

**GENDER AND REPRODUCTIVE HEALTH POLICY  
IN ERITREA**

By  
LUUL GEBREAB

Integrated Studies Project

Submitted to Dr. JANE ARSCOTT

in partial fulfillment of the requirements for the degree of

Master of Arts – Integrated Studies

Athabasca, Alberta

October, 2009

## ***TABLE OF CONTENTS***

<b><i>ACRONYMS</i></b>	<b><i>III</i></b>
<b><i>CHAPTER 1</i></b>	<b><i>3</i></b>
<b><i>GENERAL INTRODUCTION</i></b>	<b><i>3</i></b>
<b><i>INTRODUCTION</i></b>	<b><i>4</i></b>
<b><i>OBJECTIVE OF THE STUDY</i></b>	<b><i>5</i></b>
<b><i>METHODOLOGY</i></b>	<b><i>6</i></b>
<b><i>SCOPE AND LIMITATION OF THE STUDY</i></b>	<b><i>7</i></b>
Gender analysis	<b><i>9</i></b>
International and National Gender and the Health Sector Policy Milestones	<b><i>10</i></b>
<b><i>HEALTH IN ERITREA</i></b>	<b><i>12</i></b>
<b><i>THE INSTITUTIONAL FRAMEWORK</i></b>	<b><i>16</i></b>
<b><i>THE CULTURE OF THE MOH</i></b>	<b><i>18</i></b>
<b><i>HEALTH AND GENDER MAINSTREAMING STRATEGY</i></b>	<b><i>20</i></b>
<b><i>HEALTH DELIVERY SERVICES</i></b>	<b><i>21</i></b>
<b><i>GENDER AND BASIC HEALTH CARE PACKAGE (BHCP)</i></b>	<b><i>22</i></b>
<b><i>GENDER AND REPRODUCTIVE HEALTH</i></b>	<b><i>23</i></b>
<b><i>FACTORS AFFECTING MATERNAL HEALTH</i></b>	<b><i>24</i></b>
<b><i>ERADICATION OF FEMALE GENITAL MUTILATION (FGM)</i></b>	<b><i>29</i></b>
<b><i>THE ROLE OF THE NUEW IN THE STRUGGLE TO STOP FGM</i></b>	<b><i>30</i></b>

<i>MATERNAL WAITING HOMES (MWH)</i>	33
<i>CONCLUSION</i>	35
<i>RECOMMENDATIONS</i>	36
<i>WORKS CITED</i>	37
<i>APPENDIX I</i>	41
<i>APPENDIX II</i>	42
<i>HUMAN RESOURCE IN THE MOH</i>	42
<i>APPENDIX III</i>	43
<i>APPENDIX IV.</i>	44
<i>GLOSSARY</i>	45

## ACRONYMS

ADB	African Development Bank
ARHD	African Region Human Development
ANC	Antenatal Care
BCC	Behavior Change Communication
CHW	Community Health Worker
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
EASSI	Eastern African Strategic Support Initiative
EDHS	Eritrean Demographic and Health Survey
EHP	Eritrean Health Policy
EMOC	Emergency Obstetric Care
EPLF	Eritrean People's Liberation Front
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FHH	Female Headed Households
GBA	Gender Based Analysis
GDP	Gross Domestic Product
GSE	Government of the State of Eritrea
GTZ	Gesellschaft für Technische Zusammenarbeit
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IEC	Information, Education and Communications
ITN	Insecticide Treatment Net
MDGs	Millennium Development Goals
MOH	Ministry of Health
MWH	Maternal Waiting Home
NGO	Non-governmental Organization
NUEW	National Union of Eritrean Women
NUEYS	National Union of Eritrean Youth and Students
OF	Obstetric Fistula
OSAG	Office of the Special Adviser on Gender issues

PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
RHM	Reproductive Health Matters
SRHP	Sexual and Reproductive Health Policy
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Populations Fund
WHO	World Health Organization

## **ABSTRACT**

Eritrea, a country in East Africa has been striving for gender equality for the last thirty years. This study focuses on Eritrean Reproductive Health Policy and explores it, using gender based analysis. As gender equality is more easily said than done, achievements and challenges are identified. The study comes to the conclusion that achieving social justice and gender equality, and in particular enjoying the highest attainable health standard for females, requires strong commitment and work, which can be attainable in a long process. The conclusions present recommendations on the Eritrean health sector in general and reproductive health in particular for further improvement.

## **Executive Summary**

The Beijing Platform set a course for gender-based analysis (GBA) to follow world-wide. This Platform was adopted in Eritrea and applied in several policy areas, including health. Health is especially important to the well-being of women because the highest attainable level of health is not only a fundamental human right for all; it is also a social and economic imperative because human energy and creativity are the driving forces of development. As the 15 year anniversary of the Beijing Platform's adoption of gender-based analysis approaches, and the review of implementation occurred after ten years, sufficient time has passed to review the outcomes of gender-based analysis in the field of women's health in Eritrea with the aim of identifying gaps in what has been achieved to date. This analysis attends to the evaluation of current policy in order to feed information back into the policy revision cycle with recommendations about the future of GBA in health policy in Eritrea.

My project reviews and up dates findings in the area of women's health concentrating on reproductive health policy areas such as maternal health and female genital mutilation in which gender-based analysis has been most explicit. The methodology applied to this end is a qualitative approach complemented by Focus Group Discussions (FGDs). The purpose of my study is to examine the fit between the general policy commitment to gender-based analysis in the field of health and its actual selective implementation to identify its scope of success and lessons learned with a view to identifying gaps in what the policy implementation has achieved.

Based on these findings the project concludes gender is not institutionalized in the system in general. Specifically the integration of different gender needs in all aspects of the organizational life is lacking and taken for granted. As a result, the project recommends the Ministry of Health (MOH) to uphold formal its commitments to gender equality and take the necessary steps to integrate gender mainstreaming to this effect. The project also recommends that the MOH collaborate fully with the National Union of Eritrean Women (NUEW) and other stakeholders.

# **CHAPTER 1**

## **GENERAL INTRODUCTION**

Eritrea is a country situated in the horn of Africa that covers a geographical area of about 124,000 square kilometres, and it is the ancestral home of approximately 3.5 million inhabitants. Eritrea's formation as a state was accomplished during Italian colonialism that endured from 1890 to 1940. Though Eritrea's formation as a state had happened with the advent of Italian colonialism, the culture, religion, and civilization of its inhabitants was much older and can be traced in the remnants of the archaeological findings of the ports of Adulis and Zula which were famous ports in about the 4<sup>th</sup> Century in the Common Era (Wrong, p.110). Since the 15<sup>th</sup> century Turkish, Egyptian, Italian, British and Ethiopian colonizers have laid claim to Eritrean territory.

After a relentless war for independence of 30 years, Eritrea gained its independence in 1991 and joined the international community of the UN in 1993. Currently Eritrea, the youngest nation in Africa, has been described as a country scarred by the effects of war, insecurity of person and property, landmines, and rampant poverty. It is additionally burdened by the problem of demobilized soldiers, internally displaced civilians, and stateless expellees from Ethiopia.

Despite all the natural and man-made problems, the Eritrean people's resilience and commitment to have a developed and peaceful society is building momentum, and Eritrea is again determined to stand against all the odds.

As part of this venture, in this study I will examine the motto of gender equality and several challenges that Eritrea faces in mainstreaming gender in the health sector, and specifically in women's reproductive health and make recommendations to ensure that gender mainstreaming policies are transmitted into action.



## **Introduction**

During the last three decades gender relations in Eritrea have undergone a remarkable transformation. The national liberation movement from 1961 to 1991 has created a conducive atmosphere to smash the edifice of the feudal-patriarchal society. Being full partners in the war of independence, women had won a public voice and political space to promote issues of primary concern to women. The principles of social justice and gender equality have been the motto for all the social changes and social equality envisaged.

Many of the colonial laws of Ethiopia were repealed right after independence. Mention can be made of amending some articles of the family law, such as the principle that gives equal status to husband and wife. Other discriminatory practices such as dowry, kidnapping for marriage or abduction, and parental consent for marriage were repealed and replaced with provisions that ensure gender equality.

Female genital mutilation (FGM) was officially banned in Eritrea in 2007, following a concerted campaign of almost thirty years against the practice by the major stakeholders such as the Department of Health of the Eritrean Peoples Liberation Front and the National Union of Eritrean Women (NUEW). Later, after independence, the campaign to eradicate FGM was promoted by the Ministry of Health (MOH), the National Union of Eritrean Women (NUEW), and the National Union of Eritrean Youth and Students (NUEYS),

The Beijing Platform set a worldwide course for bringing gender perspectives to the center of attention in policies and programs. (UN.OSAG p.9). This Platform added an impetus to Eritrea's gender equality agenda and was adopted to be applied in several policy areas, including health. Health in general and reproductive health in particular is important to the well being of women because, without health, neither socio-economic nor political emancipation for women can be achieved. These are also policy areas in which gender sensitivity, Gender based Analysis (GBA) and gender mainstreaming might be expected to have been most effective.

Using GBA, this paper examines the fit between the draft national health policy (NHP) and specifically the reproductive health policy (RHP) with the aim of identifying

gaps in order to feed information back into the policy revision cycle with recommendations about the future of GBA in health policy in Eritrea.

GBA can be used to scrutinize the political situation such as the philosophy, values, structural and institutional setup, according to Moser and Moser (2005). So too can technical issues such as the availability of statistical data to identify achievements and gaps (p.16). This study further discusses the success achieved against the harmful practice of female genital mutilation, which strongly impacts the RH. The UN and its international agencies are approaching the fifteenth anniversary of the adoption of the Beijing Platform and a process is on going to have a general assessment of the relative success and challenges of the platform will occur. This study contributes in a small way to that assessment in the area of women's health focusing on reproductive health services.

#### *Thesis Statement*

Women's equality has been entrenched in the Eritrean constitution and affirmed and reaffirmed in various government documents, including a commitment to GBA and a gender-mainstreaming approach. These formal commitments produce the expectation that GBA is incorporated in major policy areas such as agriculture, education and health. Experience shows that the rhetoric does not live up to actual practice. This paper intends to scrutinize the extent to which such commitments are actually transforming the status of women's health.

To this end the study examines what is being done to bridge the gap of inequality in the context of the Eritrean Health Policy (EHP), and specifically, the RHP and the process of implementation to identify areas of hindrance for further improvement. Using *GBA the study will first explore how far the NHP & RHP have mainstreamed gender.* This will be followed by questioning the process of institutionalizing gender mainstreaming in the health sector and specifically the reproductive health component. Finally, the study recommends, steps to be taken to narrow the gender gaps.

#### *Objective of the Study*

In addition to fulfilling of the academic requirements for the MAIS 701 Final Project, the study will be used by my employer, the NUEW as a background study from which to advocate for policy changes. A number of recommendations have been

developed to strengthen mainstreaming gender in the health sector. These purposes exemplify an applied policy study, the main purpose of which is to produce input into the policy cycle to further the aims of an existing policy initiative.

### *Methodology*

This study employed a feminist research methodology, since the study is politically motivated, and it adopts the standpoint of gender equality with an expectation to address social inequality in its concrete particularities (Tiessen p. 20). This aspiration emanates from the social movement for change that has been going on for more than thirty years in Eritrea and my personal commitment to the actualization of a social justice agenda as measured materially through the reduction of gender inequality, advances in gender equality and social change toward parity between the genders. The study uses an exploratory approach also to acquire new insights, with a view to gaining a more complete understanding through the empowerment of actors in the health sector of gender mainstreaming. (Palys p.73).

The main approach used is qualitative, drawing policy ideas out of official government documents and reports of the Ministry of Health (MOH), the NUEW, and other pertinent documents from the WHO, UNFPA and other international sources. Some relevant electronic sources also enrich the document along with my personal observations made in my capacity as an employee of the NUEW who has worked closely with the MOH for the last ten years. The Gender Mainstreaming Strategy Workshop of the MOH in 2007, in which I participated has demonstrated the formal commitment at the governmental level and within health policy. Based on the outcome of that workshop using Sibanda's gender organizational analysis tool, a focus group discussion (FGD) of 20 employees of the Ministry of Health was held, 5 out of them were women. Another FGD was held with members of the Executive Board of NUEW, which consisted of ten women, on the issue of Stop FGM Campaign.

In addition, I discussed with key informants, two of whom were high level officials of the MOH, concerning the possible process of GBA in the EHP & RHP.

### *Scope and Limitation of the Study*

The scope of my research is limited to the Gender and Reproductive Health considered as an applied policy in the Eritrean context, specifically focusing on the strategy of mainstreaming gender on reproductive health. The proposal had initially intended to make use of comparative studies across East Africa. Limitations of time and scope resulted in a narrowing of the focus to Eritrea that had easier access to the policy documents compared to other countries in the sub-region.

The pervasiveness of health, and women's health as a subject made it possible for me to do justice to limit, that of Sexual and Reproductive Health (SRH) which is stated as RH in this paper. That narrow scope might serve as a microcosm for what is found more widely in the field of health not only in Eritrea but in other concerned countries to improve women's health, and thereby strengthen their equality in society.

### *Contextualizing Gender Mainstreaming in the Health Sector:*

Due to the advocacy work done by women's activist group and non-governmental organizations (NGOs), the UN held the first Conference on Women in Mexico City in 1975, on the theme 'equality, development and peace'. This culminated a second conference in Copenhagen in 1980 and a third in Nairobi in 1985 which changed the women in development (WID) to gender and development (GAD) approach. This has been a shift to a gender perspective taking into account the socio-economic, political and cultural differences between men and women. (UNFPA, 2003 p.21)

The strategy for gender equality endorsed in the Beijing Platform for Action, was gender mainstreaming that seeks gender based analysis at issues and the formulation of policy options, informed by a consideration of gender differences and inequalities (UN 2002 p.1).

Moser & Moser use CIDA's 1999 definition of, *gender equality* refer to: as the recognition that women and men have different needs and priorities and should 'experience equal conditions for realizing their full human rights, and have the opportunity to contribute to and benefit from national, political, economic, social and cultural development' (p.12).

Different human right treaties have provisions on women and health, such as CEDAW Committee general recommendation on health in 1999 which is very pertinent and plays a catalytic role in mainstreaming gender in the health sector (WHO 2007 p.12). For more formal definitions of this vocabulary, see the Glossary.

## **CHAPTER 2**

### **HEALTH POLICY IN RELATION TO GENDER IN ERITREA**

Gender analysis identifies, analyzes and informs action on inequalities that arise from the different roles of men and women, the unequal power relations between them, and other contextual factors such as ethnicity, sexual orientation, employment citizenship, etc. and the consequences of these inequalities on their lives, their health and well-being.(Sibanda's Training Manual for Gender Mainstreaming, 2007).

Dawson demonstrates links between poverty, discrimination against women and gender inequality and how this analysis can be used to assist the progressive development of an organization. (p.85). The way power is distributed in most societies results in women having less access to and control over resources including protection of their health. Accordingly, they are less likely to be involved in decision making and are more likely to be responsible for caring for the health of family members and others. Furthermore, gender analysis in health highlights, how inequalities disadvantage women's health, the constraints women face to improve their health, ways to address and overcome these constraints, health risks and problems men face as a result of the social construction of and masculinity and other contextual factors that impact health problems in men and women.

This paper considers the Eritrean Health Policy from a critical feminist perspective. Brayton differentiates feminist research from traditional research since it actively seeks to remove the power imbalance between research and subject; is politically motivated, and plays a major role in changing social inequality. Gender equality in this document is not taken as a means to development. Rather gender equality is taken as one of the core pillars of social justice and human rights approach that guarantees development. (Moser & Moser p.14-15; Tiessen p.20). While OSAG & et al identify that gender equality, as an issue of human rights and social justice, it is stated too as steps toward greater equality and can contribute also to the achievement of social and economic objectives. (p.10). Unger & et al have further elaborated this in the realm of health care, gender equality as a right, is an issue of development and of political and economic stability. (p.99).

The issue at stake is whether or not to advocate gender equality on the basis that it can bring efficiency and effectiveness or address it as an alienable women’s right. I concur with Moser and et al that arguments about efficiency run the risk of depoliticizing the transformative nature of the feminist agenda and must clearly advocate, the kernel of women’s right. (Tiessen p.15). Tiessen perspective that gender mainstreaming has the possibility of success, if used as a process of political or transformative change, encompassing the organizational, institutional power structure, so deeply ingrained in the structure of organizational life seems pertinent in this study too. (p.31).

This interdisciplinary investigation looks at achievements and challenges in mainstreaming gender in the health sector and RHP policies and programs specifically focusing, on biological, social and cultural aspects. Moreover, the gendered division of labor, its linkage and impact on women’s health are further explored.

### **International and National Gender and the Health Sector Policy Milestones**

The main international instruments related to health and the pertinent Eritrean legal instruments are put in a table below, for easy reference and to indicate how far Eritrea has aligned and harmonized itself with international instruments.

**Table 1: Gender and the Health Sector Policy Milestones at the International Level**

<b>Year</b>	<b>International Instruments related to Gender and Health</b>
1966	International Covenant in Economic, Social and Cultural Rights (ICESCR). The right to enjoyment of the highest attainable standard of physical and mental health, including sexual and reproductive health, Art. 12
1975	The international conference on women in 1975 created a momentum and interest in women’s health.
1979	The international convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), which was adopted in 1979, is a legally binding treaty, and as of 2006, 185 countries had ratified it. Articles 11 (1)(f), 12, 14(2)(b), 16(1) refer to non-discrimination in the field of health care.
1989	Convention on the rights of the child
1994	United Nations held the International Conference on Population and Development (ICPD) in Cairo, where more than 180 States took part and reached consensus to work on gender equality, equity and empowerment of women as well as on reproductive rights and reproductive health.
1995	Beijing Declaration and Platform for Action, an agenda for women’s empowerment, envisions removing all obstacles to women’s active participation in all spheres of public and private life, via shared power and responsibility. The strategic objective of Women and Health states that women have the right to the enjoyment of the highest attainable standard of physical and mental health. (BFPA p. 56)

1999	The UN Commission on the Status of Women considered 'Women and Health' as a priority theme at its forty-third session.
2000	<p>Beijing+5: Beijing and Beyond convenes in New York and recognizes several emerging critical issues for women and girls, including work-related rights, gender-based violence, reproductive and sexual rights, education and social security, and access to productive resources. At the Millennium Summit in New York, UN Member States commit themselves to establishing a better, healthier and more just world by 2015. The Millennium Declaration promises "to promote gender equality and the empowerment of women as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable."</p> <p>Among the eight Millennium Development Goals are:</p> <ul style="list-style-type: none"> <li>▪ Goal One: eradicate extreme poverty and hunger;</li> <li>▪ Goal Three: promote gender equality and empower women; and</li> <li>▪ Goal Four: Reduce Child Mortality</li> <li>▪ Goal Five: Improve Maternal Health</li> <li>▪ Goal Six: Combat HIV/AIDS, Malaria and other diseases</li> </ul>
2002	The World Summit on Sustainable Development in Johannesburg issues a Political Declaration, and the Johannesburg Plan of Implementation. The Summit confirms the need for gender analysis, gender-specific data and gender mainstreaming in all sustainable development efforts, and the recognition of women's land rights. Principle 18 of the declaration states: "We are committed to ensure that women's empowerment and emancipation and gender equality are integrated in all the activities encompassed within Agenda 21, the Millennium Development Goals and the Plan of Implementation of the Summit." In Paragraph 24 agreed to: "...support capacity building for water and sanitation infrastructure and services development, ensuring that such infrastructure and services ...are gender-sensitive."

UN OSAG (2002), UNFPA (2003), WHO (2007).

**Table 2: Gender and the Health Sector Policy Milestones in Eritrea**

<b>Year</b>	<b>National gender &amp; health related instruments</b>
1977	The National Democratic Program of Eritrean People's Liberation Front (EPLF) in its article of 4.B. on Women's rights states that, respecting the right of women not to engage in work harmful to their health and protect the right of mothers and children.
1979	The Constitution of the NUEW in its objectives states that it will work for the improvement of women's health and in particular will fight to stop harmful traditional practices.
1995	Eritrea after formally becoming independent and joining the UN in 1994, immediately ratified CEDAW in 1995, as it concurs with its basic principles of social equality and since then has submitted its initial, first and second report in 2004.
1997	The Constitution of Eritrea, in its preamble indicates its commitment to social equality and article 21 states that every citizen has the right of equal access to publicly funded social services, such as health and education.



2004	The Eritrean Gender Policy and National Gender Action Plan have been consistent in harmonizing it with the CEDAW and Beijing Declaration and Platform for Action. It requires the GSE to guarantee that women have a basic right to the enjoyment of the highest attainable standards of physical and mental health.
2007	Proclamation to Abolish Female Circumcision, 158/2007 of GSE, in its preamble state that FGM is a violation of women's basic human rights.

### **Health in Eritrea**

The Government of the State of Eritrea (GSE), to rectify the ingrained social ills has based its policies on a long-standing commitment of social justice and equality as stated in its Macro Policy Document of 1994. The health status of Eritrea was at its lowest ebb at the time of independence. Eritrea's enormous vision of building a society that ensures the highest attainable health standard has been a major challenge to the GSE. Demographic and epidemiological trends indicate a young population, high mortality and fertility rates, high incidence of communicable diseases, and the increasing trend of non-communicable diseases. (See Appendix I).

The State of Eritrea committed itself to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1995. The Convention requires the elimination of discrimination in all aspects of women's lives. It specifically targets inequality in relation to health services, education, family relations, employment, and violence against women, stereotypes, harmful cultural practices, child bearing, and political representation. Eritrea's commitment to the implementation of the Beijing Platform for Action has been enshrined in its constitution.

CEDAW is the central and most comprehensive binding legal instrument that brings to light all the areas in which women are denied equality with men.(UNFPA 2003. p.39). The Beijing Platform for Action has clearly stated in its mission that it is an agenda for women's empowerment. It further notes that equality between women and men is a matter of human rights and a condition for social justice and is also a necessary fundamental prerequisite for equality, development and peace. As an agenda for action the Platform tries to ensure and promote the full enjoyment of all human rights.(p.17). Mainstreaming gender has been identified as the most critical mechanism to reach this goal. That commitment to women's rights along with the advancement of human rights is

increasingly seen as an overarching framework for development that is regularly scrutinized from a gender perspective.

Eritrea has been delivering national reports towards that end to the international forum, using the indicators of the Beijing Platform of Action and CEDAW as required. In September 2000, world leaders agreed upon the Millennium Declaration, which distills the key goals and targets agreed to at international conferences and world summits during the 1990s. The UN System and other international organizations drew up a set of eight Millennium Development Goals (MDGs) with associated targets and indicators.

All the 191 United Nations Member States pledged to meet the MDGs by the year 2015. The GSE has aligned its programming with the eight MDGs. In Eritrea the data available concerning the MDG are scarce or poor with the exception of Education. (GSE –MDG Report. 2006 3-33). (See Appendix II).

The Eritrean Health System aims to provide social justice and public social services to all as a basic human right. According to Eritrea's Macro Policy Document, one of the first guiding policies of the GSE, basic health services are to be made available to both the urban and rural populations, and priority will be given to primary health care and immunization programs and it is intended to consistently and strenuously uphold equal rights of women.

The Macro Policy document, while dedicating an article on gender, and addresses the steps to be taken to change the status quo. Yet, it did not clearly identify the gross gender gap that exists in the country; this might be because nationwide gender analysis had not been done at that time. The Eritrean Gender Policy and National Gender Action Plan of 2004, promote participatory processes with relevant stakeholders. The gender policy also requires the GSE to guarantee that women have a basic right to the enjoyment of the highest attainable standards of physical and mental health. Empowering women and men to protect and care for themselves, particularly in relation to maternal and infant mortality, HIV/AIDS and other infectious diseases is set as a priority. (p.15)

Unger, Dessel and et al indicate that antenatal care encompasses, amongst other matters, primary prevention, such as free malaria prophylaxis, and insecticide treatment net (ITN) and prevention of mother-to-child transmission of HIV (PMTCT) (p.96). In the Eritrean context too, specific policies affecting health such as the Primary Health Policy,

Health Promotion Policy, HIV/AIDS Policy, and Human Resources Development Policy, have relevant policy issues on RH such as availability of prevention services to maternal and new born, & child health (MCTH), PMTCT & free ITNs bed nets for pregnant women etc are incorporated. Since all this policy documents emanate from the National Health Policy (NHP), the study focuses on the draft of National Health Policy of 2009 and Sexual and Reproductive Health Policy only.

The NHP draft of 2009 presents the economic profile showing stagnant GDP growth. Economic stagnation is due to the 1998 -2000 war unleashed by Ethiopia and the current “no war, no peace” situation is also affecting the economic status dramatically.

At present, two-thirds of the population (66.4%) subsists on annual incomes below the poverty line. The Eritrean Millennium Development Goals Report indicates that the Eritrean per capita has been estimated to have declined from \$ 200 in 1998 to \$ 180 in 2002. (p.3). The household data has not been disaggregated by gender. Had it been it would have been clear that a significant portion of all households below the poverty line are headed by women. This unreported fact indicates the gender differentiated impact of poverty on women.

Though the MOH developed a gender mainstreaming strategy which required GBA to be used to assess the differential impact to both sexes in 2007, yet the NHP falls short from applying it. Factors that affect women’s health can be considered a key indicator of the effectiveness of the GBA in the health sector. In addition to the lower economic status of many women, other related factors that have a gender differentiated impact include cultural norms and values that affect some of the major health determinants such as nutrition, maternal health and reproductive rights (p.2). The NHP did not disaggregate the Eritrean health profile by sex, age and geographical location for the major communicable diseases, except in those instances in which only women are affected such as the maternal mortality rate issue. (p.26) . (See Appendix 1).

While the NHP does acknowledge human resources (HR) as crucial to the effectiveness of the health management system, and clearly indicate that it faces daunting challenges in relation to shortages of medical personnel combined with the rapid expansion of the health infrastructure. In the NHP the expanded infrastructure, the need of standardization of service provision and the modest availability of specialized medical

technology is presented as drawbacks as well as opportunities for improved health services delivery. Here the gender dimension is also neglected. The limited available statistical data from the HR of the MOH provides an indication that at the higher professional level the scarcity of women experts exist.

Understaffing affects medical services at all levels due to shortages of trained medical personnel compared to staffing levels recommended by the World Health Organization (WHO). While achieving the WHO standard for nurses and associate nurse, Eritrea has not yet met the WHO standard vis-à-vis doctors' ratio per population.

The controversy of not having enough health personnel in all health sites is not only due to the growing population size but may be also due to the high attrition rate that needs further investigation.

**Table 3: Health Professionals per Population**

<b>Professional category</b>	<b>WHO Target for Developing Countries</b>	<b>Eritrea</b>
<b>Doctor/Population</b>	<b>1:10,000</b>	<b>1: 16,479</b>
<b>Nurse/Population</b>	<b>1:5,000</b>	<b>1:3481</b>
<b>Associate Nurse/Population</b>	<b>NA</b>	<b>1: 2238</b>

HMIS, Eritrea (2007)

The existing number of health professionals, the doctors, nurses and associate nurse are presented in NHP. The data limits itself from identifying the gender gap that exists and as a consequence the policy does not indicate the appropriate measures that need to be taken to remedy the gap. (p.7). (For further information see Appendix II profile).

For example, it is known only anecdotally that women access health services for themselves less often than men access them, and that women and men who are better off economically access the system more frequently and for a wider range of purposes than those who are less well off. Since women tend to make up a substantial portion of the poorest of the poor, the expectation would be that they and their children are least well served by the existing health services delivery model. Substantiating these propositions remains next to impossible without the statistical evidence to prove that this is the case.

The formal policies of the GSE and the MOH and its formal commitment to GBA and women's equality generally, short fall of institutionalizing gender mainstreaming. . The limited data available demonstrate, in the collection of statistical data, not establishing a system, a tool of disaggregating data by gender means has major consequence at a later stage. Tracking the gender gap over time then becomes next to impossible because the data available does not yield usable comparative data except over several decades, thereby making the process of needed social change much slower and more uncertain than it would be if a commitment were made to developing these statistics, if only because GBA mandates its collection.

Besides, the NHP in its guiding principles is obliged to promote equity in provision of health services which is in line to its philosophy of social justice, The NHP has stated as its aim the distribution of costs and benefits of health services, which needs proper attention, since it might be contrary to the core principle of social justice. Since the primary beneficiaries of the comprehensive primary health care are women and the very poor and should not be compromised. Unger and et al cautions us since the co-modification of health care as well as the neo liberal theory of cost effectiveness analysis has failed to reduce epidemics or make progress on maternal health. (pp.91-92).

From the above analysis of though the NHP, incorporated some of the critical areas of the core principle of social justice, GBA has not been utilized and did not benefit from the MOH gender mainstreaming strategy as yet. The same input is missing in the NHP, in relation to the existing National Gender Policy which is supposed to be used as a reference guide.

#### *The Institutional Framework*

As Porter and Sweetman indicate gender mainstreaming requires an institutional framework at various levels, including the internal dynamics of organizations which include policies, structures, systems, and procedures as well as operational activities program areas that have to be the focus of change (p. 4). In theory this should be automatic in the policy revision process. Unfortunately, no policy revision has occurred. Key informants working for the MOH indicate the following.

While the social justice and equality philosophy is high on the agenda amongst the employees of the MOH who participated in the FGD, and all have confirmed their commitment to the gender equality issue, the general consensus of the group was that expertise in operationalizing gender as a concept, gender mainstreaming and GBA is lacking both amongst the higher officials of MOH and in the health sector in general.

This seems to happen due to the unconscious perception that the health sector is a gender neutral field of activity. According to one expert from the MOH who shared his view at the 2007 workshop, the MOH need not differentiate its activities on the basis of gender, because its mandate was to serve both the sexes equally without distinction.

Accordingly, the policy direction implied for the MOH to remain gender-blind rather than gender sensitive, and in this way gender equality would result without any special measures having to be taken. The understanding that gender differences play a very significant role in the differential in the burden of disease between men and women is missing, by having a gender blind perspective willfully ignoring as already stated or vice versa by being adequately handling it. Since gender is not institutionalized in the health system, integrating the different gender needs in all aspects of the organizational life is lacking and taken for granted. This attitude contradicts what is ordinarily understood by GBA in feminist circles, gender mainstreaming does not mean that gender is adequately taken into account by acknowledging its relevance in formal government policy. Rather the activity of GBA must be incorporated at all levels to affirm or disconfirm whether and to what extent gender inequality exists and can be remediated successfully.

According to Rao and Kelleher to uphold the principle of gender mainstreaming, the need for political strategizing at multiple levels, and deeper institutional change, capacity building, political partnerships and strengthening women's organizations are some of the tools that can bring positive outcomes (p.59).

Looking at the organizational structure of the MOH, one can easily identify that it follows a hierarchical type, top down. Recently a female has been assigned at ministerial level, making a new precedent. In general in top management positions women are few and far between. More than 80% of the higher echelons of the ministry are comprised of

men, and the fifth who are women tend not to be evenly distributed within the management hierarchy but are clustered at or near the bottom of this rank. As a result, decision making remains the prerogative of the elite within the male population. This needs further investigation to understand the power dynamics, the priority of the few female health professionals, the culture and availability of social services etc. Currently about 20% of women qualify for these sorts of positions based solely on their education. The Human resources policy of the MOH generally state that gender and diversity should be taken into account in hiring and advancement. A standard clear guideline is not available which makes it a requirement for implementation.

The MOH's human resource development program, aggressively pursue affirmative action to remedy the diversity gap that exists. The Community Health Colleges recently established in three areas do demonstrate the will and commitment to rectify the gap.

The gender gap in top jobs in the governmental and health care sectors is unlikely to be reversed anytime soon. This is so because equal and fair opportunities need further attention and guidelines beyond the affirmative action taken, such as develop counseling and support mechanism for the females who enter the health college by quota, innovative approaches to ensure girls continue their education up-to the tertiary, promoting advocacy work and encourage attitudinal changes amongst male health service professionals to be gender sensitive. Alleviating the burden of caring role of females, who are in the health services, and nurturing their commitment to play a role model amongst female youth. A special measure needs to be taken to close the gap in recruitment and promotion in the MOH which will require integrating GBA in HRD policy and engendering all the curricula of the health colleges.

### *The Culture of the MOH*

Eritrean society is a patriarchal society. Due to the biased attitude to gender equality a conscious effort is needed to identify the imbalance that exists in all areas including the health sector. Most of the senior staff of the MOH has a genuine belief that they are committed to gender equality and support it. The majority of senior managers of the MOH have the perception that, since the majority of the population has been

neglected from having access to health services during the colonial era, and by virtue of the MOH's commitment to ensure basic primary health services to all, the needs of women are automatically taken into account. The limited available data indicate to the contrary. In the FGD it was stated having a specific policy on reproductive health and programs geared towards its achievement was indicated as proof of its effectiveness rather than being an affirmation of policy objectives that have not been realized. The existing perception did transpire in key informant discussions held with senior managers of the MOH. Mention can be made of a recent example where the Reproductive Health Unit was finalizing its Maternal Neo-natal Health Road Map (MNH) of 2009 a meeting whereby 90% of the participants were males. When I notified the facilitator about the issue the response that I got was that the agenda was not on gender issues. This situation affirms Tiessen's view that gender mainstreaming will remain unachievable without transforming the gendered power structures of society.(p.20).

When discussing the culture of the MOH, the interaction of the socialization process of each of the participants at work and home was discussed to illustrate the general case. This led to identification that there are stated and unstated norms that hamper equal participation. Most of the participants did recognize the caring role was expected to be fulfilled by their daughters, sisters or wives at home; the unconscious preference exists for the girl-child in looking after one's children. The caring role of girls and women is always taken as a norm. The bias also lingers even in the work culture, when an assigned personnel that serves tea is not available, the accepted norm from the female and the expectation from the male staff remains that the female staff member will have to continue in the caring role, such as serving tea, which seems to be a benign example but actually reflects how extensively gender expectations operate. This cultural presumption reflects the tacit gender bias and deep-rooted attitudes that die hard. All agreed that these attitudes and norms need to be reminded constantly and that a conscious effort and advocacy work would be needed for attitudinal change. Tiessen and other theorists maintain that the public sphere refers to the space where paid workforce is conducted, whereas the private sphere is the function of domestic life, where the work of housekeeping, childcare, and maintenance of the family is carried out. Women's ability



to give birth is ‘inextricably linked to their responsibility as primary caregiver for children. Thus the socially constructed norm of social support and care giving is linked to physiological differences’ (pp. 37-38). This has been affirmed in the in-depth discussion with the MOH staff members, which was a collaborative process of dismantling the socially constructed and accepted norm that caring role is a major responsibility of the female workforce.

The MOH has started to take some measures, such as the initiative in its headquarter to address the different needs of its female staff, many of whom are breastfeeding mothers, allowing flex time of working hours, and the opening of a kindergarten at the headquarters and relieves those over stressed mothers, to look after their kids and work simultaneously.

It is expected also to play a positive role in influencing others, to take similar measures elsewhere. This commendable work of the MOH is expected to be replicated in all major centers of the health sector to avoid one of the possible causes of turnover of female staff, due to their caring role.

All in all though the resistance to recognize gender difference seems to be subdued, and many came to recognize that women and men have different needs and priorities, and lack equal opportunities to access and benefit from all aspects of life, a continuous concerted effort is needed to build the capacity of GBA in the health service, that helps to recognize the gaps that exist in realizing gender equality in the entire health sector and to work seriously on issues of gender and health.

### **Health and Gender Mainstreaming Strategy**

The MOH formulated a health and gender mainstreaming strategy in late 2007 whereby higher echelons of the ministry in a participatory workshop. Moser & Moser identify the institutionalization of gender concerns within the organization itself as contributing to the transformative process of organizational culture and attitude. (p.13). This study was a good opportunity to revisit that idea to learn how far gender mainstreaming is institutionalized in the sector. The strategy dealt with the institutional and operational setup using a gender-based analysis. The current NHP bears out that the health and gender mainstreaming strategy which has been developed has not been taken seriously or used appropriately. Based on this experience I concur with Porter and

Sweetman that change must take at different levels, if organizations are to address gender inequality successfully (p.6).

*Health Delivery Services*

The MOH has devised a strategy of preventive, promoting, curative, and rehabilitative health care services to accomplish its mission. At the national level the MOH administers and oversees the work of the National Referral hospitals, specialized diagnostic and care/service giving institutions, training institutions, and regulatory bodies, services which are administered at three levels. Eritrea – CEDAW report clarify that the MOH, health service facilities are organized in three-tier system.

The first level health facilities focus on preventive, promoting and rehabilitative services and comprise Health stations (expected to serve a population of 10,000 staffed with a registered Nurse and one or two associate nurses); Health Centers (expected to serve a population of 50,000 staffed with two or three nurses, sanitarian, associate nurse, lab. technician etc);

and the first contact and referral hospitals serves over 50,000-200,000 population respectively (p.40). According to the ADB, 17 HOs, 67 HCs and 337 HSs will be needed to reach national standards. (Eritrea Gender Profile p.23).

**Table 4: Number of Health facilities by Type and Year**

<i>Type of Health Facilities</i>	<i>1991</i>	<i>2002</i>	<i>2007</i>
Hospital	16	24	26
Health Center	4	49	56
Health Station	106	169	182
Total	126	242	264

Several paradoxes affect health care provision, giving a somewhat misleading picture of recent trends. As Sen indicates, in some countries while the investment in the health care system is large, the principal beneficiaries are in the upper strata of the population, while in some others with a lower investment the health services are better off for the poor (2002). This analysis applies in the Eritrean case, as does two other paradoxes. Eritrea’s health care spending though limited tends to emphasize prevention,

for example, to achieve more than 80% rate of immunization, leading to a major decline of communicable diseases, such as malaria and HIV/AIDS (Sen. A. 2002). The result is also due to community health services that ensure the availability of basic health services, by mobilizing and empowering communities with the necessary skills. The paradox is that this avoidance of additional and higher costs to the health care system cannot be reported as a saving, and appears in budgets only as a cost without its multiplier effect in cost avoidance being recorded anywhere. Another paradox is that although more medical personnel are employed in the health sector than ever before, these increases are not necessarily keeping up with the rate of the population growth. Eritrea while achieving the WHO standard for nurses and associate nurse, it has not yet met the WHO standard vis-à-vis doctors' ratio per population.

Problem of not having enough health personnel in all health sites is not only due to the growing population size but may be also due to the high attrition rate. The WHO African Report of 2006 recognize the high attrition rate as Africa phenomena of migration, which can be in search of better working conditions, higher salaries, and opportunities for training and recognition (p.117).

#### *Gender and Basic Health Care Package (BHCP)*

The MOH adoption of the principle of social justice and ensuring basic health services to all citizens concurs with the Alma-Ata Declaration of 1978. The International Conference sponsored a declaration on the right of all people to the provision of primary health care (PHC). The principles of the Declaration have been affirmed subsequently by the MOH. The MOH has prioritized the main health problems and prevailing burden of diseases, such as reproductive health, HIV/AIDS, malaria and other non-communicable diseases related to PHC. As might be expected PHC provisions that affect gender and reproductive health are especially important. In the MOH's operational activities, it has developed a Sexual and Reproductive Health Program and will be explored further from GBA perspective.

## **GENDER AND REPRODUCTIVE HEALTH**

The International Conference on Population and Development ICPD of 2004 views reproductive Health (RH) in the broader context of providing basic health services and fulfilling the overall socio-economic development needs of the populations. The concept of reproductive health has evolved from the conventional issues of sexually-transmitted diseases and problems of prevention of maternal and prenatal mortality and morbidity, STD prevention and management, unwanted pregnancy, unsafe abortion, and programs such as maternal and child health, safe motherhood, family planning, to encompass issues such as harmful practices, gender-based violence, infertility, menopause, malnutrition, anemia, and reproductive tract cancers.

In line with this the Eritrean sexual and reproductive health policy (SRHP) referred to here interchangeably as SRH and RH. Its overall aim is “to contribute to the improvement in the equality of life and reduction of poverty through improvements in reproductive health, gender equality and equity,

reduction in HIV/AIDS prevalence and harmonization of population dynamics with sustainable development” (p.8). The SRHP has yet to address the objectives and strategy related to gender equality and equity in relation to women’s development. Furthermore, it does not yet incorporate the broader determinants of health, such as the socio-economic, cultural, physical and psychological factors that differentially impact women on the basis of gender. The linkage and the opportunity at women’s health in its entirety offer an area for immediate improvement. The SRHP states that women, men and children have the right to access sexual and reproductive rights, yet its main focus remains on the more limited topic of maternal health. Treating the related aspects of women’s reproductive health would extend and deepen the approach already taken to maternal health. One further point worth noting is that the SRH policy does not address women’s diversity with respect to ethnicity, age, ability/disability, education, and lifestyle, each of which affects the status of women’s health.

In this respect addressing gender inequality and closing the gap in reproductive health even at the stage of policy development would require highly participatory work and qualified personnel not only on the medical field but gender expertise also.

Below the implementation processes and practices of the RH program, some of the major determinants of RH in Eritrea, Maternal Health, Abortion, female genital mutilation (FGM) are discussed further below to show some areas in which GBA could be improved within the existing policy framework.

*Factors affecting Maternal Health*

The major four factors that affect maternal health are considered: poverty, culture, obstetric fistula and abortion. After first describing maternal health in general, each of the four factors will be discussed briefly in turn below.

The country lacks skilled health personnel, especially midwifery services, according to the reports of the UNFPA Eritrea. WHO defines a skilled attendant as health professionals such as midwives, doctors or nurses who have been educated and trained to normal pregnancies, childbirth and the immediate postnatal care and in the identification, management or referral of complications in women and newborns requiring additional expertise care. The SRHP notes that Eritrea faces serious challenges related to death and disability during childbirth.

The World Health Organization (WHO), the United Children’s Fund (UNICEF), the United Nations Population Fund (UNFPA) and the World Bank have made global estimates of maternal mortality in 2005. Sub-Saharan Africa had the highest Maternal Mortality Rates (MMR, at 900), followed by South Asia (490), Oceania (430), South-Eastern Asia (300), Western Asia (160), Latin America and the Caribbean (130), Eastern Asia (50), and in stark contrast to developed regions (9). (p.1).

Table 5: Estimates of MMR and range of uncertainty on MMR estimates

<b>Region</b>	<b>MMR (maternal deaths per 100,000 live births)</b>	<b>Range of uncertainty on MMR estimates</b>	
		<b>Lower estimate</b>	<b>Upper estimate</b>
WORLD TOTAL	400	220	650
Developed regions	9	8	17
Countries of the commonwealth of independent states	51	28	140
Developing regions	450	240	730
Africa	820	410	1400

North Africa	160	85	290
Sub-Saharan Africa	900	450	1500
Asia	330	190	520
Eastern Asia	50	31	80
South Asia	490	290	750
South-Eastern Asia	300	160	550
Western Asia	160	62	340
Latin America and the Caribbean	130	81	230
Oceania	430	120	1200

WHO, (2007).

In the Eritrean Demographic Health Survey of 1995, the MMR was 985 and in this estimate Eritrea stands at 450 which seems an achievement compared with the sub-Saharan African countries (p. 16). Since the fifth MDG aims to improve maternal health and to reduce MMR by 75% between 1990 and 2015, Eritrea seems to be on track. Here also a stark variation exists as births attended by skilled health personnel range from 47% in Africa, 61% in Asia, 80% in Oceania, 88% in Latin America and the Caribbean, and 99% in Europe and North America. (Shah and Say, p.21). Approximately a quarter of all births (27%) are attended by skilled health personnel in Eritrea, while the average for the Sub-Saharan African countries is 47% which puts Eritrean at the lower end.

The low level of appropriate care is an issue of concern which needs further scrutiny and proper strategies that address the problem. Increased access to safe deliveries would also decrease infant mortality. The study note an inverse relationship between levels of antenatal, delivery and post-partum coverage and maternal mortality ratio, some countries have experienced declines in maternal mortality ratio (p.23). Data about Eritrea confirms this situation. Decreases in MMR in Eritrea can be attributed to the comprehensive primary health strategy, such as community based health promotion, the free use of ITNs for pregnant women and free antiretroviral (ARV) drugs.

Use of SBA during child birth is one of the process indicators to assess progress towards the improvement of maternal health. While recognizing the shortage in this area the RHP and the SRH national strategic plan of 2006-2010, did not strategize on capacity development to close the existing chronic shortage of midwives. The recent MNH Road Map of 2009 responds appropriately, yet since this might also take time the integrative approach of capacity building of health professionals to be fit on SBA seems timely.

Every pregnancy in any environment or population faces risks, and that of any population of pregnant women, about 15% will experience obstetric complications requiring expert intervention. Most obstetric complications can neither be predicted nor prevented, but if women receive effective treatment in time, almost all can be saved. On the other hand the strategic plan indicated training of health workers on basic emergency obstetric care (EMOC), and the RH annual report of 2008 indicates that 1,076 have been trained on this area. EMOC functional health facilities have increased from 40% in 2004 to 82.3% in 2008; proportion of first line facilities with two or more EMOC trained staffs has increased from 17 % in 2002 to 100% in 2008, (Eritrean Profile Sep.2008). The overall reduction of maternal mortality can be attributed also to enhancing the capacity of health workers as well as the community involvement in health promotion.

Other determinants of maternal health such as poverty, cultural issues (underage marriage, FGM) abortion needs to be properly addressed in SRHP, and will be discussed further to understand the magnitude. The first of the four factors affecting maternal health is surely poverty. The NHP has indicated that the incidence of people living on annual incomes under the poverty line is above 60%. According to Eritrea's MDG Report the current socio-economic situation in Eritrea, due to the state of no-peace no-war situation and natural calamities, Eritrea's per capita is estimated \$180 in 2002. (p. 3).

The Eritrean Demographic Health Survey (EDHS) of 2002 also indicate that more than 40% of these families are female headed households. The thirty years war for independence, the recent war of 1998-2002 has had a dramatic impact. The war for independence and sovereignty had cost more than 100,000 lives, and the impact of war in disentangling what seemed a normal family life, pushing many to live in exile, creating a de facto separation of families.

The African Development Bank (ADB), Gender Profile reports that there is ample evidence that female headed households (FHH) are poorer than their male counterparts. (p.4). Domestic chores generally fall to women including daily household services such as of fetching water and gathering wood which are physically demanding, made more arduous by lack of basic infrastructure. For example, energy needs of the household involve the collection of biomass (dung, agricultural residue, wood and charcoal) and accounts for 79.7% of total energy consumption by households. This burden of gathering

fuel generally falls to women. More than 50% of women fetch water from river beds or from wells that are far away. More than 60% is earth roads, which do not make public transport easy and has a gendered impact (pp. 24-26), since the domestic burden remains the sole responsibility of women and girls compounded by pre-existing poverty. Women from the harsh terrain of rural areas, being the main care takers are reluctant to leave their children and stay away in a far away health center or hospital during delivery, which have adverse affects on maternal health. The non availability of public or any other means of transportation during delivery is also a major hindrance, which adds up to the cause of limited use of health facility during delivery.

The second of the four factors affecting maternal health is culture. According to Issayas, the low nutritional intake is a cultural practice, which allows the male to be served first, as usually the men eat alone in the rural areas, and the food that remains when he is done is shared between the mother and children which makes them prone to nutritional anemia. This practice strongly impacts pregnant women. Some communities consider labor to be a prolonged process taking two days, which makes it too late for many pregnant women. Many traditional birth attendants do lack knowledge to identify pregnancy related complications which can be life threatening, and when the decision is made to take the pregnant woman to a health centre after two days, due to the difficult geographical terrain and lack of public transport, accessing the health center easily makes it difficult and can be the cause of hemorrhage and loss of life. The traditional practices of FGM which is common in Eritrea, is also another barrier. Some women have to be infibulated after each birth. As the practice is forbidden in the health centers, some women also refuse the services of health centers, in order to find a traditional birth attendant service that provides infibulations. Home delivery is considered as a good omen and highly promoted for the birth of the first baby in rural communities too.

The third of the four factors affecting maternal health is Obstetric Fistula (OF). Underage marriage according to the EDHS 2002 is still high and contributes to maternal mortality and morbidity especially as it relates to fistula. The SRH action plan needs to be revisited to accommodate a detailed action plan to reverse OF. Gebrekidan notes that OF is the breakdown of tissue in the vaginal wall next to the bladder (the bladder viscose)



and/or urethral canal and the rectum (RVF) or both. The major causes of OF are early marriage and childbearing; lack of skilled and, or, timely assistance during pregnancy, labor and delivery; and harmful cultural practices related to marriage (p. 20).

These non-anatomical holes between the urinary tract and the vagina or the vagina and the rectum can result in numerous physical consequences, including urinary incontinence, renal failure, amenorrhea, pelvic inflammatory disease, secondary infertility, and foot drop. The devastating physical consequences of these unnecessary conditions in turn lead to social implications that leave affected women the victims of stigmatization, poverty, abuse, abandonment, and isolation. The NUEW reports that the incidence of fistula in Eritrea is projected to be between 1 to 3 per 1000 deliveries in areas without access to emergency obstetric care (EMOC), estimates of the prevalence of fistula in Eritrea range from 93 new cases a year with a backlog of 930 cases to 277 new cases a year with a backlog of 2770 cases (p. 2). The SRHP rarely discusses this unmet health risk and has not set a policy or strategy to address it. Yet the MOH has a successful project in collaboration with partners, and has established a dedicated OF Center and many women have had the opportunity of medical assistance which has changed their life. The final factor of the four major factors affecting maternal health program areas is abortion.

Efrem reports that in Africa it has been estimated that up to half of all pregnancy related death is the result of abortion complications (2004). The main reason for termination of unwanted pregnancy involves the social stigma and humiliation visited on unmarried girls and women, along with poverty (p. 2). Abortions have continued to feature among the top ten common causes of hospital admissions for all conditions. It was the third most common cause of health care admission in 2007, and is also the cause of 40% of maternal deaths. This can be a reflection of unmet need/demand for family planning services in the entire health system. “Abortion is not legally permitted in the country; however, under given circumstances (where a physician can certify that the woman will suffer grave and permanent damage due to severe physical and mental stress, or when the pregnancy has resulted from rape or incest) it can be undertaken if only authorized by designated personnel.” (HMIS. 2008). While the SRH acknowledges

abortion to be one of the major causes of maternal deaths and one of the components of the SRH program, here again it does not envisage a remediation strategy (p. 5).

The total fertility rate is as high as 4.8% (p.5), taking into consideration the limited negotiating power of women, the availability and affordability of female condom is not widely promoted, and needs to be revisited too. Engendering health does not mean just maternal health, but must include in depth analysis of all health issues that impact women, and many of these are directly related to reproductive and sexual health.

#### *Eradication of Female Genital Mutilation (FGM)*

According to Olenja circumcision was practiced by many cultures in the past including the Phoenicians, Hittites and the ancient Egyptians. Physicians, in England and the USA, used FGM in the 1940's to 'treat' hysteria; lesbianism, masturbation and other so called 'female deviance' (p.9). Currently female genital mutilation is known to be prevalent in 28 of the 46 countries in Africa, to a lesser extent in some Asian countries and immigrant communities the world over (GTZ, 2007). Olenja estimates that in Africa, it is estimated that more than two million girls undergo the practice of FGM every year.

FGM is a cultural practice rather than a religious one, since the practice is found among Muslims, Christians, Animists and Judaism. Yet most of the time religion is taken as a pretext, as it is strongly believed by many adherents of Christianity and Islam as a divine order.

FGM/C, one of the manifested forms of violence against women, is defined as practices that involve partial or total removal of the female external genital parts and/or injury to the female genital organs for cultural or any other non-therapeutic reasons. (ARHD p.57). FGM is a deeply rooted and widely practiced tradition in Eritrea.

Many women and men in Eritrea still believe that FGM can reduce sexual desire in girls and hence promotes their virginity and fidelity. Many adherents of Christianity and Islam are also believed to be a religious obligation in spite of the claims made by some of the most prominent religious figures in the country that it is not a religious prescription. According to the Eritrean Demographic Health Survey (EDHS) of 2002, FGM occurs nationally at the rate of 89%. While acknowledging the role of community involvement the SRH and NGOs did not identify the role of the different players and

especially did not distinguish the transformation women's movement, and the NUEW as its main partner in the fight against FGM.

### *The Role of the NUEW in the Struggle to Stop FGM*

The NUEW was established in 1979 as a non-governmental organization, with the mandate to mobilize women to fight for Eritrea's Independence and Women's Equality. It continued its commitment after independence for the latter objective. From the outset NUEW has been mobilizing women in Eritrea, especially those who live in rural areas, and empowering them in the fields directly related to women's issues. The NUEW recognizes that successfully countering FGM requires a multi-disciplinary approach. This is so because FGM is a socially constructed attitude and practice that contravenes basic human rights principles by perpetuating acts of violence against girls, such as the cruel and inhumane cutting and infibulating part of the external genitalia, It is also a gender inequality issue that hampers the bodily integrity of a girl child and many women also have to endure the practice throughout their lifetime. This practice has severe reproductive health consequences such as hemorrhage as complication after the operation, cutting-related difficulties in delivery and sexual relations and it contributes to the incidence of obstetric fistula and associated psychological trauma that lingers till across the lifespan.

Based on these considerations the NUEW strategy to eradicate FGM aligns with critical theory in deconstructing the dominant ideology, including its historical roots and deeply-rooted cultural norms and value systems.

It does so by challenging the portrayal of the practice as a dignified ritual for protecting and maintaining the chastity and purity of girls for the preservation of virginity and as a transition from childhood to maturity. As such supporters tend to regard FGM as a rite of passage from girlhood to womanhood, without the completion of which girl children are socially handicapped for the rest of their lives. In opposition to this view the NUEW strategy seeks to demystify the cultural presumption that construes women as helpless and vulnerable victims in need of control and direction and works to nurture instead a view of women as a social agents who are committed to determine the course of their own lives. Bringing this counterpoint to light and raising the consciousness and action to overthrow older but outmoded beliefs has been a major challenge for almost thirty years.

The importance of community involvement particularly those who have a great deal of influence on the perceptions and values of the community is an experience that NUEW learned in its process of mobilization. Participation of opinion makers, such as progressive religious leaders and community elders, in social mobilization created a favorable environment in the fight against FGM that brought about positive behavioral change. Moreover, it has been identified also that non-health workers who perform circumcisions play a great role in perpetuating FGM/C since they have a financial interest in practicing it. Furthermore, regular consultation and coordination between different actors were found to be essential in order to strategize the interventions and to generate the social and political environment necessary for the abandonment of FGM/C. Finally, the importance of close and constant supervision had been identified as one of the key elements to maintaining the motivation of the community volunteers who work as change agents.

Drawing on the experience gained, the NUEW strategy encompassed operational research on FGM/C practices, which brought out the specific difference that exists in the FGM practice, and the myth that exists. Izugbara and Undie note that in many African settings individuals and group rights are intertwined, the sexual and reproductive related issues be it FGM, abortion, family planning, sexuality education is tightly tied to socio-cultural, and religious beliefs (169). This has been confirmed in the operational research conducted to understand the causes of FGM.

In certain communities there is a built-in culture that ostracizes those who deviate from the culture, for e.g. an uncircumcised child has to braid her hair in a certain style to differentiate from those who have passed the rite. An uncircumcised woman cannot be buried with the grown up people as she has not cleansed herself or cannot join yearly festivities as she is thought to carry the demon in herself and is a shame to her family. Encouraging a critical approach to these entrenched attitudes involves public education. Although the cultural meaning and ideologies of the body and its ownership vary both between and within cultures, the FGM practice transcends its biological, anatomical and physiological aspects, according to Izugbara and Undie (2008). That is why the international sexual rights declaration which is accepted as universal has been

constructed upon the assumption that the body is a physical entity belonging to the individual and has to be addressed with caution. The NUEW have come to understand the reality and is painstakingly struggling to eradicate the practice of FGM using a sequence of activities including public education, advocacy work, and community-based in public meetings leading up to public declarations against FGM to be used by a number of villages that will serve as role models. Building support into coherent network of different stakeholders including representative of Local Administration, the MOH at zoba/regional level and women activists from the concerned zoba each has played a role in effecting social change. To enhance the capacity of the network a series of training activities had been conducted, approaching it from human rights and gender equality perspective.

Gender discrimination recurs through stereotyping, bias in curricula materials and school practices, and also via traditional means of storytelling and proverbs, according to Barakett and Cleghorn (2000) Relevant tools for use in the effort to see gender discrimination discontinued, and in particular the FGM practice in Eritrea, has involved a concerted anti-FGM/C Information, Education and Communications (IEC) strategy along with a mass media public education campaign has been complemented by all stakeholders. (p .46). NUEW consistently uses also popular education and different other tools of social education, such as community dialogue, leadership consultation, drama, to develop critical awareness and social action to bring about changes in the communities and nationwide (Selman & et al. p. 414).

One of the major successes of this social mobilization strategy, using popular educational tool, led to the awareness of the harmful practice amongst the large population and created role model communities into different zobas/regions, who were able to publically declare their “Zero Tolerance” for FGM. After almost 30 years of campaigning to change the attitude a consensus had been reached and the Government of the state of Eritrea in 2007 enacted a national legislation that bans FGM. (FGM Proclamation, 2007).

The NUEW while hailing the legislation is fully aware that enforcing it will need continuous advocacy work and attitudinal change that ensures the empowerment of women. Accordingly NUEW in partnership with MOH aims to see enforcement of the

legislation become a primary wellness initiative that can be used to model and exemplify GBA and gender mainstreaming. An earlier example of Maternal Waiting Homes provides several ideas about what form these best practices might take.

**Maternal Waiting Homes (MWH): Supporting Policy Concretely**

The national struggle for independence, and emergency preparedness for defense, has built a keen understanding of civilian mobilization. The maternity waiting home concept had its roots during the liberation struggle, particularly among the country's nomadic population. Due to the terrain and life style of the nomadic population it was not predictable that pregnant women will be near a health center during delivery. The Eritrean People's Liberation Front (EPLF) Department of Health in the early 1980s had to adapt the traditional Eritrean culture, to take care of pregnant women who were at risk. Nomadic families and especially the pregnant women did not feel safe to leave their home and children for some time till the time of delivery. The innovative approach taken was to give the opportunity for nomadic families with pregnant woman to simply move their own home to the nearest health facility as the delivery time approached. This initiative had proven to be effective since it solved the access problem, transportation when the pregnant women are capable, and also ease the caring role during the crucial period of the pregnant women, as basic food support is given to during that period.

This traditional communal response to the pregnant women's need, the maternal waiting home concept has been evolving to meet changing circumstances.

Seeing the obvious advantages of this arrangement, certain communities had built temporary shelter dedicated to maternity waiting homes or at times the local administration galvanizing the support of the community try to build houses. The MOH and other partners have joined the effort and up to 2007, 19 Maternal Waiting Homes (MWH) have been established (HMIS p.41).

A similar approach is being adopted with support for ending FGM. Community-level decision making is choosing to support the new legislation at the local level. Working with these communities to cultivate successful policy implementation offers a window of opportunity to take concrete steps toward effective implementation. These

innovations grounded in success achieved earlier with MWHs holds out the prospect of operationalizing the anti-FGM legislation in a way that extends and expands GBA and gender mainstreaming at the same time that it draws on past success with a uniquely Eritrean policy solution. This way forward offers the possibility of building on existing fundamental values of social justice and women's equality, building on past recent successes in the case of MWH, bringing the NUEW's GBA expertise to bear on MOH in a limited manner and operationalizing gender mainstreaming effectively where it has not previously existed. While this strategy for moving forward does not suggest any global solution to the lack of fit between national development goals and universal health care provision, it would be a useful step to increasing the fit between policy ideas and implementation.

## CONCLUSION

The socio –economic context of each country determines the status of health of the population including the struggle to alleviate poverty, improve education and reduce harmful cultural practices impact on health.

In the context of Eritrea, the study has brought to weaknesses in linkages between the engendered national constitution, gender policy and action plan. While appreciating the commitment of the MOH on gender equality the gender lens shows it lacks the institutional capacity to assess all policies and programs from a gender perspective. The organizational structure of the MOH is hierarchal and top-heavy with men in its decision-making structures. The organizational culture also lacks flexibility and is resistant to new ideas. This is reflected on the NHP draft since it has not adopted the already developed mainstreaming strategy by the sector.

Although commitment to the goal of social justice and women’s equality is formally promoted how to pursue gender based analysis is also lacking. The non availability of necessary tools, such as gender disaggregated data and other pertinent information hinders informed policies and strategies to be developed from gender perspective. The RHP and strategy is not coherent enough that integrate all aspects of the RH. Besides it lacks integration with other aspects of health that strongly impact women’s health such as HIV/AIDS and Malaria. The RHP falls short also of recognizing, one of its staunch allies in assuring women’s health, the National Union of Eritrean Women (NUEW).

Moser and Moser have shown that experiences in many countries, confirm that gender mainstreaming at all levels is easier said than implemented (p.15). The study reminds the MOH, to make good on its commitment and use at different levels GBA, building capacity consistently of GBA, pursue cultural and attitudinal change, and ensuring the participation of all stakeholders.



## **RECOMMENDATIONS**

Based on the facts and analysis as discussed above, the main recommendations involve a continuous effort to institutionalize and mainstream gender in the health sector in general and the reproductive health sector specifically in Eritrea. As a result the following points are recommended.

- Revisit the health sector and the RH policy using GBA.
- Engender the institutional and managerial setup of the health sector
- Ensure gender sensitive human resource development policy and set targets for the recruitment and training of women into the health sector
- Build capacity on gender analysis of policy, program implementation as a core skill.
- Promote an integrated approach to deal with the different aspects of RH, as well as the issue of HIV/AIDS and Malaria.
- Develop a mechanism to support the female health personnel to ease the caring role.
- Enhance and strengthen a mechanism of cooperation with the National Union of Eritrean Women and amongst other stakeholders.
- Engender the curricula of the medical and Public Health College.

## Works Cited

- Brakett, J., & Cleghorn (Eds.). (2000). *Sociology of education: An introductory view from Canada* (p. 25-45). Toronto: Pearson Education Canada.
- Haile B. (2000). *The Collusion on Eritrea*, Asmara: Eritrea.
- Cantor, N. (1994). *The Civilization of the Middle Ages*. Harper Perennial Publishers, New York.
- Efrem, S. (2004). *Why Women Abort Their Fetus*. Unpublished
- Gebrekidan, A. (2003). *National Fistula Needs Assessment*. Unpublished.
- Government of the State of Eritrea. (1994). *Macro-Policy*. Asmara: Eritrea.
- (1995). *Eritrea Demographic Health Survey (EDHS)*. National Statistics Office. Adulis Printing Press. Asmara: Eritrea.
- (2002). *Eritrea Demographic Health Survey (EDHS)*. National Statistics Office. Sabur Printing Press. Asmara: Eritrea.
- (1997). *The Eritrean National Constitution: Ratified by the Constituent Assembly*. Adulis Printing Press, Asmara: Eritrea.
- (2003). *Eritrea Country Report on International Conference on Population and Development (ICPD)*, Unpublished.
- (2004). *National Policy on Gender and Action Plan*: Sabur Printing Press. Eritrea. Asmara
- (2004). *Country Report on CEDAW: Combined Initial and Second Periodic Reports of State Parties*, Asmara: Eritrea. Unpublished.
- (2004). *Five Year Plan of Action Eritrea: Role Back Malaria Program Evaluation*. MoH. Asmara: Eritrea. Unpublished.
- (2005), *Millennium Development Report*: MBY Printing Press. Asmara: Eritrea.
- (2006). *Annual Health Services Activity Report of Year 2006*: MoH, Asmara: Eritrea.
- (2006). *Report of the 2005 Round HIV & Syphilis Sentinel Surveillance Survey in ANC Attendee Women: NATCoD*, MoH. Asmara: Eritrea. Unpublished.
- (2006). *Millennium Development Goals Report*. MBY Printing Press. Asmara. Eritrea
- (2008). *Eritrean Health Sector Strategic development Plan (HSSDP: 2008-2012)*. Unpublished.

- Issayas S. (1996). Utilizing Research on Traditional Beliefs and Practices in Development of IEC Strategy for Reproductive Health
- National Union of Eritrean Women (1999). *Eritrean women and their tradition of resistance*: Adulis Printing Press. Asmara: Eritrea .
- (2004). *Implementation of the Beijing Platform for Action and Outcome of the 23<sup>rd</sup> Session of the General Assembly: Eritrea Country Report*, Asmara, Eritrea.
- Selman, G., & Dampier, P. (1998). *The foundations of adult education in Canada* (2nd ed.). Toronto: Thompson.
- Sholkamy, H., (2008). The empowerment of women rights and entitlements in Arab Worlds: In *Gender, Rights and Development. Gender, Society & Development*. Royal Tropical Institute (KIT), Amsterdam: The Netherlands.
- Palys, T. (2003). *Research Decisions: Quantitative and Qualitative Perspectives*. Transcontinental Printing Inc. Canada.
- Sen, A. (2002). "Why health equity?" *Health Economics* 11: 659-666.
- Wrong, M. (2005). *I didn't do it for you: how the world betrayed a small African nation*. Harper Collins Publishers. New York, NY. USA.

### **Journal Articles**

- Barakett, J. & Cleghorn, A. (2000). *Theories of Schooling and Society* (Eds.), From the Readings of MDDE 611: Foundations of Adult Education.
- Dawson E. (2005). *Strategic Gender Mainstreaming in Oxfam GB*. (GAD, MCR). In *Gender and Development: Mainstreaming A Critical Review*. An Oxfam Journal, 13(2): 80-89
- GTZ. (2007). *Good Governance and Female Genital Mutilation: A Political Framework for Social Change*. Eschborn: Germany.
- Moser C. & Moser A. (2005), *Gender mainstreaming since Beijing: a review of success and limitations in International institutions*. In GAD, MCR Oxfam Journal 13(No2):11-20
- Porter F. & Sweetman C. (2005). *Gender mainstreaming since Beijing: a review of success and limitations in International institutions*. GAD, MCR. Oxfam Journal 13(2):2-10.

- Shah IH. & Say L. (2007). *Maternal Mortality and Maternity Care from 1990 -2005: Uneven but important Gains*. In *Reproductive Health Matters*. 15 (30): 17-21.
- Izugbara CO. & Undie CC. (2008). *Who owns the Body? Indigenous African Discourses of the Body and Contemporary Sexual Rights Rhetoric*. From *Reproductive Health Matters* 16 (31):159-167)
- Sibanda A. (2007). *Gender Mainstreaming Training Module*. Harare: Zimbabwe. Unpublished.
- (2007). *Gender Organizational Tool*. Harare: Zimbabwe. Unpublished.
- Unger J-P., et al. (2009). *International Health Policy and stagnating maternal mortality: is there a causal link ?* In *Reproductive Health Matters*. 17 (33):91-104.
- United Nations. (2001). *Beijing Declaration and Platform for Action with the Beijing + 5 Political Declaration and Outcome Document*. United Nations Department of Public Information, New York.
- (2002). *Gender Mainstreaming: An Overview Office of the Special Adviser on Gender Issues and Advancement of Women*. Litho in United Nations, New York.
- UNFPA. (2003). *Understanding Gender Concepts*. Gender Mainstreaming: Taking Action, Getting Results.
- (2005). UNFPA, (2005). *Eritrea: Situation Analysis on Population, Reproductive Health and Gender*: Asmara, Eritrea. Unpublished
- UNDAF. (2007-2011). *Joint Program on Gender Equity in Eritrea*: Asmara: Eritrea. Unpublished
- WHO. (2006). *The Health of the People: The African Regional Health Report*.
- (2007). *Maternal Mortality in 2005*. Estimates developed by WHO, UNICEF, UNFPA, and the World Bank.
- (2007). *Women's health and human rights: Monitoring the implementation of CEDAW*. Department of Reproductive Health & Research, Geneva, Switzerland.

## **Internet**

Brayton, J. (1997). *The Structure of Feminist Research within the Social Sciences*. Web site: [www.unb.ca/PAR-L/win/feminmethod.htm](http://www.unb.ca/PAR-L/win/feminmethod.htm)

Declaration of Alma-Ata. (1978). *International Conference on Primary Health Care*, Alma-Ata: USSR. Web site:  
( [www.searo.who.int/.../Health\\_Systems\\_declaration\\_almaata.pdf](http://www.searo.who.int/.../Health_Systems_declaration_almaata.pdf) )

Medical Women's International Association. (2002). *Training Manual for Gender Mainstreaming in Health*. Web site:  
( [www.mwia.net/gmanual.pdf](http://www.mwia.net/gmanual.pdf) )

Sen, A. (2002). "Why health equity? " *Health Economics* 11: 659-666. From *Global Inequalities in Health*. Web site: <http://ucatlans.ucsc.edu/connect.php>

UNFPA. (2009), *Guidelines on Reproductive Health*. Web site:  
(<http://www.undp.org/popin>)

## Appendix I

### Eritrean Health Profile

	1995	2002	2006
Population		3.5 million	N/A
Female Headed Households (FHH)	38%	52%	N/A
Total Fertility Rate (TFR)	6.1	4.8	N/A
Contraceptive prevalence	8%	8%	N/A
Infant Mortality Rate	72/1000	48/1000	N/A
U 5 Mortality Rate (U5MR)	136/1000	93/1000	N/A
Maternal Mortality Rate(MMR)	998/100,000	750/100,000	N/A
HIV/AIDS prevalence	N/A	2.38%	1.33%
Malaria related mortality	N/A	N/A	74/100,000
Tuberculosis related mortality	N/A	N/A	46/100,000
Antenatal Care	N/A	65.7%	65.7%
Skilled personnel Delivery/attendants	N/A	17%	27.1%
Immunization coverage	N/A	50%	80.7%

(EDHS, WHO, UNICEF, UNIFPA, and WB estimates).

Note: N/A means Not Available

## Appendix II

### Human Resource in the MOH

	1995	2002	2006
M.D.General Practitioner	N/A	105	217
Nurse	N/A	631	1012
Specialized Nurse	59	135	175
Health Technician	195	296	353
Associated Nurse	548	916	1691
Pharmacists	N/A	N/A	17
Others	83	41	N/A
”	67	12	N/A
Admin	362	321	N/A

MOH. Health Bulletin (2006).

Note: N/A means Not Available

### Appendix III

#### *MDG Progress and Prospects at a glance*

Goals and Targets	Starting value(1993-95)	Ending Value(2001-03)	Linearly projected value(2015)	MDG target value(2015)	Status
Proportion below poverty line	53	66	48	33	Off track
Prevalence of underweight children	44	40	24	24	On track
Net primary school enrollment	30	44	82	100	Off track
Ratio of girls to boys in primary school	80	81	100	100	On track
Under-five mortality	136	93	30	45	On track
Maternal mortality ratio	985	581	246	246	On track
Prevalence of HIV/AIDS	N/A	2.4	<2	<2	On track
Malaria cases per 1,000	N/A	36	<36	<36	On track
Environmental resource forest cover, of land area	13.9	32	>32	>32	On track
Proportion without access to safe drinking water	84	33	25	20	On track

MDG Report, Eritrea (2002).



*Appendix IV.*

**Gender Organizational Analysis Tool**

1. Policy on Gender: Explain if the MOH policies are engendered. Does the ministry use gender based analysis tools? Has the ministry made use of the strategies and action plans outlined in the national gender policy?
2. Structure of the Ministry: Explain the structure of the MOH, Does duties and responsibilities emanate from the perspective of equal opportunities? Are women well represented at top levels of Are women well represented at top levels of the ministry?
3. Governance: Is the policy making body gender sensitive, if yes, discuss the characteristics that express it
4. Discuss the culture of the MOH, What is the attitude of staff towards gender equality at various levels of the organization?
5. Data collection: Is the data sex disaggregated?

## **Glossary**

**Empowerment** - Process through which women and men are equally empowered to gain control over their lives and the choices they are enabled to make irrespective of socio-economic status, class, ethnicity, race or religious affiliation.(UNFPA, p.5.2005)

**Gender** - The attributes and opportunities associated with being male or female and the social defined roles and responsibilities assigned to women and men in a given culture, location, society and time (UNFPA, 2003 p.9).

**Gender analysis** – It is the process of systematically identifying gender-based inequalities in women’s and men’s roles, needs, priorities, access to and control over resources within a specific context at a particular point in time. Gender analysis aims at contribute to the understanding of implications of planned interventions and their potential outcomes, interventions are to be implemented, as well as available resources that are conducive to implementation. (ibid p.5)

**Gender Blind** – Overlooking gender –based differences in women’s and men’s needs, priorities, as well as access to and control over resources which may reinforce gender bias and gender inequality. (ibid p.5)

**Gender equality** - The recognition that women and men have different needs and priorities, and that women and men should ‘experience equal conditions for realizing their full human rights, and have the opportunity to human rights, and have the opportunity to contribute to and benefit from national, political, economic, social and cultural development’ (CIDA 1999 p.12.In:GAD. Vol.13)

**Gender equity** - Gender equity is the quality of being fair, just and right to men and women. It includes fairness and justice in the distribution between women and men of responsibilities, access to resources, control over resources and access to benefits.(Ibid p.5).

**Gender mainstreaming** - Most countries use this approach as set out by the UN Economic and Social Council 1997/2(UN, 2002, p.1). Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality. (ibid p.5)

**Gender Sensitive** – Recognition of gender issues and concerns arising from asymmetrical gender relations and gender-based differences in needs and priorities of women and men.(ibid p.6)

**Health:** the dynamic state of complete physical, mental, spiritual, and social well-being and not merely the absence of disease or infirmity.(WHO, 1998).

**Patriarchy** - as defined by Barakett, groups of individuals or groups of organizations where males hold dominant power over females in terms of access to high status positions or privileged authority.(37)

**Popular education** - involves a high degree of participation, recognizes mutual learning stresses the creation of new knowledge and is directed towards social, economic or other forms of justice and democracy. It is political in its intent and has its goal structural change. (Selman & et al. p. 414)

**Primary Health Care** - is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost

that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination.(Alma-Ata Declaration,1978.)

**Reproductive health** - a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life. (UNFPA)

**Maternal death** - is defined by WHO as “ the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes”. (Shah IH. & Say RHM: 15(30) p.17)