PROJECT REPORT

MANAGING REPRODUCTIVE HEALTH
WITH A GENDER PERSPECTIVE

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Marie Stopes International (MSI) was established in London in 1976 and grew out of the organisation originally set up by Dr Marie Stopes in 1921. In 1977, MSI set up its first overseas centre in Ireland and a year later set up a programme in India. Today, the MSI Global Partnership provides sexual and reproductive health information and services to 3.3 million people worldwide in 38 countries across Africa, Asia, Australia, Europe, Latin America and the Middle East.

Each Partner (country) programme is a non-government organisation that is locally registered, managed and staffed. The London Support Office provides capacity building, technical assistance and support to all Partners and there are also offices in Brussels, Melbourne, Tokyo and Washington DC.

Teams in each country benefit from access to knowledge built up over more than 26 years and follow the same high standards of training, information and service provision. To maintain these standards, all operations are governed by a set of clinical, financial and management protocols that were developed from best practice within and outside the Partnership. Experience and expertise is shared among the Partnership and capacity is built through a programme of exchange visits, training programmes, mentoring systems and regional and international workshops.
“Baby! My husband said, that as long as you have the ability, keep producing children (all laughed), children would serve the motherland. My two sons died in war (crying) and my husband says children help their parents.”

[Illiterate woman, age-50, children-8, district Kapisa, Afghanistan]

“In Afghanistan more right belongs to men, and women’s idea isn’t important, and the man likes large number of children.”

[Education – 5th grade, Woman, Age-30, Children-5, District Bamiyan, Afghanistan]

These experiences are not unique to Afghanistan women. Instead, they speak to women’s general lack of control over their sexuality and reproductive health. These expressed needs exist despite the availability of health services, modern medical technology and the overall improvements in maternal morbidity and mortality statistics.

These realities thus urgently call for a gender analysis in respect to reproductive health. It also takes into account how factors of social class, race, education and other socio-cultural factors interact with gender to produce discriminating impact on men and women’s reproductive health. Gender analysis is crucial to distinguish between biological causes and social explanations for the health differentials between men and women, and to understand that these gaps are outcomes of the unequal social relations between men and women, and not merely due to consequences of biology.
RELATION BETWEEN GENDER PERSPECTIVE AND REPRODUCTIVE HEALTH

The term gender refers to the manner in which roles; attitudes, values and relationships affecting women and men are socially constructed throughout the world. Almost inevitably, these gender constructs have functioned in such a way that they subordinate and discriminate against women to the detriment of their ability to exercise their reproductive rights. A gender perspective is a vision that promotes gender equality in policies and practices as well as women’s participation in decision-making about their sexual and reproductive health.

Gender is one of the most important factors to consider in designing, managing, and delivering reproductive health services. Yet gender may also be the least understood characteristic in terms of how women’s and men’s health needs differ and how those differences can best be addressed. In a country like Afghanistan, gender significantly influences a person’s ability to access health services.

In Afghanistan the difference in power relations between men and women may, for example, determine whether women can purchase or use a contraceptive, and therefore, how vulnerable they might be to an unintended pregnancy or sexually transmitted infection. Or, attitudes towards “masculinity” may result in some men continuing sexual practices that affect their own health and endanger the health and lives of their families.
Reproductive health and gender issues are closely related. Synergy exists between reproductive health and issues of women’s and men’s participation, empowerment, equity and human rights. Human rights and dignity include the core of reproductive health programs: the rights to establish a family, decide freely and responsibly the number and spacing of children, and have access to health information, education, and care.

Gender inequity profoundly affects those rights when it limits contraceptive use and choice. In countries, like Afghanistan, traditional gender roles often deny women control over their own sexual decisions, and create pressures that compel some men to undertake risky sexual behaviors. This form of inequity has serious health implications because of the increased risk of unwanted pregnancies and sexually transmitted infections (STIs), particularly HIV/AIDS.

By promoting an understanding of the links between gender roles and health, health programs and service providers can help providers of both sexes to take appropriate action. Local realities of reproductive behaviors, family structure, and gender relations need to be acknowledged and dealt with, for they can undermine the effectiveness and sustainability of a program reproductive health services that do not address gender biases and obstacles lose valuable opportunities to reduce inequities, to contribute to positive relations between women and men, or to achieve service objectives. While managers and providers are aware of these truths, they may not always know how to organize and offer services that reflect a gender perspective.
MEN AND WOMEN ROLES VIS-À-VIS REPRODUCTIVE HEALTH

“I am compelled to have more children because, if I don’t have more, my husband will take another wife. When it comes to family planning decisions, the right to decide lies with my husband, he must be informed and he must be satisfied.”

[Young Woman, Age-25, Education-8th grade Children-2 (1 miscarriage), District- Qargah, Afghanistan]

In Afghanistan, traditional male and female roles deter couples from discussing sexual matters, and may even encourage risky sexual behavior. Ultimately they contribute to poor reproductive health for both men and women. In traditional families where women play subservient role and men have the authority to make critical decisions without consulting their wives, there may be little or no discussion of sexual activity, fertility, contraceptive use, and limited access to health information and services, finances, transportation and other resources. Or when traditional attitudes and expectations about masculinity prevail, men may be encouraged to have multiple sex partners and expose them – and their partners—to risks of a disease. A gender perspective prompts attention to these patterns and ways to build constructive relations between men and women.
In reproductive health, such as contraceptive use and family planning, women lack decision-making power to negotiate about sex, childbearing and contraception as husbands assume sexual access and control. While a husband can, and often does, refuse to use contraceptives despite his persistent sexual demands, women find themselves caught in their conflicting roles as solely responsible for family planning, and at the same time are expected to be sexually available to their husbands. In Afghanistan, women still need their husbands’ approval before they can go out to seek medical treatment or health care. Or, when they do arrive at the hospital, there are numerous medical procedures that require their husbands’ signatures. Thus, it is clear that gender roles and male-female power relations rather than biology that underpin women’s health and well-being.

The roles men and women play should guide the ways in which the clinic staff assess their clients’ needs and provide care. Awareness of the conditions existing between men and women, and the adoption of appropriate responses can help women and men to improve their health and advance in life, and can enrich the quality of life in their communities.

Health providers, program managers, policy makers, and donors are increasingly aware that gender is a critical element in the design, management, and implementation of reproductive health programs, and ultimately in the success and impact of these programs. Reproductive health services that meet both women’s and men’s needs will encourage use of those services and promote sound reproductive decisions.
NEED FOR GENDER PERSPECTIVE IN MANAGING REPRODUCTIVE HEALTH SERVICES.

“I can tell you strongly that Islam doesn’t let people use them (contraceptives) because our prophet says that to increase Islam's followers and in the judgment day our prophet will be proud of his obedient followers. So when I tell my wife that she has to have more kids, she is left with no choice.”

[Young Man, Age-32, Profession – Clerk, Children-5, Mini Clinic – Kabul, Afghanistan]

In Afghanistan, despite advances, great discrepancies persist between women and men. In many places, most women are still marginalized. Their status—economic, social, and, political—has hardly changed, and women often receive far fewer of the benefits from socio-economic development than do men. The inequities make women more vulnerable to health risks. They are less likely to receive the right services and treatment. Women are more important to their families and communities than ever before, as socioeconomic pressures increase throughout Afghanistan. Community health programs, like Marie Stopes Afghanistan, are in the best position to deliver services that help close the gender gap in health, as a key to generating benefits in other areas of life for both men and women.
DEVELOPING THE CONCEPT OF A GENDER APPROACH FROM AN NGO PERSPECTIVE

Much of the major debate on women’s issues among NGOs during the past few years has focussed on moving from a ‘women-centred’ approach to a ‘gender’ approach particularly in the context of their contribution to development. Reproductive health has been one of the most recent issues to be approached in this way. The NGO Symposium *Health for All women and men: a gender perspective*, held in Geneva in October 1997, recognized that:

. . . the concept of gender refers to women’s and men’s roles and relationships which are shaped by social, economic, political and cultural factors rather than by biology. Gender, moreover, is a dynamic concept which examines the nature of these roles and relationships between women and men in the context of the perspectives and beliefs of society. These socially constructed roles and relationships have a direct bearing on the health and well being of both sexes. A gender perspective helps identify the inequalities between women and men which in the field of health can lead for both to increased illness or death from preventable causes. A gender approach to health examines how gender differences determine access to benefits and the way in which technology, information, resources and health care are distributed. It provides the foundation for maximizing human resources in development because the result of equal access to resources, benefits and opportunity to all will be a more enlightened, educated, healthy and independent society. Society as a whole will therefore be better placed and equipped to contribute to development. On the contrary the denial of opportunity and access to benefits and resources to women who make up more than half the world’s population will continue the inadequate use of this valuable human resource.
AREAS WHERE GENDER PERSPECTIVE COULD HELP IMPROVE MARIE STOPES AFGHAISTAN’S SERVICES

➢ Improving the satisfaction of both female and male clients with the way in which they are received and cared for;

➢ Improving provider practices, including communication and clinical skills;

➢ Using gender-relevant information to establish policies, set goals, develop strategies, and organize and evaluate operations;

➢ Strengthening management systems that support gender-sensitive services, including human resources, logistics, and information management;

➢ Encouraging men to develop responsibility in respecting women’s reproductive rights.
METHODOLOGY TO EVALUATE QUALITY OF CARE FROM A GENDER PERSPECTIVE AT MARIE STOPES AFGHANISTAN

The methodology consists of six tools, and is designed to be flexible in its implementation. Each tool answers specific questions regarding quality of care from a gender perspective. The tools can be used either at a sample of the clinics, or at all of them. Although it is recommended that the methodology be implemented in its entirety, the institution may choose to use only those tools that are most relevant to the issues it wishes to address. Implementation of the methodology could potentially take as little as two weeks, if the tools are used simultaneously. Based on the intensity of its use, the methodology could also take somewhat longer to implement. The tools can be applied in any order, as time and the availability of personnel permit.

The methodology is most useful when implemented in such a way that the resulting recommendations can be incorporated into the next planning cycle. It can be used at any time in the life of a program and can even serve as a baseline study prior to the initiation of gender-related activities. Thus, it can serve both as a needs assessment and a baseline to measure, program objectives and activities.
GENDER ANALYSIS PANEL

THE EVALUATION TEAM

The evaluation team is a key component of the evaluation process. The team functions as the core group of individuals who are responsible for the successful and timely execution of the study. They must have the skills necessary to implement the methodology effectively and in the end they must provide the greatest insight into the analysis of the results. It is very important that the team have the support of someone with decision-making capacity within the institution.

The ideal evaluation team will consist of a gender specialist, an evaluation specialist and experienced interviewers. The skills and characteristics of the team should include:

- gender-related expertise (preferably external to the organization);
- a combination of qualitative and quantitative research skills;
- familiarity with the reproductive health program being assessed;
- decision-making capacity within the organization; and
- interviewing skills.

The actual composition of the team will vary depending on the skills base within the organization and the availability of external consultants with various mixtures of skills. It is recommended that there be three to five persons on the team. Each team member will play a special role and have specific tasks to complete.
Gender Specialist

The gender specialist has the overall function of maintaining a gender perspective throughout the entire research process. One of her primary tasks is the document review where she critically examines policy statements to determine the level of gender equity in institutional policy and practices, and examines all IEC materials to determine coverage of specific topics and the use of language and images promoting positive messages about women. The gender specialist also ensures that the gender perspective is incorporated into the observations and interviews. If staffs are hired for these tasks, the gender specialist assists in training the observers and interviewers to ensure their awareness of gender issues and how they may manifest themselves in an observation or interview. The gender specialist should be involved in as many of the observations or interviews as she feels necessary to ensure that the gender perspective is being incorporated by the observers/interviewers. This will aid in the identification of difficulties that may arise while implementing the evaluation in the given location. While most of the team should be part of the institution, it is highly recommended that the gender specialist be a person external to the institution. An external gender specialist will be able to see gender-related issues that may not be apparent to those directly involved in the institution. The gender specialist should be someone actively involved in gender-focused programs or research.
Evaluation Specialist

The evaluation specialist keeps a skilled eye on evaluation issues. This person may call on other evaluation personnel inside or outside the institution, but is the person ultimately responsible for calculating sample sizes, selecting samples, training the observers and interviewers and tabulating the questionnaire results. The team evaluation specialist should maintain continual communication with the observers and interviewers to make sure the methodology is correctly implemented and should review completed questionnaires as they come in to ensure the collection of high-quality data. Like the gender specialist, the evaluation specialist should be involved in the observations and interviews to ascertain any difficulties the team may be encountering throughout the application of the methods.

Interviewers and Observers

The primary task of the interviewers and observers is to carry out the methodology correctly. They communicate with the gender and/or evaluation specialist about any difficulties encountered as part of the process. Other tasks may include preparing materials for the Analysis Workshop and participating in the workshop itself.
Team Coordinator

Depending on availability and skills, the team coordinator can either be the gender specialist, the evaluation specialist or the institutional decision-maker on the team. The coordinator is responsible for developing a work plan in consultation with the team and ensuring that all tasks related to the evaluation are completed. The coordinator also liaises with the executive director and with the clinic director. The coordinator handles any necessary negotiations about how the methodology will be implemented, keeping in mind the needs and purpose of the evaluation. The coordinator will serve as the troubleshooter if there is an issue that other members of the team are unable to resolve. A regular meeting time should be established for the team to touch base and bring to the coordinator’s attention any difficulties encountered. Finally, the coordinator is responsible for preparing the final report, with input from team members.

INSTITUTIONAL INVOLVEMENT

Various members of the institution will be involved in implementing the study, particularly in completing administrative and logistical tasks. The clinic director(s) (or other appropriate person) will be key to scheduling the clinic-based evaluation activities and facilitating the cooperation of staff. The clinic director(s), along with other designated staff members, will actively participate in the Analysis Workshop. The executive director will assist when needed to ensure the proper implementation of the methodology. There should be continuous communication between the evaluation team and the institution.
OVERVIEW OF THE STUDY COMPONENTS

This evaluation methodology consists of six instruments that, taken together, assess quality of care from a gender perspective. This complementary qualitative and quantitative approach has been found to provide a useful assessment of the degree to which gender issues have been incorporated into service provision. Each component of the methodology has its own purpose, unit of analysis and procedure.

1. Observation I: Physical Aspects of the Clinic.

This tool is an observation of the clinic itself, and is performed once for each clinic being assessed. The focus of the clinic observation is (1) the general physical organization and upkeep of the clinic; (2) the privacy afforded by the consultation and counseling areas; and (3) the availability and visibility of educational materials.

2. Observation II: Client Reception.

Observation II is an evaluation of the interaction between the clinic and its clients in the reception area. A sample of at least 25 women is observed from the time they enter the clinic until their consultation or counseling sessions begin. Key aspects of the observation are (1) reception of the client; (2) comfort of the waiting area; (3) activities for the client and children while they wait; and (4) general attention to the needs of the client and her children by clinic staff during the waiting period.
3. Observation III: Consultation and Counseling.

This tool is an observation of client-provider interactions during medical consultations or counseling sessions in order to determine the general care received by the client, information conveyed to the client by the provider and how the provider addresses the client throughout the consultation/counseling session. Once the screening form identifies a woman as eligible to participate, she must agree to be interviewed (a consent statement is included in the manual). It is imperative that interviewers record the number of women invited to participate and the number of women who refuse to be interviewed. All of the observations take place in the clinic, and at least 40 women should be observed in their consultations/counselling sessions.

4. Client Exit Interview

This interview provides information about the client's experience in the clinic. At least 100 women are interviewed as they exit their reproductive health consultation or counselling session, and are asked their opinions about access, waiting times, topics discussed, interpersonal relations with the provider, overall comfort and other issues. A tally is kept of women invited to participate and the number of women who refused to participate. Interviewers should not be directly affiliated with the clinic, and each interview should be conducted in a private area at the clinic in order to maximize the client's comfort and sense of confidentiality.
5. Service Provider Interview

The purpose of this interview is to assess the service provider’s perspective on the role of the institution in reproductive health, the role of the provider within the institution and the role of the provider as a conduit of the institution’s mission. These three roles are explored within a gender perspective framework. More specifically, service providers are asked about the existence of mechanisms to obtain input and suggestions by staff and clients, and the content of consultations or counseling sessions. Only staff members who have worked at the clinic for at least one year are eligible to participate. At least two individuals from each category of staff working directly with patients (i.e. doctor, nurse, counselor, etc.) should be interviewed, for a total of no more than 24 interviews.

6. Document Review

The document review portion of the methodology is a two-pronged approach to determining the extent and quality of the integration of the gender perspective into the policies and structure of the organization. This method requires the use of an individual not affiliated with the organization, preferably a local gender specialist, for successful implementation. It is imperative that the executive director work with the reviewer to obtain the required information and institutional documents. The first portion of the document review is to be completed with the help of the executive director and the director of personnel. This section covers written institutional policies regarding gender issues, and institutional personnel practices. The second portion is a critical review of the educational materials used by the organization. The reviewer examines the materials for the use of inclusive language and the use of language and images that are discriminatory or non-discriminatory to women.
CONCLUSION

This report has concentrated on the differences between men and women, exploring the impact of gender on reproductive health and reproductive health care. It has identified existing gender inequalities in reproductive health care and mapped out a methodology, which serves as a needs assessment for gender analysis and also as a baseline to measure program objectives and activities. Indeed, women’s lack of control over their bodies, inequalities in reproductive health status between men and women, and the absence of gender sensitivity in women’s treatment in reproductive health care, and requirement of mainstreaming a gender perspective in dispensing of reproductive health care are the major women and health concerns that require urgent, systematic and global intervention and change in Afghanistan.

Embarking on this study indicates a commitment; both to excellence in family planning service delivery and to helping women improve their lives.

Once the program at Marie Stopes International (Afghanistan), has adopted a gender perspective and mainstreamed gender into its services the obstacles will not simply disappear. The program director and the staff will need to continue to be alert to the external environment and internal culture, structure, and systems that can support or undermine the efforts.