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MAINSTREAMING GENDER IN THE HEALTH SECTOR: PREVENTION OF GENDER-BASED VIOLENCE AND MALE INVOLVEMENT IN REPRODUCTIVE HEALTH

Myra Betron and Lucía Fort

Background

Over the past decade, the prevention of gender-based violence¹ and male involvement in reproductive health have come to be viewed as key to advancing the fight against poverty. Research and experience have demonstrated that both issues are crucial to the objectives of gender equality, the reduction of maternal mortality and mitigating the spread of HIV/AIDS, among other important development indicators. In fact, a 1993 World Bank study showed that the global health burden from gender-based violence, domestic violence and rape in particular is comparable to other diseases and risk factors already recognized in the global agenda, including obstructed labor, HIV, maternal sepsis and tuberculosis (See Figure 1).

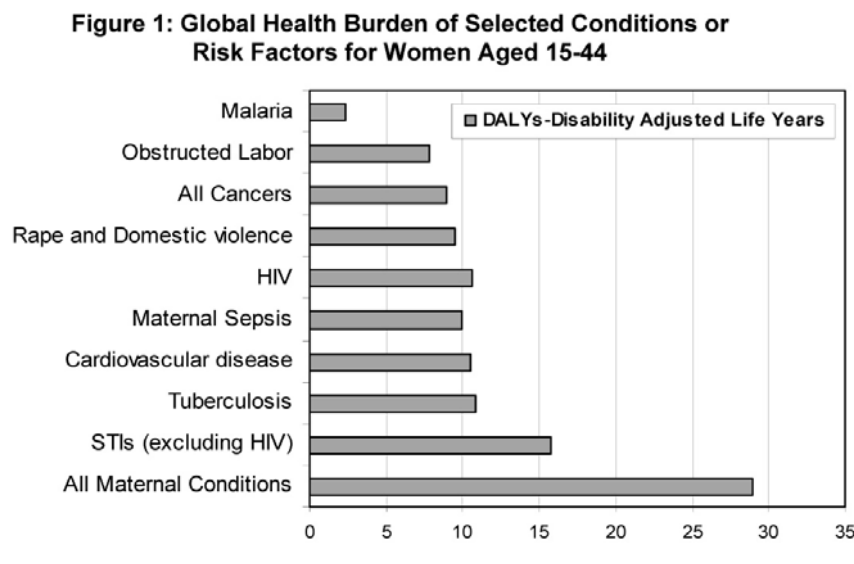
Studies have also shown the negative economic impact of gender-based violence. For example, in Nicaragua in 1995, the estimated value of lost productivity from both paid work and unpaid work, as well as the foregone value of lifetime earnings for women who died as a result of violence was estimated to be

US\$ 32.7 million or 1.6 percent of GDP (Morrison and Orlando in WHO, 2004).

Men's role in improving their own health and that of their families and the importance of addressing the gender inequities underlying poor reproductive health also cannot be denied. Family planning and reproductive health issues have traditionally been seen as concerns for women, and reproductive health programs traditionally focus on women. Although common sense dictates that men play an important role when it comes to reproductive health, Ministries of Health in developing countries almost always have special maternal health or women's health divisions, implicitly reinforcing the notion that reproductive health concerns only women. Recent findings, displayed in Box 1, underscore the fact that men not only have their own reproductive health concerns but significantly affect the

reproductive health of women. Men often decide whether women will receive medical care, as demonstrated by anecdotal evidence from various technical assistance activities of the World Bank's Latin America and the Caribbean Region's (LCR) Poverty and Gender Group.

Sexual and Reproductive Health (SRH) practitioners and scholars have recently begun to recognize



Source: World Bank. (1993), cited in Heise et al, 1994

Box 1: Sexual and Reproductive Health Practices of Latin American and Caribbean Men²

- Between 28 percent and 59 percent of unmarried sexually experienced men aged 15–24, and 37–65 percent of those aged 25–39, have had two or more sexual partners in the past year.
- Among married men aged 25–39 (including those in consensual unions), 12–36 percent have had intercourse with someone other than their wife in the past 12 months. These proportions decline to 8–22 percent among married men between 40–54 years of age.
- Between 39 and 68 percent of men aged 15–24, and 65–85 percent of those aged 25–54, did not use a condom at last intercourse.
- Between 15 percent and 39 percent of men 25–54 years of age want no more children or want to delay their next child, but are not protected by contraceptive use (their own or their partners’).

Source: Alan Guttmacher Institute. 2003. *In Their Own Right: Addressing the Sexual and Reproductive Health Needs of Men Worldwide*. New York: Alan Guttmacher Institute.

that men actually play a key role in the improvement of women’s SRH, and what’s more, have their own SRH needs apart from that of women. After the 1994 International Conference on Population and Development, governments, non-governmental organizations (NGOs), and community programs around the world began to implement SRH programs that more fully incorporate men.

The World Bank Takes Action through PROSALVAR

The Bank has hosted various conferences to address issues of male involvement in reproductive health and gender-based violence, yet no projects in the World Bank’s portfolio have directly addressed either topic.¹ Recent gender-related work in the World Bank’s health projects in Latin America has made evident the limited capacity of health personnel and communities to integrate men into family planning and reproductive health programs or to respond effectively to domestic violence cases.² Midwives at women’s birthing centers in Nicaragua, for example, have been challenged with trying to convince men who oppose family planning of the economic difficulties of raising large families.³ Moreover, sheer lack of knowledge and capacity prevents health providers from screening for and providing proper treatment to gender-based violence survivors.

The Integral Health Project for Men and Women, or PROSALVAR as it is commonly known, was designed to help build a response to these apparent gaps in healthcare projects in the LCR through pilot activities in three Highly Indebted Poor Countries: Bolivia, Honduras and Nicaragua. Financed by the Bank-Netherlands Partnership Program, the project’s main objectives were to build the capacity of

staff in health care centers and hospitals to effectively screen for intra-family violence and refer victims to appropriate services, and to better educate and involve men in sexual and reproductive health. As a pilot project, PROSALVAR also sought to help the Bank better understand its operational role in preventing and responding to gender-based violence and in promoting the male involvement agenda. The project worked to achieve these objectives through:

- Development of a guide to orient health personnel on how to detect intimate partner violence (IPV) in the health setting and provide appropriate care for IPV survivors;
- Two-day trainings of health personnel on the use of the guide;
- Development of a training manual and model on topics related to sexual and reproductive health for men;
- Application of the training model among health personnel in two-day workshops in the three countries to promote the involvement and increased knowledge of men in sexual and reproductive health;
- Design and implementation of social marketing information and education campaigns to raise community awareness about the role of men in sexual and reproductive healthcare;
- Learning events to exchange best practices and lessons learned by each project among staff, participants and World Bank staff.

The project contracted regional experts, each with more than ten years experience on gender-based violence and male involvement in reproductive health, to develop the training materials for Nicaragua and Honduras. The regional experts worked, in turn, with local trainers to help them become familiar with the material to subsequently train the health personnel in a series of two-day workshops in each country. In Bolivia, given the distinct socio-cultural milieu, the training differed slightly in that trainings on gender-based violence were preceded by a session covering the basics of the issue and the component on male involvement in reproductive health was designed by local experts on masculinity and health.

Results on the Ground

PROSALVAR was much more modest than traditional World Bank projects both in terms of time and money invested. The design and implementation was completed in a year and a half with extremely limited resources. Still, the project was able to achieve noteworthy results.

In La Paz, **Bolivia**, despite the challenges of working in a fragile political state (at times paralyzed by citizen demon-

strations), the project was able to train 196 health providers on screening and care for IPV and held workshops on the basics of gender-based violence for 376 members of the community, including health workers, municipal officials, police and NGOs, as well as 290 health providers on masculinity and sexual and reproductive health. Applying a social science model that sought to break down stereotypes related to masculinity that are detrimental to health, the project increased awareness among health providers and staff in the Ministry of Health, which now has plans to develop protocols to attend to male clients particularly in the area of sexual and reproductive health.

In *Honduras*, despite limited experience in the project's focus areas at the start of the intervention, the project produced a profound effect. Most notably, all health centers in the metropolitan health region of Tegucigalpa are now required to screen for intimate partner violence among women seeking reproductive healthcare. The project trained a total of 203 health providers in the metropolitan area of Tegucigalpa. Moreover, the sustainability of these reforms seems to be ensured by the incorporation of the production of screening guidelines and forms into the budget of the health region. The Secretary of Health has already demonstrated commitment to scaling up efforts, and interest by other donors is making it a real possibility.

In the health regions of Masaya and Jinotega in *Nicaragua*, the project trained 222 health providers on detection and care for IPV survivors and 213 health providers on male roles in sexual and reproductive health. The strong tradition of civil society's participation in development coupled with the history of inter-institutional collaboration to address violence against women in Nicaragua facilitated the inclusion of NGOs and other institutions, such as the police, in the training workshops. This multi-institutional and multi-sectoral representation, along with Nicaragua's relatively advanced system of response to IPV, resulted in a rich exchange of information and collaborative planning on how to improve a multi-sectoral coordinated response to violence against women. Both sets of trainings resulted in plans of action to be carried out by participants that involved follow-up training for colleagues and others in the community.

Lessons Learned

Community participation models are especially effective when addressing issues related to gender but take time to adapt. Not only do they help diffuse and reinforce change in attitudes by reaching a wider audience, but participants also appreciate being actively involved in discussions and learning, as demonstrated by the experience in Nicaragua. However, a community participation model cannot simply be imposed upon communities that have little experience with it. In Honduras, for example, where community-driven development is a newer concept, finding ways to

incorporate the lessons of the male involvement model was more challenging. Although one of the goals was to train health providers in health centers to reach out to the community and increase male demand of SRH services, an impact evaluation of the project in Honduras found that doctors participating in the training workshops still consider the fact that men do not seek health services as a barrier to involving men in SRH services.⁴ This continued resistance implies a need for broader reforms that deploy healthcare workers in the community to address SRH. Future activities could also help these community health workers in finding ways to incorporate male involvement in SRH into their work.

A systemic approach to reforming services for victims of IPV is essential for long-term sustainability. Reproductive health programs addressing IPV in recent years⁵ have found that the most effective way to improve health services to better address IPV is through a systemic approach, or system-wide reforms (See Box 2). In the case of PROSALVAR in Bolivia, the lack of support for the incorporation of IPV services by upper management, which also should have been involved in the trainings, made clear the need for a systemic approach. In Honduras, although upper management enforced new policies that require health providers to screen for IPV, the resulting increased caseload of IPV victims threatens to overburden family counseling units to which the victims are referred.⁶ More holistic reforms should ensure adequate norms, policies and resources to allow health providers to effectively apply the knowledge acquired in the trainings.

Box 2: What a Systemic Approach to Reform Involves

Reforms involving a systemic approach to improving IPV services typically include:

- Changes in norms, policies and protocols;
- Infrastructure upgrades to ensure private consultations, training all staff (including managers) on screening of IPV, safety planning for victims, and provision of emotional support;
- Strengthening of referral networks with other IPV services; and,
- Increased availability of emergency services, such as Sexually Transmitted Infections (STI) prophylaxis and emergency contraception.

Source: Bott, Sarah, Andrew Morrison and Mary Ellsberg. 2005. Preventing and Responding to Gender-Based Violence in Middle- and Low-Income Countries: a Global Review and Analysis. World Bank Policy Research Working Paper No. 3618.

Linking IPV and male involvement in SRH components allowed for some breakdown of prejudices of proponents of these sometimes opposing camps. Many working in the field of intimate partner violence (also known as violence against women, as women are the most frequent victims) often view the male involvement field as a threat to already meager resources for women's programs, and tend to focus on male involvement more as a method to address IPV. The project has helped widen that perspective to include other reproductive health issues, like HIV/AIDS and family planning. In Honduras, where the men's health program had been totally isolated from the Department of Mental Health that traditionally handles IPV, the project helped mainstream the issue as a public health problem rather than stigmatizing it as a "mental health" issue. In fact, studies consistently show that IPV is a learned behavior with grave reproductive health and human rights impacts, which the project helped bring to the attention of primary staff in the health ministry.

Changing norms, attitudes and behavior related to gender does not happen overnight.

Training on gender-based violence and male involvement in sexual and reproductive health involves a process of changing deeply entrenched social and cultural gender norms, which certainly cannot be done through a two-day workshop. Unless projects and programs invest adequate amounts of time and money, activities that seek to change behavior (and perhaps even attitudes) with respect to gender norms may be doomed to failure. Recent interventions' research has shown that "sensitization on gender," or the process of unlearning gender stereotypes, requires continual reiteration perhaps for as long as six months.¹ Nonetheless, whereas many initiatives hardly move beyond theoretical discussions of gender, PROSALVAR was able to identify and test concrete actions that health providers can use to address both issues, and to make evident the need for such attitudinal and behavioral change.

Overall, PROSALVAR was able to raise awareness of the implications of intimate-partner violence, IPV, and about stereotypes and myths related to gender norms and masculinity, especially with respect to reproductive health. The project made some initial steps toward incorporating the issues of gender-based violence and male involvement, namely raising awareness. This awareness-raising prompted change in some actions, especially when reinforced with changes in policies and protocols by manag-



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ers and health officials, but greater investment in both time and money are necessary to achieve sustainable impacts.

Notes

- ¹ In 1993, the United Nations General Assembly defined violence against women as "Any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering for women, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or private life."
- ² Data are from seven countries in LCR: Bolivia, Brazil, Dominican Republic, Haiti, Mexico, Nicaragua and Peru.
- ³ Male Roles in Adolescent and Reproductive Health, June 10, 1998 and The Development Implications of Gender-Based Violence, November 9, 2004.
- ⁴ The PROGENIAL program in Central America provided support for gender mainstreaming in World Bank projects in various sectors, including health, and contributed to the body of knowledge on gender issues faced in health.

- ⁵ Ruiz-Abril, unpublished.
- ⁶ ESA Consultores. (2005) "Evaluación del Proyecto PROSALVAR en Honduras: Capacitaciones en Masculinidad y Salud Reproductiva". Unpublished final report submitted to the World Bank.
- ⁷ See for example, Bott, Sarah, Alessandra Guedes, and Ana Guezmes. The Health Service Response to Sexual Coercion/Violence: Lessons from IPPF/

WHR Member Associations in Latin America. In: *Non-consensual Sexual Experiences of Young People in Developing Countries: A Consultative Meeting, New Delhi, September 2003*. Conference Proceeding. Population Council and Family Health International.

- ⁸ ESA Consultores. (2005). "Evaluación del Proyecto PROSALVAR en Honduras: Capacitaciones en Violencia contra la Mujer". Unpublished final report submitted to the World Bank.
- ⁹ Pulerwitz, Julie, Gary Barker, and Márcio Segundo. 2004. "Promoting healthy relationships and HIV/STI prevention for young men: Positive findings from an intervention study in Brazil," *Horizons Research Update*. Washington, DC: Population Council.

About the authors

Myra Betron, a Consultant in the Poverty and Gender Group of the LCR, was in charge of organizing and coordinating the PROSALVAR project in the field. Lucía Fort is a Senior Gender Specialist in the Poverty Reduction and Economic Management Unit and Regional Gender Coordinator for the Latin America and Caribbean Region of the World Bank.