

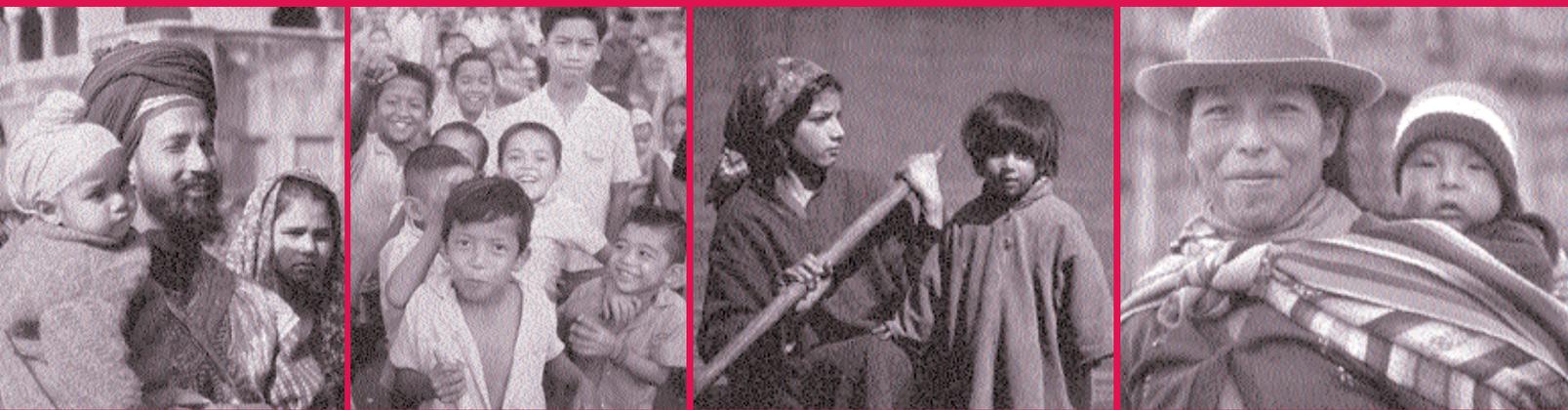
***Gender & Rights:  
A Strategy to Improve the Quality of  
Care***

***Training Manual for Reproductive  
Health Care Providers***



**CATALYST**  
consortium

STATE-OF-THE-ART FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES



STATE-OF-THE-ART FAMILY PLANNING AND REPRODUCTIVE HEALTH



**CATALYST**  
consortium

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- Centre for Development and Population Activities
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## ACRONYMS

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEDPA	Center for Development and Population Activities
CERD	Committee on the Elimination of Racial Discrimination
CESCR	The Economic, Social and Cultural Rights Covenant
CRC	Convention on the Rights of a Child
CCPR	International Covenant on Civil and Political Rights
FC/FGM	Female Cutting/Female Genital Mutilation
HIVAIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
ICPD	International Conference on Population and Development
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
OAS	Organization of American States
NGO	Nongovernmental Organization
PAHO	Pan-American Health Organization
SRH	Sexual and reproductive health
SRR	Sexual and reproductive rights
STI	Sexually transmitted infections
WHO	World Health Organization
UN	United Nations

## ACKNOWLEDGMENTS

This manual is a collective professional work presented by the CATALYST Consortium<sup>1</sup> and produced by experts in sexual and reproductive health from PROFAMILIA/Colombia (“Asociación Pro-Bienestar de la Familia Colombiana,” or “Colombian Association for Family Well-Being”)<sup>2</sup> and CEDPA (the Centre for Development and Population Activities).<sup>3</sup>

The manual is based on training modules used in Latin America and the Caribbean. PROFAMILIA/Colombia’s South-to-South Collaboration Program developed the modules with sponsorship from the Government of the Netherlands and the endorsement of UNFPA. The manual is also based on the experience of CEDPA’s program for training leaders, implemented in forty countries in Africa, Asia, Eastern Europe and Latin America.

PROFAMILIA/Colombia is a private non-profit institution that has promoted and safeguarded the human right to family planning in Colombia since 1965, and has also advocated for better sexual and reproductive health, especially among economically underprivileged classes. PROFAMILIA/Colombia also supports and advocates providing optimal quality reproductive services in the context of the human rights of both males and females within the existing constitutional framework. This manual is the result of these processes of vocational education and training in sexual and reproductive rights from a gender perspective, as undertaken by PROFAMILIA/Colombia.

The CATALYST Consortium is particularly grateful to Maria Cristina Calderón, the coordinator of this work. It is also grateful for the contributions of the following individuals who supported and participated in the development, review, and revision of this manual: Marcela Sánchez, Athala Pena, Gloria Perilla and German López (PROFAMILIA); Marie-France Semmelbeck, Maryce Ramsey, Veronique Dupont, Rahal Saeed, Sally Salisbury and Leah Freij (CATALYST Consortium); consultants Mayela García and Fatma Khafagy; and Elizabeth Neason and Ann Eckman (The Futures Group); Nancy Tian (CEDPA) for reviewing and providing valuable feedback on the manual. We would further like to thank Luz Martina Donato and Margarita Bernal, who were in charge of developing the manual. Thanks are also due to the director of PROFAMILIA/Colombia, Maria Isabel Plata, for her continuous interest and support during the entire development of the manual.

Last but not least, the CATALYST Consortium would like to thank the Colombian women and men who participated in the pilot testing of the manual, conducted by PROFAMILIA/Colombia from February 24 to March 1, 2003, in Bogotá, Colombia.

<sup>1</sup> The CATALYST Consortium is comprised of five organizations and is funded by the United States Agency for International Development (USAID). Consortium organizations offer technical leadership on sexual and reproductive health and are committed to increasing the use of sustainable, quality family planning and reproductive health services and practices through both clinical and non-clinical programs.

<sup>2</sup> PROFAMILIA/Colombia is an affiliate of IPPF (International Planned Parenthood Federation). PROFAMILIA promotes high quality, accessible family planning and sexual and reproductive health services, particularly for low income groups. For many years, PROFAMILIA/Colombia has developed and delivered clinical, preventive and promotional services and programs that focus on empowering people to use individual decision-making skills in issues of reproductive rights. Over the past decade, PROFAMILIA/Colombia has expanded its programs to include and focus on youth.

<sup>3</sup> CEDPA works with international partners to empower women through programs in reproductive health and family planning, literacy and education, individual and institutional capacity building, micro-enterprise development and political participation. Since 1975, CEDPA’s unique approach has successfully strengthened the aspirations, potentials and talents of millions of women in more than 150 countries.



## INTRODUCTION

The gender roles played by women and men in a given society have significant influence on their sexual and reproductive health. Addressing reproductive health from both a gender perspective and a human rights perspective contributes significantly toward building societies with greater social justice. In these societies, women and girls can be free from gender-based violence and can access quality sexual and reproductive health services. This can lead to the empowerment of disadvantaged groups and ensure they have full access to their rights as equal citizens.

This manual, *Gender and Sexual and Reproductive Rights: A Strategy for Improving the Quality of Care*, provides conceptual and methodological tools, from changing personal attitudes to incorporating gender and human rights perspectives into the adoption of action plans by organizations that offer family planning and sexual/reproductive health services.

### Why the Focus on Gender and Sexual and Reproductive Health?

The advocacy, recognition, and exercise of sexual and reproductive rights from a gender perspective in family planning and sexual and reproductive health services must be an ethical and political imperative for improving the quality of care.

Improving the quality of sexual and reproductive health services involves incorporating gender and rights perspectives into institutional policies, programs, and action plans. This requires political will at the managerial level, on-going vocational education and training of entire staff, design of tools such as health care protocols, and attitudinal change that will humanize care.

### Purpose, Objective and Organization of the Manual

The purpose of the manual is to consistently relate theory to practice for a better understanding of sexual and reproductive rights. It is designed so the different topics addressed can be incorporated into action plans that participants will develop individually during the training and subsequently apply at their respective sites. These action plans should be flexible, adaptable and based on cultural and political conditions, taking into consideration the social and economic needs of the organizations, countries, and regions.

The objective of the manual is to understand and use gender and rights perspectives as strategies to improve the quality of sexual and reproductive health care services.

The manual includes sections on objectives, a methodological proposal, recommended use and participant evaluations. It consists of ten sessions. The first two include the opening session, introduction of the participants and an overview of the module. Sessions three through ten address the following subjects: Gender and Rights; Gender, Rights, and Sexual and Reproductive Health; Gender-based Violence; Sexual and Reproductive Rights: International Normative Framework; International Mechanisms; Action Plans; Informed Choice; and Improving Quality of Sexual and Reproductive Health (SRH) Services, taking into account gender and sexual and reproductive rights (SRR). Participants should be given the Session Evaluation Form to evaluate each session, and the Module Evaluation

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Form upon completion of the training, to evaluate the overall training. Both these forms are included in the manual.

### The Overall Strategy

The overall strategy that guides this manual is based on the acknowledgment that all women's rights, including sexual and reproductive rights, are human rights. Therefore, the delivery of sexual and reproductive health services must be based on the fact that both female and male service providers, as well as institutional policies and programs, are adopting a gender and rights perspective. This perspective is an essential requirement for improving quality of care.

This manual is intended for health care service providers in decision making positions and with decision-making skills, who need to understand that in their work-related environment, when discussing gender stereotypes and gender roles, men and women might feel threatened by the concept of women's empowerment. The starting point of this manual is that both men and women are often victimized by the social role and gender stereotypes that they are being asked to assume.

This training manual aims to inform the participants that women's empowerment is gradual. It begins as women start to exercise their agency: asserting themselves, being autonomous, making decisions and acting on them. Participants will obtain an understanding what empowerment means, and how they can apply it in their daily lives, rather than receiving a definition of empowerment. Men's active involvement in family planning and reproductive health is stressed since their participation is crucial in achieving gender equity as well as for women's rights. In addition, the training module attempts to teach participants experientially how to integrate the concepts they have learned into their actual work arena. The action plans they develop during their training are to be implemented in their institution.

The manual aims to generate a change in the attitudes, behavior and knowledge of people who coordinate or deliver sexual and reproductive health services. Health service providers are invited to reflect on their clients' and personal gender needs and to incorporate a gender perspective in their work responsibilities and action plans that is sensitive to socio-cultural values. The manual is based on the belief that through self-reflection and designing personal action plans in accordance with their clients' needs both the health care providers and clients can exercise their sexual and reproductive rights.

Shifts in power relations between women and men and between service providers and service users enable the establishment of democratic and equitable communities and societies, where men and women share reproductive responsibilities, and where sexuality is exercised responsibly, pleasantly and free of coercion.

Human rights are universal, indivisible, interdependent, interrelated, and inalienable rights recognized under international law. All governments are legally bound to a core set of human rights founded upon universal principles of human dignity, freedom, and equality, which are applicable to all individuals. All human rights, and especially those encompassing reproductive rights, should be taken into account throughout any development program. A gender perspective in public health orients reproductive health services toward rights-based approaches. These rights-based approaches draw from provisions in

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international human rights and other covenants that safeguard the respect, dignity, equality and self-esteem of all human beings.

Human rights listed in international instruments reflect international consensus that are legally enforceable on the countries that ratify them. Programs of action developed in international conferences to address human rights provide a strong statement of the international community's agreement to take certain courses of action to address these human rights issues. The International instruments are available arguments to advocate for policy change.

International instruments such as CEDAW (the Convention on the Elimination of All Forms of Discrimination Against Women), ICPD (the 1994 International Conference on Population and Development, Cairo), Beijing (the 1995 World Conference on Women), Vienna (the 1991 Vienna Conference on Human Rights), and Rio de Janeiro (the 1992 United Nations Conference on Environment and Development), and other conferences and their plans or platforms for action should be incorporated through concrete actions in sexual and reproductive health services so they become a part of everyday life for women, girls, men and boys. This will facilitate changes in society and in the relationships between civil society and government.

#### The Three Cross Cutting Themes of the Manual

For reproductive health programs to be successful, they must recognize and embrace the complementary goals of gender equity/equality, human rights, and reproductive rights.

**GENDER:** Gender refers to the socio-cultural roles that women and men play and the relations that arise out of these socially constructed roles. These roles, and the differing powers attached to them, affect the access and control that men and women have vis-à-vis resources and opportunities, including those needed to achieve and maintain good reproductive health (Beijing Platform of Action, para. 92). Gender roles and expectations are prescribed by society and can be challenged and changed by society. In order to offer services that meet women's sexual and reproductive health needs, health care providers must understand the gender constraints that their clients face.

**HUMAN RIGHTS:** Health care providers have to provide services that respond to individual's human rights so that each individual is informed, healthy, and has equal choices, access and decision-making power. This manual takes a rights-based approach to sexual and reproductive health because the quality of health care services is significantly determined by whether the service is provided out of charity or to meet an acknowledged right.

**SEXUAL AND REPRODUCTIVE HEALTH:** Many of the factors that affect reproductive health are rooted in prevailing levels of socioeconomic development and lifestyles, as well as the accessibility and quality of available health care.

<sup>1</sup> The international conferences do not necessarily reflect the views of the US government. US government policy does not support advocacy for abortion rights.

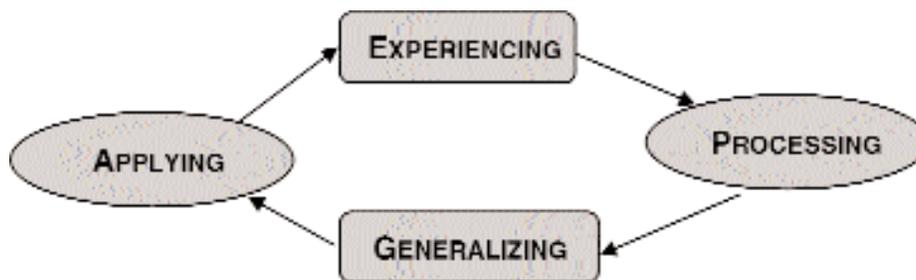
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It is true that biologically determined factors have effects on the reproductive and sexual health of males and females at different stages of life; yet there are many socio-cultural factors that influence men and women. These factors include poverty, malnutrition, education, income, access to information and services, and gender-based norms and values. Service providers must understand these factors to ensure that they are providing quality health services.

What is central to a good reproductive health program is the idea that participants and communities have the skills, knowledge, and power to make informed RH decisions. Empowerment is "the sustained ability of individuals and organizations to freely, knowledgeably, and autonomously decide how best to serve their strategic self-interest and the interest of their societies in an effort to improve their quality of life." Through collaborative work with women, men, youth, and their communities, RH programs that use a Rights-based approach and integrate gender will provide an enabling environment for individual and group empowerment.

#### The Design and Facilitation of this Module

**EXPERIENTIAL LEARNING CYCLE** : Experiential learning is conceived as a cycle in which the learner progresses through four phases of the learning process to transform information into useful knowledge.



A direct experience becomes the basis for reflection where the experience is processed. Based on this analysis, the learner is able to generalize principles, which s/he must then apply.

Adult and experiential learning experts identify that people retain:

- 20% of what they hear
- 30% of what they see
- 50% of what they hear and see
- 70% of what they see, hear and say (discuss)
- 90% of what they see, hear, say and do

This module is based on these assumptions and uses the fundamentals of the experiential learning cycle to ensure comprehension, retention and follow through.

The experiential learning cycle includes the following stages:

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1. **EXPERIENCING:** Experiencing involves engaging in an exercise or activity together and/or sharing personal experience and feelings. **DO!**
  2. **PROCESSING:** Processing involves digesting the exercise or activity and sharing observations from the "experiencing" stage. **ANALYZE/THINK!**
  3. **GENERALIZING:** Generalizing involves extracting a meaning from the experience, comparing it to other experiences and identifying general principles or patterns. **CONCLUDE!**
  4. **APPLYING:** Applying involves developing an action or plan beyond the training event, using insights gained from the previous stages. **PLAN A CHANGE OR ACTION!**

Who Should Participate in this Module?

This manual is intended for sexual and reproductive health service providers, especially managers or coordinators of services and/or programs. These individuals have the ability to make decisions to incorporate gender and rights perspectives as strategies to improve the quality of sexual and reproductive health care.

How Many Participants?

The ideal number of participants is 20 to 25.

How Long is the Module?

The training takes five days. There is an additional module on Male Involvement in the appendix. Facilitators need to adjust time frame if they want to incorporate the session into the training.

Trainer and Training Techniques

The skills of the trainer play a critical role in conveying the key concepts to the participants. Trainers are expected to have core expertise, including gender and/or rights-based approach to RH, and/or quality of care. She/he should have facilitation skills that ensure s/he challenges the participants' gender stereotypes and resistance to alternative gender roles, and encourages participants to think of innovative behaviors to address gender inequities. Within this participatory methodology, various techniques were chosen for developing the sessions. They include:

1. Presentations by trainers.
2. Individual work to allow participants to reflect on personal experiences, emotions, beliefs, conceptions and expertise, and relate them to issues addressed in the training.

- 
3. Group work to share reflections and analyze the different topics and become familiar with sexual and reproductive health-related experiences that occur in different locations.
  4. Case studies to encourage reflection on various issues, based on specific situations or stories, relating theory to practice.
  5. Role-play to stage situations of real-life or hypothetical cases to illustrate relevant training themes.
  6. Matrices and thought maps to allow participants to have an overview of a specific situation or topic.

#### How to use the Manual

This five-day curriculum is designed to meet the training goal: to understand and use gender and rights perspectives as strategies to improve the quality of sexual and reproductive health care services. There are ten training sessions with an additional session on Male Involvement in Appendix II. To start the planning process, three to five days of face-to-face preparation among the trainers and workshop staff is recommended. During this time, the trainers need to customize the training materials to address cultural and geographic realities. The following steps are suggested in preparation for the workshop:

#### Before Conducting the Module

oOptional: Ask all prospective participants to complete a survey about their programs and the services their organizations provide (survey to be developed by trainer). This survey will help the trainers become familiar with participants' backgrounds and enable them to adjust and adapt the training as necessary.

oOptional: If participant presentations are built into the module, inform participants of this expectation so they arrive prepared. Inform participants of the audiovisual equipment available to them, such as overhead projector, facilities for Power Point presentations, television/VCR, etc.

oIf the trainers choose to bring in guest presenters to conduct sessions, coordinate with the guest speaker in advance to discuss objectives, methodology, teaching guidelines and resources so the focus is consistent with the objectives of the session. Ensure that the guest speaker is aware of the three cross cutting themes and is prepared to weave the themes into her/his session.

oThe trainer should review handouts, case studies, and other materials and adapt them appropriately to the local setting and culture (e.g. change names, ensure case studies are culturally appropriate, etc.).

oEnsure there are enough copies of all the handouts for the participants.

oMake copies of the session evaluation form, which is to be completed by the participants for each session at the end of the day. For example, if Day 1 includes three sessions, the participants should

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complete three evaluation forms at the conclusion of Day 1 (one form per session). The participants should write the name and number of the session they are evaluating beside Session Name & Session number. A general evaluation form is included at the end of the introduction for reference.

oReview sessions and prepare materials (e.g. flipcharts, presentations, etc.) as indicated.

oBuild in approximate breaks, lunch, etc. into the overall session outline before the training begins.

oRead Appendix I: Games and Activities. This contains several ice breakers and other activities you can use in this training.

Read Appendix II: Men's Involvement. Decide if this session is to be included in the training, and adjust time frame accordingly.

Each session includes the following components:

**TITLE:** Defines the number and name of the session that will be conducted.

**OBJECTIVES:** Describe what the participants will be able to accomplish during the session in relation to: knowledge (list, explain, describe); for creating, evaluating, comparing and developing materials and information; and changes in attitudes and values in relation to respecting, listening to and supporting people who seek sexual and reproductive health services.

**TOTAL TIME:** Shows the duration of the session, with an average of 25 participants.

**PREPARATION:** Refers to the actions and activities to prepare prior to the session.

**MATERIALS:** Lists the materials that are required to conduct each session.

**HANDOUTS:** These provide theoretical support for topics discussed during the sessions. There are several types of handouts: for presentations given by the trainer; for documentation, and more in-depth information on some topics; individual and group job aids; and case studies. Handouts appear at the end of each session.

**FACILITATING THE SESSION:** Describes the steps necessary for conducting each session.

**STEPS:** Detailed instructions the trainer will use to carry out the session.

**NOTES TO THE TRAINER/TALKING POINTS FOR THE TRAINER:** Present clarifications, sample exercises or aspects that the trainer must emphasize when discussing the section entitled "steps" of each session.



## MODULE OVERVIEW

### Goal

To understand and use gender and rights perspectives as strategies to improve the quality of sexual and reproductive health care services.

### Day 1

- Opening and Introduction (Session 1) – *2 hours, 30 minutes*
- Module Presentation (Session 2) – *2 hours*

### Day 2

- Gender and Rights (Session 3) – *4 hours*
- Gender, Rights, and Sexual and Reproductive Health (Session 4) – *3 hours, 35 minutes*

### Day 3

- Gender and Violence (Session 5) – *3 hours, 25 minutes*
- Sexual and Reproductive Rights: International Normative Framework (Session 6) – *2 hours*
- International Mechanisms (Session 7) – *2 hours, 30 minutes*

### Day 4

- Action Plan (Session 8) – *3 hours, 45 minutes*
- Informed Choice (Session 9) – *3 hours, 30 minutes*

### Day 5

- Improving the quality of sexual and reproductive health (SRH) service delivery, taking into account gender, sexual and reproductive rights (SRR), care of victims of violence and informed choice (Session 10) – *6 hours, 25 minutes*

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## Training Techniques

Within this participatory methodology, various techniques were chosen for developing the sessions. They include:

1. *Presentations* by trainers.
2. *Individual work* to allow participants to reflect on personal experiences, emotions, beliefs, conceptions and expertise, and relate them to issues addressed in the training.
3. *Group work* to share reflections and analyze the different topics and become familiar with sexual and reproductive health-related experiences that occur in different locations.
4. *Case studies* to encourage reflection on various issues, based on specific situations or stories, relating theory to practice.
5. *Role-play* to stage situations of real-life or hypothetical cases to illustrate relevant training themes.
6. *Matrices and thought maps* to allow participants to have an overview of a specific situation or topic.

# HANDOUTS

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## How to use the Manual

### Before Conducting the Module

- Optional: Ask all prospective participants to complete a survey about their programs and the services their organizations provide (survey to be developed by trainer). This survey will help the trainers become familiar with participants' backgrounds and enable them to adjust and adapt the training as necessary.
- Optional: If participant presentations are built into the module, inform participants of this expectation so they arrive prepared. Inform participants of the audiovisual equipment available to them, such as overhead projector, facilities for Power Point presentations, television/VCR, etc.
- If the trainers choose to bring in guest presenters to conduct sessions, coordinate with the guest speaker in advance to discuss objectives, methodology, teaching guidelines and resources so the focus is consistent with the objectives of the session. Ensure that the guest speaker is aware of the three cross cutting themes and is prepared to weave the themes into her/his session.
- The trainer should review handouts, case studies, and other materials and adapt them appropriately to the local setting and culture (e.g. change names, ensure case studies are culturally appropriate, etc.).
- Ensure there are enough copies of all the handouts for the participants.
- Make copies of the session evaluation form, which is to be completed by the participants for *each* session at the end of the day. For example, if Day 1 includes three sessions, the participants should complete three evaluation forms at the conclusion of Day 1 (one form per session). The participants should write the name and number of the session they are evaluating beside Session Name & Session #. A general evaluation form is included at the end of the introduction for reference.
- Review sessions and prepare materials (e.g. flipcharts, presentations, etc.) as indicated.
- Build in approximate breaks, lunch, etc. into the overall session outline before the training begins.
- Read Appendix I: Games and Activities. This contains several ice breakers and other activities you can use in this training.

# SESSION EVALUATION

Each session includes the following components:

**TITLE:** Defines the number and name of the session that will be conducted.

**OBJECTIVES:** Describe what the participants will be able to accomplish during the session in relation to: knowledge (list, explain, describe); for creating, evaluating, comparing and developing materials and information; and changes in attitudes and values in relation to respecting, listening to and supporting people who seek sexual and reproductive health services.

ITEM	CRITERIA	Excellent	Good	Fair	Poor
<b>OBJECTIVES</b>	Clarity				
	Coherence with the work				
	Fulfillment of objectives				
	Relevance for your job				
<b>CONTENTS</b>	Clarity of presentation				
	Depth				
	Relevance for your job				
	Response to expectations				
<b>METHODOLOGIES</b>	Practice				
	Participatory				
	Time management				
	Use of educational aids				
	Theory-practice integration				
<b>EDUCATIONAL MATERIALS</b>	Clear				
	Adequate				
	Relevant				
	Useful				
	Timely				
<b>PARTICIPATION</b>	Progressive development of the action plan				
	Contributions from the group of participants				
	Observance of agreements and commitments				
	Punctuality				

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**TOTAL TIME:** Shows the duration of the session, with an average of 25 participants.

**PREPARATION:** Refers to the actions and activities to prepare prior to the session.

**MATERIALS:** Lists the materials that are required to conduct each session.

**HANDOUTS:** These provide theoretical support for topics discussed during the sessions. There are several types of handouts: for presentations given by the trainer; for documentation, and more in-depth information on some topics; individual and group job aids; and case studies. Handouts appear at the end of each session.

**FACILITATING THE SESSION:** Describes the steps necessary for conducting each session.

**STEPS:** Detailed instructions the trainer will use to carry out the session.

**NOTES TO THE TRAINER/TALKING POINTS FOR THE TRAINER:** Present clarifications, sample exercises or aspects that the trainer must emphasize about the different steps of each session.

**TRAINER:** Please provide the relevant number of copies of the session evaluation form to each participant. Each participant must fill out one form for each session at the end of each day (for example, if Day 1 includes three sessions, the participants should complete three evaluation forms at the conclusion of Day 1 (one form per session)).

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SESSION EVALUATION FORM

Thank you for your thoughtful completion of this evaluation form. Your opinion matters and the Trainer(s) will incorporate your comments into future modules.

Session #: \_\_\_\_\_

Session Name: \_\_\_\_\_

Trainer: \_\_\_\_\_

What I gained from this session (knowledge and skills):

One suggestion for making this session more effective in the future:

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## SESSION 2: PRESENTATION OF THE MODULE

### OBJECTIVES

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

- Identify the objectives, contents and methodology of the module.
- Share expectations with respect to the training.
- Understand participants' and trainers' roles.

DAY 1 TIME: 2 hours

### PREPARATION

- Session 2 objectives printed on a flipchart
- Objectives, agenda, overview and methodology of the module printed on a flipchart with copies for each participant (Handout 2B)
- Flipcharts to write names of reporters and moderators
- Principles of participatory methodology on a flipchart

### MATERIALS

- Flipcharts, markers, tape
- A copy of the module overview for each participant (Handout 2A)
- The Experiential Learning Cycle (Handout 2B)
- Index cards
- Two copies of the Session Evaluation Form, found at the beginning of this manual

### HANDOUTS

- 2A: Module Overview
- 2B: Experiential Learning Cycle
- Session Evaluation Form

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## FACILITATING SESSION #2

### STEP 1 (5 minutes)

#### SESSION OBJECTIVES

- Introduce the objective of the session (identifying and agreeing on the objectives of the training).

### STEP 2 (15 minutes)

#### ANALYSIS OF EXPECTATIONS

- Ask participants to write down their expectations about the objectives of the training to compare them with the planned objectives.
- Distribute two cards and a marker to each participant so they can write down their expectations about the module. Explain that they should write one idea on each card in clear large letters, covering no more than three lines across the card. You can also show them an example, though it is better to let them come up with their own ideas:

To learn about gender and sexual and reproductive rights to improve the quality of care.

- Allow 5 minutes for this exercise. Afterwards, collect these cards, group them and place them under the broad headings of objectives.
- Introduce the module objectives and compare them to the expectations posted on the wall. Ask participants to identify those that are impossible to meet in this module and to suggest reasons why they cannot be met.

### STEP 3 (20 minutes)

#### INTRODUCTION OF THE AGENDA AND METHODOLOGY OF THE MODULE

- Hand out copies of the module (Handout 2A) to each participant and present it from the flipchart (or posters, transparencies or Power Point).
- Ask if there are any comments, questions or concerns and clarify them.
- Discuss the methodology: clarify that each session will be conducted through presentations made by the trainers; group work where participants can share their knowledge and experience; individual tasks that will promote reflection, personal analysis and change in attitudes; and plenary sessions that will allow each group to share its contributions.
- Ask participants what participatory methodology means to them. Note their responses on a flipchart.

- 
- After four or five responses, show the flipchart with the following principles of participatory methodology:
    - a. Knowledge is developed collectively based on the experiences of each person; thus, all contributions have equal value.
    - b. It is participants' sharing of their personal and work experiences, along with their interest in changing attitudes that favor gender equity and acknowledgment of sexual and reproductive rights that determine the success of the training.

#### STEP 4 (45 minutes)

#### EXPERIENTIAL LEARNING CYCLE<sup>5</sup>

- Ask participants to personally think about a highly positive learning experience. Then ask participants to think of a negative personal learning experience.
- Ask participants to think again about their positive learning experience and to identify strategies that were used or qualities of this experience that made it positive. The trainer(s) should record participant comments on a flipchart. Now ask participants to think again about their negative learning experience and to identify strategies that were used or qualities of this experience that made it negative. Trainers should again record participant comments but on a separate flipchart.
- Explain that the next activity is intended to get participants “warmed up” to talk more about Experiential Learning.
- Facilitate “The Human Knot Icebreaker,” using the following instructions:



#### NOTE TO THE TRAINER

If there are women and men in the group, you may divide participants into separate male and female groups if that is more culturally appropriate.

#### The Human Knot Icebreaker

##### A. EXPERIENCING

- The group forms a circle.
- The participants close their eyes and begin to walk forward with their hands held in front of their bodies. When a participant finds someone else's hand they hold it. All the participants finish with both of their hands held. A large human knot has been formed. Now participants may open their eyes to see where they have ended up.
- In the next step, participants must untangle themselves, without releasing hands.
- Allow participants to complete the task of untangling themselves and then return to their seats.

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<sup>5</sup> This session is based on a session developed by Frances Houck for CEDPA's Youth Development and Reproductive Health Workshop.

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## B. PROCESSING

- Ask participants to make observations about the process. Pose a series of questions to solicit feedback (e.g. What problems arose? What was the process like for you? Did any leaders emerge? What role did the leaders play?).

## C. GENERALIZING

- Build a bridge from the “Human Knot” to the module itself by asking participants how this activity *relates* to the workshop and the goals of the training. Facilitate a discussion and focus on the importance of working together as a team to achieve the overall workshop learning objectives and to meet the personal expectations for the training. Point out that sometimes learning, change, or looking at one’s own feelings about a certain issue can create anxiety (possibly like untangling the knot) – this too is part of the learning process. Finally, ask participants about general principles or lessons that can be gleaned from the “Human Knot” activity.



### TALKING POINTS FOR THE TRAINER

- Problems can seem huge and daunting when viewed as a whole (for example, the human knot), but are manageable when approached as being made up of smaller issues (each hand held contributes to the bigger knot).
- While individuals can be seen as problems (a really bad hand hold or kink in the knot), they can also be seen as assets or sources of solutions.

## D. APPLYING

- In order to complete the last stage of the experiential learning cycle, ask participants how they can apply what they learned in the “Human Knot” activity to the real life activities they will encounter and experience during the training.



### TALKING POINTS FOR THE TRAINER

- The importance of teamwork
- Seeing other participants as assets and sources of information and solutions
- The importance of breaking large problems into manageable pieces

- Distribute the handout on the Experiential Learning Cycle (Handout 2B). Explain how the “Human Knot” activity took participants completely through the Experiential Learning Cycle. Bring up a few examples of key questions asked by participants or teachable moments observed by trainer(s) during the activity that fostered the participants’ successful completion of the Experiential Learning Cycle.
- Share the retention percentages of the Experiential Learning Cycle (Handout 2B).

- 
- Inform participants that the module is designed to foster learning and the Experiential Learning Cycle is used throughout.
  - Ask participants to revisit the lists created at the start of Step 2 related to successful learning experiences and unsuccessful learning experiences. Ask if any of these experiences can be linked to the Experiential Learning Cycle. Were the successful experiences more experientially oriented? Were the unsuccessful experiences lacking in process or application?
  - Emphasize that sometimes it is impossible to delineate specific phases in the Experiential Learning Cycle and that this, too, is part of the dynamic of learning. Inform participants that it is not unusual to have difficulty clearly identifying where one phase ends and another begins; often these lines of learning and the transition from phase to phase is imperceptible.
  - Emphasize that the learning process is not limited to formal settings. Again, encourage participants to extend their experiencing, processing, generalizing and applying outside the classroom and to learn from other participants.
  - Ask how the Experiential Learning Cycle applies to work with Gender and Sexual and Reproductive Health. Discuss how the use of the Experiential Learning Cycle links with this issue.



#### TALKING POINTS FOR THE TRAINER

- If people retain 90% of what they see, hear, say and do, Gender and Sexual and Reproductive Health and Rights programs will need to provide opportunities for people to see, hear, say and do, especially for those resistant to the concept, or for situations where the men do everything and the women are in a passive/receptive state.
- Often programs focusing on gender do not involve men as partners, so there is little to no ownership on the part of men and they are less likely to participate in the program and/or modify their behavior. **INVOLVE!**

## 2 NOTE TO THE TRAINER

To assist in planning this session or to obtain additional information on the Experiential Learning Cycle, consult the Training Trainers for Development text in the CEDPA Training Manual series (see [www.cedpa.org](http://www.cedpa.org)). CEDPA. 1995. *Training Trainers for Development*. The CEDPA Training Manual Series Volume 1. CEDPA.

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STEP 5 (10 minutes)

DEFINITION OF PARTICIPANTS' ROLES

- Tell the group that as part of the participatory methodology of the training it is necessary that the participants assume the roles of reporters and moderators.
- Two volunteers will be responsible for reporting for 10 minutes at the beginning of each morning. They can role-play, write a song, present the summary like a newsflash, or use any other resources, involving other people if necessary.
- The moderator's mission is to maintain the good humor and attention of the participants throughout the day. At the beginning of the afternoon session, or when s/he considers it necessary, s/he can conduct an interactive activity or icebreaker such as jokes, songs, dance, magic tricks, exercises, etc.
- The TRAINER should prepare two flipcharts, writing the days of the workshop on each one. One flipchart can be used for the volunteer reporters and the other for the moderators. Encourage participants to register on one of the charts and display them during the entire training.

Reporters	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

Moderators	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

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STEP 6 (10 minutes)

TRAINERS' ROLES

- **NORMS:** Explain to the participants that it is time to agree upon some norms to be followed throughout the training. Ask participants to suggest some as action plans they will each commit to doing during this training. Note responses on a flipchart, put it up on a wall, and leave it there for the duration of the entire training. Ensure that the following are included:
  - Respecting the agreed-upon schedule
  - Promoting participation and respect of individual opinions
  - Summarizing each session
  - Offering guidance on action plans and group work
  - Submitting materials for each session on timeAdd any other suggestions that participants volunteer.
  
- **PARKING LOT:** Underneath the above flipchart, paste another one and label it “Parking Lot”. Tell participants that they are free to write down issues that arise during the workshop, that are not mentioned on the above flipchart. Make sure that you check the Parking Lot at least once each day and address issues that are mentioned on it, as you consider necessary. Encourage participants to do the same.
  
- Finalize this session providing details about:
  - Schedules
  - Transportation from the hotel to the training site
  - Meals
  - Breaks
  - Airplane tickets
  - Communication with places of origin either by phone or Internet

STEP 7 (10 minutes)

EVALUATION

- For the evaluation, review the session objectives.
- Hand each person two copies of the Session Evaluation Form, found at the beginning of this manual.



### MODULE OVERVIEW

#### GOAL

To understand and use gender and rights perspectives as strategies to improve the quality of sexual and reproductive health care services.

#### Day 1

- Opening and Introduction (Session 1) – *2 hours, 30 minutes*
- Module Presentation (Session 2) – *2 hours*

#### Day 2

- Gender and Rights (Session 3) – *4 hours*
- Gender, Rights, And Sexual And Reproductive Health (Session 4) – *3 hours, 35 minutes*

#### Day 3

- Gender-based Violence (Session 5) – *3 hours, 25 minutes*
- Sexual and Reproductive Rights: International Normative Framework (Session 6) – *2 hours*
- International Mechanisms (Session 7) – *2 hours, 30 minutes*

#### Day 4

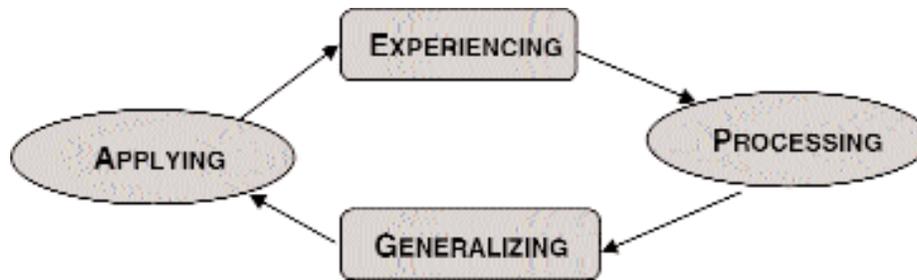
- Action Plan (Session 8) – *3 hours, 45 minutes*
- Informed Choice (Session 9) – *3 hours, 30 minutes*

#### Day 5

- Improving the quality of SRH service delivery, taking into account gender, SRR, care of victims of violence and informed choice (Session 10) – *6 hours, 25 minutes*

### EXPERIENTIAL LEARNING CYCLE

Experiential learning is conceived as a cycle<sup>5</sup> in which the learner progresses through four phases of the learning process to transform information into useful knowledge. A direct experience becomes the basis for reflection where the experience is processed. Based on this analysis, the learner is able to generalize principles, which s/he must then apply.



Adult and experiential learning experts identify that people retain:

20% of what they hear

30% of what they see

50% of what they hear and see

70% of what they see, hear and say (discuss)

90% of what they see, hear, say and do

This module is based on this premise and uses the fundamentals of the experiential learning cycle to ensure comprehension, retention and follow through.

**The experiential learning cycle includes the following stages:**

1. **EXPERIENCING:** Experiencing involves engaging in an exercise or activity together and/or sharing personal experience and feelings. **DO!**
2. **PROCESSING:** Processing involves digesting the exercise, activity and/or sharing from the “experience” stage and sharing comments and observations regarding this process. **ANALYZE/THINK!**
3. **GENERALIZING:** Generalizing involves pulling a meaning from the experience, comparing it to other experiences and identifying general principles or patterns. **CONCLUDE!**
4. **APPLYING:** Applying involves developing an action or plan for after the training or in the participant’s own work environment, using insights gained from the previous stages. **PLAN A CHANGE OR ACTION**



## SESSION 3: GENDER AND RIGHTS

### OBJECTIVES

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

- Define quality of care.
- Understand the importance of gender sensitization.
- Understand various gender terms and definitions.
- Develop action plans.

DAY 2 TIME: 4 hours

### PREPARATION

- Session 3 objectives printed on a flipchart
- Two sets of cards with gender terms and gender definitions (see Step 3 of this session)
- Flipchart with Handout 3G: The Difference between Practical Needs and Strategic Interests
- Identify space in the room to post the evolving definition of quality of care every day, incorporating the topics addressed during each session
- Flipchart with Handout 3H: Concepts of Equality and Equity

### MATERIALS

- Flipcharts, markers, tape
- Index cards
- Pens
- Copies of all Handouts (3A-N) for each participant
- Two different colored balls (e.g., one red, one blue) for the wrap up “Ball Toss” activity
- Two copies of the Session Evaluation Form, found at the beginning of this manual

### HANDOUTS

- 3A: Definition of Quality of Care from a Gender and Rights Perspective
- 3B: Reflection Tool on Personal Experiences
- 3C: Gender Concepts, Gender Roles and Relations
- 3D: Definitions of Gender Terms
- 3E: Triple Role of Women
- 3F: Practical and Strategic Gender Needs
- 3G: The Difference Between Practical Needs and Strategic Interests
- 3H: Concepts of Equality and Equity
- 3I: Reflection Tool on Practical Needs and Strategic Interests

- 
- 3J: Practical Needs and Strategic Interests Regarding Violence, STIs/HIV/AIDS, the Use of Contraceptive Methods, and Pregnancy
  - 3K: Presentation on Gender Perspective
  - 3L: The Flower of Power
  - 3M: Gender and Power Relations
  - 3N: Guide No. 1 – Action Plans
  - Session Evaluation Form

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## FACILITATING SESSION 3

### STEP 1 (20 minutes)

#### DEFINITION OF QUALITY OF CARE

- Introduce the objectives, contents and methodology of the session.
- Give each participant an index card to write down a word s/he associates with quality.
- Ask participants to form groups of five and develop a definition of quality of care, using the words they wrote down.
- Ask a volunteer to record these definitions on a flipchart and post them in a visible spot in the room.
- In a plenary session, collectively develop a definition of quality of care, which you should exhibit in the place selected for this purpose. Facilitators may consult Handout 3A: Definition of Quality of Care from a Gender and Rights Perspective. If facilitators need to review the concept of “Quality of Care”, please read Module 10.



#### NOTE TO THE TRAINER

- This exercise should be as simple as possible, so the first few ideas on quality of care can be grasped.
  - Tell the group that you hope the definition will become richer throughout the week, depending on the topics that are addressed during the training.
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- Facilitator may need to explain that Quality of Care is a philosophy of comprehensive care oriented toward client satisfaction, through changes in personal relations in services and in administrative and technical practices. Some of the major points are: (1) respect and promote clients’ autonomous decisions; (2) promote the process of empowerment of all clients; and (3) empower the exercise of rights.

### STEP 2 (35 minutes)

#### GENDER AWARENESS

- Distribute Handout 3B: Reflection Tool on Personal Experiences to each participant. Explain that for each question, it is very important to give several examples based on personal experiences.
- With the larger group, develop two flipcharts to record participants’ responses – one for women and one for men – to record why they like being men and why they like being women.
- Based on the responses, ask participants to analyze the advantages and disadvantages of being a man and being a woman, bringing out the existence of power dynamics in relationships between women and men.

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- Encourage participants to identify how activities, roles and characteristics assigned to women and men produce advantages and disadvantages in women's and men's lives in different places, such as the home, school, workplace, medical center and society in general.
  - Reflect on the flexibility of roles between men and women as a necessary, but insufficient, step along the path to gender equality.
  - To provide feedback for this plenary session, refer to Handout 3C: Gender Concepts, Gender Roles and Relations.
  - Display the posters in a visible location in the room to revisit them later on and question these stereotypes.
  - Give copies of Handout 3C: Gender Concepts, Gender Roles and Relations at the end of this exercise.

### STEP 3 (30 minutes)

#### DEFINITIONS OF GENDER TERMS

- Suggest to the group that based on the discussions they have just had concerning different aspects of gender, they will now define a number of gender-related concepts.
- Distribute Sets 1 and 2 of the cards (Set 1: gender terms, and Set 2: definitions of gender terms) by having participants draw them from a "deck". If there are more cards than participants, distribute two cards to individuals until all cards have been distributed. *(If it is necessary to distribute more than one card to individuals in order to cover all of the concepts, proceed as follows to facilitate the exercise. Decide how many participants will need to draw more than one card. Pair together the number 1) gender term cards, and 2) gender definition cards necessary, making sure that the gender definition cards that are paired correspond to the gender term cards which have been paired. In this way each participant will only need to conduct the activity with one partner, even if he/she has more than one card.)*
- Ask participants to circulate and find the colleague with the term/s or definition/s, which correspond to the definitions or terms they are holding.
- Once participants have all paired off by gender terms and definitions, ask them to discuss the terms and definitions they have drawn, examples of where these elements have been experienced in their work and/or other applications of the concepts to their work.
- Lead a large group discussion of the definition of terms, as well as their application in development programs.
- Distribute Handouts 3E, Triple Role of Women, 3F, Practical and Strategic Gender Needs, and 3G, the Difference Between Practical Needs and Strategic Interests. Ask volunteers to read the two documents to the group. Discuss any questions or observations the group may have.
- Tell the group that these terms and concepts will be used throughout the training.<sup>7</sup>
- At the end, distribute Handouts 3D and 3H: Definitions of Gender Terms and Concepts of Equality and Equity.

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<sup>7</sup> Slocum, R. *Power, Process and Participation – Tools for Change*; from CEDPA, Gender and Development; Oxfam, *The Oxfam Gender Training Manual*; and from Family Health International, *A Transformation Process: Gender Training for Top-level Management of HIV/AIDS Prevention*, 1995.

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STEP 4 (45 minutes)

PRACTICAL GENDER NEEDS AND STRATEGIC INTERESTS

- Divide participants into four groups. Review practical needs and strategic interests discussed in STEP 3:
- Practical needs are related to one's condition, such as the kind of work performed, type of housing, the need for clean water, food and education. These needs are urgent and easy to identify. People's living conditions may improve when practical needs are met, but there is little impact on their position and status in society. On the other hand, the strategic interests are linked to status and position in society. It can be measured by male/female disparities in wages and employment opportunities, participation in legislative bodies, and vulnerability to poverty and violence.

Ask each group to spend 30 minutes working on practical needs and strategic interests of women and men in the following settings: violence, STIs/HIV/AIDS, use of contraceptive methods, and pregnancy.

- Give each group a copy of Handouts 3I: Reflection Tool on Practical Needs and Strategic Interests and 3J: Practical Needs and Strategic Interests Regarding Violence, STIs/HIV/AIDS, the use of Contraceptive Methods, and Pregnancy, for this exercise.
- Ask them to make a copy of Handout 3I: Reflection Tool on Practical Needs and Strategic Interests on a flipchart for presentation to the large group.
- In a plenary session, ask each group to present its findings.
- Encourage participants to provide feedback on each topic, based on Handout 3J: Practical Needs and Strategic Interests Regarding Violence, STIs/HIV/AIDS, the use of Contraceptive Methods, and Pregnancy.

STEP 5 (10 minutes)

RIGHTS AND GENDER PERSPECTIVE

- Make a presentation on Rights and Gender Perspective (Handout 3K)
- Ask if there are any reflections, clarifications or questions.
- Distribute Handout 3K at the end of the presentation.

STEP 6 (1 hour, 05 minutes)

POWER DYNAMICS (EMPOWERMENT, EQUITY) AND GENDER PERSPECTIVE

- Give each participant Handout 3L on "The Flower of Power." Explain to the group that they must analyze and relate their own level of empowerment to the influence of powerful groups. The inner petals will have variables that characterize individuals and that will be chosen freely, including, among others, sex, age, ethnicity, sexual orientation, profession, region of origin, country, level of education, socioeconomic status, marital status, number of children, religion, and languages. In each outer petal, participants should write as variables groups that have more power in their specific societies.
- You can model the exercise with the following example: on an inner petal, a person writes her or his age (14 years), and on the outer petal s/he will write that the age group with the greatest power in her or his society is that of people between 35 and 45 years old, because it is a society that is highly discriminatory against adolescents. Likewise, someone else can write on another inner petal his sex –

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male – and then write down males on the outer petal as the group holding the greatest power in his community. In this way, the group will perceive how in some characteristics an individual forms part of the group in power, while in others s/he does not.

- In the large group, share the results by asking four different volunteers to present their flower of power (for example, one female, one male, one young unmarried person, and one middle-aged married person). Have participants reflect briefly on the different positions of power of individuals, that is, how in some situations people can be in positions of power and form part of hegemonic groups, while in others occupy places with little power.
- Mention also that the various positions of power are systems of social differentiation that are independent but also interrelated; reinforce and nurture one another; reproduce among themselves; and have been developed through historical processes in social institutions such as the family, education, the market, religion, the media, and the State, among others.
- Clarify that power is a historical construction and, as a relational category, is present in all social interactions. Power is not something that is possessed, but something that is exercised individually or in a group. Therefore, one speaks of power relationships. Also, mention that there are different types of power (power with, over, for, from within, or of affirmation).
- Distribute Handout 3M: Gender and Power Relations at the end of this exercise.

#### STEP 7 (20 minutes)

##### ACTION PLANS

- Hand each participant Handout 3N (Guide No. 1) to complete individually once the daily activities have ended. Mention that throughout the course of the module, they will receive several guides that will supplement, along with the topics discussed, the subject matter they have chosen to address in the action plan.

For question 3 on Handout 3N, facilitators may need to mention a few examples, such as Rights to Privacy, Rights to Integrity, Rights to Information, Rights to Choose, etc.

#### STEP 8 (10 minutes)

##### EVALUATION

- For the evaluation, review the session objectives.
- Hand each person two copies of the Session Evaluation Form, found at the beginning of this manual.

## DEFINITION OF QUALITY OF CARE FROM A GENDER AND RIGHTS PERSPECTIVE

### ICPD, REPRODUCTIVE HEALTH AND QUALITY OF CARE

The 1994 International Conference on Population and Development (ICPD) established the following as critical to monitoring its implementation: ensuring the achievement of quality reproductive health care services, ensuring comprehensive women's health care, and exercising and respecting women's sexual and reproductive rights. Quality of care goes beyond modifying indicators such as maternal mortality or fertility rates; it should include advocacy of women's citizenship and the need to incorporate women as equal actors in policy-making.<sup>8</sup>

"Reproductive health care is defined as the set of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving problems related to reproductive health. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not just counseling and care related to reproduction and sexually transmitted diseases".

"High quality of care is that which provides maximum well-being to the user, from a perspective of her needs, her human rights, her expectations and her empowerment. The processes of social development of genders influence each one of these parameters. Users characterize it (quality of care) according to the more or less gratifying way in which they experience such care, be it with respect to the resolution of health problems, or in reference to the understanding and treatment they receive."<sup>9</sup>

### FACTORS INFLUENCING QUALITY OF CARE

Quality of sexual and reproductive health-care services is influenced by multiple factors of both general and specific dimensions:<sup>10</sup>

- **Inclusion of the gender perspective** contributes to the democratic exercise of power between the sexes; raising women's awareness about their needs and decision-making; and acknowledging and analyzing differences, with an emphasis on women's status and position, and the differential impact on health.
- **Inclusion of the gender perspective** allows meeting specific needs and demands in the sexual and reproductive health setting. It also contributes to empowering women, reconceptualizing health care models, organizing services and promoting access, and women's participation in and control of those services.

<sup>8</sup> Centro de la Mujer Peruana Flora Tristán, *Un acto común por construir, calidad de atención en los servicios de salud reproductiva*, Lima: 1998.

<sup>9</sup> Matamala MI and Maynou P, *Manual Guía para la realización del curso taller Salud de la Mujer, calidad de la atención y género*, Santiago de Chile: Colectivo Mujer, Salud y Medicina Social, 1996 (p. 86).

<sup>10</sup> Based on Pan-American Health Organization (PAHO), *Marco de referencia, componentes y estrategias para mejorar la calidad*

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- **Existing policies, programs and action plans with respect to the population, health and development in each country** determine a vision of human beings, their needs, rights and aspirations.
  - **Definition of priorities, resource allocation and goal setting** determine the general framework for actions and services to offer in practice.
  - **Sociocultural and political configurations** at local and regional levels.
  - **Commitment of officers and providers**, their capacity to resolve and advocate; their initiatives and possibilities of participation and decision-making in the comprehensive management of sexual and reproductive health-care services; as well as the appropriate monitoring and evaluation of activities conducted.
  - **Acknowledgment, respect and promotion** of the multisectoral and multidisciplinary involvement of women's health organizations, and the assurance of including their proposals and demands.

Quality of care involves incorporating a comprehensive concept of gender, health, sexual and reproductive rights perspective as a frame of reference in planning, implementing and tracking sexual and reproductive health services.

The concept of comprehensive health goes beyond the biological aspect, as it integrates physical, psychological, social, cultural, environmental and economic factors in the process of health, disease, care and prevention. Many times in sexual and reproductive health care services, care is centered, for example, on prescribing the use of a particular contraceptive method, without probing to find out the needs of the female or male users, whether s/he has experienced violence, whether or not s/he has the autonomy to negotiate with her or his partner, or whether s/he has the financial resources to purchase the method.

The sexual and reproductive rights perspective involves accepting female or male users as people with full rights with respect to receiving appropriate information about the different contraceptive choices, their use and side effects; having all the elements necessary to make the decision that is most appropriate for her or his specific situation and needs; and receiving humane, dignified and respectful treatment. Sexual and reproductive health-care services should promote informed choice as part of sexual and reproductive rights.

A gender perspective considers the specific needs of women and men, according to the stage of their life cycle, their ethnicity, their sexual orientation and their educational level. It takes into account gender roles and daily activities carried out by men and women in both public and private spheres; the exercise of power in different human relations (couples, family, work, medical); empowers women with the autonomy to make their own decisions with respect to their bodies and their sexuality; and, in men, makes it possible to question and transform their role in contraception and in relationships.

### REFLECTION TOOL ON PERSONAL EXPERIENCES<sup>11</sup>

Based on your personal experiences, on women and men close to you, and on cases of which you know, reflect and complete on the following statements:

I feel good being a man or a woman because...

I would like to be a man or a woman because...

Please offer several examples for each statement

<sup>11</sup> Based on Centro de la Mujer Peruana Flora Tristán/OXFAM, *Manual de capacitación en género de Oxfam. Edition for Latin America and the Caribbean*, OXFAM, 1997.



### GENDER CONCEPTS, GENDER ROLES AND RELATIONS

#### Gender

Gender is a term that explains how the concepts of feminine/masculine are constructed in a given space and time, and of the relations that are established between women and men. “Gender refers to widely shared ideas and expectations (norms) concerning women and men. These include ideas about ‘typically’ feminine or female and masculine or male characteristics and abilities and commonly shared expectations about how women and men should behave in various situations. These ideas and expectations are learned from family, friends, opinion leaders, religious and cultural institutions, schools, the workplace, advertising and the media. They reflect and influence the different roles, social status, economic and political power of women and men in society.”<sup>12</sup>

One of the most widely accepted theoretical definitions of gender is that of Scott, “Gender is an element composed of social relations based on the differences that distinguish sexes and gender is a primary form of significant power relations.”<sup>13</sup> Gender as a cultural construct and culture as a symbolic system provide women and men with a series of images, representations and social practices that define spaces, roles, times and characteristics that, ideally, women and men should have.

#### Sex and Gender

It is important to differentiate between the two terms: **sex and gender**. Sex refers to the anatomical, physiological and hormonal characteristics of women and men, while gender refers to the cultural construction of what it means to be a man or a woman in a given society. Therefore, while sexual biological characteristics are permanent in time (although given scientific and medical advances with respect to sex change, this is questionable), gender is susceptible to being transformed throughout the life cycles of women and men and in the historical development of human groups. The concept of gender is commonly used to refer to women; however, gender is a relational category, which means women build their identity in relation to men and vice versa.

#### Socialization

We construct ourselves as men and women through socialization. This socialization is not neutral in relation to sex, since it is determined by that which has been culturally established as appropriate for women and men. That is how gender socialization comes into play. Gender socialization is the process through which girls and boys, men and women begin to internalize norms, values, emotions, behaviors and ways to relate to others, which culture has constructed as differential for men and women. Gender socialization has several scenarios, including, among others, family, school, the media, peer groups, the

<sup>12</sup> Ipas and Health Development Networks, *Gender or Sex: Who Cares? Skills-Building Resource Pack on Gender and Reproductive Health for Adolescents and Youth Workers With a Special Emphasis on Violence, HIV/STIs, Unwanted Pregnancy and Unsafe Abortion*, Washington: 2001 (p. 24).

<sup>13</sup> Scott J, Gender: a useful category of historical analysis, in J. Amelang et al. (Eds.), *History and Gender: Women in Modern and Contemporary Europe*, Valencia: Alfons el Magnánim Editions, 1986 (p.44).

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workplace and the community. Those spaces produce inequalities, exclusions, discriminations and the characteristics that culture establishes as appropriate for men and women, which become naturalized as if there were a masculine or feminine “essence”. In other words, socially constructed behaviors and conducts are assumed as if they originated in biology. This naturalization of feelings, thoughts and actions has the purpose of reproducing and perpetuating certain ways of thinking and acting, both individually and collectively.

### Gender Roles

These refer to “activities assigned to individuals on the basis of socially determined characteristics, such as stereotypes, ideologies, values, attitudes, beliefs, and practices.”<sup>14</sup> **Gender roles** are expressed in the assignment of the public space to men and the domestic space to women. Despite the massive influx of women into the paid workforce, one thing still carries much symbolic weight and is in daily practice: women’s primary responsibility in raising children and carrying out domestic tasks. Similarly, men are considered the main breadwinners in the household and the decision-makers in political, financial and military spheres, among others.

### Gender Identity

Throughout their life-cycle, men and women are constructing their identities, identities that are formed by gender, class, ethnicity, age, sexual preference, work or profession and the personal significance that men and women develop about themselves, based on their own life history. However, “gender identity is one of the deepest layers of personal identity, a fundamental guide for acting in this world, and one of the central biographical supports in the construction of the story of one’s self.”<sup>15</sup> Gender identity refers to “a feeling of belonging to the female or male sex.”<sup>16</sup>

In recent decades, the sharp lines of division of roles, characteristics and practices have been blurred due to economic, labor, educational, political and social changes. It is important to highlight the role of feminism in questioning society’s patriarchal model. Women have entered the educational, labor and political spheres with great force. Some men (although still very few) have become involved in raising their sons and daughters, and in carrying out domestic activities. Society is constructing more independent and autonomous female identities, and more sensitive and emotional male identities.

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<sup>14</sup> Center for Development and Population Activities (CEDPA), *Gender, Reproductive Health, and Advocacy: A Trainer’s Manual*, Washington, D.C.: CEPDA, 2000 (p. 46).

<sup>15</sup> Fuller N, *Identidades Masculinas*, Lima: Pontificia Universidad Católica del Perú, 1997 (p. 18).

<sup>16</sup> Lamas M, *Cuerpo e identidad*, in L.G. Arango et al. (Eds.), *Género e Identidad, Ensayos sobre lo femenino y lo masculino*, Bogotá: Tercer Mundo Editores, 1995 (p. 63).

## DEFINITIONS OF GENDER TERMS<sup>17</sup>

### Empowerment

Process by which individuals, local groups and/or communities organize to influence change on the basis of their access to knowledge, to political processes and to financial, social and natural resources. Collective action by oppressed people to overcome structural inequality that has put them in a disadvantaged position.

### Gender

The attribution of “male” and “female” labels to social roles and attributes, as if they arise from sexual difference although these attributes are acquired by a process of socialization. Gender refers to the economic, social, political and cultural attributes and opportunities associated with being male or female. It refers to the socially constructed roles and responsibilities of women and men. It also indicates expectations held about characteristics, aptitudes and likely behavior of women and men. These are not universal, and they are changeable.

### Gender Awareness

The ability to identify problems arising from gender inequality and discrimination, even if they are not obvious.

### Gender Bias

A tendency to make decisions or take actions based on gender.

### Gender Discrimination

Differential/prejudicial treatment of an individual based on a gender stereotype.

### Gender Division of Labor

Roles, responsibilities and activities assigned to women and men based on gender.

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<sup>17</sup> Center for Development and Population Activities (CEDPA)

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## Gender Equality

No discrimination on the basis of a person's sex in the allocation of resources or benefits, or in access to services. Women and men have an equal opportunity/equal access. The same status, rights and responsibilities for women and men.

## Gender Equity

The quality of being fair and right. A stage in the process of achieving gender equality. Fairness and justice in the distribution between women and men of benefits and responsibilities. A condition in which women and men participate as equals, have equal access to resources, and equal opportunities to exercise control.

## Gender Issues

Specific consequences of the inequality of women and men arise when an instance of gender inequality is recognized as undesirable or unjust.

## Gender Mainstreaming

Systematic application of gender-aware vision to the analysis and formulation of policies, programs and projects irrespective of sector or type, and the introduction of routine management procedures to ensure implementation. Purpose: addressing known gender disparities and gaps, and promoting gender equality and the empowerment of women in population and development activities.

## Gender Relations

Ways in which a culture or society defines rights, responsibilities, and identities of men and women in relation to one another.

## Gender Roles

Socially constructed roles and responsibilities assigned to women and men in a given culture or location and societal structures that support them. Are learned and change over time. Roles that are classified by sex, where this classification is social and not biological.

## Gender Role Stereotyping

Constant portrayal of women and men in traditional social roles based on the gender division of labor which it in turn supports and reinforces by portraying it as "normal" and "natural".

### Gender Sensitive

Being aware of the differences between women's and men's needs, roles, responsibilities and constraints.

### Patriarchy

System of male domination and female subordination in economy, society and culture. Male domination of ownership and control, at all levels of society, which maintains and operates the system of gender discrimination.

### Practical Gender Needs

Needs which are in response to immediate perceived necessity, practical in nature, often concerned with inadequacies in living conditions, such as water provision, health care and employment.

### Sex

Biological differences between women and men, which are universal, and generally permanent.

### Sex Roles

Occupations or functions for which a necessary qualification is to belong to one particular sex category.

### Strategy Gender Needs

Needs women identify, because of their subordinate position to men in their society, in relation to gender divisions of labor, power and control.

### Triple Role of Women

Reproductive work, productive work, and community managing and community politics.



### THE TRIPLE ROLE OF WOMEN<sup>18</sup>

Work can be divided into three main categories. Women's roles encompass work in all of these categories, and this is referred to as women's "Triple Role".

**PRODUCTIVE WORK** involves the production of goods and services for consumption and trade (farming, fishing, employment and self-employment). When people are asked what they do, the response is most often related to productive work, especially work which is paid or generates income. Both women and men can be involved in productive activities, but for the most part, their functions and responsibilities will differ according to the gender division of labor. Women's productive work is often less visible and less valued than men's.

**REPRODUCTIVE WORK** involves the care and maintenance of the household and its members including bearing and caring for children, food preparation, water and fuel collection, shopping, housekeeping and family health care. Reproductive work is crucial to human survival, yet it is seldom considered 'real work'. In poor communities, reproductive work is, for the most part, manual-labor-intensive, and time-consuming. It is almost always the responsibility of women and girls.

**COMMUNITY WORK** involves the collective organization of social events and services: ceremonies and celebration, community improvement activities, participation in groups and organizations, local political activities, etc. This type of work is seldom considered in economic analyses of communities. However, it involves considerable volunteer time and it is important for the spiritual and cultural development of communities and as a vehicle for community organization and self-determination. Both women and men engage in community activities, although a gender division of labor also prevails here.

Women, men, boys and girls are likely to be involved in all three areas of work. In many societies, however, women do almost all of the reproductive work and much of the productive work. Any intervention in one category of work will affect the others. Women's workload can prevent them from participating in development projects. When they do participate, extra time spent farming, producing, training or meeting, means less time for other tasks, such as childcare or food preparation.

<sup>18</sup> Center for Development and Population Activities (CEDPA)



### PRACTICAL AND STRATEGIC GENDER NEEDS<sup>19</sup>

#### Practical Gender Needs

Needs women identify in their socially accepted roles in society (that is, it is the women who assume responsibility for meeting these needs). Practical gender needs do not challenge the gender divisions of labor or women's subordinate position in society, although they rise out of them. Practical gender needs are a response to an immediate perceived necessity, identified within a specific context. They are practical in nature and are often concerned with inadequacies in living conditions, such as water provision, health care, income earning for household provisions, housing and basic services, and family food provision. The sexual division of labor has resulted in women assimilating these types of gaps as part of their reproductive role. If policies, plans, programs and projects limit themselves to meeting these types of needs, they will help preserve male dominance and female subordination in the home and society, thus making acknowledgment of strategic interests more difficult.

#### Strategic Gender Needs or Strategic Interests

**STRATEGIC INTERESTS** are related to women's position in all spheres of daily life and indicate a transformation of relationships between women and men, implying both an individual and a collective awareness; the transformation of the sexual division of labor; the value placed on activities typically considered feminine; the increase in women's political participation; the strengthening of the participation of social groups with little negotiating power; the elimination of discrimination at an institutional level (access to land, property, credit, etc.); and equitable access to and control of resources, benefits and opportunities for human development. These interests are linked to questioning power structures and eliminating various forms of discrimination. Strategic gender needs vary according to particular contexts. They relate to gender division of labor, power and control and may include such issues as legal rights, domestic violence, equal wages and women's control over their bodies. Meeting strategic gender needs helps women to achieve greater equality. It also changes existing roles and therefore challenges women's subordinate position.

Strategic gender needs may include:

- a. Abolition of gender division of labor
- b. Alleviation of the burden of domestic labor and child care
- c. Removal of institutional forms of discrimination such as rights to own land or property
- d. Access to credit and other resources
- e. Freedom of choice over child bearing
- f. Measures against male violence and control over women

<sup>19</sup> Center for Development and Population Activities (CEDPA)



## THE DIFFERENCE BETWEEN PRACTICAL NEEDS AND STRATEGIC INTERESTS<sup>20</sup>

When planning, one cannot choose either practical needs or strategic interests; both are indispensable to successfully building equitable gender relations. If a project or intervention responds only to practical needs, discrimination may be reinforced. For example, a fundraising project aimed at women could increase their workload without translating into an actual economic reward, and without transforming the inequitable sexual division of labor and power relations within the family.

Shifting from survival strategies to strategies of cultural transformation implies women's involvement in politics. Strengthening the autonomy of individuals and of women's organizations produces changes and transformations in themselves, in their relations with their partners and children, in the community, and in society in general.

Practical Needs	Strategic Interests
Focused on rank; related to situations of dissatisfaction due to material deficiencies	Focused on position; related to attainment of equity
Easily observable and quantifiable	Invisible, due to cultural factors, such as lack of awareness of gender
Related to specific areas in life: potable water, housing, etc.	Related to structural conditions, which define access and control of resources and benefits, and to personal development opportunities
Can be met with specific resources, such as equipment, credit, technical training, etc.	Meeting these interests is more complex and abstract. They demand awareness, identity changes, and everyday life changes
Related to social groups, with defined communities	Common to all women. They are expressed in various ways, based on factors such as ethnicity, region, etc.
Can be met without transforming traditional gender roles	Their attainment signifies the transformation of traditional gender roles
Can be met by others; in other words, can be granted	Require individual and collective processes of ownership
Meeting these needs leads to improved performance in activities associated with traditional gender roles	Meeting these interests leads to greater equity between genders

<sup>20</sup> Tobón M and Guzmán JE, *Herramientas para construir equidad entre mujeres y hombres. Manual de capacitación*, Bogotá: Proyecto Proequidad, DNP Colombia/GTZ, 1995.



### CONCEPTS OF EQUALITY AND EQUITY

The claim of **equality** is based on acknowledging differences. It means equality before the law, as well as equality of opportunities regarding education, employment, ownership of goods, remuneration for work and, in general, everything concerning human rights.<sup>21</sup> The women's movement claims a right to equality with respect to acknowledging women as human beings, subjects and citizens with the same value as men. It demands equality of opportunity, i.e., being born female or male does not limit how one defines oneself; it is equality of opportunity to develop all potential. Respect for difference is possible in a climate of diversity and plurality. Difference is constructed based on specific interests and needs of women and men that arise from a process of reflection on the dynamics between gender and power, rather than on stereotypes and needs as established by culture.

The interplay between equality and difference is not only valid between women and men, *intergeneric*, but also among women, *intrageneric*. "Even when there may be important points of contact among all women, there are fundamental differences among them that cannot be erased or considered merely irrelevant or secondary."<sup>22</sup> As women, they demand common rights, but factors such as belonging to an ethnic group, social class, stage in the life cycle, sexual orientation, political party, religion, etc., result in diverse female interests.

Equity for women is a political proposal that involves achieving not only equality before the law, equality of opportunities regarding access to and quality of education, work, health, credit and ownership services, etc., but also equity with respect to autonomy, political participation, and the capacity to decide and choose. In other words, equity signifies that men and women exercise full citizenship.

Promoting actual equity for women necessarily involves a profound change in the structural causes that continue preserving and reproducing gender inequities. It entails reviewing and transforming symbolic and relational elements that patriarchy has established. Structural causes refer to the sexual division of work; considering the work and income of women a secondary factor; excluding women from the economic and political process of development; stereotyping women as weak, dependent, submissive, passive, etc.; viewing the female body as an object of pleasure for others; not valuing the various contributions of women in the development of society; and claiming that women's sole achievements are those of being mothers and wives.

Equity refers to quality, to the development of equitable relations between genders in which men and women acknowledge each other as speakers with the same value, the same decision-making capacity, and the same autonomy. It also refers to processes of constructing stronger, more independent, freer female identities, with different life choices, and a more active participation of women in political, economic and social settings.

Achieving gender equity is allowing and maximizing personal, family, community and political development, based on the capabilities and interests of women and men, without distinguishing between the sexes to hinder or limit growth.

<sup>21</sup> Santa Cruz I, Sobre el concepto de igualdad: algunas observaciones, *Revista Isegoría* 6 (Consejo Superior de Investigaciones Científicas, Instituto de Filosofía, Madrid), 1992.

<sup>22</sup> Santa Cruz 1992, p. 149.



REFLECTION TOOL ON PRACTICAL NEEDS AND STRATEGIC INTERESTS

Discuss the practical needs and strategic interests of men and women with respect to gender-based violence, and list them in this table.

GENDER-BASED VIOLENCE	
PRACTICAL NEEDS	STRATEGIC INTERESTS

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Discuss the practical needs and strategic interests of men and women with respect to STIs/HIV/AIDS, and list them in this table.

STIs/HIV/AIDS	
PRACTICAL NEEDS	STRATEGIC INTERESTS

Discuss the practical needs and strategic interests of men and women with respect to the use of contraceptive methods, and list them in this table.

USE OF CONTRACEPTIVE METHODS	
PRACTICAL NEEDS	STRATEGIC INTERESTS

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Discuss the practical needs and strategic interests of men and women with respect to pregnancy, and list them in this table.

PREGNANCY	
PRACTICAL NEEDS	STRATEGIC INTERESTS

PRACTICAL NEEDS AND STRATEGIC INTERESTS REGARDING VIOLENCE, STIs,/HIV/AIDS, THE USE OF CONTRACEPTIVE METHODS, AND PREGNANCY

VIOLENCE	
PRACTICAL NEEDS	STRATEGIC INTERESTS
<ul style="list-style-type: none"> <li>• Laws to sanction and eradicate violence</li> <li>• Information on prevention (types of violence, defense mechanisms)</li> <li>• Access to medical, psychological and legal assistance services and to refuge houses</li> <li>• Training for law enforcement, health and education officers</li> </ul>	<ul style="list-style-type: none"> <li>• Women's organization to promote the implementation of laws</li> <li>• Transforming masculine and feminine stereotypes that contribute to a view of violence as normal behavior</li> <li>• Flexibility of family roles</li> <li>• Raising women's awareness so they can report violence against them</li> <li>• Transforming male identity so it is not associated with violence</li> <li>• Transforming female identity associated with economic and emotional dependence, passivity, submission, etc.</li> <li>• Incorporating a gender approach to sexual and reproductive rights</li> </ul>

STIs/HIV/AIDS	
PRACTICAL NEEDS	STRATEGIC INTERESTS
<ul style="list-style-type: none"> <li>• Access to information on prevention</li> <li>• Access to condoms</li> <li>• Access to health-care and rehabilitation services</li> <li>• Access to affordable drugs</li> <li>• Protected sexual practices</li> <li>• Information about group and risk behaviors</li> </ul>	<ul style="list-style-type: none"> <li>• Developing skills for decision-making and negotiation during sexual relations</li> <li>• Identifying women's social vulnerability to STIs/HIV</li> <li>• Incorporating a sexual and reproductive rights focus</li> <li>• Overcoming stereotypes that stigmatize homosexuals as primary transmitters of STIs/HIV</li> <li>• Reducing the cost of drugs</li> <li>• Transforming unequal power relations</li> <li>• Recognizing gender-based violence as a factor influencing the transmission of STIs/HIV</li> <li>• Raising awareness of risk among monogamous heterosexual women</li> <li>• Approach that transcends the biomedical model toward a comprehensive concept of health</li> <li>• Promoting the organization of interest groups</li> </ul>

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USE OF CONTRACEPTIVE METHODS

PRACTICAL NEEDS	STRATEGIC INTERESTS
<ul style="list-style-type: none"> <li>  Reducing the number of unplanned pregnancies</li> <li>  Access to contraceptive methods</li> <li>  Access to sexual and reproductive health care services</li> <li>  Access to information</li> <li>  Research on male contraceptive methods</li> </ul>	<ul style="list-style-type: none"> <li>  Sex education not centered on reproductive aspects, that values pleasurable and risk-free sexuality</li> <li>  Increasing male responsibility in reproductive aspects</li> <li>  Incorporating a sexual and reproductive rights approach</li> <li>  Empowering women so they can identify their best contraceptive choices</li> <li>  Having autonomy to decide whether or not to have children</li> <li>  Exercising sexual and reproductive rights</li> </ul>

PREGNANCY

PRACTICAL NEEDS	STRATEGIC INTERESTS
<ul style="list-style-type: none"> <li>  Access to prenatal, childbirth and postpartum care</li> <li>  Reducing maternal mortality</li> <li>  Access to child-care services for preschool children</li> <li>  Sanction of laws on paternity leave</li> </ul>	<ul style="list-style-type: none"> <li>  De-legitimizing maternity as the sole option for women's fulfillment</li> <li>  Promoting active exercise of paternity</li> <li>  Flexibility of roles in caring for and raising children</li> <li>  Encouraging men to reflect on the quality of life of their partners during pregnancy</li> <li>  Having autonomy to decide whether or not to have children</li> </ul>

### PRESENTATION OF GENDER PERSPECTIVE

There are Three Dimensions within Gender

- The concept of gender (discussed earlier)
- Gender relations (discussed earlier)
- Gendered systems

Gender Perspective

- A theoretical and methodological approach that allows us to recognize and analyze the identities and power relations that gender systems influence.
- Allows providers to go beyond focusing on women to view reproductive health as a family health and social issue.
- Addresses the dynamics of knowledge, power and decision-making in sexual relationships, between providers and clients, and between community or political powers and citizens (Paulson, et al, 1999).

Gendered Systems

Gender, as a system of social inequality, feeds and is nurtured by other discriminatory systems, such as class, race and ethnicity.

Resistance or Distortions about Gender Perspective

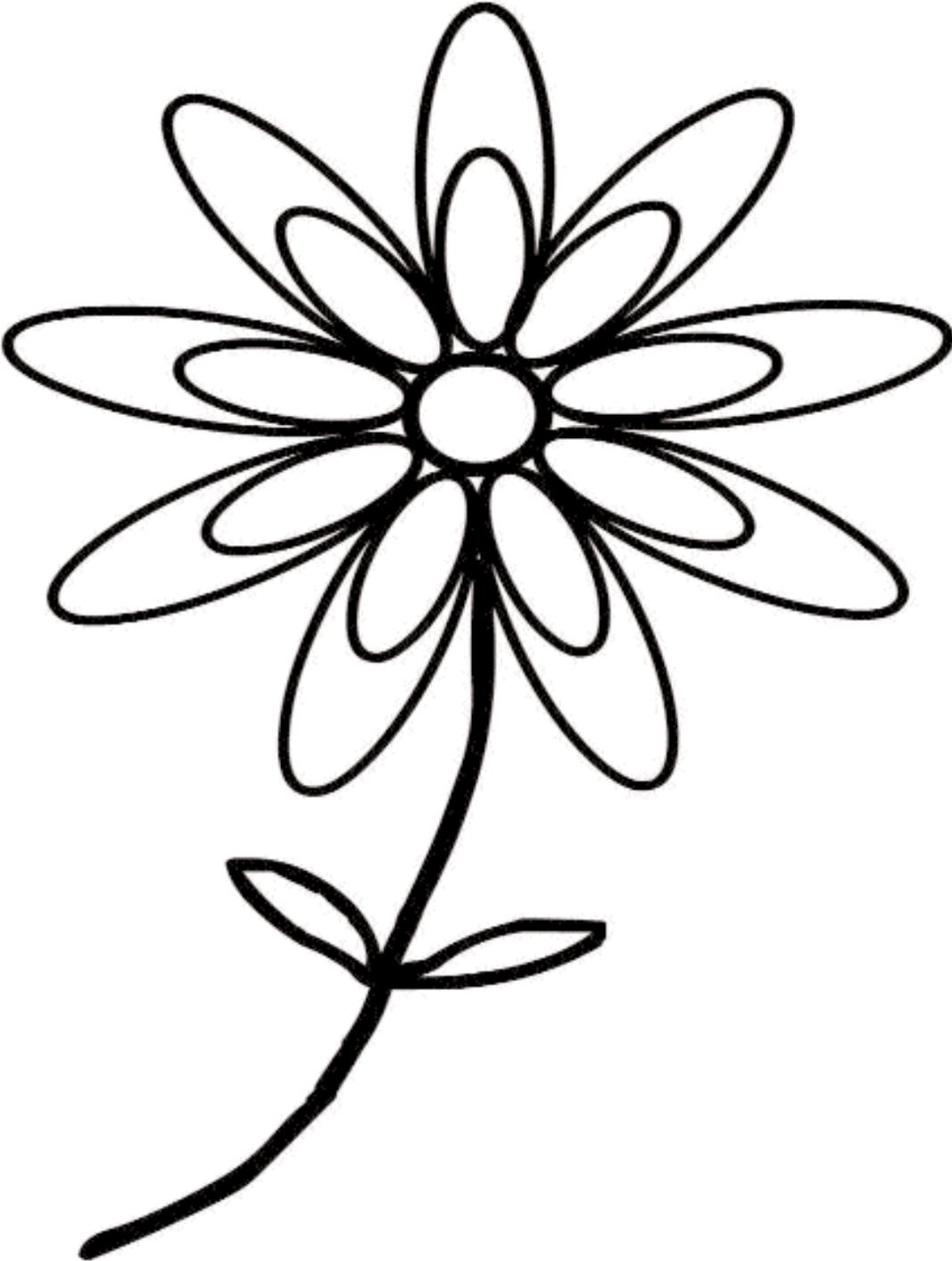
- Gender is the same as biological sex.
- Speaking of women's empowerment is equal to allowing women to dominate.
- The gender perspective threatens the concept of family as a cornerstone of society

Challenges

- Understanding this systemic level demonstrates that only by acting in various dimensions will we be able to advance toward a just and democratic society.
- Adopting a gender approach implies becoming aware of this inequality, identifying the reasons that give rise to it (research indicators), and proposing alternatives to face it.



THE FLOWER OF POWER





## GENDER AND POWER RELATIONS<sup>23</sup>

Many cultures overvalue the role of men, especially in terms of public life, rationality, strength, and competition; and devalue the role of women, such as, among others, in private life, in terms of emotion and intuition. This hierarchy reproduces power relations based on a patriarchal culture.

### Power

Some political scientists consider that **power** relations are reproduced in specific social institutions, such as legislative or executive branches of public power and military institutions, or that power is controlled through popular elections.

On the other hand, Michel Foucault demonstrated that power goes beyond that; it remains in social institutions, constituting a multiple network of forces; it forms part of human social interaction; and it is reproduced from knowledge and from sexuality itself.<sup>24</sup> Power is not held, it is exercised; that is, it becomes implied in institutions, it circulates among social dynamics, producing the dominators and the dominated, who get affected by it. Power does not always imply a dominator-dominated relationship, because it can become an articulating force that rallies and facilitates fighting for common interests. In this sense, power generates changes that are productive and emancipating for social groups.<sup>25</sup>

### Power Relations

Upon analyzing **power relations** within present-day society, Celia Amorós describes two types of patriarchal domination. The first is coercive: that is, a series of mechanisms that force women to accept power relations that exclude them from the spheres valued most by society. The second is defined as patriarchy of cohesion, and encompasses consensual mechanisms through which women accept different forms of discrimination and domination in current Western societies.<sup>26</sup> Traditionally, patriarchal cultures produced beliefs and values disposed to reproducing inequity for women, and, to this day, societies still establish norms and customs that assign hierarchical values to masculinity and femininity.

### Institutions

**Institutions** are a set of norms, functions and provisions working toward an end to meet societal needs. In addition to this functional character of institutions (producing norms and provisions to meet societal needs), they shape social perspectives, based on which a society evaluates and creates a hierarchy. It is within institutional dynamics that gender relations are reproduced.

<sup>23</sup> Based on Puyana Y and Bernal M, *Reflexiones sobre violencia de pareja y relaciones de género* (Política Nacional de Construcción e Paz y Convivencia Familiar), Bogotá: 2001.

<sup>24</sup> Rodríguez RM, *Femenino fin de siglo*, Barcelona: Anthropos, 1994.

<sup>25</sup> Rowlands J, Empoderamiento y mujeres rurales en Honduras: un modelo para el desarrollo, in M. Leon (Ed.), *Poder y empoderamiento de las mujeres*, Bogotá: Tercer Mundo Editores, 1997.

<sup>26</sup> Amorós C, as told by A. Puleo in *Diez palabras claves sobre la mujer*, Madrid: Colección 10, 1999.

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## Patriarchy

The concept of **patriarchy**, which means government of men, follows a tradition that has permeated the social order. Patriarchal power is preserved in daily life, particularly in the family, in its types of organization, in the laws of kinship, and in the regulation of lineage. The paternal last name is the first to be recognized in an individual's name, just as it is customary for women to lose their maiden name at marriage. Matrimony and the consecration of virginity, through which feminine sexuality was (and still is, in many cultures) controlled, constitute another example of the way in which patriarchy is reproduced within the family. Finally, the low value placed on domestic labor and the concentration of household tasks among women, and the high value placed on men in public life, are a product of this patriarchal division of the sexes.

## Gender Discrimination

**Discrimination** against women is also seen in politics, religious institutions and the job market. This occurs despite the massive influx of women into the workforce, and the fact that they have attained educational levels that surpass those of men. For example, in Colombia in 1996, women's salaries were on average 26.9% lower than those of men, even if they had similar jobs.

The educational system also perpetuates gender discrimination. Teacher-student interaction, textbooks and the existence of a hidden curriculum, all socialize girls and boys differently. In higher education, women continue to represent a high percentage of traditionally female careers, such as social work, nursing, bacteriology and psychology. In typically male careers, including electrical and civil engineering, architecture and veterinary medicine, male participation is much higher.<sup>27</sup> This situation results in a lower social and economic value placed on women.

Spousal violence is linked to power relations, socialization and gender identities, as well as the dynamics surrounding institutions such as the family, schools, the workplace, the church, and different spheres of social and political participation. One can conclude that inequities between the sexes are sustained and legitimized through traditional power relations and patriarchal pacts that for generations have reproduced a culture of discrimination and segregation of women.

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<sup>27</sup> Pérez F, Género y educación, in Proyecto Proequidad/GTZ, *Género, Equidad y Desarrollo*, Bogotá: Tercer Mundo Editores,





## SESSION 4: GENDER, RIGHTS AND REPRODUCTIVE HEALTH

### OBJECTIVES

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

- Identify some of the consequences of gender inequity in the course of women's lives and in their sexual and reproductive health.
- Identify ways in which unjust, inequitable, unequal and discriminatory power relationships affect women and men's sexual and reproductive health.
- Identify how lack of gender equity and unequal power relationships impede the exercise of human rights, especially women's right to life, equality, dignity and liberty.
- Define sexual and reproductive health from a perspective of Sexual and Reproductive Rights and Gender.

DAY 2 TIME: 3 hours, 35 minutes

### PREPARATION

- Session 4 objectives printed on a flipchart
- Set aside a space in the room to post a new definition of quality of care each day, incorporating the topics addressed in each session.
- Flipchart with the definition of sexual and reproductive health

### MATERIALS

- Flipcharts, markers, tape
- Copies of handouts for the participants
- Two copies of the Session Evaluation Form, found at the beginning of this manual

### HANDOUTS

- 4A: Sexual and Reproductive Rights and Gender
- 4B: Case Studies on Rights Violations
- 4C: Reflection Tool on the Lifeline
- 4D: How Does Gender Affect Sexual and Reproductive Health?
- Session Evaluation Form

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## FACILITATING SESSION 4

### STEP 1 (20 minutes)

#### RIGHTS AND GENDER

- Generate a discussion on the relationship between rights and gender. Some questions you can ask:
  - Is there a relationship between rights and gender?
  - What is the relationship (e.g., gender sensitive laws and policies will ensure greater access to reproductive rights and reproductive health)?
  - What role can different agencies, the family, and the community play in ensuring greater access to reproductive rights?
- Give Handout 4A: Sexual and Reproductive Rights and Gender to participants.

### STEP 2 (1 hour, 20 minutes)

#### HUMAN RIGHTS AND SEXUAL AND REPRODUCTIVE RIGHTS

- Ask participants to take one or two minutes to reflect on the question, “What is a right?”
- Write the question on a flipchart.
- Ask participants to give you their responses, and note them down on the flipchart.
- Once you have written down the responses, ask participants which phrases or words they agree with the most. Then collectively narrow down the list and develop a simple definition of a right.
- Ask the following questions:
  - Do we need a new definition of women’s rights?
  - Why or why not? (If not, are there any definitions that participants can recommend?)
  - If needed, remind participants that existing definitions, even so-called “neutral” ones, often have gaps. They are rooted (often unconsciously) in patterns of patriarchy and male dominance.



#### NOTE TO THE TRAINER

- Try to bring out the fact that feminist discourse has influenced the human rights debate and has pointed out the need to focus on women’s rights and to acknowledge sexual and reproductive rights as valid rights that all people must have (Handout 4A).

- Organize four work groups and hand each group one of the cases included in Handout 4B: Case Studies on Rights Violations so that, based on their personal reflections (Handout 3B: Reflection on Personal Experiences), they can identify rights that have been violated and their impact on sexual and reproductive health.
- In a plenary session, ask the small groups to present their group work.

- 
- Close by using the following question: *How do inequitable gender relationships affect women and their rights?* e.g., women remain subservient to men, lack decision-making power in the household, and lack economic autonomy. They also often lack power over their own bodies (sexual rights), or the power to decide when and how many children to have (reproductive rights).
  - Try to emphasize how inequitable gender relationships lead to greater violation of women's rights, and stress the need to incorporate a gender focus into the definition of human rights. (For this closing, you may consult Handout 4A: Sexual and Reproductive Rights and Gender).

Sexual and reproductive health is “A state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity, in all matters related to the reproductive system and to its functions and processes... implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth...” (ICPD/1994)

### STEP 3 (30 minutes)

#### DEFINING SEXUAL AND REPRODUCTIVE HEALTH FROM A SEXUAL AND REPRODUCTIVE RIGHTS AND GENDER PERSPECTIVE

Post the following definition of sexual and reproductive health on a flipchart and read it aloud:

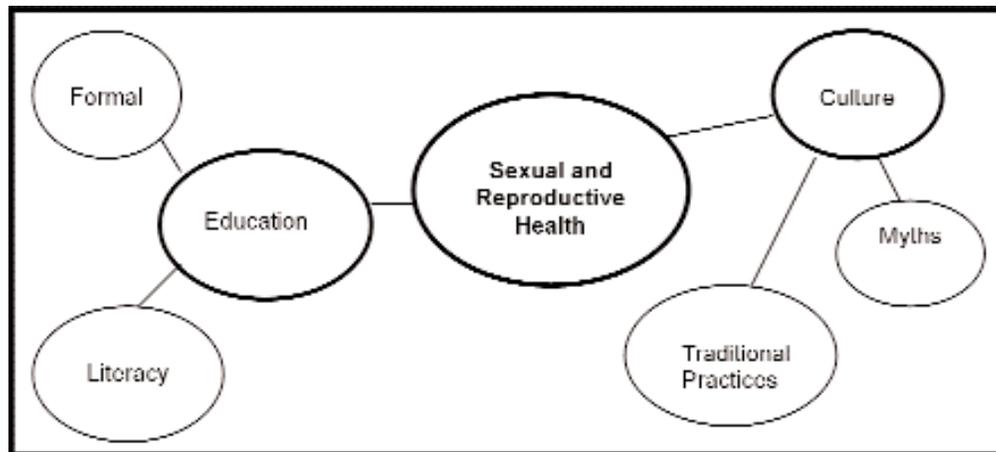
- Draw a thought map of sexual and reproductive health as follows.
- Ask participants to think about the components of sexual and reproductive health.
- In the center of a flipchart, write SEXUAL AND REPRODUCTIVE HEALTH and circle it.
- Ask the group: What are the key components that affect sexual and reproductive health?
- Write each answer in a new circle and draw a line connecting this circle with SRH. If the first component identified is, for example, culture, help the group by asking questions to identify cultural topics.
- Once the topic of culture has been discussed fully as an influential component of sexual and reproductive health, ask participants for a new factor and continue adding data to the thought map until participants have identified all the components that affect sexual and reproductive health.

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<sup>28</sup> Pérez F, Género y educación, in Proyecto Proequidad/GTZ, *Género, Equidad y Desarrollo*, Bogotá: Tercer Mundo Editores, 1998.

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Sample thought map:



STEP 4 (1 hour, 15 minutes)

#### GENDER AND SEXUAL AND REPRODUCTIVE HEALTH

- Divide participants into groups of five.
- Give each group a copy of Handout 4C (Reflection Tool on the Lifeline), a flipchart, and markers.
- Ask each group to come up with a story (based on the experiences of the members of the group or on known cases), which includes a sexual and reproductive health problem. Give them 30 minutes for this activity.
- The story must be one that is feasibly reconstructed throughout the person's life cycle.
- Ensure that some of the stories are about women and some about men.
- In the large group, ask each group to briefly present its story (five minutes per group).
- Also ask the groups to put up their lifelines on a wall for others to see them.
- In the discussion, ask participants what they think is the relationship between people's experiences and risk (try to bring out the fact that people have experiences that can place them at risk, as well as experiences that can strengthen their capacity to face risks).
- Generate a discussion on Handout 4D: How Does Gender Affect Sexual and Reproductive Health? by raising the following points if they do not come up in the discussion:
  1. How does gender influence the attitudes and behaviors that women and men develop (e.g., risky, protective)?
  2. Select two lifelines (a woman's and a man's).
  3. Ask participants to point out similarities and differences between the two. Ask the following:
    - What is the impact of risk situations on a person's life?
    - What is the short-, medium-, and long-term impact?
    - How can a risk situation that occurs early on in life affect a person later in life?
    - Should sexual and reproductive health issues be addressed with a life-cycle approach?

- 
- Why or why not? Bring out the fact that skills and services should be developed that promote the exercise of sexual and reproductive rights.
  - What is the importance of having a gender focus in health care?



#### TALKING POINTS FOR THE TRAINER

For this presentation, remember to emphasize the importance of the gender focus on health and to introduce the following points, if the participants do not mention them:

- a. Contributes to a more holistic understanding and integrates the processes of health-disease-care.
- b. Allows identification and determination of specific needs and problems related to men's and women's health care, thereby allowing providers to guide and plan the resources and actions necessary for their care.
- c. Allows for a more in-depth and comprehensive analysis of epidemiological profiles, from a complexity of influences, including biological, social, cultural, and geographic factors, among others.
- d. Contributes a critical analysis of the elements of equity and inequity among women and men, both in the health systems and in the social systems in which they are immersed.
- e. Aims to visualize and transform inequalities between men and women, in the context of health care and maintenance, service delivery, distribution of benefits, and processes of participation and decision-making regarding policies that regulate health-related actions.

#### STEP 5 (10 minutes)

##### EVALUATION AND WRAP UP

- For the evaluation, present once again the session's objectives. Give each participant two copies of the Session Evaluation Form, found in the beginning of this manual.
- Ask participants to fill out the forms and hand them in.
- To close the session, ask participants to stand in a circle.
- Show them the two different colored balls.
- Explain that you will toss each ball to a different participant to begin the activity.
- Whoever gets the red ball will have to highlight a key learning from the day.
- Whoever gets the blue ball has to give one important contribution that participants are making towards the workshop (e.g., sharing learning and experiences).



### SEXUAL AND REPRODUCTIVE RIGHTS AND GENDER<sup>29</sup>

In addressing this topic, we aim to answer two questions:

1. Why is there a need for a sexual and reproductive rights framework if there is already a “neutral” and general framework of human rights?
2. What has been the process of theoretical construction of sexual and reproductive rights and how are they defined today?

#### **1. WHY IS THERE A NEED FOR A SEXUAL AND REPRODUCTIVE RIGHTS FRAMEWORK IF THERE IS ALREADY A “NEUTRAL” AND GENERAL FRAMEWORK OF HUMAN RIGHTS?**

We must consider that human rights are essentially dynamic; their scope extends permanently as people reconsider their own needs and aspirations. The general theory of human rights is based on the dignity of human beings, and aims to balance hierarchical ways of association. Originally, this theory sought to protect the individual from control and power of the State.

The Universal Declaration of Human Rights, adopted by the United Nations in 1948, contains the common ideal toward which all nations should strive. The scope of the Universal Declaration was extended through the 1966 International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights.

An interpretation of the content of these instruments from a gender perspective revealed the gaps, inconsistencies and exclusions in such a general framework of “neutral” appearance.

Little by little, reality and feminist discourse made it clear that private spheres, such as the family and the exercise of sexuality and reproduction, are sustained on power structures where men dominate women. The worst part of this domination is that throughout the centuries it has been viewed as natural. Subordination has been preserved through culture, the unconscious and symbolism.

Thanks to the evolution of human rights, societies have recently begun breaking with the existing dichotomy between public and private life, and have recognized that sexuality and reproduction, and the “sanctity” of the home, are fields of exercising rights, in which it is necessary to set boundaries and control excesses of power. The great advancements in sexual and reproductive rights, and in the theory of universal human rights, are, on the one hand, accepting that such rights begin at the level of each individual. On the other hand, these advancements are linked to convincing the State to guarantee the exercise and respect of these rights.

<sup>29</sup> Document developed by: Calderón MC, Advisor in Rights Issues, Profamilia/Colombia, 2003.

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Recent formal international expressions about sexual and reproductive rights attempt to set aside neutrality as it relates to gender. While these expressions emphasize equality of men and women in reproductive issues, they do not ignore the specificity of women's reproductive situation; that is, women, not men, become pregnant and (in most societies) are primarily responsible for caring for and raising their children. For this reason, it is recognized that women have greater interest than men in sexual and reproductive rights, and a more intimate and direct concern with sexual and reproductive health.

The new concepts of sexual and reproductive rights are based on sexual and reproductive liberty, and should guarantee the participation of all individuals in the construction of their sexual and reproductive environment. They involve women's self-determination and responsibility, and men's co-responsibility and self-determination.

It is important to extend the spectrum of human rights to include recognition of sexual and reproductive rights, so that when a particular social claim reaches the category of human rights, it acquires a level of legitimacy.

## **2. WHAT HAS BEEN THE PROCESS OF THEORETICAL CONSTRUCTION OF SEXUAL AND REPRODUCTIVE RIGHTS AND HOW ARE THEY DEFINED TODAY?**

Defining this process requires identifying the multiple factors that have influenced the theoretical construction of sexual and reproductive rights. These include processes of industrialization, demographic and development aspects, and feminist discourse that influenced the general theory of human rights and emphasized women's needs, as is reflected in the Convention on the Elimination of All Forms of Discrimination Against Women (UN, 1979), the Action Plans of the Third International Conference on Population and Development (Cairo, 1994), and the Fourth World Conference on Women (Beijing, 1995).

The demographic aspect was marked by excessive population growth in the 1950s, which generated international concern and led to the adoption of measures to reduce birth rates.

In reply to these demographic concerns, the General Assembly of the United Nations (1966) declared that: "The size of the family should be the free choice of each individual family" (Resolution XXI).

Two years later, the International Conference on Human Rights was held in Teheran, Iran, to commemorate the twentieth anniversary of the Declaration, where participants declared: "Parents have a basic human right to determine freely and responsibly the number and spacing of their children" (Article 16).

Nonetheless, it was not until 1974 that this right was expanded to include couples and individuals. This enabled the decision of whether or not to have children to be considered as a personal prerogative and to approach other human rights.

At this conference, tensions grew between developing and developed countries with respect to the population-development link. The right to reproductive choice, established in Teheran, was reaffirmed and expanded in two ways: by mentioning that it is a right of individuals, not of couples; and also by determining that the State should play an active role in safeguarding this right, pointing out that people should have the means, education and information to put it into practice. In addition, the concept of “responsibility” was defined.

Ten years later, in 1984, the International Conference on Population, held in Mexico, reiterated that family planning “is a basic human right of all couples and individuals.” This conference advanced the definition of the term “responsibility,” urging individuals and couples to exercise their reproductive rights, taking into account their own situation and the implications of their decisions on the balanced development of their children, the community and the society in which they live (UN, 1984, Recommendation 26).

Participants maintained that, while this right is generally accepted, many couples and individuals are not able to exercise it because they lack information, education and access to an appropriate range of methods and complementary services. It is the responsibility of governments to guarantee the exercise of this right and to provide the information, education and services necessary for this to happen (UN, 1984, Recommendation 30).

Thus, so far, the concerns of States about the issue of population were clearly demographic.

Bearing in mind the above history, the conceptual and legal framework of sexual and reproductive rights today consists basically of five documents:

1. The Convention on the Elimination of All Forms of Discrimination Against Women, which emphasizes the right to equal opportunities for men and women. It refers to the human right to family planning as a component of the right to health, insisting on the need to eliminate discriminations against women that make their health care more difficult, and emphasizing the State’s obligation to offer women information, counseling and services to control their own fertility (Articles 11, 12, 14 and 16).
2. The document of the Vienna Conference on Human Rights (1993), which states that women’s rights are an integral and inalienable part of human rights. This led to the inclusion of sexual and reproductive rights at the Third International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995).
3. At the 1994 International Conference on Population and Development, held in Cairo, reproductive rights were defined, pivoting around individuals’ well being. Governments committed to eliminating all social, economic, and political inequalities that affect women as an indispensable requirement for exercising reproductive rights.

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Reproductive rights were defined in the context of the comprehensiveness and control over one's own body, thus:

“Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents:

- the basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so;
- the right to attain the highest standard of sexual and reproductive health;
- the right to make decisions concerning reproduction free of discrimination, coercion and violence.”

4. At the Fourth World Conference on Women, held in Beijing in 1995, this definition of sexual rights was expanded. Although this concept does not appear in the Platform for Action, governments used the term in the declarations of the closing session with the following scope:

“Sexual rights include the human right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.”

5. In addition, in 1994, the Organization of American States approved the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women, which consecrates the right of all women to lead a life free of violence. This instrument defines violence against women as “... any gender-based action or conduct that causes death or physical, sexual or psychological damage or suffering to women, either publicly or privately.”

In the context of these definitions, the following rights are instrumental in the field of sexuality and reproduction:

- The right to life
- The right to freedom
- The right to equality and to be free from all forms of discrimination
- The right to privacy and confidentiality
- The right to freedom of thought
- The right to appropriate and timely information
- The right to choose whether or not to marry, and to found and plan a family, and the right to decide the number and spacing of children
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to freedom of assembly and political participation
- The right to be free from torture and ill treatment

International attention given to sexual and reproductive rights is important to the daily life of women, because their reconceptualization represents the certainty that there will never be true equality as long as women cannot control their own bodies and fertility.

These advances provide us with tools to empower women, with their full participation and with the responsibilities of States to create conditions that allow the exercise of their rights.



CASE STUDIES ON RIGHTS VIOLATIONS

**CASE 1**

Elda, a 21-year-old woman, is in her fourth pregnancy, an outcome of a union arranged by her parents and husband while she was a minor. During her previous pregnancy, she asked the hospital doctors to help her prevent such frequent pregnancies with so little spacing (the first was born when Elda had barely turned 17); the doctors told her that they would only do this at her husband's request. When she returned for a prenatal visit, she asked for the same help once again, and the reply was the same. Elda does not know how to ask her husband and she is afraid of him finding out her wishes.

Choose a reporter who will document the group's main conclusions and present them on a flipchart.

1. Identify the rights that have been violated.

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2. What is the impact of this violation on sexual and reproductive health?

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CASE 2

Juan and Maria, both adults, married, with children, are dissatisfied because, after a year of requesting contraceptive surgery services for one of them, they were offered an intrauterine device at the public hospital where they usually go. The staff claimed that the hospital does not deliver those services to people who are so young and have so few children.

Choose a reporter who will document the group's main conclusions and present them on a flipchart.

1. Identify the rights that have been violated.

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2. What is the impact of this violation on sexual and reproductive health?

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**CASE 3**

Upon returning from her honeymoon, Martha was informed by the renowned service company where she works that her contract expires in 90 days, and that it is complying with the terms of legal advance notice. When Martha asked why, the reply was only that they were observing one of the clauses in the contract. Martha is one month pregnant.

Choose a reporter who will document the group's main conclusions and present them on a flipchart.

1. Identify the rights that have been violated.

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2. What is the impact of this violation on sexual and reproductive health?

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CASE 4

Alba is a 13-year-old girl whose 20-year-old boyfriend convinced her to have sexual relations. A few months later, she was pregnant. Her boyfriend says that she gave herself to him as she has done with many other men, and that he is not the father. Alba's family treats her poorly for what she did, and say that she is worthless.

Choose a reporter who will document the group's main conclusions and present them on a flipchart.

1. Identify the rights that have been violated.

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2. What is the impact of this violation on sexual and reproductive health?

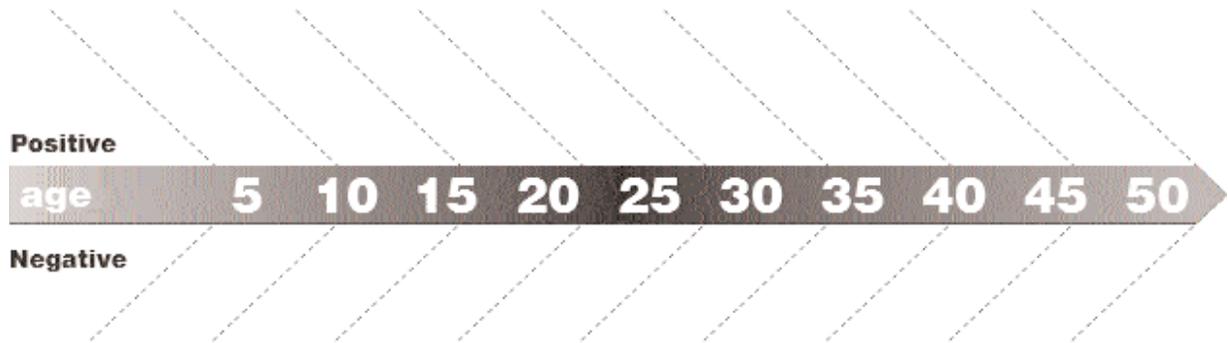
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## REFLECTION TOOL ON THE LIFELINE<sup>30</sup>

Participants analyze all factors that contributed to each stage of life to reach the situation they have developed. Discuss both positive and negative influences. Write down positive influences above the lifeline and negative ones below. Symbols, words or drawings may be used.



When they have completed the lifeline history, ask them to answer the following questions on another sheet of the flipchart.

- What circumstances and situations placed the person at risk?
- How does being a man or woman influence the ability to increase or decrease the risk?
- What situations and circumstances allowed the person to develop his or her capacity to face risks?
- What sexual and reproductive rights were violated in this case?
- What characteristics, skills and services can help individuals like the ones described in the lifeline history face situations of risk throughout their life cycle?

<sup>30</sup> De Bruyn M and France N, *Gender or Sex: Who Cares? Skills-Building Resource Pack on Gender and Reproductive Health for Adolescents and Youth Workers*, Chapel Hill: Ipas, 2001.



### HOW DOES GENDER AFFECT SEXUAL AND REPRODUCTIVE HEALTH?

Gender, as a historic and cultural construct of what it means to be a woman or a man in a particular society, is a fundamental health component because:

“There are important differences between women and men with respect to their needs, problems and access to health resources, as well as with respect to mortality and morbidity. These disparities stem not only from the distinctive biological characteristics of each sex, but also from the social guidelines that regulate gender relations.”<sup>31</sup>

#### GENDER APPROACH TO HEALTH CARE<sup>32</sup>

**Explains** how social constructs of masculinity and femininity influence health-disease-care processes and produce different processes of male and female participation in health-related issues.

**Means** exposing advantages or disadvantages between women and men to maintain health, become ill or die from preventable causes.

**Shows** that there are significant and important differences between women and men, both in mortality and morbidity, that stem not only from the distinctive biological characteristics of each sex, but also from the social guidelines that regulate gender relations.

**Makes visible** equity or inequity in the distribution of health care resources.

Sexual and reproductive health is an integral part of women and men’s health. It has been defined by the International Conference on Population and Development, Cairo, 1994, as:

“A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes ... [This] implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce, and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth...”

<sup>31</sup> Gómez E, *La salud y las mujeres en América Latina y el Caribe: viejos problemas y nuevos enfoques*, Santiago de Chile: CEPAL, 1997 (p. 5).

<sup>32</sup> Based on: Pabón ML, *Planes Locales de Salud con Equidad de Género, Bogotá: Proyecto Proequidad: Dirección Nacional para la Equidad de las Mujeres/GTZ*, 2000.

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“Sexual and reproductive health includes the enjoyment of sexual and reproductive human rights that ensure and enhance it, while the exercise of rights implies sexual freedom, that is, the capacity, full awareness, knowledge, will and responsibility of the exercise of sexuality and reproduction.”<sup>33</sup>

In sexual and reproductive health, disadvantages or advantages stemming from gender are expressed in relation to the likelihood of acquiring preventable diseases or of dying as a result of these. They are also expressed with respect to social, economic, cultural and subjective life conditions that generate greater vulnerability for women and are relative to the possibility of accessing high-quality health care services.

Examples of differences in the incidence of problems related to sexual and reproductive health conditions among men and women include:

- Morbidity and mortality associated with reproduction is a price that primarily women have to pay, despite their causes being preventable in the majority of cases. Prostate problems, on the other hand, are the result of lifestyles of a consumer society and values of masculinity that inhibit preventive care.
- The different types of sexual violence are more prevalent among women during their life cycle. Among men, there are higher rates of violent deaths resulting from accidents, homicide and involvement in armed conflict.
- Risk factors related to HIV/AIDS are different for women and men. The difference in prevalence rates has decreased due to the incidence of sociocultural factors among women, including insufficient information about means of protection, difficulty in accessing methods, little autonomy in negotiating with a partner about the use of condoms, the belief that HIV is an infection contracted by homosexuals, and that in a stable relationship there is no need to use condoms.
- Fertility regulation continues to be a responsibility that falls almost exclusively on women, since men's use of contraceptive methods (use of condoms and vasectomy) is still in the initial stages. Family planning programs reinforce this situation.

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<sup>33</sup> Londoño A, Promoción de los derechos humanos, sexuales y reproductivos. Módulos pedagógicos para formadores, Bogotá: Consejería Presidencial para los Derechos Humanos, 1999 (module 1, p. 12).

## SESSION 5: GENDER-BASED VIOLENCE

### OBJECTIVES

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

- Define and identify various types of gender-based violence.
- Identify the repercussions of violence on sexual and reproductive health.
- Take steps to prevent, detect and manage gender-based violence as strategies to improve quality of care.
- Recognize that violence is an issue that presents itself in different ways throughout a person's life cycle that has repercussions on sexual and reproductive health, and that constitutes a problem in terms both of public health and human rights violations.

DAY 3 TIME: 3 hours, 35 minutes

### PREPARATION

- Session 5 objectives printed on a flipchart
- Flipchart presenting the WHO definition of gender-based violence Handout 5A and 5B
- Flipchart presenting Handout 5D
- Flipchart presenting Handout 5F

### MATERIALS

- Flipcharts, markers, tape
- Colored cards
- Copies of handouts for participants
- Two copies of the Session Evaluation Form, found in the beginning of this manual

### HANDOUTS

- 5A: Definition of Gender-Based Violence
- 5B: Types of Gender-Based Violence
- 5C: Cases of Gender-Based Violence
- 5D: Repercussions of Gender-Based Violence on Sexual and Reproductive Health
- 5E: Reflection Tool on Prevention, Detection and Management of Gender-Based Violence
- 5F: Prevention, Detection, Protection and Management of Gender-Based Violence
- 6A: International Normative Framework: Sexual and Reproductive Rights (read for Session 6)
- 6B: Definition of the Different International Human Rights Instruments (read for Session 6)
- Session Evaluation Form



#### NOTE TO THE TRAINER

- Give copies of Handouts 6A: International Normative Framework: Sexual and Reproductive Rights and 6B: Definition of the Different International Human Rights Instruments to participants **by the end of this session. Remind them to read these documents before tomorrow's session.**

#### STEP 1 (55 minutes)

##### DEFINITION AND TYPES OF GENDER-BASED VIOLENCE DURING A LIFE CYCLE

- Invite the reporters to present the main ideas of the topics discussed the previous day.
- Hand each participant a card and ask them to define gender-based violence in one brief sentence. Allow five minutes for this exercise.
- Organize groups of three and give them 15 minutes to develop one definition. Each group should record their agreed-upon definition on a flipchart.
- In a plenary session, ask each group to present its definition of gender-based violence.
- Put up the WHO definition of gender-based violence.
- Ask participants to share reflections on the definition.
  - Is it similar to how they defined it in their groups?
  - Do they feel that this definition is relevant to the groups that they work with?
- If time permits, ask for volunteers to read one bullet point each under “Elements that help to understand gender-based violence include ...” (Handout 5A: Definition of Gender-Based Violence)
- Ask two or three volunteers to share reflections on this.
- Use Handouts 5A: Definition of Gender-Based Violence and 5B: Types of Gender-Based Violence as support.
- Emphasize that gender-based violence is a human rights violation and that there is no justification for it.

#### STEP 2 (50 minutes)

##### REPERCUSSIONS OF GENDER-BASED VIOLENCE ON SEXUAL AND REPRODUCTIVE HEALTH

- Divide participants into four small groups and give each one a case from Handout 5C: Cases of Gender-Based Violence.
- Using their case study, ask them to discuss the repercussions of violence on sexual and reproductive health.
- Hand each group a flipchart and markers to record their discussions.
- Ask each group to present its case study and discussion to the large group.
- Note significant points on one flipchart, listing the repercussions of gender-based violence on sexual and reproductive health.

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- Present Handout 5D: Repercussions of Gender-Based Violence on Sexual and Reproductive Health. Give copies of the handout to the participants.
  - Encourage participants to share thoughts or reflections they may have on the repercussions of gender-based violence.



#### TALKING POINTS FOR THE TRAINER

If it has not already been mentioned in the discussions, emphasize that gender-based violence is a public health problem due to:

- its high prevalence
- its serious health consequences

Gender-based violence is preventable

#### STEP 3 (1 hour, 10 minutes)

##### PREVENTION, DETECTION AND MANAGEMENT OF GENDER-BASED VIOLENCE AS STRATEGIES TO IMPROVE QUALITY OF CARE

- After reviewing the case studies, ask participants to come up with relevant examples from their communities How do community members receive care for their sexual and reproductive health?
- Encourage three participants to share positive experiences in receiving care with the group. Ask three other individuals to share negative examples with health care.
- Organize groups of four or five participants and ask them to discuss and identify actions for the prevention, detection and management of gender-based violence that can be implemented within their institutions. Give them Handout 5E: Reflection Tool on Prevention, Detection and Management of Gender-Based Violence to use as a guide.
- In a plenary session, ask the groups to present the results of their discussions.
- Encourage any personal observations or reflections that the participants may want to share.

#### STEP 4 (30 minutes)

##### ACTIONS FOR THE PREVENTION, DETECTION AND MANAGEMENT OF GENDER-BASED VIOLENCE

- Put up three blank flipcharts.
- At the top of the first one, write “Actions for Prevention of Gender-Based Violence”.
- On the second, write “Actions for Detection of Gender-Based Violence”.
- On the third, write “Actions for Management of Gender-Based Violence”.
- Ask participants to come up and write one or two ‘actions’ under each title.
- Then, ask them to read what everyone has written and put a check mark on each flipchart next to the two actions that they agree with the most.
- Read aloud and write, on a new flipchart, the actions for each category that have the most votes.

- 
- Give participants Handout 5F: Prevention, Detection, Protection and Management of Gender-Based Violence
  - Lead a discussion on how actions for the prevention, detection and management of gender-based violence can be implemented at the sexual and reproductive health service delivery sites to improve the quality of care.
  - Encourage participants to draw upon their own experiences in their work place.
  - Close the session reiterating that in providing assistance to victims of violence, one must include elements of empowerment, dignity and partnerships with other agencies or women's groups involved in this issue.



#### NOTE TO THE TRAINER

- It is important for you to share some key aspects of your institution's experience with the prevention, detection and management of gender-based violence.

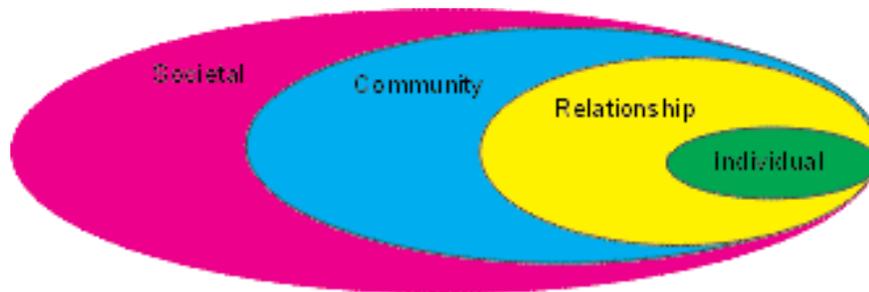
#### STEP 5 (10 minutes)

##### EVALUATION

- Remind the participants to add learning in their action plan which they started in session Three. Give each participant two copies of the Session Evaluation Form, found in the beginning of this manual.

## DEFINITION OF GENDER-BASED VIOLENCE

Defining violence, given its multiple causes, cultural notions and social values, is not an easy task. It can be approached from different research perspectives: biological, psychological and cultural, among others. Bearing in mind this complexity and the interaction of biological, psychological, social, cultural, economic and political factors, the World Health Organization (WHO) resorts to an ecological model to try to understand it.<sup>34</sup>



At the first level in the model is the individual, with her/his biological and personal history factors. The second level looks at close relationships, such as those with family, friends and intimate partners, in which an individual is immersed and which affect her/his life. The third level explores the community contexts, in which social relationships occur, such as schools, workplaces, and neighborhoods; residential mobility; population density; levels of unemployment; or the existence of drug trafficking and consumption. The fourth level includes factors related to social and cultural norms, societal ideologies, symbolism, notions about identities, social and economic policies that help to maintain inequalities, etc. These interactions are related to situations of violence and must be taken into consideration in developing actions to prevent it.

WHO defines violence as:

“The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation ... that compromises the well-being of individuals, families and communities.”

Violence affects the entire general population. However, women, adolescent females and girls are more vulnerable and at higher risk than the rest of the population, due to the existence of norms, beliefs, and socioeconomic and political positions that rule society and that subordinate, undervalue and discriminate against them. This situation is known as gender-based violence.

<sup>34</sup> Pan-American Health Organization (PAHO) / World Health Organization (WHO), *World Report on Violence and Health: Summary*, Washington D.C.: PAHO/WHO, 2002, (pp. 10-12).

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The Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women, held in Belém do Pará, defines violence against women as:

“Any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or private sphere” (Article 1).

The Declaration on the Elimination of Violence against Women defines violence against women as:

“Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (Article 1).

“Violence against women shall be understood to encompass, but not be limited to, the following:

#### NUMBERS ILLUSTRATING THE MAGNITUDE OF GENDER-BASED VIOLENCE IN THE WORLD

- Males accounted for three quarters of all victims of homicide.
- Suicide rates tend to increase with age for both men and women. The highest rates of suicide were found among men aged 60 years and older.
- In low to middle-income countries, rates of violent death are more than twice as high as those in high-income countries.
- In 48 countries, it was found that 10% to 69% of women had been physically assaulted by an intimate partner.
- Around the world, the events that trigger violence against women in abusive relationships, perpetrated by their intimate partners, are remarkably consistent. They include disobeying or arguing with the man, questioning him about money or girlfriends, not having food ready on time or not preparing it to the man’s satisfaction, not caring adequately for the children or the home, refusing to have sex, and the man suspecting the woman of infidelity.
- Approximately 20% of women and 5% to 10% of men have suffered sexual abuse as children.
- In most countries, boys are the victims of physical violence more often than girls, while girls are at higher risk of infanticide, neglect, sexual abuse and being forced into prostitution.
- Between 4% and 6% of elderly people experience some form of violence in the home.
- In patriarchal cultures, elderly women are at higher risk of being abandoned when they are widowed and of having their property seized.
- Estimates of the number of women raped by soldiers during the conflict in Bosnia and Herzegovina range from 10,000 to 60,000.

- a. Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence, and violence related to exploitation;
- b. Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- c. Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs" (Article 2).

Elements that help to understand gender-based violence include:

- Gender-based violence is an exercise of power that limits, negates or violates the human rights to life, equality, liberty and dignity of individuals.
- Gender-based violence is a public health problem.
- As an expression of power, it is based on relations of domination over, subordination of and discrimination against women.
- It is a manifestation of historical and cultural inequalities in gender relations and age.
- Its objective is the control, domination, coercion, manipulation and negation of the other.
- Gender-based violence is learned, not inherent.
- Gender-based violence can be physical, sexual, psychological, symbolic, economic, political or social.
- Gender-based violence can take place in different spheres, including the streets, workplaces, homes, hospitals, schools, churches, military or other institutions.
- Gender-based violence can be perpetrated in any of the diverse types of interpersonal relations: educator/student, mother/daughter, physician/patient, parent/adolescent, husband/wife, boss/employee, police/citizen.
- Domestic violence, or violence occurring within the family, includes violence against intimate partners, child abuse, violence between siblings, violence of children towards their parents, and abuse of the elderly. This form of violence, while recognized as a public health problem and a threat against individuals' human rights, still persists as a problem in the private sphere, hidden from public view.



### TYPES OF GENDER-BASED VIOLENCE

The different forms of violence-physical, psychological or sexual-can occur both in the public and the private spheres, and be perpetrated by State agents or individuals. In any form, violence constitutes a violation of human rights.

**PHYSICAL VIOLENCE** can be understood as a “form of aggression produced by the application of non-accidental physical force, characterized by variable injuries to the body of the person assaulted, with mild or serious consequences, including death, but that always has traumatic effects, be they psychological or emotional, since it is generated with a specific intent.”<sup>35</sup> Physical violence is expressed in diverse ways: “It may be manifested by slapping on the face, pushing, kicking, and even using objects, such as belts, cigarettes, knives, sticks and machetes ...”<sup>36</sup> Some of the consequences of this form of violence can be: pain, injuries, bruises, fractures, cuts, burns, loss of organs or of their function, mutilations, abortions, or even death. In addition, the health consequences may not be perceptible at first sight, including headaches, gastrointestinal diseases such as ulcers and gastritis, generalized fatigue, depression, and eating or sleeping disorders. Physical aggressions also have implications on mental health, such as fear, fright, anguish, low self-esteem, and reduction of autonomy, decrease in work productivity and in educational performance. It is important to note that violence produces elevated costs to the State, both to the health and the judicial systems.

**PSYCHOLOGICAL VIOLENCE** “refers to all types of aggression towards emotional life, which generates multiple emotional conflicts, frustrations and traumas, either temporary or permanent” and is expressed in three ways: as verbal aggression (humiliation, shouting, insults, ridicule, threats, denigration), “through body language: exaggerated manifestations and permanent looks of dissatisfaction, rejection or mockery; absence of expressions of affection, exclusion and isolation”, and through emotional blackmail.<sup>37</sup>

The gravest consequences of psychological violence on mental health are: low self-esteem, depression, little autonomy, anxiety, suicide or attempts of suicide, eating or sleeping disorders, fear and fright. It also has effects on physical health that cannot be perceived at a glance, such as those mentioned previously.

According to Londoño (1999:39), sexual violence is defined as any act or omission that infringes on sexual or reproductive human rights, aimed at maintaining or soliciting sexual, physical or verbal contact, or at engaging in sexual interactions by means of force or the threat of force, intimidation, coercion, blackmail, inappropriate pressure, bribery, manipulation or any other mechanism that nullifies or limits the victim’s will to decide about sexuality and reproduction.

Sexual violence, according to PAHO (2002:21), “comprises a wide range of acts, including coerced sex within marriage, date rape, rapes perpetrated by strangers, systematic rapes during armed conflicts, sexual harassment (including soliciting sexual favors in exchange for work or school grades), sexual abuse of minors, forced prostitution and trafficking in individuals, early marriage and violent acts against women’s sexual integrity, such as genital mutilation and mandatory virginity inspections. Both men and women can suffer rape while they are detained or imprisoned.”

<sup>35</sup> Vargas E, *Norma para el diagnóstico y atención integral de mujer maltratada*, Bogotá: Ministerio de Salud, 1999 (p. 3).

<sup>36</sup> Defensoría del Pueblo, *Mecanismos de protección de la mujer víctima de la violencia intrafamiliar y sexual*, Bogotá: 1995 (p. 7).

<sup>37</sup> Vargas 1999 (pp. 7-8).

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The primary victims of sexual violence are women, girls and boys. Sexual violence in couples “consists of forcing the spouse or partner to have sexual relations by means of force, blackmail related to the children or to financial support; using phrases directed towards demeaning her sexual honor and dignity; imposing certain sexual behaviors, and at the same time, not knowing her sexual needs and proposals.”<sup>38</sup> Rape in public places, medical centers, and in the context of armed conflict is, in the majority of cases, perpetrated against women. Women and girls are the typical victims of sexual harassment in educational centers and in the workplace.

In most cases, the different types of sexual violence against girls and boys – “incest, rape, molestation or touching a boy or girl with or without clothes, encouraging or allowing a boy or girl to touch a male or female adult inappropriately, and sexual abuse without physical contact; verbal seduction, indecent proposals, performing sexual acts in the presence of boys or girls, masturbation, pornography, exhibition of the genitals or sexual acts to obtain sexual gratification by spying on them while they get dressed, bathe or wash themselves”<sup>39</sup> – are committed by someone known to the child, such as the father, stepfather, uncle, friends, neighbors, teachers or priests.

While the incidence of sexual violence is greater among women, girls and boys, the occurrence of rape of adolescent or adult males is not uncommon on the streets, in prison centers and in the army, among others.

Sexual violence has adverse effects on health: depression, low self-esteem, insecurity, fear, fright, sleeping disorders, problems in establishing healthy interpersonal and sexual relationships, and adequate functioning in social life, are some of the consequences on individuals' emotional health. Other consequences include: transmission of HIV and other sexually transmitted infections, unplanned pregnancies, suicide, the abuse of substances such as alcohol, and a tendency towards risky behavior such as unprotected sex and becoming pregnant. Children who are sexually assaulted during childhood are more likely to become rapists. Boys and girls who are sexually abused are more likely to enter prostitution.

As Londoño states (1999:47), sexual violence “opposes the right to enjoy a sexual and reproductive life that is pleasurable, healthy and risk-free, which is a substantial aspect of health, quality of life, and free development of the personality.”

In some societies, different types of violence are often perpetrated against individuals whose sexual orientation is not heterosexuality.

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<sup>38</sup> Defensoría del Pueblo 1995 (p. 8).

### CASES OF GENDER-BASED VIOLENCE

#### CASE 1

ROSA and JUAN have been living together in common union for more than ten years; as a result, they have two daughters. Rosa comments that everything was going well until her partner found out that she was pregnant again. From that moment on, he began abusing her physically, verbally and psychologically; he threatened to kill her if she gave birth to a girl. These aggressions would occur in front of their daughters.

Rosa looked for work in spite of her pregnancy because her partner was not fulfilling his economic obligations and spends every weekend drinking.

After the childbirth, which produced another girl, the situation for Rosa became even worse. Juan would beat her, humiliate her, and kick up a fuss in public, until one day he left the house. However, he continued abusing her and one day he even attacked her on the street and beat her. He also forced her to have sex with him in front of one of the girls.

Due to these problems, Rosa has no control of her sphincter. The physician has told Rosa that she should also seek psychological treatment for her daughters.

#### Discussion Questions for Case 1

1. What are the repercussions of violence on Rosa's sexual and reproductive health care?
2. What is the impact of gender-based violence on her children?
3. Identify actions for prevention, detection and management for gender-based violence in this situation.

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## CASE 2

From the age of ten, MATILDE had been sexually abused by her stepfather. As a result of this abuse, she became pregnant when she was 16 years old and died during labor in a small hospital in the city where she lived. The physician who treated her had no doubts that it was a typical case of hemorrhage before childbirth due to placenta previa. He looked up the code in the international classification of diseases and filed the clinical history.

The truth was not fully stated, and others searched for better answers. Obstetricians have a committee that confidentially investigates the causes of maternal deaths, according to the patterns developed by the Federation of Obstetrics and Gynecology. The committee thoroughly examined the clinical history, and the case was reopened.

In the history, the committee discovered two crucial points: The first was that, despite the fact that Matilde had been admitted to the hospital with bleeding, she only received 500 cc of blood, which was the only blood available at the facility, a quantity insufficient to compensate her loss. The second was that she needed a c-section and this was performed late, resulting in her death. The committee concluded that Matilde's death was preventable.

### Discussion Questions for Case 2

1. What are the repercussions of violence on Matilde's sexual and reproductive health care?
2. Identify actions for prevention, detection and management for gender-based violence in this situation.
3. How can we involve men in a positive way to improve the situation?

**CASE 3**

ALFONSITO, as he is affectionately called at the nursing home, is very ill because he has suffered from prostate problems for many years. Due to his lack of resources, he was never able to seek and obtain adequate medical treatment. In addition, he felt embarrassed to tell people about his problem because he thought that he would lose his virility. Today, his health is deteriorating.

The problem gets worse, since his nephew, who was the only one paying Alfonsito's monthly bills at the nursing home, passed away fifteen days ago.

The management at the nursing home has tried to locate his sons and has contacted two of them, who have outright refused to help him or to pay for his care, talking about "that old man" in an insulting, derogatory manner.

The institution has decided that Alfonsito must leave the home. They have to evict him for financial reasons, and have informed him that he needs to find another place.

One of his peers at the nursing home, seeing that Alfonsito was very sick, took him to a health center, where they refused to treat him because he had no financial resources.

**Discussion Questions for Case 3**

1. What are the repercussions of violence on Alfonsito's health care?
2. What can we do to involve his family in a positive way?
3. Identify actions for prevention, detection and management for violence in this situation.

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#### CASE 4

ADRIANA, in her anguish, writes the following letter to JULIA:

Dear Julia:

Warm greetings! I hope you and your family are well.

As for me, everything continues as always, but now the situation has worsened. Since we don't have enough money, I have had to work extra hours at the factory to help out more with the bills, and Eduardo kicks up a fuss because I get home late. The other day I was not able to iron his clothes; he became infuriated, hit me and threw the iron at me.

Fortunately, I got out of the way in time because it could have burned me. I thought that once the baby was born, things would improve, but no. What's worse, he doesn't approve of family planning. He says that I do it so I can go out with other men, and that if I'm not good for being a mother, what good am I? We were able to buy a television set, but I never watch TV because I have no time. With washing clothes, ironing, making the bed, nursing the baby, when am I going to have time for myself?

Eduardo continues drinking alcohol; now he hangs out with a group of friends and plays soccer every Sunday morning. It's a relief to be left alone for a while, but then he comes home for lunch, and if it's not ready, he makes a racket.

At least things are going well at the factory. They appreciate me very much because they say that I'm a hard worker. The other day, they threw a party for the whole staff, but Eduardo did not let me go because he didn't want me to leave the children alone. He's the boss! My coworkers told me it was a good party. At work, I have to struggle to do things well because I feel tired, sad, without hope. Sometimes I feel like running away. I think that life is not worth living, but then I think about my children and my home, and I keep going because, what if, on top of everything, I were to lose my job?

What's more, lately I have felt this pain in my pelvis. Today I'm going to get the lab results. Based on what the female physician told me, I have a feeling that I might have a venereal disease. Well, I won't burden you any more with my problems. Receive many kisses from your friend who loves you and remembers you fondly.

#### DISCUSSION QUESTIONS FOR CASE 4

1. What are the repercussions of violence on Adriana's sexual and reproductive health?
2. Identify actions for prevention, detection and management for gender-based violence in this situation.

### THE REPERCUSSIONS OF GENDER-BASED VIOLENCE ON SEXUAL AND REPRODUCTIVE HEALTH<sup>40</sup>

Physical, sexual and psychological violence has serious effects on women's sexual and reproductive health: unwanted pregnancies, HIV and other sexually transmitted infections, pregnancy complications and other gynecological problems.

#### 1. SEXUAL AUTONOMY AND UNWANTED PREGNANCIES

Cultural notions about marriage, sexuality and feminine and masculine identities result in many women developing little sexual autonomy and often being powerless to refuse unwanted sex or negotiate the use of contraceptive methods, which leaves them at risk of having unwanted pregnancies. Numerous studies have found that violence toward women is more common in families with many children, establishing the assumption that having many children contributes to increasing women's risk of being abused. Recent research in Nicaragua, however, suggests that the relationship may be the reverse, with domestic violence increasing the likelihood that a woman will have many children.

**CONTRACEPTIVE USE:** Many women are afraid to raise the issue of contraception for fear that their husbands might react violently or that they will abandon them. Cultural factors make men associate the use of contraceptive methods with the woman's infidelity and with a loss of control over her.

#### 2. VIOLENCE LEADS TO HIGH-RISK SEXUAL BEHAVIOR

Girls and boys who have been sexually abused often engage in sexual behavior, as adolescents and as adults, that puts them at risk of unintended pregnancies and sexually transmitted infections.

**ADOLESCENT PREGNANCIES:** Many studies have found that victims of sexual abuse in childhood appear more likely than other teens to become pregnant in adolescence, become sexually active at an earlier age, use drugs and alcohol, have more sexual partners, and use fewer contraceptive methods. A study in the United States found that sexual, psychological or physical abuse in childhood increases the likelihood of adult women having unintended pregnancies.

**SEXUALLY TRANSMITTED INFECTIONS (STIs), INCLUDING HIV/AIDS:** Several research studies have shown that sexual abuse in childhood increases the risk of STIs among adults, largely through its effect on high-risk sexual behavior. One research study found that women who reported physical and sexual abuse by a partner were more than twice as likely as other women to have experienced STIs.

<sup>40</sup> Based on: Population Information Program, Center for Communication Programs, Johns Hopkins University School of Public Health, *Population Reports. Ending Violence against Women*, 27(4), 1999.

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### 3. VIOLENCE COMPROMISES HIV PROTECTION

**CONDOM NEGOTIATION:** Violence influences the risk of HIV and other STIs directly when it interferes with women's ability to negotiate condom use. Some cultural beliefs result in the use of condoms being associated with promiscuity, infidelity and prostitution, which makes it harder for women to negotiate their use, especially if it is within marriage or a stable relationship.

**VOLUNTARY COUNSELING AND TESTING:** In some places, women's fear of men's reaction has kept them away from voluntary HIV/AIDS counseling and testing. Many women do not notify their partners of the test results for fear that they will react violently.

**REDUCING PERINATAL TRANSMISSION:** Women's fear of intimate partner violence is an obstacle to the use of treatments to reduce mother-to-child transmission of HIV.

### 4. VIOLENCE LEADS TO HIGH-RISK PREGNANCIES

Around the world, as many as one woman in every four is physically or sexually abused during pregnancy, usually by her partner.

**OBSTETRIC RISK FACTORS:** Many studies have established that pregnant women who have experienced violence are more likely to delay seeking prenatal care and to gain insufficient weight. They also are more likely to have a history of STIs, unwanted pregnancies, vaginal, cervical and renal infections, and bleeding during pregnancy.

**ADVERSE PREGNANCY OUTCOMES:** Violence during pregnancy has been linked to different health problems, including risk of spontaneous and induced abortions, premature labor, fetal distress, low birth weight and gravimetric insufficiency of the newborn baby. Several explanations have been suggested for the effects of violence on pregnancies, such as abdominal trauma, extreme stress and anxiety provoked by violence in pregnancy, and an increase in women's likelihood of engaging in harmful health behaviors.

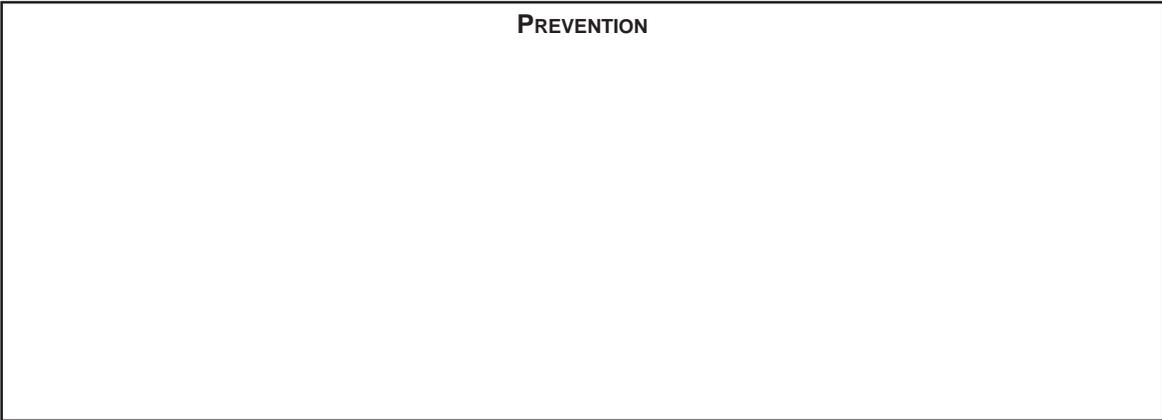
### 5. VIOLENCE INCREASES RISKS FOR OTHER GYNECOLOGICAL PROBLEMS

Childhood sexual abuse and/or physical or sexual abuse by an intimate partner increases women's likelihood of developing many gynecological disorders, including chronic pelvic pain, irregular vaginal bleeding, vaginal discharge, painful menstruation, pelvic inflammatory disease, sexual dysfunction and premenstrual distress.

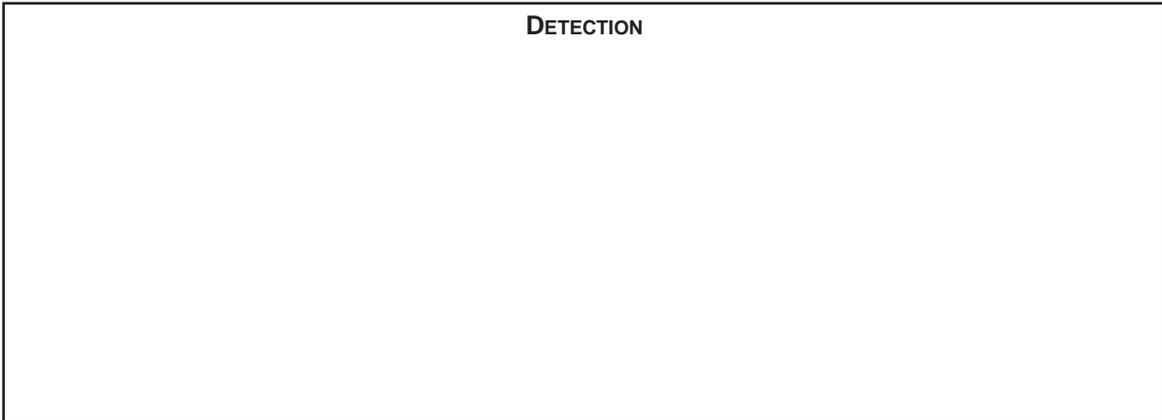
REFLECTION TOOL ON PREVENTION, DETECTION, AND MANAGEMENT OF GENDER-BASED VIOLENCE

Reflect on the actions that can be taken at your institutions and facilities to prevent, detect, and manage gender-based violence.

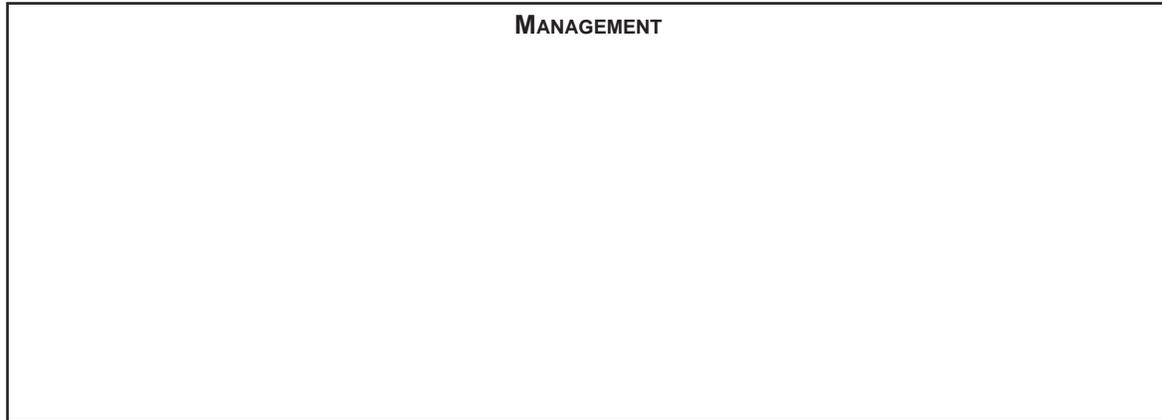
**PREVENTION**



**DETECTION**



**MANAGEMENT**





### PREVENTION, DETECTION, PROTECTION FROM AND MANAGEMENT OF VIOLENCE

“Health-care services, especially reproductive health care and family planning, are privileged settings that maintain permanent contact with women who are victims of violence. Health-care providers, early screeners and detectors of women who experience violence, could give initial information about existing legal and law enforcement services.”

At a general level, any organization working in the field of sexual and reproductive rights can support the development of action plans to promote the protection of women against all forms of violence and include in its own work plans actions to prevent, detect and manage cases of violence against women, girls, boys and men.

Preventive actions that sexual and reproductive services can take include:

- Develop posters and informational brochures about the existence of norms that sanction violence against women, boys and girls; the right to a life free of violence, services available, etc.
- Conduct workshops with groups of users about violence, its causes, consequences, dynamics, what to do, where to find support.
- Conduct workshops with groups of users about self-esteem, autonomy and human rights.
- Increase collaboration and exchange of information about violence prevention among international agencies, governments, researchers, networks and nongovernmental organizations involved in prevention.
- Promote and supervise compliance of international treaties with legislation and other mechanisms for protecting human rights.

Actions that sexual and reproductive services can take to detect violence include:

- Train Sexual and Reproductive Health staff on the signs and symptoms of physical, sexual, and psychological violence, taking into account gender and age.
- Establish information networks between civil society and the government to allow early detection of violence and its follow-up.
- Teach the population to recognize the different manifestations of violence.
- Promote campaigns to report acts of violence.

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Actions that sexual and reproductive services can take to protect against violence include:

- Provide information about protective services and organizations, as well as procedures, that can put an end to violent acts.
- Support government or civil society initiatives to create houses of refuge for victims of violence.
- Demand that governments and national health systems provide appropriate responses for protection of violated rights of victims in cases of violence.

Since violence is a problem with multiple causes, its management should take place in different settings: medical, psychological, legal and protective. Sexual and reproductive health services could take the following actions:

- Train health care, psychological care and legal service personnel on how to treat people in situations of violence.
- Design protocols for treating women.
- Include questions about the history of violence in clinical histories: type of violence, frequency, duration, perpetrator, consequences, actions taken.
- Conduct research on the incidence of violence among different populations and its consequences on capacity to work, in girls and boys, etc.
- Research existing country norms and their efficacy in implementation. If there are none, promote approval of laws that condemn violence, in partnership with human rights groups and government representatives who are sensitized to the topic.
- Research existing country laws and the effectiveness with which they are implemented. If there are none, or if they exist but are not implemented, promote approval of anti-violence laws in partnership with human rights groups and government representatives who are sensitized to the issue.

## SESSION 6: INTERNATIONAL NORMATIVE FRAMEWORK

### OBJECTIVES

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

- Understand various international instruments (ICPD, the Fourth World Conference on Women, CEDAW).
- Define Sexual and Reproductive Rights.
- Identify the important contributions of these international instruments in the exercise of Sexual and Reproductive Rights.

DAY 3 TIME: 2 hours, 10 minutes

### PREPARATION

- Session 6 objectives printed on a flipchart
- Give copies of Handouts 6A and 6B to participants at least one day before this session
- Candy, pencils or pens, if using, for the “Fishbowl” exercise

### MATERIALS

- Flipcharts, markers, tape
- Copies of Handouts for participants
- Two copies of the Session Evaluation Form, located in the beginning of this manual

### HANDOUTS

- 6A: International Normative Framework: Sexual and Reproductive Rights
- 6B: Definition of the Different International Human Rights Instruments
- 6C: Summaries of the Main International Instruments for Sexual and Reproductive Rights
- 6D: Central Aspects of United Nations Conferences on Sexual and Reproductive Health
- Session Evaluation Form

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## FACILITATING SESSION 6

### STEP 1 (30 minutes)

#### INTERNATIONAL INSTRUMENTS AND SEXUAL AND REPRODUCTIVE RIGHTS

- Introduce the objectives of the session.
- Conduct the “Fishbowl” activity as follows:
  - a. Request 8-10 volunteers to sit in a circle at the front or in the middle of the room.
  - b. Tell them that they will begin the activity by discussing a question that you will ask them about.
  - c. Request the rest of the group to sit outside the circle and observe the discussion in silence.
  - d. If someone outside the circle wishes to participate in the discussion, s/he must tap a participant quietly on the shoulder. The participant will then get up and let the other person take her/his place.



#### NOTE TO THE TRAINER

- Emphasize that participation in the discussion circle is purely voluntary.
- However, the more people who participate, the more interesting will be the discussion.
- Ideally, there should be slow, but steady, “traffic” in and out of the circle, with people changing every two or three minutes.
- Only people inside the circle can talk. If an observer wants to participate in the discussion, s/he will have to enter the circle.
- Offer a small incentive to people as they enter the circle, such as pencils, pens or candy. This also helps make the activity more fun.
- To keep the discussion flowing smoothly, you can write a few questions on separate cards and distribute them randomly to participants. Request them to discreetly ask their question at an opportune time.



#### TALKING POINTS FOR THE TRAINER

##### Sample Questions:

- What are the different international human rights instruments?
- Which ones are binding and which ones are non-binding?
- Which do you think has played the most important role in women's rights and reproductive rights (The historical process, CEDAW, ICPD, Beijing, etc.)? Why?
- How are policies designed? Do you have any suggestions that are not mentioned for how policies should be organized?

- 
- Let the discussion continue for about 20 minutes.
  - Wrap up by asking participants to share reflections, learnings and observations. Note significant observations on a flipchart.

### STEP 2 (60 minutes)

#### International Human Rights Instruments

- Divide participants into four small groups and ask each group to designate a reporter to take notes and present the group work to the large group.
- Give each group one of the summaries of Handout 6C: Summaries of the Main International Instruments for Sexual and Reproductive Rights:
  - a. CEDAW and the Optional Protocol
  - b. World Conference on Human Rights, Vienna
  - c. ICPD and ICPD+5
  - d. Beijing and Beijing+5
- Ask participants to:
  - Identify the most important contributions regarding sexual and reproductive rights made by each instrument.
  - Identify any similarities between these international instruments and participants' national constitution and laws in addressing Sexual and Reproductive Rights.
  - Identify the most important obstacles they face in their countries when attempting to implement the instruments and the national legislation concerning Sexual and Reproductive Rights.
- Instruct the groups to write down the main points of the discussion on a flipchart for the plenary session. Each reporter should present the group work in five minutes.

### STEP 3 (30 minutes)

#### Developing a Policy Document

- Ask the participants to get back into their groups (or form new ones).
- Ensure that each group has one of the summaries from the previous activity of the international instruments.
- Using Handout 6D: Central Aspects of United Nations Conferences on Sexual and Reproductive Health, ask each group to develop an outline for a policy document (bullet points) for a country that they choose, using the international instruments on implementation of sexual and reproductive rights.
- Ask the groups to write down their bullet points on a flipchart and to paste the flipcharts on a wall, creating a "gallery".
- Give them fifteen minutes for this. When they have finished, ask participants to read what each group as written.
- Take about five minutes to wrap up. Encourage one or two people to share observations on the activity.

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- Mention two or three of the most important contributions of the instruments discussed with regard to advocacy. Use those that are most relevant to your situation from Handout 6D: Central Aspects of United Nations Conferences on Sexual and Reproductive Health.

STEP 4 (10 minutes)

Evaluation

- Hand each person two copies of the Session Evaluation Form, found in the beginning of this manual.

## INTERNATIONAL NORMATIVE FRAMEWORK: SEXUAL AND REPRODUCTIVE RIGHTS

### Sexual and Reproductive Rights: International Normative Framework

Sexual and reproductive rights are a recent concept. They are human rights interpreted from the perspective of sexuality and reproduction.

#### Human Rights Systems

- Universal: The United Nations (UN)
- Regional: European, African, Asian, Inter-American
- OAS (Organization of American States)

#### Select Documents of the International Human Rights System

##### **Of a mandatory or binding nature:**

- a. Treaties/Conventions
- b. Covenants
- c. Protocols

These are laws of **higher nature** in a country.

##### **Non-binding:**

- a. Declarations
- b. Recommendations
- c. Observations
- d. Action Plans and Platforms for Action

*While these are not legally binding, they serve to support the design and formulation of policies and measure the level of compliance with commitments assumed by States.*

#### International Human Rights Standards

- a. Constitution
- b. Law
- c. Decree
- d. Resolution
- e. Circular

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## General Human Rights Framework

- Universal System: The UN (United Nations – [www.un.org](http://www.un.org))
- Universal Declaration of Human Rights, 1948
- Covenant on Civil and Political Rights; Covenant on Economic, Social and Cultural Rights, 1966
- Regional System: OAS (Organization of American States – [www.oas.org](http://www.oas.org))
- The Universal Declaration of Human Rights and the Duties of Citizens, 1948
- American Convention on Human Rights Pact of San José, 1969
- Covenant on Civil and Political Rights, 1988
- Covenant on Economic, Social and Cultural Rights, 1988

## History of Reproductive Rights

- “The size of the family should be the free choice of each individual family” (UN, 1966).
- “Parents have a basic human right to determine freely and responsibly the number and spacing of their children” (Human Rights Conference, Teheran, 1968).
- “All couples and individuals have a basic human right to decide...” (Conference on Population, Bucharest, 1974).
- “Family planning is a basic human right of all couples and individuals...” (Conference on Population, Mexico, 1984).

## Normative and Conceptual Framework of Women’s Rights, UN

Convention on the Elimination of All Forms of Discrimination Against Women, 1979 (CEDAW) Optional Protocol to CEDAW 1999.

World Conference on Human Rights, Vienna, 1993.

Third International Conference on Population and Development: Cairo, 1994 (ICPD).

Fourth World Conference on Women: Beijing, 1995.

Rome Statute of the International Criminal Court, 1998.

Convention on the Rights of the Child, 1989.

### 1. Convention on the Elimination of All Forms of Discrimination Against Women, 1979

Charter of Women’s Rights: Includes the commitment to eliminate all forms of discrimination against women.

#### CONVENTION ON WOMEN

- Article 12: Includes the commitment to eliminate all forms of discrimination against women.

## **2. World Conference on Human Rights: Vienna, 1993**

### **Vienna Declaration**

Recognized the rights of women and girls as an integral and indivisible part of human rights.

Reiterated that violence is the most insidious form of discrimination against women.

Appointed a Special Rapporteur on violence against women.

## **3. Third International Conference on Population and Development: Cairo, 1994**

The Plan of Action defined “Reproductive Rights” and “Reproductive Health.” The plan also set aside the demographic goals that characterized previous conferences and focused attention on the need to promote women’s empowerment, equality, equity and respect for reproductive rights as necessary premises to achieve reproductive health.

## **4. Fourth World Conference on Women: Beijing, 1995**

### **Beijing Platform for Action**

Defined “sexual rights” and “sexual health,” and highlighted strategic objectives and desirable goals for the true exercise of human rights of all women and girls in different walks of life.

#### **CAIRO AND BEIJING**

- When sexuality was separated from reproduction, the connection between sexual and reproductive health was completed.
- Indicated the guidelines to measure actions developed with the purpose of making women’s rights a reality.

## **5. Rome Statute of the International Criminal Court, 1998**

Visualized conducts (crimes), which directly affect women in situations of armed conflict:

- Systematic sexual rape
- Sexual slavery
- Trafficking in women
- Forced pregnancy
- Forced sterilization

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### Periodic Evaluations

- ICPD+5 and Beijing+5
- Meetings to verify and evaluate compliance with the commitments made by the States during conferences.
- Objectives are diluted by attempts to renegotiate their content.
- NGOs' presence is important for ratifying or arguing against the content of States' reports, and for preventing agreements from being weakened.

### How are Policies Designed?

- By respecting the binding normative framework (national and international).
- By following the guidelines of international agencies: WHO/PAHO, IPPF.
- By embracing the agreed-upon commitments acquired through action plans and platforms for action.
- By observing the needs and interests of the population.

### Health Policies

#### Evolution

- Maternal and Child Health.
- Comprehensive Health Eco-bio-psycho (WHO 1946).
  - a. Throughout The Life Cycle
  - b. Boys And Girls
  - c. Youth
  - d. Women
  - e. Men
- Incorporation of gender perspective and considering health as a right (since 1994).

### DEFINITION OF DIFFERENT INTERNATIONAL HUMAN RIGHTS INSTRUMENTS

There are various types of international instruments through which States are obligated to promote, defend and respect human rights, including:

#### 1. Conventions, Treaties or Covenants

These are legally binding documents ratified by the States, which create rights and obligations. The terms “convention,” “treaty,” “covenant” and “protocol” are used synonymously in most States, according to their own constitutional norms. Ratification allows them to become part of the national code of laws and they are as legally binding for the States that sign them as their own laws. The signatory States also commit to promote and protect them. Conventions have more weight than declarations, as they are legally binding for the member States, which implies they must answer for violating them.

Many of these instruments are preceded by a declaration and a document coordinated between official delegations, experts, and nongovernmental organizations, which can be extended for several years.

#### 2. Declarations

Declarations are documents with agreed-upon rules. While they are not legally binding, they reflect a concern at a given point in time on a given issue, which warrants the attention of the organization and the States.

They include: the American Declaration of the Rights and Duties of Man (1948); the Universal Declaration of Human Rights (1948); the Declaration on the Elimination of all Forms of Discrimination against Women (1967); and the Declaration on the Elimination of Violence against Women (1993).

#### 3. Optional Protocols

These are international instruments that complement a treaty or convention. They are signed and ratified in the same manner as treaties; that is, they also become part of the code of laws of the States that ratify them. They are optional because the States which have signed a treaty can, if they so decide, ratify the protocol to ensure due compliance of the rights enunciated. They are not obliged to ratify the protocols, since the protocols' contents are not incorporated automatically.

Examples include: the UN Optional Protocol to the International Covenant on Civil and Political Rights (in effect since 1976), and the UN Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women.

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#### 4. International or World Conferences

These are meetings of governments regarding specific matters, in which they discuss and adopt agreements and commitments concerning the resolution of world problems. Some representatives of civil society are also allowed to participate, but only with the right to speak, not to vote.

Agreements adopted at world conferences are called “platforms,” “plans” or “programs of action,” and though they do not have the same binding nature as treaties, they contain commitments undertaken by governments and reflect world consensus.

Conferences are very important instruments. Through diagnoses of problematic situations of global interest, they enable the governments of the world to propose what to do and how to do it, and to set goals that allow the design of policies. They are standards by which to measure compliance with the commitments of different countries.

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### SUMMARIES OF THE MAIN INTERNATIONAL INSTRUMENTS FOR SEXUAL AND REPRODUCTIVE

#### Convention on the Elimination of All Forms of Discrimination Against Women, 1979

In 1967, the United Nations General Assembly adopted the Declaration on the Elimination of Discrimination against Women, which registers inequalities and discrimination faced by women in every country, addressing their civil and political rights and concerns related to access to education, work and health.

Based on the work advanced by the Commission on the Status of Women, the United Nations General Assembly adopted the Convention on the Elimination of All Forms of Discrimination Against Women (December 10, 1979), which is still open to signature by States who thereby accept the obligation to adopt the actions required to guarantee the fulfillment of women's rights. On December 3, 1981, CEDAW entered into force after the twentieth country ratified it. Even though over 150 countries have subscribed to the treaty, many have done so conditionally, introducing reservations on certain provisions, which may limit its impact.

This convention is the first international treaty to openly condemn discrimination – both intentional as well as acts that have a discriminatory effect on women in all areas – work, health, education, credit, the family, justice – as a violation of human rights. This makes it the most important international instrument for the defense of women's legal, cultural, reproductive and economic rights. As stated by Rebecca Cook (1997:248): "The Women's Convention is designed to change the way in which half of humanity treats the other half, and to force the domineering half to elevate the subordinated half to an equal functional condition."

**Article 1 of Part I** of the Convention defines discrimination as:

"... any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."

**Articles 2 and 3** call on governments to adopt policies and legislative measures dealing with the elimination of all forms of discrimination, based on the principle of equality between men and women, and actions in all fields – in particular the political, social, economic, cultural and legislative fields – that guarantee the exercise of human rights.

**Article 4** mentions the need to adopt positive measures for the elimination of discrimination against women:

"... temporary special measures aimed at accelerating de facto equality between men and women..."

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**Article 6** reaffirms the need to suppress all forms of trafficking in women and exploitation of women through prostitution.

**Articles 7, 8 and 9 of Part II** of the convention refer to civil and political rights.

**Article 9** calls on States Parties to grant women equal rights with men in the family, regarding on their children's nationality.

**Part III** reviews rights in the socioeconomic field in its articles:

Education and training, **article 10**:

"... shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women...

h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."

Work and maternity, work and health, **article 11**:

"f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction ... 2 c) To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities."

Health, **article 12**:

"1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis on equality of men and women, access to health care services, including those related to family planning ..."

Credit, **article 13**, and conditions in rural zones, **article 14**:

"2. b) To have access to adequate health care facilities, including information, counselling and services in family planning ..."

**Article 16** talks about the measures necessary to eliminate discrimination against women in all matters relating to marriage and family relations: to freely choose a spouse, to have the same rights and responsibilities during marriage and at its dissolution, to have the same rights and responsibilities as parents, equality in the rights to choose a family name, a profession and an occupation, with respect to the ownership, acquisition, management, administration and disposition of property, among others.

“e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.”

The last part of the convention, **articles 17-30**, reviews the mechanisms for implementation of CEDAW:

### **Article 17:**

“For the purpose of considering the progress made in the implementation of the present Convention, there shall be established a Committee on the Elimination of Discrimination Against Women ... consisting, at the time of entry into force of the Convention, of eighteen and, after ratification of or accession to the Convention by the thirty-fifth State Party, of twenty-three experts of high moral standing and competence in the field covered by the Convention.”

Committee on the Elimination of Discrimination Against Women<sup>42</sup>

The Committee was created with the objective of “considering the progress made in the implementation of the present Convention,” article 17. It is composed of 23 experts on the topics of the convention from different countries and elected by the States Parties, who serve in their personal capacity for a period of four years.

### **Article 18:**

“States Parties undertake to submit to the Secretary-General of the United Nations, for consideration by the Committee, a report on the legislative, judicial, administrative or other measures which they have adopted to give effect to the provisions of the present Convention and on the progress made in this respect:

- a. Within one year after the entry into force for the State concerned and
- b. Thereafter at least every four years and further whenever the Committee so requests.”

<sup>42</sup> Cook R, *Human Rights of Women: National and International Perspectives*, Bogotá: Profamilia, 1997.

Mertus J et al., *Human Rights of Women: Step by Step*, Washington D.C.: Inter-American Institute of Human Rights, Women and Law & Development International, Human Rights Watch Women's Rights Project, 1997.

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**Article 20:**

- “1. The Committee shall normally meet for a period of not more than two weeks annually in order to consider the reports submitted in accordance with article 18 of the present Convention.
2. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee.”

**Article 21:**

- “1. The Committee shall, through the Economic and Social Council, report annually to the General Assembly of the United Nations on its activities and may make suggestions and general recommendations based on the examination of reports and information received from the States Parties. Such suggestions and general recommendations shall be included in the report of the Committee together with comments, if any, from States Parties.
2. The Secretary-General shall transmit the reports of the Committee to the Commission on the Status of Women for its information.”

The Optional Protocol to CEDAW, 1999<sup>43</sup>

Given that the sole mechanism for supervising the progress made on the Elimination of Discrimination against Women as anticipated by the Convention was that of the reporting procedure, in 1991 there was discussion of the need for an optional protocol to CEDAW that would allow the development of procedures accessible for the defense and guarantee of women’s rights. Since then, various international agencies, as well as organized women’s groups and human rights groups, have dedicated their efforts to the task of advancing this project. Thus, on December 10, 1999, the General Assembly of the United Nations adopted the optional protocol to CEDAW, which entered into force in 2000.

The optional protocol establishes procedures for communications and research. In communications, the committee is authorized to receive petitions from women or groups of women that submit individual complaints related to violations by action or omission of the States Parties regarding the rights recognized in the Convention; and to issue opinions and recommendations. The other procedure allows the committee to initiate an investigation of grave or systematic violations perpetrated by a State Party.

The protocol consists of four main sections: the preamble; the communications procedure (articles 1-7); the inquiry procedure (articles 8-10); and administrative provisions (articles 11-16 and 18-21).

In the preamble, the States Parties, recalling that the Charter of the United Nations, declarations, covenants and conventions recognize the equality of men and women’s rights and prohibit discrimination

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<sup>43</sup> Inter-American Institute of Human Rights, 2000 *Optional Protocol, Convention on the Elimination of All Forms of Discrimination Against Women*, San José, Costa Rica: 2000.

on the basis of sex, agree to adopt the necessary measures for preventing violations of the human rights of women, promoting the implementation of the Convention.

The communications procedure establishes the requirements for receipt and admissibility of a complaint, which may be submitted by individuals or a group of individuals whose rights have been infringed by the State Party. This procedure consists of three stages. In the first, the committee establishes whether it can receive the complaint and whether it is admissible. If the communication is declared admissible, it passes to the second stage where the basis of the complaint is examined and opinions and recommendations are issued. In the third stage, follow-up takes place.

The inquiry procedure authorizes the committee to initiate an investigation of particularly grave or systematic violations. This procedure allows the committee to request information on the case reported, including field visits to the site of the violation, and transmit recommendations and comments to the State Party. Upon receiving these findings, the State Party has six months to reply. The inquiry must be conducted confidentially.

The final section establishes the administrative provisions for the functioning of the protocol, including adoption by States Parties of the necessary measures to ensure that individuals are not subjected to ill treatment or intimidation as a consequence of the complaints submitted to the committee; inclusion of a summary of its activities in the annual report; commitments of each State Party to make widely known and publicize the convention, the protocol, and the opinions and recommendations of the committee; and the absence of State Party reservations to the protocol.

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World Conference on Human Rights: Vienna, June 14-25, 1993<sup>44</sup>  
Vienna Declaration and Program of Action

## **PART I**

Reaffirms the equality of rights of men and women and the responsibility of all States to promote and encourage respect for human rights and fundamental freedoms for all, without any distinction as to race, sex, language or religion. Reiterates its concern for the various forms of discrimination and violence to which women continue to be exposed all over the world.

## **PART II**

### Paragraph 9

The human rights of women and of the girl child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in political, civil, economic, social and cultural life, at the national, regional and international levels, and the eradication of all forms of discrimination on the grounds of sex are priority objectives of the international community.

Gender-based violence and all forms of sexual harassment and exploitation, including those resulting from cultural prejudice and international trafficking, are incompatible with the dignity and worth of the human person, and must be eliminated. This can be achieved by legal measures and through national action and international cooperation in such fields as economic and social development, education, safe maternity and health care, and social support.

The human rights of women should form an integral part of United Nations human rights activities, including the promotion of all human rights instruments relating to women.

The World Conference on Human Rights urges governments, institutions, intergovernmental and nongovernmental organizations to intensify their efforts for the protection and promotion of human rights of women and the girl child.

The World Conference on Human Rights expresses its dismay at massive violations of human rights, especially in the form of genocide, "ethnic cleansing," and systematic rape of women in war situations, creating mass exodus of refugees and displaced persons. While strongly condemning such abhorrent practices it reiterates the call that perpetrators of such crimes be punished and such practices immediately stopped.

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<sup>43</sup> Synthesis of the Vienna World Conference on Human Rights, 1993.

**PART III**

## II. Equality, Dignity, and Tolerance

## C. The Equal Status and Human Rights of Women

The World Conference on Human Rights urges the full and equal enjoyment by women of all human rights and that this be a priority for Governments and for the United Nations. The Conference also underlines the importance of the integration and full participation of women as both agents and beneficiaries in the development process, and reiterates the objectives established on global action for women toward sustainable and equitable development set forth in the Rio Declaration on Environment and Development and chapter 24 of Agenda 21, adopted by the United Nations Conference on Environment and Development.

The equal status of women and the human rights of women should be integrated into the mainstream of United Nations system-wide activity. These issues should be regularly and systematically addressed throughout relevant United Nations bodies and mechanisms. In particular, steps should be taken to increase cooperation and promote further integration of objectives and goals between the Commission on the Status of Women, the Commission on Human Rights, the Committee for the Elimination of Discrimination against Women, the United Nations Development Fund for Women, the United Nations Development Programme, and other United Nations agencies. In this context, cooperation and coordination should be strengthened between the Centre for Human Rights and the Division for the Advancement of Women.

In particular, the World Conference on Human Rights stresses the importance of working toward the elimination of violence against women in public and private life, the elimination of all forms of sexual harassment, exploitation and trafficking in women, the elimination of gender bias in the administration of justice, and the eradication of any conflicts which may arise between the rights of women and the harmful effects of certain traditional or customary practices, cultural prejudices, and religious extremism. The Conference calls upon the General Assembly to adopt the draft declaration on the elimination of violence against women and urges States to combat violence against women in accordance with its provisions. Violations of the human rights of women in situations of armed conflict are violations of the fundamental principles of international human rights and humanitarian law. All violations of this kind – including murder, systematic rape, sexual slavery and forced pregnancy – require a particularly effective response.

The World Conference on Human Rights urges the eradication of all forms of discrimination against women, both hidden and overt. The United Nations should encourage the goal of universal ratification by all States of the Convention on the Elimination of All Forms of Discrimination Against Women by the year 2000. Ways and means of addressing the particularly large number of reservations to the convention should be encouraged. Inter alia, the Committee on the Elimination of Discrimination Against Women should continue its review of reservations to the Convention. States are urged to withdraw reservations that are contrary to the object and purpose of the Convention or which are otherwise incompatible with international treaty law.

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Treaty-monitoring bodies should disseminate necessary information to enable women to make more effective use of existing implementation procedures in their pursuits of full and equal enjoyment of human rights and non-discrimination. New procedures should also be adopted to strengthen implementation of the commitment to women's equality and the human rights of women. The Commission on the Status of Women and the Committee on the Elimination of Discrimination Against Women should quickly examine the possibility of introducing the right of petition through the preparation of an optional protocol to the Convention on the Elimination of All Forms of Discrimination Against Women. The World Conference on Human Rights welcomes the decision of the Commission on Human Rights to consider the appointment of a special rapporteur on violence against women at its fiftieth session.

The World Conference on Human Rights recognizes the importance of the enjoyment by women of the highest standard of physical and mental health throughout their life span. In the context of the World Conference on Women and the Convention on the Elimination of All Forms of Discrimination Against Women, as well as the Proclamation of Teheran of 1968, the World Conference on Human Rights reaffirms, on the basis of equality between women and men, a woman's right to accessible and adequate health care and the widest range of family planning services, as well as equal access to education at all levels.

Treaty-monitoring bodies should include the status of women and the human rights of women in their deliberations and findings, making use of gender-specific data. States should be encouraged to supply information on the situation of women de jure and de facto in their reports to treaty-monitoring bodies. The World Conference on Human Rights notes with satisfaction that the Commission on Human Rights adopted at its forty-ninth session Resolution 1993/46 of 8 March 1993 stating that rapporteurs and working groups in the field of human rights should also be encouraged to supply this information. The Division for the Advancement of Women, in cooperation with other United Nations bodies, specifically the Centre for Human Rights, should take steps to ensure that the human rights activities of the United Nations regularly address violations of women's human rights, including gender-specific abuses. Training should be encouraged for United Nations human rights and humanitarian relief personnel to assist them to recognize and deal with human rights abuses particular to women and to carry out their work without gender bias.

The World Conference on Human Rights urges Governments and regional and international organizations to facilitate the access of women to decision-making posts and their greater participation in the decision-making process. It encourages further steps within the United Nations Secretariat to appoint and promote women staff members in accordance with the Charter of the United Nations, and encourages other principal and subsidiary organs of the United Nations to guarantee the participation of women under conditions of equality.

The World Conference on Human Rights supports all measures by the United Nations and its specialized agencies to ensure the effective protection and promotion of human rights of the girl child. The World Conference on Human Rights urges States to repeal existing laws and regulations and remove customs and practices that discriminate against and cause harm to the girl child.

**INTERNATIONAL CONFERENCE ON POPULATION DEVELOPMENT: CAIRO, 1994<sup>45</sup>**

Delegates from 179 governments and 4,200 representatives of 1,500 nongovernmental organizations from 113 countries attended this conference.

The 1994 International Conference on Population and Development (ICPD) reflects the growing awareness that population, the environment, economic growth and sustainable development are interconnected. United Nations organizers underlined the critical role of population policies to reduce poverty, halt environmental degradation, improve health and education, and empower women to participate fully in society. ICPD's general goal was to develop a plan of action on reproductive issues for the next decade that addresses population in the context of national development and women's rights, and their participation in development.

The program of action adopted a new strategy focused on meeting the needs of each woman and man instead of reaching demographic goals. It is necessary to recognize that the efforts to slow down population growth, eliminate gender inequality, reduce poverty, achieve economic development and protect the environment are mutually reinforcing. The conference called for the empowerment of women and guarantee of reproductive rights, including the right to determine the number of children desired by the family as fundamentally important in its own right; it also recognized that attaining these goals would help stabilize population growth and contribute to sustainable development.

The ICPD program of action set 20-year goals in three related areas:

- To make family planning universally available by the year 2015, or earlier, as part of a broad approach to health and reproductive rights, thus reducing mortality of breast-feeding children and mothers at all levels;
- To integrate population concerns in all policies and programs aimed at achieving sustainable development; and
- To empower women and adolescents and provide them with more options through extended access to education, health services, and employment opportunities.

More concretely, the document:

- Details actions required to ensure the empowerment of women in political social, economic and cultural life in their communities, not simply improve their status and role;
- Recognizes the central role of sexuality and gender relations in women's health and rights;
- Affirms that men should assume responsibility for their own sexual behaviors, fertility, STI transmission, and the well-being of their partners and children;
- Calls for and defines reproductive and sexual health care that provides comprehensive quality information and services (including safe abortion where it is not against the law) for all women, including adolescents.

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<sup>45</sup> Synthesis of the 1994 International Conference on Population and Development, Cairo.

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The ICPD reaffirmed the global consensus that voluntary family planning decisions are a basic human right of all couples and individuals, and that coercion of any kind is unacceptable. Within this framework of human rights, the Cairo Conference advocated for integrating family planning activities in a broader effort to meet reproductive health needs. With this new approach, family planning information and services should be provided as part of a comprehensive focus of reproductive health care that also includes prenatal care, safe childbirth and postnatal care; abortion prevention and control of the consequences of unsafe abortion; prevention of HIV and other sexually transmitted infections; infertility prevention; screening for reproductive tract infections and cervical and breast cancer; and active dissuasion of harmful practices such as female genital mutilation.

At Cairo, delegates agreed to adopt specific goals of resources for international population assistance, based on the estimates of what is required to allow all countries to make family planning and reproductive health services accessible to all individuals by the year 2015. Attainment of this goal will require, according to estimates, \$17 billion by the year 2000 and more than \$21 billion annually by the year 2015, a third of which, as agreed, should come from the international community.

#### The Role of Nongovernmental Organizations

Nongovernmental organizations (NGOs) played an important role at ICPD. The work begun in Nairobi and continued at the “Earth Summit” in Rio de Janeiro established the framework for greater participation of NGOs. More than 1,200 NGOs were represented at Cairo. Some NGOs corresponded to national delegations, while many others lobbied among delegates of their countries in corridors and separate meetings. NGOs’ participation not only contributed to the comprehensiveness of the conference’s document, but also to its legitimacy.

Women’s groups were the most organized and strategically focused in ICPD. Well before this Conference, those groups participated in developing NGO networks, applying pressure on governments and developing and distributing materials. The women’s meeting at ICPD included more than 400 organizations from 62 countries and took the initiative in representing priorities and perspectives of women worldwide.

The success of their work is evident. The final ICPD program of action addresses the empowerment of women and gender equity more comprehensively than any other international instrument, including the Forward-Looking Strategies of the Nairobi Conference on Women. Women served as agents of change who transformed the focus on population and development policies from women as goals of state population policies to women as participants in the normative process. The energy and commitment of women’s NGOs successfully guided and transformed the Cairo agenda. The message that emerged from ICPD is: women’s productive and reproductive roles are inseparable.

NGO representatives at ICPD recognized the social context of the population problem and strived to expand family planning approaches to include the empowerment of women and greater access to information and services, acquisition of professional competencies, and participation in the decision-making process at local and national levels. This extraordinary plan increases our understanding of

“population” and integrates policies related to population and development. This revolution to address population programs was due largely to the significant influence of NGOs, particularly of women’s groups from all over the world, in preparations for the ICPD, in developing the program of action, and in the ICPD itself.

ICPD+5: 1999 Special Session of the United Nations to Appraise the Advancement of the Program of Action of the 1994 International Conference on Populations and Development<sup>46</sup>

Implementation of the 1994 ICPD program of action was monitored for five years after its ratification. During the fifth year, the monitoring process culminated with a Special Session of the United Nations, held in New York in June 1999. In preparation for the Special Session, an International Forum for the Operational Review and Appraisal of Implementation of the Programme of Action was held in The Hague. Around 2,000 participants attended the forum, organized by UNFPA.

### Background

The fourth principle of the ICPD program of action establishes an essential link between advancing gender equality, equity and empowerment of women, eliminating all forms of violence against women, and women’s ability to control their own fertility as cornerstones of population and development programs. In this regard, the program of action provides strong links to many human rights instruments, including the Committee on the Elimination of Discrimination Against Women and the Vienna Conference on Human Rights, and also creates a practical base for operational integration of critical concerns raised in the Beijing platform for action. The ongoing validity, relevance and increasing importance of these premises reaffirm the fundamental role of the ICPD program of action in transforming population and development programs and, in particular, in changing the quality of women’s lives. While much progress has been made, the five-year review of the implementation of the program of action identified several areas that need strengthening.

### Progress Achieved

The five-year review shows progress in the following areas:

- The momentum created by the ICPD has been used to establish or reinforce initiatives that promote the integration of a gender perspective in policies, programs and activities.
- Many countries have reviewed their own legal systems and instituted reforms according to international mandates that abolish laws discriminating against female adults and adolescents and implement laws to protect them. Institutions, both governmental and nongovernmental, have taken measures for institutional development and strengthening, including the acquisition of abilities by staff compatible with gender equality.
- Much work has been done to eradicate violence against women, including endorsing laws, creating a legal conscience and advocacy.

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- Progress has been made in promoting protection of the girl child and her welfare.
  - Efforts have been made to encourage men to assume responsibility for their behavior and reproductive and sexual health, and to support women's health and promote gender equality and equity in general.

Areas that Need Strengthening Include:

**INCORPORATION OF A GENDER PERSPECTIVE.** The adoption and institutionalization of a gender perspective in population and development programs is a long-term process. It requires the application of gender-based analysis in policy formulation and in program development and implementation, as well as in international cooperation. There is an absence of adequate understanding as to how to interpret the concepts related to gender issues in different social and cultural contexts. Globalization of the economy has contributed toward deepening the feminization of poverty, while prioritization of the social and health sectors has increased the ratio of women who lack access to adequate social and health care services. In many countries, inequality between men and women is exacerbated by racial and ethnic discrimination.

**LEGAL CONTEXT.** Many countries still prevent women from exercising their right due to legal provisions, such as those that deny access to land and credit. Even in cases where a legal reform has been undertaken, women often continue to suffer a lack of legal protection for the exercise of their human rights. The legal mechanisms necessary to monitor gender equality and equity are weak.

**VIOLENCE AGAINST WOMEN.** Women continue to face intolerable levels of violence at all stages of their life cycle, both in public and private life. Feminization of poverty has increased new types of violence, such as trafficking and forced prostitution. Women are also the primary victims of wars and civil conflict.

**WOMEN IN LEADERSHIP AND POLICY POSITIONS AND AT DECISION-MAKING LEVELS.** Women continue to have little representation in positions of power and decision-making due to obstacles such as poverty, illiteracy, limited access to education, inadequate financial resources, a patriarchal mentality, and the double burden of domestic tasks and occupational obligations. Women are also dissuaded from occupying decision-making positions, such as electoral politics, by a setting that does not support them and discriminates against them.

**WOMEN'S PARTICIPATION IN THE JOB MARKET.** Regardless of their occupations, women with the same qualifications usually receive less pay than men for work with equal value. Their disproportionately higher portion of social and family responsibilities has negative repercussions on their training and promotion opportunities.

**VULNERABLE GROUPS.** Ongoing economic, social and health vulnerability of certain groups of women, such as elderly women, widows, displaced women, indigenous women, poor rural women, immigrants,

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<sup>46</sup> *Report of the International Forum for the Operational Review and Appraisal of Implementation of the Programme of Action of the International Conference on Population and Development (ICPD)*, The Hague: 1999.

adolescents, refugees or suburban dwellers, makes them susceptible to marginalization in normative and programmatic initiatives. Often, those groups are not consulted or do not participate in the discussion of the formulation of strategies that satisfy their needs.

**PROTECTION OF THE GIRL CHILD.** The prevalence of cultural attitudes that promote adolescents' low status, like traditional harmful practices such as female genital mutilation, the use of sex-selection technologies and sexual servitude place adolescent and women's sexual and reproductive health at risk.

**GENDER-DISAGGREGATED DATA.** Many national information and data systems do not collect gender-disaggregated data, or include those data for a limited number of variables.

**INSTITUTIONAL STRENGTHENING AND CAPACITY BUILDING.** The staff in many institutions lack the technical capacity required to undertake a gender analysis and to design, implement, and monitor programs with a gender perspective.

**PROMOTION OF MALE RESPONSIBILITY AND PARTNERSHIP BETWEEN MEN AND WOMEN.** Persistence of social and cultural attitudes prevents men from sharing family responsibilities. Men also do not participate in the discourse on gender equality and the empowerment of women. Several initiatives have been undertaken to address men's sexual and reproductive health needs, and to promote greater responsibility with respect to their sexual and reproductive behaviors. These should continue without sacrificing women's reproductive health services.

The five-year review of progress showed that the implementation of the Cairo Conference's recommendations had positive results, with many countries taking steps to integrate population concerns into their development strategies, the document states. However, for some countries and regions, progress has been limited and, in some cases, setbacks have occurred. Women and girls continue to face discrimination, while the HIV/AIDS pandemic has increased mortality in many countries. Adolescents remain vulnerable to reproductive and sexual risks and millions of couples and individuals still lack access to reproductive health information and services.

Governments are called on to take strong measures to promote the human rights of women and are encouraged to strengthen women's reproductive and sexual health, as well as the reproductive rights focus on population and development policies and programs.

The differential impact on women and men of globalization of the economy and the privatization of basic social services, particularly reproductive health services, should be monitored closely, the text stresses. Governments are also called upon to give priority to developing programs and policies that foster norms and attitudes of zero tolerance for harmful and discriminatory attitudes, including son preference, discrimination and violence against the girl child and all forms of violence against women, including female genital mutilation, rape, incest, trafficking, sexual violence and exploitation.

The document states that in no case should abortion be promoted as a method of family planning. Governments and organizations are urged to strengthen their commitment to women's health, to deal

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with the health impact of unsafe abortion as a major public health concern, and to reduce the recourse to abortion through expanded and improved family planning services.

All developed countries are urged to strengthen their commitment to the goals and objectives of the ICPD program of action. Countries should pay particular attention to cost estimates and make every effort to mobilize the agreed estimated financial resources required to implement the program of action.

Fourth World Conference on Women:  
Action for Equality, Development and Peace: Beijing, 1995<sup>47</sup>

Nearly 190 heads of government and more than 5,000 representatives of 2,100 nongovernmental organizations attended the conference, while an additional 30,000 people attended the NGO Forum.

The Beijing Declaration and Platform for Action were adopted, by consensus, on September 15, 1995. The declaration incorporated the international community's commitment to advancing women and the implementation of the platform for action, ensuring that a gender perspective is reflected in all policies and programs at national, regional, and international levels. The platform established measures for national and international action aimed at promoting women throughout a five-year period until 2000. It called for increasing women's social, economic, and political empowerment, improving their health and access to relevant education, and promoting their reproductive rights.

The conference, which convened more than 50,000 men and women, focused on the interrelated topics of equality, development, and peace, and analyzed them from a gender perspective. It underlined vital links between the advancement of women and progress of society as a whole. It clearly reaffirmed that society's issues should be addressed from a gender perspective to ensure sustainable development.

Preparations for the Beijing Conference identified the following 12 areas of concern that were the basis for the platform for action:

1. The persistent and increasing burden of poverty on women;
2. Inequalities and inadequacies in and unequal access to education and educational opportunities;
3. Inequalities and inadequacies in and unequal access to health care and related services;
4. Violence against women;
5. The effects of armed or other kinds of conflicts on women;
6. Inequality in women's access to and in their participation in defining economic structures and policies, and in the process of production itself;
7. Inequality between men and women in the sharing of power and decision-making at all levels;
8. Insufficient mechanisms at all levels to promote the advancement of women;
9. Lack of respect for and inadequate protection and promotion of the nationally and internationally recognized human rights of women;
10. Insufficient mobilization of the media to promote a positive contribution of women in society;

11. Lack of recognition and support for women's contribution to the management of natural resources and the safeguarding of the environment;
12. The girl child.

The primary message of the Fourth World Conference on Women was that the topics addressed in the platform for action are global and universal. Deeply rooted attitudes and practices perpetuate world-wide inequality and discrimination against women, in both public and private life. As a result, implementation requires changes in values, attitudes, practices and priorities at all levels.

World conferences provided a forum in which United Nations Member States can adopt common approaches to shared problems. A longer-term key objective of the conference process is to highlight the progress of each country through a review of their national plans, policies and commitments. Aware of such scrutiny-and of the opportunity to call attention to their efforts as they relate to women in particular-more than 100 countries promised concrete actions in Beijing. These national commitments have become an intrinsic part of the follow-up, providing the UN, governments, NGOs, and society as a whole with points of reference to appraise progress in the advancement of women. These commitments also serve as a powerful advocacy tool, which NGOs in each country can monitor and discuss with their national representatives.

#### BEIJING+5: Assessing Reproductive Rights, 2000<sup>48</sup>

From June 5 to 9, 2000, about 2,000 government delegates and 2,000 representatives of nongovernmental organizations from more than 180 countries gathered in New York for a Special Session of the UN General Assembly to review implementation of the 1995 Beijing Declaration and Platform for Action. The Special Session, entitled "Women 2000: Gender Equality, Development and Peace for the 21st Century" (also known as "Beijing+5"), was the culmination of more than five weeks of negotiations spread over several months. The negotiations related primarily to a document entitled "Further actions and initiatives to implement the Beijing Declaration and Platform for Action." This review document is an agreement among governments that analyzes what has occurred since 1995 and how to move implementation forward. The document constitutes a pledge by the world's governments to take measures to speed implementation of the Beijing platform's provisions. Although there were significant disappointments, the chaotic negotiations did yield some positive gains, which reflected many of the concerns that women's groups, including the Center for Reproductive Rights (formerly CRLP), put forward when the negotiations began in March 2000.

#### Outcome of Negotiations

There was evidence at Beijing+5 that progressive positions on women's human rights, including reproductive rights, have become more widely accepted. For example, many delegations that had opposed the Beijing platform's provisions on reproductive and sexual rights five years ago, notably from Latin America, supported more progressive measures to implement those very provisions. Despite the right wing's strategy to wear down delegates to the point of physical exhaustion and extract concessions along the way, the Beijing platform truly was a "floor." Even those provisions considered to be "radical" in

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1995 were accepted, demonstrating that the international community's thinking on gender equality continues to move forward as it has in recent decades.

However, in controversial areas where the language agreed to in these negotiations simply quoted the Beijing platform, it obviously failed to provide guidance on the platform's implementation. In addition, the review document fell short in meeting the most fundamental priorities of women's rights organizations for Beijing+5: commitment of financial resources and adoption of time-bound targets, indicators and concrete benchmarks to foster accountability and increase political will. The review document adds just three time-bound targets to the Beijing platform's anemic twelve paragraphs. These are: ensuring a nondiscriminatory legal environment by 2005; the incorporation of ICPD+5's time-bound goals; and the improvement of adult literacy by 50 percent by 2015. This stands in contrast to the ICPD+5 negotiations in 1999, at which governments agreed to an additional thirteen targets and benchmarks, including one on financial resources. This anomalous situation shows that governments continue to resist setting concrete goals and committing adequate financial resources to further women's equality and human rights.

As was the case at the 1994 International Conference on Population and Development in Cairo, at the 1995 Beijing Conference, and at the 1999 five-year review of ICPD (ICPD+5), reproductive and sexual rights were the primary targets of right-wing opponents of women's full equality. A small number of conservative governments and their NGO allies sought to undermine the negotiations, primarily by stalling and blocking consensus on issues such as unsafe abortion, the inclusion of reproductive and sexual rights, and discrimination based on sexual orientation; this strategy was designed to chip away at the Beijing platform's principles. North-South debates on overseas development assistance, debt relief, and globalization also complicated the negotiations. A handful of countries, including the United States, fundamentally disagreed on provisions related to sanctions, foreign occupation, and nuclear disarmament, with the United States entering reservations on several provisions as a result.

In spite of the intransigent minority determination to turn back the clock on women's human rights, and the complex North-South politics, the resulting review document – and in fact the Beijing+5 process itself – were valuable. Governments did reaffirm their commitment to the Beijing platform and pledged to undertake additional strategies and actions to speed implementation. In sum, Beijing+5 continued the momentum to bring about real changes in women's status in every country of the world.

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<sup>47</sup> Synthesis of the 1995 World Conference on Women, Beijing.

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## Gains for Reproductive Health and Rights

Affirmation of the Goals and Benchmarks of ICPD+5. The review document directs governments to “[r]eview and revise national policies, programmes and legislation to implement” the document agreed upon at ICPD+5, particularly “the specific benchmarks” related to maternal mortality, provision of the widest achievable range of safe and effective contraception, and reduction of young people’s risk of HIV/AIDS.

**REDUCTION OF MATERNAL MORTALITY.** The review document directs governments to “[e]nsure that the reduction of maternal morbidity and mortality is a health sector priority and that women have ready access to essential obstetric care, well-equipped and adequately staffed maternal health-care services, skilled attendance at delivery, [and] effective referral and transport to higher levels of care [...]”

**ADOLESCENT REPRODUCTIVE RIGHTS.** The review document reaffirms governments’ commitment to design and implement programs with the full involvement of adolescents to ensure their access to sexual and reproductive health services, education, and information. The provision makes reference to “their right to privacy, confidentiality, respect and informed consent.” Moreover, it affirms parents’ responsibilities, rights and duties to provide direction and guidance in the child’s exercise of the rights recognized in the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women (Women’s Convention), “ensuring that in all actions concerning children, the best interests of the child are a primary consideration.”

**ABORTION.** The review document simply repeats the Beijing platform’s relatively progressive provision on abortion, i.e., governments should “consider reviewing laws containing punitive measures against women who have undergone illegal abortions.” It also contains an evaluative paragraph which states: “[w]hile some measures have been taken in some countries, the actions contained in paragraphs 106 (j) and 106 (k) of [the Beijing] Platform for Action regarding the health impact of unsafe abortion and the need to reduce the recourse to abortion have not been fully implemented.”

**ADDRESSING HIV/AIDS.** Several provisions address significant issues surrounding the HIV/AIDS pandemic’s impact on women. In particular, the review document emphasizes nondiscrimination and respect for the privacy of those living with HIV/AIDS and other sexually transmitted infections, as well as increasing awareness of HIV/AIDS prevention, especially among young women, and encouraging and enabling men to adopt safe and responsible sexual behavior to prevent HIV transmission.

## Crimes of Sexual and Gender-Based Violence

For the first time in an international consensus document, the review document calls on governments to address through legislation and other measures so-called “honor crimes” and forced marriage. Language addressing other forms of violence against women, including marital rape and dowry-related violence and deaths, was strengthened by calling for stronger mechanisms to combat such practices, such as the adoption and full implementation of legislation and other policy responses. Finally, the document directs governments to “[t]reat all forms of violence against women ... as a criminal offence punishable by law ...”

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The review document affirms that the Rome Statute of the International Criminal Court is an indispensable tool in the realization of women's human rights by encouraging its ratification. Of particular import is a provision encouraging increased awareness and knowledge of the Rome Statute and the gender-based crimes it defines as war crimes and crimes against humanity, including rape, sexual slavery, forced pregnancy, and enforced sterilization, with "the aim of preventing such crimes ... [,] tak[ing] measures to support prosecution of all persons responsible ... and provid[ing] avenues for redress to victims ..."

The Beijing platform was revolutionary for its detailed provisions defining violence against women and setting out strategic objectives and actions to be taken by governments and other actors to combat it. As women's rights advocates and UN agencies have continued to emphasize the horrifying prevalence of such practices in all cultures of the world, the government negotiators at Beijing+5 felt some pressure to strengthen their past commitments to combat all such practices, including some that had not been explicitly named.

Women's Human Rights. Governments agreed that they should "[c]onsider signing and ratifying the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women." The United Nations system is directed to "[a]ssist States Parties, upon their request, in building capacity to implement the Convention on the Elimination of All Forms of Discrimination Against Women," as well as to implement the concluding comments and general recommendations of the committee overseeing the convention.

In discussing obstacles to the Beijing platform's implementation, the review document notes "insufficient recognition of women's and girls' reproductive rights, as well as barriers to their full enjoyment of those rights." The document also directs governments to "[c]reate and maintain a non-discriminatory and gender-sensitive legal environment by reviewing legislation ... to remove discriminatory provisions ... preferably by 2005, and eliminat[e] legislative gaps that leave women and girls without protection of their rights and without effective recourse against gender-based discrimination." In an important break-through, the review document provides that governments should "[m]ainstream a gender perspective into national immigration and asylum policies, regulations and practices," and, in particular, they should consider "steps to recognize gender-related persecution and violence when assessing grounds for granting refugee status and asylum."

The review document reiterates that "it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms." Finally, although most of the far right's proposals were defeated, they were successful in keeping out all references to "sexual orientation" as an explicit discriminatory barrier that women face. Even a factual statement providing that "in a growing number of countries, legal measures have been taken to prohibit discrimination on the basis of sexual orientation" was deleted from the document. The document does retain the Beijing Platform phrase of "other status" in the list of barriers in the introductory section. In addition, the expression "full diversity of women's conditions and situations" is included, which includes sexual orientation among other "conditions and situations."

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<sup>48</sup> Center for Reproductive Rights, *Beijing+5: Assessing Reproductive Rights*, New York: 2000.

CENTRAL ASPECTS OF UN CONFERENCES ON SEXUAL AND REPRODUCTIVE HEALTH<sup>49</sup>

The following are some core issues raised by United Nations conferences on sexual and reproductive health.

## Sexual and Reproductive Health

- Ensure the necessary conditions for women's exercise of their reproductive rights; use all means available to support the principle of freedom of choice in family planning; educate and inform about reproductive rights, keeping in mind the cultural and ethical considerations of the case; preserve liberty and dignity (Beijing, Cairo).
- Include reproductive health services in the context of primary health care: education, family planning information and services; treatment of infertility; responsible sexuality and fatherhood; prevention and treatment of sexually transmitted infections, including HIV/AIDS; prevention of abortion and treatment of its consequences (Beijing, Cairo).
- Promote active participation of men and provide them with information, counseling and services that enable them to share equal responsibilities relating to prenatal health, maternal and child health; prevention of unwanted pregnancy and high-risk pregnancy; recognition of equal value for children of both sexes; domestic tasks; and healthy sexual and reproductive behavior, including family planning and prevention of sexually transmitted infections (Cairo).
- Ensure universal access to safe and reliable family planning methods and reproductive health services; identify dissemination strategies and information and services that allow an increase of individual and couple's choices to make free and informed decisions about the number and spacing of their children, and offer protection against sexually transmitted infections (Beijing, Cairo, Rio de Janeiro).
- Relate delivery of reproductive health services to national population and development policies and strategies (Cairo).
- Eliminate legal, medical, clinical and information barriers to access to family planning services and methods (Cairo).
- Include in family planning programs, among others (Beijing, Cairo):
  - a. Accessible, comprehensive and accurate information for men and women about the various family planning methods, including health risks and benefits, possible side effects, and their efficacy for preventing the spread of HIV/AIDS and other sexually transmitted infections.
  - b. Sufficient and ongoing supply of essential high-quality contraceptive commodities; appropriate complementary care, including treatment of side effects as a result of contraceptives.
- Consider abortion as a major public health concern, which in no case shall be promoted as a family planning method; provide counseling and humane treatment to women who have resorted to abortion; consider the possibility of revising laws that penalize women who have had illegal abortions (Beijing, Cairo).
- Reduce abortion by offering improved family planning services; deal with the health impact of unsafe abortion; offer services to treat abortion complications (Beijing, Cairo).

<sup>49</sup> Dirección Nacional de Equidad para las Mujeres, *Compromisos de Colombia con sus mujeres. Acuerdos en Conferencias Internacionales*, Bogotá: UNICEF, 1996.

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- Increase efforts to prevent, detect and treat sexually transmitted infections, including HIV/AIDS, and other reproductive tract infections, especially at the primary health-care level; urgently adopt measures to modify high-risk sexual behavior (Beijing, Cairo).
  - Develop guidelines and create counseling services on AIDS and sexually transmitted infections, as part of primary health-care services; promote and supply high-quality affordable condoms and reliable drugs (Beijing, Cairo).
  - Recognize the role and status of women in HIV/AIDS policies and programs, with the objective of providing resources and facilities for women who provide care or financial support to infected individuals and survivors, especially children and the elderly (Beijing).
  - Identify norms and policies concerning sexual practices that place adolescent and adult women at risk of contracting HIV, and that protect women of all ages from discrimination related to HIV/AIDS (Beijing, Cairo).
  - Adopt a multisectoral focus in which sufficient attention is given to the socioeconomic ramifications of sexually transmitted infections and HIV/AIDS, including the heavy burden imposed on health care infrastructure and household incomes, its negative effect on the work force and productivity, as well as the increase in orphans (Cairo).
  - Offer health care service providers specialized training in the prevention and detection of sexually transmitted infections, in the delivery of counseling services in this area, especially infections in women and youth (Cairo).
  - Train service providers in the assessment and identification of high-risk behaviors needing special attention and services; in the promotion of responsible and lower-risk sexual behaviors; in the avoidance of contaminated equipment and blood products, and in the avoidance of sharing needles among injecting drug users (Cairo).

#### Designing Policy and Programs

- Develop national policies and legislation to protect the right of the girl child, adolescent women, and adult women to enjoy good health, keeping in mind their roles and responsibilities; to promote responsible, humane sexuality; to establish mechanisms that increase women's involvement in designing policies and programs (Beijing, Cairo, Rio de Janeiro, Vienna).
- Establish specific objectives and timeframes to improve women's health; assess programs from a gender perspective and redefine actions to fulfill the objectives (Beijing).
- Design health programs to support women in their reproductive and productive roles, with special attention to providing health care services for children and reducing the risk of maternal and infant morbidity and mortality (Rio de Janeiro).
- Develop health care programs that take into consideration women's time and the specific needs of rural, indigenous and disabled women (Beijing).
- Countries should comply with the commitments they made at world conferences and international treaties to protect the health of women and the girl child; to reform the health sector and health policies, especially as they relate to maximizing the cost-effectiveness of health programs to achieve increased life expectancy, reduce high levels of infant, child and maternal morbidity and mortality, and ensure access to basic health-care services for all people (Beijing, Cairo, Copenhagen).

### Service Delivery

- Ensure, within the primary health care system, universal access to the widest range of services, including those related to reproductive health, on the basis of equality between men and women (Beijing, Cairo, Rio de Janeiro, Vienna).
- Give priority to meeting the health needs, including reproductive health, of members of society who up until now have been underserved, especially those living in poverty, women and children (Cairo).
- Eliminate all medical interventions that are harmful to health, coercive, unnecessary from a medical viewpoint, including inadequate treatments or excessive administration of drugs (Beijing).
- Promote women's participation in the administration, planning, decision-making, management, implementation, organization and evaluation of health care services (Beijing, Cairo).
- Promote the participation of the community and of women's organizations in planning health policies and health care service delivery; decentralize the management of public health programs and intensify cooperation with local nongovernmental organizations, private health care groups, and NGOs dedicated to the health of women, girls and adolescent females (Beijing, Cairo).
- Identify formal and informal education programs that develop women's self-esteem and that allow them to acquire knowledge and assume responsibility for their own health (Beijing).
- Ensure that the introduction and testing of all new reproductive technologies are continually monitored to avoid potential abuse (Cairo).
- Recognize and encourage traditional health care showing beneficial effects, especially health care practiced by indigenous women; preserve and incorporate the value of traditional health care in service delivery (Beijing).
- Expand and upgrade formal and informal training in sexual and reproductive health care for all health care providers, health educators, and managers, including training in interpersonal communications and counseling (Beijing, Cairo).
- Develop support and training programs that enable health care providers to identify and treat girls and women who are victims of violence, sexual abuse and other types of abuse (Beijing, Cairo).
- Assign sufficient resources so that primary health care services attain full coverage of the population and support the secondary and tertiary levels, with special attention to the poorest groups in rural and urban zones; formulate policies and assign resources for investment in the health of girls and adolescent and adult females; providing particular care for their sexual and reproductive health (Beijing, Cairo).

### Maternal Health

- Base service delivery on the concept of informed choice, and include education on safe motherhood, prenatal care that is focused and effective, maternal nutrition programs, adequate delivery assistance that avoids excessive recourse to c-sections and provides for obstetric emergencies; referral services for pregnancy, childbirth and abortion complications; postnatal care and family planning (Beijing, Cairo).
- Consider the concrete needs of indigenous women with respect to access to primary health care and reproductive health care services (Beijing, Cairo).
- Include family planning counseling and information in maternal health programs to reduce high-risk pregnancies and abortions (Cairo).

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## Health of the Girl Child

- Offer health services and information for girls; facilitate comprehensive reproductive health and child health services, especially for the most vulnerable and underserved groups (Beijing, Cairo).
- Meet the specific needs of girls belonging to ethnic groups (Beijing, Cairo).
- Disseminate public information on the eradication of discriminatory practices against girls related to the distribution of foods and access to health care services (Beijing, Copenhagen).

## Research

- Promote and support preventive, biomedical, behavioral, epidemiological and health care service research on issues related to women's health, the causes and consequences of health problems, the repercussions of gender and social inequalities, of age and of urban or rural locations.
- Research should cover reproductive tract infections, HIV/AIDS, and violence against women as well as developing fertility regulation methods. Research should be gender-sensitive and examine the determinants and consequences of induced abortion (Beijing, Cairo).

## Information and Evaluation

- Introduce information systems that enable the development, analysis and use of data broken down by sex and age, for the purposes of formulating policies, and for planning, monitoring and evaluating health care programs (Beijing).
- Develop and implement client-centered management information systems, particularly for reproductive and sexual health programs, covering both governmental and nongovernmental activities and containing regularly updated data on clientele, expenditures, infrastructure, service accessibility, output and quality of services (Cairo).
- Identify criteria and methodologies for quantitative and qualitative evaluation of improved women's health (Beijing).
- Implement quantitative and qualitative measures of the results of service delivery that take into account the perspectives of current and potential users of services through such means as effective management information systems and survey techniques for the timely evaluation of services (Cairo).

## Communication

- Establish and strengthen programs and services, including media campaigns, related to prevention, early detection and treatment of breast cancer, cervical and uterine cancers, and other cancers of the reproductive system; as well as the diagnosis and treatment of osteoporosis (Beijing, Cairo).

## SESSION 7: INTERNATIONAL MECHANISMS

### OBJECTIVES

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

- Know some of the national and international mechanisms for reporting violations of or threats to the exercise of sexual and reproductive rights.
- Identify how different mechanisms for the defense of sexual and reproductive rights are implemented.
- Define quality of care, incorporating mechanisms for the defense of sexual and reproductive rights.

DAY 3 TIME: 2 hours 40 minutes

### PREPARATION

- Session 7 objectives printed on a flipchart
- Reference sources: Universal Declaration of Human Rights; International Covenant on Civil and Political Rights; International Covenant on Economic, Social and Cultural Rights; Convention on the Elimination of All Forms of Discrimination Against Women and its Optional Protocol
- Flipchart of Handout 7A

### MATERIALS

- Copies of handouts for participants
- Two copies of the Session Evaluation Form, found in the beginning of this manual

### HANDOUTS

- 7A: Presentation on Mechanisms for the Defense of Sexual and Reproductive Rights
- 7B: Case Study
- 7C: Producing Shadow Reports to CEDAW
- 7D: Guide No. 4 – Action Plans
- Session Evaluation Form

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## FACILITATING SESSION 7

### STEP 1 (30 minutes)

#### MECHANISMS FOR THE DEFENSE OF SEXUAL AND REPRODUCTIVE RIGHTS

- Review session objectives with the participants.
- Give a presentation on the mechanisms for the defense of sexual and reproductive rights found in Handout 7A.
- Allow a few minutes to clarify any doubts the participants may have.

### STEP 2 (1 hour)

#### IMPLEMENTING DIFFERENT MECHANISMS FOR THE DEFENSE OF SRR

- Divide participants into four groups and give each group a copy of the case study (Handout 7B: Case Study) and a copy of CEDAW recommendation no. 15.
- The four groups will use the same case study but will work on four different things:
  - a. Group 1 will work on the complaint;
  - b. Group 2 will work on action for protection;
  - c. Group 3 will work on the right of petition before CEDAW; and
  - d. Group 4 will work on producing a shadow report to CEDAW.
- The group working on parallel reports should receive a copy of Handout 7C: Producing Shadow Reports to CEDAW.
- In a plenary session, ask the groups to read the result of their discussions or present them on a flipchart.
- Ask participants to give feedback on the presentations and encourage them to answer each other's questions about the topic.

### STEP 3 (50 minutes)

#### QUALITY OF CARE, INCORPORATING MECHANISMS FOR THE DEFENSE OF SEXUAL AND REPRODUCTIVE RIGHTS

- Read the quality of care definitions developed so far.
- Organize groups of six, and have them incorporate the new elements in the definition.
- Groups should present their work in a plenary session.

### STEP 4 (10 minutes)

#### CLOSING

- Close the session, asking participants to highlight the main ideas and learnings of the day and their relationship to quality of care.
- Distribute Handout 7D: Guide No. 4 – Action Plans, so that participants can fill it out.

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STEP 5 (*10 minutes*)

QUALITY OF CARE, INCORPORATING MECHANISMS FOR THE DEFENSE OF SEXUAL AND REPRODUCTIVE RIGHTS

- Two copies of the Session Evaluation Form, found in the beginning of this manual.
- Ask participants to fill out the forms and hand them in.



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## PRESENTATION ON THE MECHANISMS FOR THE DEFENSE OF SEXUAL AND REPRODUCTIVE RIGHTS

### INTERNATIONAL HUMAN RIGHTS SYSTEM

- Universal: The United Nations (UN)
- Regional: Africa, Inter-America, Asia
- Organization of American States (OAS)

### Protection of Human Rights

#### Informal Mechanisms:

- a. Complaint filed with the official or institution (personal, phone, written, mail)
- b. Communication with a superior (boss, board, etc.)
- c. Hospital ethics or quality committee
- d. Monitoring entity (ministry, superintendence, prosecution, defense, inspectorship, etc.)
- e. Ethics tribunal (medicine or other professions)
- f. Trade associations

#### Formal Mechanisms at National Level:

- a. Right to petition
- b. Protection or guardianship action
- c. Popular actions – group
- d. Compliance actions
- e. Actions and exceptions of unconstitutionality
- f. Suits for civil responsibility
- g. Penal actions for injuries and other crimes

### Right to Petition

#### **American Declaration of the Rights and Duties of Man, 1948**

**Article 18:** “Every person may resort to the courts to ensure respect for his legal rights. There should likewise be available to him a simple, brief procedure whereby the courts will protect him ...”

**Article 24:** for reasons of either general or private interest.

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## Universal Declaration of Human Rights, 1948

**Article 8:** “Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.”

### Protection or Guardianship Action

**Article :** Right to protection or guardianship.

## American Convention on Human Rights, Pact of San José, 1969

**Article 25:** “Right to Judicial Protection. Everyone has the right to simple and prompt recourse, or any other effective recourse, to a competent court or tribunal for protection against acts that violate his fundamental rights ...”

### *What is the purpose of international petitions?*

- To report rights violations (complaints, communication)
- To find out the status of States’ fulfillment of their commitments (reports)

### *Through which mechanisms?*

Treaties, conventions, covenants and protocols provide various mechanisms, including:

1. Reports
2. Communications
3. Rapporteurs and work groups
4. Individual petitions
5. On-site visits

#### 1. Official UN Reports

- Human Rights Committee
- CEDAW
- Committee on the Rights of the Child
- CESC
- Committee against Torture
- Committee on the Elimination of Racial Discrimination
- Parallel reports presented by NGOs

### 2. Documents from United Nations Committees

#### *General Comments and Recommendations:*

- Guides for States Parties on how content of Conventions is interpreted, based on the human rights developments that take place
- Concluding Observations/Comments to States Parties
- Committee Decisions on Individual Complaints/Optional Protocols (few)

### 3. Communications

#### **Optional Protocol to the International Covenant on Civil and Political Rights**

**Article 2:** “individuals who claim that any of their rights enumerated in the Covenant have been violated and who have exhausted all available domestic remedies may submit a written communication to the [HR] Committee for consideration.”

- CEDAW (Optional Protocol)
- Human Rights Committee
- Committee on Civil and Political Rights
- CESCR (Committee on the Elimination of Racial Discrimination): Sub commission on Protection of Minorities
- Committee on the Elimination of Racial Discrimination
- Committee on the Rights of the Child

### 4. Special Rapporteurs and Work Groups (extra – conventional)

#### BEFORE:

- Commission on the Status of Women
- Human Rights Committee
- CESCR

### 5. Individual Petitions (six months)

- CEDAW
- Human Rights Committee
- CESCR

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***What additional strategies have women used in your country and other countries?***

**REPORTING**

- a. Testimonies
- b. Investigations
- c. Symbolic tribunals
- d. Parallel reports
- e. Demonstrations, protests
- f. Reporting through media
- g. Thematic conferences

**Parallel or Shadow Reports**

- Are submitted by NGOs to dispute, totally or partially, official reports.
- They may also suggest questions that the members of the Committee can ask of the official delegates.
- No formalities are required, but they must be highly substantiated.

**CEDAW – Mechanisms**

Optional Protocol 1999

Submitted by the victim or any individual or organization acting on her or his behalf  
Reporting of serious or systematic violations of women's human rights

**GENERAL RECOMMENDATIONS**

Gen. Rec. 14: FC/FGM  
Gen. Rec. 15: HIV/AIDS  
Gen. Rec. 19: Violence against Women  
Gen. Rec. 21: Equality in Marriage  
Gen. Rec. 24: Women and Health  
[www.un.org/womenwatch/un](http://www.un.org/womenwatch/un)

**Other General Comments by Committees**

General Comment 14/2000 CESCR:  
Right to Health  
General Comment 28/2000 CCPR:  
Equality of Rights between Men and Women  
General Recommendation 25 /2000 CERD: Gender-related Dimensions of Racial Discrimination  
[www.un.org/English](http://www.un.org/English)  
[www.unhchr.ch/English](http://www.unhchr.ch/English)  
[www.crlp.org](http://www.crlp.org)

### CONCLUDING OBSERVATIONS OF COMMITTEES TO STATES PARTIES

- Early and forced marriage (CRC Mexico)
- Reproductive health in general – maternal mortality (CEDAW – Belize)
- Contraception (CEDAW – Chile; CCPR – Peru)
- Abortion (CCPR – Argentina, Colombia, Peru)
- HIV/AIDS (All committees)



## CASE STUDY

**CASE**

Ornela Zafa is a 25-year-old nurse who lives in Rioseco (Costa Grande), and works at Hospital La Romera, a private establishment. As a result of an accident at work, she was infected with HIV. Her doctor, Jacinto Piedralisa, informed Ornela's boss of the positive test results, and he decided to fire her, after arriving at an "agreement" in which they gave her a sum of money as compensation and the possibility of having her admit herself at a center for AIDS patients, located about 200 km from her residence, suggesting that that was the best thing for her and her family. She did not want to transfer there, and was left without the protection of the social security system and without medical insurance (for her and her daughter), and she quickly ran out of the minimal compensation she received, since she had to help out with the expenses to support her two-year-old daughter, with whom she lived in her parents' house, and purchase drugs for her treatment.

Her whole family had to move to a house they had in the countryside, since the situation in Rioseco became unbearable. Ornela was not able to get another job, since the entire city soon found out that she had AIDS. Amelia Paredes, one of her coworkers, told their colleagues and soon most of the local health care staff, as well as Ornela's neighbors, knew about it.

Amelia had found out the details about Ornela's health because the director's secretary informed her; and the two of them reviewed her clinical history and confirmed all the details.

For the past ten years, in Hospital La Romera, the files and custody of the clinical histories have been left in the hands of the administrative staff and of the service providers, in an office that can be accessed freely. The shelves where they are filed are open.

Three years ago, it became known that Rodolfo, an employee in the same hospital was diagnosed HIV-positive, and he was transferred to a position that would not represent a risk to Rodolfo's health or the health of the hospital's patients. He was trained for the position of librarian, where he remains and has been able to continue his treatment, thanks to Social Security, which provides him with the drugs he needs.

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**GENERAL RECOMMENDATION No. 15 (NINTH SESSION, 1990)**

*Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS)*

The Committee on the Elimination of Discrimination Against Women,

Having considered information brought to its attention on the potential effects of both the global pandemic of acquired immunodeficiency syndrome (AIDS) and strategies to control it on the exercise of the rights of women,

Having regard to the reports and materials prepared by the World Health Organization and other United Nations organizations, organs and bodies in relation to human immunodeficiency virus (HIV), and, in particular, the note by the Secretary-General to the Commission on the Status of Women on the effects of AIDS on the advancement of women and the Final Document of the International Consultation on AIDS and Human Rights, held in Geneva from 26 to 28 July 1989,

Noting World Health Assembly Resolution WHA 41.24 on the avoidance of discrimination in relation to HIV-infected people and people with AIDS, of 13 May 1988, Resolution 1989/11 of the Commission of Human Rights on non-discrimination in the field of health, of 2 March 1989, and in particular the Paris Declaration on Women, Children and AIDS, of 30 November 1989,

Noting that the World Health Organization has announced that the theme of World AIDS Day, 1 December 1990, will be "Women and AIDS",

Recommends:

- a. That States parties intensify efforts in disseminating information to increase public awareness of the risk of HIV infection and AIDS, especially in women and children, and of its effects on them;
- b. That programmes to combat AIDS should give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection;
- c. That States parties ensure the active participation of women in primary health care and take measures to enhance their role as care providers, health workers and educators in the prevention of infection with HIV;
- d. That all States parties include in their reports under article 12 of the Convention information on the effects of AIDS on the situation of women and on the action taken to cater to the needs of those women who are infected and to prevent specific discrimination against women in response to AIDS.

**GROUP 1 – COMPLAINT**

Identify, in the Code of Medical Ethics of the country, the rights violated by Dr Jacinto Piedralisa's conduct.

Read article 1, paragraphs 1, 4 and 9; and article 2, paragraphs 34, 37 and 38.

Review CEDAW General Recommendation No.15 on HIV/AIDS.

Mechanisms for defending Ornela's rights:

- Draft a complaint to submit to the Medical Ethics Court, which exists in every country, for violation of the professional secret by the person who revealed the results of the HIV test.
- Assuming that there is an Ethics Court to denounce the conduct of nurses, and a Code such as the Code of Medical Ethics, draft a similar complaint to report Amelia Paredes' conduct. In this case, Ornela decided to give power to a female attorney from the feminist group "We Are Women" ("Somos Mujeres").
- Submit a copy of this complaint to the Health Superintendent.

---

**Complaint before the Medical Ethics Court**

City and date \_\_\_\_\_

Sirs

MEDICAL ETHICS COURT

Rioseco Province

Costa Grande

Re: Complaint against Dr. Jacinto Piedralisa and against Hospital La Romera

Dear Sirs:

I \_\_\_\_\_, of age, ID No. \_\_\_\_\_ of \_\_\_\_\_ residing in \_\_\_\_\_ take the liberty to file a complaint against Dr. Jacinto Piedralisa and against Hospital La Romera.

The complaint against the first consists of the following:

(Narrate the facts in detail, giving dates and places where the events occurred.)

1. \_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_

3. \_\_\_\_\_  
\_\_\_\_\_

The complaint against the hospital is based fundamentally on poor methods of filing and guarding the clinical histories that are available to the administrative and health care staff, in an office that can be accessed freely and where they are filed on open shelves.

The previous facts constitute an open violation of the Code of Medical Ethics, especially of its articles \_\_\_\_\_, which indicate that: \_\_\_\_\_

Annexed as proof are the following documents:

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_

In addition, the following people can give their declaration on the situations narrated:

1. (name, occupation, address)  
\_\_\_\_\_
2. (name, occupation, address)  
\_\_\_\_\_
3. (name, occupation, address)  
\_\_\_\_\_

I hope that this Court will conduct the appropriate investigation and adopt all relevant measures.

If necessary, I am available to expand on this complaint.

---

## GROUP 2 – ACTION OF PROTECTION

Identify the rights violated, reading the articles indicated on the Constitution of Costa Grande and any relevant national laws.

Also, as it is already an internal legislation (since it was ratified by the Congress of Costa Grande), use the Convention on the Elimination of All Forms of Discrimination Against Women.

Review CEDAW Recommendation No.15 on HIV/AIDS.

Mechanisms for defending Ornela's rights:

Draft an Action of Protection or Guardianship before the judge for protection of her fundamental rights, including the right to life, which are at risk because her rights to health and work have been violated. List other rights, which you consider are linked to this case and have been infringed or violated.

Constitutional Norms: Articles 5, 13, 15, 16, 28, 42, 43, 44, 48 and 49 (to facilitate the exercise, each participant should read two of the articles and excerpt the right being recognized).

Convention on the Elimination of All Forms of Discrimination Against Women: Articles 10, 11, 12, 15 and 16.

**ACTION OF PROTECTION**

Sir  
Judge \_\_\_\_\_  
Rioseco Province  
E. S. D.

I \_\_\_\_\_, ID No. \_\_\_\_\_, of \_\_\_\_\_, resident of the city of \_\_\_\_\_, acting on my own behalf, by means of this document present before you Action of Protection against \_\_\_\_\_, residing at \_\_\_\_\_, to have him or her halt all perturbing acts that infringe my right (to freedom of opinion, to freedom of assembly, to work, to information, to freedom of thought and conscience, to personal privacy, to life, to health, to autonomy, to free development of personality, to freedom of movement, and to found a family, etc.), which is being disregarded (or is being threatened or infringed) based on the following:

**Facts**

On \_\_\_\_\_ (date), Mr. or Mrs. or entity \_\_\_\_\_ (determine the person or entity who has violated the right) did the following:

(Narrate it thoroughly, clearly and briefly)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

I, under oath, hereby declare that I have not previously filed an Action of Protection for the aforementioned. I have unsuccessfully resorted to the following authorities:  
(name the rights of petition, complaint and other actions taken).

---

**FUNDAMENTAL RIGHTS**

The previous facts constitute a violation (or threat) of my fundamental right to (may be one or several). (State these fundamental rights in simple terms; there is no need to mention the articles of the Constitution, but it is preferable to review and cite some of them.)

**EVIDENCE**

Your Honor, I hereby request the decree, practice and submission of the following evidence:

1. Documentation
2. Testimonials: Your Honor, please summon Mr. \_\_\_\_\_ and Mr. \_\_\_\_\_, of the \_\_\_\_\_ profession, residing at the following addresses, to have them declare under oath about the facts stated in this complaint.

**NOTIFICATIONS**

1. Mr. \_\_\_\_\_ receives personal notifications at the following address:
2. Mr. \_\_\_\_\_ receives personal notifications at the following address:
3. Mrs. \_\_\_\_\_ receives personal notifications at the following address:
4. The undersigned receives personal notifications with the secretary of the court or at the \_\_\_\_\_ of this city.

Sincerely,

Ornela Zafa

ID # \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_

**GROUP 3 – RIGHT TO PETITION BEFORE CEDAW**

Identify the rights violated in the Convention for the Elimination of All Forms of Discrimination against Women and in the Optional Protocol to the Convention.

Read articles 10, 11, 12, 15 and 16 of the Convention and articles 2, 3, 4 and 8 of the Optional Protocol.

(Costa Grande has adopted all the previous documents). Review CEDAW Recommendation No. 15 on HIV/AIDS.

Mechanism for defending Ornela's rights:

Develop a right of petition, by means of a communication addressed to CEDAW, to have the Committee conduct the appropriate investigation and urge the State of Costa Grande to comply with the obligations assumed by the Convention, to eliminate discrimination for reasons of sex and health against Ornela and her daughter.

---

**Sample Communication to the Committee for the Elimination  
of Discrimination against Women – CEDAW**

**New York – United Nations Headquarters  
Office of the Secretary-General**

**I. Information about the author of the communication**

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

Nationality: \_\_\_\_\_

Profession: \_\_\_\_\_

Current address: \_\_\_\_\_

E-mail: \_\_\_\_\_

Address for exchanging confidential correspondence  
\_\_\_\_\_

Submits the communication in the capacity of:

a. Victim of the violations listed below: ( )

b. Designated representative (with power of attorney) of the victim(s): ( )

c. Others \_\_\_\_\_ ( )

When filling out item c), the author must explain:

i. In what capacity s/he is acting on behalf of the victim(s) (for example, as a relative or as someone with other personal ties to the alleged victim(s):  
\_\_\_\_\_

ii. Why is/are the victim(s) not able to file the complaint herself/themselves?  
\_\_\_\_\_

**II. Information about the alleged victim(s) (if different from the author)**

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

Nationality: \_\_\_\_\_

Profession: \_\_\_\_\_

Current address: \_\_\_\_\_

E-mail: \_\_\_\_\_

**III. State Involved/Internal Resources**

Name of State against which the complaint is filed:

Costa Grande

Ratified the Convention for the Elimination of All Forms of Discrimination against Women, through law of Congress 6877 of 25 July 1984, and the Optional Protocol to the same Convention, 15 May 2001.

Measures taken by or on behalf of the alleged victim(s) to exhaust internal resources (resort to courts or other public authorities, with what results, if possible, append copies of relevant judicial or administrative decisions: (mention complaints developed, the Action of Protection and the results obtained)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If internal resources have not been exhausted, explain why:(nonexistent, ineffective, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IV. Facts of the claim (add as many sheets of paper as necessary for this description)**

Detailed description of the facts of the alleged injustice and of the discriminatory practices against the woman or of the alleged violations (Including relevant dates):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

---

#### **GROUP 4 – Parallel, Shadow or Alternative Report**

Identify the rights violated in the Convention on the Elimination of All Forms of Discrimination Against Women, reviewing articles 10, 11, 12, 15, 16 and 18.

*(Costa Grande has adopted all of the previous documents.)*

Review CEDAW Recommendation No. 15 on HIV/AIDS.

Mechanisms for defending Ornela's rights:

Coincidentally, the periodic report that Costa Grande submits every four years to CEDAW will be reviewed in three months, and the Health chapter of the Official Report, states:

“The Ministry of Health has verified that HIV-positive women are treated adequately by the public and private health institutions, through a Confinement Center presided by the First Lady, where they receive comprehensive services and are kept away from the community to prevent them from contracting diseases and infections that the general population could transmit to them and to which they are vulnerable due to their low resistance, which is characteristic of HIV patients. In addition, to avoid any risk of pregnancy, they are not allowed visits from their husbands, boyfriends or partners, unless they remain in glass cabins that keep them isolated.”

Ornela resorts to an NGO based in the capital of Costa Grande, “Somos Mujeres,” to whom she tells her story. This organization wants to make public cases such as this one, and other similar cases that have been developing in the country for the past eight years.

Somos Mujeres gathers information from the Confinement Center and from other institutions, and, through a brief parallel or shadow report that is simple but well documented, reports discriminations suffered by Ornela and other HIV-positive women.

### PRODUCING SHADOW REPORTS TO CEDAW<sup>50</sup>

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), as an international instrument to promote, defend and monitor women's rights, relies on a Committee which the States Parties submit an initial report within one year of ratification and thereafter every four years on the advances made to eliminate obstacles to the equality between women and men. These reports serve to review the degree of implementation of CEDAW; help States understand their obligations relative to women's rights recognized in the Convention; facilitate the formulation of public policies; and make General Comments and Recommendations, among others.

For their part, nongovernmental organizations may develop shadow or parallel reports to officials, to demonstrate their outlook on the entire official report or part of it.

Shadow reports must include:

- Brief background information about the country, preferably complementing the State Party report.
- Indicate the section or paragraph of the official report to which you are referring.
- Indicate the articles of the Convention to which each violation or breach of the State refers.
- Transcription of articles of the Political Constitution, of secondary laws or relevant regulations and verdicts, related to the right that was violated.
- Name the actors responsible for the breach.
- Append documentation supporting the NGO report.
- indicators, such as statistics or the lack thereof, as well as case studies, among others.
- Present concrete recommendations for change.
- Include information on the NGO(s) that developed the shadow report.

“In producing a shadow report, it is important that NGOs submit both the previous official report and the Comments and Recommendations made by the Committee to the State (in cases where others have been submitted) and, of course, the one that will be submitted at the next session of the Committee. The most successful NGO strategy has been to organize their reports as comments on the Government's report; this is easier to do if one has the previous report, since that allows one to assess whether progress was actually made and whether the State observed the recommendations made by the Committee. This allows the Committee to have more criteria to assess the veracity of the official report.”<sup>51</sup>

As for the organization of the shadow report, CEDAW suggests including the following aspects for the greatest impact:

- a. Organize the information according to articles of the CEDAW Convention, and not by topics. For each topic, it is important to give examples and evidence of how it affects women of different ages, ethnic groups and social classes, among others.
- b. The report should be no more than 30 pages, including the table of contents.

<sup>50</sup> Synthesis of: Facio A, Producing Shadow Reports to CEDAW, San José, Costa Rica: ILANUD, Women, Justice and Gender Program, UNIFEM, 2001

<sup>51</sup> Vargas 1999 (pp. 7-8).

- 
- c. Provide an executive summary of no more than three pages, which should contain the main points of the report, in addition to evidence and data as support of the central points and recommendations. It is a good idea to include an English translation.
  - d. Analyze rather than simply describe the problems, including evidence of that which is being affirmed and suggestions written in a style similar to that of the CEDAW Recommendations. Documentation can include statistics (disaggregated by age, marital status, class, region), legal cases, testimony of individuals, news clips, academic research, parts of theses, laws and court rulings, among others.
  - e. Prioritize issues according to the order established by NGOs.
  - f. Include an analysis of reservations made by the country before the Convention, suggesting changes that will allow their elimination, and accounts of NGO efforts relating to their withdrawal.
  - g. Include some background information about the country or region.
  - h. Identify major obstacles and recommend approaches to removing them, as well as the actors who should be involved and how they should be involved to transform the situation at hand. Recommendations should be concrete and include specific actions or processes.

Suggested format for shadow reports:

1. Title page, including title, author(s) and date of the report
2. Executive summary
3. Table of contents
4. Introduction that gives more information about the production of the report
5. The main body, organized by Convention article, including recommended actions
6. Concluding remarks
7. Appendix (can include laws, lists of participants, etc.).

The shadow report should be presented to CEDAW at least six weeks prior to the session at which the country report is to be reviewed, to ensure that experts have access to it before the official session. Since the Committee consists of the president and 23 experts, it is recommended to send 24 copies, by certified mail, to ensure their delivery.

In each country, production of a shadow report can be a strategy for social mobilization of women, as it affords the opportunity to unify several collectives of women; to raise the awareness of society in general about discrimination against women; and to develop collective proposals to solve the inequities of and demands on the obligations that the State has assumed upon ratifying the Convention.

### GUIDE No. 4 – ACTION PLANS

Considering the topics addressed, reflect on and answer the following questions:

1. How do the activities that you have designed contribute to ensuring the process of informed choice?
2. What mechanisms for the defense of sexual and reproductive rights will you include in your activities?
3. How will your activities help to improve quality of care?
4. What indicators of quality in gender and rights will you use to measure the results of your activities?



## SESSION 8: ACTION PLANS

### OBJECTIVES

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

- Define “Quality of Care” from a gender and rights perspective.
- Complement the definition of quality of care, incorporating gender and SRR included in international instruments.
- Advance the development of action plans, incorporating gender and SRR included in international instruments.
- Be sensitized to their own experiences with gender and the exercise of rights.
- Review and complement action-plan activities with contents of previously discussed sessions.

DAY 4 TIME: 3 hours, 55 minutes

### PREPARATION

- Session 8 objectives printed on a flipchart
- Arrange to use an adequate space that will allow coaching several participants at the same time
- Trainers who have supported the sessions conducted up until now should be present to provide coaching, in case it is needed
- Instructions for designing action plans on a flipchart

### MATERIALS

- Flipcharts, markers, tape
- Copies of handouts for the participants
- Two copies of the Session Evaluation Form, found at the beginning of this manual

### HANDOUTS

- 8A: My Life, My Journey
- 8B: Guide No. 2: Action Plans
- 8C: Guide No. 3 – Action Plans
- 8D: Designing Action Plans
- Session Evaluation Form

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## FACILITATING SESSION 8

### STEP 1 (30 minutes)

#### DEFINITION OF QUALITY OF CARE FROM A GENDER AND RIGHTS PERSPECTIVE

- Review the definition of quality of care that was developed collectively from Session 3. Read it aloud.
- Organize groups of three and give each group a flipchart.
- Ask each group to take 10 minutes to incorporate the following topics into the previous day's definition of quality of care:
  - a. Rights included in international instruments;
  - b. Definition of sexual and reproductive health; and
  - c. Concepts analyzed from a gender focus (roles, practical needs, strategic interests, etc.).
- Give the groups another ten minutes to develop a new definition.
- The three definitions should be placed in a visible place in the room.
- The trainer should lead the discussion to agree on one definition of quality of care.
- Ask participants to come up and put a check mark next to the definition they agree with the most.
- Read it aloud.
- Ask if any point from the other definitions need to be incorporated into the definition selected. Since time is limited, the trainer may need to limit the suggestions to two or three.

### STEP 2 (35 minutes)

#### SENSITIZATION TO PERSONAL EXPERIENCES WITH GENDER AND THE EXERCISE OF RIGHTS

- Tell participants that this is an introspective exercise.
- Assure them that this exercise is a reflection and they do not have to share their responses with anyone if they do not want to.
- Give each participant Handout 8A: My Life, My Journey. Give them 15 minutes for this exercise
- Ask them to fill out the guide individually.
- During this activity, participants reflect without the need to share answers.
- Ask participants how they feel after the exercise.
  - Have their responses been affected by their experience of this training? In what way?

### STEP 3 (10 minutes)

#### RELAXATION

- Close the session with a relaxation exercise, inviting participants to close their eyes, take deep breaths, and visualize the place where they have always wanted to be.
- Begin saying how well they feel, how relaxed they are, how beautiful is the landscape.
- Ask them to return to the training site and slowly open their eyes.

- 
- Distribute Handouts 8B: Guide No. 2: Action Plans and 8C: Guide No. 3 – Action Plans to each participant so they can continue advancing their action plans.

#### STEP 4 (10 minutes)

##### ACTION PLANS

- Review objectives for this session.
- Tell the group that this session is designed so that each participant can progress in developing his or her action plan.
- Indicate that to initiate the work it is important to review the questions raised on previous days and answer those found in Handout 8A.

#### STEP 5 (2 hours 20 minutes)

##### DESIGNING ACTION PLANS

- Give each participant Handout 8D: Designing Action Plans and explain the different parts of the form.
- Instruct them to complete the various columns, except the “indicators” column, which will be discussed in the Quality of Care session.
- Put up and read out the flipchart below.



##### Flipchart

**Objectives:** the accomplishments to be attained through carrying out the actions. They must be clear, realistic and relevant. Objectives are intended to answer the following questions: What do we want to accomplish? What changes do we want to make in light of the problem situation we aim to resolve? Where do we want to arrive?

**Activities:** the concrete actions or tasks through which we hope to attain the proposed objective.

**Time:** date on which we hope to conduct the planned activities.

**Resources:** material, human, financial and technical resources required to carry out the activities.

**Point Person:** individual(s) in charge of carrying out the activity.

**Indicators:** specific and objectively verifiable measures of the changes or results of an activity, or of a proposed objective. Indicators serve as a pattern to measure, evaluate or show progress of an activity with respect to the objectives proposed.

- Clarify any questions or concerns.

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STEP 6 (10 minutes)  
EVALUATION

- Give each participant Handout 8D: Designing Action Plans and explain the different parts of the form.
- Instruct them to complete the various columns, except the “indicators” column, which will be discussed in the Quality of Care session.
- Hand each person two copies of the Session Evaluation Form, found at the beginning of this manual.

MY LIFE, MY JOURNEY

Read and develop answers to the following questions from your own personal experience.

What would I have liked to do in my life that I was not able to do? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What illnesses have I had in the past month and why? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What did I do to improve my health? \_\_\_\_\_

\_\_\_\_\_

If I went to a health center or facility, how did they treat me? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

---

I live in common union: YES \_\_\_\_\_ NO \_\_\_\_\_

Why? \_\_\_\_\_

I have experienced violence in this way \_\_\_\_\_

My pregnancies / my partner's pregnancies have been \_\_\_\_\_  
(planned, wanted, forced, unintended, accompanied, assisted, cared for, safe, etc.)

I/my partner have had abortions because \_\_\_\_\_

I'm afraid of \_\_\_\_\_

My work relations have been \_\_\_\_\_

The decisions I make deal with \_\_\_\_\_

### GUIDE No. 2 – ACTION PLANS

After reviewing your answers from the previous day, answer the following questions:

1. Identify the elements related to gender and rights that are present in your topic.
2. Identify how your topic is related to the Cairo, Beijing and CEDAW instruments.
3. Do you think your topic refers to practical needs or strategic interests? Why?



### GUIDE No. 3 – ACTION PLANS

1. Introduce the objectives you plan to reach in your action plan.
2. What activities do you propose to conduct to resolve your issue (objectives) and contribute to improving the quality of sexual and reproductive health care?
3. Does that solution respond to a practical need or a strategic interest? Why?
4. Do your activities allow for the prevention, detection and management of violence? In what sense?



DESIGNING ACTION PLANS

Objectives	Activities	Resources	Time	Point Persons	Indicators

Topic selected: \_\_\_\_\_



## SESSION 9: INFORMED CHOICE

### OBJECTIVES

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

- Understand that informed choice is an exercise of rights.
- Identify the elements in an informed choice process, their relationship with gender and rights, and the factors involved in the choice.
- Relate the informed choice process to quality of care in sexual and reproductive health.

DAY 4 TIME: 3 hours 40 minutes

### PREPARATION

- Session #9 objectives printed on a flipchart
- Flipchart presenting Handout 9A
- Flipchart presenting Handout 9D

### MATERIALS

- Flipcharts, markers, tape
- Index cards in three different colors
- Letter-size blank paper
- Copies of handouts for participants
- Two copies of the Session Evaluation Form, found at the beginning of this manual.

### HANDOUTS

- 9A: Informed Choice
- 9B: Informed Choice Process
- 9C: Case Studies
- 9D: Informed Choice Process
- Session Evaluation Form

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## FACILITATING SESSION # 9

### STEP 1 (50 minutes)

#### INFORMED CHOICE AS AN EXERCISE OF RIGHTS

- Invite reporters to present the central ideas of the topics discussed the previous day.
- Review the session objectives.
- Conduct the following icebreaker exercise: ask participants to make themselves comfortable in their seats, close their eyes, and breathe slowly and deeply, concentrating on their breathing.
- As they do that, facilitator talks about the importance of sexuality in the life of every individual; that sexuality is related to life itself, to sensations, feelings, the body, the skin, smell, touch.
- Ask the following question: What was the last thing you decided, accepted or rejected with respect to your sexuality and your reproduction?
- Give them a brief moment for reflecting.

#### 2 NOTE TO THE TRAINER

- For this exercise we recommend playing some music and burning incense or candles if possible.

Encourage participants to share their experiences voluntarily. Stressing confidentiality of the personal experiences shared in this workshop.

- Be prepared to share one or two comments in case people hesitate to speak at the beginning.
- List participants' comments on a flipchart.
- From these comments, ask the group to identify the rights involved in making a choice and list them on a separate flipchart.

### STEP 2 (1 hour)

#### DEFINITION AND FACTORS OF INFORMED CHOICE

- Present the definition of informed choice (Handout 9A: Informed Choice) and the factors that influence it.
- Ask for volunteers to clarify the difference between informed choice and informed consent.  
Informed choice is understood as a “dynamic decision-making process, and ultimately, the freedom and necessary conditions to make a decision that corresponds to the life and health needs of the individual, and allows him or her to carry out his or her reproductive intentions.
- Informed consent is the final product of an individual process through which the client makes an informed and voluntary choice, from a range of options, which should be offered by the health care provider and guaranteed by the Government.
- Present the following from Handout 9B: Informed Choice Process:

---

Informed choice requires:

- a. Respect of individual choice and autonomy;
  - b. Two-way communication;
  - c. Access to comprehensible information;
  - d. Options of methods or treatments available;
  - e. Time for questions and reflecting;
  - f. Right to reconsider at any moment; and
  - g. Confidentiality and privacy
- Ask participants to write on the cards the factors that influence informed choice, in normative, institutional and socio-cultural areas.
  - Give each person three cards in different colors.
  - Post on the wall or flipchart three cards, each one of a different color, with the following titles: NORMATIVE, INSTITUTIONAL and SOCIO-CULTURAL (Gender).
  - Participants should read their cards aloud and tape them onto the indicated place, according to the corresponding color.
  - Develop a matrix collectively with the factors involved in informed choice.
  - Go through the cards, omitting those that are repeated.
  - Ask participants to come up and look at the matrix.
  - Encourage a group discussion to develop cards with any missing elements.
  - In a plenary session, ask the questions:
    - Where is the problem?
    - Where to act?
  - Record responses on a separate flipchart for each question.
  - Allow five minutes at the end for the group to reflect on the discussion and to share any thoughts.

STEP 3 (1 hour, 40 minutes)

#### RELATIONSHIP BETWEEN INFORMED CHOICE AND QUALITY OF CARE

- Divide participants into two groups.
- Distribute Handout 9C: Case Studies and ask them to organize role-plays based on the case studies.
- One group should represent, based on Case 1, a situation of quality of care, considering the elements and factors of informed choice.
- The other, based on Case 2, should role-play a situation in which rights are violated.
- Give the groups twenty minutes to prepare their role-plays.
- Ask each group to present its role-play.
- In the large group, ask participants what important issues they observed in each role-play.
- Also ask:
  - a. What were the institutional factors required to ensure that an institution provides quality services?
  - b. What were the elements required to ensure that an institution provides quality services?

- 
- c. What role does the family and community play in ensuring access to, or depriving individuals of, their rights?
- Give a presentation based on Handout 9D: Informed Choice Process on the diagram of informed choice and informed consent.
  - Ask participants if they have any concerns, questions, reflections or comments on this session.

STEP 4 (10 minutes)

EVALUATION

- Hand each person two copies of the Session Evaluation Form, found at the beginning of this manual.

## INFORMED CHOICE

### Informed Choice

Informed choice is understood as a “dynamic decision-making process, and ultimately, the freedom and necessary conditions to make a decision that corresponds to the life and health needs of the individual, and allows him or her to carry out his or her reproductive intentions.”

### Informed Consent

Final product of an individual process through which the client makes an informed and voluntary choice, from a range of options, which should be offered by the health care provider and guaranteed by the Government.

### Factors that Influence Informed Choice

- a. Legal
- b. Institutional
- c. Socio-cultural



### INFORMED CHOICE PROCESS

“... the needs, wishes and human rights of each individual should be the crucial reason guiding the informed choice process and any decision resulting from it.”

Despite advances in the global and national development of informed choice, the actual implementation of the informed choice process in service delivery is far from ideal, as acknowledged by Engender Health (formerly AVSC International).

Informed choice is a principle of the international sexual and reproductive health agenda and of quality family planning services. The informed choice process should ensure clients' empowerment to make their own decisions with respect to family planning and health care, as well as to practice freely this right to make decisions in an information and service setting.

Informed choice requires:

- a. Respect of individual choice and autonomy;
- b. Two-way communication;
- c. Access to comprehensible information;
- d. Options of methods or treatments available;
- e. Time for questions and reflecting;
- f. Right to reconsider at any moment; and
- g. Confidentiality and privacy

Health care services should provide all information available to clients in language that is comprehensible; answer any doubts they may have; show the different options of contraceptive methods and their effects on health; and consider the needs and specific situation of each individual.

Informed choice is an exercise of basic human rights. The informed choice process should result in a voluntary and informed decision by the individual about whether or not he or she desires to obtain health treatment or services; which treatments or services he or she will choose; whether he or she should seek or accept referral; and whether he or she should consider the issue more carefully.

In speaking on informed choice, international conferences declare:

“All service providers should safeguard the principle of free and informed choice, providing extensive information on the whole range of safe and effective methods. Their objective should be to support responsible and voluntary decisions regarding procreation and fertility regulation methods, so as to meet changing needs during the entire life cycle” (ICPD, Cairo/94).

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“[Service providers should] [e]nsure responsible, voluntary and informed choice and consent, providing comprehensive and accurate information on a variety of medical methods and options, including potential benefits and side effects, that allow individuals and couples to make voluntary and informed decisions” (Beijing/95).

## CASE STUDIES

**CASE 1**

Luisa, a 28-year-old woman, and Pedro, a 30-year-old man, have been married for six years; they have two daughters – one is five years old and the other one three years old. Their relationship is stable. Pedro has always wanted a son, but Luisa does not want to have any more children because her pregnancies have been very complicated. Besides, she has great possibilities of being promoted at work, and she does not want to lose this opportunity due to the complications that would result from a new pregnancy. This has led to the deterioration of the couple's sexual relations. Pedro has asked her to quit her job, arguing that he makes enough money to maintain the household and that the complications of her previous pregnancies were due to the fact that she was working.

Because Luisa does not want to become pregnant, she has been using contraceptive pills since the birth of her younger daughter. This was unknown to Pedro, because he insists on having a son and does not allow her to use contraceptive methods. The pill has affected Luisa's health and, since she knows she can solve her problem by choosing a permanent method, she decides to see a gynecologist.

Luisa's mother, Filomena, advises her to please Pedro because he could get tired; although he is a very good and responsible man, he could end up leaving her. On the other hand, Teresa, a friend and coworker of Luisa, advises her to think about her health, her life and her rights, and tells her that she is free to make her own choices about her sexuality and reproduction. Luisa is very confused, but she is very clear on one thing: she does not want to have any more children.

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## CASE 2

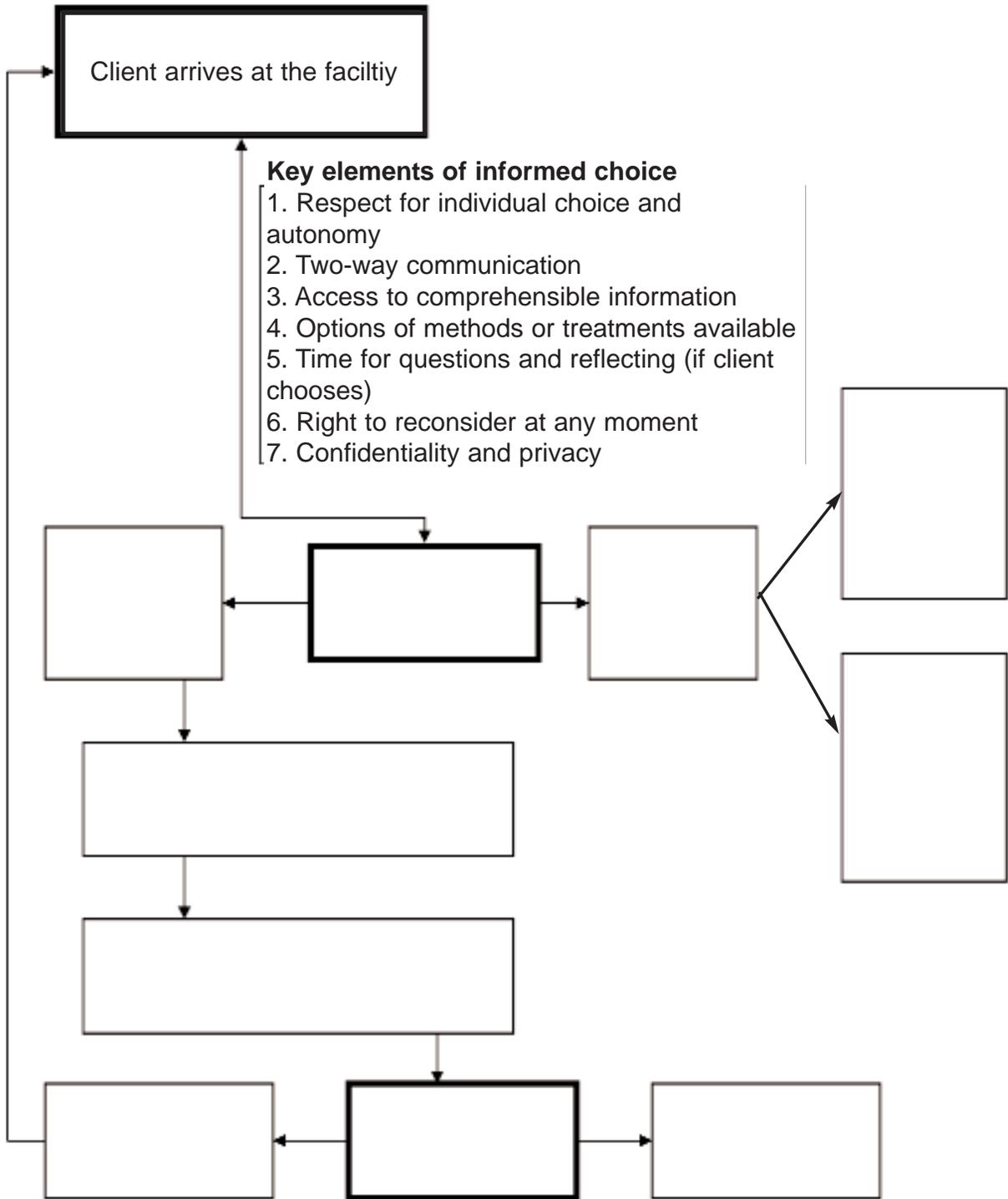
Martha and Julio are 14 and 17 years old, respectively. They go to the same school, have been dating for months and are very much in love. After a party, they have sex, which is very pleasurable for them but generates a great deal of worry in Martha because they do not use any protection.

Fortunately, Martha does not become pregnant. It is her first sexual relation. Julio has already experienced sexual relations with other women.

Martha and Julio go to a medical center with the idea of seeking information on family planning methods.

Martha's mother, Cecilia, finds out through a neighbor that her daughter and her daughter's boyfriend have been to the medical center, and she heads to the center to find out why.

INFORMED CHOICE PROCESS

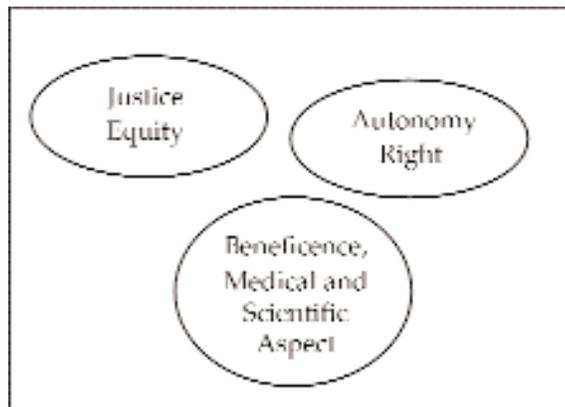


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Dual Purpose of Informed Consent

- Protection of rights and client
- Satisfaction and protection of the service provider

Principles of the Informed Choice Process



## SESSION 10: IMPROVING QUALITY OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

### OBJECTIVES

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

- Complement the definition of quality of care with all the approaches discussed.
- Produce quality of care indicators related to gender and sexual and reproductive rights, and incorporate them in the action plans.
- Develop action plans, incorporating gender and rights perspectives and expressing indicators.

DAY 5 TIME: 6 hours 35 minutes

### PREPARATION

- Session 10 objectives printed on a flipchart
- Flipchart of Handout 10A
- Flipchart of Handout 10C

### MATERIALS

- Copies of handouts for participants
- Two copies of the Session Evaluation Form, found at the beginning of this manual

### HANDOUTS

- 10A: Quality of Care
- 10B: Quality of Care – Three Settings or Levels of Implementation
- 10C: List of Gender and Sexual and Reproductive Rights Indicators
- Session Evaluation Form

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## FACILITATING SESSION 10

### STEP 1 (1 hour, 45 minutes)

#### QUALITY OF CARE

- Invite volunteers to debrief the previous day.
- Present the objectives of the session.
- Give a presentation on quality of care, based on Handout 10A: Quality of Care.
- To expand on the information related to health-care settings, refer to Handout 10B: Quality of Care – Three Settings or Levels of Implementation.
- Allow time at the end of the presentation for participants' questions.
- Review the definitions developed the day before and compare them with those of previous days.
- On one flipchart, list the elements that have been repeated; on another, list new elements found only in the most recent definitions.
- Read these elements and tell the group that they should consider these challenges to incorporate into the new definition.
- Divide participants into groups of six
- Give them twenty minutes to develop a new definition of quality of care, incorporating the new elements.
- The groups present their definitions and the entire group, in consensus, develops a final definition that incorporates all the topics and approaches that have been discussed.

### STEP 2 (30 minutes)

#### QUALITY OF CARE INDICATORS

- Give a presentation on quality of care indicators in sexual and reproductive health care services in three settings: system, provider and client, using Handout 10C: List of Gender and Sexual and Reproductive Rights Indicators.
- Encourage the participants to ask questions and make comments.
- Give each person a copy of this Handout.

### STEP 3 (4 hours)

#### FINAL DEVELOPMENT OF ACTION PLANS, INCORPORATING GENDER AND RIGHTS PERSPECTIVES AND EXPRESSING INDICATORS

- Organize groups of five or six people.
- A facilitator should accompany each group.
- Within each group, each individual should share his or her activities, and then the group should discuss possible indicators.
- Give the groups one hour for this work.

- 
- Inform participants that they will have 1 hour, 30 minutes to review and complete their action plans, and that a facilitator will be available for this individual work.

## 2 NOTE TO THE TRAINER

- For this activity, set aside different spaces and, if possible, several computers, so that participants can finish developing their action plans.

- Ask everyone to present the results of their work.
- If appropriate, three participants can be selected at random to present their action plans in a plenary session.

### STEP 4

#### EVALUATION AND WRAP UP (*10 minutes*)

- Give each participant a copy of the session and module evaluation, found at the end of this manual.
- After everyone has finished filling out the form, open up the floor for an oral evaluation, with the assistance of each member of the facilitating team.
- Ask for volunteers to express their opinion with respect to the workshop, emphasizing what they learned, changes made at a personal level, challenges they faced and recommendations for future workshops.
- To close the module, conduct the following activity:  
Have participants form a circle, and tell them to look around the room, observing all that is exhibited and has been posted throughout the week.  
Then, ask them to pair up and have one person say: "What I gave you, I gave willingly, and you may keep it", and the other reply: "I take what you gave me, and I will keep it with respect and love".
- Group hug



## PRESENTATION ON QUALITY OF CARE

### An Issue of Quality

Quality of care is a philosophy of comprehensive care oriented toward client satisfaction, through changes in personal relations in services and in administrative and technical practices.

### Quality Care

- Promotes, facilitates and ensures greater levels of comprehensive health and/or well being of individuals in psychological, social, biological, sexual and cultural aspects of life.
- Resolves the reason for consultation, contributes to the positive modification of low self-esteem, ownership of the body and the exercise of rights.
- Quality care not only offers services and resolves unmet needs (health care problems) of the population, but also fundamentally:
  - a. Recognizes and respects differences and promotes sexual diversity (acts, behaviors, meanings associated with reproduction and sexuality);
  - b. Establishes equitable relationships (for example: client-provider, couple, population and state); and
  - c. Facilitates the exchange of knowledge.
- Respects and promotes clients' autonomous decisions.
- Promotes the process of empowerment of all clients.
- Empowers individuals to exercise their rights.
- Includes active and equitable participation of all individuals involved in the delivery of health care services.
- Offering quality care from a gender perspective requires initial work at two levels:
  - a. Identifying socio-cultural aspects associated with being a woman or a man which facilitate or obstruct the possibilities of health care of the population; and
  - b. Detect the structural and personal factors in service delivery that reproduce gender stereotypes, which translates into a factor of inequity for women and men, or in health care disadvantages.
- This work includes observing how health care institutions reinforce or weaken these aspects through different services.

### Quality Settings

1. Health Care System
2. Health Care Providers
3. Client population

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## 1. Health Care System

- Implementation, management, administration and budget of sexual and reproductive health public policies
- Little presence of women at decision-making levels of the health sector and limited representation of women's needs
- University curricula that stimulate medicalization of disease, and disconnect the biomedical vision from the social and cultural aspects in health-disease processes
- Hierarchy and sexual and social division of work within the health care system
- Problems of women's access to the system, as direct users

## 2. Health Care Providers

### 2.1 Institutional Management

- Infrastructure, procurement, equipment and services offered (Prioritization of some groups over others or replication of existing inequities)
- Requirements, administrative protocols, costs
- Guarantee of confidentiality
- Privacy during the consultation
- Hours of health care services
- Contents of clinical histories: incorporation of sexual aspects, STIs, detection of gender-based violence
- Time dedicated to clients vs. productivity
- Optimal technical quality
- Diversification of services (men, adolescents, fertility, sexology, psychology, legal service)
- Educational actions promoting equity: Toll-free information hotlines, educational posters, brochures and actions to promote health
- Degree of partnership with other institutions of the health sector and other sectors and actors: the State, civil society
- Availability of ways to evaluate institutional management, including gender and rights indicators

### 2.2 Relationship Between Clients and Providers (in counseling, consultation, evaluation)

- Empathy on the part of providers, respectful and personalized treatment
- Exchange of knowledge: biomedical knowledge, clients' knowledge and subjectivity
- Horizontal relationship: clients as active participants in health care.
- Elimination of socio-cultural judgments or discriminatory attitudes based on sex, age, marital status, ethnicity, sexual orientation
- Exclusion of condemning judgments
- Promoting and respecting clients' decision-making
- Integrating the socio-cultural and biomedical perspectives in health-disease processes

### 3. Client Population

- Gender-based cultural factors can limit women and men's possibilities to assume more adequate behaviors in caring for their health and exercising their rights.
- Men approach sexual and reproductive health services from their own models of masculinity: resistance to pain, reluctance to ask for help, facing risk.
- Prostate cancer and HIV/AIDS are examples of obstacles that constructions of masculinity impose on men's health care.
- Women's position of subordination makes them relate to service providers under the same parameters.
- Women are encumbered by their fears, their negations, low self-esteem, blame, double standards of sexual morality, and their personal experiences with physical, emotional or sexual violence, in addition to operational or financial difficulties in seeking health care services.

#### 3.1 Resolution of the Reason for the Consultation

There is a need to evaluate factors that might suggest that the concept of "quality" is relative, depending on the perception of different population groups.

These factors include:

- Physical environment
- Family, work, social setting
- Cultural environment
- Lifestyles
- Educational levels
- Psychological context
- Prior experience with services
- Debate on recognizing traditional medicine

#### **IMPROVING QUALITY OF SERVICES REQUIRES:**

- A definition of quality that transcends institutional vision and incorporates clients' criteria.
- Adapting the institution: offering programs to different populations.
- Ensuring privacy.

#### **IMPLEMENTING ADMINISTRATIVE PROTOCOLS REQUIRES:**

- Sensitizing and training service providers to eliminate all forms of discrimination based on gender, ethnicity or social class.
- Ensuring a high level of technical competency.
- Exercising a professional behavior and understanding based on respect, promotion of sexual and reproductive rights, promotion of new models of what it means to be female and male, and more equitable couple relationships.



### QUALITY OF CARE: THREE SETTINGS OR LEVELS OF IMPLEMENTATION

Three settings or levels play a role in the quality of care of sexual and reproductive health services:<sup>54</sup>

#### 1. The Health Care System

“Health Care System” refers to public policies concerning reproductive health and how policies effect management, administration and service budgets. The health care system must motivate health care professionals and ensure the necessary conditions are in place for excellence. In addition, gender needs must be incorporated into the institutional culture.

#### 2. Health Care Providers

The current emphasis focuses on the health care process and on results obtained. However, management models that evaluate professionals based on their productivity, which equals the number of clients they treat per day, still persist, leaving quality and equity reliant on health care policies.

#### 3. Clients of Reproductive Health Care Services

It is necessary to keep a comprehensive focus that considers aspects such as quality of life, physical setting (house, community), psychological setting (family, work and social relationships), culture, lifestyles, educational level, emotional context, and prior experiences with services. The perspective of quality centered on clients traditionally has focused on biomedical aspects. However, a basic criterion of quality in reproductive health services is meeting patient’s (women and men) needs and interests.

Transforming quality of care means developing actions in the three settings mentioned, and being able to count on political will and personal motivation to implement them.

Matamala and Maynou (1996: 90-91) establish that an evaluation of quality of care in women’s health, from a gender perspective, can point to three levels:

- a. Observing whether care reinforces or deconstructs gender inequities and inequalities, through the visualization of mechanisms that are often used during the health care process, and that tend to blame, underestimate and undervalue women, or make them exclusively responsible for contraception.
- b. Observing whether there are inequalities or discriminations in the health care process, comparing between men and women, with respect to the discussions that take place with male and female clients: for example, discussions about sexually transmitted infections.

<sup>54</sup> Centro de la Mujer Peruana Flora Tristán 1998. *Un acto común por construir, Calidad de atención en los servicios de salud reproductiva con enfoque de género*, San Salvador: PAHO, 1995.

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- c. Observing whether there are differences in health care provided to women and men in comparable situations.

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**LIST OF GENDER AND SEXUAL AND REPRODUCTIVE RIGHTS INDICATORS<sup>55</sup>****At the Institutional Level****NATIONAL**

- Existence of policies that expressly prohibit gender-based discrimination, promote rights, and urge the exercise of sexuality in both its reproductive and erotic aspects.
- Use of IEC material and activities with the population, where the topic of equity between men and women and sexual and reproductive rights is promoted and addressed explicitly.
- Guarantee that educational material is distributed effectively.
- Address gender and rights topics at staff meetings.
- Existence of policies to ensure gender-based equity in the promotion of staff and salary increases.
- Promotion of male participation in sexual and reproductive health: existence of programs for men.
- Availability of staff specializing in the areas of gender, sexual and reproductive rights, and sexuality.
- Analysis of relationship between male and female sterilizations.
- Knowledge and use of Ministry of Health provisions related to gender and rights.
- Availability of evaluation systems that measure incorporation of the gender perspective and respect for sexual and reproductive rights, where clients can participate in defining criteria for quality.
- The institution's quality committee takes into consideration the sexual and reproductive rights and gender-based approach.
- Identifying the entire staff employed at the institution, philosophy geared towards sexual and reproductive health care from a sexual and reproductive rights and gender-based approach.
- Optimizing waiting time for educational activities related to gender and rights.
- Incorporation in all clinical histories of questions involving gender and rights.

**At the Health Center Level****GENDER**

- Availability of space to take care of female clients' children: availability of cradles, diaper-changing stations.
- Existence of a policy to address the topic of children during the consultation (e.g. children are allowed to enter exam room; there is someone available to take care of them).

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<sup>55</sup> Based on: Davies G, *Manual de atención médica en salud reproductiva*, Lima: Centro de la Mujer Peruana Flora Tristán, 1996. International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR), *Manual for Evaluating Quality of Care from a Gender Perspective*, New York: IPPF/WHR, 2000. IPPF/WHR, *How Gender-Sensitive Are Your HIV and Family Planning Services?* New York: IPPF/WHR, 2002. Pan-American Health Organization (PAHO) and Regional Office of the World Health Organization (WHO), *Reference Framework, Components and Strategies for Improving Quality of Care in Reproductive Health-Care Services with a Gender Focus*, PAHO/WHO, 1996. AVSC, *Formulario guía para el plan de acción, Evaluación de la calidad de los servicios*, New York: AVSC, 1994.

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- Existence of a policy to address the topic of partners or spouses accompanying women during consultations.
  - Waiting time recognizes women's different roles (as housewives, as workers).
  - Availability of separate bathrooms for men and women.
  - Works in collaboration with other women's groups to better women's lives by challenging social constructs that create gender injustices.
  - Provides opportunities for women to dialogue individually and in groups about the factors that contribute to STI/HIV transmission, unwanted pregnancies, gender-based violence, dependency, etc.

#### **RIGHTS**

- Facilities are comfortable.
- Availability of mechanisms for filing complaints, suggestions and claims (such as mailboxes, customer service office, complaint flyers) and encouraging clients to use them.
- Existence of staff educational activities on gender and sexual and reproductive rights.
- Availability of the full range of contraceptive methods from which clients can choose.
- Visual display of information on services offered, costs, attending providers and hours of operation.
- Client is offered the possibility to choose the provider, as well as the sex of the person from whom she wants to receive treatment.
- Provision of clear information on all the paperwork, indications, and requirements to obtain the services offered at the institution.
- Existence of willingness and information to clarify an inconvenient situation to the client.
- Staff members always carry their ID, and, whenever possible, introduce themselves by name to the client.

#### **At the Provider Level**

##### **GENDER**

- Knows and takes aspects such as suicidal thoughts or attempts, PID, hematoma, complications during pregnancy such as gestational hypertension, premature childbirth, threat of spontaneous abortion, rape, depression, anguish, stress, increase in physical abuse during pregnancy, chronic pain, frequency of sexually transmitted infections, unplanned pregnancies, into consideration in the diagnosis of the effects of violence on sexual and reproductive health.
- Uses non-sexist language.
- Greets client; is not condescending; calls client by her first and last name, without mentioning whether she is a Miss or Mrs. and without calling her by her number.
- Explores gender-based violence with all women who come to the clinic for counseling.
- Records in all clinical histories detection of violence against women, and knows the contents of the detection manual.
- Identifies a wide range of individual and social factors that render women vulnerable to unplanned pregnancies, HIV/AIDS and other sexually transmitted infections.

- Recognizes that being male or female socially constitutes risks for sexual and reproductive health.
- Recognizes the contextual issues that render women vulnerable and targets those issues, and especially the most vulnerable women, for intervention; works to help create the necessary conditions to reduce vulnerability.
- Recognizes the importance of youth exercising their sexuality free from risks, coercion or violence.
- Builds decision-making and negotiation skills on sexual relations, including condom use and personal sexual needs. Explores women's possibilities to negotiate condom use or sexual practices. Explores partner's attitude regarding family planning.
- During the consultation, addresses the topic of pleasurable sexuality and discusses with client her specific sexual practices, preferences and sexual orientation to determine her own individual risk.
- Helps women make fully informed, independent choices about their sexual lives.
- Helps women recognize and overcome gender-based abuse and power imbalances that affect their ability to make decisions and take actions to prevent unplanned pregnancies, HIV/AIDS and other STIs
- Explores risks of HIV/AIDS, STIs and other reproductive tract infections with all clients with confidentiality.
- Offers specific services to all women identified as being victims of gender-based violence or knows where to refer them.
- Helps women to realize that they have the right to decide about their own bodies and to make the most appropriate decisions for themselves.
- Takes special measures to prevent the spread of HIV and other STIs.

### **SEXUAL AND REPRODUCTIVE RIGHTS**

- Uses a rights-based approach as a motivation tool during consultations, including the right to be healthy and free of disease, unwanted pregnancies, coercion or violence.

#### Right to Privacy

- Does not accept interruptions during the consultation; does not divulge the contents of the clinical history to anyone.
- Ensures professional secrecy. Only if the client authorizes it is information divulged to her spouse, father or mother.
- Ensures that counseling spaces cannot be seen or heard from the outside.
- If there is a third party present during the consultation, explains the reason for this to the client.

#### Right to Integrity

- Considers the factors that affect the health-disease processes, beyond the biomedical aspects; in other words, favors the concept of being humane and integral, and recognizes the differences between men and women.
- Treats individuals as ends in themselves and not as means to increase, reduce or control population.
- Treats client's body appropriately; covers her with a gown or sheet.

- 
- Reinforces client's self-esteem, alluding in a positive manner to her ability, will, criteria and comprehension.
  - Promotes self-care and knowledge of one's own body.
  - Values client's needs and demands, welcomes them, and addresses client's concerns.

#### Right to Information

- During the consultation, informs client of the procedures and exams she will undergo.
- Provides adequate, comprehensible and accurate information, based on client's educational level.
- Provides educational material as backup.
- Uses kind, warm gestures and a comprehensible oral language.
- Verifies that the client has understood the information provided, motivates her to ask questions to determine whether she has doubts.
- Clarifies doubts. Identifies client's fears and concerns.

#### Right to Choose

- Requests and listens to client's opinions; avoids telling client what to do.
- Is careful not to skew power between his or her medical knowledge and client's opinions.
- Arrives at an agreement with client on the course of action to follow.
- Gives recommendations that take into account the client's concrete circumstances (time, resources, family, violence-related problems). Personalizes care.
- Insofar as possible, does not prescribe without discussing alternatives with client.
- Provides client with a wide range of alternatives to choose contraceptive methods (including emergency contraception), as well as information free of judgment related to age, ethnicity or marital status, so that the client can make an appropriate and free choice.
- Informs client of contraceptives' effectiveness, advantages and disadvantages, instructions for use, contraindications, side effects, mode of action, re-supply, change of method, and which methods protect against sexually transmitted infections.
- Has informed consent forms and ensures the correct process for implementing them; that is, ensures informed choice and informed consent.
- Promotes the right to choose contraceptive methods as an individual right and takes into account when the client cannot make this decision on her own, due to the violence she experiences from her partner.
- Discusses dual protection with every client.
- Has a policy for managing individuals who live with HIV/AIDS.

Ultimately, clients should perceive all of these factors within the services offered.

MODULE EVALUATION

Now that you have completed the Gender and Reproductive and Sexual Rights workshop, please assess how well its stated goals and objectives were achieved. Give each goal and each objective a number ranking on a scale of 1 (not at all achieved) to 5 (very well achieved). Please use the space following each question to explain a ranking lower than 3.

**Workshop Goals:**

To understand and use gender and rights perspectives as strategies to improve the quality of sexual and reproductive health care services.

1                      2                      3                      4                      5

To provide participants with knowledge, skills and attitudes that will enable them to put into action the broad, comprehensive approach to reproductive health as agreed upon in UN international conferences.

1                      2                      3                      4                      5

**Workshop Objectives:**

By end of the workshop, participants will be able to: point out some of the consequences of gender inequity on women’s sexual and reproductive health.

1                      2                      3                      4                      5

Understand how discriminatory power relationships affect women and men’s sexual and reproductive health.

1                      2                      3                      4                      5

Understand violence as a fact that presents itself in different ways throughout one’s live cycle, has repercussions on sexual and reproductive health, and is a violation of human rights

1                      2                      3                      4                      5

Identify the most important contributions of some international instruments in achieving gender equality and ensuring reproductive rights of women.

1                      2                      3                      4                      5



## ADDITIONAL SESSION: MEN'S INVOLVEMENT

### OBJECTIVES

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

- Explain men's role in the various reproductive health issues.
- Provide counseling services for males about their vital role in supporting their families' reproductive health.

Optional Training Session / TIME: 4 hours

### PREPARATION

- Session objectives printed on a flipchart
- Write Key Points on Men's Involvement on a flipchart (Handout A)
- Copies of Handout B, C, D and E for each participant.

### MATERIALS

- Flipcharts, marker, tape
- Copies of session evaluation form

### HANDOUTS

- A: Key points on men's involvement
- B: A counseling practicum working with a man who refuses to undergo semen analysis
- C: Role plays: involve men in family planning service
- D: Sample barriers for men's involvement
- E: Sample strategies for men's involvement

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## FACILITATING SESSION

### STEP 1

#### SESSION OBJECTIVES

- Introducing the objective of the session.<sup>1</sup>

### STEP 2

#### DISCUSSING THE IMPORTANCE OF INVOLVING MEN IN FAMILY PLANNING

- Facilitator asks participants to write down what comes to their mind when they talk about men's involvement in family planning. Give participants a couple of minutes to work by themselves. Then, facilitator leads a discussion on men's role in family planning issues.

#### Key points:

Reproductive health (RH) service providers are interested in males because men can play a major role in the following ways:

1. Refraining from marrying-off their daughters at an early age.
2. Encouraging their wives to use different family planning (FP) methods.
3. Supporting men to use condoms as a FP method.
4. Promoting communication between spouses by discussing with their wives family size and birth spacing.
5. Increasing awareness of the importance of early diagnosis for STDs.
6. Refraining from sexual intercourse in case of STDs until the infected party is cured.
7. Accepting different medical analyses and exploring all reasons for infertility, rather than blaming their wives.
8. Abstaining from any form of violence against their families.
9. Considering their wives' sensitivity during pregnancy, miscarriage and menopause.
10. Encouraging fathers to become actively involved in child rearing and in communicating with their offspring, especially the teenagers.
11. Involving fathers in their children's health care.
12. Refraining from practicing FGM.

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<sup>1</sup> This session was piloted in Egypt and the material presented here is based on the piloted session

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### STEP 3

#### MEN'S INVOLVEMENT IN DISCUSSING INFERTILITY PROBLEMS

- Facilitator leads an exercise on men's resistance in taking responsibility of their infertility problem. Facilitator asks two participants to conduct a counseling practicum: working with a man who refuses to undergo a semen analysis.

#### Role Play

Service provider: Good morning, Galal.

Galal: Good morning, doctor.

Service provider: I know that your wife has undergone many test analyses in order to get pregnant. All results show that there is nothing prohibiting her from becoming pregnant. I know also that she has tried several times to convince you to undergo the same analyses, but you refuse. I want to hear your reasons for refusing.

Galal: You know, doctor, I was married and had children before I married Siham. That means that there is nothing wrong with me. I know the problem is with her.

Service provider: You had your children nine years ago. Things have changed. Let's do the analysis. You might have something that can be easily cured. What about setting a time for the analysis?

Galal: I am not convinced yet, doctor. I know the process of getting the sample is difficult and humiliating.

Service provider: There is nothing humiliating in medical procedures. Every problem has a solution. You can take your wife with you to the clinic or you can obtain the sample at home if that makes you feel more comfortable. You have enjoyed having children. Galal, but your wife is still young and wants to become a mother. What about setting a time for you with a doctor nearest to your home? The nurse can assist you with this. Of course you have the freedom to choose another doctor.

Galal: Is it a one-time analysis, doctor? And what if the problem was from me? Do you have to tell my wife? And is it something that can be cured?

Service provider: Do the analyses first and let's see the results. I am sure everything will be OK. You have to visit me again after doing the analyses. I will see you next week. Galal, Good-bye.

Galal: Good-bye, doctor.

- After the practicum, ask the two participants, the one who played the service provider and the one who played Galal to debrief the group by sharing their experiences. Ask them " how did you feel during the conversation?" "What statement did you find helpful?" "Was it easy or hard to talk about the problem

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related to infertility?" "How do you feel about the service provider?" "What did he/she say that helped?" "What was not helpful?" "What could have been done or said to make the process easier?"

- Open the discussion to the group, and ask participants to provide input on how to involve men to discuss the problems of infertility and/or other family planning related issues.

#### STEP 4

##### ROLE-PLAYS ON HOW TO INVOLVE MEN IN FAMILY PLANNING

- Facilitator divide participants into groups to participate in the role play on the following two scenarios (Handout C):

First scenario: A woman goes to a clinic without her husband to talk with the service provider about family planning. The service provider informs her about the importance of family planning and discusses the different types of methods including the benefits and drawbacks of each method. The woman informs the service provider that she desires to use one of the methods but does not feel that she can discuss this matter with her husband.

Second scenario: A woman goes with her husband to a clinic to talk with the service provider about family planning issues. The service provider discusses with them different family planning methods and during the conversation, the couple decide to choose one that is suitable for them.

- Facilitator leads the debriefing discussion of the role plays by asking participants to talk about the differences when a woman goes to FP services with and without her husband. Ask the participants to relate to their own experiences when working with couples vs. wives without their husbands. List the important points on a flipchart.

#### STEP 5

##### DISCUSS WAYS TO ATTRACT MEN TO PLAY A MAJOR ROLE IN THE HEALTH OF THE FAMILY

Post a flipchart with a concentric circle indicating family level, community/peer group level, and national program/policy level. Ask the participants to think individually about barriers to men's involvement in family planning and reproductive health at the family level, then at the community/peer group level, and last at the national level. Ask them to share their thoughts with the group. Write the responses under the appropriate headings on a flipchart. Possible responses include (Handout D):

Family level barriers:

- Cultural taboos discouraging men from interacting with children
- Cultural norms reinforcing the idea that family planning is a woman's problem
- Lack of role models for men on how to be an involved father
- Cultural assumption that anything domestic is women's work

Community/peer group barriers:

- Fear of being viewed as "not man enough" by peers if caught doing housework or childcare

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- Perceive family planning services as being geared toward women's needs and are not welcoming to men

National program/policy barriers:

- Divorce and/or separation laws are not favorable to men to have custody over their children
- Inadequate legal paternity leave
- Inadequate family life education in schools to challenge youth's attitudes regarding gender stereotypes
- Family planning and reproductive health policies and programs do not address the needs of men or families
- Lack of legal support for non-traditional families
- Hospital/clinic regulations are not supportive of fathers' involvement in birth and post-partum care

Divide the participants into three groups. Assign one group to family-level barriers, one to community/peer group barriers, and one to national program/policy barriers. Ask each group to propose strategies that will address the stated barriers, and the actions that promote changes in traditional gender roles.

Invite each group to present its work. Allow 3-5 minutes per group. Encourage the audience to comment and ask questions.

## STEP 6

### WRAP UP

Summarize the session by reviewing the flipcharts illustrating strategies participants identified on the family, community, and national levels. Ask participants if other interventions are needed to encourage men's involvement. Distribute Handout E where some of the possible strategies for health providers to involve men in family planning activities are listed as resources for trainers.

Key points:

Reproductive health (RH) service providers are interested in males because men can play a major role in the following ways:

- 1.Refraining from marrying-off their daughters at an early age.
- 2.Encouraging their wives to use different family planning (FP) methods.
- 3.Supporting men to use condoms as a FP method.
- 4.Promoting communication between spouses by discussing with their wives family size and birth spacing.
- 5.Increasing awareness of the importance of early diagnosis for STIs.
- 6.Refraining from sexual intercourse in case of STIs until the infected party is cured.
- 7.Accepting different medical analyses and exploring all reasons for infertility, rather than blaming their wives.
- 8.Abstaining from any form of violence against their families.
- 9.Considering their wives' sensitivity during pregnancy, miscarriage and menopause.
- 10.Encouraging fathers to become actively involved in child rearing and in communicating with their offspring, especially the teenagers.
- 11.Involving fathers in their children's health care.
- 12.Refraining from practicing FGM.

### Role Play

Service provider: Good morning, Galal.

Galal: Good morning, doctor.

Service provider: I know that your wife has undergone many test analyses in order to get pregnant. All results show that there is nothing prohibiting her from becoming pregnant. I know also that she has tried several times to convince you to undergo the same analyses, but you refuse. I want to hear your reasons for refusing.

Galal: You know, doctor, I was married and had children before I married Siham. That means that there is nothing wrong with me. I know the problem is with her.

Service provider: You had your children nine years ago. Things have changed. Let's do the analysis. You might have something that can be easily cured. What about setting a time for the analysis?

Galal: I am not convinced yet, doctor. I know the process of getting the sample is difficult and humiliating.

Service provider: There is nothing humiliating in medical procedures. Every problem has a solution. You can take your wife with you to the clinic or you can obtain the sample at home if that makes you feel more comfortable. You have enjoyed having children. Galal, but your wife is still young and wants to become a mother. What about setting a time for you with a doctor nearest to your home? The nurse can assist you with this. Of course you have the freedom to choose another doctor.

Galal: Is it a one-time analysis, doctor? And what if the problem was from me? Do you have to tell my wife? And is it something that can be cured?

Service provider: Do the analyses first and let's see the results. I am sure everything will be OK. You have to visit me again after doing the analyses. I will see you next week. Galal, Good-bye.

Galal: Good-bye, doctor.

### Discussion questions:

- Was it easy or hard to talk about the problem related to infertility in your culture?
- How do you feel about the service provider?
- What did he/she say that helped?
- What was not helpful?
- What could have done that will make the process easier?

### Role-plays on how to involve men in family planning

First scenario: A woman goes to a clinic without her husband to talk with the service provider about family planning. The service provider informs her about the importance of family planning and discusses the different types of methods including the benefits and drawbacks of each method. The woman informs the service provider that she desires to use one of the methods but does not feel that she can discuss this matter with her husband.

Second scenario: A woman goes with her husband to a clinic to talk with the service provider about family planning issues. The service provider discusses with them different family planning methods and during the conversation, the couple decide to choose one that is suitable for them.

Sample Barriers for Men's Involvement in family planning and Reproductive Health:

Family level barriers:

- Cultural taboos discouraging men from interacting with children
- Cultural norms reinforcing the idea that family planning is a woman's problem
- Lack of role models for men on how to be an involved father
- Cultural assumption that anything domestic is women's work

Community/peer group barriers:

- Fear of being viewed as "not man enough" by peers if caught doing housework or childcare
- Perceive family planning services as being geared toward women's needs and are not welcoming to men

National program/policy barriers:

- Divorce and/or separation laws are not favorable to men to have custody over their children
- Inadequate legal paternity leave
- Inadequate family life education in schools to challenge youth's attitudes regarding gender stereotypes
- Family planning and reproductive health policies and programs do not address the needs of men or families
- Lack of legal support for non-traditional families
- Hospital/clinic regulations are not supportive of fathers' involvement in birth and post-partum care

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## GAMES AND ACTIVITIES

### Communication

1. *3-Minute Test*: This activity should be used when discussing communication. Participants are told they have 3 minutes to complete a quiz. If they follow the directions correctly, the participants only answer one of the questions. If not, they do all of the questions and it takes too long.
2. *2-Minute Talk*: This activity gets participants to speak in front of a group. Participants choose a random topic from a box and then go to their group and give a 2-minute impromptu speech.

### Creative-Thinking

1. *Join the Dots*: This exercise gets the participants thinking outside the box, meaning beyond the normal boundaries. The participants are given pieces of paper with dots on them and are told to connect with a certain amount of lines. In a traditional manner, it is impossible to do so because that way of thinking is limiting.
2. *Team Task No. 1*: This exercise gives the groups of participants a problem to solve. A group sitting around in a circle has a piece of paper with numbers in a square placed directly in the middle of them. While members of the group are figuring out the puzzle, an observer (possibly a student) watches and notes the roles each member took.
3. *Tennis Balls*: This exercise is very similar to Join the Dots and Team Task No. 1. The participants are given a problem that can only be solved by thinking outside the box. During this exercise, observations can be made as to who takes which role.

### Dealing with Team-Conflict

1. *Effects of Controversy Questionnaire*: This exercise is best used after participants have participated in a controversial situation. By filling out a questionnaire, participants can discuss how well they handled a controversy and what they could have done to improve the group's effectiveness.
2. *Signs*: This exercise is an icebreaker. The signs "Strongly Agree", "Strongly Disagree" and "Undecided" are placed on three different walls in the room. Controversial statements are read out loud and the participants are to stand next to the statement that closest represents their feelings.

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## Decision Making

1. *Common Words*: This exercise forces a group into a decision-making process. The group chooses the 10 most common words in their language and then ranks them in order, starting with the most common word.

## End of the Program

1. *Clowns*: This is an icebreaker that should be done at the end of the program. A reflection card with the name of a student on it is passed around and each student writes something positive about that person. In the future that person can take a look at this card and feel good about him/herself.
2. *Post Me a Note*: This icebreaker should be used near the end of the program because it involves saying nice things about other participants. Each student writes her/his name on an envelope and passes it around a circle. The person who receives the envelope writes a positive comment about that person and places it inside.
3. *Post-It*: This activity could be used to evaluate the program at the end of it. Around a room are large pieces of butcher paper with questions on them about the program. Participants write their comments on post-its and stick them near the appropriate question. Afterwards, the participants discuss the comments.

## Energizers

1. *Clap*: This is a fun energizer meant to pick up the pace and get the participants laughing during a lull in the activities. The participants are to applaud other participants as the facilitator gives their names and says what they have done.
2. *Pick a Shape*: This exercise is just meant to get the participants laughing. The participants are shown four shapes and asked to write down which one they associate best with. The participants are supposed to laugh when they find out the circle means those people are preoccupied with sex and alcohol.

## Icebreaker

1. *I Am*: This icebreaker consists of the participants writing down ten responses to the statement "I am..." Then they pin them to their shirts and walk around, reading each other's responses. After ten minutes, the participants talk and ask questions to those that interested them.

2. *Marooned*: This icebreaker entails the participants imagining they are marooned on a desert island. They are to choose 6 well-known personalities that they would want marooned with them.
3. *Participant Bingo*: This game is meant to assist participants in getting to know each other. Each student wanders around to find someone who meets a requirement listed on her/his sheet of paper. When he/she fills in all of the slots, that person wins.
4. *Relay*: This brief icebreaker is mainly meant as a warm up exercise. However, it does touch upon communication and synergy. In teams the players have a few minutes to agree upon a strategy. When the time is up, the players pass cards to each other until the designated end. The winning participants are asked if working out a strategy assisted in their victory.
5. *What's your name?*: This simple icebreaker is meant to help participants remember each other's names. Participants say their name and something unusual about themselves. Each student has to repeat what the other participants said. By the end, everyone should know each other's names.
6. *Telling Lies*: this exercise consists of the participants introducing themselves to the others. The introduction can include things such as their name, interests, hobbies, etc. One of the things said must be a lie. After each introduction, the rest of the group decides which thing said was a lie.

### Implementing Materials After the Program

*The Application*: This exercise will help participants think about how they will implement what they have learned back at their school or in their communities. In pairs, participants discuss with each other how they are going to implement what they learned; the group has a quick brainstorming session to assist them.

### Problem-Solving

1. *Brainstorm*: This is a brainstorming exercise. For 5-10 minutes, the participants suggest solutions to a problem without criticizing or discussing any of them. In subgroups, the participants discuss the solutions and come up with the best two or three. The subgroups then rejoin the main group and try to come to a consensus on the best solutions.
2. *Choosing Between Alternative Courses of Action*: This activity has participants identify the most important criteria when choosing a solution to a problem. With the criteria identified, participants then discuss how well each alternative meets or fits the criteria. Finally, they decide which is the best solution.
3. *Force-Field Analysis*: This activity assists the participants with understanding a problem and finding a solution to it. After coming up with possible solutions to a problem or issue, participants discuss those forces that might help overcome the problem and those that help resist change and maintain

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the status quo. Once the best possibility arises from these talks, the participants develop an action plan to implement it.

4. *Human Machines*: This exercise entails the participants forming teams and building a human machine. Each team of participants has 5 minutes to design a human machine. After the five minutes, the teams demonstrate their machines and the best one wins. A discussion about how people in society need to work together to solve problems can follow.
5. *Understanding My Response to Controversy*: By filling out a questionnaire, participants can identify the various strategies they use in handling controversy (or conflict) and which ones are positive and which are negative. It also points out when someone is too aggressive in one instance, and too quiet in another. Finally, a diagram based on the scores of the group illustrates the reasons for a group's cohesiveness or disjointedness.

#### Problem-Solving: Human Resources

1. *Orientation Quiz*: This activity is meant to get participants mixing with each other. In addition, participants should begin to realize that they all have different knowledge or resources to offer the group. The participants will be given a quiz about their society. If they don't know the answer, they are allowed to talk to the other group and find it out. Afterwards, they discuss who was the biggest assistance and why.
2. *Room 703*: This exercise gives each group a problem that they have to solve. Each member of the group is given different pieces of information. All of the information has to come together in order to solve the given problem. When complete, participants can discuss how the task was solved and the techniques used to solve the problem.
3. *Treasure Hunt*: This activity acts as a team-builder because the participants realize during it that each person has knowledge that can be used to help out. Teams of participants work together to figure out the meanings of clues and find a treasure hidden in the deep, darkest reaches of the woods.

#### Raising Issues

1. *Agenda*: this exercise gets the participants to select agenda items for discussion. Participants pair up and interview each other about a topic and items they would like to see on the agenda in relation to this topic. Then each person tells the rest of the group what her/his partner said. Common agenda items are listed on the board and those brought up the most number of times will be discussed. The others will also be discussed if time permits.

2. *Balloonatics*: This exercise gets the participants thinking about their culture or organization, whichever the concentration is on. Participants are handed out cartoons of scenes. In these scenes there are balloons above the people and the participants need to fill them in with whatever the people are saying or thinking. The filled-in statements lead to discussions.

### Self-Awareness or Perception

1. *List of Names*: This exercise gives participants an idea of how other people perceive them. It can be done in many ways, but the main idea is that participants switch roles for a period of time and act like another person. The debriefing afterwards is imperative.
2. *What do You See?*: This exercise shows the participants that different people perceive things differently. The participants are shown a picture. In it, one can see either an old or young woman or both. A discussion follows about why this happens.
3. *Them and Us*: This exercise show the participants how being left out feels. Participants are given nametags that say either “us” or “them” on them. Those with “us” are given the pleasure of eating wonderful foods at a table labeled “us”, while the others, the “them” have to eat a another table with boring foods. An important aspect of this exercise is the debriefing afterwards because participants can often feel hostility towards one another.

### Simulations/Controversial Situation

1. *Fall-out Shelter Problem*: This activity involves the group in a problem that raises stereotyping and/or discrimination issues. Participants have to choose 6 of 12 people to remain in a bomb shelter and be saved. This activity is similar to Moon Explorer Problems (see below) because the participants have to make selections individually first and then as a group without voting or compromising.
2. *Hijacked in the Desert*: This simulation places the participants in the midst of a controversial situation. A group of participants finds out their car has been hijacked in the desert, and they can only take a number of things with them to save them. They come to a consensus about which things to take and then find out what the experts said.
3. *Moon Explorer Problems*: This simulation gives each team of participants a chance to discuss and solve a problem. The participants imagine they have crash-landed on the moon. After that, they individually rank a list of 15 items they are supposed to take with them to save them; then they must come to a consensus about the order without voting or compromising.

### Stereotyping

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*A Case of Labeling:* This exercise is about stereotyping. A story is read (much like a riddle) about a car accident and the participants have to figure out the answer. The answer is simple, however, stereotyping makes it difficult.

#### Team-Building Leadership<sup>56</sup>

1. *Alien Zoo:* This activity builds teamwork among participants by getting everyone involved in solving a task. Each student is given a card with some information important to solving the task. The participants have to decide the important and unimportant information without looking at each other's cards; in other words, only discussion is allowed in solving it.
2. *Changing Places:* This activity is similar to Mine Field (see below) in that it fosters teamwork, cooperative planning and group cohesiveness. Two lines of three people standing in squares and facing each other (with an empty square in between the front two) try to exchange places without breaking the rules. Afterwards, the team discusses what could have been done better to improve their performance.
3. *Co-operation:* This exercise emphasizes the importance of working together. While facing each other in pairs, participants hold each other's right hand and make as many wishes as they can in 60 seconds. After that, they do the same thing but this time they have to touch their right hip with their right hand to get a wish granted. Those with the most wishes explain why they got so many.
4. *Mine Field:* This team-building exercise requires the participants to plan ahead and cooperate with each other. The members of a team must all cross an area of squares, the "mine field", at the same time. If somebody hits a mine, they must return the way they came to the beginning without straying from the path. If they do and hit a mine, they lose 30 seconds. This game is best done in competition with others. A discussion on the importance of planning follows.
5. *Paper Planes:* This exercise gives the participants a task whose success depends on teamwork. The teams create a prototype paper plane that they would like to sell. Once price and the potential number manufactured in 10 minutes is decided upon, they have 10 minutes to try and reach that goal. When they are finished, each team tries to sell their paper planes to a customer who was just an observer up to this point.
6. *River of Lava:* This activity acts as a team-builder. A team has to cross a "river of lava" without falling in or touching the "lava". They cross by using two pieces of wood as bridges from island to island. All players have to stay together and cross at the same time. If someone falls in or touches the "lava" they have to start again.

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<sup>56</sup> During the group activities in this section, a leader should arise making it possible to discuss the qualities of a good leader.

7. *Tanagrams*: This team-building exercise can be useful in identifying leaders. Teams of participants are given a newspaper or magazine with the pages all mixed up. They are to put it together in the correct order. The first team to finish wins. Afterwards, the teams discuss what happened during the exercise.

### Teamwork

*Scavenger Hunt*: This exercise deals with teamwork because groups of participants are given a list of items they have to find. In this activity, a natural leader should arise and the resourcefulness of all group members is tested. In addition, group cohesion is an important factor in winning.

### Team Spirit

*Tied in Knots*: This exercise energizes the participants while building team spirit. Participants stand and form a tight circle. While in this circle they grab hands in such a way that they are tied in knots. They are supposed to untie themselves by breaking their grip on each other.

### Theater-Based Activities

1. *The Child's Dreams-What I Wanted to be When I Grew Up*: This activity may reveal characteristics that the participants feel are desirable in themselves and others. Half of the group watches as the other half mimes the person or character they wanted to be while growing up. Those watching don't guess who it was they want to be but the characteristics the person is trying to express.
2. *The Child's Fear*: This activity is done similarly to The Child's Dreams but focuses on the fears of the participants to mime what is in that abstraction that scares them.
3. *Forum Theatre*: This activity empowers the participants because it makes them realize that they can change their realities. Participants first act out a scene dealing with an issue in a realistic manner. Then the participants act out the same scene except this time they do it in an ideal manner, meaning the way they would like it to be. Participants from the audience can step in at anytime and take part in the drama if they like.
4. *Illustrating a Subject Using Other People's Bodies*: This activity entails the participants reifying an oppression. A theme or issue is suggested and then a student, the "sculptor", creates a scene using four or five of the other participants as models. When he/she finishes, the remaining participants can move the models around until (almost) everyone agrees to their positioning. A discussion follows about the meaning of the scene.

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5. *Image of Transition*: This is a continuation of Illustrating a Subject. The group constructs an ideal scene in which the oppression has been eliminated. After that, they return to the real scene and the models are told to make one movement with every clap of the TRAINER. The movements are supposed to be in character, either a freeing or oppressing movement. Movements cease when all possibilities have been attempted and the scene has come to some sort of closure.
  6. *Image Theatre*: This activity assists participants in defining their oppressors. Individuals sculpt themselves in separate positions to express a given theme, first individually on stage, then together as a group. After this, the models are told to reposition themselves in a position relating to another person. If most roles are that of their own (usually the victim), then the trainer is addressed afterwards.
  7. *Multiple Images of Happiness*: This activity is another variation on Illustrating the Subject and deals with the idea that one person's happiness can oppress another person's happiness. The "director" position models in a variety of scenes to represent his/her ideas of happiness. At the clap of hands, a number of participants watching the scenes take the places of those models they feel are happiest. At the clap of hands again, the models go to be part of the scene again and a discussion follows about what happened.
  8. *Multiple Images of Oppression*: This activity is another variation on Illustrating the Subject. The participants sculpt a variety of scenes to represent the different settings of an oppression. First, some of the participants enter the scene as models. Then a student sets up what he/she considers the ideal scene. With that completed, he/she has the models return to the real scene. From the real scene the models are to move in slow motion to the ideal one so that it becomes apparent whether the ideal scene was magical or practical. Still further, the models return to the real scene and then, on cue, start moving in slow motion in accordance with the character they represent.
  9. THE SCREEN IMAGE: This activity is meant to initiate discussion about the meaning of a scene. A student creates a scene based on an oppression. The others watch and then discuss what the oppression meant to them, if they have had similar experiences, etc.
  10. THE SIREN'S SONG: This is an interesting activity about oppression. The group of participants is told to stand in the center of the room and think about an oppression against them. The TRAINER takes one by the hand and leads him/her to a corner of the room. That person makes a sound representing that person's oppression. After four people are in different corners, the others go to the corner, which they think best represents their own oppression.

#### Trust-Building

1. *Goalkeeper*: This game builds trust among participants. Six participants stand behind a goalkeeper. Then a person runs at the net with her/his eyes closed and the goalkeeper catches him/her. The key is to not slow down at all.

## BIBLIOGRAPHY

AIDSCAP Women's Initiative. 1997. *A Transformation Process: Gender Training for Top-Level Management of HIV/AIDS Prevention*. North Carolina: Family Health International

Alcalá, M. J. 1995. *Commitments to Sexual and Reproductive Health and Rights for All*. New York: Family Care International.

Amorós, C. 1999. As told by A. Puleo in *Diez palabras claves sobre la mujer*. Madrid: Colección 10.

AVSC International. 1994. *Formulario guía para el plan de acción, Evaluación de la calidad de los servicios*. New York: AVSC International.

AVSC International. 1999. *Informed Choice in International Family Planning Service Delivery: Strategies for the 21st Century*. New York: AVSC International.

The CATALYST Consortium/ Center for Development and Population Activities (CEDPA). 2003. *Adolescent Sexual and Reproductive Health: A Training Manual for Program Managers*. Washington, DC: CATALYST.

Calderón MC, Advisor in Rights Issues, Profamilia/Colombia, 2003, unpublished.

Center for Development and Population Activities (CEDPA). 2000. *Gender, Reproductive Health, and Advocacy: A Trainer's Manual*. Washington, D.C.: CEPDA.

Centre for Development and Population Activities (CEDPA). 1996. *Gender and Development: The CEDPA Training Manual Series, Vol. 111*. Washington, D.C.: CEPDA.

Centre for Development and Population Activities (CEDPA). 1995. *Training Trainers for Development: Conducting a Workshop on Participatory Training Techniques. The CEDPA Training Manual Series, Vol. I*. Washington, D.C.: CEPDA.

Center for Reproductive Rights. 2000. *Beijing+5: Assessing Reproductive Rights*. New York.

Centro de la Mujer Peruana Flora Tristán. 1998. *Un acto común por construir, Calidad de atención en los servicios de salud reproductiva*. Lima: Centro de la Mujer Peruana Flora Tristán.

Centro de la Mujer Peruana Flora Tristán/OXFAM. 1997. *Manual de capacitación en Género de Oxfam. Edition for Latin America and the Caribbean*. OXFAM.

Cook, R. 1997. *Human Rights of Women: National and International Perspectives*, Bogotá: Profamilia.

Davies, G. 1996. *Manual de atención médica en salud reproductiva*, Lima: Centro de la Mujer Peruana Flora Tristán.

de Bruyn, M., and France, N. 2001. *Gender or Sex: Who Cares? Skills-Building Resource Pack on Gender and Reproductive Health for Adolescents and Youth Workers*, Chapel Hill: Ipas.

Defensoría del Pueblo. 1995. *Mecanismos de Protección de la Mujer Víctima de la Violencia Intrafamiliar y Sexual*. Bogotá.

Dirección Nacional de Equidad para las Mujeres. 1996. *Compromisos de Colombia con sus mujeres. Acuerdos en Conferencias Internacionales*. Bogotá: UNICEF.

Facio, A. 2001. *Producing Shadow Reports to CEDAW*. San José, Costa Rica: ILANUD, Women, Justice and Gender Program, UNIFEM.

Fuller, N. 1997. *Identidades Masculinas*. Lima: Pontificia Universidad Católica del Perú.

Gómez, E. 1997. *La salud y las mujeres en América Latina y el Caribe: viejos problemas y nuevos enfoques*. Santiago de Chile: CEPAL.

Inter-American Institute of Human Rights. 2000. *2000 Optional Protocol, Convention on the Elimination of All Forms of Discrimination Against Women*. San José, Costa Rica.

International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR). 2002. *How Gender-Sensitive Are Your HIV and Family Planning Services?* New York: IPPF/WHR.

International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR). 2000. *Manual for Evaluating Quality of Care from a Gender Perspective*. New York: IPPF/WHR.

Ipas and Health Development Networks. 2001. *Gender or Sex: Who Cares? Skills-Building Resource Pack on Gender and Reproductive Health for Adolescents and Youth Workers With a Special Emphasis on Violence, HIV/STIs, Unwanted Pregnancy and Unsafe Abortion*. Washington.

Lamas, M. 1995. *Cuerpo e identidad*. In L.G. Arango et al. (Eds.), *Género e Identidad, Ensayos sobre lo femenino y lo masculino*. Bogotá: Tercer Mundo Editores.

Londoño, A. 1999. *Promoción de los Derechos Humanos, sexuales y reproductivos. Módulos pedagógicos para formadores*. Bogotá: Consejería Presidencial para los Derechos Humanos (module 1).

Marques-Pereira, B. 1997. Los derechos reproductivos como derechos ciudadanos. In *Ediciones de las mujeres N° 25: La ciudadanía a debate*. Santiago de Chile: Isis International and Centro de Estudios de la Mujer.

Matamala, M. I., and Maynou, P. 1996. *Manual Guía para la realización del curso taller Salud de la Mujer, calidad de la atención y género*. Santiago de Chile: Colectivo Mujer, Salud y Medicina Social.

Mertus, J., et al. 1997. *Human Rights of Women: Step by Step*. Washington D.C.: Inter-American Institute of Human Rights, Women and Law & Development International, Human Rights Watch Women's Rights Project..

Mertus, J., et al. 1999. *Local Action Global Change: Learning about the Human Rights of Women and Girls*. New York: UNIFEM and the Center for Women's Global Leadership.

Montaño, S. 1996. *Los derechos reproductivos de la mujer*. San José, Costa Rica: Inter-American Institute of Human Rights.

Netherlands Congress Centre. 1999. *Report of the International Forum for the Operational Review and Appraisal of Implementation of the Programme of Action of the International Conference on Population and Development (ICPD)*. The Hague, Netherlands.  
[http://www.unfpa.org/icpd5/meetings/hague\\_forum/reports/forumrept.htm](http://www.unfpa.org/icpd5/meetings/hague_forum/reports/forumrept.htm)

Pabón, M. L. 2000. *Planes Locales de Salud con Equidad de Género*. Bogotá: Proyecto Proequidad: Dirección Nacional para la Equidad de las Mujeres/GTZ.

Pan-American Health Organization (PAHO)/World Health Organization (WHO). 1996. *Reference Framework, Components and Strategies for Improving Quality of Care in Reproductive Health-Care Services with a Gender Focus*. Washington, D.C.: PAHO/WHO.

Pan-American Health Organization (PAHO)/World Health Organization (WHO). 2002. *World Report on Violence and Health: Summary*. Washington D.C.: PAHO/WHO.

Pérez, F. 1998. Género y educación. In Proyecto Proequidad/GTZ, *Género, Equidad y Desarrollo*. Bogotá: Tercer Mundo Editores.

Population Information Program, Center for Communication Programs, Johns Hopkins University School of Public Health. 1999. *Ending violence against women*. Population Reports 27(4).

Puyana, Y. and Bernal, M. 2001. *Reflexiones sobre violencia de pareja y relaciones de género* (Política Nacional de Construcción e Paz y Convivencia Familiar). Bogotá..

Rodríguez, R. M. 1994. *Femenino fin de siglo*. Barcelona: Anthropos.

Rowlands, J. 1997. Empoderamiento y mujeres rurales en Honduras: un modelo para el desarrollo. In M. Leon (Ed.), *Poder y empoderamiento de las mujeres*. Bogotá: Tercer Mundo Editores.

Santa Cruz, I. 1992. Sobre el concepto de igualdad: algunas observaciones, *Revista Isegoría* 6 (Consejo Superior de Investigaciones Científicas, Instituto de Filosofía, Madrid).

Slocum, R. et al. 1995, *Power, Process and Participation: Tools for change*, London: Intermediate Technology Publications.

Scott, J. 1986. Gender: a useful category of historical analysis. In J. Amelang et al. (Eds.), *History and Gender: Women in Modern and Contemporary Europe*. Valencia: Alfons el Magnánim Editions.

Tobón, M. and Guzmán, J. E. 1995. *Herramientas para construir equidad entre mujeres y hombres. Manual de capacitación*. Bogotá: Proyecto Proequidad, DNP Colombia/GTZ.

Vargas, E. 1999. Norma para el Diagnóstico y Atención Integral de Mujer Maltratada. Bogotá: Ministerio de Salud.

Williams, S., Seed, J. and Mwau, A. 1994. *The Oxfam Gender Training Manual*. Ireland: Oxfam.

**ADDITIONAL RESOURCES: References for International Conventions, Conferences and Conference Documents, Declarations, Protocols**

Summit of the Americas. 1994. *Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women "Convention of Belem do Para."*

<http://summit-americas.org/Belemdopara.htm>

UNHCR. December 1993. *Declaration on the Elimination of Violence against Women.*

[http://www.unhcr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.RES.48.104.En?OpenDocument](http://www.unhcr.ch/huridocda/huridoca.nsf/(Symbol)/A.RES.48.104.En?OpenDocument)

UNHCR. 22 April -13 May 1968. *Proclamation of Teheran: Final Act of the International Conference on Human Rights.* Teheran, Iran.

[http://www.unhcr.ch/html/menu3/b/b\\_tehern.htm](http://www.unhcr.ch/html/menu3/b/b_tehern.htm)

UNHCR. 14-25 June 1993. *Report of the World Conference on Human Rights and Vienna Declaration, World Conference on Human Rights.* Vienna, Austria.

[http://www.unhcr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.CONF.157.23.En?OpenDocument](http://www.unhcr.ch/huridocda/huridoca.nsf/(Symbol)/A.CONF.157.23.En?OpenDocument)

United Nations. 4-15 September 1995. *Beijing Declaration and Platform for Action.* Fourth World Conference on Women.

<http://www.un.org/womenwatch/daw/beijing/platform/declar.htm>

United Nations. 1979. *Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).*

<http://www.un.org/womenwatch/daw/cedaw/>

United Nations. 1996. *Declaration of the General Assembly of the UN, Resolution XXI.*

<http://www.un.org/documents/ga/res/21/ares21.htm>

United Nations. October 1999. *Optional Protocol to the Convention on the Elimination of Discrimination against Women.*

<http://www.un.org/womenwatch/daw/cedaw/protocol/adopted.htm>

United Nations. 5-9 June 2000. Political Declaration. *Beijing +5/ Women 2000: Gender Equality, Development and Peace for the 21st Century: Twenty-third special session.*

<http://www.un.org/womenwatch/daw/followup/beijing+5.htm>

United Nations. 5-13 September 1994. *Report of the International Conference on Population and Development.* Cairo, Egypt.

<http://www.un.org/popin/icpd/conference/offeng/poa.html>

United Nations. 3-14 June 1992. *Report of the United Nations Conference on Environment and Development*. Rio de Janeiro, Brazil.

<http://www.un.org/documents/ga/conf151/aconf15126-1annex1.htm>