2019 | Facilitator Guide

GENDER, ONE HEALTH AND INFECTIOUS DISEASE TRAINING GUIDE

This is a product of the One Health Central and Eastern Africa (OHCEA) for health professionals' training with support from the United States Agency for International Development (USAID).

Published by OHCEA

Unit 16A, Elizabeth Avenue Kololo, P.O Box 35270, Kampala - Uganda

www.ochea.co.org

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First Edition

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OHCEA
8 Countries
16 Universities
24 Institutions

Contents

Preface

This module is One of the 16 One Health Training Modules developed by the One Health Central and Eastern Africa Network (OHCEA). OHCEA is an international network, currently of 24 institutions of higher education in public health, veterinary sciences, pathobiology, global health and environmental sciences. These are located in 16 universities in 8 countries in Eastern, Central and Western Africa regions. The universities currently forming OHCEA are: Universite des Montagnes and University of Buea (Cameroon), University of Lubumbashi and University of Kinshasa (DRC), Jimma University, Addis Ababa University and Mekelle University (Ethiopia), Moi University and University of Nairobi (Kenya), Université Cheikh Anta Diop (Senegal), Muhimbili University of Health and Allied Sciences and Sokoine University of Agriculture (Tanzania), University of Rwanda and University of Global Health Equity (Rwanda), Makerere University and Mbarara University of Science and Technology (Uganda).

The OHCEA network's vision is to be a global leader in One Health, promoting sustainable health for prosperous communities, productive animals and balanced ecosystems. OHCEA seeks to build capacity and expand the human resource base needed to prevent, detect and respond to potential pandemic disease outbreaks, and increase integration of animal, wildlife and human disease surveillance and outbreak response systems. The overall goal of this collaboration is to enhance One Health policy formation and implementation, in order to contribute to improved capacity of public health in the region. OHCEA is identifying opportunities for faculty and student development as well as in-service public health workforce that meet the network's goals of strengthening One Health capacity in OHCEA countries.

The 16 modules were developed based on One Health Core Competencies that were identified by OHCEA as key elements in building a skilled One Health workforce. This network is supported by two United States University partners: Tufts University and the University of Minnesota through the USAID funded One Health Workforce Project.

Acknowledgements

Introduction to the One Health Central and Eastern Africa (OHCEA) One Health Course Modules

Training the Current and Future Public Health Workforce Using a One Health Approach

There is abundant evidence that no single sector or department can sufficiently manage the challenges of public health in any country, region or continent. Experiences from the fight against Ebola and the highly pathogenic avian influenza in the past few years demonstrated the effectiveness of multi-sectoral, multi-agency approaches and the need for specific training targeting multi-sectoral and multi-disciplinary public health professionals not limited by national or regional borders in dealing with public health threats. In response to this challenge, the One Health approach has been advocated as the global framework for strengthening collaboration and capacities of the sectors and actors involved in health service delivery.

One Health Central and Eastern Africa (OHCEA) is a network of universities in Central and Eastern Africa which are collaborating to build One Health capacity and academic partnerships between the member institutions in the region and with governments. The overall goal of this collaboration is to enhance One Health policy formation and implementation, to contribute to improved capacity of countries to respond to any emerging pandemics in the region. OHCEA seeks to expand the human resource base needed to prevent, detect and respond to potential pandemic disease outbreaks, and increase integration of domestic animal, wildlife and human disease surveillance and outbreak response systems.

OHCEA has identified One Health core competencies and developed modules based on the identified competencies that are key to delivering knowledge and skills to a multidisciplinary workforce and building a framework on which One Health curricula can be designed and implemented. They combine human health, animal health, infectious disease management with principles of ecology, social and environmental sciences. A total of 16 modules have been developed including One Health soft skills such as communication, culture, leadership, gender and core technical skills such as ecosystem health, infectious disease epidemiology, One Health concepts and outbreak response.

The modules are intended to:

- create a framework for One Health curriculum.
- improve workforce capacity to prevent, detect and respond to threats posed by infectious diseases and zoonosis.

One Health is defined as the collaborative effort of multiple disciplines working together locally, nationally, and globally to attain optimal health for people, animals and the environment

www.AVMA.org

The One Health paradigm emerged from the recognition that the well-being of humans, animals and the ecosystem are interrelated and interdependent and there is a need for more systematic and cross sectoral approaches to identifying and responding to global public health emergencies and other public health threats arising at the human animal ecosystem interface.

- generate a shift in countries workforce culture and training structure.
- enable working across sectors and disciplines for a stronger and more effective public health sector.
- allow universities to be key drivers of the future workforce as they forge partnerships and drive change.
- combine human health, animal health, infectious disease with principles of ecology and environmental sciences.

The modules can be used at both pre-service and in-service levels as full courses, workshops or integrated into course materials for professionals who impact disease detection, prevention and response, allowing them to successfully function as an integral part of a larger, multi-disciplinary, team of professionals. This is key to creating a stronger sustainable Public Health workforce.

Each module contains a Facilitator Guide, Student Guide, PowerPoint slides and a folder of resources/ references for users. These modules are iterative and are continuously being revised. For any inquiries, please email: OneHealthModules@ohcea.org or wbikaako@ohcea.org

These 16 modules were developed by collaborative efforts of multiple disciplines and teams of people from seven different OHCEA partner countries with the support of two US university partners namely Tufts University and University of Minnesota. A team of sixty (60) people were engaged in the development of these modules. All the materials represent contribution by the faculty and leadership of the OHCEA network institutions and the technical and managerial support of the OHCEA Secretariat. The modules were built off previous One Health modules developed by SEAOHUN- network: https:// seaohunonehealth.wordpress.com/ecosystem-health/ with addition of more Africa- specific materials, examples and case studies relevant and applicable to the region. Each module was reviewed by OHCEA network faculty including US university partners with technical expertise as well as partners with field experience that allows for OH application and appreciation of the local African context.

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Overview to the Gender and Infectious Disease Training

Most capacity building efforts to identify, investigate and respond to emerging infectious diseases have focused on supporting public health agencies. However, responding effectively to these diseases requires engagement of and coordination with a diversity of professions and stakeholders in both human and animal health, as well as social and environmental sciences. To improve the understanding of the epidemiology, the outcome of diseases, aid in their detection, treatment, and to increase public participation in prevention and control, gender roles must be considered.

The Ebola outbreak in West Africa illuminated the importance of gender, social and cultural issues and factors related to emerging pandemics. The spread of the infection was intertwined with cultural beliefs deeply embedded within communities, an area which most medical practitioners and public health workers are ill-equipped to handle. While many public health actors were aware that gender and cultural issues played a role, these key factors were overlooked and sidelined by policy makers, aid agencies and the multiple teams and actors working to contain the epidemic. Actors working in this space failed to address the gender issues that played a significant role in the transmission and containment of infectious diseases and public health outcomes.

Understanding gender, culture and beliefs is a key public health competency. The gender differential (biological, social, economic, etc.) poses unique health risks for men and women during their life cycle. The diverse roles that men, women, boys and girls occupy create different exposure mechanisms to domestic animals, wildlife and the environment. Gender roles, the distribution of labor, decision-making power, access to and control over resources, and benefit from these resources play an important part in the biosecurity, control, prevention and response to infectious diseases and emerging pandemics. Therefore, gender differences (including barriers and opportunities) need to be addressed to better understand the risks, to help develop effective control and response strategies and to achieve better impact.

This gender training module will allow participants to develop critical analysis skills as they explore how gender, the realm of emerging pandemics threat (EPT) and One Health intersect. It will further help them to appreciate how policies can be developed and/or implemented to meaningfully address diseases and public health threats in a gender sensitive way. Participants will be challenged to consider the implications, barriers and benefits of an engendered One Health approach in preventing and responding to any public health challenges as well as emerging pandemic threats.

OHCEA network recognizes that gender equality, equity and empowerment must be considered in all stages of any program design and is committed to ensuring that social and gender integration is identified as a high priority at institutional, country and regional levels. Gender inequalities interact with other inequalities such as ethnicity, socio-economics class and age. Therefore, gender differences need to be addressed in an intersectional manner to better understand the risks and to help develop effective control and response strategies.

The OHCEA network institutions will use a holistic approach to create more favorable incentives and structures for equitable development and assist country offices to design and implement gender and socially sensitive programs with lasting value. The secretariat will support the awareness-building and knowledge-strengthening activities, and training needed to integrate gender considerations into all aspects of programming.

Goals of the Training

The training is aimed at helping participants:

i) become more effective in their disciplines by being aware of gender dynamics and applying gender sensitive approaches to emerging pandemic prevention, disease control, surveillance and response.

ii) become effective agents of gender responsive One Health approaches using skills and knowledge they have.

iii) become transformative agents by promoting gender equality and equity in all aspects of their work and sharing this information with others.

iv) become gender trainers, helping to incorporate gender sensitive indicators and assessment tools in their courses as well as sharing information with other colleagues.

v) have basic knowledge on how to develop gender inclusive case studies.

Learning Objectives of the Course

Participants will be able to:

i) define and explain One Health concepts and illustrate the value of interdisciplinary and multidisciplinary approach.
   - Describe basic One Health concepts
   - Identify One Health core competencies
   - Apply One Health approach and core competencies in multiple disciplines to resolve public health emergencies

ii) define and explain infectious disease epidemiology and transmission process incorporating a gender sensitive aspect.
   - Explain basic concepts, theory and methods for surveillance, prevention, control and response to emerging pandemic threat.
   - Describe the global problem of emerging zoonotic diseases and the importance of an engendered One Health approach.
   - Analyze how gender impacts and is impacted by emerging pandemics processes.

iii) relate and assess how gender intersects with One Health and emerging pandemics.
   - Identify basic gender principles and related concepts.
   - Be trained in the use of gender analysis tools.
   - Recognize gender gaps in One Health and emerging pandemics threat and identify resources to address those gaps.
   - Develop gender-sensitive emergency response plans.
   - Develop an advocacy plan for engendering One Health and emerging pandemics programs using gender analysis tools and skills.

Target Audience

The immediate targets of this short module are students and faculty from the OHCEA institutions in the eight African countries as well as multi-sectoral public health professionals from multiple ministries in the public and private sectors including health, veterinary, wildlife and environment. Private sector participants including non-governmental organizations (NGOs), community based organizations (CBOs) and industry, which are the first line of response in emergencies and public health threats are also encouraged to use this module. Since no similar course has been developed for Africa, the eventual plan is that this module would be used across Africa as well as with our South East Asian counterparts, SEAOHUN.

Program

Session 1	Session 2	Session 3	Session 4	Sessions 5
Discovering basic gender, One Health, EPT terms and concepts	One Health epidemiology and gender gaps	Gender analysis tools	Gender-sensitive emergency response planning **advocacy**	Evaluation of simulation case study development
Focus on gender concepts	Focus on epidemiology and gender gaps using Ebola	Applying gender analysis tools to disease surveillance, response, prevention and control	Simulation exercise	Departure

Session 1: Discovering Basic Gender, One Health and Emerging Pandemic Threat Terms and Concepts

Session Overview

The opening session provides an overview of the workshop's goals, the week's program, and an opportunity for participants to learn more about each other's background, disciplines, and skills. Key gender, One Health and EPT terms and concepts are introduced as participants explore the different roles men and women play in health and health care of a family.

Session Learning Objectives

Participants will be able to identify basic principles and related concepts:

i)   Sex, gender, gender roles, equity, equality, and life cycle

ii)   The role of interdisciplinary teams and a focus on the human, animal and ecosystem inter-dependence in responding to an EPT

iii)   Basic principles and related concepts of epidemiology, disease transmission, and the response cycle (preparation, detection, response and evaluation)

Schedule	Topic/Activity	Learning Activity
8:00 - 9:00	Registration	
9:00 - 10:00	Introduction • Goals and Program • Expectations • Guest Speaker • Pre-Test	Presentations
10:00 - 10:15	Tea Break	
10:15 - 1:00	Discovering One Health and Gender Roles	Small Group Activity
1:00 - 2:00	Lunch	
2:00 - 3:30	Consequences of Gender Roles	Small Group Activity
3:30 - 3:45	Tea Break	
3:45 - 4:30	Quick Facts about Gender, One Health and EPT	Interactive Presentation
4:30 - 4:45	Evaluation of the Day	Plenary

The required materials include flip charts, markers, PowerPoint slides, sign in sheet, sticky notes (two colors) a tape and a pre-test

Time	Activity/Topic	Facilitator Instructions (Facilitator notes are added at the end of the session and PowerPoint slides are included to support the module)
20 min	**Registration**	• Have participants sign the OHCEA attendance register • Explain logistics (e.g. breaks, meals, etc.) • Issue per diem • If the short course is residential, check on housing accommodations
15 min	**Welcome**	Facilitator's welcome remarks and introductions Participants' introduction: • In pairs, have participants share their: • Name • Where they are from • Type of work and position • The latest One Health activity they have been engaged in • Let them prepare 1-minute introduction of their partner to the class. • Go around the room and have each pair present their partner to the class.
15 min	**Expectations**	**Set up:** Have two flipcharts in the front of the room: one titled "Expectations" and the other "Concerns." i) Give each participant two different colored sticky notes. ii) Ask them to write down their expectations for the short course on one of the sticky notes (specify color) and their concerns about the course on the second the sticky notes (specify color). iii) Have them place their expectations sticky notes on a flipchart titled "Expectations" and their concerns sticky notes on another flipchart titled "Concerns". iv) Organize the sticky notes per common themes. v) Explain the program for the week and the goals of the short course highlighting the expectations that will be met over the week and those that will not be met. Comment and address the concerns. Explain that this course is sponsored by OHCEA. • OHCEA is One Health Central and Eastern Africa network comprised of 16 universities from eight African countries consisting of schools of public health and veterinary schools with two US partners: Tufts University and the University of Minnesota. OHCEA is funded under a major USAID grant.

- OHCEA's vision is to be a global leader in One Health promoting sustainable health for prosperous communities, productive animals and balanced ecosystems. OHCEA seeks to expand the human resource base needed to detect and respond to potential pandemic disease outbreaks.

- OHCEA has identified gender, culture and beliefs as a critical competency to achieving their vision. For this reason, they are sponsoring this course.

Guest Speaker- Opening Workshop and Pre-test

15 min

In advance, be sure the speaker is prepared to address the group. Share with the speaker the short course goals and desired outcomes and what you would like him/her to emphasize in her/his address.

Introduce the invited guest speaker to "officially open the course."

Distribute copies of the pre-test. Tell participants that they have 15 minutes to complete the pre-test. Explain that a pre-test is used to gauge how much they already know; a post-test will be administered at the end of the course. The two tests will be compared. There is no grade associated with the pre-test. When participants finish, they can begin their break.

Questions:

1. List at least 5 gender concepts you know.

2. Why do you think it is important to work in multidisciplinary teams during the containment of epidemics?

3. In your view, what are the main factors that affect effective management of epidemics in Africa?

4. What is a gender responsive intervention, and how is it important in the management of disease epidemics?

5. How can we effectively implement gender concepts as part of One Health approach?

Tea Break

15 min

Prior Training Reading Material

105 min

Distribute the following three articles to participants to read before they come to the training (These articles are provided in the resources folder).

i) Ebola's Legacy by Erika Check Hayden: Nature: volume 519, 5 March 2015.

ii) Gender Issues in Human, Animal and Plant Health using an Eco-Health Perspective by Brigitte Bagnol, Robyn Alders and Robyn Mcconchie: Environmental and Natural Resources Research Vol. 5 No1, 2015.

iii) What the solution isn't: the parallel of Zika and HIV viruses for Women: Susan T. Fried and Debra J. Liebowitz: The Lancet global health blog; February 2016.

Discovery Activity; What is One Health?

10 min
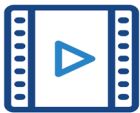
Begin the session by having the participants watch the following videos:

One Health: from Concept to Action by CDC

https://www.youtube.com/watch?v=TG0pduAYESA

One Health: from Idea to Action:

https://www.youtube.com/watch?v=gJ9ybOumITg&t=4s

Briefly discuss the two videos with the participants.
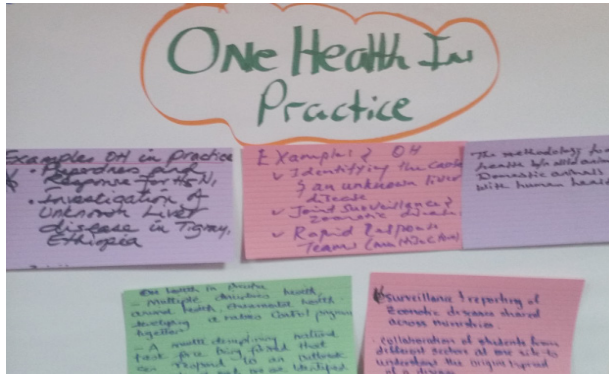
20 min

Have each participant take 5-7 minutes to think about and legibly write down on separate sticky notes the answers to the following questions:

1. Define One Health approach.

2. Identify two examples of One Health in practice.

3. Identify two to three advantages of multiple disciplines working together to promote One Health.

Have them display the sticky notes on the wall in three separate sections. Then in a plenary, review the following:

1. What are the common things identified?

2. What are the differences?

3. What is surprising about the responses?

Description of One Health

20 min

Come up with a group description of what One Health is. There are many similar definitions of One Health by different health organizations, but for the purpose of this course, we will adopt the American Veterinary Medical Association (AVMA) definition of One Health (www.avma.org).

AVMA: One Health is defined as the integrative (collaborative) effort of multiple disciplines working locally, nationally, and globally to attain optimal health for people, animals, and the environment.

Together, the three make up the One Health triad, and the health of each is inextricably connected to the others in the triad.

The common theme of One Health is multiple disciplines working together to solve problems at the human, animal and environmental interface. Collaborating across sectors that have a direct or indirect impact on health involves thinking and working across silos and enhancing resources and efforts while valuing the role each different sector plays. To improve the effectiveness of the One Health approach, there is need to create a balanced and greater relationship among existing groups and networks, especially between veterinarians and physicians. It is equally vital to amplify the role that environmental and wildlife health practitioners, as well as social scientists and other disciplines play to reduce public health threats.

Discovery Activity: What is Gender?

15 min

Ask the class to think as far back as possible and write down their first experience of realizing they/or someone they know were different from members of the opposite sex/were expected to act differently/were treated differently. Have them record the following:

1. How old were you?
2. Who was involved?
3. Where did the incident take place?
4. What incident was it?
5. How did you feel?
6. Do you think the incident or response to it would have been different if you were of the opposite sex?

7. How did other aspects of your identity (race, religious identity, nationality, social status, ethnicity) come into play?

8. If not, ask them to share a story about an experience that made them aware of the difference between men and women (i.e. household chores, who learns what in school and the role each sex occupies)

Discovery Activity: What does it Mean to be Gender Sensitive?

30 min

Divide the class into four groups. Provide each group with a separate activity. Allow them 5 minutes to review the activity provided and then have them discuss it and present their findings to the rest of the team.

The teams should be able to respond to the following questions:

1. Can you identify any gender related actions in these activities?

2. What should be done to address the gender issues?

Group 1: In this community, there is conflict between the people and the national parks because the community is collecting medicinal plants and firewood from the national parks—an area that is protected. The wildlife has also been destroying the villagers' crops and killing their domestic animals. The national park management decides to create awareness about the role of wildlife by delivering a training and awareness program primarily through night classes.

For Facilitator

The classes are held primarily at night, which limits women who are care providers for children from attending. In some communities, women are not even allowed to go out at night. The park authority does not consult the community members on its plans. Considering the fact that most of the people who collect medicinal plants and firewood are women, they should be a key stakeholder in the decision making.

Group 2: There is an outbreak of avian influenza in this community. The government decides that in order to completely eradicate this disease, they will slaughter all the birds be they ducks or chicken. They decide to compensate all poultry owners with more than 50 birds. Backyard poultry farmers are not compensated because most of them do not have more than 50 birds.

In this scenario, most backyard poultry farmers and people who keep less than 50 birds are women. If they are not compensated and yet they have lost their birds, they lose their livelihoods. As a result of this policy, whenever the women detect any sick birds, they quickly slaughter them and bring them to the markets for sale, thereby spreading the disease and exposing more people.

Group 3: The government in the country you work in wants to target farmers for training on avian influenza prevention and control in poultry production and management. They ask the animal health workers in the communities to identify people for training. Since men are the heads of households and the decision makers, they are selected to attend the training.

In most communities that were affected by avian influenza, the poultry caretakers were women. The women should therefore have been a key target for disease prevention training. However, since they are not part of the leadership circle in many communities, they are not involved in identifying trainees and cannot voice their opinion. Therefore, even if the men are trained, they will not deliver and the disease will still spread.

Group 4: There is an outbreak of brucellosis in this community. Humans have been presenting at the health center with undulating fevers. They also have increased abortions among their animals. The disease is transmitted through contaminated milk and milk products. The Department of Human Services decides to create awareness by informing people through the radios that they should boil their milk and cook the meat thoroughly. They are puzzled when the outbreak continues.

In this community, women do not generally listen to the radio. In fact, most radios are owned by men, and they usually listen to the news communally when they have men's gatherings between the hours of 2 and 5 pm at the marketplace. Women are not allowed in these gatherings. This is also the time when women are busy completing other household chores like collecting firewood.

Daily Activity clock for a household with a sick child in a community that has an Ebola outbreak

- A daily activity clock charts the activities that occur during a 24-hour period, who does them and the time it takes for them to be done.

- In plenary, have the class brainstorm the activities the community will be engaged in when there is an Ebola outbreak. The activities involve caring for a sick child in a community that has an Ebola outbreak. Record responses on a flipchart.

- They should be able to identify activities performed by men only, women only, girls only and boys only as well as communal activities such as cooking for funerals, caring for families that have lost loved ones, and attending community training sessions on Ebola prevention.

Discovery Activity: Daily Activity Clock

60 min

PPP Slides 13-19

The list should include:

i) Taking sick people to hospital
ii) Paying for transportation
iii) Preparing funerals/burial
iv) Attending funerals
v) Washing the dead
vi) Cooking food for funeral attendants
vii) Having community meetings to plan funerals
viii) Community outreach programs to prevent Ebola
ix) Talking to media/doctors/outsiders who have come into the community
x) Giving medicine
xi) Cleaning and bathing
xii) Assisting with going to the bathroom
xiii) Washing clothing and bedding
xiv) Preparing food
xv) Feeding
xvi) Calling the doctor or medical personnel
xvii) Taking to the clinic
xviii) Paying for clinic services
xix) Checking on the patient
xx) Talking to/entertaining the patient

Part 2 of Activity Clock

60 min

Part 2 of Activity Clock

i) Divide the class into four groups.
ii) Give each group flipchart paper and markers.
iii) Give each group an envelope which has one of the following four diseases:
- Brucellosis
- Tuberculosis
- Sleeping sickness (Trypanosomiasis)
- Bilharzia (schistosomiasis)
iv) Ask each group to spend 20 minutes to read about the disease they have been given. Focus on the following:
- What are the clinical signs?
- How is it transmitted?
- Is it a zoonotic disease?
- How is it prevented or treated?
- Can they identify any gender related risks in the disease transmission?
- Can they identify specific gender related disease prevention mechanisms?

v) Tell each team to create a 24-hour "activity clock" for what the men, boys, women and girls are doing in the village or community over a 24-hour period when there is a sick person and an animal in the home. An activity clock is an exercise which tracks the activities of different groups over a 24-hour period to learn what different people do in a day and to compare the activities.
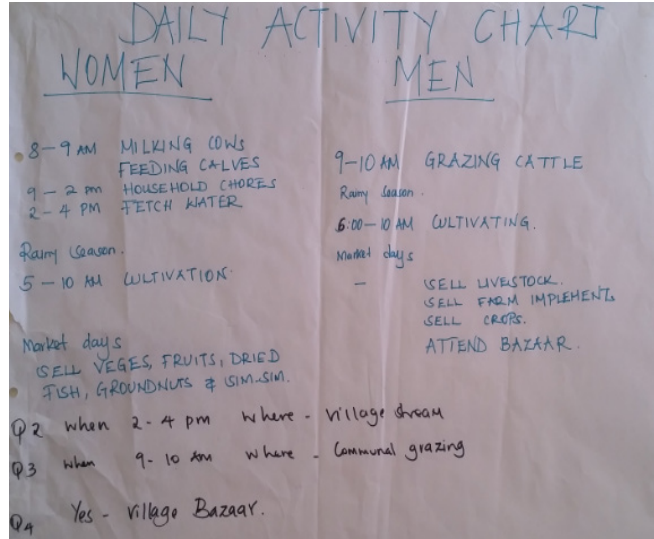
Time	Adult Men	Boys	Adult Women	Girls
02:00 am	Sleeping		Checking on the sick child	
03:00 am	Sleeping		Sleeping	
05:00 am	Sleeping		Making tea for the sick child	
05:30 am	Sleeping		Giving the sick child medicine and tea	
06:00am	Sleeping	**Sleeping**	Preparing bath and breakfast tea	Fetching water from the well

Time	Activity/Topic	Facilitator Instructions
20 min		• Post all the clocks • Have each group present its clock. • Process the activity: i) Start by focusing on "facts", that is, how time was spent. Identify activities including non-caring (e.g. working outside the house, non-paid work that benefits the household, leisure, rest, etc., and the care-giving activities identified earlier in the session.

ii) Next, focus on similarities and differences in the activities performed by men and women (e.g. similarities and differences between men and women in "caring" for the child; similarities and differences in non-care-giving activities). Identify differences related to age, class, and education.

iii) Then ask about disease-related activities and impact:

- Differences in exposure to the illness.
- Differences in contact with people outside the home.

- Debrief the activity by asking the group about:

    i) areas of agreement/disagreement among team members as they created the activity clock.

    ii) surprises.

    iii) the difference in activities among men, women, boys and girls.

    iv) what these differences mean to the group as people involved in managing disease.

    v) why these differences exist and why they are maintained.

20 min	**Short film: Promundo**	**Gather the group together and show a short film (promundo)** : http://promundoglobal.org/resources/mencare-short-rwanda/ After watching this film, have the class share similar experiences they have and the influence this has on their outlook towards men and women and the roles they are expected to play.
60 min		**Lunch Break**

Time	Activity/Topic	Facilitator Instructions
20 min	**Discovery Activity: TEDTALK**	**TEDTALK Christopher Bell- bring on the female superheroes** https://www.youtube.com/watch?v=rAZPIxYvBAE Have the class watch this TEDTALK by Christopher Bell. After the video, discuss the key ideas of this talk. 1. What is the main topic being discussed?

2. How is it related to gender roles and power?

3. Can participants give similar examples from their own past or places of work?

4. Can they suggest some solutions they think can work?

Consequences of Gender Roles

30 min

Do a PowerPoint presentation (**PPP No. 1 A**) for 15 minutes that defines basic terms: gender, sex, reproductive and productive roles, equality and equity that introduce the concept of gender. This should lead to a discussion of the gender tree (PowerPoint presentation on basic gender terms) (**PPP No. 1B**).

After this introduction, present to the participants the gender game and have them play it to differentiate between sex and gender.

Move into the discussion on the gender tree.

In most societies, women are primarily considered "caring" due to social norms. Consequently, they are often given the responsibility of taking care of the sick and the elderly – unpaid work that is valuable in the health of the household. Because women regularly encounter sick people, they are more likely to become infected. Women spend a great deal of their time in the care-giving activities which involve feeding, cleaning, washing and preparing food. Consequently, often women and young girls are less likely to be involved in political, educational and professional activities. Because they are less educated and informed, their knowledge about diseases is often less than what men have.

To understand the reasons for the differences and the impact of the difference in roles men and women play, use the metaphor of a tree.

- Branches of the tree answer the question: what institutions, legislation, policies create and maintain those gender differences?

- The leaves are the consequences of institutionalized gender differences. The leaves can represent the spread of disease (sickness, illness), food insecurity, poverty, or lack of education for women.

Understanding reasons for differences and impacts of these differences in roles men and women play

Root: **why** are there gender role differences? Culture, stereotypes, religion, legal system, political system

Trunk: **what** are the gender role differences seen? When we did the calendar

Branches: **what creates** and **maintains** those differences? e.g. policies, institutions, legislation

Leaves: **consequences**: disease , food insecurity, poverty, lack of access to resources like education

Activity: Gender Tree

45 min

Divide the class into four groups

- Give each group a piece of flipchart paper and markers. Give them three topics to discuss. You can generate 9 other topics.

- Gender roles in research/workplace at universities (engineering)

- Gender roles in politics

- Gender roles in provision of health care

- Gender roles among livestock keepers in a rural community

- Based on their topics, tell them to draw the tree describing in greater detail:

    ◊ Why there are role differences between men and women (ROOTS)
    ◊ The different roles men and women perform (TRUNK)
    ◊ What institutions, legislation and policies create and maintain gender differences (BRANCHES)
    ◊ The consequences of institutionalized gender differences (LEAVES)

- Post the trees and do a gallery walk highlighting:

    ◊ similarities
    ◊ differences
    ◊ missing aspects

Note: Use the tree above to make sure participants have a complete and accurate understanding of gender roles. When reviewing the tree, provide definitions of gender and sex. Emphasize that culture and gender roles are not static.

Debrief the session by asking students to reflect on:

1. Which part of the tree would they target for long-term, systemic intervention in order to manage disease sustainably?

2. What would they do to manage the intervention?

Activity: Gender Shoe Game

10 min

Equity and Equality

Ask four participants to come to the front of the room and remove their left shoes and put them all in a pile. Ask each person to select a left shoe that is not their own. Everyone now has a left shoe. But this distribution is not what each person needs. When we take into account other factors by acting equitably, we are inclusive and move towards equality (i.e. you receive a shoe that fits you for your purposes).

Equality means "giving everyone the same thing," but that "only works if everyone starts from the same place." Equity means giving everyone "access to the same opportunities. We must ensure equity before we can enjoy equality."

Break

15 min

Quick Facts About Gender, One Health and EPT

10 min

Concluding Comments

15 min

Quick Facts About Gender, One Health and EPT

Make a PowerPoint presentation (**PPP No. 1B**) before providing participants with a handout on basic gender terms and definitions.

Discuss these terms to ensure they understand the language used in gender related issues.

Understanding the interaction between gender roles, One Health and EPTs can lead to important insights into disease transmission patterns, strategies for prevention and control and the use of a multidisciplinary approach to inform policy and practice. Today's focus on gender, One Health and EPT terms and concepts has allowed the participants to critically analyze the convergence of gender and One Health using practical tools such as the 24-hour calendar and the tree metaphor. The four diseases selected for this purpose provide a basis that allows the participants to begin identifying the gender gaps in One Health and EPT, the resources available in the communities as well as exposure to some tools that can be used in developing a framework for gender analysis. Over the next four days, we will build on these concepts to gain a more in-depth understanding of One Health, EPT and gender.

End of Day 1 Evaluation

- Create the flipchart shown below.
- Ask the class: How did it go today?

How did it go today?

Comments:

1. Definition of One Health

There are many similar definitions of One Health by different health organizations, but for the purpose of the course, we will adopt the American Veterinary Medical Association (AVMA) definition of One Health (www.avma.org)

AVMA: One Health is defined as the integrative (collaborative) effort of multiple disciplines working locally, nationally, and globally to attain optimal health for people, animals, and the environment. Together, the three make up the One Health triad, and the health of each is inextricably connected to the others in the triad.

The common theme of One Health is multiple disciplines working together to solve problems at the human, animal and environmental interface. Collaborating across sectors that have a direct or indirect impact on health involves thinking and working across silos and harnessing resources and efforts while valuing the role each different sector plays. To improve the effectiveness of One Health approach, there is need to create a balance and a greater relationship among existing groups and networks, especially between veterinarians and physicians, and to amplify the role that environmental and wildlife health practitioners as well as social scientists and other disciplines play to reduce public health threats.

In less than 10 years, One Health has gained significant momentum. It is now a fast growing movement. The approach has been formally endorsed by the European Commission, the US Department of State, US Department of Agriculture, US Centers for Disease Control and Prevention (CDC), World Bank, World Health Organization (WHO), Food and Agriculture Organization of the United Nations (FAO), World Organization for Animal Health (OIE), United Nations System Influenza Coordination (UNSIC), various universities, NGOs and many others.

The current One Health movement is an unexpected positive development that emerged following the unprecedented Global Response to the Highly Pathogenic Avian Influenza. Since the end of 2005, there has been increasing interest in new international, political and cross-sectoral collaborations on serious health risks. Numerous international meetings and symposia have been held, including major initiatives in Winnipeg (Manitoba, Canada, March 2009), Hanoi (Vietnam, April 2010), and Stone Mountain (Georgia, US, May 2010) as well as four international One Health scientific congresses, the last of which took place in Melbourne, Australia, in December 2016.

2. Definition of Concepts and Tools Used in Gender Analysis

Sex usually defines the biological characteristics differentiating men and women. Sex is also culturally defined as the case of the South African athlete Caster Semenya showed. She and her family consider her a woman while the medical institution and the International Federation of Athletism decided that she was a hermaphrodite. Gender is a constitutive element of social relationships based on perceived differences between the sexes, and gender is a primary way of signifying relationships of power.

Gender is the wide set of characteristics that are seen to distinguish between male and female. The word has more than one valid definition. In all societies men, and women play different roles, have different needs, and face different constraints. Gender roles differ from the biological roles of men and women. Gender roles are socially constructed. They demarcate responsibilities between men and women, social and economic activities, access to resources, and decision-making authority. Biological roles are fixed, but gender can and do modify with social, economic, and technological changes. Social and economic factors underlie and support gender-based disparities:

- Institutional arrangements that create and reinforce gender-based constraints or conversely, foster an environment in which gender disparities can be reduced.
- The formal legal system that reinforces customs and practices, giving women inferior legal status.
- Socio-cultural attitudes and ethnic and class-based obligations that determine men and women's roles, responsibilities, and decision-making functions.
- Religious or/and traditional beliefs and practices that limit women's mobility, social contact, access to resources, and the types of activities they can pursue.
- Economic factors that limit women's access, control and benefits over resources, services, activities and knowledge.

Gender Analysis

At its simplest, gender analysis is seeing what our eyes have been trained not to see. It is asking about the differences between men and women's activities, roles, and resources to identify their development needs. Assessing these differences makes it possible to determine men and women's constraints and opportunities within a sector. Gender analysis can help ensure provision of services that men and women want, and that are appropriate to their circumstances. This requires analyzing quantitative and qualitative information on activities, resources and constraints, benefits and incentives related to gender roles.

(a) Gender planning

This is planning that recognizes that because women and men play different roles in society, they often have different needs.

(b) Gender roles

Gender roles recognize that in most societies, low-income women have a triple role: women undertake reproductive, productive and community managing activities, while men primarily undertake productive and community political activities.

(c) Reproductive role

These are the child-bearing/rearing responsibilities and domestic task done by women, which are required to guarantee the maintenance and reproduction of the labor force. It includes not only biological reproduction, but also the care and maintenance of the workforce (male partner and the working children) and the future workforce (infants and school-going children).

(d) Productive role

This is the work done by both women and men and is either paid in cash or kind. It includes both market production with an exchange value and subsistence/home production with actual use-value, and potential exchange-value. For women in agricultural production this includes work as independent farmers or peasant wives and wage workers.

(e) Community managing role

These are activities undertaken primarily by women at the community level, as an extension of their reproductive role to ensure the provision and maintenance of scarce resources of collective consumption such as water, health care and education. This is voluntary unpaid work, undertaken in time.

(f) Community politics role

Activities undertaken primarily by men at the community level, organized at the formal political level, often within the framework of national politics. This is usually paid work either directly or indirectly through status and power.

(g)   Differential access to, control over resources and benefits

It is important to distinguish between access to resources and control over them when examining how resources (land, labor, credit, income, etc.), are allocated between women and men. How men and women benefit from the resources should also be analyzed.

i)   **Access:** gives a person the use of a resource e.g. land to grow crops.

ii)   **Control**: allows a person to make decisions about who uses the resource or to dispose of the resource e.g. sell land. Baseline data in complete gender analysis establishes whether there is any difference in men's and women's access to key categories of resources.

iii)   **Benefit**: Allows the person to dispose of the resource in his/per interest.

iv)   **Condition and position**: Development projects generally aimed to improve the condition of people's lives. From a gender and development perspective, a distinction is made between the day-to-day condition of women's lives and their position in society. In addition to the specific conditions which women share with men, different access means women's position in relation to men must also be assessed when interventions are planned and implemented.

- **Condition**: This refers to the material state in which women and men live, and relates to their responsibilities and work. Improvements in women's and men's condition can be made by providing, for example, safe water, credit, seeds (practical gender needs).
- **Position:** Refers to women's social and economic standing in society in relation to men; for example, male/female disparities in wages and employment opportunities, unequal representation in the political process, unequal ownership of land and property, vulnerability to violence (strategic gender needs/interests).

v)   **Gender needs:** Women have needs that differ from those of men. This is due to their triple roles and subordinate position in in society. It is useful to distinguish between practical gender needs (PGN) and strategic gender needs (SGN). Practical gender needs are the needs women identify in their socially accepted roles. Practical gender needs do not change, although they arise out of gender division of labor and women's subordinate position in society. They are a response to immediate perceived necessity, identified within a specific context. They are practical in nature and often concern inadequacies in living conditions such as water provision, health care and employment.

Strategic gender needs are needs women identify because of their subordinate position in society. They vary according to contexts related to gender divisions of labor, power and control, and may include such issues as legal rights, domestic violence, equal wages, and women's control over their bodies. Meeting SGNs helps women to achieve greater equality and to change existing roles, thereby challenging women's subordinate position.

vi)   **Data disaggregated by sex/gender:** This is the information collected by questionnaires, observation or other techniques that reveals the different roles and responsibilities of men and women e.g. a gender analysis matrix chart.

vii)   **Female/gender headed households**. Female headed households may be those where no adult males are present (due to divorce, separation, migration, non-marriage, widowhood). They may also be households where men are present, but do not contribute to the household income (illness, disability, alcoholism).

viii)   **Gender blind:** This is a person who does not recognize that gender is an essential determinant of the life choices available to individuals within a society.

ix)   **Gender sensitive and/or gender responsive:** This term is used in reference to projects and planning. Gender sensitivity involves incorporating into projects activities that consider the different needs, priorities and constraints resulting from the different socio-cultural economic groups within the given project environments.

x) **Participation:** A process of communication among local people and development agents during which local people take the leading role to analyze the current situation and plan, implement and evaluate development activities.

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Session 2: One Health, Epidemiology and Gender Gaps

Session Overview

Day 2 provides a foundation for understanding One Health concepts and how developing One Health competencies enhance health professionals, practitioners, and partners' effectiveness. With this base, the day explores a gender-sensitive approach to epidemiology in addressing emerging pandemic threats.

Session Learning Objectives

Participants should be able to:

i)   explain One Health approach.
   • Describe the principles of ecosystem health and the human-animal-environmental interface.
   • Address health issues that cannot be solved through a single disciplinary approach.
i)   use a gender-sensitive approach to epidemiology.

Schedule	Topic/Activity	Learning Activity
8:00 - 9:00	Registration	
9:00 - 9:30	Morning Reflections	Plenary Session
9:30 - 10:00	Introduction to One Health	Presentation
10:00 - 10:30	Case Studies: One Health	Small Group Activity
10:30 - 10:45	Tea Break	
10:45 - 11:45	Group Presentations	Plenary Session
11:45 - 12:45	One Health Competencies	Presentation
		Small Group Activity
12:45 - 1:45	Lunch	
1:45 - 2:30	Epidemiology and Gender Gaps	Presentation
2:30 - 3:30	Case Study: Ebola	Small Group Activity
3:15 - 3:30	Tea Break	
3:30 -4:30	Group Presentations	Plenary Session
4:00 - 4:15	Evaluation of the Day	Plenary

Materials

Sign-in sheet, 2 flip charts, PowerPoint presentation, role cards, markers of different colors

Detailed Facilitator Notes

Time	Activity/Topic	Facilitator Instructions
30 min	**Attendance**	Have participants sign the OHCEA attendance register
15 min	**Morning Reflections**	Have two flipcharts in the front of the room: 1. On one flipchart write the question: "Do you think women's roles are less valued than men's?" If yes, why? And if no, why not? 2. On the other flipchart write the question: "Do you think that men are becoming marginalized? If yes, why? If no, why? 3. Discuss how these roles are playing out in the context of your country/region/district. Give each participant two sticky notes • Let participants write their responses on the sticky notes. Let them put their sticky notes on the respective flipcharts. **Debrief:** • Review and discuss the comments
30 min	**Introduction to One Health and Gender**	As infectious diseases continue to threaten the wellbeing of the world, a more strategic cross-sectoral approach is needed to counter these threats. Emerging and re-emerging diseases such as rift valley fever, Ebola virus, brucellosis, tuberculosis, increasing global trends in climate change and microbial resistance, make us acutely aware of the interdependence of human, animal and environmental ecosystems. One Health paradigm recognizes the reliance of these three systems on each other and that to prevent diseases at the human, animal and ecosystem interface cross- sectoral collaboration has to be promoted and policies, systems and processes have to be put in place. This morning's section will focus on One Health presenting definitions, the concept and rationale, and the current context of One Health in Africa. Using various case studies, we will demonstrate the interconnectivity of various health challenges and the benefits of multidisciplinary approaches. This section of One Health is aimed at sensitizing and imparting the requisite knowledge and enabling skills for the adoption and promotion of the concepts of One Health approaches to participants.

It is expected that through this, participants will be able to work in a multidisciplinary manner in the planning, implementation and monitoring of any activities that will improve their response to any emerging pandemics.

One Health Presentation

Present a brief PowerPoint (**PPP No. 2**) on One Health, what it is and the drivers of disease emergence, and why it is important to have a multidisciplinary approach. (**PowerPoint presentation on One Health and the drivers of disease emergence**)

Case Studies in One Health and Gender

(Case studies are found at the end of the session in the Facilitator Notes)

Case Studies in One Health and Gender

45 min

- Divide the class into four groups
- Give each group one of the following case studies:

  - Rabies
  - Outbreak of Tuberculosis in Uganda
  - Environmental, wildlife and health issues in Kilosa
  - Mining in Lake Tshangalele

- Have the groups read their case study, answer the questions at the end of the case and prepare a 10-minute report summarizing the case and conclusions.

Case Study: Rabies

Questions:

1. Who are the people involved and affected in this case?

2. Can you list the different sectors that you can identify who could work together well? What other sectors would you have liked to involve?

3. What would you have done differently?

4. What could you have done to prevent the situation from getting to this stage?

5. Do you support everything that the veterinarian did? Why or why not?

6. If you were a district veterinary officer, how would you manage this problem in your community?

7. What gender issues do you see in this scenario and how would you deal with them?

Case Study: Bovine Tuberculosis (TB)

Questions:

1. What are the different elements involved and who are stakeholders in the case of TB?
2. What disciplines should work together to control this re-emerging pandemic?
3. What are the benefits of cross-sectoral cooperation and the sharing of resources and information between countries?
4. What gender issues do you see in this scenario and how would you deal with them?
5. Can you make a list of some of the gender issues that are noticeable in this case study? How can you begin to address some of these issues?

Case Study: Environmental, Wildlife and Health Issues in Kilosa

Questions:

1. Why do you think this situation is ideal for One Health activities?
2. Identify key issues that are problematic in this area.
3. Can you identify the key elements and stakeholders in the area?
4. What gender sensitive One Health related interventions can be developed and how can you engage key stakeholders in the interventions?
5. What gender issues do you see in this scenario and how would you analyze and address them?

Case Study: Mining in Lake Tshangalele

Questions

1. Given this scenario, what are the One Health issues that arise, and who is affected?
2. Can you identify the multiple stakeholders or players in this scenario?
3. Can you develop a gender sensitive intervention strategy for this community?
4. Who would be your key players in the intervention strategy?
5. What do you think could be the possible causes of the health problems affecting the community?
6. How would you investigate the problem? What simple steps can be taken to investigate the problem?
7. What are the main gender considerations in this scenario and how would you address them?

Break

15 min

Time	Activity/Topic	Facilitator Instructions
80 min	**Group Presentations**	Each group has 10 minutes to present and 10 minutes to discuss their case study.

Note: Presentations should include the points that were in italics in each case study.

Have the participants complete the following stakeholder analysis exercise. |
| 30 min | **Stakeholder Analysis of the Case Study** | (This exercise was adopted from the University of Minnesota OH-SMART tool (https://www.vetmed.umn.edu/centers-programs/global-one-health-initiative/one-health-systems-mapping-and-analysis-resource-toolkit) and from work done by Professor Jodi Sandfort of UMN on Policy Field analysis)

You have been provided with a set of sticky notes.

    i)   On a sticky note, write a name of a stakeholder or player in your case study scenario. One name per note. Write as many stakeholders as you can think of. Identify them by their roles. Consider their gender as well especially at the community level

    ii)   Line the sticky notes on the plain piece of paper according to whether they are international, national, regional or local.

    iii)   Draw a circle around those stakeholders with lots of power and authority using a red marker.

    iv)   Draw a square around those players with the most interest in the activity or who are impacted the most.

    v)   Using a red marker, draw arrows that show flow of decision-making (power and authority) from one stakeholder to another.

    vi)   Using a green marker, draw arrows that show flow of resources (funding) from one stakeholder to another

    vii)   Using a blue marker, draw arrows that show communication flow from one stakeholder to another. Have the groups discuss the map and the following questions:

       1. Who has power and authority?

       2. Who do you think should have power and yet does not?

       3. Who is being left out of the different arrows and yet considered important, and how do you include them?

       4. Can you identify any gender differences in power, communication flow and resource flow? |
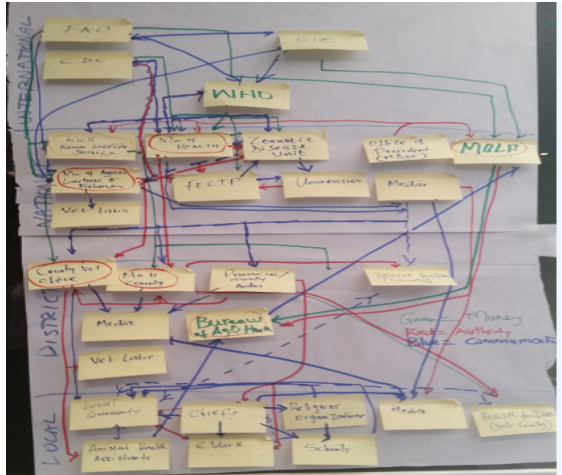
Example of a stakeholder map

The case studies demonstrated the interconnectivity of health challenges and the benefits of a multidisciplinary approach. Key concepts include:

    i)   Health emergencies are not limited to one sector.

    ii)   Human activity, agricultural practices and gender roles can contribute to disease transmission.

    iii)   The benefits of cross-sectoral cooperation and the sharing of resources leads to prevention of disease at the root, which is economic and can save lives.

    iv)   Primary health strategies need to include education about disease and disease transmission.

One Health Competencies

30 min

For effective and efficient practice of One Health approach, there are defined competencies - skills, knowledge and behaviors - that build upon the foundation of multiple health-related disciplines. One Health competencies are critical for the early identification and appropriate response to epidemics of emerging infectious pathogens.

Presentation on One Health Core Competencies
10-minute introductory presentation on core competencies and how they were developed. (**PPP No. 3**)

Note: This activity requires you to prepare "role cards" for each case. These should have the name of the health professionals, practitioners, partners and other stakeholders relevant to the case. The table below shows the cards that need to be prepared:

Group Activity: Role Cards

Rabies	TB	Kilosa District	Mining
Mother	Mother	Pastoralist (herder)	Miner
Child	Veterinarian	Farmer	Wife
Nurse	Medical doctor	Woman	Child
Veterinarian	Farmer	Park ranger	Chinese owner of mine
Village elder	Business man/woman	Tourist	Government official
Women group leader	Hunter	Government official	Fishmonger
Traditional healer	Tourist	Village elder	Herder
Government official	Government official	Environmentalist	Medical doctor
Public health person	Wildlife specialist	Poacher	Veterinarian
Dog owner	Milk consumer	Veterinarian	Environmentalist
		Disaster manager	Businessman

- Let participants return to case study groups.

- Distribute role cards for each case study.

- Have individuals assume the roles on the cards.

- Assignment:

    i)   As a group, identify the skills, knowledge, behaviors in one or two words that each role needs to work together in relation to the case study and the role. Present this on a flipchart.

    ii) After all the groups have completed, discuss as a group and identify key skills and competences that participants think are key for them to become effective in their work and the roles they played.

    iii) Have each group create a symbol that represents their group.

    iv) On a flipchart, create a "Wordle," with their group symbol in the center. A "Wordle" is a picture created by words.
    - The size of each word reflects its importance
    - Font and color are used to differentiate words
    - The words can form an outline of an objective or just fill a rectangle

v)   Conduct a "gallery" walk stopping at each flipchart
and have the group explain their symbol and design.

Example:

1. What key skills, knowledge and behaviors do you see in all
the Wordles?

2. What differences do you see?

3. What do you think this says about One Health
competencies?

15 min

Debrief:

60 min

Lunch

45 min

Epidemiology and Gender Gaps

Give a PowerPoint presentation (**PPP No. 4B**) on epidemiology and gender gaps

See PowerPoint presentation for presentation notes. Have the participants watch the following video on Ebola in Liberia.

https://www.youtube.com/watch?v=XasTcDsDfMg

As they watch it, have them think of the transmission of Ebola.

The roles of men and women in the process – hunters and sellers: Who does what? Who believes what? Who are the gatekeepers and trusted members of the community? Who controls the resources and how does this affect risk? Therefore, what role would they play in transmission and control of the outbreak? What are the risk issues to Ebola in this community?

Who in this community is being more exposed and at risk? Who should be targeted for interventions and why?

Case Study: Ebola

30 min

Case Study: Ebola

Have the participants review the case study on Ebola and discuss it. Allow the participants 15 minutes to specifically research the cases of outbreaks mentioned in the various countries through the Internet.

Write the questions on a piece of paper and have everyone pick one question and answer it in a plenary.

Questions

1. Why do you think in the 2001-2002 outbreak of Ebola in Congo and Gabon more men than women were infected in the early stages of the outbreak?

2. Why do you think the cases of women later outnumbered the cases of men in this outbreak?

3. Why is it that the female cases exceeded the number of male cases for the duration of the outbreak of 2000–2001 in Gulu, Uganda?

4. Explain why in the outbreak of 1976 in Sudan, there were more male cases than female?

Group Discussion on Case Study

60 min

Note: Discussions should include the following:

- Men were the first to be exposed through some established gender roles like hunting where they first came into contact with infected people.

- The excess in female cases may be explained by the fact that the transmission of the Ebola virus often occurs while caring for the sick, a role that is more likely to be played by women than men.

- Gender roles ascribed to women like washing of bodies and caring for the sick

- Men predominated because 75% of the medical staff in the main hospital was male (WHO International Study Team, 1976).

- The transmission of cases was almost exclusively from providing nursing care for sick relatives; 24 of 29 secondary cases had provided such care.

- Response should include the following steps:

  ◊ Carry out a thorough gender analysis to establish: gender roles of community members, time use, participation, norms, laws or codes, status of women and men in terms of access to resources (money, etc.), norms that may impact women/men in terms of what they are allowed to do, and impact of the project goals on women and men.
  ◊ Provide appropriate training and sufficient protective gears to those at the frontline of care-giving during any outbreak.

- ◊ Discourage the men in Congo from hunting and eating monkeys.
- ◊ Train those elderly women who prepare dead bodies to treat all dead bodies as potential sources of an epidemic and they should be handled with utmost caution.

Debrief with the following concluding remarks:

Ebola is a terrible outbreak with significant gender connotations.

- Men and women may be affected differently.

- Care-givers who are mainly women should always be alert and should handle every case with caution, following all bio-security measures.

Tea Break

15 min

Case Analysis: Ebola in Sierra Leone, 2014

20 min

Ebola in Sierra Leone, 2014

(*The following case activity was authored by Katherine Grassle, Andrea Rios-Gonzalez, Adel Molnar and Esty Yanco as part of their case study on Ebola at the Tufts Cummings School of Veterinary Medicine, Human Dimensions in Conservation Medicine Class, Masters in Conservation Medicine Candidates 2016*)

Read the background information provided in the Annex on Ebola titled **Ebola 2014: in Sierra Leone.**

Activity 1: Sociocultural Factors in Disease Transmission

- i) In your groups, using the framework provided, generate scenarios in which transmission of Ebola virus could occur between the individuals included in the story framework. The first transmission scenario has been provided as an example (see framework table below the background information)

- ii) Identify 3 main components of Sierra Leonean culture that contributed to the transmission of Ebola during the 2013-2015 outbreak. How do you think these components are integral to their culture?

- iii) What are some of the ways that transmission of Ebola can be reduced? Suggest 2 actions that can be taken by those in an Ebola-stricken region to curtail the likelihood of virus transmission while not imposing on cultural restrictions. Remember that lack of cultural sensitivity has fostered mistrust of outsiders during the outbreak response.

Activity 2: Risk analysis

Examine the diagram in the annex that reviews behaviors linked to Ebola transmission. Using a scale from 1 to 3 (1 = low and 3 = high) and the background information provided above and from your own knowledge, assign a relative risk of Ebola transmission to each behavior. As you assign the risk, also assign gender to each behavior based on their roles (it could be male or female or both).

Gender, Culture and High-risk Diseases

45 min

Besides roles, can you think of the other components such as division of labor, access and control over resources, and power dynamics that increase one's risk of transmission?

In 2015, WHO designated 11 diseases as high risk for severe outbreaks. Ten of these diseases are of zoonotic origin. This list includes the following: Arenaviral hemorrhagic fevers (including Lassa Fever, Crimean Congo Hemorrhagic Fever (CCHF), Filoviral diseases (including Ebola and Marburg), Middle East Respiratory Syndrome Coronavirus (MERS-CoV); other highly pathogenic coronaviral diseases (such as Severe Acute Respiratory Syndrome, (SARS), Nipah and related henipaviral diseases, Rift Valley Fever (RVF), Severe Fever with Thrombocytopenia Syndrome (SFTS) and Zika.

Group the participants in pairs. Assign each pair one of these diseases. All participants should answer the following questions:

1. In relation to the disease allocated to them, they should identify the health threat, the environmental component, the animal component (vector or reservoir), the human component as well as other One Health competencies that intersect with these three.

2. They should identify the risk in relation to gender and cultural issues i.e.: Are there cultural habits that increase the risk of the disease?

3. Are gender roles likely to impact the risk of the disease - (differences) among men and women?

4. Does access to resources, information and education, and decision-making influence the risks to the disease? Can one identify who is more at risk based on these factors?

5. How can they take gender issues into consideration in their management plan?

Participants should then present their findings, keeping the presentations to a maximum of five minutes. This should open a discussion on the importance of gender related factors that influence risk and affect exposure and consequences in cases where there are public health threats.

Article on Ebola Legacy in West Africa

25 min

Participants were requested to read this article prior to coming for the training. `*Ebola's lasting legacy by Erika check Hayden: nature: volume 519; March 2015 (included in the Annex)*

Review this article with the group, focusing on current and future impact of Ebola on maternal health and why it is so significant.

What challenges do you see in relation to your own country and other countries?

End of Day 2 Evaluation

- Create the flipchart shown below.

- Ask the class; "How did it go today?"

How did it go today?

Comments:

Session 2 Facilitator Notes

Case Study 1: Rabies

Batamuliza is a ten-year-old girl and the daughter to Mr and Mrs Baswiza. She is a resident of Nyagatare, Rwanda. She traveled to Uganda to visit her grandmother and spent there one week. While she was at her grandmother's place, she was bitten by a stray dog. When she returned to her parents' home, she was feeling unwell and the dog wounds were getting infected. She told her mother what had happened and her mother found some traditional herbs and gave them to her. When she did not get better her mother brought her to a traditional medicine man who cast out the evil spirits that he said were making her feel unwell.

After a few days, her mother realized that her daughter was getting worse and brought her to the local health center. At the health center, the nurse realized immediately that the dog might have been rabid. Batamuliza needed to receive post exposure vaccination which was very expensive. Mr Baswiza consulted with the local butcher and sold the family cow to pay for the vaccine. Batamuliza was given the vaccine. The nurse also quickly called the veterinarian in charge of the area, who called his counterpart in Uganda to ensure that the dog was captured to avoid biting more people. They found out that the dog had also bitten two other children in that village and several cows which had developed rabies.

On further investigation, the veterinarian discovered that the dog had been infected by a wild fox which liked to come and scavenge for food in the village. The women in the village liked to feed the fox because they believed in the tradition that if you fed foxes, you would be more fertile. The veterinarian called a meeting of the village elders and did a brief community training on rabies. Batamuliza got better after a few days and went out to play with her friends.

Questions:

1. Who are the people involved and affected in this case?

   Family members, mother father, children, other villagers from both Uganda and Rwanda, veterinarians in both countries, nursing personnel who treated and handled the sick, local leaders and decision-makers, traditional medicine men.

2. Can you list the different sectors that you can identify that could work together well? What other sectors would you have liked to involve?

   Health and veterinary sectors in both Rwanda and Uganda, government (local leadership and county council), immigration offices, local social work office that deals with cultural issues/traditional healers association

3. What would you have done differently?

   Taken the child immediately to hospital, inquired from grandmother in Uganda immediately if the dog was rabid and involved the medical and vet department, and any diagnostic labs; also gather the women's groups or other social networks that women engage in and conduct a community training with them.

4. What could you have done to prevent the situation from getting to this stage?

   Communicate immediately with authorities; educate mother and other mothers and women (women who are not mothers yet may also feed foxes) on rabies as well as the community

5. Do you support everything that the veterinarian did: why or why not?

   He just called village elders for a meeting. This usually leaves out women and children. He/she should

have specifically targeted women and children in school to make them aware.

6. If you were a district veterinary officer, how would you manage this problem in your community?
   - *Create awareness for both humans and animals carers, work with medical team and local community members to educate everyone about rabies*
   - *Vaccination campaign for dogs*
   - *Pre-exposure vaccination campaign for humans*

7. What gender issues do you see in this scenario and how would you deal with them?

   Gender roles: access to resources and decision-making? Mrs Baswiza was responsible for collecting traditional herbs and care for the family.

   Did Mr Baswiza consult when he sold the only cow the family had? Who has control over resources? In this community, women perform the animal care activities and yet do not control the resources.

   The Veterinarian was communicating with village elders about this disease. Are women allowed in the meeting of the village elders or is it assumed that this information will be passed onto them by their husbands? 80% of the nurses are female and the risk of exposure to infectious diseases is high.

Case Study 2: Bovine Tuberculosis
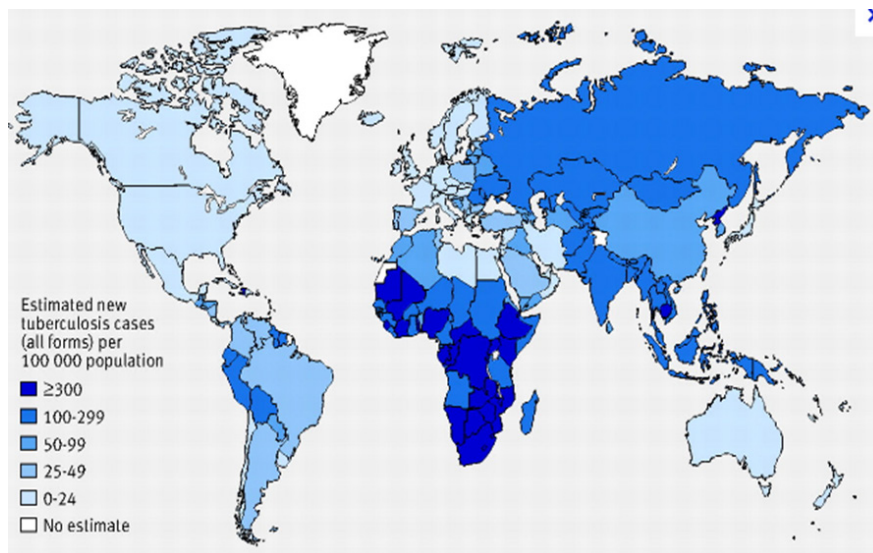
Every year, there are 8–10 million new cases of TB reported, and 2–3 million deaths attributed to TB. In many countries in Africa, HIV and AIDS is widespread. The biggest killer of people with HIV and AIDS is TB. However, the impact of Bovine TB (BTB) on humans is poorly documented. BTB is a major problem for livestock in developing countries and wildlife play a major role in the failure of TB eradication programs. In many cases, consumption of raw meat and milk and preference of bush meat consumption as a cheap source of protein are the principal routes of human contamination with BTB. Human TB of animal origin (zoonotic TB) is an important public health concern in developing countries.

African nations face a particular challenge in TB control, deficiencies in public health control measures for cattle and animal products. Once detected, 90 percent of tuberculosis cases are curable for as little as $15 per treatment. HIV and AIDS is fueling the TB epidemic, and yet coordination between the TB and HIV communities is lacking. The spread of extensively drug-resistant TB (XDR-TB) is a major threat and there is significant lack of infrastructure and capacity, including laboratory facilities and

health workers. This is exacerbated by the fact that smaller, fewer regulated farmers sell unpasteurized milk directly to consumers, and most consumers in the village do not boil milk to the required standards.

Mycobacterium bovis has a broad host range as the principal cause of TB in free-living wildlife, captive wildlife, domestic livestock, and non-human primates. Wild ruminants and carnivores, such as African buffalo, lion, cheetah, greater kudu, leopard, warthog and eland, can be infected and then infect both humans and domestic animals. Scavengers (hyenas, genet) and chacma baboons in Kenya became infected through the ingestion of abattoir wastes. Furthermore, recent development of wildlife activities such as game tourism, farming, and hunting to develop the peripheral zones of protected areas has increased human contact with wild animals. Due to international travel and migration, TB is now considered a rapidly re-emerging pandemic. Many cases diagnosed are multi-drug resistant (MDR) or XDR.

Questions:

1. Who and what are the different elements involved and stakeholders in the case of TB?
   - *Wild animals, domestic animals, humans, birds*
   - *Multiple governments, veterinarians, medical doctors, wildlife specialists*
   - *Consumers of milk and meat products, handlers of these products, business people, hunters, women selling milk and handling food, caring for the sick*
   - *International travel organizations and their governments, WHO, OIE, FAO,*
   - *NGOs involved and engaged in disease control*

2. What disciplines should work together to control this re-emerging pandemic?
   All disciplines: medical, veterinary, wildlife, anthropology, local and national leaders, businesses, consumers, multi-lateral organizations: WHO, OIE

3. What are the benefits of cross-sectoral cooperation and the sharing of resource and information between countries?
   - *Needed for the effective control of highly contagious disease emergencies*
   - *Participants should be able to brainstorm here and come up with multiple ideas*

4. What gender issues do you see in this scenario and how would you deal with them?
   - *Women are responsible for milking, and cooking food.*
   - *They are care-givers.*
   - *If not targeted for intervention, cannot be able to control TB.*
   - *Men are hunters bringing bush meat home.*
   - *Traders in illegal bush meat where women are sometimes the intermediate agents.*
   - *Access to medical care; fewer women receive training compared to men in most communities.*
   - *Drug resistance (MDR ad XDR) make control difficult.*

5. Can you make a list of some of the gender issues that are noticeable in this case study? How can you begin to address some of these issues?
   - *Multi-disciplinary cooperation*
   - *Cross-regional, cross-country and multiple governments*
   - *Working with anthropologists and social scientists*

Case Study 3: Environmental, Wildlife and Health Issues in Kilosa

Human domestic Wildlife Environment interface
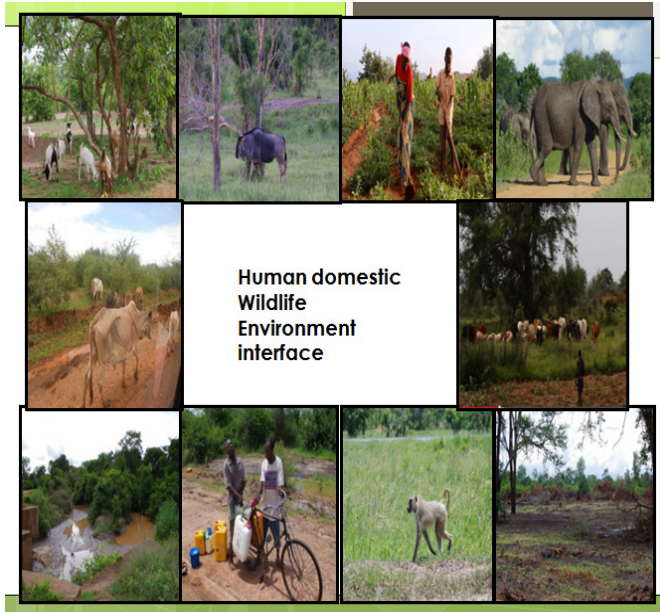
Considering the increasing global demographics, disease emergence and intensified encroachment on natural habitats, meeting the needs of the community and safeguarding their health is becoming a significant challenge. Engaging communities in One Health activities is one way to ensure that they are involved in the planning, implementation and management of activities and interventions right from the beginning. In Kilosa district of Tanzania, close to Mikumi National Park, wildlife, livestock and people live in close proximity, making the plains a potential "hot spot" for emerging pandemic threats. This area has been identified as ideal for a One Health demonstration site. Specific human health, animal health, and ecosystem challenges and impact were identified such as human, livestock and wildlife diseases, habitat fragmentation, edge effect and biodiversity loss.

The Kilosa region is strategically positioned in terms of cultural resources and vulnerable populations as well as endemic or threatened wildlife species. Rabies, Rift Valley Fever and milk borne BTB and Brucellosis as well as water borne zoonoses are identified by community members as priority diseases that could be intervened effectively using One Health approach. There is an ongoing conflict among pastoralists and farmers, and the national parks administration. Wildlife like elephants constantly destroyed farmers' crops and human–wildlife conflict was rampant. Environmental degradation is evident with community members cutting down trees to sell charcoal. Recent flooding in the area had led to massive soil erosion as well as people and animal displacement. As a result of this, there is conflict over scarcity of water resources for wildlife, animals and humans.

Poaching in Mikumi National Park was constant and road kill of wildlife was a big problem since this was the main highway for transnational tracks from Tanzania to Southern Africa. Conflict between the national park rangers and communities also results from women going into the park to gather firewood and fruits. Potential opportunities for the demonstration site to contribute to the local economy by virtue of employment, improved subsistence resources, conservation and sustainability, biodiversity protection, improved recreation or appreciation by tourists are present.

Questions:

1. Why do you think this situation is ideal for One Health activities?
    *   *Specific human, animal, and ecosystem health challenges and impacts*
    *   *Consistent with One Health themes and competencies (e.g. local human, livestock and wildlife diseases, habitat fragmentation, biodiversity loss)*
    *   *Examples of, and/or future opportunities for community-based participatory research, training and interventions*
    *   *Presence of ongoing/resolved issues/stakeholder conflicts and degree to which such issues present opportunities or obstacles to success in the teaching and learning environment*
    *   *Involvement/presence of community and district stakeholders/personnel who are willing to be part of the team*

2. Can you identify key issues that are problematic in this area?
    *   *Zoonotic diseases: rabies, rift valley fever and milk BTB and brucellosis as well as water borne zoonoses were identified by community members as priority diseases for which intervention would be effective using One Health approach.*
    *   *Human-wildlife conflict, conflict between farmers and the national park rangers, conflict over scarcity of resources such as foliage and water, poaching in Mikumi National Park, conflict between pastoralists and herders*
    *   *Flooding and displacement and what happens to animals*
    *   *Tourism and its impact, traffic in the area and road kill of wildlife*
    *   *Gender issues*

3. Identify key elements and stakeholders in the area?
    *   *Wildlife, domestic animals, crops*
    *   *Farmers, herders, pastoralists, women collecting firewood, internally displaced people*
    *   *Poachers, different ministries, national park rangers*
    *   *Veterinarians, medical doctors, disaster management teams, district officers in different departments*
    *   *Police officers, tourists, car owners traveling to other countries*

4. What One Health related interventions can be done and how can you engage key stakeholders in the interventions?
    *   *Rabies, Rift valley fever and milk BTB and brucellosis as well as water borne zoonoses were identified by community members as priority diseases for which intervention would be effective using One Health approach.*
    *   *Ongoing conflict among pastoralists, farmers, and the national parks administration presents opportunities for research and novel intervention systems.*
    *   *Tourism and road kill are key issues for the park to deal with.*
    *   *All the activities mentioned as One Health issues can become interventions with community*
    *   *Look for opportunities to engage the communities in the interventions.*

5. What gender issues do you see in this scenario and how would you deal with them?

Case Study 4: Mining in Lake Tshangalele: Environmental and Health Impact Assessment in the Democratic Republic of Congo

Improvised ventilation for a mine shaft at the Tilwezembe site, near Kolwezi, Katanga

http://www.amnesty.org/en/news/chinese-mining-industry-contributes-abuses-democratic-republic-congo-2013-06-19

To provide incentives and attract investors to the mining sector, a new mining code was enacted in the DRC in July of 2002. The new code attracted several new mining companies, but which are generally smaller in size compared to those operating at the time of the reform. For economic reasons, small mining operations tend to operate closer to large populations creating health and environmental problems. To mitigate the environmental impact of extractive industries, the government of DRC has recently enacted an environment framework law. However, the 2011 legislation still needs other implementation measures to guarantee its effectiveness.

The increase in mining operations in Lubumbashi, a city of 1.3 million inhabitants, and the surrounding areas has led to air and water pollution that directly affects humans, animals and the food chain. The mines are estimated to provide direct employment to between 200,000 and 280,000 permanent full-time miners who are located only 0.1 km from the edge of the city (see Figure). During the peak season, the total number of miners reaches an estimated 400,000 workers. About 74% of miners are diggers while the remaining are sorters and washers.

Miners and their families are exposed to heavy metals through dust inhalation, food and water contamination. In Shinkolobwe and Kolwezi, miners are exposed to radiation of up to 24 mSv/year. Poor sanitation conditions in the miners' camps also favor epidemics. Recent studies have shown a significant risk of heavy metal contamination in humans, goats and fishes. Massive excavations related to copper mining operations affect the ecosystem such that the natural habitat of rodents and other animals become carriers of pathogens. These may cause known and unknown diseases as they invade human habitats creating a serious health risk.

In 2011, an outbreak of unknown disease with hemorrhagic fever like symptoms caused several deaths and hospitalizations in Kapolowe District Health Center which is 114 Km North West of Lubumbashi. However, a follow-up was not made as there was generally poor understanding of these exposures and their specific effects. There were also inadequate capacities to study and mitigate these problems. Evidence suggests fish from Lake Tshanga-Lele located in the same district are heavily contaminated. Fish from this lake constitute a main source of protein for the population of the city of Lubumbashi.

Illnesses of unknown origin have also been observed in goats within the same area. These kinds of exposures from mining and its related activities may be associated with significant disease burden. World Health Organization (WHO) estimates that environmental risk factors contribute to 24% of the global burden of disease from all causes and up to 23% of deaths; emphasizing that this is likely a conservative estimate because for many diseases, the associations are poorly understood (Prüss-Üstün and Corvalán, 2006).

Questions

1. Given this scenario, what are the One Health issues that arise and who is affected?
   - *Pollution, heavy metal contamination, waterborne illnesses, lung problems, animal/human diseases, dust inhalation, food and water contamination*
   - *Miners and their families, business people and consumers, fishermen and consumers of their fish, animal owners, government, extractive industry*

2. Identify the multiple stakeholders or players in this scenario.

   Miners and their families, business owners and private industry, medical, environment, and veterinary professionals, fishermen and other people who rely on the fish, goat keepers or herders and those who purchase the animals for food, government, law and policy makers regarding mining.

3. Develop a gender sensitive intervention strategy for this community.
   - *Scenario can be different but should involve community and government legislation, miners and private industry*
   - *This scenario has particular relevance to inform zoning policies in the Katanga province, decrees to be issued to accompany the environmental framework law enacted in 2011 and the design of effective emergent and re-emergent diseases surveillance and outbreak response mechanisms. Other regions of DRC and many countries in Africa face the same mining problems.*
   - *It should also help to develop and strengthen environmental and occupational health-related regional research collaborations and to inform nationally and internationally relevant policy development.*

4. Who would be your key players in the intervention strategy?
   - *Both male and female community of miners, private industry, professionals/ vet/medics/ environmentalists, government and policymakers, community leadership whether male or female.*

5. What do you think could be the possible causes of the health problems affecting the community?

6. How would you investigate the problem? What simple steps can be taken to investigate the problem?
   - *Carry out simple participatory exercises among the community to identify levels of infection in humans, animals and community; collect samples from water, animals, fish, humans, test samples for heavy metals*
   - *Perform a risk assessment*
   - *Perform a rapid gender analysis (in person or desk review)*

7. What are the main gender considerations in this scenario and how would you address them?
   - *Identify the gender roles and responsibilities:*
   - *Women in this community have excessive exposure because they are fetching water from the rivers and cooking the contaminated foods.*
   - *Men are mostly exposed because they work in the mines and therefore lung diseases would be more common among them*
   - *Among those who died, who were affected the most: males or females?*

Case study 5: Ebola

In the 2001–2002 Ebola outbreak that occurred in the Congo and Gabon, more men than women were infected during the early stages of the outbreak, a situation that was reversed during the later stages of the outbreak. In contrast, the number of female cases exceeded the number of male cases for the duration of the outbreak of 2000–2001 in Gulu, Uganda. During an outbreak, health officials usually compare the cumulative distributions of male and female cases. Cumulative distributions can sometimes mask potentially informative fluctuations in numbers of cases over the course of an outbreak. For the outbreak in Gulu, for example, the cumulative distribution was greater in females throughout, whereas in the outbreak in Gabon it switched from predominantly male to predominately female.

If only the cumulative distribution had been plotted for the outbreak in Gabon, the switch in incidence from an excess of male cases to an excess of female cases would not have been seen until later in the outbreak when the total number of females infected was greater than the total number of males. Interestingly, the outbreaks in Sudan are notable exceptions. Although no published data are available on the proportion of female cases in a relatively large outbreak that occurred in 1976, it has been reported that males predominated. The 1979 outbreak in Nzara and Yambio in Sudan was also unusual, in that, despite its small size, a large proportion of those infected were female (69%).

Questions

1. Why do you think in the 2001-2002 outbreak of Ebola in Congo and Gabon more men than women were infected in the early stages of the outbreak?

2. Why do you think the cases of women later outnumbered the cases of men in this outbreak?

3. Why is it that the female cases exceeded the number of male cases for the duration of the outbreak of 2000–2001 in Gulu, Uganda?

4. Explain why in the outbreak of 1976 in Sudan, there were more male cases than female?

Ebola 2014: In Sierra Leone

The following case activity was authored by Katherine Grassle, Andrea Rios-Gonzalez, Adel Molnar, Esty Yanco as part of their case study on Ebola at the Tufts Cummings School of Veterinary Medicine, Human Dimensions in Conservation Medicine Class, Masters in Conservation Medicine Candidates 2016)

Read the following background information. Origins of disease	Scientific evidence suggests that the virus lies dormant in fruit bats. The virus is transmitted to chimpanzees and gorillas in the forest which get sick and die of Ebola. The virus is often transmitted to humans through consumption of infected meat (World Health Organization 2016a).
Methods of transmission	Ebola is transmitted from person-to-person when an uninfected individual gets in contact with the body fluids (e.g., blood and saliva) of someone who is showing symptoms of Ebola either directly or through exposure to contaminated surfaces (World Health Organization 2016a).
Disease progression	The first signs of Ebola appear at 2 to 21 days after infection. Initial symptoms include fever, muscle pain, and headache. As the disease worsens, sick individuals experience vomiting, diarrhea, decreased kidney and liver function, and sometimes bleeding (both internal and external). On average, 50% of those infected die from Ebola. Rehydration and supportive care are currently the most widely used and effective treatment for Ebola (World Health Organization 2016a).

Roles of women	Once married, a woman will move from her ancestral home to that of her husband. Women are responsible for childcare, tending to the ill (both in hospitals and at home), and trade in goods and food. Research estimates that women are responsible for up to 70% of all cross-border trade in Sierra Leone and Liberia. Studies further estimate that women made up approximately 75% of the total number of Ebola cases in Liberia during the 2014 outbreak (Diggins and Mills 2015).
Funeral rituals	When a male member of a household dies, the other male members participate in funeral rituals by washing the body of the deceased. The wife of the deceased shaves her hair and covers her head with mud made from a mixture of the washing water and soil, which they believe protects her from her husband's jealous spirit if she remarries (Richards et al. 2015). When a female member of a household dies, the women from her family's village travel to the home of the deceased to wash her body. The body is then transported back to the woman's ancestral home for burial (Richards et al. 2015).
Mistrust of authorities	Many people do not trust international agencies that arrive in their villages to manage the disease outbreak. They dress differently (wearing personal protective equipment such as body suits) and mandate rules that are not familiar to the villagers. Poor communication and lack of cultural sensitivity has led to many fearing international authorities and avoiding seeking care for their illnesses (Richards et al. 2015, Pellacchia et al. 2015)
Travel across borders	In West Africa, borders between countries are fluid—they are not demarcated and guarded strictly like those along the political lines of the United States. Trade, marriage and family visitations can require an easy passage across village and country borders.

Session 3: Gender Analysis Tools

Risk Analysis Diagram
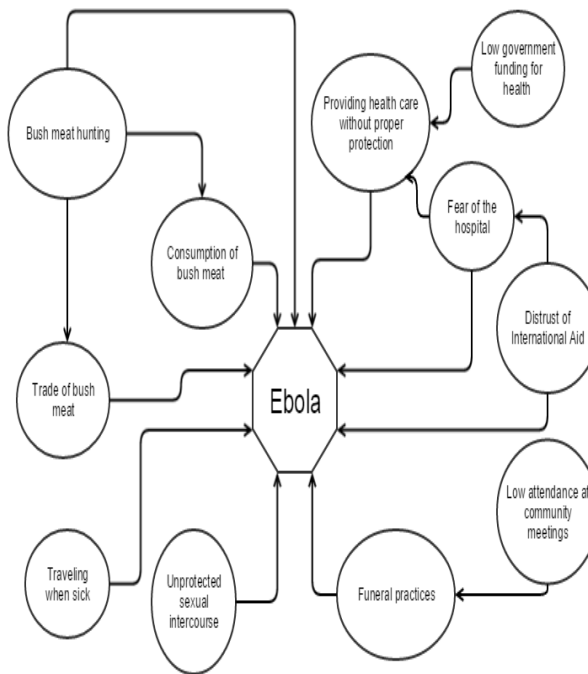
Learning and Applying Gender Analysis Tools in Disease Surveillance, Response, Prevention and Control

Session Overview

The day flows with a succession of analysis tools being introduced and applied. The session uses concepts that were presented in the afternoon of Day One in the specific context of disease surveillance, response, prevention and control. Throughout the day participants will use as examples, four different diseases (TB, brucellosis, Ebola and bilharzia). Please note that there are materials to assist the facilitator in this session. These are at the end of the session.

Learning Objective

Participants will be able to:

i)   select the relevant gender tool.
ii)   use the gender tool.
iii) understand the importance of using gender tools and conducting gender analyses.

Schedule	Topic/Activity	Learning Activity
8:00 - 9:00	Registration	
9:00 - 9:15	Introduction to Day 3	
9:15 - 9:45	Gender Matrix Development	Group Activity
9:45 - 10:15	Group Presentations	Plenary Session
10:15 - 10:20	Data on Gender Difference in Ebola Outbreak	Plenary Session
10:20 - 10:50	Gender Analysis – 5 Domains	Group Activity
10:50 - 11:00	Tea Break	
11:00 - 11:30	Group Presentation	Plenary Session
11:15 – 12.00	Social Network Analysis-Stakeholder and Resource Mapping Vulnerability Mapping Group Presentation	Plenary Session
12.00 -12.30	Communication Profile Presentations	Group Activity
1:15 - 2:15	Lunch	
2:15 - 3:15	Gender Continuum	Plenary Session
3:15 - 3:45	Monitoring and Evaluation of Interventions Using Gender Tools Implications of Gender Issues for Surveillance, Response, Prevention and Control	Plenary Session
3:45 - 4:00	Tea Break	
4:00 - 4:20	Summary of the Day	Plenary Session
4:20 - 4:30	Evaluation of the day	Plenary Session

Materials

- Sign in sheet
- PowerPoint
- Evaluation Chart

Time	Activity/Topic	Facilitator Instructions
5 min	**Opening Comments**	Have participants sign the OHCEA attendance register. Introduce today's topic by saying: "Today flows with a succession of analysis tools being introduced and applied. The session uses most of the concepts that were already discussed in Day 1 (afternoon) in the specific context of disease surveillance, response, prevention and control."

Participants work in the same four groups all day (at least four groups so that surveillance, response, prevention and control can be covered) and apply the tools to an imaginary rural community according to the disease that was assigned to them. They will use a gender lens to collect relevant data in the context of health. Then the data accumulated in relation to the fictional community will allow them to develop a gender sensitive intervention. In the morning, they use tools to understand the community and in the afternoon, they use tools to develop an intervention to mitigate the impact of the disease.

Introduction to Day 3

15 min

Gender Analysis in Infectious Diseases (part 1)

Why do Gender Analysis?

Who does what?
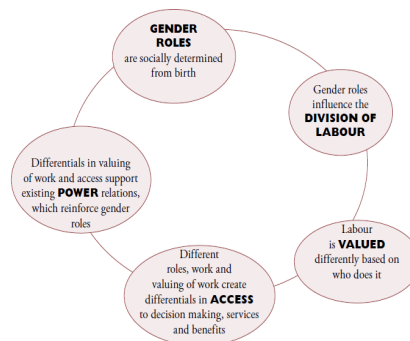Who has what?
Who decides?
How?
Who gains?
Who looses?

- It is important to identify the Gender-related practices which increase the probability of men or women getting an infectious disease.
- Harmful practices can then be discouraged while helpful ones adopted.

Give a brief PowerPoint presentation (**PPP No.5**) on gender analysis, gender indicators and gender sensitive indicators and statistics.

Also discuss the different gender analysis concepts.

What a good analysis should provide:

- Gender awareness - understanding of gender relations and their implications for development, policy and implementation
- Analysis of the division of labor - activities, access and control and benefit from division of labor
- A review of women's priorities - restraining and driving forces
- Recommendations to address women's practical needs and/or strategic interests
- Productive/paid and unpaid work

GENDER ROLES are socially determined from birth

Gender roles influence the DIVISION OF LABOUR

Labour is VALUED differently based on who does it

Different roles, work and valuing of work create differentials in ACCESS to decision making, services and benefits

Differentials in valuing of work and access support existing POWER relations, which reinforce gender roles

Gender Analysis Tools

The day will focus on the following tools:

i)   Gender analysis matrix
ii)   Community resource mapping
iii) USAID's 5 domains of analysis
iv)   Communication profile
v)   Gender continuum
vi)   Monitoring and evaluation using gender tools

Instructions: During the day, participants will be divided into four groups. They will use gender tools to collect relevant data in the context of health. The data will be used to develop a gender-sensitive intervention.

- Briefly introduce the gender analysis domains

- Divide the class into four groups

    - Ask four volunteers (2 women and 2 men.)
    - Have the volunteers come to the front of the classroom.
    - Have each volunteer pick someone in the class they have not worked with yet and do not know as well. That person stands behind the volunteer.
    - Ask the second person in line to pick someone they have not worked with yet and do not know well.
    - Continue until everyone is on a team.

Gender Analysis Tools: Gender Analysis Matrix and Domains

30 min

Activity 1: Gender Matrix on Vulnerability Exposure and Response to Disease Outbreak and Gender Domain Matrix

USAID five Domains of Gender Analysis

This session introduces the USAID five domains of gender analysis which are the core domains upon which our gender analysis is based. The USAID five domains for Gender analysis framework will be used to capture data related to barriers, opportunities and strategies for improving women's entry and participation. Discuss the USAID five domains as listed below

- **Laws, policies, regulations and institutional practices**:

    i)   Are men and women treated equally in legislation, and by official policies and institutions in the country?
    ii)   How could this impact your project or activity?

- **Access to and control over assets and resources (including income, employment, and assets such as land):**

    i)   Who has access to which resources?
    ii)   Do men and women have equal access to the resources needed to participate in this project?

- **Gender roles, responsibilities and time use:**
    - i) Who does what?
    - ii) How do gender roles and responsibilities impact the likelihood that men and women will participate in this project and in development activities in general?
- **Cultural norms and beliefs:**
    - i) What beliefs and perceptions shape gender identities and norms?
    - ii) Do gender stereotypes function as a facilitator or barrier to men's or women's engagement in this activity?
- **Patterns of power and decision-making:**
    - i) Will women have control over assets and benefits that may accrue from them because of participating in the project?

Directions:

Part A
- i) Ask participants to select a specific urban or rural setting and a different community in different countries.
- ii) Assign different diseases to different groups. Let participants select a disease that most of their group members did not work on during Day 1 or 2. The diseases include: brucellosis, TB, Ebola or bilharzia.
- iii) In their selected setting, participants should complete the handouts identifying the vulnerability, exposure and response to disease outbreak as it affects men and women, the household and entire communities.

Part B
- i) The next step involves the groups completing the 5 domains of analysis for each disease and how it impacts community members.
- ii) Each group should present this information on a flipchart.

The discussion should emphasize the fact that men and women are often not involved in the same social activities. While men are more likely to be involved in hunting, commercial crops growing, large livestock and formal employment, women are gathering wood, edible and medicinal plants, caring for small livestock, and producing subsistence food. Women are also responsible for the nutrition and health of their households, especially when

preparing daily meals and taking care of the sick and the elderly (both as paid professionals and as unpaid and untrained persons). Livestock, crops, natural resources and activities, are thus "gendered" as well as the risk to contract disease because of these activities. Distinguishable exposure is often the result of patterns of activities resulting from socially defined gender roles that influence the timing of the contact with the infectious agent within the cycle of the outbreak.

Activity 2: Access, Control and Benefit over Resources

30 min

Introduce exercise by showing Slide 3 and review the data on gender differences in an Ebola outbreak. (*Refer to Activity 2 in the annex*).

Use the table with data on Tanzania and Zambia as an example of some of the resources to consider.

Instruct participants to complete Activity 2 and to discuss the implications of the data on the impact of disease and the provision of health care and education about the effects of treatments for their assigned focus (e.g. outbreak, surveillance, prevention, response, control).

Each group should prepare a 5-minute presentation.

15 min

Tea Break

Group Presentations

20 min

In plenary, ask the different groups to present their findings.

Discuss gender differences relating to the impact of disease and provision of health care and knowledge about the effect of treatments.

Gender does not only impact on the risk of contracting diseases, but it also influences the likelihood of accessing information and treatment, resources to get access to treatment, to the evolution of the disease and the outcome of the treatment.

Access to services depends on several factors that include among others, gender, class, religion and education. While women regularly go to the health center when they are pregnant or with young children who they take for weighing or immunization, they are less likely than men to go to the health center for their own health problems. Often, they do not have the resources to do so and require a formal authorization from their partners. Also, in some cases with norms of social behavior, women may not have the decision-making authority to take their children to a health center and to consult the health center for their own health issues.

While some groups can be more prone to infection by a disease, some others such as pregnant and breast-feeding women find themselves in a situation where the side effects of the medicine on both the fetus and the breast-feeding child are not always well known.

Stigma can also affect men and women differently. Discrimination and stigmatization are important issues in highly pathogenic avian influenza, (HPAI), Ebola (WHO, 2007) Marburg and HIV.

Activity 3: Community Resource Mapping

105 min

Community resource mapping is a method of showing information regarding the occurrence, distribution, access to, use and control over and benefit from resources. It covers the topography, natural resources, human settlements, and activities in a locality from the perspective of the community. This is a mapping tool to help people understand, visualize, discuss and improve situations in which many different actors influence outcomes. This analysis tool will specifically focus on participants identifying what they consider as places of significance in a community for different stakeholders. The resources in the community are identified.

- They may be physical: water source, forest, wildlife, and wetland.
- They may include social services – hospitals, schools, places of worship, transport.

They may include economic resources like cattle, agricultural gardens, human resource (health workers, teachers, household as a unit).

It is key to identify who in the community has access to these resources and who controls them.

Community Resource Mapping	Community Resource Mapping
Social **Environmental** **Economic** Health personnel Market Village Well Traders Teachers School Hospital Forest Livestock ☐ Who has access to them? ☐ Who controls them?	**What does Community Resource Mapping tell us?** • How people within a community view their environment. • Community members' analysis of the natural resources found in their community and how they are used. **What can Community Resource Mapping be used for?** • Identifying and examining relationships between a community's resources, topography, settlements, and activities • Enabling people to picture resources and features and to show graphically the significance attached to them • Identifying problems, possibilities, and opportunities

Group Activity: Teso Case Study

⏱ 45 min

📄🔍

Participants should read the TESO case study. *Based on a report from Kenya Finland Collaboration project-KEFINCO-Western Kenya Water Supply Program 1996 (WKWSP)*

Installing water system in Teso District - Very Tricky

Group Activity: Resource mapping: Teso

Have the groups answer the following questions:

1. Plot a resource map indicating issues of use: Who has access, ownership and control?

2. What would be the best time to meet the women and where would the meeting be?

3. What would be the best time to meet the men and where would that meeting be?

4. Is it possible to have a combined meeting for the men and women? Where would it be and when?

5. Why did the women shun the tap built by the NGO's?
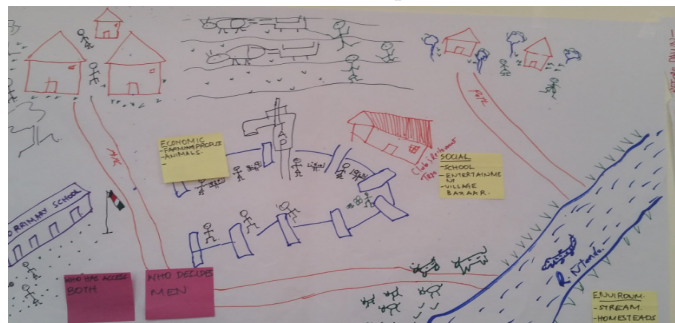
Resource Mapping

Divide the participants into four groups: women, men, children (noting differences in/with girls and boys, medical personnel (again noting differences in female vs male personnel). They should assume they are in an Ebola outbreak community in Sierra Leone. Each group should then map out the stakeholders and specific resources/places they consider important to them, or what they should use the most to meet their needs. They should identify and discuss:

• Similarities in groups.

• Differences in groups.

• significance of those differences.

• How the differences affect access to and control over resources.

Vulnerability to Risk Mapping

This is essential to identify who is most vulnerable in an infectious disease outbreak and why, which capacities need to be strengthened and what relief and services are needed. Vulnerabilities and capacities of individuals and social groups evolve over time and determine people's abilities to cope with and recover from disaster.

Group Activity: Resource and Risk Mapping for an Ebola Community

30 min

i)   Each group should map out the risks faced by their teams (women, men, children, medical personnel).

ii) Identify/ map out signs of those risks in the community.

iii) Add resources that can be used to mitigate those risks to the maps in different colors.

Communication Profile (*This is a communication matrix tool developed by ACDI/VOCA – found in the Annex as Activity 4)*

This is a very simple tool that provides information on how women and men access and share information.

- Based on the community they are working in, have participants fill out the communication matrix for their community.
- They should then display this communication matrix and discuss it with the rest of the class.

Give a brief introduction using a PowerPoint presentation on what the gender continuum is. (**PowerPoint Presentation on Gender Equality Continuum**)

This Gender Equality Continuum Tool shows the ways in which programs can address gender or not. Some programs are gender blind; they do not address gender at all. Other programs are aware of how gender norms/inequalities influence behavior and they address those norms in their activities.

Gender accommodating programs work around gender norms and dynamics. Gender transformative programs seek to change gender norms and dynamics. These programs also may be synchronized or may intentionally work with women and men in mutually reinforcing ways to address and challenge gender norms.

Programs can include both gender accommodating and transformative elements to achieve/address gender inequalities that are barriers to healthy behavior.

Activity 4: Communication Profile

30 min

Activity 5: Gender Equality Continuum Tool

20 min

Cases on Gender Equality Continuum

Have participants review the following brief case studies or select an activity or project that they work with. It could be their university, a specific project or a specific activity in the OHCEA work plan and analyze it against the continuum.

The Fredonian Hand-washing Initiative aimed to reduce morbidity and mortality among children less than 5 years through a communication campaign promoting proper hand-washing with soap to prevent diarrheal disease. Four soap companies launched hand-washing promotion campaigns: radio and television advertisements; posters and flyers; school, municipal, and health center programs; distribution of soap samples; promotional events; and print advertisements. The basic approach was to present a mother as caretaker of the family and to describe or illustrate the three critical times for hand-washing: before cooking or preparing food; before feeding a child or eating; and after defecation, cleaning a baby, or changing a diaper. They also emphasized essential aspects of the hand-washing technique: use water and soap, rub one's hands together at least three times, and dry them hygienically.

Zika is a disease caused by Zika virus that is spread to people primarily through the bite of an infected *Aedes* species mosquito. The most common symptoms of Zika are fever, rash, joint pain, and conjunctivitis (red eyes). The illness is usually mild with symptoms lasting for several days to a week after being bitten by an infected mosquito. People usually do not get sick enough to go to hospital, and they very rarely die of Zika. For this reason, many people might not realize they have been infected.

Once a person has been infected, he or she is likely to be protected from future infections. During the first week of infection, Zika virus can be found in the blood and is passed from an infected person to another through mosquito bites. An infected mosquito can then spread the virus to other people.

We do not know how long the virus is present in the semen of men who have had Zika. We do know that the virus can be present in semen longer than in blood. Not having sex is the best way to be sure that someone does not acquire the Zika virus by sexual transmission.

Cases on Gender Equality Continuum

20 min

Grappling with a mosquito-borne virus linked to brain damage in infants, Blanktown is advising all women in the country not to get pregnant until 2018. One community leader said that a government clinic in his neighborhood shut down three months ago after repeated threats from gangs, the kind of condition that experts say make it harder to treat and combat the virus. Stagnant water which allows the insects to breed is a fact of life here as are the pools of trash cloaking many city streets in the dense neighborhoodsthat carve through the hillsides of the capital. An expert said that members of the armed force would go door-to-door with information for women to delay pregnancy to help in mosquito eradication efforts ahead of the country's holiday celebrations. The government plans to also distribute mosquito repellents to some 400,000 pregnant women who receive cash-transfer benefits.

Case 1: Handwashing for Diarrheal Disease Prevention in Fredonia

10 min

As part of its commitment to the health and well-being of its workers, an international mining company in South Africa set up a health clinic near one of its mines to provide health services to its workers. As part of their required annual checkups, all mine workers are tested for HIV and receive integrated NACS (nutrition assessment, counseling and support) services.

The nutritional assessment revealed that several of the miners suffer from a Vitamin C deficiency as well as moderate malnutrition. Appropriate nutrition counseling is offered to these clients, with follow-up visits scheduled to re-assess the miners' nutritional status.

Case 2: Zika Virus in Blanktown

10 min

Unfortunately, upon reviewing the quarterly data, clinicians discovered that despite receiving nutritional counseling, the miners' nutritional status did not improve. The clinic undertook a Quality Improvement (QI) process to try and understand what was happening. The process revealed that while NACS was being properly implemented in the clinic, the malnourished clients had a difficult time adopting some of the essential nutrition actions that were recommended, specifically eating a variety of foods and increasing the intake of nutritious foods.

Case 3: Overcoming Structural Barriers to Improve Nutrition for Men

10 min

Upon closer examination, the QI team discovered that the malnourished miners had migrated to South Africa from their home in Lesotho and they did not know how to cook – cooking being a skill that was not traditionally taught to boys in Lesotho but was the responsibility of women and girls. As such, the miners had not been able to improve their dietary diversity.
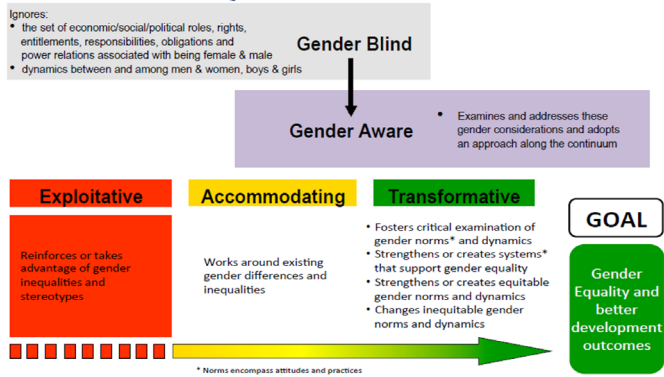
The clinic decided to incorporate basic information on how to prepare and cook nutritious foods into its nutrition counseling sessions and referred the miners to a community support group that was working on improving the overall health of the mining community. They also informed the community support group of the challenges facing the miners' ability to maintain adequate nutrition, and suggested they incorporate cooking demonstrations into their community outreach activities.

Questions for review and analysis based on continuum.

1. Are the cases gender blind/ gender aware:
    - exploitative?
    - accommodating?
    - transformative?

2. Begin to think of ways to make them transformative.

3. What specific action items can they come up with?

GENDER EQUALITY CONTINUUM TOOL

Ignores:
- the set of economic/social/political roles, rights, entitlements, responsibilities, obligations and power relations associated with being female & male
- dynamics between and among men & women, boys & girls

Gender Blind

Gender Aware — Examines and addresses these gender considerations and adopts an approach along the continuum

Exploitative — Reinforces or takes advantage of gender inequalities and stereotypes

Accommodating — Works around existing gender differences and inequalities

Transformative
- Fosters critical examination of gender norms* and dynamics
- Strengthens or creates systems* that support gender equality
- Strengthens or creates equitable gender norms and dynamics
- Changes inequitable gender norms and dynamics

GOAL — Gender Equality and better development outcomes

* Norms encompass attitudes and practices

Gender Framework Domains

IGWG

Directions: 1) Identify key gender issues for each domain and list the constraint or opportunity related them.
2) Then identify how that constraint or opportunity will affect proposed objectives of the program. Consider any additional information you may need to collect to better identify constraints and opportunities.
3) Consider how the program as it is currently designed (pre-gender integration) will affect the status of men and women (gender equity).
4) Brainstorm and select possible actions to address gender-based constraints and opportunities.
5) Design monitoring and evaluation indicators that will measure whether (a) the gender-based opportunity has been taken advantage f or (b) the gender-based constraint has been removed.

Integrating Gender into Programs

Gender Domains	(1) What is the identified gender-based constraint or opportunity?	(2) How does the gender-based constraint or opportunity affect the objectives of the program?	(3) How will the expected results affect the status of men and women?	(4) Possible actions to address the constraints and opportunities to achieve more equitable outcomes	(5) M&E indicators to measure whether (a) the gender-based opportunity has been taken advantage of or (b) the gender-based constraint has been removed.
Access					
Knowledge, Beliefs and Perceptions					

Gender Framework Domains

15 min

Have participants engage in the above activity following the instructions provided in the table.

Please refer to the monitoring and evaluation in **Activity 6** of the annex.

Divide participants into four groups. Participants will work with a fictional community either urban or rural (the group members choose the community).

Using the following gender tools, develop interventions related to your assigned RESPOND activity (e.g. response, surveillance, prevention, control) to address an Ebola outbreak for the village community you have been working on.

Activity 6: Monitoring and Evaluation Using Gender Tools
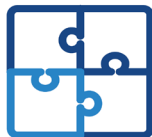
20 min

Presentation of gender tools:

- Condition and position
- Practical and strategic needs
- Equity/equality
- SWOT analysis
- Gender sensitive indicators

All the data accumulated on the fictional community need to be used to develop a gender-sensitive intervention and the relevant gender sensitive monitoring. Assign one group to work on surveillance, another on prevention, one other on control and the last one on response. The groups should use the new tools introduced:

Gender Sensitive Intervention

20 min

- Condition and position
- Practical and strategic needs
- Equity/equality
- SWOT analysis
- Gender-sensitive indicators

Time	Activity/Topic	Facilitator Instructions
60 min	**Group Presentations**	• In plenary ask the different groups to present their findings. • Regroup and analyze the groups findings.
	Implications of Gender and Cultural Issues for Disease Surveillance, Control and Response	**Elements for the Discussion and the PowerPoint** **Give a 20-minute PowerPoint presentation (PPP No.7) that focuses on gender and disease surveillance, control and response.** Guidelines for disease surveillance and response systems rarely include specific indicators for gender and cultural issues. However, as discussed earlier, gender differentials create different circumstances with impact on the implementation of biosecurity and eco-security measures. Similarly, socio-economic and cultural aspects influence the socially accepted measures to be taken. As a consequence, gender and cultural aspects need to be collected and taken into consideration during all phases of both the collection of information and the intervention. For example, gender and cultural aspects have been identified as a major issue in relation to the prevention and impact mitigation of HIV and AIDS (UNAIDS, 2009a; 2009b). **Gender Sensitive Disease Surveillance, Control and Response** It is important to understand disease epidemics and responses in terms of gender in order to meet the needs of all groups within a community. All data such as infection rate and case-fatality should be disaggregated by sex. Similarly, the profile of symptoms for men and women should also be separated. The use of relevant sex and age-disaggregation helps to build the knowledge necessary for programming action and for developing gender-responsive programming. It is necessary to gather and use sex and age-disaggregated data and other relevant socio-cultural, economic and legal data in addition to carrying out gender analyses in all phases of programming and action. It enables understanding of the varying impact of infectious and emerging diseases at all levels of society on women, men, girls and boys as people that are or can be infected and affected by the diseases in various ways. The epidemiology of risk and vulnerability for all groups must be analyzed, taking into account the economic, legal and sociological contexts that fuel the spread of the disease, increase their burden of care, and prevent effective treatment and support (UNAIDS, 2009b).

Culturally Sensitive Disease Surveillance, Control and Response

Local differences in both the cosmological views and the etiology of the diseases and in the treatments, impact on all phases of an intervention. Thus, understanding the context is fundamental to draw upon local knowledge to strengthen disease surveillance and response (Hewlett and Hewlett, 2008). Specialists in cultural issues (anthropologists or sociologists) should be involved whenever possible (WHO, 2007). A participatory approach that enables discussion and the sharing of both the biomedical approach and the local knowledge on medical issues facilitates dialogue with communities to develop messages and measures together to limit risk and treat specific signs and syndromes.

The health burden carried out by women should be reduced by involving men in care-giving services for the sick and by sharing the responsibilities of caring for babies and children (Sweetman, 2002; The Guttmacher Institute, 2003, Father Incorporated, 2003). Health programs that emphasize women's role in the care-giving responsibilities reinforce gender stereotypes and contribute to maintaining women in a gender confined world with limited access to information and resources.

15 min

Break

20 min

Summary of the Day

- Review gender analysis tools
- Review activities
- Ask participants the following questions:
  - i) What stood out as key learnings?
  - ii) What surprised you?
  - iii) How do you see using gender analysis tools and techniques in your work?

10 min

End of Day 3 Evaluation

- Create the flipchart shown below.
- Ask the class: "How did it go today?"

> **How did it go today?**
>
> ☺ 😐 ☹
>
> *Comments:*

Productive and Reproductive Roles

Definitions

Gender division of labor: In all societies, tasks and responsibilities are typically undertaken by either women or men. This allocation of activities on the basis of sex is known as gender division of labor. This practice is learned and is clearly understood by all members of a given society. Both women and men understand well the circumstances under which the typical practices can be varied and the limitations of this variation. Change usually takes place when a society is under some form of stress, for example, when a community migrates to find work, and their tasks must be undertaken by other members of their families. Sexual division of labor is perhaps the most significant social structure governing gender relations.

Gender roles and responsibilities: This is another term for the division of labor. It is used most frequently in those analytic frameworks, especially the Harvard Framework. Its derivatives such as the POP Framework, which emerged before the use of the term "gender relations", became widespread during the 90s.

Productive work: This is work that produces goods and services for exchange in the marketplace (for income). Some analysts, especially those working on questions of equality between men and women, include the production of items for consumption by the household under this definition, even though they never reach the marketplace. They regard this as consumption of a form of non-monetary income. Both men and women contribute to family income with various forms of productive work, although men predominate in productive work, especially where remuneration is higher. In most societies, history shows that changes in economic structure and in the structure of productive activities, have led to changes in the sexual division of labor and gender relations.

Reproductive work/unpaid work: This work involves all the tasks associated with supporting and servicing the current and future workforce - those who undertake or will undertake productive work. It includes child-bearing and nurturing, but is not limited to these tasks. It has increasingly been referred to as "social reproduction" to indicate the broader scope of the term than the activities associated with biological reproduction. Socially reproductive activities include childcare, food preparation, care for the sick, and socialization of the young, attention to ritual and cultural activities through which a society's work ethic is transmitted, and the community sharing and support which is essential to the survival of economic stress.

Reproductive work is essential for its economic importance, even though most of it is unpaid, and therefore unrecorded in national accounts. Women and girls are mainly responsible for this work which is usually unpaid.

Community managing role: Activities undertaken primarily by women at the community level as an extension of their reproductive role to ensure the provision and maintenance of scarce resources of collective consumption, such as water, health care and education. This is voluntary and unpaid work undertaken during "free" time.

Community politics role: Activities undertaken primarily by men at community level when organizing a formal political activity, often within the framework of national politics. This is usually paid work, either directly or indirectly, through status and power.

The intersection of peoples' productive and reproductive responsibilities, is the principal focus of a gender analysis.

Example: Social Roles and Risk Differences in an Ebola Out break

Information available on the Ebola hemorrhagic fever virus published by WHO (2007: 23-32) shows gender differences in the transmission route and in the timing of the infection. Ebola virus is often fatal in humans and primates and is transmitted through contact between animals, animals and humans and between humans[1]. At the onset of the outbreak, men in contact with infected primates, often hunters, may become infected, but as the outbreak progresses, more women are exposed due to specific gender roles such as caring for sick people either at home, in a health center, as traditional healers or as midwives.

As a result of cultural practices and as a way to prevent the younger generation from being exposed to the risk of contracting the Ebola hemorrhaging fever virus, it was found out in some communities that old women were responsible for caring for the sick and performing the cleansing of the dead body (Helmett and Amola, 2003; WHO, 2007). Therefore, the gender, the role of the person and the age can be important risk factors that need to be taken into consideration alongside the cultural characteristics.

During an outbreak of Ebola Hemorrhagic fever in Kikwitt in DRC in 1995, a large number of women were infected in the maternity clinic (WHO, 2007). Thus, maternity clinics and hospitals can be places where nosocomial spread is observed and the outbreak amplified. Health professionals and people who will frequent the facilities are at increased risk to contract the infectious disease at an early stage of the outbreak when preventive measures are not yet in place.

Difference in Exposure to the Ebola Hemorrhagic Fever Virus by Men and Women

Transmission Route	Gender Role	Human Group Affected	Period of the Outbreak Cycle
From infected primate	Hunting	Adult male	Onset of the outbreak
From infected persons	Caring for sick people	Female youth, adult and elderly women	Successive phase of the outbreak
From infected persons	Caring for sick people	Health care staff usually female	Successive phase of the outbreak
From infected persons	Caring for sick people	Traditional healers and midwives	Successive phase of the outbreak
From infected persons	No specific gender role	Sick patients in hospital	Successive phase of the outbreak
From infected persons	Preparing the body of the dead	Usually women, influenced by gender and social norms	Successive phase of the outbreak

Source: WHO, 2007: 23-32 and www.cdc.gov

Instructions

i) Select a rural area of the country and identify all the different activities carried out by men/boys and women/girls. Specifically look at the activities connected to the disease you have been assigned. Complete the table on the following page by providing detailed comments on the activities performed by women and girls and men and boys. **Note:** *Typical activities have been listed as examples.*

ii) Discuss the implication of gender roles identified in the event of an outbreak of the disease assigned to your group:

- Brucellosis

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[1]   http://www.who.int/csr/disease/ebola/en/

- TB
- Sleeping Sickness (Trypanosomiasis)
- Bilharzia

Productive and Reproductive Role

Activities	Women/Girls	Men/Boys	Implications in the Event of Disease
Productive Activities			
Agriculture:			
i) Seedling			
ii) Harvesting			
iii) Post-harvest care			
Livestock:			
i) Taking care of big animals			
ii) Taking care of small animals			
iii) Milking goats			
iv) Milking cows			
Income Generating:			
i) Milking cows			
ii) Hunting bats, apes, big animals			
iii) Hunting rats, fishing			
Employment:			
i) Nurse			
ii) Midwife			
iii) Traditional healer			
iv) Extension worker			
v) Veterinarian			
vi) Community activist			
vii) Other			

Activities	Women/Girls	Men/Boys	Implications in the Event of Disease
Reproductive Activities			
Water related:			
i) Fetch water			
ii) Wash clothes			
Fuel related:			
i) Getting fire wood			
Food:			
i) Killing big animals			
ii) Killing small animals			
iii) Cutting the meat into pieces			
iv) Food preparation			
Childcare:			
i) Taking care of the children			
ii) Cooking for the children			
iii) Cleaning for the children			
iv) Washing the children			
Health related:			
i) Taking care of the sick			
ii) Cooking for the sick			
iii) Cleaning for the sick			
iv) Washing the sick			
v) Washing dirty clothes of sick people			
Market related:			
i) Selling			
ii) Cleaning			
iii) Other			

Activities	Women/Girls	Men/Boys	Implications in the Event of Disease
Community managing role			
i) Cleaning and repairing			
ii) Cooking for ceremonies			
iii) Preparing the dead body			
iv) Carrying the coffin			
v) Other			
Community politics roles			
i) Decision-making			
ii) Contact with community outsiders, authorities			
iii) Other			

Discussion Notes:

Exercise adapted from:

- Moser, O. N. C. (1993). Gender Planning and Development, Theory, Practice and Training. London: Routledge.

- Fong, S. M., Wendy, W. and Anjana, B (1996). Toolkit on Gender in Water and Sanitation. Gender Toolkit Series Nº 2. Washington: World Bank.

- United Nations Development Programme (2001). Gender in Development Programme. Learning & Information Pack. Gender Analysis. UNDP

Activity: Access to and Control over Resources and Benefits

Instructions

Use the rural community you used in the previous activity to complete the table below by identifying the access, control and benefit of men and women in relation to the different resources. Focus specifically on the resources that are relevant for the disease you are analyzing.

Use the table with data on Tanzania and Zambia as an example of some of the resources to consider.

	ACCESS TO		CONTROL OVER	
	Women	Men	Women	Men
• Land • Equipment • Labor • Cash • Education/training • Other				
• Outside income • Asset ownership • Basic needs (e.g. food, clothing, shelter) • Education • Political Power/prestige • Other				

What are the implications of access to resources on health issues including outbreak, surveillance, prevention, response and control?

Definitions and Data

Differential access to and control over resources and benefits from resources: It is important to distinguish between access to and control over resources as well as benefits from them when examining how these resources (land, labor, credit, income, etc.) are allocated between women and men.

- **Access:** Gives a person the use of a resource e.g. land to grow crops.

1. What kind of resources do women and men have access to?
   - i)   Financial
   - ii)   Services
   - iii)   Information
   - iv)   Social capital
   - v)   Knowledge

- **Control:** Allows a person to make decisions about who uses the resources or to dispose of the resources e.g. sell land. Baseline data in a complete gender analysis establishes whether there is any differential in men's and women's access to three key categories of resources:

i) Economic/productive/resources (land, credit, cash income, employment)

ii) Political resources (education, political representation, leadership)

iii) Time (a critical resource which increasingly acquires a monetary value)

- **Benefit from:** Ability to utilize and benefit from the resources connected to agency. It is not enough to have access; does the society allow women/girls to benefit from those resources too?

Percentage of persons who usually take decisions about purchases in the household*	Mainly Wife		Wife and Husband Jointly		Mainly Husband	
	Tanzania	Uganda	Tanzania	Uganda	Tanzania	Uganda
Major household purchases	6.9	16.2	31.9	41.2	57.7	42.0
Person who decides how women's cash earnings are used	35.9	52.7	47.2	30.9	16.6	14.3

Percentage of persons who usually take decisions about purchases in the household and percentage of currently married women, aged 15 to 49, with cash earnings in the past 12 months by person who decides how the women's cash earnings are used. Tanzania DHS, 2010; Uganda DHS, 2011

Decision-making percentage distribution of currently married women by person who usually takes decisions about health care	Mainly Wife		Wife and Husband Jointly		Mainly Husband	
	Tanzania	Uganda	Tanzania	Uganda	Tanzania	Uganda
Own health care	15.8	23.3	45.0	36.9	38.1	39.1

Tanzania DHS, 2010; Uganda DHS, 2011

Indicators related to gender differences in literacy and access to information	Tanzania		Zambia	
	Women	Men	Women	Men
Women and men aged 15 to 49 who cannot read (%)	27.4	17.6	36.1	18.3
Women and men aged 15 to 49 who are not regularly exposed to any media (TV, radio, or written press) at least once a week (%)	36.0	18.8	33.1	19.1

Tanzania DHS, 2010; Zambia DHS, 2007

Case Study: Installing Water System in Teso District – Very tricky

A village in eastern Uganda consists of a farming community that keeps livestock and grows crops. The children go to school in the morning then help their parents with chores in the evening. The men's activities generally consist of taking the cattle for grazing in the communal fields at around 9:00–10:00am. This would be after the women have milked the cows and have fed the calves. The young boys take the goats and sheep that are tethered around the home to graze and browse in the nearby fields upon returning home from school. Cultivating in the crop garden during the rainy season starts in the cool morning just before dawn and ends by around 10:00am. Both men and women participate and oxen may be used to draw the ploughs. Sometimes children help especially in the planting just before they go to school at 8:30am. The women use the remainder of the day to do their household activates. Notably, the afternoons up to 4:00pm are set aside to collect water from the village stream. The market day is usually held twice a month on Saturdays. This is an activity where the whole family participates.

The men would be selling livestock, farm implements, farming pesticides and acaricides, as well as crops like rice and maize. The women, on the other hand, sell vegetables, fruit, smoked fish and oil seed crops like groundnuts and sim-sim. It is during this period that village bazaars or entertainment are held. It is interesting that due to strong religious and cultural beliefs, the men do not intermingle.

Recently, an NGO visited the village and upon the suggestion from the men, built and installed a water tap in the center of the village. This was hoped would help the women by decreasing the amount of time spent collecting water from the stream. However, to their dismay, the women neglected using the tap and instead went in their groups to collect water from the stream. Only in cases when one had to attend to a sick patient at home, did she use the nearby tap.

Case Study Activities

1. Draw a daily activity chart for the men and women in the village.

2. What would be the best time to meet the women and where would the meeting be?

3. What would be the best time to meet the men and where would that meeting be?

4. Is it possible to have a combined meeting for the men and women? Where would it be and when?

5. Plot a resource map indicating issues of accesses, ownership and control.

6. Why did the women shun the tap built by the NGOs?

Activity: Gender Tools

Gender Analysis Toolkit for Health Systems

http://reprolineplus.org/system/files/resources/Gender-Analysis-Toolkit-for-Health-Systems.pd

Activity: Communication Matrix Developed by ACDI/VOCA

ACDI VOCA

Gender Analysis, Assessment, and Audit Manual & Toolkit
August 2012

Communication Methods	Women		Men		Comments?
	Receive information	Give information	Receive information	Give information	
In Person					
Formal meetings (community, school, government)					
Attend meetings and listen					
Speak at meetings					
Organize meetings					
Work on a committee					
Casual meetings					
Shop					
Restaurant					
Family event					
When taking children to school or activities					
Waiting for a ride					
Family members					
Friends					
ICTs					
Mobile phone - talking					
Mobile phone - SMS					
Mobile phone – internet					
Radio					
Internet/email					
Television					
Movies and videos					

Activity: Monitoring and Evaluation of Interventions Using Gender Tools

Questions asked in the Engendered Log Frame

Engendered Log Frame	Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumption
Goal	Do gender dynamics in any way influence the project goal?	What measures can verify achievement of gender conscious goal?	Is the data for verifying the goal sex-disaggregated and analyzed in terms of gender? What gender analysis tools will be used?	What are the important external factors necessary for sustaining gender conscious goals?
Purpose or objective(s)	Does the project have gender responsive objective(s)?	What measures can verify achievement of gender responsive objective (s)?	Is the data for verifying the purpose sex-disaggregated and analyzed in terms of gender? What gender analysis tool will be used?	What are the important external factors necessary for sustaining gender responsive objective(s)?
Outputs	Is the distribution of benefits taking gender roles and relations into account?	What measures can verify project benefits that accrue to women as well as men, and different types of women?	Is the data for verifying the purpose sex-disaggregated and analyzed in terms of gender? What gender analysis tool will be used?	What are the important external factors necessary for achieving project benefits (specifically benefits for women)?
Activities	Are gender issues clarified in the implementation of the project?	Inputs: What resources do project beneficiaries contribute to the project? Is the contribution of women as well as men accounted for? Are external resources accounting for women's access and control over resources?	Is the data for verifying the purpose sex-disaggregated and analyzed in terms of gender? What gender analysis tool will be used?	What are the important external factors necessary for achieving the activities and especially ensuring the continued involvement of men and women participants in the project?

From: Odame, Helen Hambly. 2000. Engendering the Logical Framework. Presented at a workshop on: Gender and Agriculture in Africa: Effective Strategies for Moving Forward. Nairobi and www.cgiar.org

Monitoring for Gender Issues: Gender-sensitive impact indicators can describe actual gender-related change arising from a project such as labor change, income change attributable to project activities, etc. Gender-sensitive output indicators can describe the actual project in a gender-sensitive way, such as the number of men versus women trained on a specific issue. 'An indicator is a pointer. It can be a measurement, a number, a fact, an opinion or a perception that points at a specific condition or situation, and measures changes in that condition or situation over time' (CIDA, 1996).

An 'indicator' is something that can be measured. Indicators should be easily quantifiable and collected.

Indicators can measure short and long-term changes.

- Short-term changes in number of:
    ◊ children in the households.
    ◊ households involved in vaccination campaigns.
- Medium-term changes in number of animals:
    ◊ sold or traded.
    ◊ consumed.

The table below contains some possible indicators for monitoring gender and cultural issues for consideration at national (Nat.), provincial (Prov.), district (Dist.) and community (Com.) levels of RESPOND.

Indicators	Nat	Prov	Dist	Com
Gender-disaggregated indicators on benefits from resources and projects				
• % of the total budget of the program directed to gender related activities	x	x	x	x
• % of the budget benefiting women	x	x	x	x
• % of arrangements that accommodate women's roles				x
Gender-disaggregated indicators on access over resources and project activities				
• Do men and women have access to resources equally? (transport, telephone, computer, other privileges, etc.)	x	x	x	x
• % of male and female staff in all positions	x	x	x	
• % of men and women involved in the project				x
• % of men and women receiving inputs (define which) from the project				x
• % of men and women receiving salary from the project				
Gender-disaggregated indicators on capacity building				
• % of training related to gender issues for men and women	x	x	x	x
• % of women and men participating in training	x	x	x	x
• Compare gender awareness at the beginning and at the end of the training	x	x	x	x
• % of women and men participating in exchange program	x	x	x	x
• % of training for women only				x

Indicator				
Gender-disaggregated indicators on participation in decision-making	x			
• % of women and men in senior management and executive positions in the project	x			
• % of women and men in the project coordination committee		x		
• % of women and men in provincial positions			x	
• % of men and women in district councils			x	x
• % of men and women on committees	x			
Gender-disaggregated indicators on control over resources and project activities	x	x	x	x
• % of groups and committees with female chairpersons				x
• % of men and women in all positions in the committees				
Indicators on strategic needs/empowerment				
• % of policies, documents or guidelines produced that address development toward gender equality and equity within the program	x	x	x	
• % of men and women gender focal points/specialist	x	x	x	
• % of projects addressing gender strategic needs	x	x	x	x
• % of NGOs with a gender focus involved in project activities	x	x		
Cultural indicators for training				
• % of hours addressing cultural issues	x	x	x	x
• % of facilitators/professors dealing with cultural issues	x	x	x	x
• % of traditional healers participating as trainers	x	x	x	x
• % of traditional healers participating as trainees	x	x	x	x
Cultural indicators for participatory epidemiology and disease surveillance				
• % of indicators developed taking into consideration communities understanding of disease	x	x	x	x
• % of traditional healers participating in surveillance team				x

Instructions

- Using the following gender tools, develop interventions related to your assigned activity (e.g. response, surveillance, prevention, control) to address an Ebola outbreak for the village community you have been working on since morning.
  - Condition and position
  - Practical and strategic needs
  - Equity/equality
  - SWOT analysis
  - Sex disaggregated and gender sensitive indicators
- **Complete the implementation table and give reasons for your options of intervention.**

Recommendations:

(Reference: http://sbccimplementationkits.org/gender/evidence-based-gender-recommendations/)

Definitions

Condition and Position: Development projects generally aim to improve the condition of people's lives. From a gender and development perspective, a distinction is made between the day-to-day condition of women's lives and their position in society. In addition to the specific conditions which women share with men, differential access means women's position in relation to men should also be assessed when interventions are planned and implemented.

- Condition: This refers to the material state in which women and men live, and which relates to their responsibilities and work. Improvements in women and men's conditions can be made by providing, for example, safe water, credit, seeds (practical gender needs).

- Position: Position refers to women's social and economic standing in society in relation to men; for example, male/female disparities in wages and employment opportunities, unequal representation in the political process, unequal ownership of land and property, vulnerability to violence (strategic gender need/interests).

Practical and Strategic Needs: Women's needs differ from those of men. A distinction is made between practical gender needs and strategic gender interests/needs.

- Practical gender needs: Women and men can easily identify these needs as they often relate to their living conditions. Women may identify safe water, food, health care, cash income, as immediate interests/needs that they should meet. Meeting women's practical gender needs is essential in order to improve their living conditions, but this alone will not change the prevailing disadvantaged (subordinate) position of women. It may, in fact, reinforce the gender division of labor.

- Strategic gender interests/needs: Strategic gender interests/needs are those that women themselves identify by their subordinate position to men in their society. They relate to issues of power and control, and to exploitation under the sexual division of labor.

SWOT Analysis

Strengths	Weaknesses
Opportunities	Threats

Sex- Disaggregated Data and Indicators: All activities developed and implemented should include gender and cultural awareness as well as gender and cultural relevant issues. Monitoring and evaluation of these activities needs to take into consideration the development of quantitative and qualitative indicators to monitor the impact and progress of the project in relation to the inclusion of gender and cultural aspects (see table on next page).

1. Gender and health are inextricably linked and should be addressed in tandem.

2. It is important to note that relationships between gender norms and inequalities and health exist in different areas of the world, for example, how men and women live, interact, and are treated is tied to broader cultural norms that can and do differ across communities and by social identities, including but not limited to social class, ethnicity, caste, etc. Those involved in program design and implementation should ensure that their work is culturally sensitive and not built on assumptions about gender equality.

3. Use a gender transformative approach. In light of the trends identified in this training, activities should seek to bring about changes in one or more of the following areas, as well as seek to bring about changes in health behaviors and health outcomes.

    i)   Household decision-making
    ii)   Spousal communication
    iii) Power relations between men and women (both in relationships and in the community)
    iv)   Unequal access to opportunities such as employment, education and healthcare
    v)   Cultural norms like gender preference
    vi)   Feminine norms that often relegate women to physically taxing work, household responsibilities and/or reproduction
    vii) Masculine norms that encourage dominance, aggression and power
    viii) Violence

4. Balance the priority health needs of men and women, as well as adults and children. This holistic approach will improve health and development outcomes. A focus on women's reproductive and maternal health are common, but more SBCC programs should assess effects on both men and women's reproductive health outcomes and child health outcomes (Richards et al., 2013). Furthermore, much of the research summarized in this section focuses on the roles of women and health outcomes. Although researchers and international organizations use the term "gender" to describe their work, most of these efforts fail to explore the important role of men in health. Recent focus on the importance of men's involvement in family planning decisions and prenatal care may make a change in these trends. However, future work should address how men and women interact as well as the health needs of men independent of women, instead of focusing exclusively on the experiences and needs of women.

5. Improve couple communication. Communication between partners plays an important role in women's access to and use of healthcare services. Facilitating this conversation so that women and men are involved in health-related decisions is an essential contribution of SBCC programs. To improve couple communication, effective programs should determine whether the target audience should be only women, only men, or both men and women.

    i)   Sometimes programs should work with only women to build efficacy, skills and confidence to communicate and work with men.

    ii)   It is also important to target men directly to build their efficacy, skills and confidence to communicate and work with women.

    iii) Programs should highlight the benefits of working towards gender equity to both men and women, which does not represent a zero-sum game but capitalizes on the strengths of interdependence.

6. Consider socio-cultural contexts when defining male involvement. Although research has demonstrated the importance of greater male involvement for improved health outcomes, few studies have defined how and to what extent such involvement should occur. Programs must acknowledge that socio-cultural contexts and individual preferences play an important role in defining "ideal" male involvement. For example, some women may not want their partners to go to the clinic with them, but may desire their support in other ways. Therefore, programs should identify the gender norms and practices that are culturally and individually relevant barriers to health services. Then, programs should develop specific strategies to work with both men and women to improve health outcomes without prescribing what male involvement should entail.

7. Gather data from both men and women. Often, our knowledge about gender norms and practices is drawn from responses from women. In formative research and M & E, programs should also collect information from men on their attitudes, concerns and aspirations instead of relying solely on women's perceptions.

Session 4: Gender-Sensitive Emergency Response Planning and Communication

Session Overview

The morning of Day 4 focuses on gender sensitive emergency response planning. The session takes the approach of student-based learning, facilitating participants to reflect on the relevancy of and gaps in what they do daily in their work of managing disease pandemics. Participants will be able to develop a gender lens so as to see gender gaps in the emergency planning as it impacts men, women, boys and girls, young and old. The rest of the day will engage participants in a simulation exercise in which they will be expected to construct a visual plan of their engaging either with the community or stakeholders. This will require participants to be innovative and come up with exciting and new ideas on how to present their plan to the community.

Session Learning Objectives and Activities

Participants will be able to:

i)   create and implement gender-sensitive disease outbreak emergency response plans across all phases (e.g. preparation and planning, detection and risk assessment, response and evaluation) of a response.

ii)   advocate for One Health change.

iii) prepare and deliver gender-sensitive risk communication.

Schedule	Topic/Activity	Learning Activity	Materials
8:00 - 9:00	Registration		Sign in sheet
9:00 - 9:15	Introduction to Day 4		
9:15 - 10:15	Fundamental Principles of Gender-Sensitive Emergency Response Planning in Disease Outbreaks	Plenary Session	PowerPoint
10:15 - 10:30	Tea Break		
10:30 - 11:30	Advocacy and Risk Communication	Group Activity	PowerPoint Presentation and Group Activity
11:30 - 1:00	Simulation Exercise and First Presentation	Group Activity	Activity
1:00 - 2:00	Lunch		
2:00 - 3:00	Simulation Exercise	Group Activity	Internet Access
3:00 - 3:15	Tea Break		
3:15 - 4:30	Simulation Exercise	Group Activity	
4:30 - 4:45	Summary of Simulation	Plenary Session	
4:45 - 5:00	Evaluation of the Day	Plenary Session	Evaluation Chart

Time	Activity/Topic	Facilitator Instructions
10 min	**Attendance**	Have participants sign the OHCEA attendance register.
15 min	**Introduction to Day 4**	This session focuses on gender-sensitive emergency response planning that is both efficient and effective in planning properly for men and women, boys and girls, young and old. Participants will be able to develop a gender lens to see gender gaps in their response planning for: • preparation and planning. • detection and risk assessment. • response. • evaluation. Review program for Day 4
60 min	**Fundamental Principles of Gender-Sensitive Emergency Response Planning in Disease Outbreaks**	**Give a PowerPoint presentation (PPP No.7) on Emergency Response Planning** Interactive lecture covering: i) What emergency response planning is ii) The fundamentals of emergency response planning during disease outbreak iii) Brief overview of CARE's tool on conducting rapid gender analysis in emergency situations. Explain to the groups that the tasks are suggestions and should be tailored contextually (and that not all questions should or need to be asked).
30 min	**Reading: Care International Emergency Response Planning Tool**	Divide the participants into 4 groups. Give a brief overview of CARE's tool on conducting rapid gender analysis in emergency situations. Ask groups to read the guidelines and discuss and answer the question. Explain to the groups that the questions are suggestions and should be tailored contextually (and that not all questions should or need to be answered). There is no presentation to be discussed in plenary; it is a group reading and group discussion. See reading at the end of the document.

At the end of the session, every group member should write on an index card four points they consider key for emergency response planning (reading found in the facilitator notes).

Almost all development initiatives focused on transformed gender relations by involving in their advocacy, women and men, boys and girls who are affected. In order to effectively operationalize gender issues in One Health and emerging pandemics, there is need for:

i) continuous awareness creation campaigns and establishment of formal coordination mechanism for gender and One Health approach.

ii) ensuring political will and availability of favorable gender policies within OHCEA and at national and regional levels.

iii) building capacity of health care professionals in gender and One Health sectors for operationalization of an engendered One Health approach.

In this section, we will briefly discuss advocacy issues related to increasing awareness of pertinent gender issues as they relate to One Health and emerging pandemics.

Select one of the videos from the list below.

- Her Royal Highness Princess Haya with OIE Against Rabies at http://www.youtube.com/watch?v=XjbBeie2G7I

- No More Deaths from Rabies at https://www.youtube.com/watch?v=qoBumMaDr3g

- Fighting Rabies in Asia at http://www.youtube.com/watch?v=RS4_38sZF3w&feature=c4-overview&list=UUYWwT1w9Yv2qpKChz9Hoomg

Ask four or five participants to share an experience when an individual or organization advocated on their behalf a health issue which changed a dynamic in their lives. How did it feel to have someone advocate for them? Ask four or five participants to share their experiences when they had opportunity to advocate for someone about a health issue. What were the challenges and how did they overcome them? How did they feel advocating for someone?

Introduction to Advocacy

30 min

Video: Rabies Advocacy

15 min

Debrief the Video:

15 min

Gender Advocacy

10 min

Show the PowerPoint presentation (PPP No. 8) of "Do you know?"- a gender advocacy presentation.

Discuss the video and get views on how people have advocated for multiple issues and why.

15 min

Tea Break

Introduction to Risk Communication PPPno. 8

30 min

Give a PowerPoint presentation (**PPP No. 9**) on risk communication and message mapping.

Risk communication is an open two-way exchange of information and opinion about risk that leads to better understanding, and better risk management decisions by all groups involved. It is critical to have a plan in place to deal with a crisis before it happens. Communicating information about possible life-threatening issues can be difficult, but if it is not done well, the communicator can put the public at greater risk by creating misunderstanding or possibly inciting panic. Professional communicators have a responsibility to the people and agencies they represent, as well as to the public to be prepared deal with a crisis – natural or manmade. Establishing trust and credibility are two of the cornerstones of effective risk communication. When an issue is of high concern, such as the 2001 anthrax incidents or the threat of a smallpox outbreak, trust and credibility on the part of communicators is essential. Without them your message will not be heard, people will not make informed decisions, and problems can escalate.

Risk communication is important because:

    i)   every action or inaction involves risk.

    ii)   health professionals communicate across a wide range of risks and audiences.

    iii)   health professionals are often trusted sources of information in the community.

The PowerPoint presentation covers the following topics:

i) Brief overview of communication theory and practice: the differences between myths and truth and how beliefs in some common myths interfere with risk communication

ii) Basic gender-sensitive risk communication rules: who defines the issues? Are they involving the public as partners: men obtain information differently from women and have different specific concerns, who has access to the media?

iii) Factors that influence risk perception: An individual's perceptions of the magnitude of risk are influenced by more than numerical data. Gender roles and access to and control over resources influences risk perception and response.

iv) Avoiding pitfalls in communication and making your communication gender-sensitive: presentations and interviews and presentation aids.

v) Managing hostile situations: issues of health and environment can arouse strong anger and hostility. How does culture play into emergency situations? Consider some things you can do to diffuse anger and re-direct hostile energy.

Present the following scenarios to participants and have them find solutions through think, pair and share technique. They should think of an answer, pair with a neighbor, share with each other and then have one of them share with the rest of the group the solutions they came up with.

Think, Pair, Share

10 min

Scenario 1

i) You are the spokesperson for the National Emergency Taskforce leading government response to an outbreak of anthrax in a wildlife national park. The outbreak has now spilled over to domestic animals and humans. Over 500 hippos have so far died.

ii) Following the initial press release about the outbreak, you are miss-quoted in the international media; the misinformation which may cause undue concern or alarm and massively affect the tourism industry (outrage!).

iii) As a spokesperson how should you address inconsistent messages about the outbreak?

Scenario 2

i) You receive information that there seems to be a "strange disease". It is hemorrhagic fever outbreak in a remote town.

ii) As a One Health leader, how can you communicate appropriate risk messages and ensure that you are communicating to the right audience (take gender roles into consideration: who has access to what communication channels?).

iii) Identify one audience, one to two communication vehicles and develop 3 key points (messages).

Ask the participants to read through the following brief case studies.

As they read through these case studies; they should pay specific attention to gender-based risks at exposure and release levels. They should also clearly underscore the role of gender among the different stakeholders and the most vulnerable populations and the significance of that. How does this affect management strategies and risk communication?

Spend some time discussing these three case studies and the role that gender plays in risk analysis and communication.

Intestinal Parasitic Infections in Rural Communities Northeast Thailand

This study presents a survey of the prevalence of intestinal parasitic infections among the people in rural Thailand. The community-based cross-sectional study was conducted in villages in Khon Kaen Province, northeastern Thailand, from March to August 2013. A total of 253 stool samples from 102 males and 140 females, aged 2-80 years, were prepared using formalin-ethyl acetate concentration methods and examined using light microscopy. Ninety-four individuals (37.2%) were infected with 1 or more parasite species. Presence of parasitic infection was significantly correlated with gender (P=0.001); nearly half of males in this survey (49.0%) were infected. Individual males, those aged 61-80 years, those who had completed only the primary school, and those in the laborer sub-category exhibited the highest prevalence of *O.*

Case Studies on Gender Based Risks

45 min

Case Study 1

Viverrini (shows a rather similar picture for *S. stercoralis* infection). Again, males and those of lower educational attainment exhibited the highest prevalence in their categories. Merchants and persons aged 41-60 years had the highest prevalence of parasitic infections in the occupation and age categories, respectively. The present study showed a significant correlation between gender and parasitic infections (P=0.001), with males having a higher prevalence for all parasite species. This result was similar to the previous findings. The gender difference may be due to male-specific behavioral factors such as eating raw meat, drinking alcohol with colleagues, and taking risks with their work in the farm.

Full article found here https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3916464/

Case Scenario: Burden of Brucellosis in Human, Livestock and Wild Animals in East and Central Africa

Case Study 2

25 min

Wildlife infected with brucellosis can transmit the disease to domestic livestock or humans; while domestic animals commonly transmit the disease to humans. *Brucella* organisms are small aerobic intracellular coccobacilli, localized in the reproductive organs of host animals that cause abortions and sterility. Brucella organisms are shed in large numbers in the animal's urine, milk, placental fluid, and other body fluids. The main route of entry for *brucella* organisms into a host is oral, that is, by the ingestion of food or water contaminated with secretions or aborted fetal remains from infected cows, or by licking the vaginal secretions, genitals, aborted fetuses or newborn calves of infected cows.

While the venereal route is not generally considered to be epidemiologically important in transmitting brucellosis in cattle, infected semen used in artificial insemination could be important. Infected cows shed *brucella* organisms in their milk and this is key in its transmission to calves and humans.

Gender-based Vulnerabilities, Risks and Opportunities in Laos

(Taken from European Union Commission report: study on the gender aspects of the Avian Influenza crisis in South East Asia, June 2008)

Case Study 3

25 min

http://ec.europa.eu/world/avian_influenza/docs/gender_study_0608_en.pdf

Women through their roles as backyard poultry producers and (market) sellers and as caretakers (slaughter of poultry and preparation of food, raising of children, care for the sick) for their family and as health care workers in hospitals and health facilities, are at risk of contracting avian influenza. The risk factor is even increased as women are less educated than men and are often ignored in poultry production and management training courses or specific courses for avian influenza prevention and control.

Women are exposed to avian influenza infections due to their roles in poultry production, marketing and food preparation. They are usually responsible for the slaughter, preparation and cooking of poultry and poultry products. Raw duck blood is a preferred dish. Women are also caretakers of the family. In many ethnic communities, men are often exclusively attending trainings and meetings. Men often do not allow women to participate and they hardly share what they learn from the meetings/trainings with their wives and children. Moreover, most village veterinarians and volunteer health workers are men. As most women, particularly in rural and remote areas are not comfortable dealing with men, it significantly deprives them of support and services for their livelihoods and health care needs.

Language barriers can also increase the avian influenza risks for women in ethnic communities. Many women, because of their isolation and less schooling, do not speak the national Lao language. This limits their ability to understand the avian influenza campaign messages which are usually in Lao language and not adapted to the local situation. Due to language barrier, the women are unable to interact and communicate with avian influenza campaign agents who only speak in Lao.

Debrief: After discussion of these case studies, review gender-based risks and ways in which risk communication can be balanced to ensure everyone who is at risk receives correct information and is included right from the planning stage.

Developing Risk Communique

30 min

Divide class into five groups.

Each group will develop an interim plan for risk communication and information dissemination to educate the public regarding exposure risks and effective public response on an emergency of the group choice. Their plan has to be gender-sensitive e.g. consider education levels of males and females in the community: is it the same? What media do you use for the different groups? Who has access to TV and radios? Who has more time to obtain information?

Note: When evaluating the group presentations, the following key issues need to be addressed in the plans:

Group Presentations

45 min

i)   Identify key One Health spokespersons who can effectively communicate with the public and media to prepare for and respond to the risk. Explain how the person was selected.

ii) Establish an emergency public information system, including call-down lists of One Health contacts, backup personnel who can be activated to address communication and information dissemination issues during the emergency.

iii) Establish mechanisms for tracking and monitoring message dissemination and exposure, media coverage, audience reaction and feedback, and changing communication issues and priorities.

Best practices in risk communication include:

i)   Remembering that communication is two-way street

ii)   Being aware of cultural and language differences

iii) Listening to your audience and seeking understanding

iv)   Communicating with empathy and concern

v)   Using appropriate terminology

vi)   Accepting uncertainty

vii) Using key points

viii) Providing resources

Concluding Comments

ix)   Fostering partnerships

x)   Remaining accessible

Time	Activity/Topic	Facilitator Instructions
200 min	**Simulation Exercise**	The rest of the day will be spent developing a simulation exercise. The participants will form 4 groups: i) Preparation team ii) Detection (surveillance) iii) Response iv) Post-emergency response and evaluation

Simulation Exercise

Time	Activity/Topic	Facilitator Instructions
200 min	**Simulation Exercise**	**Using a Simulation to Integrate Course Concepts, Skills and Knowledge** A simulation is a tool used for the reproduction of an event and analysis of its results in order to improve readiness for an eventual occurrence of the situation or similar situations. From the point of view of "One Health," a simulation is defined as a multi-sector and coordinated approach integrating fauna, animal health, human health, the environment and communication with the aim of responding in a more effective way to an emerging pandemic threat. This approach recognizes the need to strengthen collaboration, communication and the coordination amongst specialists of different sectors. This implies the need to create bridges between disciplines in order to complete planning, intervention in terms of surveillance or response, reporting, data analysis and evaluation of activities in an integrated manner in order to better fight pandemic threats.
5 min	**Outbreak Investigation Steps**	**Give a brief presentation (PPP No. 7) on steps in containing a disease outbreak (PowerPoint Presentation on Steps in Outbreak Investigation)** STEPS IN CONTAINING A DISEASE OUTBREAK Preparation → Detection → Response → Evaluation In this course, we are using a simulation to integrate skills and knowledge across the domains of: • Epidemiology • Emerging pandemic threat response • Gender analysis • One Health

This simulation will evaluate the participants' ability to develop a gender sensitive emergency response plan while considering the following:

i) Integrating knowledge across multiple domains

ii) Identifying the necessary actions within the framework of a national plan of preparation to a pandemic

iii) Following procedures when planning and responding to epidemics and epizooties

iv) Working on multi-disciplinary teams

v) Coordinating actions across sectors

vi) Communicating clear and consistent messages to multiple audiences

In this section, participants will be able to prepare and respond to an emergency, taking into consideration all the gender tools given during this training; identify and manage challenges that occur in any emergency. Provide participants with notes on the roles of the team provided at the end of this section to assist them. Begin by presenting the following scenario to them:

Scenario

5 min

You have just been informed that there is a suspected Ebola outbreak in Luwero village in western Uganda bordering, Rwanda. A total of 14 people have died and 26 others are reportedly sick. There is only one health center in the area manned by one local doctor and two nurses. The Government is putting you in charge of the emergency response. You have been given a budget of 10,000 dollars to mobilize a team to prepare and respond to this emergency.

Break the participants into four groups: Preparation team, Detection team, Response team and Evaluation team. The different groups are first expected to get together, brainstorm and draw up a plan of action for each different group: preparation, detection, response and post emergency & evaluation team (provide notes on teams' roles).

The following are the key points to consider when brainstorming. Target the following questions:

1. Coordination structures:
   - How do you bring gender into coordination structures you are creating?
   - How do you proactively support gender and protection services (gender continuum could be useful here)?

2. Gender analysis to inform preparedness, during and after:
   - What gender analysis tools are you going to use to support your activity?
   - What gender lessons would you anticipate, what are the lessons to learn and what are the recommended actions?

3. Vulnerability assessments
   - What tools and approaches can you use to map the gender differentiated risks?
   - What technical support will you provide to gain gender differentiated insight into the capacities and the vulnerabilities of the affected communities?
   - What kind of gender technical support can you provide to monitor threats to vulnerable groups?

4. Information gathering and management
   - How do you ensure an appropriate mix in an assessment team?
   - How do you ensure that you are consulting with all the required parties?
   - How do you ensure post-assessments capture relevant data by sex, age, disability and vulnerability?

5. Information sharing and communication
   - Provide technical support to ensure that information and communications flow to all groups in the community.

6. Planning
   - How do you ensure that outbreak response prioritization is based on gender analysis?
   - How do you ensure that gender and diversity are included in capacity assessment?
   - How do you ensure that any contingency plans are gender sensitive, and that gender gaps are identified in any section of preparedness, response and evaluation?
   - How do you ensure that gender is mainstreamed in emergency preparedness training?

7. Capacity building
   - What existing knowledge among your community members can you build on or enhance?
   - What coping strategies can you identify among the different groups and how do you use this more effectively?
   - How do you facilitate the community to become self-sustaining /create and implement a disaster management plan?
   - How do you help train and build the capacity of key stakeholders and implementing partners?
   - How do you ensure the capacity building efforts are gender balanced and sustainable?

8. Resource mobilization

- *How do you ensure that gender needs are reflected in each part of the process and that resources being mobilized are utilized to address all groups?*
- *How do you evaluate to see if you handled everything in the right manner?*
- *How do you develop/put in place a gender-sensitive risk assessment and preparedness plan to ensure you are prepared for another outbreak?*
- *What are the key challenges facing this community and the country after the outbreak has been contained?*

Step 1

Using flipcharts and sticky notes, map out a plan of action including the personnel and resources you will need in your group. Put the resources and personnel and action items on the left side of one flipchart. On the right, indicate how you will make the process gender sensitive by responding to the above questions. Present this to the plenary. Each group has 10 minutes to make a presentation.

Step 2

Based on the above, identify/select 5 key activities that your group feels are important to achieve your objective of an efficient gender-sensitive preparedness, response or post emergency evaluation program.

Step 3

Using the material provided create/build a visual of your plan focusing on the five activities mentioned above and ensuring that gender issues are reflected in that visual.

Step 4

Each group will be allowed 10 minutes to present its visual/construction plan to the rest of the class. All participants will then grade the groups depending on how good their visual is, how easy it is to understand, how it encompassed gender issues discussed in the training and how efficient it seems to be to achieve its objective. The participants will then select what is considered as the best visual.

As you debrief the participants, keep them focused on the following:

i) Why? – Why are we doing this activity?

ii) What? – What is the work that needs to be performed to successfully complete the activity? What are the major products/deliverables?

iii) Who? – Who will be involved? What will be their responsibilities? How will they be organized?

75 min

15 min

45 min

60 min

Debrief:

30 min

iv) When? – What is the timeline? When will milestones be completed?

v) Where? – Where is the engendered One Health initiative taking place (e.g. the location)?

(These questions are critical in defining the limiting constraints on an initiative, or the scope, resources and schedules available in an emergency.)

Visual of final product

As each group's response and actions need to build on the work of other groups, it is important that during the debrief, you review the presenting team's performance and give feedback to ensure that participants know what the complete and accurate actions should be.

Session 4: Facilitator Notes

Provide the following notes on roles of the different teams.

Preparation Team

The team:

i)   forms a gender balanced Outbreak Technical Committee (OTC). The team should have at least one member of opposite sex.

ii)   ensures all sectors directly affected are represented on the team (veterinary, health, wildlife, security, media, community development/gender expert, community leader/politician, development partners).

iii)   holds outbreak coordination meetings chaired and co-chaired by commissioner for health and commissioner of veterinary services respectively.

iv)   puts in place a surveillance system: weekly reports to Ministry of Health, Ministry of Animal Industry, WHO, OIE and FAO.

v)   develops an outbreak response plan: resources, skills and activities required.

vi)   conducts a full or rapid gender analysis and resulting gender strategy.

vii)   stockpiles sampling kits, chemicals, drugs and vaccines.

viii)   develops contingency plans for isolation wards in hospitals and quarantine of poultry.

ix)   puts in place a laboratory support.

Detection Team

i)   From the preliminary laboratory sample reports and circumstantial evidence, the outbreak technical team has been convinced that there is an outbreak in the country, and thus recommends the concerned sectors to constitute field detection team immediately. The field detection team directly reports to the OTC.

ii)   The team applies information from the gender strategy in their plans.

iii)   The field detection team of relevant experts is formed consisting of the veterinarian, medical doctor, nurse, wildlife expert, disease anthropologist/socio-economist, laboratory technologist, and communication expert.

iv)   The team sets out to the field to collect interview responses and laboratory samples from poultry and human beings with suspected clinical signs.

v)   The team should be gender balanced and should deliberately include female respondents.

vi)   The samples are submitted to the laboratory.

vii)   Tests are carried out, and reports written and submitted to the OTC.

Response Team

i)   The Outbreak Technical Team recommends formation of a response team.

ii)   The response team consists of expert members from the relevant sectors (veterinary, medical, nurse, wildlife, gender/community development expert, communication expert, community leader, and international organizations (e.g. FAO and WHO)).

iii)   The response team should consist of at least a member of opposite sex to avoid gender-insensitive conclusions and decisions.

iv)   The response team studies the reports (both laboratory and field reports and gender strategy and analysis) to confirm outbreak.

v) Clinical specimens are dispatched to CDC laboratories for confirmation.

vi) The response team counts the number of cases and determines the size of the population to calculate attack rate.

vii) The team analyzes descriptive data to date e.g. time/date of onset, place/location of cases and individual characteristics such as age and sex.

viii) The team determines the at-risk population (this should be age and gender-disaggregated).

ix) The team formulates hypothesis for pathogen/source transmission.

x) The team follows up cases and contacts.

xi) The team produces a report (results and recommendations for action).

xii) The team discusses the report with the OTC.

xiii) The team implements control and prevention measures specific for the disease (press releases, public education messages, radio and TV talk shows, memos from the ministry headquarters to district directors of health, commissioner of veterinary sciences to DVOs).

xiv) The team institutes quarantine if necessary.

xv) After the disease is seemingly under control, e.g. no reports of new cases, the OTC writes a recommendation for the formation of an evaluation team.

Evaluation Team

The team:

i) consists of at least one of the following experts: veterinarian, medical doctor, nurse, wildlife expert, community development expert and media expert.

ii) assesses the appropriateness of containment measures.

iii) assesses timeliness of outbreak detection and response.

iv) assesses the preparedness of the country as far as the disease is concerned.

v) assesses the effectiveness of the various teams in terms of gender composition and One Health compliance.

vi) assesses the integration of gender considerations in response.

vii) writes and disseminates the outbreak report, declaring the status of the disease and recommendations where necessary for future implementation.

CARE International Emergency Response Planning Tool

- Objective: To inform teams on who is affected and how by emergencies. This tool seeks to understand protection needs, access to resources/services, coping strategies, capacities and gendered aspects of decision-making.

- Materials/Preparation: In addition to reviewing the emergency assessment planning checklist, teams should consider the time required and key informants needed for each set of questions. Meetings should be divided by themes and perhaps multiple meetings to fit participant schedules.

- Participants: Men and women in single-sex groups.

Guidelines

Through focus-group discussions, researchers facilitate questions on the following topics. These questions have been drafted by CARE's emergency team, drawing from the IASC Gender Handbook for Humanitarian Action.

1. *Sex and Age*
    i) What is the breakdown by sex and age of:
        - the disaster-affected population?
        - households headed by a single person or a child?
    ii) What is the number of pregnant and breastfeeding women?
    iii) What is the average family size and structure?

2. *Impact of Emergency*
    i) How has the emergency affected the community?
    ii) Are women, men, girls and boys affected differently?
    iii) What were social, political, cultural and security conditions like before the emergency?
    iv) What has changed since?
    v) What specific risks has the emergency caused?

3. *Vulnerabilities*
    i) Who is vulnerable?
    ii) What are they vulnerable to, and why?
    iii) What are the different vulnerabilities of women, men, boys and girls? (Don't assume only women and girls are vulnerable)

4. *Capacities and Coping Mechanisms*
    i) How are women and men capable of coping and responding?
    v) What different coping mechanisms are women, men, boys and girls using?
    vi) What resources or support are they relying on?
    vii) How can your program support the best coping mechanisms?

8. *Gender Roles and Responsibilities*
    i) What were the usual gender roles and responsibilities before the emergency?
    ii) Have they changed since? (Be aware that men and women may give very different answers)
    iii) Who does what work? (e.g. household chores, care-giving, farming, earning cash income)
    iv) Who controls resources and family assets?
    v) Who makes decisions (formally and informally)?

9. *Access and Participation*
    i) Do women, men, boys and girls have enough access to humanitarian assistance?
    ii) Who has been consulted about the humanitarian response and how?
    iii) Are women and men both participating in assessment and programs?

10. *Social Organization and Cultural Context*
    i) What social/cultural structures does the community use to make decisions?
    ii) How do women and men participate in these?
    iii) What is the role of religious and cultural practices, beliefs and institutions in the community?
    iv) How do they affect gender roles?

11. *Sector-specific Questions*
    i) Water and Sanitation
        - What are the community's water, sanitation and hygiene practices? How do they vary for women, men, boys and girls?

- How do women, men, girls and boys use water? What are they responsible for (e.g. collection, cooking, sanitation, gardens, livestock)? How do family members share water with each other (quantity and quality)?
- Who has access to and control of water and sanitation resources? Who is responsible for decisions and management?
- Are water points and sanitation facilities safe? Can people (especially women and children) use them safely?
- Are water points, toilets and bathing facilities located and designed for privacy and security?

ii) Health

- How has the health of the population changed since the crisis? Are women and men affected differently by diseases or other health problems?
- What is the breakdown by sex and age of the crude mortality rate? Is there a disproportionate number of deaths among women, men, girls or boys? If so, why?
- Who provides health care and to whom? For example, do local beliefs and practices let male health workers care for women?
- What are the local beliefs on and practices for pregnancy and birth, disposal of dead bodies, washing, water use, cooking and animal care? Are any of these bad for women, men, girls or boys?
- Do women and men talk about and/or get information about health differently?
- What cultural and religious practices affect health care?

iii) Non-food items

- What are the different non-food item needs of women and men, by age and ethnic background? (Look at what they had before the emergency)
- Do women and men have cash for non-food item s?
- What cultural practices affect women's hygiene and sanitary needs, especially during menstruation?
- How does the community collect firewood? What types of cooking stoves do they use?
- What are the sleeping and bedding arrangements (including use of mattresses and blankets)?
- What clothes do women and men normally wear? What are their daily clothing needs? Do pregnant and breastfeeding women have specific clothing needs?
- How did destitute women and households headed by women get non-food items before the emergency?

iv) Food Distribution

- Can all members of the community/household get and prepare food? Does food insecurity differ by gender?
- Who gets food aid on behalf of the household? Who decides how to use it?
- How is food shared within households? Who eats first?
- Are single-headed and child-headed households getting enough food?
- Are there any food taboos or restrictions for women, men, children under five and pregnant and breastfeeding women?
- What are the eating habits of the population?
- What are the cultural or religious food preferences of women and men in the community?

v) Nutrition

- How does nutritional status (<-2 z-score weight for height) breakdown by sex and age? Is any group (e.g. girls or boys) disproportionately affected? Why?

- What is the nutritional status of women of childbearing age? What are the levels of anemia?
- How are gender and social position connected to malnutrition?
- What are the special nutritional needs of pregnant and breastfeeding women, people with HIV and AIDS and other vulnerable groups?
- Are there any beliefs or practices that may affect the nutritional status of women, men, girls and boys differently?
- Are many women having trouble breastfeeding? Are baby girls and boys breastfed differently?
- Do boys and men have the skills to prepare food for themselves?
- How are children fed when they are at school?
- Can households get sources of micronutrients?

vi) Food security
- What community and household power structures affect the use of food, land and other productive resources? Who (in the community and the household) controls these resources?
- How do women and men get food locally? Do they have equal access to the local market?
- Can both women and men get cash and food-for-work opportunities, credit and agricultural materials and services?
- How sufficient are crops for households?
- Do women, men, girls and boys have trouble getting food aid or reaching the local market or farmland because of weapons, landmines or other dangers?

vii) Livelihoods
- What main livelihood assets (land, livestock and equipment) does the community need? How has the emergency affected these?
- What livelihood assets do women and men control? Has the emergency affected who controls what?
- What types of agriculture, farming, fishing, trade and food supply existed before the emergency? What role did women and men play in these sectors?
- What local practices affect ownership and distribution of agricultural land? What are women's property and inheritance rights?
- What skills do women have? What skills do men have? What training does each group need?
- What tasks do local customs forbid women or men from doing?
- How much time do women, men, girls and boys spend on unpaid work (fetching water, cooking, collecting firewood, caring for children, washing clothes, etc.)?

viii) Shelter
- Who builds shelters? How are women, men, girls and boys involved? Which groups (gender and age) may not be able to build their own shelters?
- How are shelter materials shared? How does this affect women and girls?
- What are the community's cooking, washing and house cleaning practices?
- Do the toilet, washing, bathing and sleeping areas have latches and locks?
- Do households have materials for partitions to allow privacy?
- What are the shelters for girls and boys without parents like? Are they safe/ culturally appropriate?
- Do single women have separate and safe shelters? Is this culturally correct, or should they be with a male relative?

- Who owns land and property? What protection (laws, customs, etc.) do women, men, girls and boys have for their land and property rights?

ix) Education

- How has the emergency affected girls' and boys' access to education?
- How many adolescent girls and boys are out of school?
- What safety and access problems do schools have?
- Do girls and boys have equal access to school locations? Do they have equal access to all levels of schooling?
- Are some girls and boys stigmatized by their war experiences (e.g. being raped or a child-soldier)? Does this stop them from going to school?
- What are the direct and indirect costs for girls and boys to attend school?
- Do parents think the school is close enough for girls and boys to get to? Is the way safe for girls and boys?
- Are the school toilets accessible and safe? Are they enough? Do girls and boys have separate toilets? Is water available for washing hand at the toilets?
- Does the school have male and female teachers? At all grade levels? What are their qualifications and experience?
- Do school staff know how to report and follow up harassment and SGBV? Do they have suitable materials and services to help boys and girls recover from SGBV?

x) Protection

- What are the specific protection needs of women, men, boys, and girls? What are the continued risks for each group (e.g. vulnerability to conscription)?
- What factors increase tensions and civilian casualty numbers, and how do they affect women, men, boys and girls? How does the spread of weapons affect women, men, boys and girls?
- How do human rights and humanitarian law violations affect women, men, boys, and girls differently?
- How does military presence affect the risks of SGBV for women, men, boys and girls?
- Can people safely report and seek redress for violations of humanitarian law (e.g. SEA by peacekeepers and humanitarian workers)?
- What are the community's laws and customs on abductions, trafficking in humans, sex work, slave-like practices, SGBV, early/forced marriages and property rights? How do these affect women, men, boys and girls differently?

Session 5: Putting it all Together: Engendered One Health Case Study Development and Evaluation

Session Overview

The morning session on the simulation evaluation is followed by a session on developing brief gender-sensitive case studies that can be used as part of this training. Based on examples already used in the training, participants will be required to develop 4 case studies in total.

Session Learning Objectives

To develop gender sensitive case studies, and to carryout evaluation of participants' ability to use gender analysis to respond to an emerging pandemic threat as members of One Health team.

Schedule	Topic/Activity	Learning Activity
8:00 - 9:00	Registration	
9:00 – 9.15	Simulation Self-evaluation	Plenary Session
9:15 – 9.45	Team Evaluation	Small Group Work
9.45 – 10.15	Introduction to Case Study Development	Plenary Session
10.15 - 11:15	Case Study Development	Plenary Sessio
11:15 - 11:30	Tea Break	Self-reflection
11:30 – 12.00	Presentation of Case Studies	Plenary Session
12.00-12.30	Summary of Next Steps	
12:30 – 1.00	Closing Ceremony and OHCEA Evaluation	Group Presentation
1.00- 2.00	Lunch and Departure	Plenary Session

Time	Activity/Topic	Facilitators Instructions

15 min	**Self-Evaluation**	• Refer participants to the self-evaluation in their guidebook.
		• Ask them to rate how effective they were in:
		  ◊ *communicating to their team.*
		  ◊ *using gender analysis.*
		  ◊ *being a One Health team member.*
		• Let participants get back to their simulation groups and complete the team evaluation in their guidebook.

25 min	**Team Evaluation**	• Tell participants that as a team, they need to come to consensus on how effective they were:
		  ◊ as a team.
		  ◊ in using gender analysis.
		  ◊ in using a One Health perspective.

- Each team should be prepared to share their responses to the open-ended questions at the end of the team evaluation:
  - ◊ What did the team do well in the response and areas that were challenging?
  - ◊ Was there anything they would do differently as a team the next time they respond to an emerging pandemic threat?
  - ◊ How might they use the knowledge from the simulation in their workplaces?

Sharing the Learning

15 min

Case Study Development

20 min

Tea Break

15 min

Post Test

1. Handout post-test

2. Tell participants they have 30 minutes to complete the post-test.

30 min

3. If they finish early, ask participants to remain quiet until everyone has done the work.

Closing Session and Course Evaluation

15 min

Closing Session and Course Evaluation

1. Have participants form a circle and ask each of them to say something in one or two words.

2. Give out certificates.

3. Give out OHCEA Event Evaluation Form.

4. Tell participants to place their completed evaluation forms in an envelope.

5. Seal the envelope and give the evaluations to the OHCEA course coordinator.

Simulation Self-Evaluation	Not Effective	Partially Effective	Effective	Quite Effective	Very Effective	Comments
Communication Skills						
Listened						
Shared my point of view						
Challenged appropriately						
Ensured everyone contributed						
Valued equally the opinion of men and women in my group						
Gender Analysis Skills						
Advocated for use of gender analysis/use of gender tools						
Used gender-sensitive language						
Ensured that women were present and participated in the discussions/activities						
One Health Team Member Skills						
Considered the interrelationships among men, women, domestic animals, wildlife and the environment						
Brought to the discussion my disciplinary skills and knowledge						
Solicited inter-disciplinary knowledge						

Simulation Team Evaluation	Not Effective	Partially Effective	Effective	Quite Effective	Very Effective	Specific example of what they did well?	Specific example of what they did poorly?
Team Effectiveness							
Ensured everyone listened, contributed and opinions were valued							
Managed time so that we could create a response plan							
Utilized team members' skills and strengths							
Gender Analysis Skills							
Advocated for gender tools							
Used gender-sensitive language							
Ensured that women were present and participated in the discussions/ activities							
One Health Perspective							
Considered the interrelationships among men, women, domestic animals, wildlife and the environment							
Solicited inter-disciplinary knowledge							

Ensured it was participatory; including all stakeholders							
Included all relevant categories of staff							
Considered budget implications							

1. As a team, summarize what your team did well in the response and areas that were challenging.

2. Is there anything you, as a team, would do differently the next time you are responding to an emerging pandemic threat?

3. How can you use a simulation in your work?

Handouts
- Simulation scenarios for each team
    - ◊ *Prepare team*
    - ◊ *Detection team*
    - ◊ *Respond team*
    - ◊ *Evaluation team*
- Post-test
- OHCEA event evaluation

OHCEA EVENT EVALUATION - Gender and One Health Short Course

Facilitators: _____

Dates: _____

OHCEA supported you to attend the **Gender and One Health** training event. Please take a few minutes to fill in the following confidential questionnaire. Your responses will help us better understand the value of this event and improve future programs. Thank you!

Please circle your response to each of the following:

1. This event met my expectations.
    - i)   Strongly disagree
    - ii)   Disagree
    - iii)   Agree
    - iv)   Strongly agree
    - v)   Don't know

2. This event was relevant to my personal interests.
    - i)   Strongly disagree
    - iii)   Disagree
    - iv)   Agree
    - v)   Strongly agree
    - vi)   Don't know

3. This event was relevant to my professional interests.
    - i)   Strongly disagree
    - ii)   Disagree
    - iii)   Agree
    - iv)   Strongly agree
    - v)   Don't know

4. The information presented was new to me.
    - i)   Strongly disagree
    - ii)   Disagree
    - iii)   Agree
    - iv)   Strongly agree
    - v)   Don't know

5. The amount of information provided was
    - i)   Not enough
    - ii)   Enough
    - iii)   Too much

6. This event helped clarify my understanding of One Health.
    - i)   Strongly disagree

ii) Disagree

iii) Agree

iv) Strongly agree

v) Don't know

7. The pre-event logistics were well organized.

    i) Strongly disagree

    ii) Disagree

    iii) Agree

    iv) Strongly agree

    v) Don't know

8. The event itself was well-organized.

    i) Strongly disagree

    ii) Disagree

    iii) Agree

    iv) Strongly agree

    v) Don't know

9. Overall, I found this event to be worthwhile.

    i) Strongly disagree

    ii) Disagree

    iii) Agree

    iv) Strongly agree

    v) Don't know

10. I intend to take action in my work because of what I learned at this event.

    i) Strongly disagree

    ii) Disagree

    iii) Agree

    iv) Strongly agree

    v) Don't know

11. Describe what, if any, actions you will take in your work because of this event.

_____
_____
_____

12. What were the strengths of this event?

_____
_____
_____

13. What can be done to improve this event?

_____
_____
_____

14. What single most important lesson did you learn from this event?

_____
_____
_____

15. Please write any additional comments you may have about this event.

_____
_____
_____

16. Did you present at this event?

    i)   Yes

    ii)   No

16 (a) .If yes, what was the topic of your presentation?

_____
_____
_____

17. What is your *primary* area of work?

    i)   Nursing

    ii)   Human medicine

    iii)   Veterinary medicine

    iv)   Wildlife medicine

    v)   Public human health

    vi)   Public veterinary health

    vii) Other (please specify): _____

18. Which sector do you represent?

    i)   Government

    ii)   Private

    iii)   Education

    iv)   Non-governmental organization (NGO)

    v)   Research

    vi)   Other (please specify): _____

19. Gender identity: _____

20. Nationality: _____

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