GUIDE FOR PROGRAMMES AND PROJECTS ON

SEXUAL AND REPRODUCTIVE HEALTH IN AFRICA

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GUIDE FOR PROGRAMMES AND PROJECTS ON

SEXUAL AND REPRODUCTIVE HEALTH IN AFRICA

[1] The VITA Programme of Cooperation for Health care Development in Africa was founded in January 2004, promoted by the Spanish International Cooperation Agency, the Ministry of Foreign Affairs and Cooperation and endeavours to achieve the maximum level of coordination and complementarity in Spain for developing the healthcarehealth care sector in Africa.

The VITA Programme enjoys the participation of the Ministries of Health and Consumption, Finance and Inland Revenue, Education and Science and Industry, Trade and Tourism and of the following Autonomous Communities:

Autonomous Government (Generalitat) of Catalonia, Autonomous Government (Xunta) of Galicia, Autonomous Government (Junta) of Andalusia, Government of Cantabria, Region of Murcia, Government of La Rioja, Autonomous Government (Generalitat) of Valencia, Government of Aragon, the Autonomous Government (Junta) of the Communities of Castile-La Mancha, the Government of the Canary Islands, the Autonomous Government (Junta) of Extremadura, the Government of Navarra, the Government of the Balearic Islands, the Community of Madrid and the Autonomous Government (Junta) of Castile-Leon.

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PROLOGUE

The World Health Organisation dedicated the World Health Day 2005 to Women's and Children's Health. Therefore, the VITA Programme, in collaboration with the Carlos III International Foundation for Health care and International Cooperation and the Illustrious Official College of Surgeons and Physicians of Madrid organised Technical Conferences on Cooperation focusing on this subject, with the participation of health care experts from more than 20 countries in Africa and about 120 professionals from the spheres of health care and cooperation from International Bodies, Public Administrations, DNGOs, Universities, etc..

The objective of these conferences was to reach a consensus on the current situation of maternal and infant mortality; the new perspectives of international cooperation in the field of sexual and reproductive health; the involvement of women in public health care policies and primary health care. This practical Guide is the result of the contributions of the participants in the four work benches carried out during the conferences.

Improving sexual and reproductive health is one of the specific priority lines of action in the new Master Plan for Spanish Cooperation 2005-2008 and of the VITA Programme with a view to achieving the Millennium Development Goals.

Moreover, this Guide for Programmes and Projects on Sexual and Reproductive Health in Africa is the answer to one of the Horizontal Priorities of Spanish Cooperation, consolidated in the Master Plan: Gender Equality. This implies the transversal integration of the gender perspective, with a Gender and Development (GAD) approach in all cooperation initiatives and planning instruments. Only then will it be possible to overcome the problems derived from unequal power relationships between people, which hinder the increased autonomy for women and perpetuate poverty.

We intend to give the greatest possible dissemination to this Guide and afford a higher standard of quality to the Spanish cooperation projects and programmes in the field of sexual and reproductive health in the African continent so that we can together work towards achieving the Millennium Development Goals.

Leire Pajín Iraola
Secretary of State for International Cooperation

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INTRODUCTION

Sexual and reproductive health is currently one of the most important areas of intervention in the field of cooperation for development and health. This is evident from the main international commitments and in the Master Plan for Spanish Cooperation (2005-2008).

The Vita Programme of cooperation for health care development in Africa intends to take a practical approach to work in this particular area of health with this Guide. It brings together knowledge on this subject and the latest advances regarding programmes and projects on sexual and reproductive health, with the aim of guiding and aiding those that have to make decisions and formulate interventions on sexual and reproductive health in Africa.

Taking sexual and reproductive health as the departure point, as defined in the Programme of Action of the International Conference on Population and Development of Cairo (ICPD, 1994), and as is already taken for granted in the aforementioned Master Plan, the Guide is intended as a useful instrument for outlining the priority fields of action and the specific strategies for promoting health.

With this purpose in mind, the first two chapters describe the links between gender and sexual and reproductive health; standing international commitments and the current situation of the African continent. The last two chapters describe the four major strategies for promoting sexual and reproductive health and how they are applied in four practical cases. Specifically, the gender mainstreaming approach, the primary health care approach, the education for health approach and the empowerment of women are applied to work on complications in pregnancy and childbirth, gender-based violence, contraception and HIV/AIDS.

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[1] The Guide takes as its departure point the contributions made by the organisations and institutions that took part in the “Technical Conferences on International Cooperation: Women’s and Children’s Health in Africa”. These Conferences were organised by the Vita Programme and took place on 5th and 6th April at the headquarters of the Official College of Surgeons and Physicians of Madrid.

1. SEXUAL AND REPRODUCTIVE HEALTH IN THE CONTEXT OF INTERNATIONAL COOPERATION

1.1
GUÍDE FOR PROGRAMMES AND PROJECTS ON SEXUAL AND REPRODUCTIVE HEALTH IN AFRICA

The various health patterns in men and women are not solely related to their biological differences, but are largely linked to the unequal positions of men and women in society and the lack of rights of the latter. Despite the fact that women have a longer life expectancy than men in almost every country of the world, their living conditions and health are generally poorer. This is very clear in terms of reproduction and sexuality.

On the other hand, health problems regarding reproduction and sexuality are usually exclusively associated with women and explanations often allude to their biological characteristics. However, work in this field requires that attention be paid to both sexes and that the social and cultural component of health be acknowledged.

The concept of **"sexual and reproductive health"** includes this social and cultural component of health, emphasising sexual and reproductive rights and underlining the importance of working with both men and women. As we shall explain in further detail in the following point, this concept, which is the fruit of the feminist movement in the 70s and 80s, which strongly vindicated sexual rights, was not consolidated at international level until the International Conference on Population and Development in Cairo (ICPD, 1994). Hitherto it had not been included in approaches to development. Actually, it is the Gender and Development approach (GAD) that really incorporates the concept of "sexual and reproductive health". Nonetheless, we shall review the main characteristics of the welfare approach, the Women in Development (WID) approach and the Gender and Development (GAD) approach and how each one conceives the issues related to reproduction and sexuality.

On the one hand, the **welfare approach,** which originated in the early decades of development in the United Nations, refers to maternal-infant health and not sexual and reproductive health. Women are considered to be passive receivers of the development processes and their fundamental role in society is that of mothers and caregivers. There is no analysis of women's health conditions as regards reproduction and sexuality beyond the aspects that are related to their biological characteristics and the strategy for action focuses on the reproductive work of women.

In the decade of the seventies, the **Women in Development (WID) approach** started to gain ground. In the seventies and eighties, three different strategies were developed within this approach: the equality strategy, the combat poverty strategy and the efficiency strategy. Each of these has aspects that are worthy of study. The equality strategy seeks to achieve greater equality between men and women; the combat poverty strategy seeks to ensure that the poorest women may increase their productivity as a mechanism for promoting development, and the efficiency strategy seeks to support more efficient and more effective development by incorporating women as active economic subjects (Moser, 1995).

In general terms, the WID approach stresses the importance of women as active contributors towards development, which is understood to mean economic growth, and it considers that the incorporation of women into the productive sector will bring about equality between the sexes. Thus the approach focuses on "analysing women, their roles and activities in a highly differentiated, if not entirely opposite, manner to men" (Cirujano Campano, 2004).

More specifically, women are still considered in isolation when it comes to reproduction and sexuality. Lines of action target visualising the health problems of women and implementing health policies and programmes directly intended for them. Women's ability to get pregnant and their reproductive role receives special attention and is analysed without taking men's role in this whole process into account. Economic growth requires that specific attention be paid to women's health, emphasising the problems that are specific to women. In this regard, it is considered necessary to define and defend "women's rights", which were equivalent to family rights in the welfare approach.

In turn, the **Gender and Development approach (GAD),** which was promoted in the decade of the eighties, was consolidated at international level at the Conference of Beijing (1995) as a work approach in the area of development and equality between men and women. The GAD approach represents a radical about-turn and the acceptance of the concept of "sexual and reproductive health". The major contribution of this approach is the concept of gender that "refers to the roles, responsibilities and opportunities assigned to the fact of being a man and being a woman and to the socio-cultural relations between women and men and girls and boys. These attributes, opportunities and relations are built in society and learned during the socialisation process. They are aspects specific to each culture and which change over time, among other reasons, as a result of political action" (AECI, 2004: 15).

The inequality between men and women, which is manifested in the subordinated role of women in society, explains the poor health indicators existing in terms of reproduction and women's sexuality.

On the other hand, the issues of reproduction and sexuality are not just women's issues. Men's role in this area, with regard to their disposition and the exercise of their responsibilities, is fundamental for equality to be attained, allowing for equal enjoyment of the right to health. Despite the fact that women bear the brunt of the lack of and exclusion from social, economic and political resources, the strategies to achieve sustainable changes must take men into account, reinforce their responsibility and review the power relationships existing between the sexes. The vindication is for the "sexual and reproductive rights" of men and women.

The GAD strategy for action therefore opts for involving both genders and analysing their unequal relations in order to design and implement policies and programmes. In general terms, the three approaches that we have described have been used over the course of recent decades, although one or another may have prevailed depending on the concept of development in vogue. Currently, the GAD approach responds better to the current person-focussed

understanding of development and as we have already indicated, it is the only approach that includes the concept of "sexual and reproductive health".

Table 1. Development approaches and the conception of health in the area of reproduction and sexuality.

Approaches	Concept of health as regards reproduction and sexuality	Strategy for action
Welfare approach 1950-1970	The term that is used is maternal-infant health.	Work is aimed at women as mothers and caregivers.
Women in Development Approach (WID) From 1970 onwards.	Se incorpora la dimensión de la salud sexual junto a la reproductiva. Sin embargo, se ligan exclusivamente a salud y derechos de las mujeres.	The focus is on the reproductive role of women as an economic asset. There are three different strategies: > Equality strategy. > Combat poverty strategy. > Efficiency strategy.
Gender and Development Approach (GAD) From the mid-80s onwards.	Sexual and reproductive health is related to the inequalities existing between the genders. The concept is understood according to the definition given at the ICPD (1994).	Efficiency strategy. Aimed at involving men and women in the policies and programmes via two strategies: > Gender mainstreaming. > Empowerment.

Source: Internal.

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Points to Remember

- The differences in the health patterns of men and women may not be explained solely because of their biological differences. The social, political, economic and cultural inequalities existing between the sexes must be considered.
- It is necessary to work with both women and men in the field of reproduction and sexuality.
- The concept of **"sexual and reproductive health"**, which was internationally accepted after the ICPD (1994) includes the social component of health, placing the emphasis on the exercise of sexual and reproductive rights and promotes work with both sexes.
- Regarding approaches to development, the **welfare approach** focuses on women's health as mothers, closely linking their health to the health of their sons and daughters.
- The **Women in Development approach (WID)** includes the dimension of sexual health, but focuses on women on an exclusive basis.
- The **Gender and Development approach (GAD)** is the only approach that includes the concept of "sexual and reproductive health". It underlines the importance of working with women and men in order to reduce inequalities in the health patterns of both sexes, which are related not only to biological, but also social, cultural, economic and political reasons.

1.2
INTERNATIONAL COMMITMENTS

From the middle of the 20th Century onwards, health has been acknowledged as one of the fundamental rights of human beings and a key condition for a decent life in the text of the Universal **Declaration of Human Rights** (1948). The Declaration also contains the first direct reference to maternal and infant health, indicating in article 25.2 that "motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection".

The Constitution of the World Health Organisation (1948) includes among the functions of the organisation "to promote health and assistance for mothers and children, and encourage the ability to live in harmony in a world in constant change" (Article 2.l).

As for maternity care, the **International Labour Organisation** passed in 1952 the "Maternity Protection Convention", which has been ratified by Spain and by some African countries[2].

Almost three decades later, the **Conference of Alma-Ata** (1978) emphasised the vital link between health and development and committed the participant nations and bodies to work from the perspective of Primary Health Care (PHC) to attain "Health for all by the year 2000". This comprehensive proposal includes as minimum components "maternal and child health care, including family planning", as well as work in the area of maternal and infant health (Declaration of Alma- Ata, VII.C).

One year later, in 1979, the **Convention on the Elimination of all Forms of Discrimination Against Women** (CEDAW), the result of years of work by the Committee on the Legal and Social Condition of Women, includes a similar position in its article 10, which advocates "access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning".

However, it was not until the **International Conference on Population and Development** (Cairo, 1994) that the definitive accent was placed on sexual and reproductive health and on the importance of the exercise of sexual and reproductive rights.

The term maternal and infant health is no longer used, but rather the concept of sexual and reproductive health. The understanding is that the concept of maternal health, which is related exclusively to maternal mortality and morbidity, should include the acknowledgement that maternal deaths and illnesses are violations of women's rights and that they are directly linked to their social status, economic independence, political position and in short, to the lack of equality between men and women.

[2] This convention (C103) was revised in the year 2000 by a new convention (C183). The 1952 convention was signed by Ghana, Equatorial Guinea and Libyan Arab Jamahiriya.

The concept of **reproductive health** is currently defined as being "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so" (UNFPA, 2004). From this perspective, the term "reproductive health" presents a holistic conception of health related to sexuality and reproduction.

Minimum standards in Reproductive Health
> Services to provide information, advice, education and communication on the matters of contraception and reproductive health.
> Prenatal education and health care services, risk–free childbirth and post-partum care.
> Health care for newborns.
> Access to safe, modern methods of contraception.
> Information and treatment for infections, including sexually transmitted infections.
> Safe abortion services and treatment for possible complications.
> Prevention and adequate treatment for infertility.
> Information, education and advice on sexuality, reproductive health and responsible parenthood. Special emphasis on the young population.
> Participation of women in management, planning, decision-making, etc. in sexual and reproductive health services.
> Education and care services in the area of gender-based violence.

Source: Internal, based on information provided by Médicos del Mundo (1999).

On the other hand, the objective of **sexual health** is defined as "the development of life and personal relations and not merely advice and attention in matters of reproduction and sexually transmitted infections" (UNFPA, 2004).

The ICPD emphasises the importance of sexual and reproductive health and of sexual and reproductive rights as keys to combating poverty. Far from being a paradigm focused on demographic growth and family planning, Cairo proposes a rights-driven paradigm where the key is people wellbeing. Sexual and reproductive health is understood as another human right within the general right to health. The aim is both to improve health and to promote the acknowledgement of the rights of men and women under a paradigm of equality. It also refers to maternal health, but with a wider view of sexuality and reproduction.

Along the same lines, one year later, the "Platform for Action" adopted at the **Fourth United Nations World Conference on Women** (1995, Beijing), insists that "women's human rights include their entitlement to exercise control and decide in a free and responsible manner on issues related to their sexuality, including their sexual and reproductive health, free from coercion, discrimination and violence" and acknowledges that "the right of all women to control all aspects of their health, in particular their fertility is basic to their empowerment".

Minimum Standards in Sexual and Reproductive Rights	
Reproductive Rights	Sexual Rights
> To decide on a free and responsible basis as to the number and spacing of one's sons and daughters. > To have the information, education and means to do so. > To make decisions on reproduction free from discrimination, coercion and violence. > To have access to quality primary health care services. > To have access to maternity protection measures.	> To decide, freely and responsibly, on all aspects related to sexuality. > The right to exercise sexuality without risks, free from discrimination, coercion or violence related to sexuality. > The right to physical and emotional pleasure. > The right to free sexual orientation. > The right to information on sexuality. > The foregoing in conditions of equality, full consent and mutual respect, sharing responsibilities in sexual relations and the consequences of the latter. > The right to have access to health care services.

Source: Internal, based on information provided by Médicos del Mundo (1999).

On the other hand, the **European Union** and all of its member States formally adopted the "Cairo Programme of Action on Population and Development" in 1996. From that moment onwards, the Union's policy in matters of sexual and reproductive health is enshrined in the principles of the ICPD, as may be seen in the "Regulation of the European Parliament and of the Council on aid for policies and actions on reproductive and sexual health and rights in developing countries" (2003). The Union promotes a "holistic approach to, and the recognition of, reproductive and sexual health and rights,... including safe motherhood and universal access to a comprehensive range of safe and reliable reproductive and sexual health care and services" (Article 1.2).

The **Development Assistance Committee** (DAC) of the Organisation for Economic Cooperation and Development continues in the path opened by Cairo. Therefore, it states that "sexual and reproductive health is an essential component in human well-being" and proposes the development of policies that can acknowledge the links existing between equality and the exercise of sexual and reproductive rights (DAC, 1998).

In turn, the two of the Millennium Development Goals (MDG) agreed upon by the UN at the **Millennium Summit** (2000) address aspects that are fundamental for improving reproductive health at global level: the reduction of maternal mortality and progress towards equality between the genders, as well as empowerment for women In this direction, according to the latest reports on the subject, the indicators for both goals are dropping.

But what has happened in recent years? What are the **perspectives on the matter of sexual and reproductive health today?** Since ICPD (1994), the global consensus reached on sexual and reproductive health and rights is encountering difficulties because progress towards meeting the commitments is not fast enough.

Despite the fact that they involved a review and new ratification of the commitments undertaken in 1994, the International Conference on Population and Development (Cairo, 1994), the **ICPD+5** (1999) and **ICPD+10** (2004) have revealed the risks faced by the contemporary agenda on the issue of sexual and reproductive health.

In the same direction, the **Beijing + 10** (2005) Conference concluded that the lack of rights in matters of sexual and reproductive health, the high rates of violence against women all over the world and the increasing incidence of HIV/AIDS among women reflect that "in many aspects, equality is not a reality for women"3 and that much has still to be done.

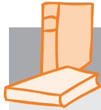
Generally speaking, despite these difficulties, the commitments of Cairo and Beijing have been ratified again and it is time that these commitments, undertaken by almost every country in world, including Spain and a great number of African countries, were met[4].

[3] Declaration during the Conference Beijing+10, by Carolyn Hannan, Director of the Division for the Advancement of Women (UN).

[4] The African States that were represented at the Cairo and Beijing Conferences are listed in Appendix II.

Points to Remember

- Since the ICPD (1994), the concept of sexual and reproductive health, which places a special emphasis on the full exercise of **sexual and reproductive rights** by women and men, has been used.
- The concept of sexual and reproductive health, unlike that of maternal-infant health, introduces a **holistic view** of health in matters of reproduction and sexuality.
- Working on sexual and reproductive health implies reinforcing minimum standards of reproductive health and the minimum standards of sexual and reproductive rights, while promoting equality between men and women.



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1.3

SPANISH COOPERATION POLICY

"Spaniards are equal before the law and there may be no discrimination for reasons of birth, race, sex, religion, opinion or any other personal or social condition or circumstance"

Article 14, Spanish Constitution

The declaration of non-discrimination for reasons of sex in the Spanish Constitution is the first reference of the orientation of the Spanish State towards equality. In the Spanish cooperation sector, this orientation is seen in the defence of the equality of men and women as a principle for articulation and the social integration of women as a sectoral priority (International Cooperation Act 23/1998).

In matters of sexual and reproductive health, this orientation towards gender equality is revealed in the **Master Plan for Spanish Cooperation (2005-2008),** in which "improving sexual and reproductive health and reducing maternal mortality" are acknowledged among the strategic lines and priority actions.

To be specific, the Spanish cooperation policy follows in the lines set out by the ICPD (1994) and subscribes to the United Nations Millennium Development Goals.

On the one hand, in accordance with the commitments reached in Cairo, it recognises "respect and defence of the sexual and reproductive rights of women and men (...), contemplating the entire cycle of the sexual lives of individuals" as the guiding force in its policies.

On the other hand, with regard to Goal 5 in the MDGs, it establishes the following priority actions in maternal health:

- To improve gynaecological health care for women, acknowledging their health care needs throughout their lifecycle.
- Sexual education and information and awareness campaigns on family planning for women and men, providing information and access to family planning methods.
- Activities aimed at promoting the participation and shared responsibility of men in sexual and reproductive health, fatherhood, family planning, prenatal, maternal and infant health, the prevention of sexually transmitted infections and education.
- Prenatal control and neonatal and postnatal health care services.
- Basic care for mothers provided by qualified personnel and access to health care structures of a high standard.
- Improved accessibility of health care facilities for women.
- Gynaecological health care to prevent Sexually Transmitted Infections and other complications derived from pregnancy.
- Support for Programmes to combat Female Genital Mutilation.

As regards the **VITA Programme** for Cooperation in Health care Development in Africa, which is consolidated in the new Master Plan for Spanish Cooperation and in consonance with the Millennium Development Goals, the programme confirms the need to work towards reducing maternal mortality. One of its four priority lines of action is Maternal-infant Health, focussing on the following:

- The promotion of health care during pregnancy and childbirth.
- Improving the skills of traditional midwives and health care personnel.
- Development of prevention and treatment for sexually transmitted infections.
- Encouraging good use of health and family planning services.

Moreover, in accordance with the new Master Plan, the VITA Programme will continue its work of coordinating the Sexual and Reproductive Health projects run by Spanish Cooperation in Africa, promoting the training of health care professionals, cooperation and the dissemination of best practices in work in this sector, complementing other initiatives by International Bodies such as UNIFEM and UNFPA.

Points to Remember

- The Cairo **commitments and the Millennium Development Goals** constitute the basis of Spanish cooperation policy in the area of sexual and reproductive health.

Further information

- Vita Programme and the Master Plan, available on the AECI webpage: http://www.aeci.es/vita

2. THE SITUATION OF SEXUAL AND REPRODUCTIVE HEALTH. THE CASE OF AFRICA

As is evident from the international commitments and despite the long road yet to be travelled, sexual and reproductive health is still a fundamental line of action in combating poverty. The main problems in sexual and reproductive health include the following:

- Maternal mortality and morbidity.
- Gender-based violence.
- Sexually transmitted infections.
- HIV/AIDS.

Maternal mortality and morbidity

Obstetric complications are the main cause of death among women of fertile age in developing countries and account for 18% of global illnesses. Moreover, despite the economic progress made in some countries, maternal mortality has remained at the same levels for the last ten years (UNFPA, 2004).

Therefore, despite the fact that measuring **maternal mortality** is complex and does not demonstrate the total magnitude of the problem, the most recent data available indicate that in the year 2000, 529,000 women died during pregnancy or within 42 days of childbirth for reasons derived from or aggravated by pregnancy. One woman dies every minute from complications in pregnancy, childbirth and the postpartum period, which means that 1,400 mothers die every day and more than half a million die every year.

The greatest number of these deaths is evenly divided between Asia (253,000) and Africa (251,000). Just 4% and 1% of such deaths, respectively, occur in Latin America, the Caribbean and in the developed countries.

If the maternal mortality rate contained in the Human Development Reports issued by the UNDP for a great number of countries is taken into account, the rate was 400 deaths for every 100,000 live births in the year 2000. This rate also reveals that although there are similar figures for deaths from causes associated with pregnancy, it is the African continent that registers the highest maternal mortality. Whereas in Asia, the ratio is 330, in Africa it rises to 830 (WHO and other sources, 2004).

Both of these figures on maternal mortality reveal that between the mid-nineties and the year 2000, there was a stabilising trend and the number of women that died due to causes related to pregnancy, childbirth and the postpartum period rarely varied.

On the other hand, considering the proportion of births attended by qualified personnel as an indirect indicator of maternal mortality, between 1995 and 2002, the percentage of attended births in the world was 58%. In Sub-Saharan Africa, the figure was only 42% of births (UNDP, 2004).

The **causes of maternal mortality** are constant throughout the world and linked to the feminisation of poverty and the secondary role given to women in society. Approximately 80% are directly due to obstetric complications: haemorrhages, sepsis, complications in abortion, preeclampsia and eclampsia and obstructed births. The remaining 20% are due to indirect causes, generally related to anaemia, malaria, hepatitis and the increase

of AIDS (UNFPA, 2004). However, there are major differences in the data for maternal mortality depending on the area in the world. In this regard, the possibility to access health care services attended by qualified personnel means that women rarely die from complications in pregnancy, childbirth or in the postpartum period.

The cost of these services and treatments, according to the OECD, is 3 dollars per person per annum in low-income countries. Some examples of the low cost of good maternal health are China, Cuba and Sri Lanka which, despite their low incomes, "have reduced maternal mortality through measures intended to provide greater access to primary health care, reinforce health systems and improve healthcare quality" (IMF and other sources, 2000:15).

Unsafe abortion is another of the causes of maternal mortality and constitutes a public health problem. According to the commitments reached in Cairo, women are entitled to access to quality services for treating complications during abortion, which should never be used as a method of contraception.

Measuring pregnancy terminations is complex because this practice is illegal in several countries. This means that the number of registered abortions is lower, especially in illegal abortions.

According to the UNFPA, 45 million abortions are performed each year, of which 19 million are performed by unqualified personnel and in non-hygienic conditions. Approximately 70,000 women die each year as a result of unsafe abortion practices, which represents 13% of the deaths related to pregnancy, childbirth and the postpartum period.

Abortion may be due to unwanted pregnancies, complications in pregnancy, short intervals between pregnancies, the possible transmission of STIs including HIV/AIDS or to dangerous pregnancies in women that are too young or too old.

On the other hand, all of these factors that contribute towards maternal mortality mean that **illnesses and lesions suffered during pregnancy and childbirth** are the second cause, in order of importance and after HIV/AIDS, of the years of healthy life that are lost among women of fertile age in developing countries; this represents the loss of almost 31 million "disability-adjusted life years"5 (DALY) each year (UNFPA, 2004).

Similarly, the risk of maternal illness or death contributes towards an increase in **neonatal and infant mortality.** Infant mortality may be derived from poor maternal health and inadequate care during pregnancy, childbirth and the period immediately after childbirth. Infections, asphyxia and damage to the child during childbirth account for the majority of cases of neonatal mortality. Low birth weight, complications and congenital malformations also contribute to the infant mortality rate.

[5] A DALY is defined as "a year of healthy life lost" and is calculated as the "sum of the years of life lost due to premature mortality (YLL) in the population and the years lost due to disability (YLD) for incident cases of the health condition " (WHO, 2004).

On an international scale, infant mortality has been falling in the last three decades. According to data from the UNDP, whereas in 1970 the infant mortality rate was 96 deaths per thousand births, this figure had been reduced to 56 by the year 2002. Despite the fact that this drop in infant mortality has been generalised throughout the planet, the intensity of the drop has varied between regions. In this regard, the regions that have witnessed the largest reduction in infant mortality were Europe, America and South-East Asia. The last places in the ranking are occupied by Africa and the Eastern Mediterranean region.

Regarding the African continent, despite presenting the worst figures for maternal mortality and morbidity, they vary between regions. In this regard, the continent reflects a dual reality. "The risk of dying from causes related to pregnancy, childbirth and complications in the latter in Africa is 1 in every 19 cases, in Asia it is 1/132, in Latin America, it is 1/188 and in the most developed countries, just 1/2976" (Mazarrasa and Montero, 2004: 215). However, in the African continent, the figures vary greatly if we focus on the North of Africa or if we consider Africa South of the Sahara Desert. The distance between both regions of Africa in terms of economic and social development materialises in the diverging indicators for mortality.

North Africa, which is placed among the Arab States by the UNDP, presents maternal mortality indicators that are much lower than those for Sub-Saharan Africa. Therefore, in the year 2000, 4,600 women in the North of Africa and 247,000 in Sub-Saharan Africa died as a result of pregnancy or childbirth. The maternal mortality ratio in the countries in North Africa was 130 deaths for every 100,000 live births, whereas in the Sub-Saharan countries this ratio rose to 920 deaths (WHO and other sources, 2004).

Whereas in Tunisia, in the year 2000, the maternal mortality rate was 120 deaths per one hundred thousand live births and in Morocco it was 220, the ratios for Sub-Saharan countries like Ghana and Burkina Faso rose to 540 and 1000 deaths respectively (UNDP, 2004).

These data are linked, among other aspects, to a low percentage of births attended by qualified personnel. Between 1995 and 2002, this percentage was 67% in North Africa and 42% in Sub-Saharan Africa (UNDP, 2004). As regards abortion, many countries allocate a high percentage of hospital beds to women requiring emergency post-abortion treatment. In Sub-Saharan Africa, 50% of hospital admissions in gynaecology are related to complications in abortion (UNFPA, 2004).

The figures for infant mortality also outline the division between the North and South of the content. In North Africa there has been a major decrease in infant mortality since the decade of the seventies, dropping by almost 65%, from 128 to 48 deaths per thousand births. In Sub-Saharan Africa, however, the reduction was just 21%, falling from 139 to 108 deaths per thousand births, and there has been a regression in the last decade due to the incidence of HIV/AIDS. According to the WHO, in Sub-Saharan Africa, HIV/AIDS was the main cause of 8% of the deaths of infants under the age of five in the year 2001 (WHO, 2004).

Gender-based violence

On the other hand, gender-based violence has an influence on the sexual and reproductive health of women. Gender-based violence is supported by a social order that is formed on the basis of inequality between men and women and is a social practice that has tragic consequences for the sexual and reproductive life of women (Mazarrasa, 2005).

Gender-based violence:

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

Declaration on the Elimination of Violence against Women, United Nations.

Violence may be the cause of unwanted pregnancy, punishment for getting pregnant or the origin of sexual dysfunctions and miscarriages, among other issues. Some of the clearest manifestations of violence towards women and girls are sexual violence, sexual trafficking, the preference for sons, discrimination or neglect towards daughters, early marriage, levirate marriage[6], abortion of female foetuses and female infanticide. In turn, **female genital mutilation** (FGM), which consists of the partial or total extirpation of the female genital organs, is possibly one of the most widely extended systematic violations of the human rights of women and girls.

Worldwide, around 130 million girls and women have suffered genital mutilation and a further two million are added to the statistics each year (WHO, 2000). It is practised in more than 28 African countries, and Egypt, Ethiopia, Kenya, Nigeria, Somalia and Sudan account for 75 percent of all cases. In Djibouti and Somalia, 98 percent of girls suffer some form of mutilation. In the case of Kenya, a study carried out in 1998 showed that 38 percent of women aged between 15 and 49 years had suffered genital mutilation (WHO, 2000).

[6] Institution in Mosaic Law that obliges women that are widowed to marry their deceased husband's brother.

Sexually transmitted infections. HIV/AIDS.

More than 340 million new cases of sexually transmitted infections (STIs) are registered on a yearly basis, including syphilis, gonorrhoea, chlamydia and trichomoniasis, in the population aged between 15 and 49 years. Despite the fact that the majority are treated, lack of access to adequate health care services hinders the diagnosis and follow-up of infections. Between 60 and 80 million people are affected by infertility as a result of an untreated STI.

On the other hand, the risk of contracting an STI is higher among women than among men, while the possibility of detection is lower. Whereas only 10% of men do not present symptoms when affected by an STI, this percentage rises to 70% in the case of women. The lack of diagnosis and treatment in pregnant women increases the risk of transmission to the foetus and of premature birth, low birth weight or neonatal blindness.

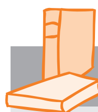
The AIDS pandemic stands out among the STIs. Although it may be transmitted in other ways, around 75% of the five million new HIV infection cases per year are caused by unsafe sexual relations. It is therefore a disease that is closely related to sexual and reproductive health (UNFPA, 2004). According to data provided by UNAIDS, in 2004, there were 39.4 million people living with HIV and the epidemic is affecting an increasing number of women and girls. Worldwide, slightly less than half of the people living with HIV are women. Women and girls represent a growing proportion of people living with HIV compared to the figures for five years ago (UNAIDS, 2004). Not only does this jeopardise the health of women, it also increases the risk of transmission of HIV from mother to child.

On the other hand, the vulnerability of women and children to infection by HIV is not due merely to the lack of information, but also to the feminisation of poverty and the general lack of emancipation among women. The majority of women worldwide are infected by HIV because they do not have access to protection methods and as a consequence of their partner's high-risk behaviour, over which they have little or no control. The urgent situation of women and girls against AIDS highlights the need to put into practice strategies that can approach the interaction between AIDS and gender-based inequality and strategies to combat the severe stigmatisation suffered by infected women.

Sub-Saharan Africa is still by far the most affected region, with 25.4 million people living with HIV. Slightly less than two thirds (64%) of the total number of people living with HIV correspond to Sub-Saharan Africa. Similarly, this region accounts for more than three quarters (76%) of all women living with HIV. On the other hand, the number of people affected by the HIV epidemic in the **North of Africa** stands at around 540,000 (UNAIDS, 2004).

Points to Remember

- **Sexual and reproductive health** is a fundamental line of action in combating poverty.
- **Complications during pregnancy,** childbirth and the post-partum period constitute the main cause of death and the second cause of loss of healthy years of life, after HIV/AIDS, among women of fertile age. The causes are constant and are associated with the feminisation of poverty and the secondary role granted to women in society.
- **Gender-based violence,** the roots of which lie in the inequality existing between men and women, has a direct effect on sexual and reproductive health.
- The risk of suffering a **sexually transmitted infection** (STI), including HIV/AIDS, is greater among women than men. The infection may for the most part be explained by unsafe sexual practices over which women have scant decision-making power.



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3. STRATEGIES FOR PROMOTING SEXUAL AND REPRODUCTIVE HEALTH

As we have already seen, the promotion of sexual and reproductive health constitutes a fundamental issue for improving the all-round health of people and particularly of women. However, the limitations on this promotion are numerous and of various types depending on the socio-economic and cultural characteristics of each country. The main limitations include the invisibility of problems related to the sexual and reproductive health of women and their causes; the scarcity of resources; the limited health care coverage, the difficulty of access to services by women; the limited information and participation of the population; and the limited power of women in making decisions in the various spheres of social, political and economic participation and in the exercise of rights concerning their health.

Only by attending to these limitations on a combined basis may we bring about a comprehensive improvement in the sexual and reproductive health of the population. In order to do so, we must have recourse to four action strategies, which complement each other and must be implemented at the same time. Despite the fact that they all deal with the six aforementioned limitations, each one places the emphasis on particular limitations (See Graph 1).

These four strategies for intervention, according to the limitations that they address, are as follows:

1. **Gender mainstreaming:** Strategy adopted at international level at the United Nations Beijing Conference (1995) that seeks to incorporate the gender equality perspective into health policies at all levels. Therefore, on the basis of gender analysis, it endeavours to make problems related to sexual and reproductive health and their causes visible. It must carry through to primary health care and education for health and is also complementary to empowerment.

2. **Primary Health Care (PHC):** Strategy that has been developed strongly since the Alma Ata Conference (1978). Its most important characteristics are the understanding of health from a multidisciplinary, equitable and participative approach. In the case of sexual and reproductive health, we shall be focussing on two aspects: coverage and access to first-level health care services and education for health, which shall be given a strategy status in this document, due to its importance. This strategy should be combined with the gender mainstreaming approach and is complementary to empowerment.

3. **Education For Health (EfH):** Strategy that was also promoted from the Alma Ata Conference as part of the PHC and a cornerstone in promoting health. Aimed at improving the information and participation of the population in developing its capacity to control and make decisions concerning its sexual and reproductive health. It is intimately linked to the empowerment strategy and must also incorporate the gender mainstreaming approach.

4. **Empowerment of women:** Established, like gender mainstreaming, at the Conference of Beijing as an international

strategy for development, empowerment seeks to increase the power of women in making decisions about their health and about the exercise of their sexual and reproductive health and the exercise of their sexual and reproductive rights. In a global intervention, this is complemented by gender mainstreaming, PHC and EfH.

Graph 1. Limitations and strategies for promoting sexual and reproductive health.

Source: Internal, on the basis of the diagram made by A. Lacer, L. Mazarrasa et al R.I.S.G-ISCIII.

Points to Remember

- The limitations affecting the promotion of sexual and reproductive health require comprehensive **action covering** the four indicated strategies: gender mainstreaming, primary health care, education for health and empowerment.
- Despite the fact that each of these strategies address the limitations indicated, they each focus on **particular limitations:**
  - > Gender mainstreaming in the invisibility of the problems related to sexual and reproductive health and causes.
  - > Primary health care in difficult access and poor coverage of first-level health care services.
  - > Education for health in limited information and participation by the population.
  - > Empowerment of women in their limited power in decision-making.

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3.1

GENDER MAINSTREAMING

The sexual and reproductive health problems that affect women often become invisible. They are difficult to detect, and when they are detected, they receive limited, unspecialised care. On the one hand, the subordinated position of women in society means that their health problems are often considered to be non-priorities or secondary and their causes are not analysed. On the other, the role of caregivers given to women in society means that they focus their concern on the family’s health and hardly pay attention to their own health care needs. This brings about an underestimation of the health care problems of women in this area and inadequate care and treatment, which proves that women’s health is still not actually recognised as a fundamental human right.

Gender mainstreaming, as a strategy for promoting health, seeks to place the study of gender inequality at the centre of all political decisions related to sexual and reproductive health and shed some light on the deficient indicators that the great majority of women present in this matter, especially in Africa. To be specific, it centres on the introduction of gender analysis into the proposals for programmes and projects for visualising the problems associated with sexual and reproductive health and their causes. It also works on awareness-raising and training in gender issues for the managers and beneficiaries of the programmes as a key component in ensuring the sustainability of interventions.

Gender analysis: a key instrument in gender mainstreaming

Gender analysis consists of **identifying** the structures and processes (legislation, social and political institutions, socialisation practices, employment practices and policies) that can perpetuate the patterns of inequality between women and men **in order to assess** if the needs and priorities of women and men are adequately reflected in the particular policy or programme and if there are opportunities for reducing or avoiding gender imbalances.

Source: Sojo and others. (2002: 131)

[7] Appendix III details the fundamental steps for carrying out a gender analysis.

As a general strategy, gender mainstreaming, which was approved by the United Nations at the Beijing Conference (1995), involves "an active and visible policy of integrating the gender perspective in all policies and programmes", meaning that "before decisions are made, it is necessary to analyse the effects on women and men, respectively" (López Méndez, 2000: 72 and 73). On the other hand, this means shifting "the attention to equality policies towards everyday policies and to the activities of the players that are normally involved in the political processes at stake" (Spanish Women's Institute, 2001: 26).

In this regard, gender mainstreaming constitutes a strategy to be developed from the moment of identification and throughout the entire cycle of the programme. The various effects of certain conducts and attitudes on men and women should be analysed before the programme is designed and implemented, and throughout it, and the importance of all the players should be given due consideration.

More specifically, **in sexual and reproductive health** programmes, from the outset the negative effects that the unequal power relationships between men and women cause to the sexual and reproductive health of women, for the most part, should be taken into account. Thus, it may be seen that late attention to many complications in pregnancy is related to the low level of concern that such complications provoke in the affected woman herself and in her family and social circle; and how the transmission of HIV/AIDS is due to unsafe practices about which women have hardly any decision-making power, among other examples.

Only by making the causes of these situations visible and by strengthening gender equality will it be possible to carry out an efficient programme with sustainable results.

However, this is not an easy task and in order to bring about an effective change of approach that will take into account and act on these gender inequalities, both a clear political will and a method for designing gender-sensitive programmes and projects are necessary.

Often, although there are clear commitments regarding gender inequalities and sexual and reproductive health, they are rarely put into practice. The introduction of the gender perspective into the cycle of the project is crucial for real mainstreaming. The following **five tools,** which may be used throughout the project cycle management, both in sexual and reproductive health and in other areas, promote the inclusion of gender issues in programmes and projects:

1. **Gender-specific data** in the first stage of identifying and diagnosing needs.

2. **Analysis and planning with the gender perspective**[9] in the stages of design and implementation.

3. **Gender-sensitive indicators**[10]**,** essentially for implementation and assessment.

4. **Specific activities aimed at gender equality,** in the implementation stage.

5. **Awareness and training in gender** issues, from the first to the last stage.

However, the use of these tools must be accompanied by sufficient specialised human resources, sufficient economic resources and adequate information. Moreover, the interests of the parties involved must be taken into consideration, as well as the social values and conceptions of the latter, while always promoting equality between women and men (See Graph 2).

Finally, it is fundamental to include the active participation of women and men throughout the process and, as indicated before, to train management personnel in gender issues. In order to overcome the invisibility of the sexual and reproductive health problems of women and their causes, both sexes must acknowledge their existence and develop a body of managers that are aware of the causes of this situation of inequality.

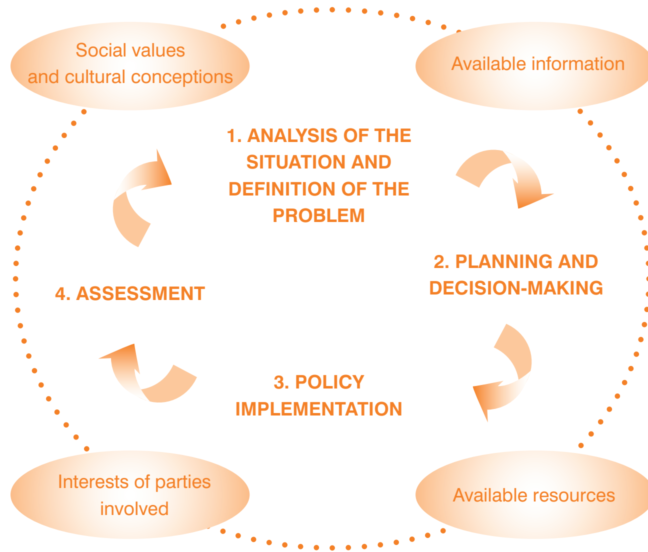
[8] The project cycle management defines the various life stages of a project with decision-making procedures and well-defined management activities. The main stages of a project are as follows: identification, formulation or design, execution or implementation, follow-up and assessment.

[9] Planning with the gender perspective implies taking into consideration the conclusions obtained after the “gender analysis” in the proposal of the general and specific objective of the project and in the results and activities to be carried out.

For further information on planning with the gender perspective, see Sojo, D., Sierra, B. and López, I. (2002) Salud y género. Guía práctica para profesionales de la cooperación. Madrid. Médicos del Mundo. Available at: www.medicosdelmundo.org

[10] Appendix IV describes the main gender-sensitive indicators in the area of sexual and reproductive health.

Graph 2. Gender-sensitive project cycle management.



Source: Adaptation of M. Juárez (2005)

Points for working on gender mainstreaming in sexual and reproductive health

1. **Analysis of the different patterns of sexual and reproductive health** in men and women, considering both biological factors (fertility) and economic, social and cultural factors (for example the decision on the number of children to have).

2. **Gender-specific data.** For example, women and men presenting sexually transmitted infections (STIs); women and men that are informed regarding safe methods of contraception.

3. Deeper knowledge, by means of **gender analysis,** of the relation between gender inequality and the worse health indicators among women rather than men. Therefore, the early births that cause serious problems in the sexual and reproductive health of women are supported by the fact that many women are not socially or economically independent and are identified solely as mothers. Similarly, the insufficient development of services to attend to pregnancy, childbirth and the postpartum period has serious consequences for women's health shows that women's health is conceived to be of secondary importance.

4. **Increasing the community's awareness** of gender contents regarding health and specific training in the gender perspective for both men and women in charge of managing the various programmes and projects. Emphasis on how an equal relationship between men and women improves the indicators for sexual and reproductive health.

5. **Full integration of women** throughout the entire process, without losing sight of the importance of men's participation. It is necessary to promote the participation of the population, ensuring that women that are usually excluded from the decision-making spaces are included and that men are shown to be co-responsible for the sexual and reproductive health of the community.

6. **Designing the programme or project** on the basis that no political process is neutral in gender terms and that therefore it is essential to remember to carry out gender analysis. Gender analysis proves that the different patterns of sexual and reproductive health in men and women are explained by the gender inequalities that exist and this must be incorporated in the design of the programme, in its objectives, results and activities, as well as in identification. The design must focus on doing away with the cultural inequalities that lead to the insufficient care for pregnant women, violence against women and the unequal knowledge of and use of safe methods of contraception, among other aspects.

7. Preparation and use of **gender-sensitive indicators** for following up on and assessing programmes and projects. For example, population with access to health care services according to sex; percentage of women and men on decision-making bodies.

8. **Budgetary support** and the existence of **personnel specialised** in the gender perspective.

9. **Support for equality between men and women** by means of communication with the parties involved and on the basis of their social and cultural conceptions

Points to Remember

- Gender mainstreaming, by means of gender analysis, pursues the incorporation of the **gender equality** perspective into health policies at all levels and programmes to highlight the causes of the poor indicators of women's sexual and reproductive health. It also promotes awareness on gender issues.
- These characteristics mean that it is the **first strategy to be developed** and that it must remain present throughout the entire life cycle of the programme or project.
- Real implementation of gender mainstreaming requires that gender issues be incorporated using **five tools** during the life cycle of the project: data disaggregated according to sex; gender analysis and planning; gender-sensitive indicators; specific activities aimed at gender-equality and awareness and training in gender issues.
- **Resources** are also required, as well as the **active participation** of the beneficiary population if the programme is to be effective and have lasting effects over time.

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3.2

PRIMARY HEALTH CARE (PHC)

Of the almost 130 million births that are registered each year worldwide, more than 60 million do not receive health care. To be specific, in North Africa, 33% of births are assisted by health care, whereas in Sub-Saharan Africa this figures rises up to 58% (2004, UNDP). Moreover, more than 350 million couples worldwide, i.e. one in three couples, do not have access to full information and sexual and reproductive health services. A third of women of reproductive age in developing countries do not have access to safe contraception methods. (Spanish Family Planning Federation, 2004).

Primary health care (PHC) is nowadays a fundamental strategy for addressing the limited coverage and difficult access to first level health care services. To this end, it is supported by the principles of multi-sectorality, equity, participation and health promotion. As explained previously, it must be complemented by gender mainstreaming. It includes education for health and is complementary to women's empowerment.

In general terms, the Cairo Programme for Action and the trends in maternal and neonatal mortality and the impact of HIV/AIDS have driven initiatives in PHC towards **sexual and reproductive health** services that understand the problems in a more holistic manner compared to the traditional maternal health care services, which were focussed mainly on prenatal care, safe childbirth and post-natal care. However, this conception does not always exist in PHC policies. In this regard, "sexual and reproductive health care services, as part of primary health care, must be comprehensive, accessible in both financial and geographical terms, offered on the basis of privacy, confidentiality and with due respect for the person's dignity and comfort" (Spanish Family Planning Federation, 2004).

The initiatives in the area of sexual and reproductive health that are part of PHC must include the lines that belong to this strategy for action. Thus, this strategy is characterised by the fact that it is supported in practice by scientific evidence, the needs manifested by the population and the social and economic conditions in the country. Similarly, PHC within the health care system is the first continued health care element and promotes preventative, curative and

rehabilitating services, representing the initial contact with health care services, of great importance for sexual and reproductive health.

On the other hand, the PHC strategy is characterised by a comprehensive, horizontal conception of the various health problems. PHC incorporates all of the agents engaged in health. It should be part of the strategies for action that include other components with which it is interrelated, such as hospital care. It is related on a participative basis to both the community and the health care personnel and includes preventative, health promotion and welfare components.

More specifically, in the **field of sexual and reproductive health** there must be a political and community intention to develop the sexual and reproductive health component in PHC.

Once this requirement has been met, correct PHC is based on thorough diagnosis of the area of application, analysing both the sexual and reproductive health status and the socio-cultural behaviour and factors, including gender, that have an influence on it. On the basis of this diagnosis, PHC offers competent personnel, services and quality material as well as methodologies that are appropriate and accessible from an economic, social and cultural standpoint. This whole process should be carried out while paying attention to the inequalities between men and women and reinforcing gender equality.

PHC and gender inequality

In its definition, primary health care presents a holistic conception of health that takes into account the various socio cultural factors that have an influence. However, there is currently a tendency at internal level to contemplate PHC on a reductionist basis, which only pays attention to the healthcare aspects of the strategy.

Therefore, it is more urgent for PHC to reconsider the social and cultural aspects that affect health, including gender inequality. In this regard, PHC must be a gender-sensitive strategy and acknowledge the different gender roles11; the need for full participation by men and women in controlling resources and making decisions; the similar importance of the knowledge, values and experience of men and women.

[11] Gender roles are defined as the roles that are granted to men and women in society. They are related to the obligations, rights and the power status of both sexes in a particular society.

On a parallel basis, PHC advocates the use of participative methodologies for greater appropriation of services by the beneficiary population. Specifically, PHC must promote the participation of women in all of the management and decision-making processes regarding sexual and reproductive health, from designing to assessing the interventions. Similarly, men's participation in this matter should be promoted as they are affected by the problems that exist and their role in decision-making is important. In any case, it is necessary to ensure that the priority work targets the most vulnerable population, which includes male and female adolescents.

It is important not to forget the key role of training for health care personnel, community leaders and the community in general in order to put sexual and reproductive health problems on the agenda and provide an adequate response.

Follow-up and assessment of the PHC processes are extremely important in ensuring proper use of resources, an appropriate response to the population's needs and learning about the intervention itself.

In general, the PHC strategy is defined by the fact that it promotes the establishment of an extensive network of first level sexual and reproductive health care services to respond to and cover for most of the health care needs of both men and women, while at the same time improving access to same. Because it may imply changes in the socio-cultural sphere, it should be contemplated as a **long-term strategy** that requires adequate identification, design and assessment.

Points for working on the PHC strategy in sexual and reproductive health

1. To carry out a **socio-anthropological study** of the area in order to find out the various problems in the area of sexual and reproductive health and analyse these problems and the various factors that impact gender. The main influencing factors are the different roles and responsibilities of men and women, the cultural rules associated with fertility, the social values related to motherhood and those associated with youth.

2. To support the creation of a **community health council** with the participation of women and men in order to address sexual and reproductive health problems.

3. **To design the intervention** according to the national strategies and the socio-cultural situation, so that it has adequate and sufficient human and economic resources and a methodology that is appropriate for men and women. It is important to take gender inequalities into account and facilitate women's access to the services, as well as a correct diagnosis.

4. To develop **comprehensive services** that respect the confidentiality of people, both men and women, and their right to decide freely on their sexual and reproductive life, while paying special attention to male and female adolescents.

5. To promote access to quality preventative and curative services in the area of sexual and reproductive health, for both women and men.

6. To incorporate these **services into the health** care planning for the region.

7. To use **participative technologies** in order to ensure greater participation by the various beneficiaries and promote services which are better matched to their needs.

8. Activities aimed at increasing the **participation** of women and men in exercising their rights and responsibilities in sexual and reproductive health. The need to consider women and men on a related, not isolated basis.

9. **Specific training** for health care personnel, community leaders and the community in general.

10. To establish a **follow-up and assessment system** for the purpose of learning and improving the intervention in the long term

Points to Remember

- The aim of the Primary Health Care strategy is to provide a response to the **insufficient coverage and difficult access** to first level health care services.
- It constitutes the second strategy to be developed after gender mainstreaming and is entirely linked to the latter. A gender-sensitive **PHC strategy must be fostered.**
- PHC promotes the establishment of a network of sexual and reproductive health care services to meet the **needs of men and women** and match their **values, socio-economic conditions and socio-cultural factors.**
- One crucial component in PHC is the **participation** of the population via the use of participative techniques that help to ensure that the services match their needs.

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3.3
EDUCATION FOR HEALTH (EfH)

The insufficient information on sexual and reproductive health and the low percentage of participation by the population in this matter are other limitations that were mentioned at the start of this chapter. **Education for health (EfH)** is the main strategy for ensuring that the population has training and information and may develop its capacity for control and decision-making on sexual and reproductive health on a community and individual basis.

EfH is the third of the strategies presented. It must be complemented by the gender perspective and is part of primary health care and complements women’s empowerment. Derived from the “health for all strategy” that marked the character of PHC and was promoted at the Alma Ata Conference (1978), education for sexual and reproductive health is also based on a comprehensive conception of health that takes socio-cultural factors into account, placing a special emphasis on gender issues. More specifically, this proposal for comprehensive education includes all aspects related to reproduction, sexuality and affectivity so that people, both men and women, may acquire genuine autonomy

and responsibility over their life decisions, including those related to the exercise of their sexual and reproductive rights.

In general terms, EfH "should deal with providing elaborate, critical and accessible information on the health situation (...). This information shall include:

a. The identification of the determining factors of health and of the risk factors, either environmental or related to unsafe practices.

b. The possibilities of protection, either environmental or personal.

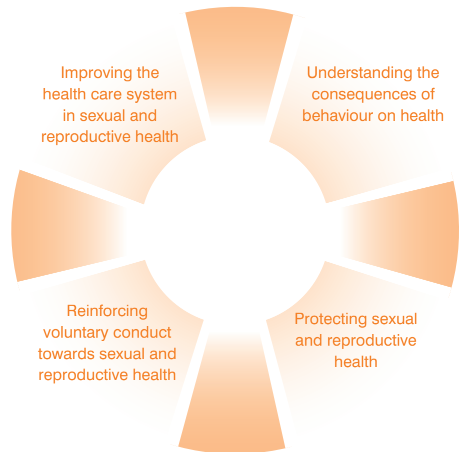
c. The possibilities of primary, secondary or tertiary prevention.

The foregoing together with information on the health care and social services and programmes that are available for protection and prevention" (Mazarrasa, 2003: 399)

By applying this scheme to the specific area of **sexual and reproductive health,** four different types of activities may be carried out in order to implement the education for health strategy: activities related to understanding the risks posed to health; activities related to protecting health; activities aimed at reinforcing voluntary conduct and activities for reinforcing the care system (See Graph 3).

On the one hand, there must be **activities related to understanding the risks posed to health** in order to highlight the risks that certain gender-related behaviour has for

Graph 3. Education for Health activities in sexual and reproductive health



Source: Adaptation of L. Mazarrasa (2003).

health. In this regard, the activities may be directed at highlighting the negative consequences of unsafe sexual relations, violence against women or neglecting women's health on health.

The work with this type of activities should be focussed on the whole population and not just the population affected by the particular problem. The objective is to create changes in society as a whole that will drive transformations in individual conduct. Therefore, these educational activities must target the specific persons and groups that are affected,

their closest family and social group, the social networks in the community (associations, organised groups, etc.), the health care personnel working on the programme and the people that are in charge of and that run the policies in the area.

On the other hand, **the activities related to health protection** inform on the environmental factors that affect sexual and reproductive health. These activities are aimed at educating, for example, on the importance of using contraception to avoid unwanted pregnancy, on the relevance of follow-up during pregnancy and the need for equalitarian relations between men and women in order to prevent gender-based violence.

As regards **activities aimed at reinforcing voluntary conduct,** these focus on modifying living conditions and the social restrictions that hinder free choice from the available options. The objective is to promote healthy lifestyles, and they focus on promoting the development of personal and social skills such as expressing oneself, negotiating, reaching consensus, knowing how to listen, etc… In sexual and reproductive health, it is important to carry out activities that promote equality between the genders in decision-making on the number of children to have, the use of methods of contraception and sexual practices. These activities should also combat the isolation and marginalisation of women with regard to health care services or the various social organisations.

Finally, **activities aimed at improving the health care system** should basically focus on the formal sector, the health care and social services, but also the informal sector, the health care services usually carried out by women. In the formal sector, activities must ensure that the sexual and reproductive health needs of the community are reflected in the health care services and that the latter include adequate information services. In the informal sector, activities should promote improvements in care for pregnant women or the victims of gender-based violence, among others, and self-care as well as family co-responsibility.

Nonetheless, none of these activities should be considered as closed, but rather they should be open for learning. "Education for health cannot be predetermined towards a particular health or lifestyle model" (Mazarrasa, 2003: 402). Education for health is a participative process in which the community plays a decisive role and in which its experience and knowledge are key for learning.

The use of an active, participative methodology, based on the exchange of ideas and personal work, promotes education in sexual and reproductive health and the creation of a health model that is suited to the needs of the population.

Therefore, it is necessary to understand that the educators that are used in this field must be people that are trusted by the population, with a thorough understanding of their situation and social contexts and that the function of the external cooperation is, wherever possible, to facilitate these processes and empower these local educators.

Therefore, EfH promotes participation, dialogue, self-esteem, involvement and

group cohesion, the development of a critical spirit, among other aspects, as departure points for introducing changes in the way in which sexuality is lived and guiding towards healthy practices.

One of the fundamental tools that may be used for this is "education between peers". This consists of insisting on the two-way character of EfH: the information does not flow in just one direction, but rather the group of peers exchanges information on sexual and reproductive health.

Education between peers

Education between peers is based on a horizontal communication model rather than the classical hierarchical or vertical model, which emphasises the need to involve the communities in the whole educational process. The objective is to transmit information to a particular group by means of people of the same sex, age, socio-economic status and cultural characteristics.

The advantage of this tool is that it allows access to vulnerable groups, which also present multiple barriers to fluent communication and disseminate among them preventative messages that are culturally adapted to their needs in order to promote healthy behaviour that will reduce this vulnerability.

In sexual and reproductive health, this is a fundamental tool for working with adolescents and young people.

Source: Adaptation of L. Mazarrasa (2005b).

Points for working on EfH in the area of sexual and reproductive health

1. To gather knowledge of the **social and cultural environment** where the work is to be carried out.

2. To provide **information that is accessible, culturally acceptable and non-sexist** on sexual and reproductive health for both men and women. Sourcing existing documents and experiences from the country where the work is to be carried out or which might be adapted to the situation should be one of the first elements to be taken into account.

3. To create an environment that is suitable for **equal participation** by men and women in order that they may incorporate their experience and knowledge into the process of learning on sexual and reproductive health.

4. To carry out activities about **understanding risks** for health that highlight behaviour in the area of reproduction and sexuality that brings negative effects on health, particularly women's. More specifically, work on this type of activities with the widest possible number of social groups: those directly affected, their immediate family and social groups, social organisations, healthcare personnel, politicians and managers. There should be a balanced proportion of men and women.

5. To implement activities related to **health protection** that will underline the environmental factors that affect sexual and reproductive health.

6. To carry out activities aimed at reinforcing **voluntary conduct** that promotes gender equality and integration, such as activities that foster promote fair treatment in healthcare services.

Points for working on EfH in the area of sexual and reproductive health

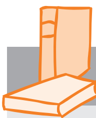
7. To carry out activities to promote the improvement **of the health care system** in sexual and reproductive health. Specifically, these activities should strengthen the formal health care system and promote a greater degree of family co-responsibility and a higher standard of quality in care.

8. To use **participative methodology** in all of the activities carried out.

9. To support **"education between peers"** as a fundamental instrument in sexual and reproductive health in order to promote participation and learning.

Points to Remember

- As a health promotion strategy, this is part of the primary health care strategy, integrating the gender perspective and complementing women's empowerment.
- Specifically, education for health is aimed at the **community as a whole and at specific groups.** Since the aim is to bring about changes in lifestyles and behaviour regarding reproduction and sexuality, the work must focus on both social change and individual change.
- The **learning process** is considered to be an **open** process in which the community adapts the information that is received according to its experience and knowledge.
- This strategy is supported by a **participative methodology** and one of the tools for work is "education between equals", which provides access to isolated, vulnerable groups with culturally adapted proposals in the area of sexual and reproductive health.



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3.4 EMPOWERMENT OF WOMEN

As we have already mentioned, the subordinated role of women in the majority of modern societies means that women have hardly any say in decision-making in the various spaces for participation. From the most personal decisions to others of a social, economic or political nature, women are largely conditioned by the social rules that confer more power upon men. This fact undoubtedly has patent effects on the enjoyment of their sexual and reproductive health. For example, the limited power of women to decide on the number of children that they want to have and gender-based violence, the manifestation of men's power over women.

The **strategy of women's empowerment** seeks to promote "the woman's ability to increase her self-esteem in life and influence in the direction of change" (López, 2000: 62). It does not seek for women to dominate to the detriment of men, but rather a situation of equity in the power to transform the most immediate social reality. The method for this is to increase women's control over material and non-material resources (Moser, 1991).

The empowerment strategy promotes women having the personal resources that will allow them to make decisions on the most immediate life issues and to position themselves in the power spaces.

What is the empowerment of women?

It is a process by which women, on an individual and collective basis, gain awareness of the power relationships that operate in their lives and gain the self-confidence and the strength that are necessary to change gender inequalities in the home, the community and at national, regional and international levels. A complete definition includes the following components:

- **Cognitive:** This refers to women's understanding of the conditions and causes of their subordination and micro and macro levels.
- **Economic:** This requires that women must have access to and control over productive resources to ensure a certain degree of financial autonomy.
- **Political:** This implies that women must have the ability to analyse, organise and mobilise social change.
- **Psychological:** This includes the belief that women can act at personal and social levels to influence their individual realities and in the societies in which they live.

Source: López Méndez and Sierra Leguina (2001: 34 and 35)

Therefore, it is fundamental to increase the participation of women both in the family arena and in community and political arenas and to reinforce their educational level.

In this regard, the strategy of empowering women is very closely linked to education for health, which is guided by participation and information for the empowerment of the whole population, not just women, in order that health living habits may be developed in the life of the community. It is also linked

to the gender mainstreaming strategy since, albeit on a complementary basis, it also pursues equality between men and women.

Within the area of **sexual and reproductive health,** empowerment is based on working with women in order to increase their decision-making power in the various dimensions indicated. In order to attain this objective, it is necessary to increase women's access to and control over family, economic and social, political, educational and time resources (see Figure 3).

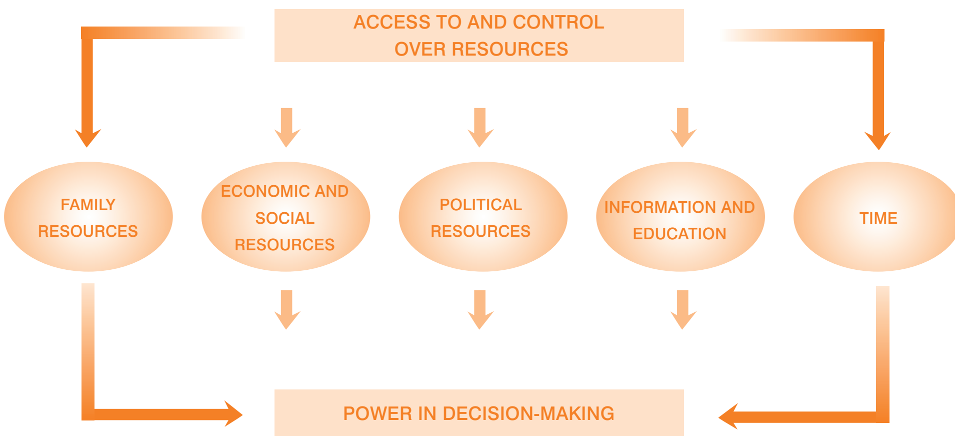
The fundamental methods for promoting this increase are education for health and support for the creation of organisations and networks of associations of women that are specialised in this area.

With regard to access to and control over family resources, women must be able to make decisions on their sexual and reproductive life, on the number of children, the type of sexual relationship and the use of contraceptive methods, among other aspects.

As far as economic and social resources are concerned, work must focus on making the sexual and reproductive health care services accessible to women and on considering their needs for improvement. In terms of political resources, the action should focus on active participation by women in sexual and reproductive health policies and programmes, as well as in associations.

Moreover, the access to and control of educational resources must be bolstered by means of training specifically aimed at women, involving them in all stages of the educational process. Lastly, as regards time resources, sexual and reproductive health care services and programmes must ensure that women dedicate part of their time to caring for themselves and enjoying their own sexuality.

Figure 4. Relations between access to and control over resources and power in decision-making.



Source: Internal

Points for working on sexual and reproductive health from the strategy of women's empowerment

1. **To analyse the sexual and reproductive health** of women, identifying sexuality as inherent to women.

2. To use **participative techniques** that will favour a bottom-up process: to promote the participation of women in making decisions that affect their lives to effectively influence development programmes and projects.

3. To involve **men** in the process of change. It is important to discern the possible implications of empowerment for women and men and the possible effects on their attitudes and actions. Men should be considered as being co-responsible for caring for sexual and reproductive health.

4. To strengthen **women's self-esteem** by developing abilities and skills at individual, family and community level, with a view to improving sexual and reproductive health in general.

5. To broaden the concept of the "reproductive role" of women, introducing their right to full sexual and reproductive health. As well as being mothers, women are also **subjects with rights** (the right to sexuality without risks, the right to decide on motherhood, to choose their partner, to choose the number of children they wish to have, among other rights).

6. To carry out **participative workshops** for defining women's sexual and reproductive health needs.

7. To design programmes that focus on **covering needs** and eliminating the barriers that women have detected in this area.

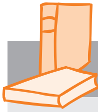
8. To create **spaces and opportunities** in sexual and reproductive health services and programmes so that women may analyse their own personal situation.

9. To carry out **activities** in order to promote **access to and control** over resources for women: family, economic, political and time resources, among others.

10. To strengthen **women's associations** working in the area of sexual and reproductive health at local level by linking them to other regional, national and international associations.

Points to Remember

- The women's empowerment strategy constitutes the fourth and last strategy to be developed and is strongly linked to education for health, as well as gender mainstreaming, which is present in all of the health promotion strategies.
- By means of the participation and training of women, women's empowerment seeks to increase their personal resources (family, economic, political etc.) in order to increase their **decision-making power** on issues related to reproduction and sexuality.



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4. LINES OF ACTION. FOUR PRACTICAL CASES

Now that the four strategies to address the main limitations in the area of sexual and reproductive health have been presented, we shall go on to the practical application stage, with four cases that have been selected because of their relevance and importance in the African continent. These practical cases are intended as a guide for carrying out programmes and projects in this area and in order to consolidate the notions of gender mainstreaming, primary health care, education for health and the empowerment of women as a set of complementary strategies for promoting sexual and reproductive health.

4.1

COMPLICATIONS IN PREGNANCY, CHILDBIRTH AND THE POSTPARTUM PERIOD

“An African woman is 500 times more likely to die from causes related to pregnancy than a Scandinavian woman”

(Spanish Family Planning Federation, 2000: 31).

As we have already explained, complications derived from pregnancy and childbirth are the second cause of loss of healthy years of life among women of fertile age in developing countries and account for half a million deaths each year.

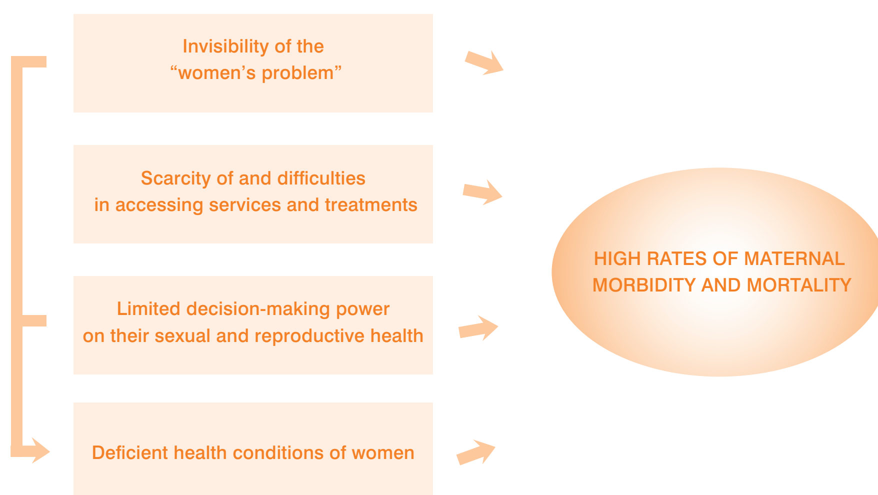
This high maternal morbidity and mortality is associated with the scarcity of health care services and the difficulty in access, the deficient standard of quality in care, late, inadequate treatment and the low percentage of births attended by qualified personnel. If we add to these factors the deficient social and health conditions of women, the risks are considerably increased. In this regard, the high maternal morbidity and mortality are due not only to poverty issues and the general situation of the health care systems, but also to the role that women occupy in these societies.

On the other hand, we should not forget that 13% of deaths related to pregnancy and childbirth are due to unsafe abortion practices that also carry a high cost for women’s health. The practice of abortion in poor conditions may result in infections, haemorrhages infertility and chronic pain, as well as death.

As regards maternal morbidity and mortality, there are various **parallel processes** (See Figure 4). On the one hand, the invisibility of this health problem which, according to UNICEF, is the problem that is given the least care in the world as it is seen as a “women’s problem”. On the other hand, as we have already mentioned, the lack of adequate health care services and the fact that they are of difficult economic, social, geographical and cultural access despite the fact that the majority of complications are preventable with simple technology if treated in time by qualified personnel. Moreover, women’s limited control and decision-making capacity regarding their sexual and reproductive health, which is often considered to be of secondary importance by the women themselves, who pay more attention to their family and the community than to looking after their own health. Finally, without detracting

from its importance, the deficient indicators for the general health of women, related to their invisibility and lack of power, which are the result of their subordinated position in society (Antolín, 1997).

Figure 4. Causes of high maternal morbidity and mortality



Source: Internal

In this context, interventions must promote the visualisation of complications during pregnancy, childbirth and the postpartum period and the causes of such complications; increase resources; improve access to and the quality of grassroots community services; mobilise communities and women, among other aspects. We shall now take a look at the elements that a programme focusing on maternal morbidity and mortality should contain, considering all the health promotion strategies together.

Gender mainstreaming

As explained in the previous chapter, gender mainstreaming implies integrating gender issues in all sexual and reproductive health policies and programmes while also considering gender as a category of analysis to bear in mind when identifying, designing, implementing and assessing programmes aimed at reducing complications in pregnancy, childbirth and the postpartum period. The aim is to make the magnitude of this problem visible, encouraging the participation of women and men and analysing the causes and possible ways of attenuating its circumstances. Applying the gender mainstreaming strategy in a programme on obstetric complications means:

1. Training and involving the working group and the beneficiaries in gender analysis.

2. Promoting a study on the link between the subordinated role of women and complications during pregnancy, childbirth and the postpartum period. For example, the link between the difficulties encountered by women in accessing healthcare services because the scant resources are directed at men's health problems or because they are excluded from this sphere of services and these health care complications.

3. Increasing the awareness of the entire community regarding the link between gender inequality and poor maternal morbidity and mortality indicators and regarding the importance of their attitudes in improving maternal health.

4. Encouraging active participation by women and men in the programme. It is necessary to promote the co-responsibility of men by means of specific measures to underline that pregnancy is not exclusively a women's issue, but that men are also equally responsible for how it progresses.

5. Involving women in all stages of the programme, from design to assessment. It is necessary to consider the needs of women in terms of sexual and reproductive health as a basic part of the programme for a greater sense of belonging.

6. Inserting, throughout the programme, the gender analysis of the causes of maternal morbidity and mortality as a key component in understanding the problem better and finding more efficient solutions.

7. Developing and using gender-sensitive indicators, such as the following[2]:

- Reproductive risk index.
- Main causes of maternal mortality
- Main illnesses suffered by men and women of fertile age.
- Proportion of women of fertile age (15-49 years) that suffer anaemia.
- Family nutritional level and distribution of food, differentiating according to sex and age.
- Percentage of women with access to health care services, according to age.
- Percentage of women belonging to health care personnel.
- Percentage of pregnant women with health care control during pregnancy and health care in the event of complications.
- Percentage of births attended by qualified personnel.
- Access to post-partum services per 100 births.
- Registered number of voluntary pregnancy terminations.
- Young female fertility rate: Number of births of mothers under the age of 20 years, divided by the total number of women aged between 14 and 19 years, multiplied by 1000

[12] These and other indicators may be revised in Appendix IV. Main gender-sensitive indicators in sexual and reproductive health

- Number of pregnancies and spacing between births.
- Family co-responsibility indicator: Father's participation in the most difficult tasks. For example, fetching water.
- Family and labour burdens of women in puerperal period: caring for children, other family members, paid and unpaid work.
- Participation of women in political institutions and organisations that work in the area of sexual and reproductive health.
- Maternity protection policies and the percentage of women that are protected according to each sector of activity (salaried workers working for third parties, according to employment sectors). Percentage of unprotected women according to activity sector (self-employed workers, according to employment sectors).

In many cases, data on these indicators will not be available and it will be necessary to build a registration system and adapt the indicators to the particular reality of the African context.

8. Promoting the inclusion of the concept of gender inequality in each of the cultural traditions, emphasising the harmful effects on health of certain social practices derived from this inequality. For example, showing the complications of early pregnancy for maternal health or the short time between one pregnancy and another.

9. Promoting policies of maternity protection and paternal co-responsibility in care.

Primary Health Care

The primary health care strategy, in turn, seeks to increase quality health care services, especially preventive and curative services and to facilitate the accessibility of the latter. The approach here is horizontal: considering all the agents involved in the problem and the various perspectives, matching methodology to users and promoting participation. As part of a programme on prevention and attention to complications in pregnancy and childbirth, complemented by the gender perspective, the PHC strategy involves the following:

1. Socio-anthropological study of the area including the causes of complications in pregnancy, childbirth and the postpartum period, which we have already analysed, as well as the no. of centres/ inhabitants, no. personnel/ inhabitants, midwives/ inhabitant,…

2. Implementing the necessary services in the area (maternities, health centres, personnel and material available), their quality and accessibility.

3. Creating/ supporting the community health council and incorporating problems occurring in pregnancy, childbirth and the post-partum period on its agenda.

4. Providing accessible emergency obstetric services to deal with births in which complications occur.

5. Designing services to protect the rights of women. The services must promote women's right to decide on their sexual and reproductive health, their right to quality information, their right to choose their partner and their right not to suffer violence, among others.

6. Providing health care services during pregnancy, childbirth and the postpartum period to women of procreating age, regardless of their marital status.

7. Intensifying the supervision and training of personnel and using systems that pursue good-quality health care based on a gender perspective.

8. Improving the training of the personnel closest to the population: leading women and men, traditional midwives, primary nurses, midwives.

9. Providing adequate personnel, in terms of numbers and skills.

Education for health

The education for health strategy seeks to create changes in the attitudes and living habits of society as a whole regarding sexuality and reproduction. As we have already seen, this is a fundamental step in order to increase the population's information and participation and thus contribute to increasing their control over sexual and reproductive health. Within the PHC strategy, it opens the doors for developing the strategy of women's empowerment. In a sexual and reproductive health programme, the EfH strategy may be carried out along the following lines:

1. Training educators in sexual and reproductive health.

2. Using a participative methodology for carrying out the various educational activities in order to engage the population as active participants in the learning process.

3. Information on changes, risks and illnesses that may be associated with pregnancy, childbirth and the postpartum period.

4. Increasing awareness on complications in pregnancy, the causes of the latter and treatment targeting the whole community, men and women.

5. Incorporation of the experience and knowledge of men and women in the process of learning about complications in pregnancy, childbirth and the postpartum period. This learning should be viewed as an open process.

6. Also, information on care during pregnancy and preparations and conditions for childbirth.

7. Education on the relevance of equalitarian relations for preventing complications in pregnancy, childbirth and the postpartum period. Co-educational activities that promote the development of equalitarian attitudes.

8. Education in co-responsibility and care, highlighting the role of the father as caregiver during pregnancy, childbirth and the postpartum period and the enjoyment of responsible fatherhood.

9. Carrying out activities specifically for the most vulnerable and isolated groups, using "education between peers". For example, work with young mothers on the importance of self-care and with young men on responsibility in the exercise of their sexuality, as a form of self-care and care for women (condoms, methods of contraception, etc.).

Empowerment of women

Women's empowerment strategy seeks to increase the degree of power that women have over their sexual and reproductive life. In the pursuit of this goal, in a care programme for obstetric complications, the work is directed at empowering women to look after their health before, during and after pregnancy.

It also seeks to empower women so that they may take an active part in the policies, programmes and projects related to this matter. The empowerment strategy, which is derived from gender mainstreaming, PHC and EfH strategies, is applied by implementing the following guidelines:

1. Providing information to women on the changes that they may make in order to have a more healthy pregnancy and on the possible risks and illnesses that they may suffer during pregnancy and childbirth.

2. Working to increase the self-esteem of women in the stages of pregnancy, childbirth and the postpartum period.

3. Identifying the importance of care during pregnancy, childbirth and the postpartum period.

4. Promoting self-care and the negotiation of care with men and other family members.

5. Insistence on the relevance of caring for the woman's health beyond pregnancy and childbirth with a view to other possible births and especially, to the enjoyment of a healthy life.

6. Determining and expressing the needs of women before, during and after pregnancy: economic, social, affective needs, among others.

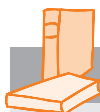
7. Helping women to decide on attending pregnancy check-ups and the assistance of qualified personnel at childbirth.

8. Involving women as the managers of programmes to prevent obstetric complications.

9. Involving women in designing maternity protection policies and paternal co-responsibility.

Points to Remember

- A comprehensive programme on **complications in pregnancy and childbirth** should work on the four health promotion strategies: gender mainstreaming, PHC, EfH and the empowerment of women.
- **Gender mainstreaming involves women as an active part** of the project while also promoting the co-responsibility of men. In particular, gender analysis is integrated in obstetric complications in all phases of the programme. Accessible, high-quality services that meet the needs of women in this area should be implemented via primary health care.
- The **education for health strategy** promotes participation-based learning about the risks that may arise during pregnancy and childbirth, as well as protection and prevention methods. Co-education is also sought
- Finally, a comprehensive programme of care for obstetric complications must also channel its action towards strengthening the abilities and skills of women before, during and after pregnancy so that they may occupy active roles in self-development and in the development of the community. This means that the women's **empowerment** strategy must be applied.
- All these strategies must promote maternity protection and paternal co-responsibility policies.



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4.2
GENDER-BASED VIOLENCE

On much of the planet, violence against women is still legitimised by the submission that women are expected to accept to men. Gender-based violence is manifested in both physical and psychological aggressions in daily life (intrafamily violence, harassment at work) and in other aggressions associated with traditional practices (female genital mutilation, early marriage, neglect of daughters and female infanticide). Similarly, this violence is exercised in all spheres, in the family and in the community, and even at State level (See Table 2). All these acts of violence are legitimised by cultural values based on unequal gender relations.

Despite the fact that the community and the State exercise gender-based violence, it occurs for the most part in the domestic arena. Family members, fathers, mothers, partners or spouses are main aggressors, responsible for the serious consequences of violence on the physical, mental and emotional health of women. We shall now analyse how work may be done in two specific cases of this type of violence: intrafamily violence and female genital mutilation (FGM).

Table 2. Types of gender-based violence depending on the player involved

Family	Community	State
> Intrafamily violence. > Female infanticide. > Neglect of daughters. > Sexual abuse of girls. > Female genital mutilation. > Early marriage. > Dowry-linked violence. > Marital violence. > Rape. > Violence and exploitation.	> Rape. > Sexual abuse. > Sexual harassment and intimidation at work. > Sexual trafficking of women. > Forced prostitution.	> Poor treatment in public services, including health care services. > Violence perpetrated or allowed by the State, no matter where it occurs (police stations, by police, military establishments, institutions, etc.)

Source: L. Mazarrasa (2005).

4.2.1
INTRAFAMILY VIOLENCE

As we have already explained, the majority of aggressions towards women take place in the family. The family is considered to be a harmonic whole where violence is justified by alluding to the socially defined distribution of family power. Therefore, the violence of the husband or partner towards his wife and certain types of aggressions committed by the father towards the daughter are extended as a manifestation of the greater power that one sex has over the other. The aggressions committed by mothers on daughters, however, are due to the generational distribution of power, in the same way as the aggressions committed by fathers against their sons. We shall focus on violence by men against women as it is the former who commit acts of aggression most often, and latter are the main victims of this type of violence.

Gender mainstreaming

The introduction of gender mainstreaming in an intrafamily programme or project is characterised by making the problem visible and by systematically considering the social inequalities existing between men and women from identification through to assessment as explanatory causes for this category of violence. There are various possible initiatives to be carried out in this regard.

1. To render women's sexual and reproductive health problems that are related to intrafamily violence visible by displaying their nature, their roots and the physical, psychological and social consequences of such problems.

2. To integrate gender analysis on a permanent basis in the study of family violence, indicating the factors that increase the risk of exercising and suffering this type of violence.

3. To raise the awareness of the whole community, via the community health council, on the perverse effects of intrafamily violence on sexual and reproductive health, especially of women, but also of men.

4. To provide specific training to those in charge of the programme and/or bring in expert personnel.

5. To integrate women in all stages of the programme in order to introduce their experiences as well as introduce men as allies. To work with women and men on designing, implementing and assessing the programme. The intention is to break down the cultural conceptions that justify intrafamily violence and which are accepted by both women and men.

6. To draw up, execute and assess the programme, considering the causes of violence, its effects on women and the role undertaken by abusive men.

[13] All of these indicators are contained in Appendix IV. Main gender-sensitive indicators in sexual and reproductive health

7. To design a set of indicators that will be used to measure gender-based violence. We shall now list some indicators[13] that may be useful. However, they may be difficult to achieve and it would be advisable to adapt them to the African context and start a registration system.

- Existence of associations for supporting the victims of gender-based violence.
- Inclusion of awareness-raising and the prevention of abuse in the educational process.
- Physical and/or psychological assistance to the victims of gender-based violence provided by the health care services.
- Indicator of sexual violence exercised against people.
- Indicator of psychological damage.
- Indicator of morbidity associated with women's unease.
- Indicator of suicides and attempted suicides by women.
- Indicator of non-fatal injuries, including psychological and social damage and death due to intrafamily violence.
- Indicator of legal penalties for violence against women.
- Number of victims of gender-based violence per 100 people, according to sex.

8. Promoting research in the field of intrafamily and gender-based violence.

Primary Health Care

Work from the primary health care strategy focuses on providing services and access to women that suffer intra-family violence. The aim is to prevent abuse and propose solutions both to the abused women and to their aggressors. Carrying out a programme or project on intrafamily violence that is supported by this strategy involves the following:

1. A socio-anthropological diagnosis to learn about the situation that propitiates the intra-family violence.

2. Developing the problem via the community health council and establishing systems for prevention, early detection and identification of gender-based violence.

3. Developing, in accordance with the socio-cultural reality of the area of work, services to attend to women that have been the victims of violence, addressing the cultural values that place women on a secondary level.

4. Introducing constant, scheduled care services that will make women feel capable of leaving the circle of violence. In this regard, it is essential first of all to increase community awareness regarding the problem of intrafamily violence and promote a local political commitment against this type of violence. These issues are worked on from the perspective of gender mainstreaming and education for health.

5. Paying special attention to the important role played by health care professionals:

> Training and awareness-raising of male and female professionals.

> Encouraging an open attitude by the professional personnel that will transmit a feeling of security and support and ensure that intimacy is preserved. The professional should never judge or criticise the victims of gender-based violence, but rather listen actively and show empathy towards the problems of violence against women.

> Promoting respect for women's sexual and reproductive rights among health care personnel.

6. Incorporating a registration system.

7. Establishing, with the above indicators, a system for assessing and following up the programme in order to ensure that it functions properly and make the necessary adaptations.

Education for health

The main task of the education for health strategy is to increase community awareness in general of the negative consequences of intrafamily violence on sexual and reproductive health, and to promote the development of skills and abilities that contribute to reducing this type of violence. In this regard, the main points to be taken into account are as follows:

1. To carry out activities aimed at increasing the awareness of the entire community regarding intrafamily violence.

2. To inform on the risks that intrafamily violence poses for the sexual and reproductive health of women and men.

3. To promote education for health activities aimed at women and men that will allow them to identify the causes and consequences that provoke violence in health and the power relationships existing between men and women in the family and in society.

4. To encourage the exchange of experiences and knowledge on intrafamily violence throughout the learning process and guide towards non-aggressive, equalitarian relationships.

5. To carry out prevention programmes aimed at men and women. The abuser perpetuates the social order that traps him as an aggressor.

6. To take into account the socio-cultural characteristics of the area of work (for example, inherited religions or customs) to encourage attitudes that favour gender equality.

7. To work with males on the prevention of violence. Education in affectivity and the expression of feelings.

8. To use the "education between equal" tool for the most vulnerable population. For example, carry out training activities on intrafamily violence with groups of women, according to age.

9. To implement "zero tolerance" programmes on violence in the community.

Empowerment of women

Women's empowerment strategy is fundamental in reducing intrafamily violence, because it is largely linked to the limited power and low self-esteem of women. Supported for the most part by EfH, empowerment seeks to develop women's skills, particularly those that will allow them to act against intrafamily violence. The lines of action to be carried out include the following:

1. To work on a participative basis with women in general and women in situations of risk. To study which groups are most at risk of suffering family aggressions. Specific activities may then be carried out with these groups.

2. To provide assistance to women who are victims of violence, encouraging the formation of self-help groups both in rural and urban areas.

3. To create specific spaces for the exchange of ideas and experiences by women who are victims of violence.

4. To develop the critical ability of women to question the position of subordination and passivity assigned to them by society.

5. To improve and increase self-esteem, personal development, mental health, social relationships, self-care, social support networks and autonomy.

6. To provide alternative social, police, psychological resources that may be of help to women.

7. To strengthen their skills for them to take an active part in political decision-making.

8. To promote support networks between associations and groups of women working on the subject of intrafamily violence.

4.2.2
FEMALE GENITAL MUTILATION

Despite the fact that female genital mutilation or ablation is punished by the internal community, as we indicated before, every year a further two million girls suffer this fate in the world and it is practised on a general scale in many African countries. Today, it constitutes one of the most blatant violations of human rights and reflects a hierarchical social order that establishes the power of men over women, as FGM represents a mechanism to control women's sexuality from an early age. However, it is also one of the health problems that it is most difficult to work on because deeply rooted "cultural traditions" in the societies where FGM is practised must be confronted. For this reason, apart from considering the indicated lines when dealing with intrafamily violence, other possible initiatives need to be addressed in a comprehensive FGM reduction programme.

Gender Mainstreaming

Gender mainstreaming in a programme aimed at eliminating FGM involves acknowledging the existing social structures and the types of relationships that the latter support. Gender mainstreaming shows the social causes that promote FGM by presenting a systematic gender analysis of the factors that encourage the development of this type of practices. Applying the strategy of gender mainstreaming, as well as the aspects indicated when referring to intrafamily violence, entails:

1. Analysing the gender conditioning factors that encourage the practice of FGM, by means of a study of the particular area.

2. Raising the awareness of the members of the team on FGM, as well as the community as a whole.

3. Integrating men and women, analysing the role that each one plays in FGM. Violence in this case is often caused by other women.

4. Considering the social and cultural difficulties that hinder the elimination of FGM, designing, executing and assessing the particular programme or project while taking into account the different gender roles and how they will condition the success of the intervention.

5. Negotiation to introduce FGM as a priority health care problem on the local, regional and national political agenda.

Primary Health Care

Through the PHC strategy, the programme shall provide accessible services for dealing with the complications that FGM generates for women's health throughout their lives (haemorrhages, pelvic infections, problems in childbirth, etc.). Under no circumstances shall the medicalisation of FGM be supported. This means that establishing health care services to perform the mutilation it should be prohibited. In this regard, we may highlight some aspects that should be borne in mind in a programme or project of this type:

1. Socio-anthropologicalanalysistounderstand the roots and social consequences of FGM, in order to introduce the debate among the population and adapt the intervention.

2. To provide training to health care personnel on the possible consequences and side-effects of FGM for the purpose of care and treatment.

3. To open a debate on FGM on the community health council.

4. To establish health care services to treat the physical and psychological side-effects of FGM.

Education for health

The most important work is perhaps in the case of a programme against FGM in education for health. The main problem to be solved is a problem of harmful customs where the EfH strategy emphasises its work. In this regard, the following lines of action may be introduced from the perspective of EfH:

1. To inform the population through campaigns on the negative consequences of FGM for women's health and rights. In this regard, the experience and support of local networks from the country that works against FGM should be leveraged.

2. To relate FGM to other health issues such as motherhood, sexually transmitted infections and HIV/AIDS.

3. To provide truthful, non-sexist information in which sexuality as inherent to women is defended.

4. To open up debate among the population and generate critical attitudes, insisting on the negative effects that FGM has on the sexual and reproductive health of both men and women.

5. To exchange knowledge and experiences of men and women, without losing sight of the fact that although the woman is mutilated, both sexes play an active part in the mutilation. FGM is almost always performed by the mother or by another woman.

6. To focus on educating particular population groups: healthcare workers, community leaders, police officers, politicians, traditional midwives, women and men. It is possible to work with the most vulnerable groups via "education between peers". Education between peers in groups of young people may help to contribute towards a better understanding of the negative effects of FGM on health and towards the rejection of FGM from this early stage.

7. To involve men in this issue, which is viewed as being a "women's issue". This means approaching FGM as a public health problem.

Empowerment of women

On the other hand, the strategy of empowering women is also a key component in eliminating FGM. While FGM is not exclusively a "women's issue", it is crucial for women to become empowered, without this meaning that men are not involved in this process of change. What would the main lines of action be?

1. To inform women, and especially young women, about FGM.

2. To promote reflection and a critical attitude towards female genital mutilation on a permanent basis so that women may develop a critical spirit.

3. To promote the development of women's self-esteem and their being viewed as sexual beings.

4. To involve women in the campaigns to eliminate FGM and train leaders.

5. To support networks of women working in this same direction and invite other networks to exchange opinions on FGM.

6. To promote the participation of women in policies and programmes for eliminating FGM at national and local levels.

TWO PROJECTS COMBATING GENDER-BASED VIOLENCE. THE LESSONS LEARNED BY MEDICUS MUNDI AND AMREF-FLYING DOCTORS.

Few projects work directly in combating gender-based violence in Africa. However, the experience of Medicus Mundi and AMREF-Flying Doctors in Burkina Faso and Tanzania, respectively, show that it is possible to work and achieve positive results in this area.

The Medicus Mundi project to combat FGM works, together with the **National Committee Fighting Excision** (CNLPE), in the regions of Goulmu and Yatenga, Burkina Faso. This organisation uses dynamic activities such as drama, radio workshops and debates with monitors on the subject of FGM. The general aim is to heighten awareness on the ground where FGM is a fact that is practised and accepted by communities. Medicus Mundi and the CNPLE have also drawn up awareness materials which are especially intended for areas to which access is difficult.

One of the keys to the success of awareness using theatrical representations is that they are carried out by members of local groups that are very close to the community, in their own language and using elements of their traditional culture such as music and hand-crafted masks.

Some of the lessons learned from this project are as follows:

> The activities that are carried out in the context of the project are foreseen in the plans of action of the Provincial Committees to Combat FGM. This means that they are part of the national effort in this regard.

> Theatrical representation is an efficient vehicle in transmitting messages, more so when the actors are members of the community and share the social reality that is being represented.

The Jijenge! (which means “build yourself!” In Swahili) Project by AMREF-Flying Doctors has the general objective of training and disseminating initiatives that allow to improve the sexual and reproductive health of women in the area of Lake Victoria, Tanzania, emphasising awareness against gender-based violence.

Work is carried out on three levels – communities, health care centres and civil society. The Jijenge! Project organises activities to promote sexual and reproductive rights by means of drama workshops, music and campaigns. Another important initiative is the training of community leaders and facilitators, emphasising the multiplication potential of consortiums and organisations that demand policies that are favourable to women's rights.

Some of the lessons that have been learned from the Jijenge! programme are as follows:

> It is essential for influential members of the community to promote women's rights. This lays the foundations for the formulation of community laws against gender-based violence and for changing traditions that are harmful to women's health, such as FGM.

> It is necessary to increase the awareness of health care providers, social and legal services regarding gender-based violence and give them tools to be able to act against this violence.

> The results with the most impact are obtained when work is carried out on a parallel and complementary basis in the three spheres of intervention: communities, healthcare centre network and civil society.

Despite the innovative nature of these projects, tangible results have already been achieved in both cases. In the regions where the Medicus Mundi project is being deployed, it is now possible to openly discuss the problems caused by the practice of FGM. The members of the communities are prepared to debate on gender-based violence and take action against it. This was unthinkable twenty years ago.

As regards the Jijenge! project, five years after it first started, the members of the communities are ready to debate women's rights, specifically gender-based violence and act against it. The cases of gender-based violence in the area of influence are notified and registered: every quarter, 350 women receive medical treatment at a health care centre and 250 women request support and advice from the community facilitators and volunteers trained by the project.

Source: AMREF--Flying Doctors and Medicus Mundi Andalusia

Points to Remember

- Any programme, either to reduce **intra-family violence** or female genital mutilation, must contemplate the four strategies proposed in order to give a comprehensive response: gender mainstreaming, PHC, EfH and empowerment of women.
- By means of the gender **mainstreaming strategy,** we try to integrate the gender perspective into all policies and initiatives related to violence against women. In a particular programme, the task consists of focusing on gender inequality as a key component in explaining, understanding and combating this type of violence. In this regard, gender analysis must be present throughout the programme.
- Regarding **PHC,** work is based on providing services to attend to the consequences of violence on women's physical and mental health. It is of particular relevance to train specialists in order that they know how to provide adequate care.
- By means of **education for health,** the most important work on heightening the awareness of the population regarding the need to change violent behaviour is carried out.
- **Empowerment** of women is fundamental in order to work on their damaged self-esteem and promote their social and political roles in communities, as well as to promote the disappearance of this practice and support other women that have already suffered it.

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4.3
CONTRACEPTIVE PRACTICES

"The right of women to decide freely and responsibly on the number of children and the interval between births, as well as to have access to information, education and resources that allow them to exercise these rights, is a fundamental human right"

(Spanish Family Planning Federation, 2000: 28)

In general terms, women are still the greatest users of modern methods of contraception14, whereas the undertaking of responsibility by men in preventing unwanted pregnancies is still very limited. To be specific, "the pill and the Intra-uterine device (IUD) are the most used modern methods in the most advanced countries in Africa" (Spanish Family Planning Federation, 2000: 29).

Despite the fact that the majority of countries have increased the use and access to methods of contraception in recent years, one third of women of fertile age in developing countries are still lacking in modern methods of contraception. On a parallel basis, the majority of people that use methods of contraception do not have sufficient information on how to use them or the method that best suits their needs. Moreover, the systems for following up and supervising the use of such methods are still extremely limited.

In this regards, principle number 8 of the Programme of Action of the IPCD acknowledges that "all couples and all persons have the fundamental right to decide freely and responsibly on the number and spacing of their children and to have the information, education and resources to be able to do so".

Generally speaking, it is possible to differentiate between contraception, which is related to men's and women's right to prevent pregnancies and STIs as part of responsible sexual relations, and family planning, which is linked to family decisions on the number of children and the time interval between their births. Therefore, contraception implies a more general perspective from where it is possible to work on the prevention of pregnancies and STIs even if a family unit has not been formed.

Gender mainstreaming

As part of a contraception or, specifically, a family planning programme, gender mainstreaming attempts to highlight the different access to and control over methods of contraception by men and women and to analyse the causes and consequences of both on sexual and reproductive health. This therefore implies analysing men's and women's access to information and to safe methods of contraception; their ability to decide on the use of the latter and the specific needs of each sex as regards this matter. The objective is to ensure that decisions on contraception are made on the basis of consensus between both sexes,

[14] Modern methods of contraception are the contraceptive pill, injections, the intra-uterine device, vaginal tablets, spermicides, diaphragms and male and female sterilisation.

which means that equality-based personal relationships must be promoted. The main points that need to be revised in order to verify if a contraception programme has introduced the gender perspective are as follows:

1. Analysis and in-depth study of the causes for the differences existing between men and women regarding access to and the decision to use methods of contraception.

2. Study of the needs of men and women regarding methods of contraception. For example, the need for specific work aimed at men regarding the use of condoms.

3. Information aimed at managers and the community in general regarding the consequences of unequal access to methods of contraception by men and women on health and the lack of equality when deciding to use them. It is necessary to emphasise the negative effects of unsafe sexual relations, doing away with the possible cultural myths associated with masculinity.

4. To design the programme while bearing in mind the importance of gender equality in access to and the ability to use contraception with a view to healthy sexuality and reproduction.

5. To involve both men and women on this type of programmes. This type of programmes is often aimed at women as the main beneficiaries. Although women have traditionally had less resources and decision-making power on the use of methods of contraception, the co-responsibility of men in this matter must not be forgotten.

6. Follow-up and assessment of the programme according to these gender-sensitive indicators and others that may be designed for the particular case in hand[15]:

   - Rate of use of contraception among men and women.
   - Access and assistance to information services on contraception according to sex and age.
   - Indicator of inclusion of education on contraception in the educational process aimed at young people, women and men.
   - Degree of knowledge of the various contraceptive techniques, according to sex.
   - Ideal number of children, expressed by men and women, compared to the total number of children.

[15] The gender-sensitive indicators are contained in Appendix IV. The main gender-sensitive indicators in sexual and reproductive health.

Primary health care

The work that is to be done by the PHC strategy is to make safe contraceptive methods and information services accessible to both men and women. Primary health care understands the problems derived from this lack of comprehensive access, considering all the socio-cultural factors that influence and promote the participation of the population. We shall now analyse the general characteristics which a contraception programme integrating PHC should have:

1. Socio-anthropological study of the area in order to ascertain the causes that hinder access to and the use of methods of contraception, emphasising the cultural notions of motherhood, fatherhood, family and sexuality and highlighting the stereotypes and restrictions on female sexuality.

2. Creation of a community health council with the participation of men and women, to deal with contraception and men's and women's right to enjoy their sexuality.

3. Design a programme, in accordance with national policies and the socio-cultural reality that promotes access to methods of contraception and advisory and information services. Provision of emergency contraception.

4. Specific training aimed at health care personnel to ensure that they inform in an adequate manner.

5. Development of comprehensive services that respect the confidentiality of people, men and women, and their right to decide on the methods of contraception, placing special emphasis on eliminating the barriers to access faced by young men and women.

6. Creation of specific services for contraception among adolescents which promote effective use by the target group.

7. Integration of these services within the health care planning for the region.

8. Development of participative methodologies that involve men and women in the development of the programme.

Education for health

Education for health contributes to creating healthy living habits. In a contraception programme, its functions are aimed at promoting responsible, healthy sexual relations by promoting the equality of men and women. The following are the most important lines of action:

1. Creation of an adequate space, by means of the use of participative methodology, for the exchange of experience and knowledge of contraception by men and women in order to provide information on safe methods.

2. To attach the same value to the contributions of men and women throughout the whole learning process.

3. To organise activities to ensure that people understand the risks of not using

methods of contraception, taking into consideration their cultural conceptions of sexuality and reproduction. For example, campaigns targeting the whole community on the need to use modern contraceptive methods in order to prevent unwanted pregnancies.

4. To carry out activities to promote the prevention of pregnancy and possible STIs and the development of personal and social skills. For example, it is important to do away with the three "I"s of young people, who believe themselves to be infertile, immune and immortal, and to promote attitudes that will help them to protect themselves.

5. To carry out activities that will promote self-care among women and care for others among men. Women must protect themselves, but men are also responsible for avoiding pregnancy or the transmission of STIs.

6. To use the "education between peers" tool, especially in work with young people and adolescents, as they are initiating their sexual lives but lack reliable information on contraception.

7. To focus all the activities, emphasising both the more biological aspects of sexuality and reproduction and aspects that are related to affectivity and equality between men and women.

Empowerment of women

Empowerment of women is a fundamental strategy in a contraception or family planning programme. Since it promotes the acquisition of power by women, both for their more personal decisions and for decisions more related to the community or society, empowerment enables women to participate in protecting themselves against unwanted pregnancy, STIs and HIV/AIDS. Therefore, empowerment contributes to reducing the consequences of the failure to use methods of contraception. In this regard, this strategy focuses on the following points:

1. Use of participative techniques that involve women as fundamental agents in protection.

2. Development of individual, family and community skills and abilities. For example, the development of the skill of negotiating the use of contraception in sexual relations.

3. Identification of the reproductive role of women, but also of their right to healthy, satisfactory sexuality.

4. Design of the programme should take into account the needs and barriers evinced by women in this area.

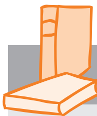
5. Creation of spaces and opportunities for women to analyse their personal situation regarding contraception and open doors to possible solutions.

6. Strengthening of women's associations engaged in the area of contraception and the establishment of networks with other similar networks in the region, country and in other countries.

7. Participation in policies that facilitate universal access to safe contraception.

Points to Remember

- A **contraception or family planning programme** requires a comprehensive approach that will work on the four health promotion strategies: gender mainstreaming, PHC, EfH and women's empowerment.
- The gender **mainstreaming** strategy allows to analyse the causes for the differences in access and decision-making on the use of contraception by men and women and to design the programme, its objectives, results and activities, with this gender inequality in mind.
- In turn, the **primary healthcare strategy** provides the population, both men and women, with counselling and information services as well as safe methods of contraception.
- As regards the **EfH** strategy, it promotes the development of healthy, affective and equalitarian sexual relationships.
- **Empowerment** helps develop women's abilities and skills in protecting themselves against pregnancy and STIs and increasing their power within organisations and institutions that work in the area of contraception.



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4.4

SEXUALLY TRANSMITTED INFECTIONS. THE CASE OF HIV/AIDS

As we have already mentioned, approximately 340 million new cases of sexually transmitted infections (STIs) are detected each year. To be specific, the HIV/AIDS pandemic, which in 75% of cases is transmitted through unsafe sexual practices, is having a major impact on the health of numerous women and men in the African continent, especially in Sub-Saharan Africa.

In general terms, women and girls are more vulnerable to catching STIs and specifically HIV/AIDS, both for biological causes and psycho-social reasons. The possibility of sexual transmission of HIV/AIDS from man to woman is up to 12 times greater than from woman to man, due to the following biological factors:

> Semen has a higher infectious capacity than vaginal fluid.

> In vaginal intercourse, women expose a mucous surface that is more fragile and more likely to suffer tiny fissures than the male tissues.

> STIs, some of which are very frequent among women and remain untreated for a long time, such as cervix lesions, increase the risk of infection (Spanish Women's Institute, 2002a: 45).

In terms of pyscho-social causes, the vulnerability of women and girls to infection by HIV is explained by the lack of information and above all by their lack of emancipation. Women that accept traditional gender roles are at a greater risk of being infected and are also more resistant to practising safe sex. They accept their subordinated role to men and establish sexual relationships with men that do not practise safe sex with sporadic partners or stable partners for cultural reasons. Apart from these factors, their limited control over means of prevention, social isolation and affective and economic dependence influence on a greater risk of contracting HIV (Spanish Women's Institute, 2002a: 49).

The risk of contracting HIV is compounded by the social stigmatisation that many women suffer when they are infected. This stigmatisation is due to the cultural and social structures that place women second in importance. Therefore, on many occasions, the limited value given to women leads to family and social marginalisation and their low economic autonomy means that they are left entirely helpless.

Therefore, there is a need for programmes and projects that not only act on the biological causes of HIV/AIDS, but which are aware of how the gender order influences the transmission and effects of the disease. We shall now analyse various intervention models according to the different strategies that have been presented.

Gender mainstreaming

"We shall be performing gender mainstreaming when we influence policies and techniques to ensure that gender is taken into account in the planning and development of a programme for the prevention and monitoring of HIV/AIDS, in order to detect the need for care according to gender and to impact the socio-cultural conditioning factors that influence, to a greater or lesser degree, the likelihood of infection or the vulnerability of women and men and preparing measures to change these conditioning factors that hinder prevention" (Spanish Women's Institute, 2002b: 34). Therefore, in order to apply gender mainstreaming to a programme for preventing and/or monitoring HIV/AIDS, the following ideas must be promoted:

1. Development of awareness regarding the link between gender and HIV/AIDS within the particular institution or organisation where the programme is drawn up.

2. Differentiation of the needs of men and women, with an emphasis on the adolescent and young population, both in terms of prevention tasks and monitoring tasks.

3. Establishment of gender analysis systems in the transmission of HIV/AIDS or living with it in order to determine the social and cultural aspects that generate different patterns depending on gender.

4. Design of objectives, results and activities that bring about a change regarding the influences and consequences associated with gender.

5. Use of indicators to measure the impact of the programme on gender patterns for monitoring and assessing the programme. The following, among others, may be used:[16]:

   > Rate of variation in the number of people registered as infected by HIV/AIDS, according to sex.

   > Proportion of cases of human immunodeficiency virus in adults, according to sex.

   > Proportion of HIV cases among pregnant women between 15 and 24 years of age.

   > Percentage of men and women that use condoms throughout intercourse, according to age.

Primary health care

From the primary health care approach, HIV/AIDS must be addressed from a comprehensive standpoint, analysing the social causes and engaging the population. This requires adequate methodology and sufficient resources. The following points may guide specific interventions in prevention and/or follow-up:

1. Socio-anthropological study of HIV/AIDS in the particular region, verifying if there is a stigma attached to people that are ill or who carry HIV and if the numbers of infected women is on the increase.

[16] Further information on gender-sensitive indicators is contained in Appendix IV. Main gender-sensitive indicators in sexual and reproductive health.

2. Training and specialisation activities on HIV/AIDS with a gender-based approach for health care personnel, allowing for quality health care.

3. Ensuring accessibility to information services and promoting the establishment of health care networks for correct monitoring and care of men and women infected by HIV.

4. Ensuring access to adequate diagnosis and treatment.

5. Providing access to condoms and promoting their use.

6. Participation of men and women in all stages of the programme in order to integrate their knowledge.

7. Establishment of a link between the health care personnel and the infected or sick person that can lead to a change in attitude to their self-care and protection for their partner/s.

8. Transmitting personalised, confidential information on the epidemiological transmission chain.

Education for health

In EfH, this strategy aims to promote both protection via healthy practices and the integration of people infected by HIV/AIDS. The following activities may be carried out in a prevention and/or monitoring programme:

1. Work on a community scale on HIV/AIDS, its modes of transmission, prevention methods and the consequences of infection, combating the stigma and promoting the social integration of those that are infected and particularly of infected women, as they bear the brunt of the marginalisation.

2. Heightening awareness of possible unsafe sexual practices and informing on "safe sex" practices from adolescence onwards.

3. Providing resources for the "safe sex pact", whose difficulties lie in the submission to the traditional gender roles. Promoting negotiation of the use of condoms by women.

4. Informing men and women on the greater physical and social vulnerability of women to the virus.

5. Listening to the population and allowing it to participate on an active basis throughout the learning process, promoting the development of skills and of a critical attitude regarding HIV/AIDS and transmission of the latter.

6. Carrying out activities that promote the care system. For example, informing on how to care for a person with HIV/AIDS and that this care must be provided by men on an equal basis.

7. Specific "education between peers" activities among the most vulnerable groups.

Empowerment of women

To be effective, an HIV/AIDS prevention and/or monitoring programme needs to modify the attitudes associated with the different gender roles. The subordinated role of women, as we have already indicated, constitutes one of the explanatory factors in the transmission and the different effects of HIV/AIDS on men and women. Modification of this situation is supported by work on two fronts: empowering women in their relationship with their own bodies and empowering them to ensure that they are present when prevention and care policies and programmes are being drawn up. The intention is therefore to strengthen both the development of women's self-esteem and their role in political organisations, health care services and NGOs. On a parallel basis, the participation of men in the change and their acceptance of the modification in the power relationships is crucial for the success of the whole process.

The implementation of the empowerment strategy in a particular programme or project must promote the following:

1. Information on the transmission of HIV/AIDS and unsafe practices, emphasising the greater vulnerability of women.

2. Criticism of the sexual stereotypes that facilitate the acceptance of unwanted behaviour that may represent a risk for sexual and reproductive health.

3. The right of women to decide on their sexuality and to express their own decisions, from adolescence onwards.

4. Negotiation of the use of condoms.

5. Training for women on the subject of HIV/AIDS.

6. Combating the stigmatisation of women infected by HIV/AIDS.

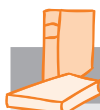
7. Their presence in political institutions and organisations where the lines of action in the area of HIV/AIDS are drawn up.

8. Creation of communication networks between women, associations and institutions working in HIV/AIDS.

9. Complicity of men in the process of empowerment of women via information on unsafe practices and values associated with gender.

Points to Remember

- Prevention and/or follow-up on **HIV/AIDS** requires, like the other cases analysed, a comprehensive programme supported by the four health promotion strategies indicated: gender mainstreaming, PHC, EfH and women's empowerment.
- The **gender mainstreaming approach** is used to detect the different needs and risks of infection in men and women in order to be able to create specific measures for intervention.
- **PHC** provides specific customised health care services and information. On the other hand, education for health helps to eradicate taboos on HIV/AIDS, promoting the social integration of those who are ill. It also contributes to disseminating the practices and attitudes that can help to prevent the disease.
- **Women's empowerment** helps women to become active subjects in combating HIV/AIDS, by negotiating safe sexual practices and by joining the decision-making bodies of the institutions that work in this area.



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CHARTS

CHART I

Male participation in sexual and reproductive health

Sexual and reproductive health information and services are often aimed specifically at women, leaving men aside. The AIDS epidemic has exposed the consequences of certain male behaviour for health. Similarly, violence towards women and the lack of responsibility in the area of reproduction require a greater degree of commitment to gender equality by men.

Surveys, especially in Africa, reveal that men are more interested in reproductive health than what is normally thought. According to Nzioka (2005), men can contribute to mobilising resources and redistributing them fairly between men and women, changing the cultural institutional rigidity and thus reinforce the strengthening of women, reducing the inequalities between the sexes in the area of sexual and reproductive health patterns, and institutionalising gender equality as a priority.

Having said that, how should men be involved in sexual and reproductive health programmes? Taboos and cultural rules hinder communication men and women on these issues. At the same time, the unequal power relationships mean that it is impossible to propose a greater degree of equality between the sexes. Therefore, communication channels and spaces for building on equality need to be opened up. In order to achieve these two objectives, the intervention should aim at the following:

- Reach out to the male population with appropriate messages, using the available public dissemination resources and emphasising the adolescent and young population.
- Encourage men to take a higher degree of responsibility in their sexual behaviour.
- Inform on gender identities and the values associated with masculinity that are involved in unsafe sexual conduct.
- Inform on condoms and vasectomy and offering a variety of health care services.

Provide men with access to sexual and reproductive health services.

- Increase the awareness of men regarding communication with their partners and joint decisions regarding contraception and sexual practices, underlining the importance of the influence of gender.
- Support reproductive health needs of both individuals and couples.

Source: Internal, on the basis of Drenan (1998), UNFPA (2000) and Nzioka (2005).

CHART II

Work with young people in the field of sexual and reproductive health

The young population today represents a major part of the world population. According to Population Action International, 1,700 million of the 6,300 million people that inhabit the planet are aged between 10 and 24 years, and this is the most numerous generation in the history of mankind. Moreover, young people are a particularly vulnerable population to sexual and reproductive health problems because despite the fact that they are initiating their sexual and reproductive lives, they encounter difficulties in being informed and equipped with the skills and resources to have a responsible and healthy attitude in their transition towards adulthood. These difficulties, linked to cultural beliefs on reproduction, sexuality and gender, often mean that young people are not included as a beneficiary group in programmes and projects.

Some of the main health problems faced by the young population are the high number of unwanted pregnancies in adolescents, abortions in poor conditions; the high rate of VIH/AIDS infection among young people, who accounted for approximately 50% of infections last year and STIs in general; the risks for women's health caused by early marriage and pregnancy and the psychological and physical effects of female genital mutilation, an operation that is usually performed immediately before adolescence, among others.

Paragraph 7.44 of The Programme for Action of the International Conference on Population and Development that was held in Cairo (1994) states that there is a need to "address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group".

In order to commence this task, it is fundamental to "acknowledge young males and females as individuals that are enabled, with rights and key participants in their own development" (Greene and others, 2002: 6). On the other hand, their sexual and reproductive health needs should be met from a "propitious environment", with the transmission of information and the transmission of ability, the ability of young people to adopt responsibilities for their health and their relationships. In any particular project, the following must be taken into account:

- Determine the key areas for promoting the sexual and reproductive health of young males and females.
- Promote sexual education and aptitudes for life, encouraging equality between the genders as a method of reducing sexual and reproductive risks. For example, gender inequalities explain the sexual intimidation of young females and the unsafe sexual practices that are often considered to be manifestations of "masculinity" among young males.
- Increase the awareness of parents, educators, health care providers, community leaders, politicians, religious leaders and older people on the importance of the health of young males and females.
- Strengthen the laws that provide for the elimination of discrimination and sexual abuse. More specifically, guarantee that pregnant adolescents continue in the educational system and support for laws regarding minimum marriage age.
- Involve young people in all stages of the project and adapt the services and rules to their special needs.
- Actively involve fathers and mothers and families insofar as they exercise a crucial influence on the sexual attitudes and behaviour of young people.
- Set up networks with organisations that work in attending young males and females.

Source: Internal, on the basis of Greene (2002) and WHO, UNFPA and UNICEF (1997)

CHART III

Participative techniques for sexual and reproductive health programmes

The participation of the population is a fundamental element in ensuring that a project is feasible and has permanent effects in time. However, there are many degrees of participation that may be addressed in a programme, from the merely symbolic presence of the population to active participation throughout its life cycle (See Table 3).

Table 3. Participation Ladder

8	**Programme started, developed and run by the group. Decisions made by other institutions.**
7	**Programme started, developed and run by the group. External agents introduce modifications in the project.**
6	**Programme started by external agents and decisions shared with the group.**
5	**The group is informed and consulted.**
4	**The group is informed on the decisions that are made on an external basis.**
3	**Symbolic participation, appearance.**
2	**'Decorative' or 'showroom' participation.**
1	**Manipulation of the group.**

Source: Adapted from Arnstein, S.R. (1969) "Eight rungs on the ladder of citizen participation" in Cahn Citizen participation: effecting, community changes. Editorial Praeger Publishers, New York.

How is it possible to promote participative processes in a sexual and reproductive health programme? We shall now take a look at three participative techniques that can facilitate the participation of the population in identifying, planning, following up and assessing programmes.

Source: Garay (2001) and Geilfus (199/).

Brainstorming

This is one of the most useful methods for generating ideas and is useful in analysing the causes of problems and exploring possible alternative interventions.

Steps for performing this technique:

1. Select between 10 and 12 people with knowledge and experience on the subject.
2. Introduce the dynamic with an open-ended question on the subject at hand.
3. Write or visualise the question.
4. Participants have to express all their ideas on cards (one per card, maximum 3 lines). Those that are better able to write help the others.
5. The facilitator collects all of the cards, shuffles them and puts them on the board, reading each one out loud. No cards are eliminated.
6. The cards that express the same idea are grouped together. No card leaves the board unless there is consensus.
7. The cards that deal with directly related ideas are grouped together.
8. The decision on what work to be done with the result is made. Depending on each case, there is a new brainstorming procedure on each of the items that arose. Analysis and prioritisation exercises.

Dialogue with working groups or nominal group technique

Work is done with a small group of people, between 7 and 10 people who are directly involved in the problem under study in order to find out the needs of the population and the possible lines of intervention.

Steps for performing this technique:

1. Establish an interview guide, with a maximum of 6 or 7 issues, on key subjects.
2. Select group members.
3. Explain clearly the objective of the working group. It is necessary to explain why it is being done, why the participants are selected, what the institution in charge is, how the information will be used and what actions may be expected.
4. Dialogue. The answers may be viewed on the board or using cards to stimulate discussion.
5. The information obtained should be compared to other sources: other dialogues, the results of other exercises on the same subject.

Dialogue with household members

Work is focussed on all of the members of a family unit. This technique is used when it is necessary to deal with issues related to life strategies and problems from the perspective of all the members of the family. Dialoguing with the family group guarantees a much more comprehensive vision than just consulting the head of the household.

Steps for performing this technique:

1. Establish an interview guide, with a maximum of 6 or 7 subjects, clearly summarising the fundamental points on which work is to be done.
2. Select the family group that is to be interviewed. The family groups should be representative of the different categories existing in the community.
3. Presentation; clear explanation of the objective of the interview. It is necessary to explain why the dialogue is being organised, what institution is in charge, how the information will be used, what actions may be expected. Select a time that is convenient for people and to ensure that all active members of the household are present (father, mother, sons and daughters that work).
4. Make sure that the answers of the various members are "triangled" and that the head of the family does not monopolise the answers. This is achieved by asking open-ended questions such as" could you tell me something more about this?"
5. The information obtained must be compared to other sources: other dialogues from other exercises on the same issue.

APPENDICES

APPENDIX I.
COMMITMENTS OF THE INTERNATIONAL COMMUNITY ON SEXUAL AND REPRODUCTIVE HEALTH

Conference	Commitments
International Labour Organisation (1952 and 2000)	Maternity Protection Convention (C103), came into force in 1952 and was revised in 2000 with a new convention (C183).
Alma Ata Conference (Alma-Ata, 1978) World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF)	Commitment to attain Health for all by 2000 from the comprehensive proposal of primary health care (PHC), including maternal and infant health care and family planning.
"Convention on the elimination of all forms of discrimination against women", CEDAW (1979) Committee on the Legal and Social Condition of Women, United Nations (UN)	Based on the United Nations Declaration on the Elimination of Discrimination against Women of 1967, this Convention defines what discrimination against women means and establishes a series of commitments in order to eradicate it. Link between health and family.
United Nations (UN) International Conference on Population and Development (Cairo, 1994)	Agreements on universal access to health care, information and services in the field of reproductive health for 2015 and on acknowledgement of sexual and reproductive rights.
Conference of Beijing (Beijing, 1995) Fourth World Conference on Women, United Nations (UN)	The right of women to enjoy the highest possible standard of comprehensive health throughout their life cycle.
Millennium Summit (2000) United Nations (ONU)	The Millennium Development Goals decided by consensus between the countries in the North and South are established and acknowledged by the main multilateral bodies. Goals related to sexual and reproductive health: 3. To promote gender equality and empower women. 5. To reduce the maternal mortality rate by three-quarters. Goal is related to child health: 4. To reduce child mortality rate by two-thirds.
Cairo +5 (1999) and Cairo +10 (2004)	Review of results and ratification of the agreements reached in 1994.
Beijing at Ten	Review and evaluation of the Beijing Platform for Action. Ratifies CEDAW, Cairo and Beijing and readapts the millennium goals according to Cairo and Beijing.

APPENDIX II.
AFRICAN STATES REPRESENTED AT THE CONFERENCES OF CAIRO (1994) AND BEIJING (1995)

African states represented at the Cairo International Conference on Population and Development (1994) which approved the Cairo Platform for Action.	African states represented at the Fourth World Conference on Women (1995) which approved the Beijing Platform for Action.
Angola	Angola
Algeria	Algeria
Benin	Benin
Botswana	Botswana
Burkina Faso	Burkina Faso
Burundi	Burundi
Cape Verde	Cape Verde
Cameroon	Cameroon
Chad	Chad
Comoros Islands	Comoros Islands
Congo	Congo
Ivory Coast	Ivory Coast
Djibouti	Djibouti
Egypt	Egypt
Eritrea	Eritrea
Ethiopia	Ethiopia
Gabon	Gabon
Gambia	Gambia
Ghana	Ghana
Guinea	Guinea
Guinea-Bissau	Guinea-Bissau
Equatorial Guinea	Equatorial Guinea
Libya	Libya
Kenya	Kenya
Lesotho	Lesotho
Liberia	Liberia
Madagascar	Madagascar
Malawi	Malawi
Mali	Mali
Morocco	Morocco
Mauritius	Mauritius
Mauritania	Mauritania
Mozambique	Mozambique
Namibia	Namibia
Niger	Niger
Nigeria	Nigeria
Central African Republic	Central African Republic

African states represented at the Cairo International Conference on Population and Development (1994) which approved the Cairo Platform for Action.	African states represented at the Fourth World Conference on Women (1995) which approved the Beijing Platform for Action.
Democratic Republic of Congo	Democratic Republic of Congo
Rwanda	Rwanda
São Tomé and Príncipe	São Tomé and Príncipe
Senegal	Senegal
Seychelles	Seychelles
Sierra Leone	Sierra Leone
South Africa	South Africa
Swaziland	Swaziland
Tanzania	Sudan
Togo	Tanzania
Tunisia	Togo
Uganda	Tunisia
Zambia	Uganda
Zimbabwe	Zambia
	Zimbabwe

APPENDIX III.
GENDER ANALYSIS IN SEXUAL AND REPRODUCTIVE HEALTH [17]

Gender analysis is a key instrument in implementing gender mainstreaming in a programme or project. The aim of this analysis is to identify the social structures and processes that contribute to maintaining the inequality existing between men and women. We shall now list the steps that can be of help in a sexual and reproductive health programme. Each one of the steps indicated may be addressed in groups with the beneficiary population and the personnel in the organisation.

1. **Profile of men's and women's activities: roles and analysis of how time is distributed.** The aim is to address the various roles and jobs that are performed by men and women in society in order to gain a better understanding of the causes of the poor sexual and reproductive health indicators presented by women. In this first step, the following questions must be answered:

   > Who does what?

   > For how long?

   > Where?

   > When?

   > With whom?

   > Are these tasks acknowledged and valued in society?

   > How do the tasks affect the sexual and reproductive health of men and women?

   > How much time is dedicated to self-care?

   A distinction must be made between reproductive, productive and community work. The first of these refers to care and maintenance of the home and its members; the second refers to the production of goods and services intended for sale and consumption and the third to the collective organisation of social events and services.

2. **Access to and control of resources and benefits.** By means of the study of various places (the home, the community, the market and the state), gender analysis outlines the barriers that women confront in developing their right to sexual and reproductive health under equal conditions to men. These barriers may be related to rules, customs, obligations, resources, benefits, jobs and roles and decision-making power. In this case, the main questions to be answered are as follows:

   > Who makes the decisions in the home? On what issues?

   > Who decides on how income and food are distributed?

   > Who in the home decides when it is necessary to visit the doctor and which means of transport is used?

   > Who buys and sells at the market? Is there a difference between the commercial activities of men and women?

[17] For further information on gender analysis, see Sojo and others (2002) and López y Sierra (2001).

> Are there specific limitations for men and women regarding access to credit, transport of goods, negotiation when deciding prices?

> Who decides on issues that affect the community?

> Does the State promote rules that impose barriers on certain groups, women, regarding specific issues in the community? For example, are contraception policies only aimed at married couples?

3. **Identification of the needs and interests of men and women.** Men and women, as we have already stated, present different health patterns for biological and cultural reasons. The programme must address the specific needs of both. The following items must be reviewed:

> What differences exist in the health profiles of men and women?

> What do women need?

> And what do men need?

> What needs does the project identify (practical or strategic needs)?

> How are they identified?

In identifying needs, a distinction must be made between practical needs, of an immediate nature and which arise from daily obligations, and strategic needs, which are "focussed on reducing the inequalities that lead to deteriorated health, the autonomy of one's own body and the will to experience greater physical and psychological wellbeing" (Sojo and others, 2002: 139).

4. **Participation of men and women.** Gender analysis allows us to identify the unequal power relationships that limit the participation of women in development programmes in order to promote equalitarian participation by both sexes. We must ask ourselves the following questions:

> Who participates in the programme?

> To what degree, where, with whom, how, when and with what objective in mind?

> What control will the participants have over the result of the programme?

5. **Ability of organisations in charge to work with a gender perspective.** It is also fundamental for the organisation in charge of the programme to have integrated the gender perspective in its policies and among its personnel. Increasing the awareness of the personnel in charge is the first step towards working in the area of sexual and reproductive health. The question to be asked is:

> Have the organisations in charge integrated gender policies in their policies, structure and culture?

APPENDIX IV.
THE MAIN GENDER-SENSITIVE INDICATORS IN SEXUAL AND REPRODUCTIVE HEALTH

A gender-sensitive indicator is one that considers the main factors that promote inequality in the sexual and reproductive health of men and women. We shall now go on to explain a series of gender-sensitive indicators that can be of help in designing, following-up on and assessing sexual and reproductive health programmes.

Often, the data on these indicators will not be available and it will be necessary to build a registration system and adapt the indicators to the specific reality of the African context. In order to adapt the indicators or create new ones, one must clearly define what is to be measured and then do so with the highest possible degree of detail and clarity, considering both the variable to be measured and the specific characteristics of the area.

General indicators

1. **Life expectancy at birth, according to sex.**Defined as the mean number of years that the newborn would live if all of the years of life of the cohort to which they belong were equally divided among their components.

2. **Global fertility rate.** Defined as the mean number of children that each woman in a hypothetical cohort would have at the end of her fertile period, who, during the reproductive stage (15 to 49 years), had the fertility according to the age of the study population and was not subject to mortality between birth and the end of her fertile period.

3. **Percentage of the health budget destined to sexual and reproductive health.**

4. **Percentage of the population with access to sexual and reproductive health services according to sex.**

5. **Existence of sexual and reproductive health associations.**

6. **Number of women and men on decision-making bodies, on a percentage basis.**

7. **Percentage of women and men in the formal job market.**

8. **Time dedicated to unpaid tasks, per sex.**

9. **Indicator of the inclusion of sexual and reproductive education in the education process.** Mention of the existence of sexual education in official syllabi, at what level of the educational system and for how many school-days.

10. **Percentage of women and men in education system in levels: primary, secondary, tertiary or university.**

Complications in pregnancy, childbirth and the postpartum period

1. **Reproductive risk rate:**
   This includes adolescent fertility, the prevalence of the use of contraception, prenatal care, assistance at childbirth provided by skilled personnel, anaemia in pregnant women, prevalence of HIV/AIDS infection in adult women, prevalence of HIV/AIDS infection in adult men, abortion policy, global fertility rate and maternal mortality rate.

2. **Main causes of maternal mortality.**

3. **Main diseases suffered by men and women of fertile age.**

4. **Proportion of women of fertile age (15-49 years) that suffer anaemia.**

5. **Family nutrition levels and food distribution, differentiated according to sex and age.**

6. **Percentage of women with access to health care services, according to age.**

7. **Percentage of women that belong to health care personnel.**

8. **Percentage of pregnant women with health care monitoring during pregnancy and with health care assistance in the event of complications.**

9. **Percentage of births attended by qualified personnel:**
   Births attended at health care services, divided by the total number of births recorded in the vital statistics, by 100.

10. **Access to post-partum services:**
    Number of women, out of every 100, that visit the doctor after childbirth.

11. **Registered number of voluntary pregnancy terminations.**

12. **Young female fertility indicator:**
    Number of births of mothers under the age of 20 years divided by the total number of women aged between 14 and 19 years, by 1,000.

13. **Number of pregnancies and spacing between births.**

14. **Paternal co-responsibility indicator:**
    Father's participation in the hardest tasks. For example, in looking for water.

15. **Women's participation in the institutions and political organisations that work in the area of sexual and reproductive health.**

16. **Maternity protection policies and percentage of women protected per sector of activity (salaried women working for third parties, according to employment sectors). Percentage of unprotected women per sector of activity (self-employed workers, according to employment sectors).**

Gender-based violence

1. **Existence of associations to support the victims of gender-based violence.**

2. **Inclusion of awareness and prevention of abuse in the educational process.**

3. **Physical and/ or psychological assistance to the victims of gender-based violence from health care services.**

4. **Indicator of sexual violence against people.**
   Number of women and girls that are victims of sexual violence (rape and sexual abuse) and who reported this violence during the year, divided by the total number of women of all ages, by 100.

   Number of men and boys that are victims of sexual violence (rape and sexual abuse) and who reported this violence during the year, divided by the total number of men of all ages, by 100

5. **Psychological damage indicator.**

6. **Indicator of morbidity associated with women's ill-being.**

7. **Indicator of suicides and attempted suicides by women.**

8. **Indicator of non-fatal injuries, including psychological and social damage and deaths from intrafamily violence:**
   Number of women and girls that are victims of non-fatal injuries due to intrafamily violence, divided by the total number of women of all ages, by 100, and the number of women and girls that have died from intra-family violence, divided by the number of women and girls that have died by homicide, by 100.

9. **Indicator of legal sanctions on violence against women:**
   List of laws with specific penal actions against intra-family violence, sexual harassment, rape, sex trafficking.

10. **Number of women that are the victims of violence.**
    Number of women that are the victims of violence in the year, divided by the total number of women.

    Health care records (clinical histories) must contain the history of abuse: time, duration, psychological, physical, sexual and social damage caused throughout the life of the woman that is the object of the abuse.

Contraceptive practices

1. **Rate of use of contraception among men and women:**
   Number of adult women (generally between the ages of 15 and 49 years) that use some type of safe contraception, divided by the total number of women in this age group, by 100.

   Number of adult men (generally between the ages of 15 and 49 years) that use some type of safe contraception, divided by the total number of men in this age group, by 100.

2. **Access to and attendance at contraception information services, according to sex and age.**

3. **Indicator of the inclusion of education on contraception in the educational process and aimed at young people, women and men.**

4. **Degree of knowledge of the various contraceptive techniques, according to sex.**

5. **Ideal number of children expressed by men and women compared to the total number of children.**

STIs. The case of HIV/AIDS.

1. **Rate of variation in the number of people registered as infected by HIV/AIDS, according to sex:**
   Number of women registered with HIV/AIDS in the last year, divided by the number in the previous year, by 100 and the number of men registered with HIV/AIDS in the last year, divided by the number in the previous year, by 100.

2. **Proportion of cases of HIV/AIDS in adults**
   Number of cases of HIV/AIDS registered and accumulated, according to sex and over a particular age limit (for example, 15 years old), compared to the total population in this age bracket, by 100.

3. **Proportion of cases of HIV/AIDS in pregnant women aged between 15 and 24 years of age.**
   Number of cases of HIV/AIDS in pregnant women aged between 15 and 49 years of age recorded in a period (for example, one year), divided by the total number of pregnant women cared for in the same period, by 100.

4. **Percentage of men and women that use condoms in all sexual relations with penetration, according to age.**

GLOSSARY

- **PRIMARY HEALTH CARE:**
  Strategy characterised by the fact that it is supported by practice, scientific evidence, the needs evinced by the population and the social and economic conditions of the country from a comprehensive perspective of the various health problems. PHC constitutes in the health care system the first element of continued health care and promotes the preventative, curative and rehabilitating services.

- **SEXUAL AND REPRODUCTIVE RIGHTS:**
  These are fundamental human rights regarding the free exercise of sexuality in safety, physical and emotional pleasure, free sexual orientation, free choice of the number of children to have, maternity protection and other aspects. These rights were defined as such at the Cairo Conference (1994).

- **GENDER INEQUALITY:**
  The lack of equality derived from relationships between men and women in which the latter are placed at a disadvantage to the former due to social and cultural conceptions regarding the distribution of power.

- **EDUCATION FOR HEALTH (EfH):**
  Strategy supported by educational and informative activities designed to extend the population's knowledge of health and to develop the understanding and personal skills that promote health and participation in decision-making on policies and at all levels.

- **EMPOWERMENT OF WOMEN:**
  Strategy that promotes the process by which women, on an individual and collective basis, become aware of how power relationships operate in their lives and gain the self-confidence and the strength needed to change the gender inequalities in the home and in the community and at national, regional and international levels. A full definition of empowerment includes cognitive, psychological, political and economic components, all of which are interlinked.

- **GENDER:**
  This term identifies socially constructed characteristics which define and relate to the spheres of what it means to be male or female and what they do, within specific contexts. Gender refers to the network of cultural symbols, regulatory concepts, institutional patterns and subjective elements of identity that differentiate the sexes via a process of social construction, while also articulating them within the power relationships over resources and decisions.

- **GENDER MAINSTREAMING:**
  A strategy that places issues related to equality between the genders at the centre of the most important political decisions, institutional structures and the allocation of the most relevant resources, including the points of view and priorities of men and women in making decisions on the processes and objectives of development.

- **GENDER RELATIONSHIPS:**
  The type of social relationships that are determined by people's gender and which create differences in the relative position of men and women on an individual basis in each context.

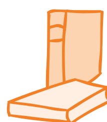
  The relative position is expressed as a set of reciprocal rights, obligations and responsibilities, which are dynamically interlinked and therefore susceptible to change. If the political, economical or political conditions change, the rights and responsibilities that delimit the spheres of action of men and women are redefined in accordance with the changes.

- **SEX:**
  Identifies the biological differences between women and men, which are perceived as universal and unchangeable.

- **SEXUAL AND REPRODUCTIVE HEALTH:**
  Comprehensive approach for analysing and meeting the needs of men and women as regards sexuality and reproduction.

ABBREVIATIONS AND ACRONYMS

- **PHC:** Primary Health Care.
- **DAC:** Development Aid Committee.
- **CEDAW:** Convention for the Elimination of All Forms of Discrimination against Women.
- **ICPD:** International Conference on Population and Development.
- **EfH:** Education for Health.
- **FPFE:** Spanish Family Planning Federation.
- **UNFPA:** United Nations Population Fund.
- **GAD:** Gender and development.
- **STIs:** Sexually transmitted infections.
- **WID:** Women in development.
- **OECD:** Organisation for Economic Co-operation and Development.
- **MDG:** Millennium Development Goals.
- **ILO:** International Labour Organisation.
- **WHO:** World Health Organisation.
- **UNAIDS:** The Joint United Nations Programme on HIV/AIDS.
- **PAI:** Population Action International
- **UNDP:** United Nations Development Programme.
- **AIDS:** Acquired Immunodeficiency Syndrome.
- **UNIFEM:** United Nations Development Fund for Women.
- **HIV:** Human Immunodeficiency Virus.



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