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# **GENDER MAINSTREAMING WORKSHOP**

**USAID/ARMENIA AND PROJECT NOVA**

**July 11-13, 2006**

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**GENDER MAINSTREAMING WORKSHOP  
FOR  
USAID/ARMENIA,  
PROJECT NOVA AND PARTNERS  
YEREVAN, ARMENIA**

**July 11-13, 2006**

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## ACRONYMS

ADS	Automated Directive System
AED	Academy for Educational Development
ANC	Antenatal Care
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CPH	Community Partnership for Health
CTO	Cognizant Technical Officer
EGAT	Economic Growth, Agriculture and Trade Bureau
FM	Family Medicine
FP	Family Planning
GBV	Gender-based Violence
HAG	Health Action Groups
IC	Infant Care
IGWG	Interagency Gender Working Group
IQC	Indefinite Quantity Contract
MCH	Maternal and Child Health
MDG	Millennium Development Goals
NGO	Non-Governmental Organization
NOVA	Innovations in Support of Reproductive Health ( <i>transliterated Armenian acronym</i> )
PHC	Primary Health Care
PHCR	Primary Health Care Reform
PLP	Population Leadership Program
PMP	Performance Monitoring Plan
STI	Sexually Transmitted Infection
STTA&T	Short-term Technical Assistance and Training
TDY	Temporary Duty
TMF	Tapping Resources Project ( <i>transliterated Armenian acronym</i> )
TOT	Training of Trainers
USAID	United States Agency for International Development
WID	Women in Development

## **INTRODUCTION**

Between July 4 and 15, 2006, the USAID Office of Women in Development (EGAT/WID) collaborated with USAID/Armenia and Project NOVA to provide a two and a half day gender training workshop for USAID/Armenia's health projects and associated NGO and Ministry of Health staff.

The purpose of the workshop was to enhance the gender integration skills of Project NOVA (in Armenian, "Innovations in Support of Reproductive Health"), the Eye Care Project, AED (Academy for Educational Development), PHCR (Primary Health Care Reform), and World Vision staff and local counterparts. The expected outcome of the workshop was to improve the capacity of USAID/Armenia-funded Project NOVA staff and counterparts to analyze the gender dimensions of reproductive and child health services and to develop concrete actions to integrate gender into programmatic activities. The workshop helped participants to recognize the importance of gender analysis in development policies and programs, and to improve the integration of gender analysis findings into program and policy planning, implementation, monitoring, and evaluation.

In addition, the consultant conducted a two-hour session for USAID Mission staff on the requirements for gender integration in the USAID Automated Directive System (ADS), and on priority gender issues in Armenia. She also worked with the Project NOVA Monitoring and Evaluation Team to integrate gender considerations in their Performance Monitoring Plan (PMP).

The workshop was facilitated by Deborah Caro, of Cultural Practice, LLC, under the Short-term Technical Assistance and Training (STTA&T) Task Order of the WID Indefinite Quantity Contract (Contract Number: GEW-I-01-02-00019-00) held by DevTech Systems. She worked with Jina Sargizova, a gender expert and Project Coordinator of the NGO Center in Armenia. Iren Sargsyan, the Project NOVA Gender Advisor, also contributed to the design of the training and will be responsible for overseeing the implementation of commitments that emerged from the workshop. Project NOVA provided all local support for the training venue, translation of materials, interpretation during the workshop, and other logistics.

## **BACKGROUND**

The Mission saw the training as an opportunity to operationalize its commitment to gender as a cross-cutting issue in program components and project activities. The Armenian government and civil society attribute many of the gaps in the reproductive health status of its population to gender inequalities. The Mission believes that it is critical to have an informed understanding of the gender implications of these issues in order to seek the most effective interventions to address these gaps.

During the tenure of the PRIME II Project in Armenia, under which IntraHealth implemented a successful pilot program (2002-2004) to address gender-based violence (GBV) within the reproductive health sector, staff and local stakeholders gained valuable experience and understanding of gender issues. Funds were not available to continue the program, but the project is committed to integrating gender aspects – including GBV – across all project activities.

Project NOVA had specified gender training of its staff and partners as a deliverable under the project. USAID requested the assistance of EGAT/WID through STTA&T Task Order to launch the project's effort to foster a better understanding of gender issues in reproductive health in Armenia and to integrate gender components across all current and future project activities in a structured and systematized way.

## TRAINING PROCESS

### Day One:

The training followed the basic structure of the gender integration module currently used by both STTA&T and the Interagency Gender Working Group (IGWG) health trainers. The framework and the exercises for the training program are included in Appendix I. The first day began with a focus on gender concepts and the rationale for addressing gender in programs. In the first exercise, the participants broke into groups to discuss their ideas about what characterizes Armenian men and women. Two groups focused their discussion on women, one on rural women and the other on urban women. Two other groups focused on men, one in rural areas, and the other in urban centers (see page 17).

The second exercise involved participants in writing their associations with the word “gender” on cards (see page 18). Jina Sargizova wrote the contents of the participants’ cards on one of three flip charts denoting elements, factors leading to change, and outcomes. Once the contents of all the cards had been fully explored conceptually, Deborah Caro used the words on the flip charts to weave together a definition of gender. She then compared this definition to some of the gender-related definitions contained in the packet of written materials prepared for the trainees.

A follow-on exercise involved distributing cards, half of which had characteristics associated with sex, and half with characteristics associated with gender. Participants roamed around the room, trying to find matched opposites. The pairs then went to the front of the room to place their cards on flip charts marked “sex” or “gender.” As they placed their cards on one side or the other, they stated why they belonged where they placed them (see page 18).

The afternoon session commenced with a “Vote with your Feet” values clarification exercise (see page 19), using three statements to stimulate discussion. Each statement was read, in turn, to the participants, who then had to decide if they agreed or disagreed with it. The participants volunteered their reasons for their decisions and a lively discussion ensued. The three statements were:

- Men will feel threatened if too many women are in leadership positions.
- Women naturally make better parents.
- If there were more male contraceptive methods available, men would be more interested in participating in family planning.

Except for the last statement, the participants were fairly evenly divided on the issues. The leadership question was a contentious issue, as it touched on capacity, opportunity, and acceptability of women as leaders. The debate about women as better parents mostly revolved around whether mothering was an innate or learned capacity. The final statement produced considerable consensus that the issue was not lack of contraceptive options for men, but rather the widely held belief that contraception was women’s responsibility.

The afternoon proceeded with a more in-depth discussion of the concept of gender and its importance for health programs. During the presentation, we reviewed some of the basic concepts discussed in the morning and the rationale for gender mainstreaming in the health sector. This led into a presentation and discussion on the Gender Analysis Framework, facilitated by Deborah Caro.

After the presentation, the participants broke into five groups to apply the Gender Analysis Framework (Matrix I) to a case study of three Armenian villages (see Exercise 5 on page 20). Each group analyzed one domain in the Framework, except the last group, which covered domains five and six. The groups worked for about 45 minutes to identify information from the case study that was relevant to their assigned domain.

The groups presented their findings on the case study in plenary. Other participants and the facilitators offered questions and feedback on the findings to improve the participants' understanding of how to optimally apply the Gender Analysis Framework.

#### Day Two:

The second day began with a fun exercise to question the inevitable and exclusive association of particular qualities and traits with men or women. Jina Sargizova asked each participant to select an M&M candy to eat. She then told them that overnight a new pill had been invented to make both men and women pregnant and give birth within five minutes. During the five minutes prior to birth, the participants had the opportunity to select the sex of their babies, which would be the only children they would have in their lifetime. She asked each participant to state the sex he/she had selected and to say why. She wrote the answers down on the flip chart and then counted how many boys and how many girls. There were twice as many boys as girls. A short discussion ensued about the implications for the society of such a skewed sex ratio in the population. As a second part of the exercise, Jina read off the qualities that the participants had associated either with boys or girls in justifying their baby's chosen sex. She then asked if the quality was associated with a boy, a girl, or both. The participants concurred that most qualities were associated with both boys and girls, thus questioning some of their original assumptions.

The participants spent the rest of the morning on Matrix Two (see page 27) to analyze which of the gender issues they had identified from the case study was either a gender-based constraint or opportunity for project objectives. Each group worked on two domains, identifying gender-based constraints and opportunities as well as activities to address them. In the last column of the Matrix, they assessed whether the activities also addressed gender inequalities. The groups did an excellent job in the analysis and demonstrated a more sophisticated understanding of the categories of the Gender Analysis Framework than they had on the first day.

The afternoon began with the Gender Integration Strategies Continuum (page 33). The focus of the exercise was to help participants understand that there are different ways to address gender that range from strategies that exploit differential power to achieve desired health outcomes (gender exploitative) to strategies that aim to transform gender inequalities in the process of achieving better health outcomes (gender transformative). An intermediate strategy (gender accommodating) accommodates existing gender differences without intentionally reinforcing unequal distribution and exercise of power. The participants broke into pairs to read through six different project descriptions. Two pairs read the same descriptions independently of one another and then placed them on the continuum. A fourth designation, gender-blind, was reserved for projects that had not considered gender issues at all in the design or implementation. There was lively discussion about the placement, especially when there was disagreement within or between pairs.

The afternoon of Day Two continued with a presentation by Dr. Mary Khachikyan of the For Family Health Association of Armenia. She presented the results of a recently completed adolescent sexuality and reproductive health survey. The findings were used to develop a gender integrated strategy for increasing reproductive health knowledge among youth by using Matrix Three, Gender Integration in the Program Cycle (page 34). The process entails identifying relevant information on gender relations and identities, pinpointing constraints and opportunities, and then, based on this information, developing gender-integrated objectives, activities, and indicators. The process was facilitated in plenary with the understanding that the participants would apply it to their own program activities the following day.

An exercise on action planning (page 35) initiated the participants' work on their project activities. They divided into three groups around Project NOVA Program Areas to identify concrete steps they would take in the next few months to apply the knowledge and skills gained through the workshop to their work in Project NOVA, or their own projects.

Area 1:	Improving reproductive and child health knowledge and skills for rural primary care providers and providing basic medical equipment and supplies to support program activities.
Area 2:	Developing the capacity of regional health managers to improve the management, quality and supervision of rural facilities.
Area 3:	Accelerating the momentum of reform in the health delivery system to be more responsive to the reproductive and child health needs of the population.
Area 4:	Increasing consumer demand for high-quality services through community education and mobilization activities.

Areas Two and Three worked together. The Action Plans developed by the groups focused on concrete changes that they intended to make in project implementation as a result of the workshop to address gender issues they believed were affecting effective implementation of the project (see *Outcomes* on page 8).

Day Three:

Jina Sargizova began the day with a brief presentation on the Armenian Government’s international and national commitments to gender mainstreaming. Armenia has signed the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and committed to implementation of specific policies through the national action plan. She summarized the assessments conducted by the CEDAW committee in 1997 and 2002 and the government’s response. The participants stated that it was very important to hear this information and to understand both the Armenian Government’s position on gender as well as the USAID requirements in the ADS.

The participants spent the rest of the morning applying the three matrices to their programs, (i.e., Matrix 1: gender analysis and data collection; Matrix 2: analysis and activity planning; and Matrix 3: gender integration into the program cycle). The results are summarized in the “Outcomes” section below. Upon completion, the Program Area groups shared their results in plenary. All three presentations stimulated passionate discussion about how existing gender roles and responsibilities shaped the proposed adjustments to the program and how gender roles and responsibilities might be affected by their proposals.

The workshop concluded with an evaluation and the distribution of certificates by Janean Martin, the USAID Cognizant Technical Officer (CTO) for Project NOVA.

**OUTCOMES, COMMENTS, AND NEXT STEPS**

This section of the report presents the results of the participants’ application of the gender analysis and integration tools to Project NOVA. It presents their proposals and a concluding commentary section on issues they should consider and ways to move forward with their proposals.

The participants started to identify concrete steps for integrating gender into the different programmatic areas of Project NOVA during the action planning segment of the training. They developed the ideas in more detail and made sure that they were based on a sound analysis of gender relations extant in the Program Areas during the third day of training. While the plans are still preliminary, they do provide a basis for implementing specific activities in the regions where the project is currently working, especially for Program Areas One and Four. The proposals developed by the combined group for Program Areas Two and Three are longer-term and will require a combination of additional gender analysis, coherent policy formulation, and advocacy for successful implementation.

## OUTCOMES

### Area One –Skill Improvement (Participants- Gohar P., Hovh, Lilit, Alla-Knarik, Sofik)

Steps 1 and 6 Project objectives, intermediate objectives, and results	Step 2 Types of data to be collected – what do we need to know about whom?	Step 3 Gender-based constraints and opportunities to achieving objectives and results	Step 4 Activities and interventions that reduce gender-based constraints and take advantage of gender-based opportunities	Step 5 Indicators to measure gender (removal of constraints or building on opportunities) and health impacts of interventions
<p><u>Original project objective:</u> <i>To improve maternal and childcare clinical skills</i></p>			<p><u>Original Project Activities:</u></p> <ol style="list-style-type: none"> <li><i>To involve representatives of both sexes in trainings</i></li> <li><i>To prepare nurses for community work</i></li> </ol>	<p><u>Original project indicators:</u></p> <ol style="list-style-type: none"> <li><i># of primary health care providers(PHC) trained in RH/MCH<sup>1</sup> disaggregated by type of provider and sex</i></li> <li><i># of PHC providers performing to quality standards of clinical performance in ANC, IC, FP and STI<sup>2</sup> by type of care and type of provider</i></li> </ol>
<p><u>Revised or additional gender-related project objectives:</u></p> <p><i>To improve providers’ maternal, child, and men’s reproductive health care skills</i></p>	<p>[Fill in with case study data from gender analysis data collection <u>Matrix 1</u>]</p> <ol style="list-style-type: none"> <li><i>Data on health providers (disaggregated by sex)</i></li> <li><i>Data on local population (disaggregated by sex)</i></li> </ol>	<p>[Fill in with case study data from gender analysis <u>Matrix 2</u>]</p> <ol style="list-style-type: none"> <li><i>Male physicians do not participate in counseling trainings/few men are participants in training</i></li> <li><i>Male clients will not seek care from women doctors (who are most of the doctors at PHC)</i></li> </ol>	<p>[Fill in with case study data from gender analysis <u>Matrix 2</u>]</p> <ol style="list-style-type: none"> <li><i>Prepare educational module on men’s reproductive health for physicians and nurses</i></li> <li><i>Conduct training on men’s reproductive health for healthcare providers</i></li> <li><i>Publish materials on men’s reproductive health</i></li> </ol>	<p><u>Revised gender-related project indicators that measure improvement in gender equity:</u></p> <ol style="list-style-type: none"> <li><i># of referrals for men’s reproductive health problems</i></li> <li><i># of PHC providers performing prostate and cancer screening according to quality standards</i></li> <li><i># of consultations for men’s reproductive health concerns</i></li> </ol>

<sup>1</sup> RH: Reproductive Health, MCH: Maternal Health Care

<sup>2</sup> ANC: Antenatal Care, IC: Infant Care, FP: Family Planning, STI: Sexually Transmitted Infections

<sup>8</sup> Gender Mainstreaming Workshop  
USAID/Armenia, Project NOVA

### Areas Two and Three - Management and Policy

(Participants: Gohar J., Lusine, Zara, Marina Ohanyan, Krin Garielyan, Sonya, Karina, Marina Vardanyan)

DOMAIN	GENDER-BASED CONSTRAINT	ACTIVITY TO ADDRESS CONSTRAINT
Access	<ul style="list-style-type: none"> <li>Incompleteness of legislation</li> <li>Lack of motivation</li> </ul>	Development of reproductive health program for men
Knowledge, Beliefs, and Perceptions	<ul style="list-style-type: none"> <li>Lack of knowledge among decisionmakers</li> <li>Lack of knowledge among managerial staff</li> </ul>	Overcoming obstacles in the process of implementation of reproductive health program for women <ul style="list-style-type: none"> <li>Family Planning vs. Obstetrics/Gynecology</li> </ul>
Practice	<ul style="list-style-type: none"> <li>Non-proportionality in the number of health providers is a result of socio-economic situation in the Republic of Armenia, but not of discrimination</li> <li>There are more female students in medical universities than male students</li> </ul>	Development of protocols <ul style="list-style-type: none"> <li>Gender-sensitive protocols</li> <li>Skills for management of reproductive health care of women and men</li> <li>Organization of reproductive health care of women and men               <ul style="list-style-type: none"> <li>Separate rooms (or)</li> <li>Different reception hours for women and men</li> </ul> </li> </ul>
Time & Space	<ul style="list-style-type: none"> <li>Yerevan vs. marzes</li> <li>PHC level – 4 hours + 2 hours [Women don't have time to occupy the more time-intensive administrative positions in Yerevan]</li> </ul>	
Rights & Legal Status	<ul style="list-style-type: none"> <li>Equity and equality [Men are not interested in occupying lower-level administrative and clinical positions in the marzes because of low pay. Fewer young men go into medicine than young women because of the low pay]</li> </ul>	“Positive discrimination” <sup>3</sup> for boys in medical universities [e.g., tuition incentives to study medicine and salary bonuses to go to rural areas]
Power	<ul style="list-style-type: none"> <li>Decisionmakers are mostly men</li> </ul>	

<sup>3</sup> Jina Sargizova pointed out that the term “positive discrimination” is conventionally used for addressing historic inequalities rather than the situation described whereby men choose not to work in low-paying positions. The assumption is that they choose to do that from a position of power rather than of subordination.

<sup>9</sup> Gender Mainstreaming Workshop  
USAID/Armenia, Project NOVA

**Area Four- Demand and Community Mobilization**

(Participants: Varvara, Anush, Sofik, Anahit, Heghine, Gohar Gh., Natalya, Guram, Yura, Arthur, Iren)

DOMAIN	GENDER-BASED CONSTRAINT
Access	<p>There are insufficient health service sites.                      Health clinics lack medicines and the infrastructure is inadequate.                      Doctors are mostly women (men will not visit a female doctor).                      Supervisory doctors do not make regular visits.                      Men do not have access to health care.                      Nurses lack knowledge and skills to attend to the different reproductive health care needs of men and women.</p>
Knowledge, Beliefs, and Perceptions	<p>Men lack knowledge of reproductive health, maternal health, child health, childcare and hygiene, family planning, and STI prevention.                      Knowledge and responsibility for health care is considered to be women's concerns, not the concerns of men.</p>
Practice and Participation	<p>Women are too busy to find time to visit health posts.                      Women do not participate in community meetings where decisions about the health services are made.                      Men do not participate in health trainings because of stereotypes of counseling being women's concern.</p>
Time & Space	<p>Providers work irregular hours.</p>
Rights & Legal Status	<p>Women do not register births after delivery, do not sign relevant agreements, and as a result are deprived of their rights to children and property upon divorce.</p>
Power	<p>Women have no right to make decisions about their own and their children's health.</p>

**Area Four- Demand and Community Mobilization (Continued)**

(Participants: Varvara, Anush, Sofik, Anahit, Heghine, Gohar Gh., Natalya, Guram, Yura, Arthur, Iren)

Steps 1 and 6 Project objectives, intermediate objectives, and results	Step 2 Types of data to be collected – what do we need to know about whom?	Step 3 Gender-based constraints and opportunities to achieving objectives and results	Step 4 Activities and interventions that reduce gender-based constraints and take advantage of gender-based opportunities	Step 5 Indicators to measure gender (removal of constraints or building on opportunities) and health impacts of interventions
<u>Original project objective:</u> <i>To improve maternal and childcare clinical skills</i>			<u>Original Project Activities:</u>	<u>Original project indicators:</u>
<u>Revised or additional gender-related project objectives:</u> <i>To improve providers' maternal, child, and men's reproductive health care skills</i>	[Fill in with case study data from gender analysis data collection <u>Matrix 1</u> ] <i>Work with Health Action Groups (HAG) to improve reproductive health and child health care, and community health through gender mainstreaming</i>	[Fill in with case study data from gender analysis <u>Matrix 2</u> ] <ol style="list-style-type: none"> <li>1. <i>The provider works at home</i></li> <li>2. <i>Providers are women</i></li> <li>3. <i>Lack of educational materials and trainings</i></li> <li>4. <i>Gender stereotypes related to health care</i></li> </ol>	[Fill in with case study data from gender analysis <u>Matrix 2</u> ] <ol style="list-style-type: none"> <li>1. <i>Regulate the nurses' work schedule</i></li> <li>2. <i>Community outreach to change men's perspectives</i></li> <li>3. <i>Educate providers</i></li> <li>4. <i>Prepare educational materials to obtain distribution and usage</i></li> </ol>	<u>Revised gender-related project indicators that measure improvement in gender equity:</u> <ul style="list-style-type: none"> <li>• <i>Special work hours to attend men</i></li> <li>• <i>Visits by men and women recorded in registers</i></li> <li>• <i># of participants disaggregated by sex who attend thematic discussions</i></li> <li>• <i>Changes in attitudes and practices measured through sociological surveys</i></li> <li>• <i>Records on visitors to the health library disaggregated by sex</i></li> <li>• <i>Assessment of media participation</i></li> <li>• <i>Qualitative and quantitative assessment of discussions in schools</i></li> </ul>

## **COMMENTS ON PROPOSALS**

The proposal for Area One focused on how to address gender issues within the context of improving health care providers' knowledge and skills. The group identified two major constraints with regard to men's use of health care services. The first constraint focused on the lack of health care providers' knowledge of and interest in men's reproductive health issues. The second constraint focused on men's own lack of knowledge about reproductive health and their reluctance to seek care from female providers, regardless of whether they are nurses or physicians. The majority of health care providers in rural areas are female. The responses developed by the Area One group address providers' knowledge and skills (new training modules) and in a more limited way men's knowledge about their reproductive health (materials on men's reproductive health).

It is not clear how the group intends to interest male doctors in attending trainings that focus on counseling. The group may consider whether there would be more interest if the sessions were particularly focused on how to counsel male clients. The other issue that was not clearly addressed by the group is how to assist providers in engaging men's interest and participation, and in assuming greater responsibility for the health care of other members of their households, including their partners and children. Finally, is there a way to prepare female doctors to more effectively reach out to men in the community? In the short and medium terms it is unlikely that the proportion of providers who are male will change significantly. What other strategies might be successful?

The group working on Areas Two and Three presented important recommendations for revising policies to improve health care for both men and women, including changes in management skills, the organization of space and hours within clinics, and making protocols more gender-sensitive. Their presentation stimulated a heated debate about whether the only way to attract men to work in health care in rural areas was to offer salary bonuses and incentives beginning in medical school. The group analyzed the current situation and identified a number of gender-based constraints that segregated women in the lower-paying and less time-demanding rural administrative positions and men in the higher-paying but more time-demanding urban administrative posts.

Men are not interested in the rural posts because the low salaries do not allow them to adequately support their families and there are fewer opportunities in rural areas for working in private practice to supplement their income. Women generally do not occupy the higher-paying urban administrative positions because their household and childcare responsibilities do not allow them to work the long hours that these positions require. The group suggested that salary incentives might stimulate more men to work in rural areas, but did not propose any solutions to ease women's triple burdens of the household, employment, and children. The discussion during the presentation highlighted that the activities put forward by the group might be effective in overcoming a gender-based constraint, but did not adequately address inequalities of power based on gender.

The group for Area Four conducted the most thorough gender analysis of the three groups. They suggested several ways to achieve more equitable participation of men and women in health action groups. They also suggested educational activities aimed at changing gender-specific attitudes and behaviors associated with health care practices. For instance, they suggested that the practice of nurses working out of their homes was a constraint to both men and women seeking care, but for different reasons. Women do not feel comfortable approaching a nurse in her household for fear that a male relative might answer the door and thus be perceived by the woman as a gate keeper, or provoke her own husband's jealousy. A man, in turn, would be unlikely to approach a nurse in her home or clinic because he would be ashamed to discuss his health problems with a woman, especially in her home. They proposed regular clinic hours that were well publicized for overcoming the constraint for women, and educational outreach for men to overcome their reluctance to seek care.

This solution to increase women's access to health services overcomes one constraint, but does not overcome another constraint addressed by the group, which is women's lack of decision-making power. The work with men to change attitudes and current practice is a positive attempt to overcome both men's lack of access and to begin to make gender relations more equitable.

It is not possible to give a comprehensive appraisal of the proposed plans as much was lost between their presentation in the workshop and the abbreviated way they were recorded on flip charts. All of the plans require a more deliberative planning process that was not possible during the brief time available during the workshop.

### **NEXT STEPS**

A training over two and a half days serves as an introduction to gender issues and the application of a more analytical approach to addressing them. The expected outcome is that participants gain an appreciation of how gender relations affect health outcomes, how they can begin to identify ways to address gender within the context of their work, and how they can initiate some measures to track the impact of activities designed to address gender issues in their projects.

It is evident that there is considerable gender expertise in Armenia on which the project can draw under the direction of project Gender Coordinator, Iren Sargsyan, in order to further the process of gender integration. An important step will be to conduct a gender analysis in the new regions that Project NOVA will enter in the next two years. A more immediate step is to develop the plans elaborated during the training with more in-depth analysis and attention to whether they address gender-based constraints in a way that also addresses gender-based inequalities. Suggestions made by Deborah Caro to the Project NOVA Monitoring and Evaluation Team will also assist in tracking how gender affects the implementation and outcomes of the project. As the Area Teams move ahead with their gender integration plans they should discuss revisions to indicators with the Monitoring and Evaluation Team.

Finally, Deborah Caro had discussions with the Gender Team at Project NOVA and with the new Project Director and US-based Activity Manager about a recommendation to conduct a follow-on training for gender experts in Armenia. The focus of the workshop would be to develop expertise around the gender analysis and integration tools presented in the first workshop and to introduce the participants to additional qualitative participatory tools for gender analysis. This would contribute to building a cadre of experts that the USAID Mission and its projects could call on to conduct gender analyses.

## EVALUATION OF WORKSHOP

As a result of this workshop, to what extent do you believe that you have increased your capacity and skills to:	Self-evaluation N=23		
	Not at all	A little	A lot
Define and understand gender and related concepts and terms?	0	4 (17%)	19 (83%)
Identify the benefits of mainstreaming gender in programs and organizations?	0	7 (30%)	16 (70%)
Understand, use, and apply the gender analysis framework to your project or program?	0	5 (22%)	18 (78%)
Integrate gender into the different stages (steps) of the program cycle?	0	2 (8%)	21 (91%)
Identify different programmatic strategies, along the gender continuum, for addressing gender inequalities in programs?	0	4 (17%)	19 (83%)
Develop concrete actions to mainstream gender in your own work?	0	7 (30%)	16 (70%)

The evaluation of the workshop was very positive. A vast majority of the participants believed that their knowledge and skills had increased *a lot* in all categories. In response to a question on evaluating their knowledge before and after the workshop, the average qualification on a scale of 1 to 5 was 2.7 before and 4.1 afterward. Overall, participants said that their knowledge had increased and their understanding had improved greatly. Only one person said that he/she needed more time to understand the concepts. The areas in which they felt their knowledge had increased most are gender in health care and the community, gender analysis, understanding of gender terminology, theory, and project design from a gender perspective.

Over a third (seven) of the participants said that they found the group work most useful. Six people said that all components of the training were most useful. Three people mentioned the gender continuum strategies, and another two gender mainstreaming. Other topics mentioned were the gender analysis and gender integration of their own activities, work on constraints and opportunities, gender terminology, the case study analysis, the presentations, and all of the topics covered on the second day of training. With regard to the elements or components that were least useful, 16 said none. Others that were mentioned were lunch, breaks that were too short (three), a packed agenda, the gender continuum strategies, long discussions, and some unclear explanations.

In response to the question about how they anticipate applying their new knowledge, nine participants said that they would mainstream gender in their project activities. Another seven said that they would share what they had learned either with beneficiaries of their project or with other members of their organizations. Two people mentioned that they would like to organize awareness raising events or collaborate with the mass media to disseminate information on the importance of gender equality. Next steps mentioned by the participants included data collection, gender analysis, and integration of gender into the design of existing and new projects. Others discussed greater inclusion of men as participants and health care providers, advocacy, and revision of indicators.

Other comments included appreciation of the trainers, the workshop organization, the excellent interpretation, and the content of the training. The only criticism had to do with the length of the work day during the training.

## APPENDIX I: TRAINING MATERIALS AND EXERCISES

### Workshop Program

#### Mainstreaming Gender in Reproductive Health and Safe Motherhood Programs USAID Armenia and Project Nova

July 11-13, 2006

#### Day 1

- 8:30 – 9:30 Welcome and Introduction to Workshop
- 9:30 –10:30 **Exercise 1:** Gender Roles and Identities in Armenia -*What Makes a Man; What Makes a Woman?*
- 10:30-10:45 Break
- 10:45-11:45 **Exercise 2:** Developing a shared concept of gender
- 11:45-12:30 **Exercise 3:** Sex or Gender?
- 12:30 -1:30 Lunch**
- 13:30 – 14:00 **Exercise 4:** Vote with Your Feet
- 14:00 – 14:30 The Importance of gender mainstreaming to Reproductive Health and Maternal and Neonatal Survival, and Overview of USAID Gender Requirements and Guidelines (PowerPoint presentation)
- 14:30 – 15:30 Introduction to the Gender Analysis Framework (PowerPoint Presentation and Discussion)
- 15:30-15:45 Break
- 15:45-16:30 **Exercise 5:** Application of the Gender Analysis Framework to a Case Study - Work in small groups (Matrix 1)
- 16:30-17:15 Small group presentations in plenary (each group presents 1-2 domains)
- 17:15 -17:30 Wrap up for Day One

#### Day 2

- 8:30 – 9:30 **Exercise 6:** Do you Want a Boy or a Girl?
- 9:30 – 9:45 Introduction of the concepts of **constraints** and **opportunities**
- 9:45– 10:45 **Exercise 7:** Identification of key constraints and opportunities for accessing life-saving maternal health care (Matrix 2)
- Work in small groups
- 10:45-11:00 Break
- 11:00 – 12:30 Group presentations of Matrix 2 in plenary

<b>12:30 – 1:30</b>	<b>Lunch</b>
13:30 – 14:30	<b>Exercise 8:</b> Gender Continuum
14:30- 15:45	<b>Exercise 9:</b> Presentation of Gender Integration in the Program Cycle (Matrix 3) through real project (in plenary) with the collaboration of Dr. Mary Khachikyan, President of the For Family and Health Armenian Association
15:45 – 16:00	Break
16:00 –17:30	<b>Exercise 10:</b> Action Planning in Project Nova program area groups and presentations in plenary
<b>Day 3</b>	
8:30 – 9:15	The National and International Commitments of the Armenia Government to Gender Mainstreaming (National Plan, CEDAW, and MDGs)
9:15 – 10:30	Apply Matrices 1 and 2 to participants own projects in small groups
10:30 -10:45	Coffee Break
10:45- 11:30	Design or redesign an objective, set of activities, or indicators to incorporate a gender perspective (Matrix 3) in small groups
11:30- 12:30	Presentations by groups in plenary
12:30 – 1:00	Evaluation and Certificates

## **Exercise I: Gender Roles and Identities in Armenia - What Makes a Man; What Makes a Woman?**

Trainer's Notes (adapted from IGWG training in Mali on Men's Engagement):

- **Tell** the group that they are going to define, in the Armenian context, gender roles and identities, or “what makes a man a man” and “what makes a woman a woman in Armenia.”
- **Divide** the group into 4 small groups.
- **Tell** the groups that you want them to do the following:
  - ✓ Group one will define what make a woman a woman in a rural setting;
  - ✓ Group two will define what makes a man a man in a rural setting;
  - ✓ Group three will define what makes a woman a woman in an urban setting;
  - ✓ Group four will define what makes a man a man in an urban setting
- **Tell** the group to discuss it first, then brainstorm a list of the characteristics and roles.
- **Distribute** flip chart paper and markers to each small group.
- **Give** the groups 20 minutes for this exercise.
- **Begin** the exercise.
- **Check** in with the groups after 15 minutes to see how they've progressed. Determine if they need more time.
- After 20 minutes, **call** time.
- **Ask** each group to report out their findings.
- After the groups report out, **ask** the following:
  - ✓ What shaped your views of what makes a man a man and a woman a woman?
  - ✓ What do you think about the information shared?
  - ✓ What, if any, are the similarities between urban and rural women? Men?
  - ✓ What, if any, are the differences between urban and rural women? Men?
  - ✓ Were there any surprises?
  - ✓ Were there disagreements among members of your group on characteristics?
  - ✓ Do you think all of these characteristics are true?
  - ✓ Are there assumptions or stereotypes built in here?
  - ✓ Other comments
- **Explain** to the group that we often make assumptions about gender roles and identities, and such assumptions often guide the design of projects.
- **Say** that from the moment we are born, we receive a series of messages based on our sex. These messages define different limits and opportunities that shape men's and women's roles.

Note: At the end of day I and upon completion of Exercise One of the Gender Analysis Framework, ask participants to compare their findings with what they said in the morning during this exercise.

## Exercise 2: Developing a Shared Concept of Gender

### Training Notes:

- Ask the Group to write down a word or phrase they associate with the word *gender* on a card.
- The facilitator collects the cards and reads each one aloud.
- Write the contents of the participants' cards on one of three flip charts denoting elements, factors leading to change, and outcomes.
- Once the contents of all the cards has been fully explored conceptually, the facilitator crafts a definition using all the words on the flip charts.

## Exercise 3: Sex or Gender?

- As a follow-on exercise to Exercise 2, distribute cards of two different colors to the participants. Half of the cards have characteristics associated with sex, and half with gender. Cards should be prepared as pairs but do not write all sex-related terms on one color or all gender related terms on the other—mix them up.

<b>Sex</b>	<b>Gender</b>
Universal	Varies from place to place
Does not change over time	Changes over time
Can not be changed	Can be modified
Is determined by physiology	Is socially constructed
One is born with it	It is learned
Is perceived as an anatomical difference	Is perceived through behaviors, beliefs, and ideas
Is designated by nature (at conception)	Is assigned by society (from birth to death)
A set of physical and biological characteristics	A set of cultural, social, and psychological characteristics

- Instruct participants to roam around the room to find matching opposites.
- Ask participants to come up to the front of the room, one pair at a time, to place each card on either on a flip chart marked sex or gender. As they place their cards on one side or the other, they should state why it belongs where they place it. Ask the rest of the participants if they agree. If there is dissent, allow for debate and then bring the discussion to a resolution by asking the participants to recall their shared definition of gender.
- After all cards have been placed on the flip charts, review the characteristics of the two terms and how they differ.

#### **Exercise 4: Vote with your Feet**

- Ask the group to stand in the center of the room.
- Explain that you will read a statement and they have to decide if they agree or disagree. If they agree, they must move to the left side of the room and if they disagree to the right. Explain that no fence sitting is allowed.
- Read statement one. After everyone has chosen a side, ask someone on the Agree side why he/she agrees with the statement. Then ask someone on the Disagree side why he/she disagrees. Paraphrase the statement and ask people on the opposite side what they think. Go back and forth, asking for other reasons, until a dialogue develops across the two sides. Allow people to change sides if they change their minds.
- Summarize the arguments made by each side and then state that we all have ideas and experiences that shape our views of gender roles and expectations with regard to programs.
- Repeat the exercise 2-3 times with different topics/statements.
- Statements used with Project NOVA:
  - Men will feel threatened if too many women are in leadership positions.
  - Women naturally make better parents.
  - If there were more male contraceptive methods available, men would be more interested in participating in family planning.
- Statements used with USAID/Armenia:
  - Women naturally make better parents.
  - The Armenian government should prioritize policies that support job creation for men because they are the principle bread winners of the family.
  - Women are less corrupt than men.

## Exercise 5: Gender Analysis Framework - Case Study and Matrix I

### Case Study: Integrating Gender and Healthcare into the TMF Water and Sanitation Project in the Villages of Hayanist, Fantan, and Dzoraghbyur<sup>4</sup>

#### Instructions:

1. Read through the case study description.
2. For your assigned domain of the gender integration framework, use the information presented in the case study to complete Worksheet One by **first**, identifying the gender-relevant information in the case (second column), and **second**, identifying areas of information that might be missing or to raise concerns about relevant gender-related issues (third column).

**Project Objective:** To improve the utilization of basic healthcare services in rural areas.

**Background Information:** In 2005 the Armenian NGO “Armenian Women for Health and Healthy Environment” in partnership with the Dutch NGO Women in Europe for a Common Future initiated the Tapping Resources Project (TMF) in three agricultural villages in the Ararat Marz Province. The project goal is to reduce poverty by improving water, sanitation, and agriculture, and by increasing participation in local government.

A survey conducted in the three villages at the beginning of the project revealed that access to affordable quality healthcare was also a serious problem. The survey respondents characterized the current healthcare system as “unsocial.” The project implementers would like to amend the project to include a healthcare component. They are very concerned that the activities under the new component take into consideration gender differences within and between the villages to ensure that they meet the different needs of boys and girls, young women and men, and adult women and men at different stages of the life cycle.

#### Description of the Villages

Household Organization: Most families live either in nuclear (a mother, father, and their unmarried children) or in extended households of multigenerational members. Most often a young woman, upon marriage moves into her husband’s family’s household. Younger sons tend to remain in their parents’ household while older sons tend to establish separate residences.

Marriages can take place within the church or in front of a government registrar. In the advent of divorce, women can only make claims on common property if they have been married by a registry official. Often couples wait until just before the birth of their first child to register their marriage.

Decision-making at household level varies across households. In some households the husband is the main decision-maker, in a few it is the husband’s mother (i.e. the mother-in-law of the wife), but there are also households where husband and wife make decisions jointly. In *Hayanist* it is also common for women to be the decision-makers with regard to how money is spent.

In *Dzoraghbyu*, men mainly make decisions about spending in two-fifths of the households. In about a third of the households the husband and wife share decision-making, while in another one-third

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<sup>4</sup> This case study was developed by Deborah Caro (Cultural Practice, LLC) under the Short Term Technical Assistance and Training Task Order of the EGAT/WID IQC, based on information contained in the Armenia Socio-economic and gender survey of Hayanist, Fantan and Dzoraghbyur for the TMF Project, Tapping our Resources by Solomiva Babvak (<http://www.wecf.org>) and other materials listed in the attached bibliography. It was adapted for use in the training.

women are the principal decision-makers about spending household resources. Often the key decision-maker in these households is the mother-in-law.

Employment and Livelihood: Virtually all households in the three villages own agricultural land (0.5-5 hectares) in addition to a yard and homestead, but few cultivate all or most of their land due to the high costs of inputs, the absence of irrigation, poor soils, poor harvests, and low market prices. In *Hayanist* and *Dzoraghbyur*, where there is water for irrigation, some households cultivate vegetables and fruit trees in their gardens.

More women are unemployed than men. However, many (married) women without a job consider themselves to be housewives and do regard themselves as unemployed. Some husbands do not allow their wives to work, even if a household could use the additional income. In *Fantan*, it is more common for men than for women to search for work, especially outside the village (Charencavan or Russia). Women feel responsible for the house and family, and all women-respondents described themselves as housekeepers, and not as unemployed. Those (few) women in *Fantan* who are employed, mostly work as teachers. The school director is also a woman, as are the bookkeeper and the secretary in the mayor's office. The mayor and the elected village council members are all men.

Whether they work outside the home or in agriculture, most women also are housewives whose responsibilities are housekeeping and taking care of children. Housekeeping in rural Armenia often includes activities such as baking bread, milking cows and making cheese and preserving vegetables and fruit. Certain heavy tasks such as carrying water (if there is no tap in the home) are often done by women, men and/or children.

It is very common in rural areas for households to bake their own bread – lavash. Almost every household has its own “bread house” – a small shed in the yard with the hole of 1.5 –2 m (deep or wide?) in the ground. Baking lavash is women's responsibility. They prepare the dough near the hole, while squatting on the ground. Some husbands make special holes that allow the wife to put her feet into, as making lavash is a long procedure and legs can start hurting from squatting.

Men, in turn, are responsible for earning money and for agricultural activities. Nevertheless, the respondents indicated that many agricultural tasks are done by both men and women, for example land preparation, weeding and harvesting. Fertilizer application and spraying of agrochemicals are mostly done by men. Depending on the household, either a woman or a man is responsible for selling produce.

In *Hayanist*, only 3 out of 11 respondents mentioned that women from their households are also fully involved in agricultural activities. In one of these cases the husband is handicapped and thus the entire workload fell on his wife's shoulders. In other cases, when a man was absent or disabled, the family quit agriculture. Gender roles in families of *Fantan* are rather similar to those in *Hayanist*. However, in *Fantan* more men are involved in agricultural activities (work on land and livestock keeping). The women are firstly responsible for childcare and housekeeping (cleaning house and yard, cooking, baking bread, preparing and selling dairy products, etc). Fetching the water is mainly a task of women and/or children. In *Dzoraghbyur* men were said to “earn money to support the family” and “agricultural and livestock activities” or “all the works, connected with activities outside the house,” “repairing in the house,” “cutting wood and maintaining the fire” and even “shopping.” In addition to housekeeping, women in *Dzoraghbyur* are also responsible for milking cows and making cheese.

Political and Community Organization: Men are also the main decision-makers outside the households, at community level. In *Fantan* and *Dzoraghbyur* the decisions at village level are made by the mayor and the village council who are all men. In *Fantan*, many men were interested in serving on the community committee to address village problems (in the context of the TMF project). Village women suggested that their husbands be chosen as members of such a committee. Two-thirds of

the respondents in *Dzoraghbyur*, however, were interested in becoming a member of a community committee. One woman said that she is highly interested in becoming such a member but she was afraid that her husband would not allow her to join. Her explanation was that her husband is very jealous and does not often allow her to go outside the house. Another interested respondent said that due to his seasonal work he, unfortunately, could participate in meetings only in the winter. In *Hayanist*, however, three of the seven village council members are women. The fact that the population of *Hayanist* has an urban background (mainly refugees from *Baku*) may play a role in this.

Education: More women have completed higher education than men, although the high costs of education mean that not all graduates from secondary school who are interested in higher education can attend. In *Hayanist*, it is more common for daughters to attend universities than sons. The villagers gave the following reasons: (1) male students prefer to go to the Military Academy (as it is free) and (2) it is sometimes easier for men to find employment as wage laborers (e.g. as migrant workers in Russia) than as academics. The school teacher in *Dzoraghbyur* had an alternate explanation. She said girls in school are more responsible in their studies than boys. Even if boys are more gifted than girls, the girls have better results, as they are more persistent. The director likes to encourage her pupils, and in particular girls. Other teachers at school do not always support her in this as they are more traditional.

Health: In all three villages poverty has a major impact on health. Few households have adequate heating. Medicines and medical care are too expensive for most households and therefore village residents often do not seek out the healthcare or purchase medicines that they need. Poor and under-nutrition is also prevalent. Poor quality drinking water and sanitation practices contribute to outbreaks of infectious diseases and the high incidence of intestinal parasites. Children suffer from respiratory and diarrheal diseases. Adults are afflicted mostly by arthritis, high blood pressure, blood and endocrinological disorders. In addition both children and adults are exposed to parasites, and tuberculosis is a problem among workers who have returned from migrant labor in Russia.

The inhabitants of *Hayanist* can receive primary health care at a healthcare center staffed by two doctors, a general practitioner, a pediatrician, and a midwife, but many prefer to go to Yerevan or other cities as they believe that the hospitals in the cities have better-trained staff and are better equipped. As healthcare is not free for adults (free maternal healthcare is only available for certain vulnerable groups), patients tend to ask for doctors' help only in extreme situations, and, in such cases they prefer to go directly to a hospital.

One medical assistant works in the healthcare center in *Fantan*. She complained that the center lacks essential equipment and medicines. The Ministry of Health occasionally supplies the center with vaccines for children. The health center is almost always closed. The villagers know where the medical assistant lives and, if necessary, they contact her directly. The health center does not provide villagers with medicines; they buy them in the drug-stores in *Charencavan* or in Yerevan.

The medical staff of *Dzoraghbyur's* health center informed that heart and blood related diseases are the most common ones among adults. Children suffer most from intestinal disorders and infectious diseases. Especially, there are many cases of diarrhea among babies. Outbreaks of diarrhea among all inhabitants are common both in summer and winter. Intestinal parasites are also rather widespread. The survey results confirmed the prevalence of intestinal disorders and several respondents mentioned that one or more of their young children had been hospitalized due to dysentery or other such infections. One respondent said that her 6 month old child died from dysentery last year.

**Directions:** Read through the case study. Find information in the case study on gender relations and identities. Categorize the information by domain. Review the project objective and then identify any additional gender-related information that you feel would be critical for making the project more responsive to gender differences. Develop a list of gender-related questions for each domain that need to be answered through additional research or information collection from other sources.

**Matrix I: Gender Analysis Framework**

<b>DOMAIN</b>	Project Objective:	
	Information or issues on gender relations and identities found in the case study	Additional information on gender relations and identities, <i>not in the case study</i> , that is pertinent to developing a more gender inclusive program. Identify the type of information needed and formulate relevant questions.
<b>ACCESS TO ASSETS</b>		
<b>KNOWLEDGE, BELIEFS, AND PERCEPTIONS</b>		

<b>DOMAIN</b>	Information or issues on gender relations and identities found in the case study	Additional information on gender relations and identities, <i>not in the case study</i> , that is pertinent to developing a more gender inclusive program. Identify the type of information needed and formulate relevant questions.
<b>PRACTICES AND PARTICIPATION</b>		
<b>SPACE AND TIME</b>		

<b>DOMAIN</b>	Information or issues on gender relations and identities found in the case study	Additional information on gender relations and identities, <i>not in the case study</i> , that is pertinent to developing a more gender inclusive program. Identify the type of information needed and formulate relevant questions.
<b>LEGAL RIGHTS AND STATUS</b>		
<b>POWER</b>		

### **Exercise 6: Do you want a boy or a girl?**

- Offer each participant one M&M candy.
- Tell them that overnight a miracle pill was invented and they will instantly be pregnant and give birth within 5 minutes (both men and women).
- While waiting to give birth they must decide the sex of their child, which will be the only child they will ever have.
- Go around the room and ask each participant what sex they have chosen and why? No twins or other multiples are allowed.
- Record the answers on a flip chart.
- After recording the answers, count how many boys and how many girls. Report the sex ratio to the participants. Ask them, what they think about the sex balance (or imbalance) and how that might affect the society. Discuss why boys are favored over girls.
- Without referring to the association with a boy or a girl, read off the different characteristics and qualities listed by the participants as justification for having a boy or a girl.
- Ask if the characteristic is associated with a boy or a girl or both.
- Review the answers and compare to the sex distribution on the first chart to see if these answers still are still closely linked with gender when not described as such.

**Exercise 7: Identify Gender-based Constraints and Opportunities**

**MATRIX 2: GENDER ANALYSIS AND APPLICATION**

**Directions:** Take the information that you identified in Matrix 1 and try to analyze the implications of that information using the categories in Matrix 2.

Key Gender Constraints / Opportunities	What are the gender-related issues that either limit (constraints) or facilitate (opportunities) the achievement of results?	(1) How will the gender-based opportunity or constraint affect the achievement of sustainable results?	Possible actions to overcome the constraints or take advantage of the opportunities in order to achieve more equitable outcomes?	(2) How will the proposed activity affect the relative status of men and women? Are there aspects of the program that will either impede or contribute to making gender relations more equitable?
Access				
Knowledge, Beliefs, and Perceptions				

Key Gender Constraints / Opportunities	What are the gender-related issues that either limit (constraints) or facilitate (opportunities) the achievement of results?	(1) How will the gender-based opportunity or constraint affect the achievement of sustainable results?	Possible actions to overcome the constraints or take advantage of the opportunities in order to achieve more equitable outcomes?	(2) How will the proposed activity affect the relative status of men and women? Are there aspects of the program that will either impede or contribute to making gender relations more equitable?
Practices and Participation				
Space and Time				

Key Gender Constraints / Opportunities	What are the gender-related issues that either limit (constraints) or facilitate (opportunities) the achievement of results?	(1) How will the gender-based opportunity or constraint affect the achievement of sustainable results?	Possible actions to overcome the constraints or take advantage of the opportunities in order to achieve more equitable outcomes?	(2) How will the proposed activity affect the relative status of men and women? Are there aspects of the program that will either impede or contribute to making gender relations more equitable?
Formal and Customary Legal Frameworks				
Power				

## A FRAMEWORK FOR GENDER ANALYSIS IN STRATEGIC PLANNING

USAID policy requires all activities funded with USAID money to examine two key questions with regard to gender issues:

- (1) *How will gender relations affect the achievement of sustainable results; and,*
- (2) *How will proposed results affect the relative status of men and women?*

In order to adequately address these two questions, program implementing agencies must take into account the *different roles of men and women*, as well as *the relationship and balance between them and institutional structures that support them*.<sup>5</sup>

The framework presented here facilitates the analysis of how gender relations operate in different domains of social life and development activities. It also helps to identify whether there are specific gender-based structural and institutional constraints that affect the relative status and opportunities open to men and women that can be addressed by development activities. In this framework, gender relations are analyzed across six domains to identify existing gender-based constraints. These six domains do not encompass the total range of human activity and there is some overlap among them, but they nevertheless provide a conceptual framework for addressing the two questions posed by the USAID policy (listed above).

This framework should help USAID operating units and their implementing partners to move beyond simply disaggregating process indicators by sex. It will move staff towards more accurately predicting the impact of development strategies and programs on the relative status of men and women as well as accounting for how well consideration of gender enhances the success of USAID programs.

The six domains that structure the gender analysis and identify gender-based constraints in this framework are:

1. **Access:** Access refers to being able to use the resources necessary to be a fully active and productive participant (socially, economically, and politically) in society. It includes access to resources, income, services, employment, information, and benefits.
2. **Knowledge, Beliefs, and Perceptions:** This domain refers to the culturally-mediated gender ideologies that shape beliefs about the qualities and life goals or aspirations appropriate to different gender categories. It involves understanding how people interpret aspects of their lives differently according to gender categories. Men and women may have access to different types of knowledge, have diverse beliefs, perceive situations differently, and conform to gender-specific norms. In many cultural systems, some knowledge may be proprietary to only one gender category and hidden from another, limiting peoples' ability to participate in the full range of social experiences.
3. **Practices and Participation:** This domain refers to people's behaviors and actions in life – what they actually do – and how this varies by gender. It encompasses not only current patterns of action, but also the way that people engage in development activities. It includes attending

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<sup>5</sup> Automated Directive System (ADS) Chapter 201.3.8.4 *Gender Analysis*

meetings, training courses, accepting or seeking out services, and other development activities. Participation can be both active and passive. Passive participants may be present in a room where a meeting is taking place, and therefore may be aware of information transmitted, but do not voice their opinions or play a leadership role. Active participation involves voicing opinions and playing an active role in the group process.

4. **Space and Time:** Gender often structures the availability and allocation of time as well as the space in which time is spent. This domain includes recognizing gender differences in the division of both productive and reproductive labor, identifying how time is spent and committed during the day, week, month, or year, and in different seasons, and determining how people contribute to the maintenance of the family, community, and society. The objective here is to determine how people in different gender categories spend their time and what implications their time commitments have for their respective availability for program activities. An important question to ask about time availability is whether it is flexible, negotiable, and fungible.
5. **Legal Rights and Status:** Analysis of this domain involves assessing how people in different gender categories are regarded and treated by both the customary and formal legal codes and judicial systems. It encompasses access to legal documentation such as identification cards, voter registration, and property titles as well as rights to inheritance, employment, redress of wrongs, and representation.
6. **Power:** This sphere of social life pertains to the ability of people to decide, to influence, to control, and to enforce. It refers to the capacity to make decisions freely and to exercise power over one's body and within an individual's household, community, municipality, and the state. This includes the capacity of adults to decide about the use of household and individual economic resources, income, and their choice of employment. It also encompasses the right to engage in collective action, including the determination of rights to and control over community and municipal resources. Finally, it includes the capacity to exercise one's vote, run for office, be an active legislator, and to enter into legal contracts.

Against this background information about how gender relations are expressed in these six domains, the next step towards strategic planning requires identifying **gender-based constraints** that might influence the achievement of sustainable results. Gender-based constraints are those barriers that limit or prohibit equal rights and equitable access to resources and opportunities. Similarly, analysis may also reveal gender-based opportunities for development.

- **Gender-based constraints** are factors that inhibit men's or women's access to resources, behavior and participation, time use, mobility, rights, and exercise of power based on their gender identity.
- **Gender-based opportunities** are structural and institutional factors that facilitate women's and men's equitable access to resources, behavior and participation, time use, mobility, rights, and exercise of power

## **Guide Questions for Gender Analysis**

### **Examples of Key Questions**

- (1) How will gender-based constraints and opportunities affect the achievement of sustainable results?

#### **Access:**

**Constraint:** Does unequal access to project resources and services prevent the project from reaching its goals?

**Opportunity or Facilitating Factor:** Are there instances of equitable access with regard to certain types of resources that might provide a model for access to other resources?

#### **Knowledge, Beliefs, and Perceptions:**

**Constraint:** Are there gender-specific beliefs that will impede project outcomes?

**Opportunity or Facilitating Factor:** Is there gender-specific knowledge that will facilitate decisions that are essential for reaching project goals?

#### **Practices and Participation:**

**Constraint:** Are people who are excluded based on their gender (even inadvertently) result in passive or active sabotage of project activities?

**Opportunity or Facilitating Factor:** Are there types of gender-specific leadership roles that might provide the basis for broader participation?

#### **Space and Time:**

**Constraint:** Are there gender-specific roles that prevent some people from participating in program activities because they work in a particular place?

**Opportunity or Facilitating Factor:** Does the gendered division of labor provide a useful framework for distributing project resources equitably and in a way that will be supportive of project objectives?

#### **Legal Rights and Status:**

**Constraint:** Do gender-discriminatory laws inhibit rights to property?

**Opportunity or Facilitating Factor:** Does a gender-neutral legal structure create an opportunity to push for gender equity in employment benefits or inheritance?

#### **Power:**

**Constraint:** Are people who are excluded from making decisions based on their gender likely to suffer adverse consequences from the decisions made by others?

**Opportunity:** Is it possible to organize individuals who are excluded from making decisions based on their gender into groups or coalitions that may be able to negotiate for greater decision-making power?

- (2) How will proposed activities affect the relative status of men and women?

What is the impact of the project on:

- Access and control over resources by different individuals and groups?
- Validation or challenges to different people's knowledge, beliefs, and practices?
- Different peoples' interests and needs?
- Participation of different individuals and groups?

## Exercise 8: The Gender Continuum

Gender Blind
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Gender Exploitative	Gender Accommodating	Gender Transformative
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- Explain the different strategies for integrating gender considerations into programs, as reflected in the continuum:

**Gender Blind** means that no gender analysis is conducted prior to developing a program, so that the project design does not address gender and therefore may encounter gender-based constraints to meeting its objectives or may result in producing greater gender inequalities.

**Gender Exploitative** strategies utilize unequal power relations or stereotypes based on gender to achieve development results expediently. This approach often exacerbates unequal gender relations of power by reinforcing the power of people who already are sole or key decision-makers. An example is to convince men that as the principle decision-makers about reproductive health, they should insist that their partners use contraceptives to space or limit the number of their children.

**Gender Accommodating** approaches adjust program activities to existing gender differences in order to overcome gender-based constraints and reach the results of the project. An example is to deliver health education and contraceptives to women in their households when they are unable to venture out on their own without permission.

**Gender Transformative** strategies address gender-based constraints by promoting more equitable gender relations as a means to reach development outcomes.

- Hand out duplicate copies of case studies to groups of two or three. Ask each group to read the short case studies and to place them where they think they go on the continuum.
- Have the first group read the case study out loud. Ask them why they put it where they did. Then ask the second group with the same case study to explain their placement.
- Ask the other participants what they think, and then help to guide the discussion about the placement.
- Repeat this with the other cases. Compare and contrast the case studies and their placement. Highlight ambiguities. Explain that accommodating strategies can be a first step towards transformation; that strongly transformative strategies sometimes have backlash that may result in temporary reinforcement of unequal power relations. Nevertheless, USAID is focused on responding to both questions in the ADS and that the second one means that we should strive for transformative approaches.

**Exercise 9: Integrating Gender throughout the Program Cycle**

**Matrix 3**

<b>Steps 1 and 6</b> <b>Project objectives, intermediate objectives, and results</b>	<b>Step 2</b> <b>Types of data to be collected – what do we need to know about whom?</b>	<b>Step 3</b> <b>Gender-based constraints and opportunities to achieving objectives and results</b>	<b>Step 4</b> <b>Activities and interventions that reduce gender-based constraints and take advantage of gender-based opportunities</b>	<b>Step 5</b> <b>Indicators to measure gender (removal of constraints or building on opportunities) and health impacts of interventions</b>
Original project objective:			Original Project Activities	Original project indicators:
Revised or additional gender-related project objectives:	[Fill in with case study data from gender analysis data collection <a href="#">Matrix 1</a> ]	[Fill in with case study data from gender analysis <a href="#">Matrix 2</a> ]	[Fill in with case study data from gender analysis <a href="#">Matrix 2</a> ]	Revised gender-related project indicators that measure improvement in gender equity:

**Exercise 10: Action Planning**

What is one concrete action you can take to mainstream gender in your organization?	What is the expected result or outcome of your action?	What constraints or barriers might you encounter in trying to carry out your action?	What are some opportunities or facilitating factors that will help you to accomplish your action?	How will you overcome the constraints and barriers, and how will you take advantage of the opportunities?	What is the timeframe for completing your action?	What resources (e.g., human or financial) are necessary for successfully carrying out your action?

**APPENDIX 2: EVALUATION OF WORKSHOP**  
**EVALUATION FORM: Gender Workshop – Armenia**

As a result of this workshop, to what extent do you believe that you have increased your capacity and skills to:	Self-evaluation N=23		
	Not at all	A little	A lot
Define and understand gender and related concepts and terms?	0	4 (17%)	19 (83%)
Identify the benefits of mainstreaming gender in programs and organizations?	0	7 (30%)	16 (70%)
Understand, use, and apply the gender analysis framework to your project or program?	0	5 (22%)	18 (78%)
Integrate gender into the different stages (steps) of the program cycle?	0	2 (8%)	21 (91%)
Identify different programmatic strategies, along the gender continuum, for addressing gender inequalities in programs?	0	4 (17%)	19 (83%)
Develop concrete actions to mainstream gender in your own work?	0	7 (30%)	16 (70%)

**1. Which components of the workshop were most useful?**

- Gender Continuum Strategies (3)
- Gender analysis and integration into the project cycle (own projects)
- Group work (7)
- Gender mainstreaming (2)
- Gender constraints and opportunities
- Gender indicators
- Everything (6)
- Case study analysis
- Gender terminology
- Presentations
- Second day topics

**2. What components or elements of the workshop were least useful?**

- None (16)
- Lunch
- Breaks were not long enough (3)
- Overloaded agenda
- Some explanations were not clear
- Gender continuum strategies
- Long discussions

**3. How do you anticipate applying what you learned in the workshop in your work?**

- Continue my education on gender issues (2)

- Conduct a gender analysis of my project
- Will share the information with project beneficiaries (5)
- Will take gender into account when working on project design
- Will try to consider gender issues in all my activities
- Develop activities to address gender issues
- Reflect on the issue some more
- Share the information with other members of my NGO (2)
- Mainstream gender in my projects (9)
- Organize awareness raising events
- Collaborate with mass media to disseminate the idea of gender equality

**4. What are the necessary next steps to continue the process of mainstreaming gender in your work and how do you intend to participate in the process?**

- Data collection, planning, organization, implementation, evaluation, and work on mistakes
- Design a manual (2)
- Increase number of men who are doctors
- Make a presentation on the concept of gender for my community
- Information sharing events
- Integration of gender into healthcare projects (5)
- Implementation
- To begin working with men
- To organize a meeting in two months to share results and achievements
- To advocate for gender mainstreaming in all programs
- Gender analysis of the existing projects
- Mainstream gender into reproductive health projects (5)
- To learn more about the concept
- Revisit indicators (2)
- No response (1)

**5. In what areas do you feel your knowledge has increased as a result of the workshop?**

- Gender in healthcare (2)
- Gender in the community (2)
- Concept of gender
- Gender analysis (3)
- Sociology
- Project design from a gender perspective
- Gender mainstreaming (4)
- Women's and men's reproductive health
- In all areas (4)
- Theoretical knowledge
- Terminology
- No response (3)

**6. Evaluate your level of knowledge and understanding before and after the workshop.**

(On a scale of 1-5)

Average, before: 2.7

Average, after: 4.1

- Excellent
- Increased (2)
- Very useful (2)

- Finally understood
- I need more time to understand the concepts
- No response (1)

**7. Other comments:**

- Very important training
- Well organized (5)
- Very good trainers (4)
- Excellent interpretation (9)
- Friendly environment (2)
- Good job (2)
- Thank you (8)
- A lot of new techniques and interesting discussions
- Working days were too long
- Special thanks to Debbie, Jina, and Khachik
- Progressive concept
- Thanks for the materials that were distributed
- No response (3)

### APPENDIX 3: BIBLIOGRAPHY

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## **APPENDIX 4: SCOPE OF WORK**

### **Proposed Scope of Work**

Integrating Gender into Reproductive Health in Armenia

July 6-15, 2006

### **Purpose**

To work with USAID/Armenia-funded Project NOVA staff and counterparts to analyze the gender dimensions of reproductive and child health services and to develop concrete actions to integrate gender into programmatic activities.

### **Background**

Project NOVA is a nation-wide program that seeks to improve the quality of reproductive health (RH) and maternal and child health (MCH) care in the majority of rural primary health care (PHC) facilities in Armenia. The project has four main program components:

- Area 1: Improving reproductive and child health knowledge and skills for rural primary care providers and providing basic medical equipment and supplies to support program activities.
- Area 2: Developing the capacity of regional health managers to improve the management, quality and supervision of rural facilities.
- Area 3: Accelerating the momentum of reform in the health delivery system to be more responsive to the reproductive and child health needs of the population.
- Area 4: Increasing consumer demand for high-quality services through community education and mobilization activities.

The Mission views gender as a cross-cutting issue that should be reflected in all program components and activities of the project. (The gender approach is summarized in attachment A of this document.) Under PRIME II in Armenia, IntraHealth implemented a successful pilot program (2002-2004) to address gender-based violence (GBV) within the RH sector. Staff and local stakeholders gained valuable experience and understanding of gender issues. Funds were not available to continue the program, but the project is committed to integrating gender – including GBV – aspects across all project activities.

The Armenian government and civil society recognize many of the gaps in the Reproductive Health (RH) status of its population. It is critical to have an informed understanding of the gender implications of these issues to seek the most effective interventions to address these gaps. Key RH issues in Armenia can be summarized as follows:

- Sex / reproductive health education is virtually non-existent in the high schools.
- Due to lack of education and contraception, abortion is a common form of birth control.
- Less than 10% of Armenians use condoms, putting couples/partners at high risk of sexually transmitted infections (STIs).
- Secondary infertility among women is very high, in part due to STIs and abortions.
- According to estimates, up to 40% of Armenian women suffer from violence from a family member. However, there is widespread cultural acceptance of the practice.
- Men are critical decision-makers in the home, yet are not involved in care seeking and care giving practices for maternal and child health issues.

- In terms of health management, the majority of health care providers are women, yet men hold most key management and decision-making positions. For example, 70% of marz health directors and 80% of the chief ob/gyns are male.

This assignment will serve to more formally launch the project’s effort to bring a better understanding of gender issues within RH in Armenia and to integrate gender components across all current and future project activities in a more structured and systematized way. USAID/Armenia proposes to use funding from the USAID/Women in Development Indefinite Quality Contract, Quick Response Short-Term Technical Assistance and Training to access a senior level gender expert Deborah Caro to conduct this assignment.

The gender expert with the local consultant and key project staff will conduct a two-day training workshop for staff and counterparts on gender concepts, gender analysis, and integration of gender into RH. It is expected that the training workshop will be informed by the gender training modules developed by USAID Washington’s Interagency Gender Working Group (IGWG).

The list of proposed trainees is in attachment B. The expected objectives are as follows:

- Orient core team of government experts and project staff on gender concepts and gender analysis.
- Build the skills of workshop participants in conducting gender analysis.
- Develop a set of key global recommendations for better integration of gender into the RH sector in Armenia.
- Reach agreement on specific implementation actions related to integrating gender into Project NOVA programs, objectives, strategies, initiatives and activities.

Following the workshop, the expert will work with sub-groups of the workshop participants to further plan and begin implementation of concrete actions related to integrating gender and RH. As per USAID’s interest, the expert will also give a public presentation on gender and health for staff of USAID and its implementing partners. In addition, the expert will provide consultation to Project NOVA staff on the project evaluation framework and performance monitoring plan (PMP).

<b>Proposed personnel</b>	<b>Specialty/Responsibility</b>	<b>Time requested</b>
WID IQC Gender Expert Deborah Caro	Gender and RH	TBD # days (including 8 work days in country) 6-day workweek
Jina Sargizova (Project Coordinator, “NGO Center” Civil Society Development Organization)	Social Services, Gender	9 days (to be covered locally by USAID/Armenia through Project NOVA)

The gender consultants will work in partnership with the IntraHealth Senior RH Program Manager (based in Chapel Hill), the Project NOVA Acting Chief of Party/Program Manager, and the Community Advisor (who is also responsible for gender) and other relevant staff as appropriate. The subcontractor IntraHealth is the lead technical agency responsible for this assignment.

### **Specific Tasks**

#### *Prior to Travel*

1. Prepare draft objectives, agenda, tools and related materials for a 2-day gender workshop for approximately 25 people (project staff and government counterparts)
2. Review key project tools to better understand the project and its gender focus (see attachment C for summary of project tools).
3. Prepare a 2-hour in-service presentation on gender and health/development for the USAID/Armenia Mission staff and interested implementing partners

*During Travel*

4. Meet USAID and Project NOVA staff to review scope of work, schedule of activities and expected outcomes.
5. Plan for and conduct (with support from project staff) a two-day workshop on gender in RH/MCH services.
6. Hold working sessions with staff and counterparts following the workshop to design action plans related to each of the four project components.
7. Conduct a two-hour in-service on gender and health/development for USAID Mission staff and partners.
8. Hold a working session with Project NOVA staff to review project PMP and monitoring indicators.
9. Prepare a draft report with written recommendations within 7 working days after consultants return to the US. The Mission will review the draft and return comments within 5 working days, and the consultant will send the final version within 3 days after receipt of comments.
10. Debrief with the IntraHealth Senior RH Program Manager (via phone) within two weeks after completion of the activity.

**Outcomes**

- Staff and counterparts more aware of gender issues (approximately 25).
- Technical report with general recommendations to Armenian counterparts for opportunities to integrate gender into reproductive health and detailed implementation plans created on ways to integrate/strengthen/expand gender aspects in RH/MCH according to the four main project components.
- USAID and other contractors updated on gender dimensions of health.
- Project NOVA PMP indicators revised to better reflect gender considerations.

## **ATTACHMENT A: PROJECT NOVA'S GENDER APPROACH (Adapted from USAID contractual agreements)**

Project NOVA takes a systematic approach to integrating gender analysis into program development, implementation and evaluation, and consideration gender issues in Armenia's health care sector. The approach includes gender analysis and gender integration in programs, and gender sensitivity assessment of provider performance, training curricula, service delivery and community partnership. Some examples are described below:

**Provider Performance:** The team will address gender issues in three ways: empowering female providers, sensitizing all providers to gender barriers, and ensuring gender sensitivity in services offered. The team will train providers on necessity of gender sensitivity and will offer simple tools to trainers, service providers and managers for assessing the gender sensitivity and equity of RH/FP services, including indicators for gender-sensitive pre- and postnatal consultation, family planning services and HIV/STI prevention and treatment.

**Management and Supervision:** The team will ensure that gender issues are included in the human resource section of PHC management handbook. The modular training program, based roughly on the handbook, will be given to a gender-balanced group of 15-20 leaders in the marz health system. The project will incorporate gender analysis in data collection; management training and quality improvement initiatives as they relate to such issues as establishment and collection of gender-specific indicators, gender imbalance between managers and providers, and decision-making in home related to health care seeking behaviors.

**Policy:** The team incorporates gender equity into policy formulation and the regulatory environment. This can be done by targeting both national policy officials, and educating local-level officials. The team will adapt and use IntraHealth's "Orientation to Gender and Reproductive Health" which has been used many times in various countries to raise the awareness of policy makers, RH/MCH program planners and implementers, training, and primary-level service delivery personnel to gender dimensions of reproductive health and family planning. Such orientation can be adapted to several audiences.

**Consumer Demand:** The community partnership for health will seek to better understand the gender implications for health seeking behavior, community decision-making, and relationships between the health facility staff (often women) and the community leaders (nearly all men). In forming our Health Action Groups (HAGs), care will be taken to ensure gender equity. The community meetings will educate women as their rights when seeking services, and will provide information on how gender norms affect health and health-seeking behaviors. These messages will also seek to involve men in RH and MCH.

## **ATTACHMENT B: LIST OF POTENTIAL PARTICIPANTS**

### **Project NOVA Staff (12 total)**

Acting Chief of Party/Program Manager  
Community Advisor/Gender Specialist  
Health Systems Analyst  
Reproductive Health Advisor  
Clinical Manager  
Quality Advisor  
Program Associate  
Community Mobilizers (3)  
Monitoring and Evaluation Officer  
Translator/Media Coordinator

### **Government Counterparts (13)**

#### **Area One: Provider Performance (3)**

National Training Experts

- Family Medicine Trainer (probably a practicing family physician)
- Safe Motherhood Trainer (probably a maternity hospital obstetrician or neonatologist)
- STI trainer (probably a practicing venerologist or obstetrician)

#### **Area Two: Management and Supervision (2)**

Management Expert (Head of Health Management School)  
Quality Improvement (head of facility involved in quality improvement)

#### **Area Three: Policy (4)**

Ministry of Health representatives (2)  
Marz health authority representative  
Faculty member from NIH, SMU or BMC

#### **Area Four: Consumer Demand (4)**

Representative of each local NGO (2)  
Rep from a health action group (2)

#### **Other Project Representatives (4)**

USAID/Armenia-supported Mobile Outreach Project  
USAID/Armenia-funded Primary Health Care Reform Project  
USAID/Armenia-supported Armenian American Wellness Center  
USAID/Armenia-supported Armenian Eyecare Project

## **ATTACHMENT C: SUMMARY OF NOVA TOOLS AND PRODUCTS AND EXPRESSED NEEDS FOR GENDER SUPPORT**

### **Monitoring and Evaluation**

Each year, the project conducts quality assessments in all PHC facilities in the new regions where the project will intervene. Approximately 150 health facilities and 250 providers are assessed each year. The research involves application of 11 tools using clinical observations of provider performance; interviews with providers, clients and communities; inventory of facilities; and geographic data on communities (e.g., population size, distance from regional centers). It should be stressed that sex-age distribution of population is a key element in policy development.

***NEED: The project team would like a review of the tools (and the overall evaluation framework to ensure that it is gender appropriate)***

### **AREA ONE: Provider Performance**

The project has three main clinical skills training courses it conducts for different types of RH providers (including different categories of primary health care physicians, nurses and midwives). Each training course is designed for a specific professional cadre and is on a RH/MCH different topic. The training methodology relies on competency-based participatory training and combines theoretical learning with practical skills acquisition. For each training program, we have developed a package of materials including protocols, clinical checklists, lecture notes and measurement tools. We have a team of Armenian professionals who facilitate each training course. Those trainers are not staff, but are generally highly-skilled clinicians working in facilities in Yerevan or the regional capitals. The project provides these trainers with TOT and technical updates prior to using them as facilitators. The three courses are:

- Safe motherhood clinical skills for rural nurses (6-month self-paced learning program)
- Reproductive health clinical skills for family physicians (10-day classroom and clinical practice program)
- Integrated management of STIs for outpatient physicians (5-day classroom and clinical practice)

***NEED: The project team would like to incorporate a section on gender sensitivity into each training program. That might be a 1-2 hour session on the two classroom training programs and a self-study section in the nurse training program. There may be other ways that this consultancy can expand the project's understanding of gender and RH services and would be open to other activities.***

### **AREA TWO: Management and Supervision**

The project has worked on improving supervision of rural RH services through development of a resource guide on management of RH services designed for distribution to heads of rural health facilities. The handbook includes topics related to organizational support, quality of care, supervision, legal issues and financial management. The handbook is then used to train the managers from our target sites.

The project has also piloted a quality improvement initiative to strengthen care in these facilities. The initiative entails use of a self-assessment and action planning tool by a quality team from selected health facilities. The self-assessment tool has over 100 indicators and includes several gender-sensitive topics including male involvement in services. The teams are reviewing their quality and designing and implementing action plans to improve the quality of services.

***NEED: The Management Handbook is already published but the accompanying training curriculum is adaptable. Based on our learning in the workshop, the team would like to***

***incorporate gender into the management training. Regarding the quality improvement initiative, the approach does have some gender sensitive indicators and components and the project team has some lessons learned to share regarding provider interest in such topics as male involvement.***

### **AREA THREE: Policy**

Project NOVA supports the government in strengthening the policy environment for improved RH services. The project helped facilitate the development of a government-approved regulation on infection prevention in maternity hospitals.

Over the last three years, the National Assembly has passed a Law on Reproductive Health (2002), and the Government adopted a Poverty Reduction Strategy Program (2003) and a National Strategy on Maternal and Child Health (2003). The project provided valuable feedback in the development and review of these documents and they are considered the cornerstone for the country's approach to reproductive and child health. Mainstreaming gender aspects into PRSP and other strategic socio-economic and health programs is essential in increasing their effectiveness.

***NEED: We see the workshop has a great opportunity to assist the government in reviewing their own RH laws and strategies using a gender lens. Some Ministry of Health experts are well acquainted with gender concepts, but may not have necessarily put them into practice or become strong advocates for gender analysis and/or integration.***

### **AREA FOUR: Consumer Demand**

Project NOVA implements an initiative referred to as Community Partnership for Health (CPH). In this program, the project brings together health providers and community members/leaders to identify and solve gaps in health service quality (with an emphasis on RH). This is a labor intensive program whereby project mobilizers support community health action groups to implement significant improvements in health services in very rural communities. Communities have renovated health facilities, established health outreach activities, created small health information libraries and solved other human resource problems.

The project has developed a set of client education materials (brochures) on key RH topics: pregnancy care, STI prevention, family planning, cancer prevention. These materials are designed for use in rural communities.

***NEED: We would like to develop a set of key gender messages that communities and health action groups can use while educating their populations (which may result in job aids or client educational materials). We also want to better understand how we might orient our health action groups to gender concepts.***

## APPENDIX 5: PARTICIPANT LIST AND PEOPLE CONTACTED



Workshop: Integrating Gender into Reproductive Health

July 11-13, 2006/ Congress Hotel

### List of Participants

#	Name	Position	Organization	Contacts	E-mail
<b>Consultants</b>					
1.	Deborah Caro	International Consultant	Director, Cultural Practices		dcaro@culturalpractice.com
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<b>Area One: Provider Performance</b>					
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<b>Area Three: Health Policy</b>					
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<b>Area Four: Consumer Demand</b>					
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21.	Natalya Musaelyan	Community Nurse	Archis Community, Tavush mars	3-57	-
22.	Arthur Harutunyan	Village Mayor	Hatsik Community, Shirak marz	(091) 76 18 02	-
<b>Partners</b>					
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## **People contacted**

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3. Nancy Nolan, Senior Advisor, Health/Social Protection, Democracy and Social Reform Office, USAID/Armenia
4. Janean Martin, Public Health Advisor, USAID/W with TDY as CTO for Project NOVA USAID/Armenia
5. Ruben Jamalyan, Health Project Management Specialist, Democracy and Social Reform Office, USAID/Armenia
6. Alisa Pereira, Health and Social Advisor, Democracy and Social Reform Office, USAID/Armenia
7. Dr. Mary Khachikyan, M.D., Ph.D., “For Family for Health” Armenia Association