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Gender in FP-MCH and the 5Rs for Gender-Based Violence Victims/Survivors Trainer's Guide



Gender in FP-MCH and the 5Rs for Gender-Based Violence Victims/Survivors

Trainer's Guide

July 2014

This document is made possible by the support of the American People through the United States Agency for International Development (USAID). The contents of this document are the sole responsibility of Chemonics International, Inc. and do not necessarily reflect the views of USAID or the United States Government.

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ACRONYMS

DSWD	Department of Social Welfare and Development
FP-MCH	Family Planning-Maternal and Child Health
GBV	Gender-Based Violence
IRR	Implementing Rules and Regulations
MDG	Millennium Development Goal
PNP	Philippine National Police
UNFPA	United Nations Population Fund
VAW	Violence Against Women
VAWC	Violence Against Women and Children
WCPU	Women and Child Protection Unit
WHO	World Health Organization

INTRODUCTION

This guide, **Gender in FP-MCH and the 5Rs for Gender-based Violence (GBV) Victims/Survivors**, is intended for trainers of gender sessions of Family Planning Maternal and Child Health (FP-MCH) trainings. This session teaches participants, mostly private health care providers, how to integrate gender concerns into FP-MCH services. This guide will train them how to recognize, report on, record and refer victims of gender based violence (GBV), and raise the awareness of GBV among FP-MCH clients.

In conducting this training, PRISM2 seeks to integrate gender considerations in FP-MCH services. The approach, gender synchronization, focuses on both women and men, girls and boys “in an intentional and mutually reinforcing way that challenges gender norms, catalyzes gender equality, and improves health” (Greene & Levack, 2010, p. vi)¹.

The core of gender synchronized FP-MCH is the promotion of equitable participation and benefits to both women and men in FP-MCH, and the involvement of FP-MCH service providers in addressing gender-based violence. GBV is a violation of human rights and an obstacle to seeking and using FP-MCH services and products. Therefore, addressing GBV is a public health and social responsibility, as well as a means to help achieve FP-MCH goals. The learning objectives reflect this focus.

Learning Objectives

The general objectives of this training are to raise the awareness of FP-MCH service providers on the importance of the health of women and children, and to develop their capabilities to recognize and respond to clients who are experiencing GBV. After attending this training, FP-MCH providers are expected to: (a) be able to understand how gender issues affect FP-MCH; (b) be able to recognize, record, report, and refer GBV victims/survivors to organizations providing comprehensive and professional assistance; (c) be able to give psychological help to GBV victims/survivors, by compassionately listening and referring to the proper agencies; (d) be able to raise client’s awareness on gender and GBV by integrating these topics into group conversations with clients on FP-MCH; and (e) be willing to be part of a GBV referral network and support group in their province, city or municipality.

More specifically, at the end of the one-day training, participants will be able to:

- I. Define gender and its relevance to FP-MCH;

¹ Greene, M. & Levack, A. (2010) for the Interagency Gender Working Group (IGWG), *Synchronizing Gender Strategies: A Cooperative Model for Improving Reproductive Health and Transforming Gender Relations* (Washington, DC: Population Reference Bureau).

2. Explain how the pursuit of gender equality can contribute to the achievement of FP-MCH objectives (i.e., reduced maternal mortality ratio and infant mortality rate, increased contraceptive prevalence rate and more skilled birth attendant-assisted deliveries);
3. Identify gender issues in FP-MCH including the nature, extent and general causes of GBV or violence against women and children (VAWC);
4. Follow the 5Rs (recognition, recording, reporting, referral and raising awareness) for GBV victims/survivors; and
5. Provide psychological help (through compassionate listening) before referring a GBV victim/survivor to organizations that provide professional assistance.

Module Sessions

This module is divided into three parts:

Part 1: The basic concepts of gender and its relevance to FP-MCH

Part 2: Nature and causes of gender-based violence

Part 3: 5Rs (recognition, recording, reporting, referral and raising awareness) for GBV victims/survivors

A CD with the PowerPoint presentation of the module is provided in the pocket of this manual.

MODULE SESSIONS

Administration of Pre-test

Begin by administering a pre-test. Distribute the pre-test form (See Annex A) and explain the instructions. Emphasize the following:

1. The pre-test and post-test will be administered at the beginning and end of the sessions. These tests are tools designed to evaluate the effectiveness of the sessions in providing knowledge about gender and gender-based violence (GBV) in FP-MCH. In addition, the tests will assess the actions that FP-MCH providers can take to assist GBV victims/survivors, rather than evaluate the participant's knowledge on gender. Additional knowledge resulting from the training will be measured by computing the difference between the post-test and pre-test scores;
2. Identities of participants will be kept confidential. Participants will be asked to write codes rather than their names;
3. Both the pre-test and post-test have four main statements. Each main statement has four sub-statements. Participants can tick more than one sub-statement for each main statement; and
4. Scoring is the number of correct answers minus the number of incorrect answers. Participants should be careful in selecting the correct sub-statements for every main statement.

Collect the answered pre-test forms and check the answers (after the gender sessions) using the Answer Key provided in Annex B. Compile a table with the pre- and post-test scores for each numbered participant (no names or other identifiers should be used).

Overview of the Gender Module

CONTENT	TEACHING-LEARNING PROCESS
<p style="text-align: center;">Gender in FP-MCH and the 5Rs for Gender-based Violence Victims/Survivors</p>	<p>While this slide is being flashed, explain the reason for this discussion on the concept of gender. The effective delivery of this gender session will depend on the trainers' appreciation of the basic concepts of gender, its relevance to FP-MCH, and knowledge of what FP-MCH providers can do if a client is a victim/survivor of gender-based violence.</p>
<p>Key Questions</p> <ol style="list-style-type: none"> 1. What is gender? What is the importance of this concept of gender to MNCHN/FP-MCH? 2. What is gender-based violence (GBV)? 3. How can health providers assist GBV victims-survivors? 	<p>Say that in this session, you will be discussing the answers to the following questions.</p> <p>Read the questions. Each question corresponds to one part of the gender session.</p> <p>After giving this overview of the gender session, proceed to Part I.</p>

PART I: BASIC CONCEPTS OF GENDER AND ITS RELEVANCE TO FP-MCH

Learning Objectives

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

- Differentiate between the concept of gender and the concept of sex;
- Identify the manifestations of gender inequality in households and communities; explain how gender inequality and GBV affect FP-MCH;
- Explain the importance of and general approaches to the pursuit of gender equality in FP-MCH; and
- Describe the behaviors and practices of a gender-sensitive FP-MCH service provider.

Methodology

- Structured learning exercise using a video clip, “The Impossible Dream” as the activity/ experience to reflect on and analyze
- Short lecture

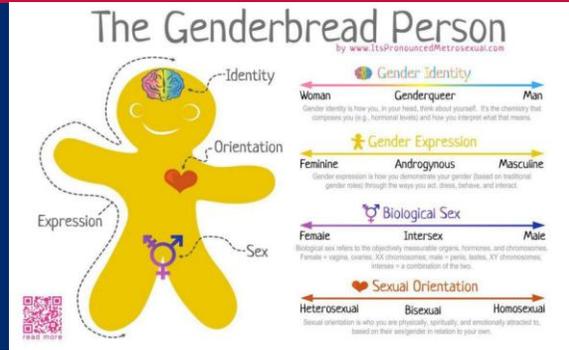
Time Allotment: 1 hour 30 minutes

Needed Materials

- Video clip: “The Impossible Dream”
- Laptop, LCD projector, and sound system
- Visual aid to be printed as handouts
- Whiteboard and marker

CONTENT	TEACHING-LEARNING PROCESS
<p style="text-align: center;">PART 1: Basic Concepts of Gender and its Relevance to FP-MCH</p> <p style="text-align: right; font-size: small;">PRISM21</p>	<p>Read the slide and state the objectives of the session (next slide).</p>
<p>Learning Objectives</p> <p>At the end of this session, participants will be able to:</p> <ol style="list-style-type: none"> 1. Differentiate between the concept of gender and the concept of sex; 2. Identify the manifestations of gender inequality in households and communities; explain how gender inequality and GBV affect FP-MCH; 3. Explain the importance of and general approaches to the pursuit of gender equality in FP-MCH; and 4. Describe the behaviors and practices of a gender-sensitive FP-MCH service provider. 	<p>Read the objectives.</p>
<p>The Concept of Gender</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>THOUGH GENDER IS RELATED TO SEX, IT IS NOT ABOUT SEX.</p> </div> <ul style="list-style-type: none"> • Sex refers to the biological characteristics (genital organ, reproductive system) of males and females • Sex of a person is since conception/birth • Male and female physical characteristics are universal 	<p>Begin by differentiating the term “gender” from the term “sex”. Read the slide. Emphasize that sex refers to the biological or natural characteristics of males and females.</p> <p>Gender does not refer to the biological or given (since conception) characteristics of individuals.</p>

CONTENT	TEACHING-LEARNING PROCESS
<p>Understanding the Concept of Gender</p> <hr/> <ul style="list-style-type: none"> • Video clip, "Impossible Dream?" <div style="text-align: center;">  <p>(Impossible Dream?)</p> <p>http://videos.recettes-de-cuisine.eu/1/video/impossible%20Dream/v-12,RPBIFRZY.html</p> </div>	<p>If gender is not sex, then what is it? Say that to facilitate a discussion on the concept of gender, you will show a video clip entitled, "The Impossible Dream?"</p> <p>Let the participants watch the 8-minute video clip.</p>
<p>Guide Questions</p> <hr/> <p>A. Discussion on the video clip</p> <ol style="list-style-type: none"> 1. What did you see in the video clip? Describe the relationship of the husband and wife, girl and boy? 2. What do you think are the effects of this kind of relationship on the health of the woman and the man? 3. What are the effects on the girl and boy? 4. In this relationship, who is/are at the disadvantaged side? 	<p>After the video clip, say that there will be two sets of questions that will guide the discussion. In the first set, questions focus on the video clip. Suspend any discussions regarding its relation to real life or situations as this will be the focus of the second set of questions.</p> <p>Because of time limitations, only two or three participants should give a brief answer. Then, summarize the answers.</p>
<p>Guide Questions</p> <hr/> <p>B. Reflection on Filipino society, own community, own family</p> <ol style="list-style-type: none"> 1. Do you think this is happening in Filipino society? 2. Do you want it changed? Why? 3. Can the situation be changed? How? 4. Based on this video, what do you think is gender and what are examples of gender issues? 	<p>Highlight the questions on "change". You will use the answers to questions related to change as a talking point in defining gender. That is, the understanding of the man (husband) and the woman (wife), and the girl (daughter) and boy (son) on how to be a woman/girl or a man/boy is learned, not innate, and can be changed if this is unfair and inequitable.</p>

CONTENT	TEACHING-LEARNING PROCESS
<p>What is GENDER?</p> <hr/> <div style="border: 1px solid black; padding: 5px;"> <p>GENDER REFERS TO:</p> <ul style="list-style-type: none"> • Socially/culturally/individually constructed characteristics, roles, rights, opportunities and limitations as well as power differences of women and men • Varies from society to society, person to person • Can be contested and changed </div>	<p>Using their answers to the questions, explain the concept of gender.</p> <p>You may cite countries with different attitudes toward the roles and capabilities of women in society.</p>
<p>What is GENDER?</p> <hr/>  <p>The diagram 'The Genderbread Person' illustrates four aspects of gender: <ul style="list-style-type: none"> Identity: A spectrum from Woman to Man, including Genderqueer. It is described as how you see yourself and how others see you. Orientation: A spectrum from Feminine to Masculine, including Androgynous. It is described as how you demonstrate your gender. Biological Sex: A spectrum from Female to Male, including Intersex. It is based on objective characteristics like chromosomes and genitalia. Sexual Orientation: A spectrum from Heterosexual to Homosexual, including Bisexual. It is who you are attracted to. </p>	<p>Further differentiate the concept of gender from the concept of sex by presenting this slide.</p> <p>This slide shows that sexual orientation (to whom one is attracted – same sex or homosexual, opposite sex or heterosexual, both sexes or bisexual, or transgender) may not be entirely biologically-based.</p>
<p>Sex: Hypothalamus^{1,2&3}</p> <hr/> <ul style="list-style-type: none"> • Study of LeVay (1991) found the male INAH-3 to be more than twice as large as that of female INAH-3; and also more than twice as large as that of homosexual male INAH3. This finding suggests that sexual orientation is biologically based or at least biologically expressed. • It is not clear how environmental factors, including the effects of stress in the second trimester, might influence the size of INAH-3. A number of hereditary and environmental factors may have a significant influence on the size of INAH-3 (Solms & Turnbull, 2002; Carey, 2005). <p style="text-align: center;">8</p>	<p>To support the view that sexual orientation is more biologically- than socially-constructed, share the study of Levay (1991). Emphasize that sexual orientation is much more complicated than what this study indicates.</p> <p>See Annex C for copy of the study.</p> <p>Do not show the slide on the left to participants. You will use this in explaining why sexual orientation is considered biological.</p>

CONTENT	TEACHING-LEARNING PROCESS						
<p>Gender: A Development Concept</p> <hr/> <p>An ANALYTICAL LENS which looks at:</p> <ul style="list-style-type: none"> • WHAT - the norms/beliefs/practices of a society related to the roles, rights, opportunities and limitations of men and women; • EFFECTS - of norms/beliefs/practices on the health, social and economic conditions and needs of women and men, as well as their power relations in the household/family, community/workplace and society; • HOW TO TRANSFORM inequitable norms/beliefs/practices to achieve holistic and sustainable development of persons (male and female), families, communities/organizations, and society. 	<p>State that gender is also a development concept.</p> <p>Like a gender lens to a pair of eyeglasses. If one with defective eyesight is not wearing a pair of eyeglasses, then she/he will tend to ignore things that she/he will not see. Same with a gender lens: if one does not wear gender glasses (figuratively) then she/he will tend to ignore gender issues. But if worn, this gender lens will sensitize the person to situations in the environment (e.g., the context of FP-MCH clients' lives, political and economic opportunities, role of alcohol in the culture) that affect the role, opportunities and relations of men and women.</p> <p>What are norms? Norms are rules that people carry around in their heads that justify and provide guidance for what people ought to do and what is acceptable for them to do. Norms lead to social expectations.</p> <p>Read the slide.</p>						
<p>Example: Transforming Gender Norms and Rewriting Gender Scripts in FP-MCH</p> <hr/> <table border="1" data-bbox="233 1390 748 1661"> <thead> <tr> <th data-bbox="233 1390 483 1423">Gender Norms/Beliefs</th> <th data-bbox="483 1390 748 1423">Effects on FP-MCH</th> </tr> </thead> <tbody> <tr> <td data-bbox="233 1423 483 1528"> <ul style="list-style-type: none"> • Men are the breadwinners and heads of families, while women are the house-keepers and child-minders. </td> <td data-bbox="483 1423 748 1528"> <ul style="list-style-type: none"> • Women are the ones involved in family planning and child health care; </td> </tr> <tr> <td data-bbox="233 1528 483 1661"> <ul style="list-style-type: none"> • Men are independent and superior, while women are dependent and inferior. </td> <td data-bbox="483 1528 748 1661"> <ul style="list-style-type: none"> • But men as the heads of families and income earners decide on when and how women and the couple will use FP services and methods </td> </tr> </tbody> </table>	Gender Norms/Beliefs	Effects on FP-MCH	<ul style="list-style-type: none"> • Men are the breadwinners and heads of families, while women are the house-keepers and child-minders. 	<ul style="list-style-type: none"> • Women are the ones involved in family planning and child health care; 	<ul style="list-style-type: none"> • Men are independent and superior, while women are dependent and inferior. 	<ul style="list-style-type: none"> • But men as the heads of families and income earners decide on when and how women and the couple will use FP services and methods 	<p>Show how gender stereotypes and gender norms/beliefs affect men's and women's roles and their participation in FP-MCH.</p> <p>Do an exercise. Before showing the second column of the table in the slide, ask the participants what are the effects of these gender stereotypes on FP-MCH behavior.</p>
Gender Norms/Beliefs	Effects on FP-MCH						
<ul style="list-style-type: none"> • Men are the breadwinners and heads of families, while women are the house-keepers and child-minders. 	<ul style="list-style-type: none"> • Women are the ones involved in family planning and child health care; 						
<ul style="list-style-type: none"> • Men are independent and superior, while women are dependent and inferior. 	<ul style="list-style-type: none"> • But men as the heads of families and income earners decide on when and how women and the couple will use FP services and methods 						

CONTENT	TEACHING-LEARNING PROCESS				
<p>Example: Transform Gender Norms and Rewriting Gender Scripts in FP-MCH</p> <hr/> <table border="1" data-bbox="235 415 750 604"> <thead> <tr> <th data-bbox="235 415 483 443">Gender Norms/Beliefs</th> <th data-bbox="483 415 750 443">Effects on FP-MCH</th> </tr> </thead> <tbody> <tr> <td data-bbox="235 443 483 604"> •Women are naggers, emotional, vain, rumor monger, and fickle-minded; while men are rational, consistent and controlled in behavior. </td> <td data-bbox="483 443 750 604"> •Violence against women is sometimes, if not oftentimes, justified. </td> </tr> </tbody> </table>	Gender Norms/Beliefs	Effects on FP-MCH	•Women are naggers, emotional, vain, rumor monger, and fickle-minded; while men are rational, consistent and controlled in behavior.	•Violence against women is sometimes, if not oftentimes, justified.	<p>Repeat the exercise with another gender stereotype. Show the gender stereotype/belief in the first column of the table. Ask the participants about the effects of the gender stereotypes on attitudes towards violence against women.</p> <p>Explain that stereotypes aren't rules for behavior the way norms are, but that stereotypes are often used to justify behavior.</p>
Gender Norms/Beliefs	Effects on FP-MCH				
•Women are naggers, emotional, vain, rumor monger, and fickle-minded; while men are rational, consistent and controlled in behavior.	•Violence against women is sometimes, if not oftentimes, justified.				
<p>Example: Gender Issues in Health (FP-MCH)</p> <hr/> <ul data-bbox="235 961 722 1096" style="list-style-type: none"> • NDHS 2008: Women of reproductive age who participate less in decision making in the households have the highest unmet family planning need and are less likely to seek postnatal care. 	<p>Say that the effects of gender issues on FP-MCH have been demonstrated by studies. Read the findings of the National Demographic and Health Survey of 2008.</p> <p>Read the next slide.</p>				
<p>Example of gender issues in health (FP-MCH)</p> <hr/> <ul data-bbox="235 1432 734 1675" style="list-style-type: none"> • NDHS 2008: Women who believe that wife beating is justified for 3-5 reasons have higher ideal size than women who do not say wife beating is justified (p.199) • NDHS 2008: Married women who participate in more decisions and women who accept fewer justifications for wife beating are more likely to use contraception (p. 198) 					

CONTENT	TEACHING-LEARNING PROCESS
<p>If gender inequality affect FP-MCH, then FP-MCH providers should advocate for gender equality.</p>	<p>Before flashing this slide, ask the participants about the challenges to FP-MCH providers, given the relation between gender issues and FP-MCH service access. Then, read this slide to state the overall conclusion of the connection of gender issues with FP-MCH.</p>
<p>The Pursuit of Gender Equality IN Health</p> <p>Gender equality is both a means and an end.</p>  <pre> graph LR A[Health Services] --> B((Gender Equality)) B --> C((Health Service Goals & Objectives)) </pre>	<p>The aim is to pursue gender equality in health; gender equality is both a means and an end.</p> <p>As an end, gender equality is a goal to be achieved, and is something that we aspire to bring about because it is good in itself. If a man and a woman respect each other’s rights, dignity, worth and capabilities, then they will have a more harmonious and equitable relationship. FP-MCH providers can contribute to this goal by making their health services responsive to women and men, transforming gender relations between clients and their partners as well as transforming gender relations in health care provision.</p> <p>Gender equality is also a means to an end. If a man and woman have a good relationship, then they are more likely to take care of each other and promote each other’s health. Therefore, women will be more likely to use family planning methods, and visit and deliver with a trained health service provider. FP-MCH providers will thus have more clients (good business).</p>

CONTENT	TEACHING-LEARNING PROCESS
<p style="text-align: center;">How can we pursue gender equality in health?</p>	<p>While this slide is being shown, say:</p> <p>Gender equality is 1) good in itself, 2) will help increase the clients of private FP-MCH service providers, and 3) will help achieve MDGs 4 and 5. So, how then can we pursue gender equality in health?</p>
<p>Gender Synchronization</p> <p>Focuses on both women and men, girls and boys “in an intentional and mutually reinforcing way that challenges gender norms, catalyzes gender equality, and improves health” (Greene & Levack, 2010, p. vi).</p>	<p>The answer is through gender synchronization. Read the slide.</p> <p>Emphasize that gender synchronization (that is, responding to the needs of, and engaging both women and men) should/should be (each term in the definition):</p> <ul style="list-style-type: none"> • Intentional: it is part of the plan or interventions used by the health service provider; • Mutually Reinforcing: developed for both women and men, and clients and service providers; • Challenge Gender Norms: seeks to change gender inequality in FP-MCH and other health areas; • Catalyze Gender Equality: facilitates gender equality in practice or initiatives (in the case of the public sector) • Improve Health: the ultimate result is the improvement of everybody’s health. The family will be happier, and thus healthier. Additionally, women and their families will be able to access needed health services and will have better spaced children, leading to both improved maternal and child health.

CONTENT	TEACHING-LEARNING PROCESS
<p>Example: Features of a Gender Synchronized FP-MCH Services</p> <ul style="list-style-type: none"> • Meets the FP needs of both men and women of reproductive age; • Raises awareness of clients/patients on the importance of making FP and child care a shared responsibility of couples (both men and women); • Proactively advocates for men’s support for or constructive involvement in maternal health care; • Behavioral change communication materials on FP-MCH are meant for both men and women of reproductive age; they promote shared responsibility. 	<p>Give some features of a gender-synchronized FP-MCH service.</p> <p>Read this slide and the next slide.</p>
<p>Example: Features of a Gender Synchronized FP-MCH Services</p> <ul style="list-style-type: none"> • Ensure both women and men participate in the bodies/structures/mechanisms for health improvement; • Personnel, management and client databases should be sex-disaggregated; • Develops competency in gender sensitive Recognition, Recording, Reporting and Referring of gender-based violence cases, and Raising of awareness on GBV (5Rs). 	
<p>How can this health provider be gender sensitive and responsive?</p> 	<p>End Part I of the gender session by asking the participants to analyze this slide.</p> <p>Ask: If the client answers “No”, what will happen if the health provider is not gender sensitive, or is not wearing a gender lens? On the other hand, what will he/she do if he/she is gender sensitive, or is wearing a gender lens?</p> <p>The expected answer is that the health provider will not ask the client further questions if the provider is not gender sensitive.</p>

CONTENT	TEACHING-LEARNING PROCESS
 <p data-bbox="219 436 324 541">My husband does not want me to take contraceptives. I am afraid of disobeying him and they say that it is bad for my health.</p> <p data-bbox="381 352 511 420">I'd like to use a condom or undergo a vasectomy but others say it has side effects.</p> <p data-bbox="568 340 690 373">Do you want to talk about Family Planning methods?</p> <p data-bbox="406 571 527 630">I don't like my wife to use contraceptives and I will beat her if she will insist.</p> <p data-bbox="544 583 592 613">SABANGAY HEALTH CENTER</p>	<p data-bbox="803 319 1372 462">If the health provider is gender sensitive, he/she will ask questions to ascertain possible gender issues causing the client to say no, and will plan appropriate interventions.</p> <p data-bbox="803 520 1372 661">The second slide shows possible gender issues. Read the slide. These are the perceptions men and women have on contraceptives and power relations.</p>

PART 2: THE NATURE AND CAUSES OF GENDER-BASED VIOLENCE

Learning Objectives

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

- Define GBV and its different forms;
- Discuss the four levels of factors that perpetuate GBV;
- Identify that GBV or VAWC is never justifiable and is a public health concern requiring a comprehensive and multi-stakeholder response; and
- Explain FP-MCH providers' key role in recognizing and addressing GBV.

Methodology

- Structured learning exercise: Agree or disagree with statements.
- Short lecture

Time Allotment: 1 hour

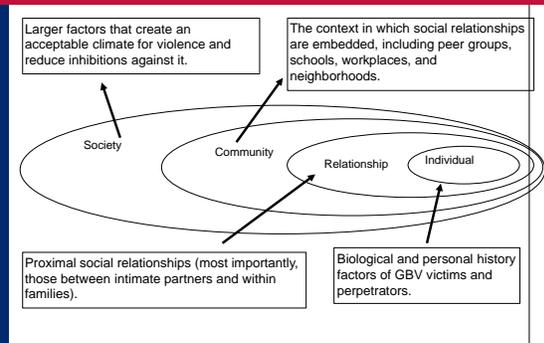
Needed Materials

- Laptop and LCD projector
- Visual aid (PowerPoint Presentation) to be printed out as handouts

CONTENT	TEACHING-LEARNING PROCESS
<p style="text-align: center;">PART 2: Nature and Causes of Gender-Based Violence</p>	<p>Say that this session is about the worst manifestations of gender inequality, which is GBV. GBV poses a serious problem to maternal and child health care and is a barrier to effective family planning.</p>
<p>Exercise: Agree or Disagree?</p> <ol style="list-style-type: none"> 1. Men sometimes have good reasons to use violence against their wives. 2. It is not appropriate for FP-MCH service providers to intervene in problems related to gender-based violence. <p>QUESTION: What is gender-based violence?</p>	<p>Begin with this exercise.</p> <p>Ask the participants to stand up.</p> <ol style="list-style-type: none"> 1. Flash the first statement. Tell the participants who agree with the statement to go to the left side of the session hall; and those who disagree with the statement to go to the right side of the session hall. 2. Ask those who agree with the statement to explain their reasons for agreement. Ask those who disagree with the statement to explain their reasons. 3. Move to the second statement. Repeat the same process as above. 4. Say that at the end of the session, you will come back to these two statements and state the answers given by gender equality advocates. 5. Show the question <p>Ask the participants about their understanding of gender-based violence.</p>

CONTENT	TEACHING-LEARNING PROCESS								
<p>Definition of GBV</p> <ul style="list-style-type: none"> • Violence involving men and women, • The female is usually the victim; • Derived from the unequal power relationships between men and women; • Includes, but is not limited to, physical, sexual, and psychological abuse 	<p>Say that this is the international definition of gender-based violence, taken from the United Nations Population Fund (UNFPA).</p>								
<p>Definition of Violence: RA 9262, Sec. 3</p> <ul style="list-style-type: none"> • Any act or a series of acts committed by any person against a woman who is his wife, former wife, or against a woman with whom the person has or had a sexual or dating relationship, or with whom he has a common child, or against her child whether legitimate or illegitimate, within or without the family abode, which result in or is likely to result in PHYSICAL, SEXUAL, PSYCHOLOGICAL HARM OR SUFFERING, OR ECONOMIC abuse including threats of such acts, battery, assault, coercion, harassment or arbitrary deprivation of liberty. 	<p>The Philippines, Republic Act 9262 or the Anti-Violence Against Women and Children (VAWC) Act of 2004 is defined as having four forms: physical, sexual, psychological and economic. Read the slide.</p>								
<p>FORMS of GBV</p> <p>PHYSICAL ABUSE: Acts that include bodily or physical harm</p> <table border="1" data-bbox="233 1493 599 1669"> <tr> <td>Slapping</td> <td>Burning</td> </tr> <tr> <td>Shaking</td> <td>Kicking</td> </tr> <tr> <td>Beating with fist or object</td> <td>Strangulation</td> </tr> <tr> <td colspan="2">Inflicting injury through knife or other weapons</td> </tr> </table> 	Slapping	Burning	Shaking	Kicking	Beating with fist or object	Strangulation	Inflicting injury through knife or other weapons		<p>Present the different forms and examples of gender-based violence.</p>
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Shaking	Kicking								
Beating with fist or object	Strangulation								
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CONTENT	TEACHING-LEARNING PROCESS															
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CONTENT	TEACHING-LEARNING PROCESS
	<p>If you have statistical data on GBV reported cases in the area, insert a slide here with those data.</p>
<p>Factors Perpetuating GBV</p>  <p>Larger factors that create an acceptable climate for violence and reduce inhibitions against it.</p> <p>The context in which social relationships are embedded, including peer groups, schools, workplaces, and neighborhoods.</p> <p>Society</p> <p>Community</p> <p>Relationship</p> <p>Individual</p> <p>Proximal social relationships (most importantly, those between intimate partners and within families).</p> <p>Biological and personal history factors of GBV victims and perpetrators.</p>	<p>Present the ecological model in analyzing the factors that perpetuate GBV. Say that there are four levels of factors. All of these factors interact in perpetuating GBV.</p> <p>Even if psychological treatment of perpetrators at the individual level is important, it is not enough to eradicate GBV. There must be multi-sector, multi-disciplinary interventions – including private health providers – in addressing the issue of GBV.</p>
<p>Examples: GBV Individual Risk Factors</p> <ul style="list-style-type: none"> • A history of violence in the perpetrator's or victim's family of origin (including intimate partner violence and child abuse) • Male alcohol use • Male personality disorders 	<p>Use the content of the slide on the left to further explain the four levels of factors.</p> <p>Do NOT show these slides to the participants.</p> <p>Remember that these are the RISK factors. In other words, they increase the chances of experiencing GBV.</p>
<p>Examples: GBV Risk Factors in Relationships</p> <ul style="list-style-type: none"> • Marital conflict • Family dysfunction • Male dominance in the family • Economic stress • Marrying at an early age • Large number of children • Friction over women's empowerment • Family honor considered more important than the health and safety of the victim 	

CONTENT	TEACHING-LEARNING PROCESS
<p>Examples of GBV Factors in Communities</p> <ul style="list-style-type: none"> • Poverty • Weak community sanctions against GBV • Traditional gender roles for women who are in transition • Normative use of violence to settle all types of disputes • Social norms that restrict women's public visibility • Lack of safety in public places • Lack of shelter or other forms of assistance/sanctuary 	
<p>Examples of GBV Factors in Society</p> <ul style="list-style-type: none"> • Traditional gender norms that give men economic and decision-making power in the household • Social norms that justify violence against women • Lack of criminal sanctions against perpetrators of GBV (impunity) • High levels of crime • Armed conflict 	
<p>Exercise: Agree or Disagree?</p> <ol style="list-style-type: none"> 1. Men sometimes have good reasons to use violence against their wives. 2. It is not appropriate for FP-MCH service providers to intervene in problems related to gender-based violence. <p>QUESTION: What is gender-based violence?</p>	<p>End the session by returning to the questions raised at the start of the session. Give your concluding answers:</p> <ol style="list-style-type: none"> 1. Violence in all forms against any person is never justified. To stop the vicious cycle of violence, one has to stop using violence as a way of resolving problems. 2. FP-MCH service providers – both private and public – are the front line of health services, and therefore have a big role in detecting and addressing the issue of GBV. 3. What can FP-MCH service providers do? This is our next topic.

PART 3: WHAT FP-MCH PROVIDERS CAN DO: RECOGNIZE, RECORD, REPORT, REFER GBV VICTIMS/SURVIVORS AND RAISE AWARENESS OF GBV TO FP-MCH CLIENTS (5Rs)

Learning Objectives

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

- Perform the 5Rs for GBV victims/survivors: recognition, recording of profile, reporting of statistical data, referral to proper agencies for assistance, and raising awareness on GBV with the goal of ending GBV and transforming unfair gender relations;
- Provide psychological first aid to a victim/survivor through compassionate communication; and
- State why it is important for them to be part of the GBV referral network in their area.

Methodology

- Participants' sharing of experiences in handling GBV victims/survivors
- Lecturette

Time Allotment: 1 hour 30 minutes

Needed Materials

- Laptop and LCD projector
- Visual aid (PowerPoint Presentation) to be printed out as handouts

CONTENT	TEACHING-LEARNING PROCESS
<p style="text-align: center;">PART 3: What can FP-MCH providers do? = 5 Rs</p>	<p>If health service providers should be included in the advocacy for the elimination of GBV, what can they do?</p> <p>Ask participants whether they have been approached by a client who is or was a victim/survivor of GBV. Let two or three participants share their experiences. If not mentioned, ask: what form of abuse was experienced? What did the health provider/ participant do? What happened?</p> <p>Summarize the key points.</p>
<p>Key Laws Related to GBV</p> <ol style="list-style-type: none"> 1. RA 7610: Special Protection of Children Against Abuse, Exploitation and Discrimination Act of 1992 2. RA 7877: The Anti-Sexual Harassment Act of 1995 3. RA 8353: Anti-Rape Law of 1997 4. RA 8505: Rape Victim Assistance and Protection Act of 1998 5. RA 9208: Anti-Trafficking in Persons Act of 2003 6. RA 9262: Anti-violence Against Women and Their Children Act of 2004 7. RA 9710: Magna Carta of Women (MCW) of 2009 	<p>State the laws that define interventions or assistance to GBV survivors. Due to lack of time, you will not be able to discuss each of these laws.</p> <p>If possible, provide the participants with copies of these laws (e.g., in CDs).</p>
<p>5Rs</p> <ol style="list-style-type: none"> 1. RECOGNIZE GBV victims-survivors among clients 2. RECORD the profile of the victim-survivor for reference on his/her case; treat this as confidential. 3. REPORT statistical data (not personal identities) of assisted GBV victims-survivors to the proper authorities (VAWC Referral Network). 4. REFER GBV victims-survivors (with their consent) to agencies or organizations providing services to GBV victims-survivors 5. RAISE AWARENESS on GBV and its ill-effects on FP-MCH as well as on the growth and wellness of male and female family member. 	<p>Say that this training promotes the 5Rs for GBV victims/survivors.</p> <p>Give an overview of the 5Rs for GBV victims/survivors. Read the slide. Say that you will discuss each of these Rs.</p>

CONTENT	TEACHING-LEARNING PROCESS
<p style="text-align: center;">RECOGNIZING A GBV VICTIM-SURVIVOR</p>	<p>This is the title slide for the first R.</p>
<p>Physical Signs of GBV</p> <ul style="list-style-type: none"> • Bruises (single or multiple) or injuries that look like they came from choking, punching, or being thrown down • Black eye, red or purple marks in the neck, or sprained wrists • Perforated eardrums 	<p>First, ask the participants what are the signs or indicators of GBV. How would they know if an individual is experiencing GBV?</p> <p>Participants usually mention the physical signs listed on the slide. Read these signs.</p>
<p>Psychological Signs of GBV</p> <ul style="list-style-type: none"> • ATTEMPTING TO HIDE BRUISES with makeup or clothing • MAKING EXCUSES FOR BRUISES like tripping or being accident-prone or clumsy. Often the seriousness of the injury does not match up with the explanation • Having FEW CLOSE FRIENDS AND BEING ISOLATED from relatives and co-workers and being kept from making friends • Having LOW SELF-ESTEEM; being extremely apologetic and meek • Having a DRUG OR ALCOHOL PROBLEM • Having SYMPTOMS OF DEPRESSION such as sadness or hopelessness, or loss of interest in daily activities • Talking about SUICIDE OR ATTEMPTING SUICIDE 	<p>Say that aside from physical signs, there are also psychological and behavioral signs. Read this slide and the next slide.</p>

CONTENT	TEACHING-LEARNING PROCESS
<p>Behavioral Signs of GBV</p> <ul style="list-style-type: none"> • Accompanied by a male who answers all the questions • Gives explanations that do not account for the injury • Avoids eye contact while explaining causes of injury • Minimizes/trivializes injury or blames themselves for being clumsy • Gives a quick ready-made response before being asked 	
<p>RA 9262, Sec 35: Rights of a Victim-Survivor</p> <ul style="list-style-type: none"> a) To be treated with respect and dignity b) To be accorded confidentiality c) To avail of legal assistance from the Public Attorney's Office or any public legal assistance office d) To be entitled to support services from the Department of Social Welfare and Development and local government units e) To be entitled to all legal remedies and support provided by the Family Code; f) To be informed of their rights and the services available to them, including their right to apply for a protection order. g) To avail up to 10 days of paid leave of absence in addition to other paid leaves (Sec 43). 	<p>Say that when a health service provider detects or suspects a client to be a victim of GBV, the first thing to do, according to RA 9262, is to inform the client of her/his rights.</p> <p>Read the slide.</p>
<p>What to do When Abuse is Recognized</p> <ul style="list-style-type: none"> •Try to elicit admission <ul style="list-style-type: none"> — <i>“Misis, may pasa ka, ano ang nangyari dyan?”</i> — <i>“Kumusta po sa bahay? Kumusta ang pagsasama po ninyo ni Mister?”</i> 	<p>A health service provider can try to invite a victim/survivor to confide in them.</p> <p>Read the slide.</p>

CONTENT	TEACHING-LEARNING PROCESS
<p>If a victim-survivor decides to disclose abuse:</p> <ul style="list-style-type: none"> • Let them talk at their own pace • Be accepting of what they say – there is no right or wrong way to feel • Be attentive, kind, caring and respectful • Express concern and empathy through body language, tone of voice, words and actions. • Compassionately listen; don't be judgmental; don't interrogate or sound like a reporter. 	<p>Read the slide.</p> <p>Stress that it is important for the health service providers to give a victim/survivor psychological first aid; this can help in their healing and recovery process.</p> <ul style="list-style-type: none"> • First and foremost, assure them that they are in a safe place, and everything that they will share will be treated confidentially • If the survivor is distressed, link them to somebody that they trust. Ask them whom they would like to be with at that moment. If that person may be contacted by phone, contact her/him and ask her/him about the situation and the needs of the victim/survivor. • Don't blame the victim for their situation. Forget your gender bias even if you think the victim/survivor provoked the violence. • Read the slide. • Say that you will explain the techniques for compassionate listening.
<p>Tips in Compassionate Communication</p> <ul style="list-style-type: none"> • Compassionate communication skills include the use of statements that are reflective and clarifying, supportive, empowering (Brymer et al, 2006) and information seeking (WHO, 1996). 	<p>Give an overview of the elements of compassionate communication. Read the slide.</p>

CONTENT	TEACHING-LEARNING PROCESS
<p>Reflective and clarifying statements mirror what the speaker says.</p> <p>Example 1: “It sounds to me like you are afraid of going back to your house. Is this correct?”</p> <p>Example 2: “You are saying that you are unsure about leaving your husband because your child is still young and you don’t have a job. Did I get that right?”</p>	<p>Explain the first element of compassionate communication: reflective and clarifying statements and give examples. Read the slide.</p> <p>Ask the participants how, in their opinion, giving reflective and clarifying statements will affect GBV victims/survivors.</p> <p>Then ask two to three participants to give examples of reflective and clarifying statements.</p>
<p>Supportive statements convey a message of support to the victim or survivor.</p> <p>Example 1: “That’s really hard...,” or “That’s tough... I can feel your pain.”</p> <p>Example 2: “I am so sorry to hear about that...”</p>	<p>Move to the next element of compassionate communication, the giving of supportive statements. Read the slide.</p> <p>Then, ask the participants how, in their opinion, giving supportive statements will affect GBV victims/survivors</p> <p>Ask another two to three participants to give examples of supportive statements.</p>
<p>Empowering statements tap into victim/survivors’ coping mechanisms:</p> <p>Example: Your decision to come here seems to show your desire to end the abuse. You can also decide to accept or refuse any assistance that will be given to you.</p>	<p>Move on to the third element of compassionate communication, empowering statements. Read the slide.</p> <p>Say that the purpose of empowering statements is for the victim/survivor to reclaim the power he/she lost when he/she was abused sexually, physically and/or psychologically.</p>

CONTENT	TEACHING-LEARNING PROCESS
<p>Information seeking statements are used when there is a need to get information to understand the nature of the problem and how a person can be helped.</p> <ul style="list-style-type: none"> • Ask questions in a calm and slow manner; • Refrain from insisting that the person should answer you; • Refrain from sounding like a reporter or interrogator; and • Think of how your question might affect the person. 	<p>The fourth element of compassionate communication is information seeking statements.</p> <p>This is related to the next R (Recording). Read the slide so that the participants can understand the general guidelines which they should use when seeking information from the victim/survivor.</p> <p>Demonstrate how a reporter or an interrogator would ask questions (not how a health care provider should ask these questions). Emphasize that a reporter or interrogator questioning, whose main purpose is to gather information rather than show empathy, is not compassionate communication. Therefore it is not the model that participants should emulate in questioning a GBV victim-survivor.</p>
<p>What to do When Abuse is Recognized</p> <ul style="list-style-type: none"> • If you are not a trained/authorized medico-legal examiner, don't perform any genital examination/treatment on the victim, unless her/his condition is life-threatening, wherein you (if a doctor) are in the best position to provide emergency assistance. • Do not touch the victim/survivor or invade her/his space unless she/he allows you to. • Never ask the victim/survivor to remove their clothing to explain or demonstrate abuse. 	<p>Read the slide.</p>

CONTENT	TEACHING-LEARNING PROCESS
<p style="text-align: center;">RECORDING THE PROFILE OF A GBV VICTIM-SURVIVOR</p>	<p>Move to the second R. Read the slide.</p>
<p>RECORDING GBV: Duties and Functions of Health Care Providers (RA 9262, IRR Sec 49)</p> <p>Any healthcare providers from public or private hospitals, clinics or rural health units, including, but not limited to, an attending physician, nurse, clinician, barangay health worker, therapist or counselor who suspects that a female patient or her children are victim/survivors of abuse shall:</p> <ol style="list-style-type: none"> a) Record all complaints, observations, and circumstances from the examination; b) Properly document all the victim's physical, emotional, and/or psychological injuries; c) Properly document all the victim's observation, emotional or psychological state and safeguard the record and make them available to the victim/survivor upon request at actual cost; d) Provide the victim/survivor immediate and adequate notice of rights and remedies provided under the Act, and the services available to them; e) Provide emergency care assistance to victims. 	<p>Read this slide (Sec 49 of the Implementing Rules and Regulations of RA 9262) to show that all health service providers, in public and private health facilities, are obliged by the law to record or document the profile of a GBV victim/survivor.</p> <p>Emphasize the part which says that recording must be properly done.</p>
<p>Importance of Recording GBV Cases</p> <p>Recording will help in:</p> <ul style="list-style-type: none"> • Diagnosing a problem, • Determining the service/intervention needed, • Tracking the progress of the condition of the person at risk or victim/survivor. 	<p>Read this slide to explain the purpose of recording the profile of a GBV victim/survivor.</p>

CONTENT	TEACHING-LEARNING PROCESS
<p>Guidelines in Recording</p> <ul style="list-style-type: none"> Recording should be undertaken with utmost care and precision because a medical record can be subpoenaed for evidence Avoid subjective interpretation of data; just record what you saw (be objective) and heard (the survivor's own words "patient stated.....") NOTE: it is not the health service provider's responsibility to determine whether an assault occurred: that is a LEGAL DECISION; health service providers can help legal authorities by keeping thorough medical records 	<p>Section 49 of the IRR RA 9262 states that the profile of a victim/survivor must be properly documented. Present these guidelines to provide the rules for proper documentation. Read the two slides on recording guidelines.</p>
<p>Guidelines in Recording</p> <ul style="list-style-type: none"> Confidentiality of personal data, for both the survivor/victim and the perpetrator, should be kept confidential unless subpoenaed. Ensure that the interview is done in a private place (will not be overheard by other clients, etc.) and say that their answers will be treated confidentially. 	
<p>RA 9262 (Anti- VAW and their Children Act)</p> <p>SEC. 44. Confidentiality. - All records pertaining to cases of violence against women and their children including those in the barangay shall be confidential and all public officers and employees and public or private clinics or hospitals shall respect the right to privacy of the victim. Whoever publishes or causes to be published, in any format, the name, address, telephone number, school, business address, employer, or other identifying information of a victim or an immediate family member, without the latter's consent, shall be liable to the contempt power of the court.</p> <p>Any person who violates this provision shall suffer the penalty of one (1) year imprisonment and a fine of not more than Five Hundred Thousand Pesos (P500,000.00).</p>	<p>Read this slide to stress the importance of complying with the rules of confidentiality.</p> <p>Emphasize that recording is required, but sharing information about a GBV victim/survivor with anyone else is a betrayal of the confidentiality you promised, and should never occur. Ask what might happen if a health service provider consciously or inadvertently told a friend or colleague about the abuse suffered by a patient.</p>

CONTENT	TEACHING-LEARNING PROCESS
<p>Recording Tool</p> <hr/> <ul style="list-style-type: none"> To identify women/men experiencing GBV or at risk of becoming a victim of GBV. 	<p>To record instances of GBV, the FP-MCH providers can use the Family Planning Form #1 (Participants who have undergone the Family Planning Competency-based Training Level I are familiar with this form.) See Annex D.</p> <p>Show them a copy of FP Form #1 on violence against women (VAW). Show them where the health service provider will be able to identify whether a client is a victim/survivor or is at risk of becoming a victim of GBV.</p>
<p>FP Form #1</p> <hr/> <p>Risks for Violence Against Women:</p> <ul style="list-style-type: none"> <input type="checkbox"/> History of domestic violence or VAW <input type="checkbox"/> Unpleasant relationship with partner <input type="checkbox"/> Partner does not approve of the visit to FP clinic <input type="checkbox"/> Partner disagrees with using FP 	<p>This is the VAW section of FP Form #1. Read the slide.</p>
<p>Questions to Ask</p> <hr/> <ol style="list-style-type: none"> In the past, was there any instance when you experienced physical or sexual or psychological abuse or economic deprivation by your husband/wife/partner? Are you still experiencing this or are you afraid that you might experience this again? Would you like to share the problem with me? Does your partner know that you came here for FP consultation? Does he/she agree with your visit here? Does he/she agree with your use of contraceptives or family planning method? 	<p>According to the Department of Health’s FP-CBT Level I Training Manual, to identify whether a client has a history of domestic violence ask, “How is your relationship with your husband/partner?”</p> <p>To make it easier for the client to say if she/he is or was a victim of domestic violence, think about converting this question into a closed question. Read the first question. Tell the client they don’t have to speak, they can just gesture “yes” or “no”.</p> <p>If a client answers “yes” to the first two questions, then she/he is a victim/survivor of</p>

CONTENT	TEACHING-LEARNING PROCESS
	<p>GBV. If she/he answers “no” to the last two questions, then she/he is at risk of GBV.</p> <p>The second question, if answered affirmatively, is followed up by “Would you like to share the problem with me?” Because the health service provider is opening an emotional wound, she/he must show compassion to the client.</p>
<div style="border: 1px solid black; padding: 10px; text-align: center;"> <h2 style="margin: 0;">REPORTING STATISTICAL DATA ON ASSISTED GBV VICTIM-SURVIVOR</h2> </div>	<p>Move to the third R. Read the slide.</p>
<p>Reporting GBV: Key Points to Consider</p> <ul style="list-style-type: none"> • Reporting will help in: <ul style="list-style-type: none"> – Monitoring the extent of GBV in an area; – Developing needed area-wide (multi-sectoral) interventions • Reports should specify the number of victims/survivors, their ages, the types of abuse, and the types of services provided. Under no circumstances should the report include the victim/survivor’s name or any personal or identifying information • Only statistical data (should not contain personal information about the person at risk or victim/survivor, and the perpetrator/s) - number of female and male survivors, their ages, types of abuses, types of services provided. 	<p>Read the slide.</p> <p>Stress that the report should NOT contain the personal identities of the victims/survivors nor that of their perpetrators.</p>

CONTENT	TEACHING-LEARNING PROCESS
<p>Reporting Tool</p> <hr/> <ul style="list-style-type: none"> • PRISM2 Monthly Service Record on FP-MCH 	<p>For PRISM2 partners, request them to make use of the back page of the Monthly Service Record on FP-MCH when presenting consolidated data on assisted GBV victims/survivors. By “assisted,” we mean those that you identify and help through the five Rs.</p> <p>Explain how to fill up the form. See Annex E for a copy of the form.</p>
<p>REFERRAL OF GBV VICTIMS/SURVIVORS TO PROPER AGENCIES FOR FURTHER ASSISTANCE</p>	<p>Move to the fourth R. Read the slide.</p> <p>Say that it is important to refer clients, who are GBV victims/survivors, given the service provider’s limitations in assisting the client.</p>
<p>Refer To Agencies that are Legally Mandated to Provide Services for GBV Survivors</p> <hr/> <ul style="list-style-type: none"> • Barangay Council for the issuance of barangay protection order • DSWD for the provision of psychosocial services (counseling, temporary shelter, livelihood, financial support during court hearing.) • DOH/PHO/CHO/MHO (WCPU) medico-legal services and issuance of medico-legal certificates; • NBI/PNP Women and Children’s Protection Desk for investigation of the case, and rescue and protection of the victim-survivor • DOJ/PAO/PROSECUTOR’s Office for legal/prosecution services. 	<p>Read the list of agencies and the services they provide that are mandated by RA 9262 (and other laws) to assist GBV survivors.</p>
	<p>If you have information on the available services and contact information of agencies or organizations that provide those services to</p>

CONTENT	TEACHING-LEARNING PROCESS
	GBV victims/survivors in the local area(s) of the participants, you may insert them here.
<p>Legal Protection of Service Providers</p> <ul style="list-style-type: none"> • RA 9262 SEC. 34. Persons Intervening Exempt from Liability. – In every case of violence against women and their children as herein defined, any person, private individual or police authority or barangay official who, acting in accordance with law, responds or intervenes without using violence or restraint greater than necessary to ensure the safety of the victim, shall not be liable for any criminal, civil or administrative liability resulting therefrom. • RA 9262 IRR Section 44. Protection of Service Providers. – In all cases, the privacy and identity as well as the locations of service providers, including NGOs and POs shall not be disclosed by any person who has knowledge of the VAWC cases. 	Read the slide on the protection given to individuals and organizations assisting GBV victims/survivors.
<p style="text-align: center;">RAISE AWARENESS OF FP-MCH CLIENTS ON GBV TO HELP ELIMINATE GBV AND POSITIVELY TRANSFORM GENDER RELATIONS</p>	Move to the fifth and last R. Read the slide.
<p>Raise Awareness Through the USAPAN</p> <p>4 USAPAN Modules:</p> <ul style="list-style-type: none"> • The quality of the relationship between a husband and wife is important to FP-MCH • A serious problem that can affect FP-MCH is gender inequality and GBV • Actions that spouses can take to stop GBV and enhance their relationship. • Available services for women and men experiencing GBV 	Read the slide for the general content of the gender section of the four <i>Usapan</i> modules.

At the end of Part 3, distribute the post-test. Collect the forms once the participants have finished answering.

EVALUATION

The effectiveness of the gender session training is measured in two ways:

The first is by computing the difference of the scores of a participant's pre-test and post-test results. A positive difference (post-test score minus pre-test score) means that a participant acquired new knowledge from the training.

Before the closing activity of the training, present the overall results of the tests. See the table below for the example. Note that 18 participants got higher scores in their post-tests compared to their pre-tests; thus the difference is a positive number. One participant got zero, which indicates no additional knowledge; and one participant got a higher score on the pre-test than on the post-test (thus the difference is a negative number), which indicates that the session did not increase his/her knowledge, but rather confused her/him about the correct answers.

Pax #	Post-test Score	Pre-test Score	Difference
1	20	10	10
2	20	16	4
3	20	16	4
4	20	14	6
5	20	12	8
6	20	6	14
7	20	14	6
8	18	12	6
9	18	12	6
10	18	10	8
11	18	16	2
12	18	12	6
13	16	10	6

14	16	14	2
15	16	14	2
16	14	12	2
17	14	12	2
18	12	6	6
19	6	6	0
20	8	14	-6

Once you have figured out the pre- and post-test scores, make a table similar to this example, and record them. Participant's names will not be recorded; instead everyone will be assigned a number in the table, as shown above. Return the answered pre-tests and post-tests to the participants. (Note: If the participants used codes rather than their real names, let them search for their own papers). Explain the correct answers to the participants. As you may need these tests for your report, request that they return them to you before they leave.

The second way to assess the training is by observing participants during the gender sessions. Focus on the way the assigned participant: (a) states the linking statement from the previous topic; (b) explains the exercise; (c) encourages participation during the exercise, shares his/her reflections and analysis after the exercise and lecture-discussion; (d) begins the lecture smoothly after sharing reflection/analysis; (e) explains each of the slides in the lecture portion; (f) gives the ending statement of the gender portion; and (g) effectively uses the job aid provided.

ANNEXES

ANNEX A. Pre/Post-Training Test Questionnaire for Training on Gender in FP-MCH and in the 5Rs for Gender-Based Violence Victims/Survivors

TRAINING ON GENDER IN FP-MCH AND IN THE 5Rs OF GENDER-BASED VIOLENCE VICTIMS/SURVIVORS

Pre/Post-Training Test

Code: _____ (Please use same code in the pre-test and post-test forms. Thanks)

Sex: Female Male

Occupation: _____

City/Province: _____

Date: _____

Instructions: Please tick the best answers for each of the following statements. You may tick more than one answer for each statement. Scoring is right minus wrong.

Statement 1:

It is important to integrate gender-related concerns in Family Planning and Maternal and Child Health (FP-MCH) care program/service because:

- 1. In a family, women (and not the men) are responsible for family planning and maternal and child health (FP-MCH) care; and FP-MCH providers should therefore help the women understand and effectively perform this responsibility
- 2. Unequal relations of men and women (such as less participation of women in decision-making in the households) can affect FP-MCH;
- 3. One way of correcting men's dominance in a family and achieving gender equality is to urge men not to be involved in FP-MCH.
- 4. Upholding gender equality is a recognition of the equal rights, worth and dignity of women and men.

Statement 2.

As part of its guiding principle and philosophy, a clinic/hospital/school/workplace resolved to integrate gender in its programs and services. This means:

- 1. Developing and implementing any program or service for women.
- 2. Developing and implementing a program/service that will address or resolve the inequitable relations of men and women.
- 3. Developing and implementing a program/service that will make men and women become sensitive and responsive to the needs of each other.
- 4. Conducting regular medical mission for women in the communities as the most important activity.

Statement 3:

Gender-based violence (GBV):

- 1. Is violence involving women and men, but in most instances the victim is a woman and the perpetrator is a man.
- 2. Is sometimes justified, such as when the victim provoked the perpetrator to commit the abuse).
- 3. Is rooted on the unequal power relations of men and women.
- 4. Can be completely resolved by treating the personality disorders (e.g., anger management, uncontrolled sexual desires) of individual perpetrators.

Statement 4:

When a service provider detects or is approached by a GBV victim/survivor, it is important for the service provider to:

- 1. Immediately make clear to the victim/survivor that the provision of service for GBV is a responsibility of the government, and that a private service provider should not in any way intervene so as not to duplicate and complicate the process.
- 2. Report to the media the incidence, including the identities of the victim/survivor and perpetrator, to protect the victim/survivor and avoid the recurrence of violence.
- 3. Attend to the victim/survivor and inform her/him of her/his rights.
- 4 Explain to the victim the different services available from government and non-government/private organizations, and then refer the victim to the organization whose service is needed and preferred by the victim/survivor.

Statement 5:

It is important to record and report the GBV case. In relation to this:

- 1. Recording is done as a part of diagnosing the problem and determining the appropriate action.
- 2. Reporting of statistical data on GBV victims/survivors and perpetrators is important so as to know the extent of problem in the area and alert government and non-government organizations on the need for comprehensive multi-stakeholder response.
- 3. A service provider is allowed to reveal the identities of the victim and perpetrator to the media and other interested individuals and groups.
- 4. A service provider can include in the records her/his own judgments about the condition.

ANNEX B. Pre/Post-Test for Training on Gender in FP-MCH and in the 5Rs for Gender-Based Violence Victims/survivors

ANSWER KEY

Name: _____ (Please write your name; rest assured, we'll keep the results confidential)

Sex: Female Male

Occupation: _____

City/Province: _____

Date: _____

Instructions: Please tick the best answers for each of the following statements. You may tick more than one answer for each statement. Scoring is right minus wrong.

Statement 1:

It is important to integrate gender-related concerns in Family Planning and Maternal and Child Health (FP-MCH) care program/service because:

- 1. In a family, women (and not the men) are responsible for family planning and maternal and child health (FP-MCH) care; and FP-MCH providers should therefore help the women understand and effectively perform this responsibility
- 2. Unequal relations of men and women (such as less participation of women in decision-making in the households) can affect FP-MCH;
- 3. One way of correcting men's dominance in a family and achieving gender equality is to urge men not to be involved in FP-MCH.
- 4. Upholding gender equality is a recognition of the equal rights, worth and dignity of women and men.

Statement 2.

As part of its guiding principle and philosophy, a clinic/hospital/school/workplace resolved to integrate gender in its programs and services. This means:

- 1. Developing and implementing any program or service for women.
- 2. Developing and implementing a program/service that will address or resolve the inequitable relations of men and women.
- 3. Developing and implementing a program/service that will make men and women become sensitive and responsive to the needs of each other.
- 4. Conducting regular medical mission for women in the communities as the most important activity.

Statement 3:

Gender-based violence (GBV):

- 1. Is violence involving women and men, but in most instances the victim is a woman and the perpetrator is a man.
- 2. Is sometimes justified, such as when the victim provoked the perpetrator to commit the abuse).
- 3. Is rooted on the unequal power relations of men and women.
- 4. Can be completely resolved by treating the personality disorders (e.g., anger management, uncontrolled sexual desires) of individual perpetrators.

Statement 4:

When a service provider detects or is approached by a GBV victim/survivor, it is important for the service provider to:

- 1. Immediately make clear to the victim/survivor that the provision of service for GBV is a responsibility of the government, and that a private service provider should not in any way intervene so as not to duplicate and complicate the process.
- 2. Report to the media the incidence, including the identities of the victim/survivor and perpetrator, to protect the victim/survivor and avoid the recurrence of violence.
- 3. Attend to the victim/survivor and inform her/him of her/his rights.
- 4 Explain to the victim the different services available from government and non-government/private organizations, and then refer the victim to the organization whose service is needed and preferred by the victim/survivor.

Statement 5:

It is important to record and report the GBV case. In relation to this:

- 1. Recording is done as a part of diagnosing the problem and determining the appropriate action.
- 2. Reporting of statistical data on GBV victims/survivors and perpetrators is important so as to know the extent of problem in the area and alert government and non-government organizations on the need for comprehensive multi-stakeholder response.
- 3. A service provider is allowed to reveal the identities of the victim and perpetrator to the media and other interested individuals and groups.
- 4. A service provider can include in the records her/his own judgments about the condition.

ANNEX C. A Difference in the Hypothalamic Structure Between Heterosexual and Homosexual Men

A Difference in Hypothalamic Structure between Heterosexual and Homosexual Men



Simon LeVay

Science, New Series, Vol. 253, No. 5023 (Aug. 30, 1991), 1034-1037.

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growth, nuclear segregation, DNA repair, and meiosis, and deletion of *HRR25* results in cell cycle defects. These phenotypes, coupled with the similarity of the *HRR25* sequence to the sequence of the Raf-c-Mos protein kinase subgroup (Fig. 3A), suggest that *HRR25* might play a similar role in *S. cerevisiae* growth and development. The defects in DNA double-strand break repair and aberrant growth properties revealed by mutations in the *HRR25* kinase extend the possible functions of protein kinases in cell growth and place *HRR25* with *CDC7* in a functional category of yeast kinase associated with DNA metabolism.

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- The *HRR25* gene was isolated by complementing for MMS sensitivity with a genomic library constructed in the plasmid YCp50 (27). An *hrr25-1* strain was transformed by standard methods (27), and transformants were replicated to media containing 0.01% MMS. Among 1200 transformants, a single MMS-resistant isolate was identified.
- Transposon mutagenesis with mTn10/UK was by the methods described by O. Hoisman *et al.* [*Genetics* **116**, 191 (1987)]. Double-stranded DNA sequencing primers used to locate the end points of the mTn10 insertion in Figs. 1 and 3 were 5'-CTGCCCGGATTACAGCA-3' and 5'-GACGTGTGTAACGACGG-3'.
- Deletion of the *HRR25* coding sequence used a *hisC::URA3::hisG* cassette [E. Alani *et al.*, *Genetics* **116**, 541 (1987)]. The 3.1-kb *HRR25* Sal I fragment (Fig. 1) was first cloned into pBluescript (Stratagene). This plasmid was digested with Bgl II, and the two Bgl II fragments that span the entire *HRR25* gene and its flanking sequences were deleted (Fig. 1). Into this deletion was introduced the 3.8-kb Bam HI-Bgl II *hisC::URA3::hisG* fragment from pNKY51 to create the *hrr25Δ* allele. Sal I digestion yielded a linearized fragment that deleted the entire *HRR25* locus.
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- An MFH14 *hrr25::I.U.K* heterozygous transformant was dissected onto a thin film of YPD-rich medium on a sterilized microscope slide, and segregants were allowed to germinate under a cover slip by incubation of the slide in a moist 30°C chamber. Photographs of colonies were taken after 2 days of growth.
- We thank I. Caballero, A. M. Quinn, S. Hanks, N. Dhillon, and T. Hunter for helpful comments and assistance with sequence alignments; R. Keil for help with x-irradiation screening; and S. Reed and his lab for assistance with an initial microscopic examination. M.F.H. is a Lucille P. Markey Scholar in Biomedical Sciences. Supported by grants from the Lucille P. Markey Charitable Trust and the NIH.

26 February 1991; accepted 23 May 1991

A Difference in Hypothalamic Structure Between Heterosexual and Homosexual Men

SIMON LEVAY

The anterior hypothalamus of the brain participates in the regulation of male-typical sexual behavior. The volumes of four cell groups in this region [interstitial nuclei of the anterior hypothalamus (INAH) 1, 2, 3, and 4] were measured in postmortem tissue from three subject groups: women, men who were presumed to be heterosexual, and homosexual men. No differences were found between the groups in the volumes of INAH 1, 2, or 4. As has been reported previously, INAH 3 was more than twice as large in the heterosexual men as in the women. It was also, however, more than twice as large in the heterosexual men as in the homosexual men. This finding indicates that INAH is dimorphic with sexual orientation, at least in men, and suggests that sexual orientation has a biological substrate.

SEXUAL ORIENTATION—SPECIFICALLY, the direction of sexual feelings or behavior toward members of one's own or the opposite sex—has traditionally been studied at the level of psychology, anthropology, or ethics (1). Although efforts have been made to establish the biological basis of sexual orientation, for example, by the application of cytogenetic, endocrinological, or neuroanatomical methods, these efforts

have largely failed to establish any consistent differences between homosexual and heterosexual individuals (2, 3).

A likely biological substrate for sexual orientation is the brain region involved in the regulation of sexual behavior. In nonhuman primates, the medial zone of the anterior hypothalamus has been implicated in the generation of male-typical sexual behavior (4). Lesions in this region in male monkeys impair heterosexual behavior without eliminating sexual drive (5). In a morphometric study of the comparable region of the

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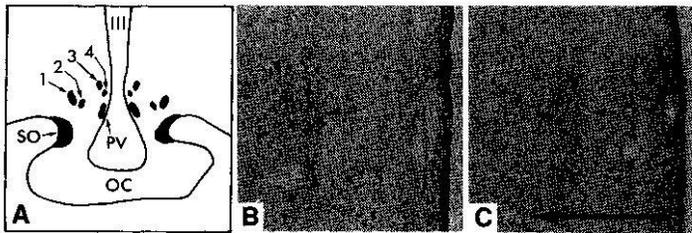


Fig. 1. (A) Semidiagrammatic coronal section through the human hypothalamus at the level of the optic chiasm (OC). The four cell groups studied (INAH 1, 2, 3, and 4) are indicated by the corresponding numerals. All four nuclei are not generally visible in the same coronal section: INAH 1 lies most anteriorly and INAH 4 most posteriorly. Supraoptic nucleus, SO; paraventricular nucleus, PV; and third ventricle, III. (B) Micrograph of INAH 3 from the left hypothalamus of a heterosexual male. The third ventricle is at the right of the figure. Arrowheads outline INAH 3. (C) Section from a homosexual male comparable to that in (B). INAH 3 is poorly recognizable as a distinct nucleus, but scattered cells similar to those constituting the nucleus in the heterosexual men were found within the area indicated by the arrowheads. The illustrated sections are near the middle of the anteroposterior extent of the nucleus in each case. The scale bar (1 mm) applies to (B) and (C).

human hypothalamus (from men and women of unknown sexual orientation), two small groups of neurons (INAH 2 and 3) were reported to be significantly larger in men than women (6). Thus, these two nuclei could be involved in the generation of male-typical sexual behavior.

I tested the idea that one or both of these nuclei exhibit a size dimorphism, not with sex, but with sexual orientation. Specifically, I hypothesized that INAH 2 or INAH 3 is large in individuals sexually oriented toward women (heterosexual men and homosexual women) and small in individuals sexually oriented toward men (heterosexual women and homosexual men). Because tissue from homosexual women could not be obtained, however, only that part of the hypothesis relating to sexual orientation in men could be tested.

Brain tissue was obtained from 41 subjects at routine autopsies of persons who died at seven metropolitan hospitals in New York and California. Nineteen subjects were homosexual men who died of complications of acquired immunodeficiency syndrome (AIDS) (one bisexual man was included in this group). Sixteen subjects were presumed (7) heterosexual men: six of these subjects died of AIDS and ten of other causes (8). Six subjects were presumed heterosexual women. One of these women died of AIDS and five of other causes (8). The mean age of the homosexual men was 38.2 years (range, 26 to 53 years), that of the heterosexual men was 42.8 years (range, 33 to 59 years), and that of the women was 41.2 years (range, 29 to 59 years). The subjects were younger and closer in age than those studied in previous investigations; tissue was not taken from elderly heterosexual men or women so that an approximate age-match would be pre-

served with the homosexual men, who were predominantly young or middle-aged adults (9).

The brains were fixed by immersion for 1 to 2 weeks in 10 or 20% buffered formalin and then sliced by hand at a thickness of about 1 cm in, or close to the coronal plane. Tissue blocks containing the anterior hypothalamus were dissected from these slices and stored for 1 to 8 weeks in 10% buffered formalin. These blocks were then given code numbers; all subsequent processing and morphometric analysis was done without knowledge of the subject group to which each block belonged. The blocks were infiltrated with 30% sucrose and frozen-sectioned at a thickness of 52 μ m in planes parallel to the original slices. The sections were mounted serially on slides, dried, defatted in xylene, stained with 1% thionin in acetate buffer (15 to 30 min), and differentiated with 5% rosin in 95% alcohol (4 to 10 min). With the aid of a compound microscope equipped with a camera lucida attachment, the outlines of four nuclei (INAH 1, 2, 3, and 4) were traced in every section at a linear magnification of $\times 83$. These four nuclei included the two nuclei reported by Allen *et al.* (6) to be sexually dimorphic and two other nuclei (INAH 1 and 4) for which no sex differences were found (6). The criteria described in (6) were followed in identifying and delineating the nuclei (Fig. 1). The outline of each nucleus was drawn as the shortest line that included every cell of the type characteristic for that nucleus, regardless of cell density. In 15 cases the nuclei in both left and right hypothalami were traced. In 12 cases only the left hypothalamus was studied, and in 14 cases only the right. The areas of the traced outlines were determined with a digitizing tab-

let, and the volume of each nucleus was calculated as the summed area of the serial outlines multiplied by the section thickness.

In the 15 cases where both left and right sides were studied, no significant interhemispheric differences were found for any of the four nuclei. Therefore, in further analysis, the mean of the two sides was used, and the cases where only one side was available were analyzed without regard to the side of origin.

One-way analysis of variance (ANOVA) was used to look for significant differences between subject groups (Fig. 2). No differences were found for INAH 1, 2, or 4. These results for INAH 1 and 4 are consistent with those of Allen *et al.* (6, 10). However, INAH 2 was reported to be about twofold larger in men than women (6). The failure to replicate that finding may have to do with the relatively young age of the subjects in the present study; as noted in (6), no sex difference was apparent when women of reproductive age were compared with men of similar ages. Thus INAH 2 is not dimorphic either with sex or with sexual orientation, at least within the age range studied.

INAH 3 did exhibit dimorphism. One-way ANOVA showed that the three sample groups (from women, heterosexual men, and homosexual men) were unlikely to have come from the same population ($P = 0.0014$). Consistent with the hypothesis outlined above, the volume of this nucleus was more than twice as large in the heterosexual men ($0.12 \pm 0.01 \text{ mm}^3$, mean \pm SEM) as in the homosexual men ($0.051 \pm 0.01 \text{ mm}^3$). Because of uncertainty about the nature of the underlying distribution, the significance of this difference was evaluated by a Monte Carlo procedure (11); this showed the difference to be highly significant ($P = 0.001$). The difference was still significant when the homosexual men were compared with only the six heterosexual men who died of complications of AIDS ($P = 0.028$). There was a similar difference between the heterosexual men and the women (mean $0.056 \pm 0.02 \text{ mm}^3$; $P = 0.019$), replicating the observations in (6). There was no significant difference in the volume of INAH 3 between the heterosexual men who died of AIDS and those who died of other causes or between the homosexual men and the women. These data support the hypothesis that INAH 3 is dimorphic not with sex but with sexual orientation, at least in men (12).

INAH 3 is situated about 1 mm lateral to the wall of the third ventricle, and about 1 to 2 mm dorsal to the anterior tip of the paraventricular nucleus. It is spherical or ellipsoidal and contains relatively large,

densely staining, polygonal neurons (Fig. 1B). The borders of the nucleus are not well demarcated; hence a blind procedure was used to reduce bias effects. In most of the homosexual men (and most of the women), the nucleus was represented only by scattered cells (Fig. 1C). Because of the difficulty in precisely defining the neurons belonging to INAH 3, however, no attempt was made to measure cell number or density.

Brain tissue from individuals known to be homosexual has only become available as a result of the AIDS epidemic. Nevertheless, the use of this tissue source raises several problems. First, it does not provide tissue from homosexual women because this group has not been affected by the epidemic to any great extent. Thus, the prediction that INAH 3 is larger in homosexual than in heterosexual women remains untested. Second, there is the possibility that the small size of INAH 3 in the homosexual men is the result of AIDS or its complications and is not related to the men's sexual orientation. This does not seem to be the case because (i) the size difference in INAH 3 was apparent even when comparing the homosexual men with heterosexual AIDS patients, (ii) there was no effect of AIDS on the volumes of the three other nuclei examined (INAH 1, 2, and 4), and (iii) in the entire sample of AIDS patients there was no correlation between the volume of INAH 3 and the length of survival from the time of diagnosis. Nevertheless, until tissue from homosexual men dying of other causes becomes available, the possibility that the small size of INAH 3 in these men reflects a disease effect that is peculiar to homosexual AIDS patients cannot be rigorously excluded.

A third problem is the possibility that AIDS patients constitute an unrepresentative subset of gay men, characterized, for example, by a tendency to engage in sexual

relations with large numbers of different partners or by a strong preference for the receptive role in anal intercourse [both of which are major risk factors for acquiring human immunodeficiency virus (HIV) infection (13)]. Sexual activity with large numbers of partners is (or was until recently) common among gay men, however, and therefore does not define an unrepresentative minority (14). In addition, the majority of homosexual men who acquired HIV infection during the Multicenter AIDS Cohort Study (15) reported that they took both the insertive and the receptive role in anal intercourse, and the same is likely to be true of the homosexual subjects in my study. Nevertheless, the use of postmortem material, with the consequent impossibility of obtaining detailed information about the sexuality of the subjects, limits the ability to make correlations between brain structure and the diversity of sexual behavior that undoubtedly exists within the homosexual and the heterosexual populations.

The existence of "exceptions" in the present sample (that is, presumed heterosexual men with small INAH 3 nuclei, and homosexual men with large ones) hints at the possibility that sexual orientation, although an important variable, may not be the sole determinant of INAH 3 size. It is also possible, however, that these exceptions are due to technical shortcomings or to misassignment of subjects to their subject groups.

The discovery that a nucleus differs in size between heterosexual and homosexual men illustrates that sexual orientation in humans is amenable to study at the biological level, and this discovery opens the door to studies of neurotransmitters or receptors that might be involved in regulating this aspect of personality. Further interpretation of the results of this study must be considered speculative. In particular, the results do not

allow one to decide if the size of INAH 3 in an individual is the cause or consequence of that individual's sexual orientation, or if the size of INAH 3 and sexual orientation covary under the influence of some third, unidentified variable. In rats, however, the sexual dimorphism of the apparently comparable hypothalamic nucleus, the sexually dimorphic nucleus of the prooptic area (SDN-POA) (16), arises as a consequence of the dependence of its constituent neurons on circulating androgen during a perinatal sensitive period (17). After this period, even extreme interventions, such as castration, have little effect on the size of the nucleus. Furthermore, even among normal male rats there is a variability in the size of SDN-POA that is strongly correlated with the amount of male-typical sexual behavior shown by the animals (18). Although the validity of the comparison between species is uncertain, it seems more likely that in humans, too, the size of INAH 3 is established early in life and later influences sexual behavior than that the reverse is true. In this connection it would be of interest to establish when the neurons composing INAH 3 are generated and when they differentiate into a dimorphic nucleus.

REFERENCES AND NOTES

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2. M. Pritchard, *J. Ment. Sci.* 108, 616 (1962); H. F. L. Meyer-Bahlburg, *Prog. Brain Res.* 61, 375 (1984); G. Dörner et al., *Arch. Sex. Behav.* 4, 1 (1975); S. E. Hendricks et al., *Psychoneuroendocrinology* 14, 177 (1989); D. F. Swaab and M. A. Hofman, *Dev. Brain Res.* 44, 314 (1988).
3. The suprachiasmatic nucleus (SCN) of the hypothalamus has been reported to be larger in homosexual than in heterosexual men [D. F. Swaab and M. A. Hofman, *Brain Res.* 537, 141 (1990)]. There is little evidence, however, to suggest that SCN is involved in regulation of sexual behavior aside from its circadian rhythmicity [P. Södersten, S. Hansén, B. Srebro, *J. Endocrinol.* 88, 125 (1981)].
4. A. A. Perachio, L. D. Marr, M. Alexander, *Brain Res.* 177, 127 (1979); Y. Oomura, H. Yoshimatsu, S. Aou, *ibid.* 266, 340 (1983).
5. J. C. Slamp et al., *ibid.* 142, 105 (1978).
6. L. S. Allen, M. Hines, J. E. Shryne, R. A. Gorski, *J. Neurosci.* 9, 497 (1989).
7. Two of these subjects (both AIDS patients) had denied homosexual activity. The records of the remaining 14 patients contained no information about their sexual orientation; they are assumed to have been mostly or all heterosexual on the basis of the numerical preponderance of heterosexual men in the population [A. C. Kinsey, W. B. Pomeroy, C. E. Martin, *Sexual Behavior in the Human Male* (Saunders, Philadelphia, 1948)].
8. The causes of death for the ten male subjects who did not die of AIDS were lung carcinoma (two

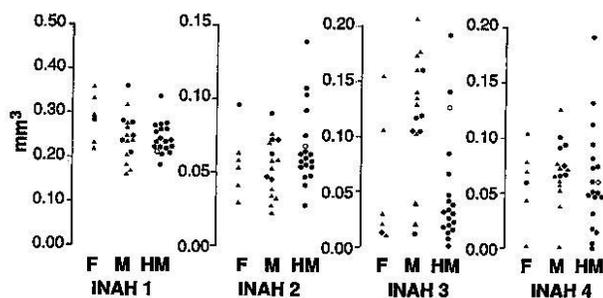


Fig. 2. Volumes of the four hypothalamic nuclei studied (INAH 1, 2, 3, and 4) for the three subject groups: females (F), presumed heterosexual males (M), and homosexual males (HM). Individuals who died of complications of AIDS, ●; individuals who died of causes other than AIDS, ▲; and an individual who was a bisexual male and died of AIDS, ○. For statistical purposes this bisexual individual was included with the homosexual men.

- cases), renal failure (two cases), coronary thrombosis, acute lymphocytic leukemia, amyotrophic lateral sclerosis, pancreatic carcinoma, pulmonary embolism, and aspiration pneumonia. For the five female subjects who did not die of AIDS, the causes of death were systemic lupus erythematosus, pancreatic carcinoma, liver failure (two cases), and abdominal sepsis secondary to renal transplantation. All six of the heterosexual male AIDS patients and three of the homosexual men had histories of intravenous drug abuse. Three of the women, two heterosexual men who did not have AIDS, and one homosexual man had histories of chronic alcohol abuse.
9. Criteria for inclusion of subjects in the study were as follows: (i) age 18 to 60, (ii) availability of medical records, (iii) in AIDS patients, statement in the records of at least one AIDS risk group to which the patient belonged (homosexual, intravenous drug abuser, or recipient of blood transfusions), (iv) no evidence of pathological changes in the hypothalamus, and (v) no damage to the INAH nuclei during removal of the brain or transection of these nuclei in the initial slicing of the brain. Fourteen specimens (over and above the 41 used in the study) were rejected for one of these reasons; in all cases the decision to reject was made before decoding.
 10. INAH 1 is the same as the nucleus named the "sexually dimorphic nucleus" and reported to be larger in men than women [D. F. Swaab and E. Eilers, *Science* 228, 1112 (1985)]. My results support the contention by Allen *et al.* (6) that this nucleus is not dimorphic.
 11. The ratio of the mean INAH 3 volumes for the heterosexual and homosexual male groups was calculated. The INAH 3 volume values were then randomly reassigned to the subjects, and the ratio of means was recalculated. The procedure was repeated 1000 times, and the ordinal position of the actual ratio in the set of shuffled ratios was used as a measure of the probability that the actual difference between groups arose by chance. Only one of the shuffled ratios was larger than the actual ratio, giving a probability of 0.001.
 12. Application of ANOVA or correlation measures failed to identify any confounding effects of age, race, brain weight, hospital of origin, length of time between death and autopsy, nature of fixative (10 or 20% formalin), duration of fixation, or, in the AIDS patients, duration of survival after diagnosis, occurrence of particular complications, or the nature of the complication or complications that caused death. There were no significant positive or negative correlations between the volumes of the four individual nuclei across the entire sample, suggesting that there were no unidentified common-mode effects such as might be caused by variations in tissue shrinkage. The mean brain weight for the women (1256 ± 41 g) was smaller than that for either the heterosexual (1364 ± 46 g) or the homosexual (1392 ± 32 g) men, but normalizing the data for brain weight had no effect on the results. There was no correlation between subject age and the volume of any of the four nuclei, whether for the whole sample or for any subject group; this finding does not necessarily conflict with the report in (6) of age effects in INAH 1, and possibly INAH 2, because in (6) a much wider range of ages was examined than was used in the present study.
13. J. S. Chmiel *et al.*, *Am. J. Epidemiol.* 126, 568 (1987); W. Winkenstein, Jr., *et al.*, *J. Am. Med. Assoc.* 257, 321 (1987).
 14. In the largest relevant study [A. P. Bell and M. S. Weinberg, *Homosexualities: A Study of Diversity among Men and Women* (Simon and Schuster, New York, 1978)], nearly half the homosexual male respondents reported having had over 500 sexual partners.
 15. R. Detels *et al.*, *J. AIDS* 2, 77 (1989).
 16. R. A. Gorski, J. H. Gordon, J. E. Shryne, A. M. Southam, *Brain Res.* 148, 333 (1978).
 17. K. D. Döhler *et al.*, *ibid.* 302, 291 (1984); R. E. Dodson, J. E. Shryne, R. A. Gorski, *J. Comp. Neurol.* 275, 623 (1988); G. J. Bloch and R. A. Gorski, *ibid.*, p. 613; R. W. Rhee, J. E. Shryne, R. A. Gorski, *Dev. Brain Res.* 52, 17 (1990).
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 19. I thank the pathologists who made this study possible by providing access to autopsy tissue; P. Sawchenko, C. Rivier, S. Rivest, G. Torres, G. Carman, D. MacLeod, S. Lockery, and J. Rice for comments and suggestions; and B. Wamsley for assistance with preparation of the manuscript. Supported by a PEIS Biomedical Research Support Grant to the Salk Institute.

29 January 1991; accepted 24 June 1991

Technical Comments

Forensic DNA Tests and Hardy-Weinberg Equilibrium

DNA tests based on biochemical procedures are being widely used for the identification of accused individuals (1). When the DNA pattern obtained from a specimen at the scene of a crime matches that obtained from a suspect, the prosecution seeks to prove that the suspect is the only possible source of the specimen. That inference depends on knowing something about the distribution of genotypes of the entire population of other people, any one of whom might be the actual criminal. In forensic applications of DNA testing so far, that inference has been based on an assumption of Hardy-Weinberg equilibrium (H-W). H-W justifies the assumption of statistical independence implicit in formulas used to calculate the probability that the DNA patterns of a specimen and of a suspect would match by chance alone. H-W can (2, 3), and sometimes does (4, 5), fail under realistic conditions.

To evaluate H-W, Devlin *et al.* (6) developed methods "to test for an overall excess or dearth of heterozygotes" in a sample of humans and applied these methods to a database provided by Lifecodes, Inc., one of the major vendors of services for forensic DNA testing. Devlin *et al.* have provided a useful service in drawing further attention to the problem of coalescence, that is, the

appearance of a single, blurred band in autoradiographic films resulting from DNA fragments of different but similar size. However, their assertion that "the arguments so far presented against [H-W] are incorrect" is unconvincing for several reasons.

1) Devlin *et al.* reject the finding by Lander (2) of an excess of homozygosity in a Hispanic population. They use a data set drawn from a Caucasian population [reference 18 of (4)] and report no direct test of the logistic model for Hispanics, but instead use the model from the Caucasian data to interpret the Hispanic data. Their model is untested on the population from which Lander drew his data.

2) Devlin *et al.* have not used the data on apparent homozygotes. These are the data most likely to reveal an excess of homozygosity. They eliminate a subset of data that deviates from the expectations under H-W, and then test the remaining data for agreement with H-W. This predisposes them toward finding no deviation from H-W.

3) Devlin *et al.* note correctly that population subdivision must affect the overall number of heterozygotes, but they do not acknowledge that not all allelic classes need have too few heterozygotes relative to H-W. Some heterozygote classes may be in H-W,

others in excess, and still others deficient: it is only the total of all heterozygotes that is necessarily deficient when the population is subdivided (7). Because the method of Devlin *et al.* tests only a subset of the heterozygote data, they might observe no deviation from H-W in that subset and incorrectly conclude that there is no departure from H-W overall, when, in fact, there is.

4) No information is given by Devlin *et al.* about how the populations of Caucasians, blacks, and Hispanics were sampled. There is no reason to believe that these samples are random or representative samples of the corresponding self-identified cultural groups in the United States. Hence inference from the given samples to the population at large, or to the entire self-identified cultural groups, is perilous. For example, the Hispanic population around New York is primarily of Puerto Rican origin, that around Miami of Cuban origin, and that in the southwestern states of Mexican origin; there are varying mixtures of other Hispanic origins in all three regions. If the Hispanic data studied by Devlin *et al.* were drawn primarily from the New York region, the conclusions could well be invalid for the other major Hispanic subpopulations separately or for all Hispanics as a group.

5) Devlin *et al.* say that it is not appropriate to pool data from different races, yet they treat "black" and "Hispanic" as if these were biologically meaningful races. The population identified as "black" in the United States is a continuum of individuals ranging from people of primarily African origin to people of primarily European origin (and

Instructions for completing the FP Service Record or FP Form 1

Side A

1. Fill out or check the required information at the far right of the form:
 - Client number, date and time client was interviewed
 - Client name: her maiden name, family name first, date of birth, education, and occupation
 - Spouse name: family name first, date of birth, education, and occupation
 - Complete address of the client: number of the house, street, *barangay*, municipality, and province
 - Average monthly income in peso
 - Choose “yes” or “no” for the couple’s plan for more children
 - Choose “new” or “continuing/current user” for type of acceptor
 - Number of living children
 - Previously used method
 - Reasons for practicing FP: completed the desired family size, economic, and others
 - Check among the list of FP method, the method accepted
2. Fill in the required information on medical, obstetrical/ gynecological history, physical examination, pelvic examination, client signature, and date.
3. Refer to a physician for any abnormal history/findings prior to provision of any method for further evaluation.

Side B

1. Fill in the required information at the far left of the form on client number and name, date of birth, education, occupation, and address.
2. On the first column, record the date when the service was delivered to the client.
3. On the second column, record the method accepted/number of supplies given.
4. On the third column, record the following:
 - Medical observations
 - Complaints
 - Services rendered, procedures/interventions done (lab, treatment)
 - Reasons for stopping or changing the methods
 - Laboratory results
5. On the fourth column, record the name of the provider with the corresponding signature.
6. On the fifth column, record the next service date or appointment date.

11.16

PRISM2 Monthly Services Record on FP-MCH Form -PMPv.3 (MSR Form)

Brand Name	Date of Delivery	DR Number	No. of Units Purchased	Brand Name	Date of Delivery	DR Number	No. of Units Purchased									
INTRAUTERINE DEVICE (Unit = 1 piece)				DIAZINK (Unit = Pack of 100 tablets)												
OXYTOCIN IN UNIJECT																
Integration to Service Delivery Network																
Does the facility have a signed partnership agreement with local government unit as part of SDN? <input type="checkbox"/> Yes <input type="checkbox"/> No																
If yes, please indicate date of signing of partnership agreement with LGU _____ (attach partnership agreement) and date of community launching _____																
If no, are you interested in joining the service delivery network? <input type="checkbox"/> Yes <input type="checkbox"/> No																
At Risk of Gender-Based Violence (get data from FP Form 1, section on Violence Against Women; and from Adolescent and Youth Health Assessment Form)																
Age Group	At Risk of GBV		Given Psychological First Aid		Attended Session on GBV		Referred to									
							DSWD		WCPU		NGOs		Others			
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female		
Below 15																
15-19																
20-24																
25-29																
30-34																
35-39																
40-44																
45-49																
50 & over																
Total																
Victim-Survivors of Gender-Based Violence (get data from GBV/VAWC Client Card – VAW Form 1)																
Age Group	Sexual abuse		Physical (not sexual)		Psychological		Given Psychological First Aid		Referred to							
									DSWD		WCPU		PNP		Others	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Below 15																
15-19																
20-24																
25-29																
30-34																
35-39																
40-44																
45-49																
50 & over																
Total																
_____ Prepared by: Name and Signature of Health Provider																
_____ Date Prepared																