, media etc). Ask each group to discuss the questions and allow each group to present the findings:

• How does the institution/system create and maintain gender stereotypes? Give examples of stereotypical behaviours, practice, and policies in the institution.

• What are some of the situations in which we see gender differences? (social, political, educational, economic).
Keep in mind that many other factors relate in complex ways to these institutions. As a trainer, you can choose to discuss the interrelationships between all factors, or limit the discussion to gender.

Sample Timetable: Module 6

<table>
<thead>
<tr>
<th>TIME</th>
<th>SHORTER COURSE</th>
<th>TIME</th>
<th>LONGER COURSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 min</td>
<td>Introduce goals and objectives: Focus on equity or gender</td>
<td>15 min</td>
<td>Introduce goals and objectives: Focus on both equity and gender</td>
</tr>
<tr>
<td>90 min</td>
<td>Activity 1: Terms and definitions</td>
<td>90 min</td>
<td>Activity 1: Terms and definitions</td>
</tr>
<tr>
<td></td>
<td>Activity 1A – Defining Power and Equity</td>
<td></td>
<td>Activity 1A – Defining Power and Equity</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Activity 1B – Defining Gender and Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 min</td>
<td>Activity 2: Brief Presentation: On the consequences of inequities for health outcomes</td>
<td>45 min</td>
<td>Activity 2: Brief Presentation: On the consequences of inequities for health outcomes (include longer discussion period)</td>
</tr>
<tr>
<td>60 min</td>
<td>Activity 3: Meaning and description of social and gender inequities/ inequalities in Ecohealth.</td>
<td>90 min</td>
<td>Activity 3: Meaning and description of social and gender inequities/ inequalities in Ecohealth.</td>
</tr>
<tr>
<td>60 min</td>
<td>Activity 4: Reflecting on Power and Equity</td>
<td>90 min</td>
<td>Activity 4: Reflecting on Power and Equity</td>
</tr>
<tr>
<td>60 min</td>
<td>Activity 5: Gender, roles and expectations, stereotypes and influences</td>
<td>90 min</td>
<td>Activity 5: Gender, roles and expectations, stereotypes and influences</td>
</tr>
<tr>
<td>5h10</td>
<td>Total time</td>
<td>8h30</td>
<td>Total time</td>
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</tbody>
</table>
Evaluation

Participants may benefit from time outside the structured session to reflect on what has been discussed. You could suggest options like participants writing in their journal, or doing a quiet walk. You could also allocate time during your classes for such an activity.

A short survey or class discussion could be used to obtain feedback from the learners about the module and teaching of this topic.

Observation of group discussion can be used to assess participant interaction, confidence, and use of analytic approaches and emotional intelligence.

Terminology

Power
The capacity or ability to direct or influence the behaviour of others or the course of events (http://oxforddictionaries.com)

Social equity
The state, quality or ideal of being just, impartial, and fair.

Gender and Sex definitions:

NOTE FOR INSTRUCTORS

Gender
“The roles and responsibilities of men and women that are created in our families, societies, and our cultures. The concept of gender also includes the expectations held about the characteristics, aptitudes, and likely behaviour of both women and men. These roles and expectations are learned. They can change over time and they vary within and between cultures. The concept of gender is vital because it facilitates gender analysis, revealing how women's subordination is socially constructed. As such the subordination can be changed and ended.

“Sex describes the biological differences between men and women, which are universal and determined at birth” (UNESCO 2005).
Gender equity
Fairness and justice in the distribution of benefits, power, resources, and responsibilities between women and men. The concept recognizes that women and men have different needs, power, and access to resources, and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes (WHO).
Gender equity in relation to health addresses inequalities between women and men in terms of their resources and their opportunities for health, including differences in how well health systems meet their specific needs.

Gender equality
The result of the absence of discrimination on the basis of a person’s sex in opportunities, allocation of resources or benefits, and access to services (UNDP).

Gender issues
The addressing men and women in a holistic way while considering their options, quality of life, experiences, perceptions, power resources, physical traits, and family relations (relations between men and women).

Gender roles
Vary by age, social and economic status, ethnicity, religious affiliation, and other social characteristics, including differences in status, power, roles, vulnerability, and access to resources.

Gender mainstreaming
The shift from sex-counting to a transformative approach. Gender mainstreaming addresses issues of male/female equity and equal opportunities to access and control over resources, development benefits and power in decision making at every stage of the development process, projects, programs, or policy.

Gender sensitivity
Acknowledges and highlights existing gender differences, issues, and inequalities and incorporates these into strategies and actions. Gender sensitivity indicators compare the situation of males to that of females, and show an aspect of advantage or disadvantage.

Empowerment
Both men and women taking control of their lives by setting their own agendas, gaining skills, building self-confidence, solving problems, and developing self-reliance.

Key References


Other case studies, as well as some tools, are described in the Appendix.

Additional References


Gender and Health Collaborative Curriculum Project: http://www.genderandhealth.ca/


Gender Analysis Framework

This Appendix will be most useful for more advanced learning objectives.

ADVANCED LEARNING OBJECTIVE:

- Explain how social equity and gender analysis can be used to achieve more relevant research that accommodates life patterns, biological differences, needs and interests of different cultures, genders, generations, and species.

The tools presented below are all oriented towards gender analysis. The process and concepts presented in them can but adapted to look at other types of inequities. The following link presents a social equity audit tool from the Social Equity Watch http://www.socialequitywatch.org/.


Working in Communities where Inequities are Deeply Embedded

Depending on how rigidly gender and other inequities are embedded in a community, different approaches may be taken. In some communities differences are very deeply entrenched and researchers and practitioners cannot address them directly. For instance, in some communities, it will not be possible, at least at first, to have men and women, or people of different economic classes, attending the same workshops, or, if they do, one group will dominate the other. Some approaches take advantage of existing gender inequities, behaviours, and stereotypes, or respond to different roles and identities of women and men. Thus the research and interventions may target men and women differently and separately (e.g. through male and female doctors, or separate schools, self-help groups and markets). They do not deliberately challenge unequal relations of power or address underlying structures that perpetuate gender inequities; however, by giving equal attention to different groups, researchers may begin to help the community “soften” some of the boundaries.

“Gender Transformative” approaches explicitly engage women and men to examine norms, question, and change the institutions and norms that reinforce gender inequalities, and as a result achieve both health and gender equality objectives.

(1) Ask the participants to examine the sample case studies used in this course (or their own work) for examples of gender and social differentials, how they interact, and how one might work with them or transform them. You could also identify new examples to use for this module. Suggestions for the types of scenarios could include:

- Communication campaign promoting the importance of men’s participation in family planning decision making on television
- Targeting poor rural women for cell-phone-based banking systems
• Engaging women and men in a process of critical reflection leading to an understanding of human rights to eliminate harmful cultural ritual practices
• Working with communities affected by Agent Orange in Vietnam to work through differential impacts of dioxins on men and women, and relationships of those differential impacts to poverty and cultural history.

More Tools: Gender Analysis Framework

Background Information: What is gender analysis?

Gender analysis is a systematic analytical process used to identify, understand, and describe gender differences and the relevance of gender roles and power dynamics in a specific context. Gender analysis examines different gender roles, rights, constraints, and opportunities of men and women and its relation between them. The analysis also involves examining the different impacts of development policies and programs of women and men, and the collection of sex-disaggregated or gender-sensitive data.

An analysis of gender relations provides information on the different conditions that woman and men face, and the different effects that policies and programs may have on them because of their situations. This information can inform and improve policies and programs, and is essential in ensuring that the different needs of both women and men are met.

Tools for Gender Analysis: two tools that have been used for analyzing gender and other power relationships are The Activity Profile and a Gender Analysis Table.

The Activity Profile

This tool assists in identifying the productive and socially reproductive activities of women and men, girls and boys. Other data disaggregated by gender, age, or other factors can also be included. It can record details of time spent on tasks and their location.

Doing an activity profile:

• Identify the tasks in the activity (e.g. agriculture-production of beans)
• Examine the tasks done by women/girls and men/boys in the activity
• What resources are needed to perform each task?
• Who has access to/control over the resources?
• What are the main benefits?
• What are the gender issues identified?
• Do the activity profiles differ according to economic status or ethnic group?
• What are the effects of the above issues on success of the activity?
• How can we solve the identified issues?
Activity Profile:
Specifically, what roles women/girls, men/boys perform in each activity and at what times:

Productive activities: Agriculture, income generation, employment, marketing crops.

Reproductive Activities: Firewood collection, water collection, cooking, household cleaning, childcare.

Community Activities: Meetings, community road construction and repair, community activities for public health.

The trainer may ask the following questions after presentation of daily activity – CLOCKS

- How is the time for each category of people (women/men) divided?
- How much time is devoted to productive activities, domestic activities, community activities, leisure, sleep, and how do they vary by season?
- For each category, it is time fragmented among several different kinds of activities or concentrated on a few?
- How do the women’s and men’s clocks compare?
- Whose clock is the busiest?

Daily Activity Clocks for women and men in the hot and rainy seasons
These show that both women and men work long hours in the fields during the rainy season, but during the hot season men enjoy a great deal of leisure time while women carry out a multitude of activities, including gardening. Within a community, how do the activity clocks differ by social and economic class? Are some groups expected to engage in different patterns of activity within the community (business and political leaders versus farmers, for instance)?
A FRAMEWORK FOR GENDER ANALYSIS (DATA COLLECTION AND ANALYSIS)
(Source: USAID 2009)

<table>
<thead>
<tr>
<th>DATA COLLECTION AND SYNTHESIS STEP 1</th>
<th>DATA COLLECTION AND SYNTHESIS STEP 2</th>
<th>ANALYSIS STEP 1</th>
<th>ANALYSIS STEP 2</th>
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<tbody>
<tr>
<td>What are the key gender Relations related to each domain And to power?</td>
<td>What additional information is needed about gender relations?</td>
<td>What are the gender-based constraints to reaching program objectives?</td>
<td>What are the gender-based opportunities for reaching program objectives?</td>
</tr>
</tbody>
</table>

Consider these relations in different contexts – individual, partners, family and communities, health care and other institutions, policies.

Access to Resources
Land, labor, capital, entrepreneurial skills
Information/communication
Education/training
Income/debt
Health services
Employment benefits (Family assets e.g. bicycle, radio, food, clothing shelter/new house, decision-making)

Knowledge, Beliefs, Perceptions: Knowledge Stereotypes Beliefs/ideology Behaviours Daily activities Self-perceptions Self-confidence Religion/ritual
<table>
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**Practices & Participation:**
Freedom
Activities (meetings, training, political process, health, social services)
Development activities
Allocation and availability of time to participate

**Legal Rights and Status:**
Inherit and own property
Legal document (ID card, house registration)
Reproductive choice
Healthcare security card

**Power, Control, and Decision-making:**
Acquiring resources and disposing of resources
Choosing to believe
One’s own body
Reproductive choice
Occupation
Examples of case studies that can be used in this module

Cadmium, Sex and Gender

The statements below are all based on scientific studies. Read them through, then talk with the participants about sex, gender, and equity questions that arise.

During the post-war years in Japan, several hundred women who worked in, and ate from, certain rice fields, developed a severe, very painful, and often fatal disease of the bones referred to by those affected as “itai-itai” (ouch-ouch) disease.

The rice fields were irrigated with cadmium-contaminated water from a zinc mine.

The miners were men, who generated income for their homes.

Cadmium attacks the kidneys. While only about 5 per cent of cadmium is absorbed by people, it takes about 30 years for half the cadmium to be cleared from the human body once it’s there.

Cadmium is concentrated through industrial processes, batteries, electroplating, and is a contaminant in other metals we use.

In some studies, women have double the concentrations of cadmium in their blood than men. This could be linked to iron transport mechanisms: the body is trying to compensate for iron loss during menstruation, taking up iron through intestinal transporters. Possibly aiming for iron but having an affinity for cadmium.

Iron deficiency during pregnancy leads to increased cadmium absorption and body burden. Multiparous women exhibit additional increases with increasing age.

Smoking remains a major source of cadmium exposure to people; women of the developing world are currently the fastest growing group of “smokers.”

Relative to other foods, the highest levels of cadmium are in the healthiest foods: root vegetables, whole wheat, unpolished rice.

Case study

The Case of Agent Orange in Vietnam

“Millions continue to suffer”: Excerpt from a speech delivered to the launch meeting of Agent Orange Justice Australia Vietnam Solidarity Network, held in Sydney on June 1, 2011, by the Vietnamese consul general in Sydney, Mai Phuoc Dung.

“A recent investigative study conducted by US scientists showed that US forces from 1961 to 1971 deployed in Vietnam about 80 million litres of toxic chemicals (more than half of which was Agent Orange) containing nearly 400 kg of dioxin, an extremely dangerous substance which has destroyed much of our environment and many people’s health.
With about 80 million litres of toxic herbicides, mostly Agent Orange, containing high concentrations of dioxin, the most powerful toxin ever known, this “chemical warfare” was sprayed on at least 4.8 million Vietnamese and poisoned three million of them. Out of this population, many have died or are dying; many who survive, especially children born with severe deformities, suffer a fate even worse than death.

Right from the first spraying in the early 1960s, many US scientists raised their voices to protest the use of toxic chemicals in Vietnam.

The war is over. Vietnam has made its marvellous rebirth. Nevertheless, millions of people continue to suffer from deadly incurable diseases caused by dioxin exposure. Thousands of those affected have died in agony with deep indignation towards the perpetrators of these crimes. Many women suffered reproductive complications or even lost their right to be a mother. More painfully, their descendants, who had nothing to do with the war, have been, are, and will be victims of dioxin, born with inherited diseases and without even a minute of the happiness of living like an ordinary human being. The victims of Agent Orange/dioxin are the poorest and the most miserable people and, with many deformed offspring, their families live in poverty. Despite all efforts by the government and people of Vietnam, supported by the contributions of progressive humanity, the life of Vietnam’s Agent Orange victims is still extremely wretched. Many of them face ever worsening illnesses or new diseases; many others can no longer work to earn their own living and support their families; and many children with birth defects are suffering and getting nearer to death.”

Further notes: Many of the people who have moved into the heavily contaminated sites are very poor, as this is the cheapest land available. Women are expected to “produce” healthy children to help work and earn money. The form of dioxin in the herbicide is one of the most toxic substances ever produced, causing a variety of cancers and severe birth deformities. The babies that survive require high levels of care, which poor families are not equipped to provide.

Case study example: A case of the Plague

David Waltner-Toews, in his book “The chickens fight back: pandemic panics and deadly diseases that jump from animals to humans” (Greystone 2007), describes the following situation:

In the nineteenth century, the plague arrived in an area of what is now Tanzania along the trade routes, and became established in several parts of the country, but in one particular village and its environs. Then, in the 1940s, the inhabitants of this village were plagued with an explosion of the rodent population, but without the occurrence of the plague. Nevertheless, the damage from the rats was sufficient to require the intervention of a special healer, who, in the manner of any good epidemiologist, intervened when the epidemic was at its peak and would thus decrease no matter what he did. A couple of decades later, the rat plague returned, this time carrying human disease with it. Local people consulted the healer, who, it turns out, had not been paid the last time; after receiving appropriate apologies and offerings, he again suggested some cures. This time, however, perhaps because the people didn’t believe hard enough or do exactly the right things, the plague persisted. Over the decade of the 1980s, thousands of people became sick, and hundreds died.

In the meantime, veterinary scientists were trapping rats and taking blood and fleas from a random sample of people and dogs, looking for Yersinia pestis, or antibodies to it. Every possible preventive action seemed to have been tried, but nothing worked, at least not very well. Some research suggested that dogs were carrying the disease; maybe if they got rid of the dogs the problem could be solved. An anthropologist was sent in to talk to the people to see if he could determine why nothing seemed to work.

A complicated picture emerged from the anthropologist’s report, including what had been tried, and why it hadn’t worked.

Doctors tried to quarantine sick people, but they resented this intrusion into their daily lives. Under quarantine, they were prevented from leaving their homes or villages to take part in agricultural activities, gather food, care for sick relatives, or attend special occasions; some people could find loopholes, however, especially through bribery. In any case, if rat fleas were carrying the disease, it was not clear that quarantine would have any effect besides making it look as if something were being done.

One could fall back on simply diagnosing and treating cases as they came up. Since the plague is generally treatable with inexpensive antibiotics such as tetracycline or streptomycin, this approach is often the most cost-effective for sporadic (non-epidemic) cases of the plague. Treating people
quickly is dependent on local treatment centres that are accessible, well-staffed and stocked with antibiotics, however. In Tanzania, the local treatment centres were accessible but not always stocked with drugs; patient records were sometimes mixed up, lost, or leaked beyond the centre, raising questions of confidentiality. Patients were to bring their own bed-sheets and the like; some could not do so, or were ashamed of their poverty.

In many parts of the world, diagnoses are made by playing the odds. “If you hear hoof beats,” our professors at veterinary school in Saskatchewan used to say, “think horses, not zebras.” But that advice needs to be taken in context. In Kenya, you might well think “zebra” at the sound of hoof beats. In North America, we often call a fever together with either respiratory or gut problems the flu; but often it’s not influenza (especially the gut form, since influenza in people is usually a respiratory disease). Sometimes that doesn’t matter; “flu-like” illnesses in North America are often caused by viruses, and doctors usually treat “flu like” viral diseases similarly (chicken soup and bed rest). In parts of Africa where the plague is known to be endemic, a lot of non-plague diseases are called the plague, including malaria. Unfortunately, malaria is not treatable by antibiotics. If only some forms of the plague, broadly interpreted as any general illness, responded to antibiotic treatment, then what advantage did those modern methods have over traditional healers?

Public health authorities tried pesticide spraying and rat poisoning in houses. People from households that had been sprayed were asked to shut all windows and doors for six hours, as well as not to clean house for three to six days. Those householders did not like to share a dwelling with dead rats and fleas for that amount of time. Moreover, the pesticides had good market value and were either allocated according to favouritism, or resold to farmers as treatments for crops and foodstuffs. Some people complained of becoming ill after spraying; chickens sometimes died, and cattle became ill.

Authorities proposed that villagers plaster and seal their houses, so that the rats couldn’t get in from outside. Most of this work was supposed to be done by women and children under twelve, who were the ones getting sick, and who did not have the energy for house renovations. Besides, there was a shortage of water needed for plastering, and men controlled the money that would pay for plastering. It was not done.

Households could move food storage outside so that the rats wouldn’t come into the house: traditionally, the maize was stored outside the house. However, a decline in maize production associated with an increase in cash crop production related to an opening of world markets made maize more valuable as a food commodity; this development, together with a decrease in social trust (related in part to competitiveness and modernization), increased the need for vigilance. Hence the maize was now stored in the wooden ceiling of the house. Rats followed the
maize into the house; this move made the dogs happy to stay around the house as well.

Public health officials recommended that householders clear shrubs and bushes from around the houses and field crops so that rats would have fewer places to hide. But arable land was scarce, and people wanted to maximize land use by planting very close to the house. Borders of fields were planted with trees to prevent soil erosion, with grasses as cattle feed, and with medicinal plants for household use. These practices were encouraged by some government agencies (obviously not those involved in eradicating the plague) to conserve soil and water. Some shrubbery was also maintained as a link to family ancestors, who were believed to live in the shrubs near the house.

Even something as apparently simple as removing food scraps from near dwellings was a problem, since this organic “waste” was thrown into the fields around the house to serve as fertilizer for the crops.

Since women and young girls prepared the food, they were disproportionately affected by the disease. Since children played with dogs that were infected by fleas from rats, they also got the plague.

What should these people do? To keep up agricultural production and prevent soil erosion, farmers should plant bushes and shrubs around their houses and fields. To prevent the plague, they should pull them up. To make more money, they should plant more cash crops. To bring down the price of local food, they should plant more maize. To improve their health, they should cooperate with their neighbours and move their grain into outside storehouses. To become more competitively efficient in the global market, they should compete with their neighbours.

What questions might you ask with regard to gender? Access to money? Distribution of wealth within families and communities? Inequality? Inequity?