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K4Health Knowledge for Health

Gender and HSS eLearning Course Participant Study Group Summary Report

August 4-13, 2014

http://www.globalhealthlearning.org/user?destination=community/70607

BACKGROUND

To enhance learners understanding of the main concepts in the Gender and Health Systems Strengthening course, the K4Health Project and the course author Constance Newman, MPH, MSW, Senior Team Leader, Gender Equality and Health, IntraHealth International/Capacity*Plus* facilitated an online, time-bound, cohort-based learning event in which learners were able to learn from each other by discussing questions, challenges, and successes in promoting gender equality and women's empowerment in health systems strengthening. By the end of the formal study group period, learners should have not only felt more conversant in gender considerations in health system strengthening but also felt better equipped to promote multiple, dynamic interactions among the health systems components to bring about better gender and health systems outcomes.

The formal study group ran from August 4-13, 2014. Prior to each day's discussion, the course author asked participants to read 2 sessions of the course and then visit the online learning space to reflect on the discussion questions, ask questions, share experiences related to gender working in the field of health system strengthening, and learn from each other as to how they have and/or plan to apply what they have learned from the course into their job.

MAIN THEMES AND GUIDING DISCUSSION QUESTIONS

The following summarizes the main themes that were shared in response to the study group guiding discussion questions.

Post 1 (August 3, 2014)

In **Session 1**, the course covered gender norms and inequalities and listed some gender-related factors that are important determinants of health and well-being (i.e., women with lower cash income than her husband cannot spend household resources to access needed health services without husband's permission).

- *What kinds of gender-related factors have you encountered that impact health and what kinds of experiences do you have in addressing these gender norms? In your experience, in what ways was the health system supportive of dealing with gender inequalities? How or how not?*

In **Session 2**, the course introduces the "Gender Equality Continuum Tool" which helps health systems leaders analyze the intended and unintended outcomes of their approaches. The session offers

examples of *gender accommodating* approaches to improve and increase access to health services (i.e. provide transportation to health facilities; offering childcare at health facilities).

- *What kinds of gender accommodating approaches have you seen in your work? In what ways did they accommodate existing gender differences and inequalities? In what ways can we promote gender transformative programs to bring about better gender and health systems outcomes?*

Emerging Themes: Post 1

In response to Post 1, one participant asked why there is so much outcry (or interest) about gender issues. A number of participants responded to this comment based on their experience, reiterating a number of the key concepts outlined in Session 2 related to the need for health service delivery to be responsive to the different needs of women, men, boys, and girls, to help increase service access, coverage, quality, and safety. This, in turn, will contribute to a more responsive and efficient health system and improved health. For example, gender norms affect men's and women's decision making (such as need for spousal permission to use family planning), mobility (such as restrictions on women's travel outside the household or the threat of violence), differential burden of labor, all of which prevent women from accessing health care. Masculine norms may also contribute to men's reluctance to seek health services. Also, a participant from Kenya gave many examples of how gender inequality impedes health for all. If health planners are aware of these gender issues, then they will design more responsive services.

Another theme of the discussion focused on the gender continuum approaches when it comes to health programs and health system strengthening programs. At this point in the discussion, participants' understanding of these concepts were still quite nascent. For example, a participant shared an evaluation of an under-5 measles immunization program that found that health visitors scheduled immunization visits when women—who are responsible for child care and immunization—were off in the fields and unavailable when the health immunization visits took place. The participant explained that this information will inform the next program, *"either health workers visit such locations, after noon, when the mothers are back from the farm, or mass sensitization programs will be carried out before the Immunization so that both or either parent will be available to ensure the children Under5 are immunized."* However, the participant wasn't able to identify where this program falls on the continuum. The original program took *a* gender *blind* approach (that is, ignoring the economic and social roles, responsibilities, or obligations, constraints and opportunities associated with being male or female, gender dynamics) and will either take an accommodating approach in the future by adjusting the time in which health visitors visit mothers or a transformative approach by also carrying out a mass sensitization program to inform and engage both parents about the importance of immunizations.

In response to Post 4 and Session 8 about the Brothers for Life campaign, the conversation about gender accommodating and gender transformative programming became much more nuanced, revealing a deeper understanding of these concepts.

Post 2 (August 5, 2014)

In Post 2, the discussion focused on gender issues in the Session 3: Workforce and Session 4: Information.

In **Session 3**, the course considers five key gender issues related to health workforce:

1. Systemic gender discrimination;
2. Men's overrepresentation in top health leadership;

3. Women's overrepresentation at the primary level;
4. Non-support of lifecycle events and the family/woman unfriendliness of health workplaces; and
5. Health provider education that is unresponsive to gender differences and inequalities.

Transformative strategies challenge existing gender inequalities, accommodating strategies do not.

- *To what extent should we pursue accommodating approaches in the face of multiple forms of gender discrimination faced by women in the health workforce? In what ways has your country and/or organization implemented transformative measures (e.g., affirmative action) to address women's underrepresentation in top management and leadership positions? What have been challenges and successes?*

In **Session 4**, the course explains the ways sex-and age-disaggregated data can be collected, analyzed and reported, and used to strengthen health workforce, services or other health system component. Sex-disaggregated data and special studies can illuminate the ways gender norms affect the achievement of health program objectives, and the way a proposed health program might affect the status of men and women.

- *In your setting, are sex-disaggregated data collected? Have you ever used gender-related information to improve some aspect of the health system?*

Emerging Themes: Post 2

In response to Post 2's Session 3: Workforce guiding discussion questions, participants shared successes in getting affirmative action into constitutions and into work policies and government quotas to challenge women's exclusion from top political posts and management. Having maternity leave policies that maintain mothers' and children's health and workplace crèches (also referred to as a workplace nursery) are examples shared of family- and woman-friendly interventions that promote women's workforce participation and career progression. There are many other ways to integrate life and work, and there is an ongoing debate about whether workplace accommodations are *accommodating,* or whether they are *transformative*, unless they challenge a male workplace model that makes little room for women's childbearing/caring roles during their working lives. One participant noted that pursuing gender accommodating approaches would just promote gender discrimination more—a point worth reflecting on. It may be that (in addition to equal opportunity measures and anti-discrimination policies) health workforce planners should promote gender equality by redesigning health workplaces to take parenting by both genders into account—a transformative approach.

We also received important observations about the gap between policy and implementation, between rhetoric and reality. Related to this, several implementation difficulties mentioned appeared gender-related, including those considered "cultural." For example, gender stereotypes about men's natural leadership or assumptions about women's natural weakness and incompetence are embedded in and reflect local culture. In addition, participants likened women's underrepresentation in health workforce leadership to why women do not compete for government posts or avail themselves of parliamentary quotas. Time constraints imposed by women's burden of work, lower educational attainment (including pregnancy-related school leaving), as well as the impact of sociocultural beliefs and attitudes were all mentioned. Closing the gap between the rhetoric and reality of gender equality requires advocacy, alliances, and accountability mechanisms (e.g., indicators and progress monitoring).

Availability of gender-related information is central to accountability. In response to Session 4: Information comments, we read about country examples in which qualitative and sex-disaggregated data were used to develop gender-aware service delivery and understand utilization patterns. Human resources information system (HRIS) gender reports (such as the Kenya and Uganda examples in Session

4) can provide baseline information on women's and men's changing concentrations in workforce leadership that workforce planners can use to inform recruitment and promotion policies and training packages. One participant remarked, *"… I had no idea that data could be used in various ways to create gender aware programs. The illustrations on Kenya and Uganda were good lessons for this topic area!"* We also read comments describing instances where sex-disaggregated data were collected but not used for planning, or limited practical skills in using gender-related data, which may currently rest with gender specialists, seeming to suggest a too-narrow range of health information users.

A number of the contributions to Post 2 confirmed the need for more deliberate interactions between the *Information* and *Workforce* and *Services* components of the health system in assisting program planners and policy makers in actualization more gender-aware service and workforce policies.

Post 3 (August 7, 2014)

In Post 3, we explore the gender dynamics and inequalities that impact the health system components of Session 5: Availability of and Access to Medical Products, Vaccines, and Technologies and Session 6: Health Financing.

In **Session 5**, the course explains that despite the limited research on the role gender plays in the availability of medical products and in logistics, we know that gender influences product needs, purchasing and access, and the role of men and women in logistics and supply chain management.

- *Are you aware of any programs or interventions underway in your organization or country to address any of these gender issues? Can you share an example of a successful program or intervention that promoted women's empowerment or gender equality in supply chain and logistics management programs?*

In **Session 6**, the course discusses the importance of considering gender factors in health financing schemes.

- *How might sex-disaggregated data illuminate gender issues in health financing schemes (for example, finding out which groups are most financially vulnerable)? Has your organization or country conducted gender-responsive budgeting? With what results?*

Emerging Themes: Post 3

Comments related to Session 5: Medical Products interventions suggested that health systems are not promoting women in the supply chain logistics workforce, and that health systems in participants' countries are struggling to provide access to products for the most vulnerable. We saw a program of free condoms for vulnerable groups including girls, women, street children, and commercial sex workers, but that supply was not sustained. Comments on the Session 6: Health Financing questions provided examples of using information to inform financing decisions by identifying vulnerable groups, including women, girls, the disabled and rural populations. Women's education and economic empowerment to increase buying power were also mentioned.

We learned of attempts to improve health financing through gender-responsive budgeting by the Ministry of Finance, though in that case, it was unclear whether this effort was entirely successful. It seems that exemptions to eliminate user fees, co-pays, and out-of -pocket expenses and making some essential women's health (e.g., maternity, antenatal care, fistula repair) services free of charge were key gender-aware interventions. In one case, national health insurance was supposed to supplement free services at a certain point, but there were implementation problems at health facilities, and expensive drugs and tests were not covered. From the responses, it appeared that sliding scales, community-based

health insurance, and vouchers are not being used; this might be an interesting area to further explore and introduce in your settings. One participant asked: "*How can these gaps be strengthened in terms of gender?"* Although the issues appear by no means simple, perhaps health program leaders should start by viewing the *Health Financing, Medical Products,* and *Service Delivery* components of the health system as interrelated, and work with actors and information from all these components to respond to the needs of clients.

Underlying many comments to date is the role played by Session 7: Leadership and Governance component of the health system components. In Post 4, we explore consideration as to how gender aware leadership and governance can promote gender equality and women's empowerment in health systems strengthening, to achieve gender-related health system goals and outcomes, such as:

- Increased fairness in access to and coverage by health services and medical commodities and products for girls, women, boys, and men and universal access to services that address women's greater reproductive risks;
- Improved quality and responsiveness of health systems and their components to the different needs of women and men, girls, and boys;
- Increased financial and risk protection so that the most vulnerable of health systems users are not at risk of poverty due to service consumption or production;
- Improved reproductive and other health and social outcomes; and
- Increased gender equality and women's empowerment.

Post 4 (August 11, 2014)

In Session 7: You will consider the intersection of gender equality and the empowerment of women and girls in governance entry points, such as stewardship, accountability, decentralization, and leadership and participation.

- *Do you have experiences and lessons learned on ways to promote gender equality and the empowerment of women and girls to improve health system accountability or responsiveness? Have you implemented any of the Session 7 Illustrative Interventions?*

In **Session 8:** The course describes the *Brothers for Life Campaign* in South Africa that used SBCC (including interpersonal communication, mass media, and advocacy) to reach men as health decision makers, addressing traditional norms that influenced notions of manhood and constructive engagement in health issues.

- *Were campaign approaches transformative, accommodating or exploitative? How did this campaign promote gender equality and women's empowerment?*

Looking ahead to **Session 9** and your action plan later this week, please (re)read the Mexico case (or the actual publication), which describes how the Mexican government promoted multiple, dynamic interactions between all health systems' components to improve both health and gender outcomes. Please come to the last study group session on August 12 with examples of ways to promote multiple, dynamic interactions with other health system components, from the health system component or project *in which you most actively participate*. Please share successes and caveats.

Emerging Themes: Post 4

In response to Session 7: Leadership and Governance questions, two participants mentioned government accountability measures such as a Ministry of Gender spearheading gender-responsive budgets, and (government and or/civil society?) support to MDG3. Another mentioned that influential people in the community, such as religious leaders, traditional leaders, ward executive officers, and

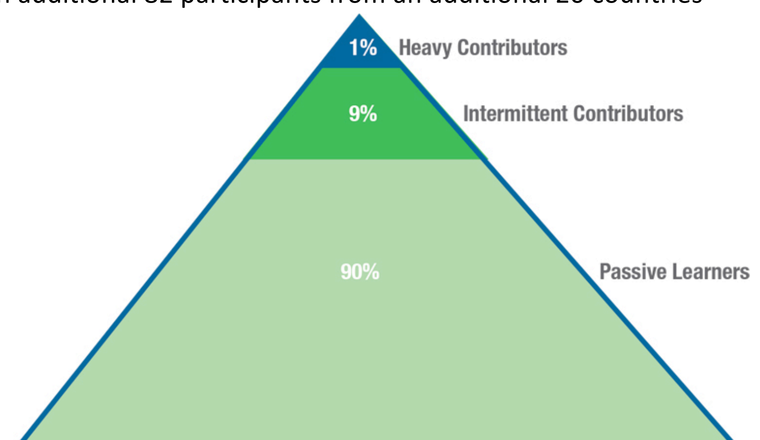
Parliament members, (often referred to as "power actors") had been used to challenge harmful gender norms, gender inequality, and their negative effects to women's and girls' health. Another observed that in his or her context, most faith-based leaders talk about the negative impacts of HIV/AIDS but were unwilling to address sexual behavior change or support condom and contraceptive use due to conflict of interest with religious doctrine. The course author shared a number of examples and resources that have been developed to help religious leaders speak more openly about sexuality, reproductive health, and HIV in the context of faith communities.

In response to Session 8: Behavior and Health Systems questions, participants mentioned experiences with various component of SBCC: mass media, community-level activities, interpersonal communication, and advocacy. There was much lively comments on what aspects of the *Brothers for Life* campaign was accommodating or transformative: One theme was that the men-only design excluded women (one participant remarked, *"where were the women and girls in the entire campaign??"*), accommodated patriarchy, and did not promote gender equality (for example, men as health decision makers, rather than men and women as joint health decision makers). Another theme was that the campaign attempts to transform gender norms and reduce the risks associated with multiple concurrent, sex, alcohol, and gender-based violence by addressing traditional ideas of manhood and male engagement in health. Having both approaches is possible in a project, but questions emerge: Did the campaign designers *intend* to accommodate patriarchal modes of decision making, and were they aware of this possible interpretation? The course author shared the campaign website and PRB's publication on gender-synchronized approaches for more information to inform these discussions.

In response to the guiding questions of Session 9: Multiple, Dynamic Interactions Among Health Systems Components, there were two key messages: First, when we promote gender equality and women's empowerment, health systems become more effective because they better meet the health needs of women, girls, boys, and men. Second, it is most effective to promote gender equality and women's empowerment in each health system component, and among them, to improve the health and social outcomes.

CONCLUSION AND LESSONS LEARNED

The Gender and HSS study group is the first GHeL study group to date. It was extremely well-attended, eliciting more than 63 contributions from 22 active participants in 10 countries—with more than 98% of participants coming from outside the U.S. An additional 82 participants from an additional 20 countries signed up and followed the discussions. Twenty-one percent of participants actively posted comments to the study group. This participation rate is exceptionally high according to emerging research from the Nielsen Norman Group which suggests that in most online communities 90% of members are passive learners, while 9% of members contribute a little and 1% of members account for most of the contributions and interactions. From the participant



contributions, it appeared that participants were more interested and/or comfortable discussing issues around health workforce, service delivery, and information, while there was much fewer comments shared about medical products, financing, and leadership and governance. These were also the sessions/topics that most Gender and HSS post-study group survey respondents reported needing additional training.

K4Health conducted an After Action Review with the course author and one of the course's US-based participants to discuss what worked well, what didn't, and suggestions for how to do things differently for future study groups. The course author reported that she felt well-prepared; that preparing the discussion questions ahead of time made a big difference in alleviating the time pressure that she felt. She felt that she had enough time during the actual week and a half of the study group to respond to the contributions. She would read through them and draft initial thoughts one evening and then go back over her response, do some additional research and reading, and then finalize her post the next day. In total, each post took approximately 4 hours.

However, the course author did state that *"nothing could prepare you for the actual experience"* since it was sometimes disconcerting that participants did not stay on topic and respond to the study group questions. Also, it was challenging to both do justice to the range and depth of responses and at the same time pithily reflect learners' responses. According to the study group participant who participated in the After Action Review, she did an exceptional job facilitating these diverse threads of the discussion. The course author and K4Health were also very pleased to see that fellow participants were often responded to each other's comments which aided in the flow of the discussion.

The issue of timing was also discussed and whether or not the study group should have been extended over 2 to 2.5 weeks and even longer and whether or not this would have assisted participants in responding to each post and staying on schedule with the discussion questions. It was noted that the participants are all busy professionals and that timing would always be an issue to a certain extent due to people's schedules. K4Health confirmed that the average learner of the Gender and HSS course spend 19:30 minutes on each session so the course is broken down in appropriate sessions/chunks of content. To address the issue of compressed time related to the study group, the study group participant who participated in the After Action Review recommended that K4Health reiterate the course calendar with every email about the post so that participants were always reminded as to what was coming up next.

Forty-six percent of post-study group survey respondents noted that the time estimate of the course (2 hours and 30 minutes) was accurate, while the same percentage (46%) noted that it took them more time to complete it. 86% reported that they clicked on the links for additional resources in the course, which is why the course may have taken some longer than others. Along these same lines, 47% of post-study group survey respondents suggested that the course be made longer and 71% would have liked more examples.

However, 79% reported that they found participating in the study group useful in providing them with additional examples from the field. Eighty-four reported that it provided them with an opportunity to learn from others and 53% reported that their participation clarified concepts in the course. Ninety-five percent of post-study group survey respondents reported that they felt somewhat confident to much more confident to apply what they had learned as a result of participating in the study group discussion.

There is still room for improvement. For example, the course author wished that there had been enough time to review the participants' Action Plans and discuss them. Overall, she reported that it was a very

worthwhile experience and something that she would be happy to do again. She concluded by saying *"In fact, I don't know if I'd do an online course in the future without a study group or some kind of discussion opportunity. The value in the discussion is allowing participants to apply the concepts learned."* K4Health looks forward to applying the lessons learned from this first study group experience to future study groups and will continue to document each experience for future improvements and transferring this capacity to others interested in implementing this type of blended learning event.

Discussion Statistics

Number of participants: 104
Number of participants' countries: 30
Number of contributions: 63* (made by 22 active participants)
% of contributions from developing countries: 98% (only 1 contribution was made from the US)
Number of countries contributing: 10
Contributing countries: Nigeria, Kenya, Gambia, Ghana, Rwanda, Tanzania, Botswana, Ethiopia, Zambia, and the US
*The full contributions from all of the participants can be found in Appendix A.

Summary of Post-Study Group Survey Results

N of surveys completed	25
% who shared information from the discussion with others	89%
% who felt the discussion helped them to apply what they learned from the course	68%
Suggestions for improvement	Most suggestions related to allowing for more time. For example, • *Time for of posting the questions and discussion could be for two days, to give more enough time to look on reference and linkage related to discussion.* • *Create more time to respond to Questions because we did the study group discussion concurrently with our usual day to day activities. It was a struggle on some days to get time to participate since work schedules are also time consuming and hectic. Maybe weekends would also work best because we're taking 2 days off work.* Another suggestion was providing opportunities for the participants to meet face-to-face. For example: • *"We need to meet personally or at a forum so that we interact more and discuss more."*

For the full report on the post-study group online survey results, see Appendix B on page 25.

APPENDIX A: FULL CONTRIBUTIONS FROM PARTICIPANTS

In Response to Post 1: Sessions 1 & 2

Submitted by magetod@gmail.com on Mon, 2014-08-04 06:27 – Dennis Mageto, Kenya, Other/USAID
apart from women their are men when they marry a woman who earns more than him he is subjected to harsh treatment and above it the woman feels she can have even an affair out of their marriage which at the end they are affected halth wise through getting STDs and other infection.

Submitted by magetod@gmail.com on Mon, 2014-08-04 06:37
session 2
some of the gender accomodating approaches are doing referrals for children at their guardians who visit our drop in centres.
we also set aside some alocation of money that helps the female sex works when they have some health related issue to beef up on the small amount of money they have. this will cater for their medical.
trnsformative programs that can bring better health system is to have special centres at the community that can provide comprehensive health care.

Submitted by abidega@yahoo.com on Mon, 2014-08-04 08:09 – Olufunmilayo Adedayo, Nigeria, Programmatic/National-Local NGO
It was discovered during an M&E program to assess the efficiency of the Measles Immunization coveragecarried out recently that in many rural locations, most of the women are farmers and leave home early to the farm. This resulted in many children (ages 1-5yrs) not being immunized as the Health workers visited such locations when the parents were off to the farm. Usually the fathers do not invovle themselves with the immunization and leave it to the mothers.
This will be taken into consideration during the next program, either health workers visit such locations, after noon, when te mothers are back from the farm, or mass sensitization programs will be carried out before the Immunization so that both or either parent will be available to ensure the children Under5 are immunized.

Submitted by abidega@yahoo.com on Mon, 2014-08-04 08:41
While i was working in an environment where gender inequalities prevail due to religion, a female laboratory tech had to be recruited to take swab samples from women and a male staff also recruited to give the men VCT counselling. Due to religion, it will take some time before gender transformative programs can be promoted. For now, gender accomodating programs prevail.

Submitted by preang.soko432@... on Mon, 2014-08-04 13:55 – Precious Mary Soko, Zambia, Programmatic
The women are usually burdened with a lot of responsibilities. They are often tasked to take care of the sick in the communities, attend funerals, fetch foorewood, do some field work. Even when they are not feeling well they forced to do some work. They rarely have a second to take of themselves. This is noticeable in most rural areas of my country.

Submitted by jgichukibds@gma... on Mon, 2014-08-04 15:18 – Judy Gichuki, Kenya, Clinical/National Govt

In many low income families, women are disadvantaged as the men usually contol the meagre family resources. To ensure that all women have access to health services, all maternal and child health services in Kenyan health facilities are now free of charge. This has resulted in increased number of women delivering in health facilities and may contribute to reduced maternal mortality.
However, even with free maternal services, women living in slums are faced with challenges of accessing health facilities at night due to insecurity. To assist in this, one non-governemental organization in conjuction with the district health management team has come up with a system of utilizing youth groups to serve as escorts to women at night so that they can safely access health facilities.

> Submitted by walterkirui@yma... on Tue, 2014-08-05 15:17 --
>
> I totally agree with you. i reside near PUMWANI AND MAJENGO SLUM AREAS OF nairobi and i administer a CBO in the area. The challenges are there and both county and national governments should be involved.

Submitted by obaseki2001@yah... on Mon, 2014-08-04 13:14 – Isaac Obaseki, Nigeria, Student

Why is there so much outcry about gender issues

> Submitted by welavunuka@yahoo.com on Mon, 2014-08-04 15:12 – Epher Welavunuka, Kenya, Clinical/INGO
>
> There is so much outcry about gender issues because, for a long time the world health organization has wanted to achieve health for all but this has never been realised because of the issue of gender inequality. If both gender is represented at all levels and in all settings, we are sure to achieve our goal of health for all. Man or Woman represented at a given level of organisation, will have their needs addressed accordingly because a woman knows better what a fellow woman's need is and vise versa, and therefore everyone's need, man or woman will be addressed appropriately. Gender inequality is discriminative, biased and manipulative. In most cases women are vulnareble, for example an organization mainly represented by men at the top senior posts may descriminate women when it comes to budgetary aloccations, this may be deliberate or it may be due to lack of knowledge to address women needs. A government which is less sensitive about gender equality and therefore have only one gender represented mainly men, may have laws enacted which may favour man or boy and indiscriminate woman or girl child. A country that will have an equal representation at the pliament is likely to succeed as every need of man or woman is addressed from the top level. For example, insome societies where girl child has no choice of when to marry, who to marry and how many children to have and when or how often, really needs both genders to discuss the issue in order to come up with a concrete strategy to be able to address such an issue. This is a problem of every one and not just the society or community. A 14 year old married off, it means she has been entrusted the responsibility of caring for her family, the question is what knowledge does a14 year old have, and what decisions about peoples health can she make? Hence, the so much outcry about gender issues, in order to come up with policies that can function to cab such.

Submitted by klamboly@yahoo.fr on Mon, 2014-08-04 16:14 – Lamboly Guy Noel Kumboneki, Botswana, Clinical/National Govt

Hello everybody,
I would like us to explore the possibility of making gender equity a rerality than a dream as it is now the case almost worlwide but worse in Africa.

In fact many governments have consacred a good chapter to this topic in their constitution but as we know the reality is still far frm what is written;what strategies can we design and implement in Africa and how will those strategies not contradict the traditions and culturals values?

> Submitted by preang.soko432@... on Tue, 2014-08-05 14:48 – Zambia, Programmatic
> Regarding traditional and cultural values which sometime pose as a barrier to Gender equity and equality, the best is to target traditional rulers. Most of them are well educated and are very critical to helping their subjects understand the importance of Gender issues. Most traditional leaders in Zambia are helping to campaign against Gender Based Violence which is really on the increase in Zambia. Women are often disadvantaged because the men have to make decisions without involving them. In workplaces women tend to shy away from participating in certain top jobs. They are comfortable with lower positions. Some women even fight their fellow ladies when they assume higher positions because they feel men are the only ones who can do better jobs.

Submitted by gracekawo@gmail.com on Wed, 2014-08-06 12:29 - Tanzania, Programmatic, INGO

Sociocultural and economic factors are important to address when considering gender and health systems especially in Africa.

Girl education will make women more economically empowered and can pay for health care services including transport to health provision clinics or centers,can pay for house help to reduce their workload.

Gender accommodating services are more user friendly.

In Tanzania maternal and child care services are given for free, but sometimes supplies and drugs are not available and have to be bought by the client.

Women need to be escorted by their husbands to health care services especially at night to avoid gender based violence, or due to lack of funds for transport or to pay for out of stock supplies.

In some districts and hospitals men are invited and encouraged to accompany their wives at RCH clinics by rewarding them in various ways.

Submitted by welavunuka@yahoo.com on Wed, 2014-08-06 13:54

Gender norms is the biggest problem that leads to gender inequality. I work in a community that strongly beleives girl child is a source of income whereas a boy child is a source of security. The economic levels of this community is very low having faced a lot of challenges that come with civil conflicts and so more boys should be delivered to replace the lost in the conflicts and girls should be born and get married to bring wealth to the family. Now with this in mind, family planning can never be a priority.

Due to poverty, access to education is very limited for both girl and boy child, the little income would rather be spent on food than any other thing including access to health services. Since the girl does not go to school, immediatey after attaining age 14, she is married off to a man of the family's choice, upon getting pregnant someone has to make a decision for her ante natal clinic attendance and take her there, the same is to happen when the time of delivery comes. In most cases deliveries are conducted at home by the old ladies who even lack the skills and this endangers the life of a young girl who by virtue of her age she is at risk of labor and delivery complications and even death. If the girl is lucky to go through labor and delivery successfully, there awaits the responsibility of taking care of an underfive as young and uderknowdged as she is. The boy child is raised to be a warrior a belief that should be condemned in the toughest term possible.

The experience here is that change is not easy,especially when dealing with the old,my recommendation is that in as much as we are trying to sensitize eveyone on the dangers and risks of such kind of norms,

addressng this, should start at a tender age in school. Education on gender equality should be incoporated in the school curriulum.
The health system tried to deal with gender inequalities by trying to have both gender represented at different levels but a lot still needs to be done, for example, overall managment is mostly men whereas departmetal is female and of course the heavy pay is at the overall leadership.

Submitted by welavunuka@yahoo.com on Wed, 2014-08-06 14:09
The world is focusing on gender equality and women empowerment, my concern is, as a woman, what is my role in achieving this, or rather what am i doing to achieve this very impotant objective of the global health? It is an outcry for gender equality yes, but is the woman doing her part? Lets take for example, parliametary seats, women are encouraged to turnout in large numbers, in most cases they turn out in few numbers and the few who turn out i expect that women should vote their own so as to be fully represented but we do not! What is your take on this one group members?

Submitted by carolmwakio@gma... on Tue, 2014-08-05 11:55 – Caroline Mwakio, Kenya, Student/National-Local NGO
Session 1
Gender related challenges:
Most women fail to attend maternal health clinics or take their children to pediatric clinics because they cannot afford it or have to attend to other caregiver duties at home. Women also do not prefer attending GBV counseling, sexual reproductive health/ family planning counseling and couples' counseling with their spouses because they fear that their spouses might react negatively by leaving them or becoming violent. Most men do not like attending family planning or discordant couples' counseling clinics either due to the propagated stereotypes mentioned in the reading for session 1.

Submitted by carolmwakio@gma... on Tue, 2014-08-05 12:03
Health System Support on these Gender Challenges: How or How not?
The policies put in place for mental health reforms are seldom used by healthcare workers because of inadequate knowledge on certain issues such as Gender. Some NGOs engage the community on primary level training on GBV and other Gender related norms that may be harmful to individuals or how to seek help in case of health needs. They also advertise free GBV counseling services through the use of mass media to disseminate information although the coverage is limited to a small area e.g. the city so the larger rural areas are left out. The rural areas do not have adequate access to health care services but there are a few mobile clinics available with inadequate medical supplies that help out.

Submitted by carolmwakio@gma... on Tue, 2014-08-05 12:27
Session 2:
Gender Accommodating Approches:
The introduction of free maternal medical and counseling services in antenatal and labour wards in hospitals. Although working very well in the urban areas, the rural areas may be inadequately staffed and lack medical supplies. The whole antenatal clinic comprehensive treatment package addresses most of the gender related challenges faced by men and women as highlighted in Session 1 of the course. It covers antenatal check ups, GBV counseling, discordant couples' counseling for patients experiencing IPV (spousal participation optional), breastfeeding and nutritional counseling, HIV testing and counseling (with spouses present) among other services. In the past, women could not afford these services or did not make time for them because they had caregiver burden at home. Those in rural areas especially ASALs, still experience difficulty in accessing health care facilities.

Submitted by fmuja123@yahoo.fr on Tue, 2014-08-05 14:59

For away in Rwandan traditional culture ,females had definite job,and those which were in charge of men. women had in their attributions to take care of children, including take them to Hospitals for treatments, Men had to provide food and security to the family.
It was very had to to women because of travelling a long distance to ward Hospitals of health centers.

Submitted by walterkirui@yma... on Tue, 2014-08-05 15:21

Kenya has put a lot of investment in infrustructure and this will help alot in women accessing health care facilities. The first lady has also rolled out a program for mobile clinics at least one in every county towards maternal health care. There is now free maternal health care services in the country

Submitted by yarnoff@gmail.com on Tue, 2014-08-05 16:45 - USA, Student

In 2012, I conducted qualitative programmatic evaluation research on gender-based violence in GBV in Kibera, Kenya. There, I observed how gender norms contributed to the inter-generational occurrence of violence. Kibera is a very ethnically diverse place and participants in this GBV program would often report how some tribal traditions and values were used to justify the practice of violence against women in their community. The program I was evaluating sought to address these norms by conducting a multi-media communications campaign that debunked these notions and targeted all demographic age and sex groups within the community. The health facilities in the surrounding area sought to strengthen their GBV services by establishing one-stop shop centers where GBV patients could access medical and psychosocial services, as well as be referred to legal aid, increasing their hours of operations, ensuring anonymity of their patients, maintaining a non-judgmental and helpful attitude, and facilitating survivor support groups. These services were supportive in dealing with gender inequalities as they promoted stigma-free and safe spaces where survivors of violence could access appropriate services. These GBV services offered by the health facilities were gender aware, but mostly accommodating due to the fact that they provided treatment to GBV survivors, rather than aiming to prevent the future occurrence of GBV. However, that is why the program was multi-pronged and included a strong communications/behavior change component. Through the use of peer-education workshops, the project sought to address normative and cultural beliefs around GBV by espousing gender equitable values and ideas.

In Response to Post 2: Sessions 3 & 4

Submitted by walterkirui@yma... on Tue, 2014-08-05 15:41 – Epher Welavunuka, Kenya, Clinical/INGO

With the new constitution in kenya which came into effect in 2010, emphassis has been put on women occupying at least two thirds of all positions in the public sector including senior government positions and paliamentary representation which has been achieved to some extent. There are still challenges though specially nin rural areas where education and cultural issues still discriminate against the girl child and women are under represented in the higher professional level in the medical field and are a mojority in the lower levels in the nursing and clinical proffessions. However the university entry level for girls is lower than that of boys which may in future enhance a level playing field for both gender.

Submitted by walterkirui@yma... on Tue, 2014-08-05 15:45

sex dissagregated is now being used in most health facilities and related institutions .

Submitted by BOchola@path.org on Tue, 2014-08-05 13:04 - Kenya, Programmatic

thanks for this good question, there is dire need for all of us to understand the reasons why gender responsive approach to program is key. on the extent to which we need to go to with accomodative approaches, i want to say all the levels of employment currently there is need to be conscious of the gender transformative measures.this needs to be enshrined in the constitution and work policies. in kenya we have seen more vibrant steps taken by the government to ensure affirmative actions are in place e.g athird representation of females in all that we do to benefit both. however sometimes follow up of the breach to this is slow because of many men at the top most decision/ implementation levels. not unless the civil societies make noise it may go un noticed. two women still need alot of empowerment to tackle issues immediately minus waiting for time to elapse then cry voidly. however we are happy more women are currently in parliament and other deciding positions which they had feared to venture into. but interms of polical angle women still feel fellow women cannot lead, they have also not invested into it by taking voter cards.
for data collection, yes it is the order of the day to disaggregate data as most of the data tools are designed to conform to gender related information collection and sharing. this has also assisted when we want to give targeted services to each group e. g VMMC, HTC,ANC, couple counseling, health talks/education, sensitizations etc.. the mostly ignored factor is the need to practice data interrogation interms of gender which in most cases has been left to the gender specialists or practicioners. two it is also challenging getting this kind of data when doing community activities e.g celebrating world breastfeeding week at a launch, you are so engaged that estimations are only the option left, as doing registration is overwhelming and many will only register if some goodies are assured.

Submitted by magetod@gmail.com on Wed, 2014-08-06 02:01 – Kenya, USAID/Other

in kenya we have also sen some improved accomdative strategies where women are know given priorities to work in bigger offices and are among the top positions.
the major challenge that they face also comes due to the cultural aspect that is in our mind since the traditional old age. that challenge is that most of the culture regard women to be children.
Also issues still regarding culture is that in kenya not only men but women still say it hasnt reached that time when a woman can be the top leader (president).
But with the new constutution we are able to see majority of women now getting post at the government institution and they are good in leadership

Submitted by fatispa2003@yah... on Wed, 2014-08-06 05:24 – Gambia, Clinical
we are collecting gender sagregated data but itis of little use because it is not nsed for planning for health need of the population

Submitted by abidega@yahoo.com on Wed, 2014-08-06 08:43 – Nigeria, Programmatic/INGO
The current Government in my country promotes gender equality and are fulfilling the MDG 3 (to promote gender equality and empower women). So in Government Ministries, Departments and Agencies, they purposefully recruit and promote women for a certain percentage of positions. Maternity leave of staff working in Govt Offices was also increased from 3 paid months to 4 paid months. This has really encouraged more women to work,further their careers and improved both Maternal and child health!

There are certain programs targeted at empowering women like YouWiN! stands for Youth Enterprise with Innovation in Nigeria. YouWiN! Women was designed for only female entrepreneurs aged 45 years or less. These programs have been successful as they provide financial resources for self-starter women.

To encourage women to take up jobs and reach the top cadre of the Organization, an NGO established and in-house creche for their staff. This has encouraged more female workforce on all cadres of the Organization.

Submitted by fmuja123@yahoo.fr on Wed, 2014-08-06 10:13 - Rwanda, Student
In my country Rwanda women and girls are respected ,Our goverment says that they should be represented in all domains
by the rate of 30% for instance in the Parliament and in goverment.
This equality starts in families the boy and girl have the same rights. The boy and girl are educate to complete one to another.
In early education (primary School) girls are encouraged and motivated to have the self reliance and confidence in themselves.Some Schools of excellence are built for them. The First Lady found the project (Imbuto foundation) who helps them by giving prize to the brilliant girl students.

Submitted by rosek208@yahoo.com on Wed, 2014-08-06 10:19 – Tanzania, Programmatic, INGO
To pursue gender accommodating approaches in the face of multiple forms of gender discrimination faced by women in the health workforce, we need to enhancing a policy and laws which protect women from gender discrimination, for example in Tanzania we have a law which protect women from sexual harassment at workplace but is not all health workforce they knew.
In Tanzania we have seen gender transformative addressed from the grass root, where all boys and girls at the age of starting primary school should go to school. At secondary and universities education girls are given an opportunity to be enrolled more than boys especially on sciences subject which are perceived as men’s subjects. In public sectors women have given a privilege to hold some senior position and member of parliaments although is not many compare to men. To enhance this, Tanzania constitution are in reviewing process and among section expected to be reviewed is gender mainstreaming, so that we can have equal presentation for both men and women in education and management and leadership.
Gender socialization is among factor which makes, some men to continuing to hold gender stereo types, with believes that women are weak, cannot hold some position in senior management and leadership. There is a need to addressing gender issue from the family level thin including incorporating gender education at schools.
Data dis aggregated by sex have been collected, but it is on family planning beneficiaries'.

Submitted by carolmwakio@gma... on Wed, 2014-08-06 11:53 - Tanzania, Programmatic, INGO

Session 4 really shed some light on the significance of using sex-disaggregated data. Research is now becoming an important part of the National Healthcare System in Kenya for policy making but I had no idea that data could be used in various ways to create gender aware programs. The illustrations on Kenya and Uganda were good lessons for this topic area! Thank you so much.

Submitted by jgichukibds@gma... on Wed, 2014-08-06 12:57 - Kenya, Clinical, Natl Govt

As stated by colleagues from Kenya, sex -disaggregated data is routinely collected in health facilities. A review of sex dis-aggregated data in one of the public health facilities in Nairobi found that more than 60% of those being counselled and tested for HIV at the VCT were females. To address the low number of men getting tested, outreach HIV counselling and testing services targeting men working at the industrial region were conducted in order to reach those men who might not have a chance to reach VCT services due to their work hours.

Submitted by welavunuka@yahoo.com on Wed, 2014-08-06 14:47 – Kenya, Clinical, INGO

In the face of multiple gender descrimination faced by women in the health workforce, persuing gender accommodating approaches would just promote the gender descrimination more. Transformative approaches should be implemented right away as the health workforce continues to be empowered with knowledge about the dangers of gender inequality.
In my country the government has enacted a law which supports women representation at government levels and in the top leadership and managment posts. There are challenges that come with this law, though women representation is encouraged in the parliament, still all, whether man or woman have to go through the process of vying for seats and though they may turn out in large numbers, they are not voted so the same law throws them out . The success is that we are now seeing women representatives in the parliament who have addressed some of the issues affecting woman and girl child that were never before addressed. Women groups are currently encouraged and are given financial aid to help improve their social economc lives. Equal education opportunities for both girl and boy is being, implemented all these as aresult of women representation in the pariament. Prices for sanitary pads have been tremendously lowered. This is because someone who understands a woman's need i s up there. Maternity services are now free.

Submitted by gracekawo@gmail.com on Thu, 2014-08-07 12:09

As far as gender issues related to workforce is concerned, differences in levels of education need to be addressed. Currently in Tanzania, all children eligible for school enrolment are registered for primary education. At higher levels of education girls can be at a disadvantage because they can be discontinued due to teenage pregnancies.

Men are over represented in top health leadership because there was no equality in education in the past. As a result women are over represented at primary level because of lower education qualifications.

Women representation at higher levels of management including parliamentary positions is encouraged. The challenge to this still remains the fact that some men and even women will not elect women representatives because of their sociocultural beliefs and attitudes.

In my setting, sex- aggregated data are available, and they help to make some of the current reforms to promote education of the girl child and position of women in general.

In Response to Post 3: Sessions 5 & 6

Submitted by BOchola@path.org on Fri, 2014-08-08 07:51

it is important to note that the issues of gender inequality is still abig challenge to health access. today we have put in place an arry of activities to make sure that women are empowered positively to to challenge the negative normative cultures. we address these through community awareness dialogues and sensitization where gender analysis directs the session questions, we also have an village savings and loaning methodology integrated in the community units which provides easy access to finance for the members borrowing and use, then returns with an interest rate as per their aggreement. after one year they share out interest and boost their capital base for small businesses which eventually culminates to big dreams and reality. there are aslo efforts to capacity build the members of the county assemblies to have skills needed for doing a gender responsive budgets within their work of allocating resources to the county. the programe staffs have been oriented and keep track of how to allocate resources to the beneficiaries and just to understand the level of vulnerability of households. the number of males and females served by different services are responding to the needs identified through

Submitted by rosek208@yahoo.com on Fri, 2014-08-08 09:46

Gender role have hindered both women and men in accesing halth services, not only at community level, even decion makers.However there are have several intervention which are take place for both Tanzania government and non-government organizations to increase availability and accessibility of health services. For example mortality rate in Tanzania is still high and this influence Ministry of Health and social welfare in collaboration with other NGOs' such as JHPIEGO, EngenderHealth and AMREF to build and renovate maternity wards at every health centers, trained health workers and purchase of ambulance to some health centers as well as delivery supplies to meet the women reproductive health service's needs. This have reduced Maternal Mortality Rate from 578 per 100,000 per live births to 454 per 100,000 live births although(TDHS 2012)

The Vodafone Foundation Tanzania, has been working with the Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) to treat women with obstetric fistula. The CCBRT hospital uses the mobile transfer system (M-Pesa) to send money to local ambassadors who arrange travel for women who would unable to reach the hospital for corrective surgery. This initiative has helped to increase the number of women receiving fistula treatment from 168 in 2009 to 713 in 2013.

on session 6. **About sex-disaggregated data illuminate gender issues in health financing schemes**
Sex is a determinant of health, and risk factors are very different by sex, causes of death and other outcomes which vary between women and men. It is important to differentiate data for women and men because they will require different emphases in health financing scheme. Unemployed women, and those are leaving in rural areas in Tanzania, are more vulnerable in access health services compare to men. The factors include the lack of time for services, the lower socioeconomic which cannot afford to pay for health services. Using sex- disaggregated data will help to track who is in a need to be covered with health financing scheme.

The Tanzania Health Sector Strategic Plan III states in section 5.3, address gender responsive budgeting which state ministry of health and social welfare to ensure a gender focus in all policy development, guidelines and protocols and elaborates gender sensitivity in terms of specific services needs as well as activities to stimulate equality of men and women. However in intervention is not much effective because deficit of budget, politics issues and lack of awareness for implementers.

Submitted by walterkirui@yma... on Fri, 2014-08-08 10:22

kenya has undertaken several steps in addressing gender issues. the new constitution of 2010 enhanced female representation in all economic and political activities including the right to inherit and own property. Women now fully participate in bussiness sector and the government has allocate thirty percent of its tenders to women and youth.

as an organization we seek to secure funding for HIV positive mothers, orphans and vulnerable children in income generating activities.

The government now fully funds free maternity and child services nationally.

As an organization we conduct a gender responsive budget-which HIV positive mothers and children have benefited.

Submitted by welavunuka@yahoo.com on Fri, 2014-08-08 11:45

Session 5
The most affected with gender issues are the nations experiencing conlicts be it civil or political. During conflicts people, women or men, girls or boys are displaced yet life cycle continues whether man or woman, or girl or boy. The challenges that come with this is issues to do with reproductive health life, women are displaced while pregnant, others get pregnant during the conflicts, and women and girls continue through their reproductive life cycles i.e menstrual cycle. A time comes when the pregnant women have to give birth or the non pregnant have to have their menstrual periods amid conflicts. Programs are underway in my organization (UNFPA), to address this gender issues. Midwives have been deployed in the war torn areas, in the IDP camps and also in the various hospitals within the war torn South Sudan. Pregnant women are able to access skilled maternity services despite the conflicts. The deployed international midwives are making sure every pregnancy is wanted, every birth is safe and that everyone counts. During conflicts, no one wishes to get pregnant and give birth in such an environment, so women may opt for unsafe abortion whch in most cases complicates leading to maternal mortality or morbidity. UNFPA has provided family planning servces to curb this. HIV councelling and testing, and syphllis testing is done for both men and women ad treatment initiated for those who test positive, and treatment continuation for those aready on reatment,is ensured. Condomns are provided and made accesie to all.

Submitted by abidega@yahoo.com on Fri, 2014-08-08 14:52

In the Northern part of my country, Jhpiego works in collaboration with the government to bring the much needed health care to women especially in remote areas where they live and increase access to HIV prevention, care and treatment services. Merging HIV services with maternal and child health care and family planning makes certain that women get all the services needed in one location. This project is directed at vulnerable populations in rural areas which avails women and children who normally wouldnt receive such services, HIV prevention services.

The project which places emphasis on most-at-risk individuals, tagerts over 40.000 people; the project trained and educated health workers & volunteers on different aspects of PMTCT/HIV counselling and testing, M&E and quality assurance controls; the project also provided ARVs for HIV positive women who are pregnant and referrals for men and non pregnant HIV women.

Submitted by preang.soko432@... on Fri, 2014-08-08 15:59
My organization does not deal in Supply Chain Management programs. The USAID funding does not allow for procurement of Drugs or medicine. The USAID funding under the STEPS OVC project does not allow for this activity. However, women are refferred to nearest health centers by the caregivers who are trained to reach out to their communities. Oftentimes there are drug outages and women are given prescriptions to buy their own medicines from the Drug store or Chemist. Only those who can afford buy the drugs.
Dissagregation programs are helpful because it is easy to know whether it is the women who need assistance by assessing the data to see which population access health facilities. Women are often vulnerable and they lack the resources so they rarely access Health Services.

Gender equality in supply chain and logistics management programs and Gender-responsive budgeting
Submitted by charlesacqua@ya... on Fri, 2014-08-08 17:27
I am not aware of any program or intervention underway in my organization or country that promoted women's empowerment or gender equality in supply chain and logistics management programs. Gender considerations are very limited in program designs and implementations, neither had we conducted gender-responsive budgeting to the best of my knowledge. The closest we came towards gender-sensitive budgeting was three years ago when the Ministry of Finance trained representatives of the MDAs on gender budgeting but it did not go far.

SESSION 5&6
Submitted by patriciaantwibo... on Fri, 2014-08-08 19:41
I am happy to be part of the session now. Thanks to the GHEL team who were able to trouble shoot my log in problem. Ican easily see health financing and gender mainstreaming in Ghana at health centres. For example pregnant women can now attend antenatal for free till a certain point where National Health Insurance takes over. However the challenge I see is that the National health Insurance system is not working.Clients who use these cards are made to join long queues to assess health services, the expensive drugs are not taken care of and lab tests that are highly specialised need to be paid out of the pocket.These challenges affects the poor and vunerable who might not be able to afford the cost.How can these gaps be strengthened in terms of gender???

Session 5
Submitted by munageza@yahoo.com on Sat, 2014-08-09 01:14
Family planning program intervention that promoted women's empowerment in supply chain and logistics was that access to female condom in government health institutions for most at risk groups like girls and women for unwanted pregnancy, sexual abuse and sexualy transmitted infections. For example street children's and commercial sex workers the female condom was distributed for free. I do not have an evidence how successful the program was at that time.But the major challenge was the sustainability of the supply. Now a days the distribution of this supply is reduced or near to nil.

Submitted by munageza@yahoo.com on Sat, 2014-08-09 01:30
The funding for the program stated is to be sustainable for the program to be successful. To increase access awareness creation and advocacy for the supply should be integrated with the program.

Submitted by preang.soko432@... on Mon, 2014-08-11 14:27
In my country the women can now access female condoms as they attend underfive clinics and and dliberate programs or health talks organized by the Ministry of Health and some Civil Societies. Previously they had no say over safe sex because they felt it was awkward to buy male condoms which

are more common in the country. However, the challenge is that some big local NGOs do not deal in condoms because of religious beliefs. This makes the communities they are covering more vulnerable especially girls and women.

Submitted by preang.soko432@... on Mon, 2014-08-11 14:34

My country recently introduce the Ministry of Gender and this Ministry is spearheading Gender issue including Gender responsive budgets. There are some women empowerement programs where women's clubs are given equipment, loans and trainings in order for them to generate income and be able to meet their health needs. There has been discussions on Gender responsive budgets

Submitted by fmuja123@yahoo.fr on Wed, 2014-08-13 07:55

in my cuntry it is a part of the priorities for Support to Accelerate Progress to Achieve MDG 3 key interventions must be planned and implemented specifically on programmes for women's economic empowerment and for support women to start HEs and move into non-farm jobs; programmes to train teachers and lectures so that the curriculum in schools, vocational and technical and higher education is engendered; programmes to tackle gender-based violence and negative cultural attitudes to women.
In order to ensure sustainability, men should be involved in all the process, making them a responsible part in reaching a gender equal society in Rwanda. Involving men in training and skill building for gender equality so they understand the benefits to all of the empowerment of women.

Submitted by walterkirui@yma... on Thu, 2014-08-14 06:23

there has been an issue in kenya were the government were proposing free distribution of condon in primary schools. I have the opinion that more emphasis should be put into sex education and gender and reproductive health.

In Response to Post 4: Sessions 7, 8 & 9

Submitted by walterkirui@yma... on Mon, 2014-08-11 13:03

To promote gender equality and empowerment of women and girls to improve health we need to enhance the education level.in most african and asian societies education of women is lower to that of men and boys because of cultural barriers and early marriages. Cultures should be modernised and early marriages discouraged. Women should be encourage to take more proffessional health related courses at university level to attain a level playing field among both gender.
As a civil society organization we share sex and age dissagregated information for both gender in our programmes by building leadership and capacity of women and girls to communicate their needs.

Submitted by preang.soko432@... on Mon, 2014-08-11 15:03

On session 7 I would say efforts have been made by most Health facilities to involve men in some Health issues such as PMTCT. Men have to accompany their wives as they attend the first ante nental clinic for HIV Counselling and Testing. They opt out if they are not ready but it seems mandatory in some places.

Submitted by rosek208@yahoo.com on Mon, 2014-08-11 22:34

Increase community awareness on gender equality and wome empowerment it is pontential in all aspects . of health, social and economically. In our program we are using influential people in the communities, such as religious leaders, traditional leaders, wards executive officers, and Parliament members (we call them as power actors) to challenge harmful gender norms, gender inequality and effects to the women and girls on health issues. This have increased for both men and women to accesses health services i.e. Reproductive health services.
On session 8. Basing on the case study from Brothers for life. My view i can say, tihis campaign it follows into two categories,gender transformative because it actively transform gender norms by addressing risk behavior associated with multiple concurrent, sex, alcohol and gender based violence by using communication campaign. While another categories is gender accommodating because it work around gender differences and inequality by involving men for a change. Hower concening this campaign does not promote , gender equality and women's empowerment because all activities in this program focused on the men only.

Submitted by carolmwakio@gma... on Tue, 2014-08-12 10:18

Session 8:
The Brothers for Life Campaign:
Gender-accommodating – because it involved primarily boys and men to solve gender issues affecting women, girls, boys and men. Perhaps because most parts of Africa are predominantly patriarchal societies so it would make sense to have boys and men in the campaign although it's still not a good justification for doing so seeing as it was a multi-agency nationwide campaign. The **Men's Wellness Toolkit** (naming bias, perhaps?) addressed issues that continue to undermine the health of both men **and women** targeting boys and men as agents of social/behavior change but where were the women and girls in the entire campaign??
Gender-transformative - because it addressed health issues such as sexual risk behaviors, alcohol use and gender based violence. The use of mass media and popular male figures to send out the message on behavior change is a smart behavioral reinforcer. I know I would easily remember information if it came from a celebrity on social media than an unpopular source. I think the campaign promoted gender equality and women's empowerment by educating men and boys on the importance of involving women and girls when making sexual and reproductive health choices.

Submitted by carolmwakio@gma... on Tue, 2014-08-12 10:19

Just one question, since the program involved HIV testing, male involvement in PMTCT and general health seeking behaviors for men, did the campaign also involve VMMC? I read in an earlier session of this course about including VMMC in HIV testing programs, did they include it? Was it under general health seeking behaviors? I'm sorry I haven't read the Brothers for Life Campaign case study yet.

Submitted by carolmwakio@gma... on Tue, 2014-08-12 10:21

In an NGO I worked for, the use of radio broadcasting was quite efficient in spreading information on where to get immediate and free GBV counseling and medical services in the event of SGBV or IPV. **Time** being a very important consideration here. Most of the patients said they found out about the clinic's services through an ad on radio (a popular radio station in the area being served by the clinic) or posters, leaflets and community awareness campaigns that would be done by community health workers and social workers from the NGO in the target area ever so often. Mass media targets women, girls, boys and men so it's gender-aware method of disseminating information.

Submitted by carolmwakio@gma... on Tue, 2014-08-12 10:23

On Advocacy, most faith based leaders talk about the negative impacts of HIV/AIDS in society but seldom want to address issues on sexual behavior change. They may not be pro-condom use or for family contraceptives and may fail to **directly** engage girls and boys in sex Ed. talks because of the conflict of interest with doctrine. Sex Ed. Is then left to the teachers at school which then links the education sector to the healthcare sector and possibly communication sector through mass media messages on billboards, posters, social networks and TV ads all targeting girls and boys as highlighted in session 9; a multi-sectorial interaction of some sorts.

Submitted by preang.soko432@... on Wed, 2014-08-13 13:41

To me the campaign was transformative as it involved the key ares that affect women as a result of their social disposition. If the men adhered and put into practice what they learnt it would would bring about empowerement in the lives of women and girls. they would make decisions together and this would help prevent HIV.

Submitted by magetod@gmail.com on Thu, 2014-08-14 01:34

first of all women assuaring accountability, in our organisation we have women who are handling the finance office and with that she has made each and every individual be accountable of what she has given to them and she is realable .

on the isssue of women being the key actorst adocate fr equality their is a programme started at our rganisation called sister to sister where girls and women e empowered and they are now able to reach to the other girls at the grassroot level on health issues. i.e HIV and AIDs.

Side Comments/Interests (New threads)

Women Empowerment

Submitted by alawiyatu72@yah... on Tue, 2014-08-05 15:43 – Tanzania, Programmatic, INGO
I am concerned about the issue of women and girl empowerment, what strategies can we use to change the level at which we are going in our various countries? Considering the level of illiterate adults worldwide, women account for 64% of illiterate adults(UNESCO 2008)

> Submitted by alawiyatu72@yah... on Tue, 2014-08-05 16:01
> Marrying microcredit program into health programmes by NGOs will assist in making women and girls empowered to gain a greater freedom and capacity to make and take decisiondecision.

> Submitted by abidega@yahoo.com on Wed, 2014-08-06 08:38
> To encourage women to take up jobs and reach the top cadre of the Organization, an NGO establisged and in-house creche for their staff. This has encouraged more female workforce on all cadres of the Organization.
> the Goverment of my country recently increased Maternity leave of staff working in Govt Offices from 3 paid months to 4 paid months. This has really encouraged more women to work,further their careers and improved both Maternal and child health!

Concern

Submitted by lydiah.manoti@g... on Tue, 2014-08-05 21:22 – Kenya, Other
Thanks for the gender course discussion which brings fresh insights on importance of inclusiveness of the girls and women in developing our strategy.
I do agree that this approach is important but I disagree again from a different angle altogether. I once worked in a Usaid program where we were struggling to make this happen, but it didn't come out clearly bon the initiatives we brought on board. And for sure, looking at many more programmes, all this is in paper. How can we practically make this happen?? This is my dilemma. More so on top leadership levels other thasn intentionally setting aside posts for women who have no clear say and roles leading to further discrimination?
On the other end, some progressions require balance in order not to discriminate the boy child and strike balance. Its good to clearly think through this lines as we continue with the herein discussions.
Lydiah Manoti

WHY GENDER ISSUES IS STILL A PROBLEM IN AFRICA

Submitted by kiobya_anna@yma... on Wed, 2014-08-06 04:06 – Tanzania, Programmatic, INGO
Hallow collegues,
For me and what i have observed despite different efforts towards Gender issues being adressed but it is still a problem in Africa?
May be we can share from different countries what real the root cause of this

> Submitted by njiraine72@yaho... on Wed, 2014-08-06 05:46 - Kenya, Programmatic
> The term gender has been misunderstood in Africa. This in turn affects how gender issues are understood and addressed. African communities being patriachal in nature tend to bestow decision making power and hence control to resources on the man. This therefore has an adverse effect on health and hygiene of the family and community in general

The fight against gender inequality

Submitted by welavunuka@yahoo.com on Thu, 2014-08-07 05:31

As we all know, one of the Millenium development goals is gender equality and women empowerment, this shows how much the world has recognised that the two are problems interelated and leading to each other, a woman unempowered will be descriminated, and with gender equality, a woman will be empowered. We have seen how different governments ,authorities and organizations are trying their level best to implement strategies towards achieving this very goal, for example my government enacted laws to include a specific percentage of women in the parliament and top management posts, and women are encouraged to turn out in large numbers and contest for this parliamentary seats, the challenge is women will turn out in small numbers to contest, those who do not contest are encouraged to turn out in large numbers and vote their own, my observation is, few who turn out to contest, majority are voted out and this is because a fellow woman does not vote her own colleague or does not turn out to vote at all, so, despite the enacted laws to include women in leadership posts, the same law requires you to acquire a specific percentage of votes to win a seat, and so, e same law again throws the woman out due to the failure to achieve the number of votes and at the end of the day, leadership continues to be overepresnted by men. According to me this has caused delay in achieving this great goal. Women probably lack the knowledge on gender equality and its benefits, so its a high time gender equality lessons be incooporated in the school curriculum, this way we may achieve. We have been brought up in a culture where men were the only ones in the top positions and changing this kind of a culture requires a period of transition, so as we sensitize the old folks to try and achieve this, children should start getting this eduction right from a pimary level.

APPENDIX B: POST-STUDY GROUP ONLINE SURVEY RESULTS

1. In which country do you work?

Number	Response Date	Country:
1	Aug 26, 2014 8:36 AM	Tanzania
2	Aug 25, 2014 7:34 AM	RWANDA
3	Aug 24, 2014 5:24 PM	Botswana
4	Aug 23, 2014 10:37 PM	Ghana
5	Aug 23, 2014 7:31 PM	Kenya
6	Aug 23, 2014 9:17 AM	CAMEROON
7	Aug 22, 2014 4:50 PM	RWANDA
8	Aug 22, 2014 3:32 PM	Zambia
9	Aug 21, 2014 9:44 PM	India
10	Aug 20, 2014 5:18 PM	ETHIOPIA
11	Aug 18, 2014 8:46 PM	South Sudan
12	Aug 18, 2014 7:19 PM	Tanzania
13	Aug 18, 2014 6:27 PM	KENYA
14	Aug 18, 2014 3:02 PM	Nigeria
15	Aug 18, 2014 1:12 PM	Malawi
16	Aug 18, 2014 12:06 PM	Malawi
17	Aug 16, 2014 5:58 PM	Zambia
18	Aug 15, 2014 5:23 AM	Tanzania
19	Aug 14, 2014 7:11 PM	Zambia
20	Aug 14, 2014 11:10 AM	NIGERIA
21	Aug 14, 2014 10:28 AM	Kenya
22	Aug 14, 2014 9:21 AM	Kenya
23	Aug 14, 2014 5:14 AM	kenya
24	Aug 14, 2014 4:23 AM	Nigeria
25	Aug 13, 2014 11:38 PM	Nigeria

2. Please describe the type of organization in which you work.

Response Text
EngenderHealth, this an International organization working on Reproductive health, Gender and HIV/AIDS. At Country level (Tanzania) we are working on Family(planning,Long and permanent methods) PMTCT, male involvement in Reproductive Health, Gender based violence and Violent against children by supporting Regional health management teams and Council health management teams and health facilities in offering those services.
Education: School of Nursing and Midwefery. I am midwefe Clinical Instructor, During training in all area students teach community : IEC (Information, Education,communication)
Government
Ghana Health Service, the service implementing agency of the Ministry of Health
National and Referral Hospital - KNH and formerly working a humanitarian aid organization - MSF.
I WORKED FOR UNFPA CAMEROON AS BEHAVIOR CHANGE COMMUNICATION EXPERT IN ADOLESCENT/YOURT SEXUAL AND REPRODUCTIVE HEALTH.

School of Nursing and Midwifery
Friendly working envirronment
Independent Public Health Physician
CIVIL SOCIETY
I work for UNFPA, supporting and strengthening capacity building in the Republic of South Sudan. Promoting gender sensitive reproductive health, ensuring every pregnancy is wanted, every childbirth is safe and that every man and woman, boy and girl have access to quality reproductive health, because everyone counts.
Hiv/Aids organazation which called ICAP-Tanzania
MINISTRY OF HEALTH
Primary health care department Bauchi local govt. Bauchi State.
World Vision International a child focused non governmental org. mainstreaming gender in development
OSSEDI Malawi(NGO)
l work in a public institution at provincial medical office in Luapula Province
Private medical practice
It is a local NGO which works through the Church to reach OVC and PLWHA
The Nigerian Urban Reproductive Health Initiative (NURHI) is a five year project (2009- 2014), funded by the Bill and Melinda Gates Foundation to reduce barriers to Child Spacing/ Family Planning use, and increase the contraceptive prevalence rate by 20% points in selected urban areas of Nigeria. NURHI envisions a Nigeria where barriers to Child spacing uses are eliminated particularly among the urban poor. NURHI project objective includes provision of quality family planning service. To promote quality care and sustained improvement, NURHI is building the capacity of service providers to deliver quality and sustainable Family Planning services across the NURHI sites.
I work for an organization supporting HIV positive people especially mothers, orphans and vulnerable children
I am a clinical Psychologist working in a private clinic. I do psychosocial First Aid, Capacity Building and Behaviour change and i am a researcher.
the organization is a non governmental organization that deals with the OVCs and Key Population where we advocate for social determinants of health and health education respectively
In a civil society organization which who mostly work with women and OVC,s
Health Management, monitoring & Evaluation

3. Did you complete the course:

Answer Options	Response Percent	Response Count
Yes, before the study group began.	36.0%	9
Yes, as part of the study group. → Q7	32.0%	8
No, I started the course and plan to complete it. → Q7	28.0%	7
No, I started the course but don’t plan to complete it.	0.0%	0
No, I didn’t even start the course. → Q11	4.0%	1
	answered question	**25**
	skipped question	**0**

4. Did you develop an Action Plan after completing the course?

Answer Options	Response Percent	Response Count
Yes → Q6	64.7%	11
No	35.3%	6
	answered question	**17**
	skipped question	**8**

5. Why didn't you?

Response Text
I will develop an action plan after taking the online course test.
I am an individual Activist. I am always working for gender equity and women empowerment.
I was busy in the field towards the end of the group discussion and poor network in some of our areas.
I was facing problem of traced my password to enter.

6. Was the time estimate of 2 hours and 30 minutes for this course accurate?

Answer Options	Response Percent	Response Count
Yes, the time estimate was accurate.	46.2%	6
No, the course took less time to complete.	7.7%	1
No, the course took more time to complete.	46.2%	6
	answered question	**13**
	skipped question	**12**

7. Did you click on any of the links to additional resources in this course?

Answer Options	Response Percent	Response Count
Yes	85.7%	18
No	14.3%	3
	answered question	**21**
	skipped question	**4**

8. Which sessions/topics did you find most useful?

Response Text
session 3 Health workforce, session 5 Availability of and medical, products ,Vaccine and product
Empwering women to stand up , to develop them serve, taking,making decision about their health,in the family,in community
The information on determinants of health, gender-equality continuum tool, sex-disaggregated data collection and use for research programs in health sector, good critique of projects carried out in other parts of the world, illustrations used for the course. Everything was relevant and insightful.

INFACT THE WHOLE COURSE WAS VERY USEFUL BUT AS SOMEBODY DOING IN CHANGE COMMUNICATION I FOUND THE PART ON SBCC MOST USEFUL TO ME.
All
Gender as Determlnant of Health
ALL
Empowering women & girls
Most of the topics
It help me to understand my professional into practices and reality
All of them
Session 1 and 2
All the topics were very useful.
GENDER AND REPRODUCTIVE HEALTH
sessions 7, 8, and 9
wemen representation and family planning.
gender equality and gender equity
Behavior and Health systems Availability of and Access to Medical Products, Vaccines, and Technologies

9. Which sessions/topics do you feel like you could use more training on?

Response Text
session 2. Health services delivery, especially on Quality of care.
Family Planning, promote project for women developpement.
Medical Products, Vaccines and Technologies and the topic on Leadership and Governance. I had trouble relating to the topics in a practical manner. Perhaps due to lack of experience in that area.
SBCC
5,6,7,8 and 9
Gender systems strengtheening intervention and gender Equality Continuul
NONE
None
Yes, it is very useful
All of them
Session 5 and 6
The one with Case studies on Mexico and South Africa
HEALTH FINANCING
session 5
All the topics were good and educative and i would use the can be applied at all times,
gender equality and gender equity
Health information

10. If you could, what would you change about the course? Select all that apply.

Answer Options	Response Percent	Response Count
Make course shorter	5.9%	1
Make course longer	47.1%	8
Include more examples	70.6%	12
Other (please specify)		5
	answered question	**17**
	skipped question	**8**

Other (please specify)
gender issues in third world in particular
allow more time for the responses before posting a new session.
None
Leave it the way it is and may be learn more in the net if need be because technology changes with time.
Nothing

11. Did participating in the study group help you to better understand the course content?

Answer Options	Response Percent	Response Count
Yes	100.0%	21
No → Skip to Q13	0.0%	0
	answered question	**21**
	skipped question	**4**

12. What specifically did you find useful about participating in the study group? Select all that relate to your experience.

Answer Options	Response Percent	Response Count
It clarified concepts in the course	52.6%	10
It provided me with additional examples from the field	78.9%	15
It provided me with additional resources and references	42.1%	8
It provided me with an opportunity to ask questions that I had	31.6%	6
It provided me with an opportunity to learn from others dealing with similar issues	84.2%	16
Other (please specify)		2
	answered question	**19**
	skipped question	**6**

Other (please specify)
It was very useful, any session i go through i have to look on my country level what are in place related to sesion, other program how they do gender issues retaleted to HSS, if ther any program out of health system is supporting on HSS i.e constutuion, policies.
It provided me with more knowledge on Gender and Health Strengthening System

13. To what extent do you feel that the discussion helped you to apply what you learned from the course?

Answer Options	Response Percent	Response Count
I definitely feel more confident to apply what I have learned	68.4%	13
I feel somewhat confident to apply what I have learned	26.3%	5
I do not feel confident to apply what I have learned	0.0%	0
I did not learn anything new	5.3%	1
	answered question	**19**
	skipped question	**6**

14. What discussion thread was the most useful and informative during the participant study group? Why?

Response Text
session 3.Workforce, if we want to strengthening Health system and making sure women holding upper management and leadership and can make a decision, there is a need make sure women have an opportunity to be educated this can be done by using multi approaches.
The first thread and the last one. I was able to share insights of my daily experiences in relation to what i go through at work. The thread on Leadership and Governance was also informative because i learned from others through the discussions especially in topic areas that i do not encounter in my line of work.
The 1st, 2nd, 3rd and 4th. To me in particular, the discussion was clear and well understood, the rest needed a bit of clarification for me to be able to participate actively.
Gender related goals and outcome because increased access to health services Improved quality and responsiveness
ALL
Gender and reproductive health
Gender norms and inequalities
How to empower women and girls to promote gender equality. It helped me think of how we need to come up with practical ways to bring this about.
generally all threads were important-and i learn a lot from it
The way participants answered their questions and examples on the topic.
the interactive part where you realize that the issue are cross cutting
Session 1 & 2

15. What parts of the discussion were not useful? Please provide suggestions for improvement.

Response Text
I dont think there was anything not useful , everything was.
NONE
not all at the health systems
They were all useful
They were all useful in that I learnt new things from others
none
I would say ir was okay.
lost of people comment but we also need to know where one went wrong and how to improve when participating in such a group

16. Did you post a message in the study group?

Answer Options	Response Percent	Response Count
Yes	61.1%	11
No → Skip to Q18	38.9%	7
	answered question	**18**
	skipped question	**7**

17. If so, how did you find posting?

Answer Options	Response Percent	Response Count
Easy → Skip to Q20	81.8%	9
Difficult → Skip to Q19	18.2%	2
	answered question	11
	skipped question	14

18. Why didn't you post a message?

Response Text
I MISSED OUT WHEN THE DISCUSSIONS WERE STARTING AND I ONLY COMPLETED THE COURSE INDIVIDUALLY, BUT I TOOK TIME OFF TO VISIT THE COMMENTS POSTED BY THE PARTICIPANTS
Network Internet. problem
could not manage due to travel
I have network challenge in my area

19. What was difficult about posting?

Response Text
sometimes when you want to write it take time to respond it.
Coulldnt open my mails
internet was too slow

20. Did you share any information from the discussion with others (colleagues, friends, etc.)?

Answer Options	Response Percent	Response Count
Yes	88.9%	16
No	11.1%	2
	answered question	**18**
	skipped question	**7**

21. Please let us know if you have any suggestions for future study group discussions or activities.

Response Text
Time for of posting the questions and discussion could be for two days, to give more enough time to look on reference and linkage related to discussion.
inclease the time
Create more time to respond to Questions because we did the study group discussion concurrently with our usual day to day activities. It was a struggle on some days to get time to participate since work schedules are also time consuming and hectic. Maybe weekends would also work best because we're taking 2 days off work.
ADAPT TIME TO COUNTRY TIME LINE REALITIES OF THE REGISTERED MEMBERS.
We should be going in community. While. The discussion is on and later share experiences
Please provide more time for responses before posting a new discussion topics. Like for me being a student, i needed extra time as i had also to study for my exams and respond to the discussion at the same time, so before i could respond to one, the next had already been posted and so i kind of had a backlog which made me not participate fully and this disappointed me because i had really wished to participate fully (100%).
This should continue
provide hand copy through online and opportunity of interaction through workshop and capacity building face to face
We need to meet personally or at a forum so that we interact more and discuss more.
The time for the discussion was too short if extended it will give room for more participating.
he should have more regular study groups in various issues related to HIV
Time differences should be communicated in advance.
because we are members in one study group we can plan to have forums where we can meet as group active group members and see what people face in different countries.
The community Home site sometimes goes off, does not allow postings, or gives error ..Access denied.