NATIONAL GENDER MAINSTREAMING MANUAL FOR HEALTH

MINISTRY OF HEALTH OF ETHIOPIA

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FOREWORD

Ethiopia endorsing the agenda 2030 of the global sustainable developmental goals since 2015 has make progress in mainstreaming gender in the health sector programs and institution. The Ministry of health take note that achieving gender equality and empowering all women and girls is integral to realizing all 17 Sustainable Development Goals (SDGs). To achieve the SDGs and the promise to "leave no one behind", it is imperative first to tackle the gender inequalities and discrimination that women and girls continue to face around the country.

To ensure this focus is brought into all the Health Sector Transformation Plan II (HSTP II) to promote the principles of equality and non-discrimination, putting gender equality at the heart of the national strategic programming, driving the active and meaningful participation of both women and men, and the empowerment of all women and girls.

The second verse of the national gender mainstreaming manual launched in 2014 had served to make notable first step difference in the conventional method of programming and the organizational culture to move towards gender transformation actions. HSTP II cognizant of gender mainstreaming approach, has equity in its principle that includes gender in its analysis of determinant of health as well as follows the human right-based approaches of inclusiveness both at provider and service utilizers' levels. "People centered approach" and "health in all policies" are principal approaches both at the health sector and multi-sectoral level of outcomes respectively. With development and changes in health services and delivery strategies, gender mainstreaming becomes more and more important for better health outcome and resource management. Thus, the ministry is obliged to revise and update the national gender mainstreaming manual to match the ongoing global and national changes in provision of public health products and services.

The ministry would like to thank the Women, Child and Youth Directorate and the technical working group for their inputs in making the revision friendly and simple for application.

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State Minister of Health

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The ministry would like to pay special thanks to EngenderHealth-Ethiopia for the initial revision of gender mainstreaming manual. The manual has been re-visited in line with the HSTP II with the gender technical working group and the ministry recognize the unprecedented commitment and technical inputs to the manual.

Most of all the ministry would like to pay special recognition to World Health Organization for the second phase review to harmonize the document with the newer updates, editorial process taking this document at higher level.

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ACRONYMS

FGM	Female Genital Mutilation
GAM	Gender Assessment Matrix
GAT	Gender Assessment Tool
GRAS	Gender Responsive Assessment
HSTP	Health Sector Transformation Plan
HIV	Human Immuno-Deficiency Virus
MOH	Ministry of Health
R&I	Research and Innovation
STI	Sexually Transmitted Infection
SDG	Sustainable Developmental Goals
UHC	Universal Health Coverage
WHO	World Health Organization

SECTION ONE: GENERAL OVERVIEW

1.1 BACKGROUND

Cognizant with the fact that development of any country in all its spheres could not be achieved without the equal participation and empowerment of women that constitute half of the world demographic dividend, the United Nations, in its 15th Session of the General Assembly, 1997 passed the resolution to mainstream gender into all policies and programs based on the 4th World conference on Women health in Beijing in 1995 - " Beijing declaration and platform for action" that in turn based its decision on the 1985 World conference on equality, development and peace held in Nairobi.

The Ethiopian government, in line with its national goals and objectives aligned to the global commitment, has established a firm commitment to mainstream gender across all line ministries, agencies and private institutions and communities.

Sustainable Developmental Goals (SDGs)recognize that gender equality is both a goal in itself (SDG-5), and a condition for the achievement of all other goals. Achieving the SDGs will strengthen the capacities of the health sector for peace and prosperity that women should take part in its accomplishment.

The ministry of health has acted on its responsibilities for mainstreaming gender in the health sector through structure that formulate Women, Children and Youth Directorate.

Gender relevance is marked in the vision statement of MOH as "to see a **healthy**, **productive** and **prosperoussociety**"which means inclusiveness and serving the vulnerablefor health and well-being of the people living in Ethiopia so that its citizens become productive tomove towards prosperity. This vision could only be realized only if women, taking the 50% of stock of demographic dividends, are engaged in and benefit from health strategic interventions. Furthermore, the mission statement that states *"promote the health and wellbeing of the society through providing and regulating a **comprehensive** package of health services of the highest possible quality in an **equitable** manner*"reflect and mandate that the health services is entangled by equity analysis of all programs and operations to act based on needs. The specific needs for women and men are included in the comprehensive package of the health services.

Therefore, Women, Children and Youth directorate is tasked to mainstream gender perspective in policies, programs and operations across the four pillars of the HSTP II (2020-2025) namely, accelerated progress towards Universal Health Coverage;Protect people from health emergencies; Woreda transformation and Improve health system responsiveness.

The second version of the National Gender Mainstreaming Manual has been in effect since its launch in 2014, which the concept has been introduced and scaled up across the health sector; however with limitation in building institution-wide capacity for gender analysisinprogram and planning cycle (i.e. no baseline analysis has been produced so far); bringing gender into the

mainstreaming in MOH management that denoted actionable commitments of leadership; promoting use of sex disaggregated data and gender analysis; and establishing accountability which minimum standards for gender mainstreaming in all key functions are lacking.

1.1.1. Rationale for update the 2013 Health Sector Gender Mainstreaming Manual

Since 2013, there are major changes ongoing in the country that influence the health sector operation and the need for reviewing the gender mainstreaming manual for health. However, the following three critical shifts were the basis for review:

- The strategic shift from Health Sector DevelopmentalPlanning to Health Sector Transformational Plan with a central focus on equitable service deliveryand access to health servicesbased on needs that streamlined the vulnerable society including women, children, youth and persons with disability.

- The introduction of the Sustainable Development goals, as well as new national legislations like The Financial Administration Proclamation No. 970_2016 ,The Federal Civil Servants Proclamation 1064-2017 and The Labor Proclamation No. 1156-2019 demanding the mainstreaming of gender to be more aligned and focused.

- The introduction ofgender equality score card and gender responsive assessment scale that are criterial for assessing programs/operations and policies

1.1.2.Purpose of the manual

The purpose of this manualis to assist Ministry of Health (MOH) staff to effectively integrate a gender perspective into all aspects of work, from strategic planning, developing normative standards, designing and delivering thematic and regional programmes and working through the project cycle. Working towardsachieving gender equality is a collective, organizational and programmatic effort that is a task that all staff, across all levels, need to ensure is being done. Many programmes, projects and activities still weakly address gender concerns or are even completely gender blind. Applying a gender perspective to MOH's work involves being aware of the gendered dimensions of any activity, which requires analysis, information and consultations with both women and men. Ultimately integrating a gender perspective will result in a more balanced and representative approach, thus a more effective response in all ofMOH's thematic areas of work.

1.1.2. User of Gender Mainstreaming Manual

This third revised manual is to be used by different actors in the health sector ranging from decision makers, health planners to program managers and health service providers inclusive of monitoring and evaluations as well as operation staff to strengthen the gender dimension in the day-to-day actions. In addition, it helps set a common framework for mainstreaming

actions in the institutional functions at all levels of the health sector to contribute to the organizational culture. In addition, it will help gender experts to implement, coordinate and monitor the gender mainstreaming activities in systematic and scientific pattern including health partner's collaboration activities.

1.2 INTRODUCTION TO GENDER MAINSTREAMING

1.2.1 Basic Concept of Gender

There is widespread confusion about what is meant by the term 'gender' and how it differsfrom the term 'sex', partly because they are closely related. However, sex and genderare not the same. Categories related to sex include 'male' and 'female' and are used todescribe differences in the biology and physiology of men and women. While categoriesrelated to gender include'masculine' and 'feminine' and are used to describe roles,behaviors, activities, and attributes that are socially constructed and that have been traditionally associated with men and women in a given society.

Beliefs about women and men, boys and girls are passed down through generationsthrough the socialization process. These beliefs, or 'gender norms', determine whatis considered appropriate behavior for men and women in a given society.

Gender norms also determine what activities, tasks, and responsibilities are defined asmale and female. In turn, 'gender roles' assigned to boys and girls, and men and womeninfluence the gender-based division of labor within the household, community andworkplace. These include employment in the formal sector as well as household tasksand caretaking responsibilities. Generally, these roles can be divided into productive, reproductive and community work:

Productive work refers to production of goods and/or services for either consumptionor trade. Examples include farming, fishing, working in a factory or working in aconstruction site, and can be in the form of employment or self-employment. Whenasked what they do, people respond in terms of productive work, especially work thatis compensated.

Reproductive work refers to family caregiving and household maintenance andincludes bearing and caring for children and taking responsibility for the health careof the family. It also includes providing nutrition to family members by preparingfood, collecting water and fuel, subsistence agriculture, and other housekeeping work.

Community work refers to the collective organization of social events, services andactivities that aim at improving the community, as well as celebrations, ceremonies and participation inpolitical activities and other community organizations. These activities are critical for the survival and well-being of the household and are generallytime-consuming and labor-intensive. Yet, this work does not generally receivefinancial compensation and is traditionally undervalued, resulting in high opportunitycosts, instead it is undertaken as a social role, usually based on family relationships.

On the other hand, community work includes work related to the provision of socialservices, improvement of infrastructure, and other tasks for the collective benefit of thecommunity. It also includes community political work, in both the informal and formalspheres. In many communities, men undertake community political roles – which are usuallycompensated either financially or through an increase in status and power –while women assume community managing roles as an extension to their reproductivework during their 'extra' or 'free' time. This work is typically voluntary. These rolesinclude running and maintaining community resources, and the provision of socialsupport through volunteerism, participation in community councils, and social andreligious networks.

It is important also to note that the dynamics of gender changes from one society to another,even among neighboring communities. However, on the whole, women are more likelyto be disadvantaged, have less access to resources and face tougher workloads than men.

Gender norms and roles also influence the type of work men and women perform withinpaid labor markets. In many countries, women tend to be concentrated in occupationsand sectors that mirror the type of activities that have traditionally been considered thedomain of women within the household, such as the provision of care, housekeepingand clothing industries. Since these activities have not typically been paid when performedby women within their ownhouseholds, society tends to undervalue these tasks.

Additionally, since men are often considered to be the primary wage earners for thehousehold in many societiesincluding in Ethiopia, women's earnings may be seen as supplemental to men'swages. These beliefs about roles of women and men within the household, communityand workplace, and the valueof these roles, has resulted in women being concentrated

The term 'unpaid care work' is defined based upon three essential attributes:

- 'Unpaid' highlights the fact that the work has no financial compensation.
- 'Care' indicates that the work focuses on service provision to promote the wellbeingof others.
- 'Work' signifies that the activity costs time and energy and shows it is anobligation arising outof societal or familial relationships and is accepted as such.

Together, gender norms and roles influence 'gender relations', the social relationsbetween and among women and men. This refers to interactions at the personallevel between individual women and men, as well as to relations between and amonggroups of women and men at the societal level. These relations may be supported bycustomary practices, religious beliefs and value systems; they may also be upheld formallythrough institutions and legislation.

Therefore, the second Health Sector Transformation Plan (HSTP II) with four pillars namely Accelerate progress towards Universal Health Coverage; Protect people from health emergencies; Woreda transformation, and Improve health system responsiveness, aimed at mainstreaming gender in all its activities and narrowing the gender inequities while improving the quality of the health services.

1.2.3 Gender Mainstreaming in health Policies and legislatives

The Government of Ethiopia is a signatory to the multiple international and continental conventions and declarations that support women empowerment and gender equality. Of these the 1979 Convention on the Elimination of All Forms Of Discrimination Against Women (CEDAW), The 1993 Vienna Declaration and Programme of action, the 1994 International conference on population and development (ICPD), the 1995 Beijing declaration and call to action, The Millennium Development Goals, In 2013, the Commission on the Status of Women (CSW) adopted, by consensus, The Sustainable Development goals, the 2010 formation of UN WOMEN, new UN Entity for Gender Equality and the Empowerment of Women.

Regarding declarations and agreements of the African Continent to which Ethiopia is a signatory, the 2003 Abuja agreement, the 2006 Maputo declaration as well as African SDGAgenda 2063 are few to mention.

While among the local laws, the Ethiopian constitution unequivocally declares the rights of women as **equal citizen of the country** in chapter 35, other policies also support these assumptions including but not limited to the National Population Policy, the Ethiopian Women Policy and Health Policy created in 1993, which is currently under revision with one of the emphasis of equitable access to marginalized communities including young girls and rural populations.

In addition various laws introduced recently in Ethiopia like The Financial Administration Proclamation No. 970_2016 ,The Federal Civil Servants Proclamation 1064-2017,Proclamation No 1097/2018 establishing the Ministry of Women , Children and Youth and The Labor Proclamation No. 1156-2019 give more rights and protection to women.

1.3 OBJECTIVE

To enhance and ensure effective gender mainstreaming at all levels of the health sector and in policies, programs and operations for quality and equitable health service access and provision.

Gender mainstreaming will focus on these specific objectives

- Build MOH's capacity for gender analysis in all the Health Sector Transformation Plan II (HSTP II) programmatic interventions, operations,leadership including policies;
- Bring gender into the mainstream of planning cycle of health actions and reporting;
- Promote the use of sex-disaggregated data and gender analysis; and
- Establish accountability at all levels

1.4CORE PRINCIPLES

The following basic principles are expected to be adhered by health care professionals while implementing the manual.

- **Equity and quality**- Health service delivery must meet the quality standard to serve both men and women in an equitable manner with quality and safety.
- **Inclusiveness**- All health programmes and operations are to be gender inclusive and guarantee equitable service for advancement of health and well-being.
- **Engagement**- The contribution of women in leadership, decision making, mentorship, service delivery, monitoring and evaluation has to be guaranteed
- **Human rights**- Health service must be re-oriented in a human-right-based approach that respect the rights of women, young girls and boys and persons with disabilities to obtain quality health services
- **Accountability**- There needs to be appropriate system in place to implement monitor and evaluate gender-mainstreaming activities.
- **Maintaining Standard**- Strengthening and sustaining the standards described in the strategy of gender mainstreaming needs to be adhered
- **Sustainability-** While following the vision of the Ministry of Health, integrating gender issues in the promotion, curative, preventive and rehabilitative aspects of the health care as well as in the institutional operation has to be done in sustainable ways

1.5 CORRECT USE OF TERMS[1]

Sex is not gender!

Sex refers to the biological and physiological characteristics that define a person asmale or female, such as both internal and external reproductive organs as well ashormones and chromosomes, among others.

[1]Gender mainstreaming manual for health managers: A practical approach. Geneva, World Health Organization, 2011. (http://www.who.int/gender/mainstreaming/tools/en/index1.html, accessed January 1, 2012)

Gender refers to characteristics that are socially constructed for women and men.Norms, roles and relationships of and between groups of women and men areall examples of these characteristics. Most people are born with a defined sex,but they learn respective appropriate norms and behaviors from their societies, including proper interactions with individuals of the same or opposite sex, withinhouseholds, workplaces and their communities. Gender tends to vary acrosssocieties and can change over time.

Gender equality refers to equal chances or opportunities for groups of women andmen to access and control social, economic and political resources, includingprotection under the law (such as health services, education and voting rights). It isalso known as formal equality.

Gender equity refers to the different needs, preferences and interests of womenand men. This may mean that different treatment is needed to ensure equalityof opportunity. This is often referred to as substantive equality and requiresconsidering the realities of women's and men's lives.

Health equity refers to the absence of unfair, avoidable or preventable differencesin health among populations or groups defined socially, economically, demographically or geographically.

SECTION TWO: GENDER MAINSTREAMING AND STRATEGIC ALIGNMENT IN THE HEALTH SECTOR

2.1. BASICS OF GENDER MAINSTREAMING

The concept and benefits of gender mainstreaming have not always been sufficiently understood.The gender perspective looks at the impact of gender on people's opportunities, social roles and interactions. Successful implementation of the policy, programme and project goals of national and regional healthorganizations is directly affected by the impact of gender and, in turn, influences the process of social development. Gender is an integral component of every aspect of the economic, social, daily and private lives of individuals and societies, and of the different roles and responsibilities ascribed by society to men and women.

Sex refers to the permanent and immutable biological characteristics common to individuals in all societies and cultures, while gender defines traits forged throughout the history of social relations reinforced through social institutions. Gender, although it originates in objective biological divergencies, goes far beyond the physiological and biological specifics of the two sexes in terms of the roles each is expected to play. Gender differences are social constructs, inculcated on the basis of a specific society's particular perceptions of the physical differences and the assumed tastes, tendencies and capabilities of men and women. Gender differences, unlike the immutable characteristics of sex, are universally conceded in historical and comparative social analyses to be variants that are transformed over time and from one culture to the next, as societies change and evolve. These differences are armored through values and norms held among the society and reinforced through social institutions such as religion, education, family, politics and economy.

Common misunderstandings include the confusion between gender mainstreaming and achieving gender balance; concerns that it is trying to make women and men the same; that women will be privileged over men; or that it is interfering with local culturesand structures. These misunderstandings have meant that there continues to be a lack of comprehensive application of gender mainstreaming.

What is gender mainstreaming?

Gender mainstreaming is simply looking at the human implications of any activity, highlighting the differences between women and men and thus the potential differential impacts and designing the activity to ensure that both men and women will benefit equally. It is a strategy to

Gender mainstreaming refers to:
"…the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, 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 programmes 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."

Adopted from WHO gender mainstreaming for health manager, 2011

achieve gender equality. It does not view gender as a "separate question", but explicitly integrates a gender dimension into all activities.

Gender mainstreaming implies that the impact of all policies and programmes on women and men should be considered at every stage of the programming cycle—from planning to implementation and evaluation.

2.2. COMPONENTS OF GENDER MAINSTREAMING

1. **Gender Analysis**:Gender analysis is a *core* gender mainstreaming skill that generatesprocesses and information needed for health planning and programming. It includes critical questions that dig for information where it is often not easily found (see also Annex 1).

   Gender analysis identifies, assesses and informs actions to address inequality that stems from ***gender norms, roles and relations***; unequal power relations between and among men and women; and the interaction of contextual factors with gender, such as ethnicity, education or employment status etc.
   Health effect of gender norms: Low social status of women for example, can contribute to higher rates of blindness. Available studies consistently indicate that, in every region of the world and at all ages, females have a significantly higher risk of being visually impaired than males. Nevertheless, many women do not have equal access to surgery for eye diseases due to inability to travel to a surgical facility unaccompanied, differences in the perceived value of surgery for women and/or lack of access to health information.

   Teaching boys to be men according to harmful norms and rites of passage encourages them to put their lives and those ofothers at risk. Through processes of socialization, many boys are taught they should not cry (to avoid being "girlish") and that violence is an accepted problem-solving technique (for example). Specific rites of passage into adulthood can involve tobacco, alcohol or drug consumption or unsafe sex with multiple partners. The health repercussions of such socialization include delays in seeking health care, substance, alcohol and tobacco use, which can lead to chronic health problems and even death. Other consequences include increased exposure to STI, including HIV.
   Health effect of Gender roles: Domestic chores are considered women's tasks and can jeopardize their health. Elevated risk of exposure to unsafe fumes in low- and medium-income countries during food preparation, is associated with elevated risk of chronic obstructive pulmonary disease, is another example of how gender roles can increase women and girls' risk and vulnerability to illness and poor health.

   Men's jobs contribute to higher reports of injury among men of working age. The gender-based division of labor tends to define male occupations (or male gender roles in the work place) as truck drivers (with an increased risk of road traffic injuries) and in the

construction industry (with an increased risk of occupational injuries due to operating heavy machinery, accidents and falls from heights).These roles contribute to the fact that men are overrepresented in nearly all forms of traumatic injury.

Health effect of gender relations: Unequal power relations between women and men contribute to gender-based violence. Women experience physical, sexual and mental violence in their homes, often from intimate partners, in conflict settings and in communities. Sometimes they die from this violence, and at other times, they remain in unsafe settings

Early and/or forced marriage places young girls at risk for early pregnancy and unsafe, coerced sex. Early or forced marriage increases risk for early pregnancy and unsafe and/or coerced sex, which can lead to the transmission of HIV or other STI. Early marriage also removes girls from schools (thereby increasing the range of health effects due to lack of education), reduces their decision-making power within households and may even limit their social support networks, which are often crucial to ensuring informed and timely health-seeking behavior.

These are just examples to show how health of men/boys and women/girls could be compromised due to gender.

Gender-based discrimination refers to any distinction, exclusion or restriction (such as unfair or unequal treatment)based on gender norms, roles and relations that prevents women or men of different groups and ages from enjoying theirhuman rights. It perpetuates gender inequality by legitimizing stereotypes about men and women across ages andgroups distinguished by religion, class, socioeconomic status, ethnicity, sexuality, language, etc.

The following are important points to remember:

- Gender-based discrimination is often based on traditional beliefs about women and men.
- Gender-based discrimination can be direct or indirect; in other words, either through overt prejudicial treatment (direct discrimination) or through “neutral” laws and policies that may result in unequal treatment between groups (indirect discrimination).
- Gender-based discrimination may not always be intentional – it results from normalized beliefs and practices in many instances. This does not, however, make it excusable!
- Normalized beliefs and traditions may be passed from generation to generation without any question as to their validity or fairness.
- The limited access to and control over resources many women face is often the result of gender-based discrimination.
- Health programmes and policies must respond to instances of gender-based discrimination when they pose potential or real harm to the health of males or females at any age.

- Public health workers must understand how gender-based discrimination may influence health to be able to develop sound responses. They also need to know some of the strategies to counteract discrimination that might be incorporatedin their programmes.

Female genital mutilation(FGM) is an example of gender-based discrimination. Female genital mutilation, the partial or complete removal of female genitalia for nonmedical reasons, can be considered a way to control women's sexuality based on cultural expectations around virginity and marital fidelity. In some contexts, it is considered part of preparing a girl for adulthood and marriage. In so doing, it reinforces norms and beliefs around female sexuality and the lower social status of women. Who is disadvantage? These are young women and girls in certain sub-national states in Ethiopia. What health effect does this gender-based discrimination have? Immediate physical complications include severe pain and bleeding, difficulties urinating – even urinary tract infections. Long-term physical consequences: cysts, abscesses, scar formation, damage to the urethra resulting in urinary incontinence, pain during sexual intercourse, infertility and difficulties with childbirth (including newborn deaths).

Gender analysis in health looks at the consequences of gender inequality with respect to health and well-being and contributes to understanding health differences and disparities among and between groups of women and men in the following areas

- ***risk factors and vulnerability***:
- ***patterns of disease, illness and mortality***; and
- ***the health effects of policies, legislation or programmes***.

Though gender analysis is the mainstem to manage gender inequalities, however, understanding the health risk factors and vulnerability and how to analyze is important for evidence based sound health decision making.*Risk factors* are elements associated with the development of disease or illness, or the underlying causes of disease and illness. Some risk factors, such as tobacco consumption, are related to several diseases, whereas some diseases, such as cardiovascular disease, are related to several risk factors. Understanding them can lead to interventions that diminish the harmful effects of exposure or eliminate exposure altogether. Therefore, exposure to such risk factors is often linked to gender norms, roles, and relations and therefore differs among and between populations of women and men.

Example of risk factors

Socioeconomic status or factorsof social position,including poverty, age, ethnic affiliation and gender inequality

Geographical location or factorsof location(such as ruralor urban), including housing and/or working conditions andphysical access to services

Psychosocial factors or lifestyleor individual factorssuch astobacco or alcohol consumption, nutrition and physical activity

Physiological factors such as sex, body type, genetics,blood pressure and serum cholesterol

Vulnerability refers to the degree to which individuals, communities and systems are susceptible, or have diminished capacity, to cope with exposure to risk factors.
Differences in access to and control over resources may increase vulnerability to illness and disease.Having less access to nutritious food, lifestyle risk factor, increases the vulnerability of females to infectious diseases and to complications in childbirth. Gender inequality-driven uneven feeding practices between girls and boys also contribute to increased vulnerability to illnesses such as anemia among girls and women. (see Annex 2 GAM)

Gender analysis in health can highlight **differences in access** to

- health services and other necessary resources for preventing disease and promoting health, such as education, transportation and information; and
- decision-making processes related to health and the organization of health systems.

Components of access

Availability: existence and sufficiency of needed health services

Affordability: patients' ability to pay for services, including free services and other coverage issues

Accessibility: location of population and services, transport and other related costs to access and use health services (such as transport costs)

Accommodation: compliance of health services with the time and communication needs of patients, which contributes to the perceived quality of the services received

Acceptability: fit between services and the community or individual, based on cultural understandings

Access to quality health care and the use of these services are crucial factors in determining positive health outcomes.In examining gender norms, roles and relations – including gender inequality – and how they affect access to and use ofhealth services, it is important toremember that access includes *availability, affordability, accessibility, accommodation* and use of quality health services should address all components.

Health-seeking behavior refers to actions carried out by a person with a perceived need for health services in order to address a given health problem. This includes both allopathic and alternative health services.

The following factors have been shown to influence health-seeking behavior: socioeconomic status, including household poverty and levels of education; proximity to health facilities; type, duration and perceived severity of illness; long waiting times; unsatisfactory or negative staff attitudes and adequate health education in addition to sex and gender.

Treatment optionsDifferent health conditions requirevariable prevention, treatmentand rehabilitation. Options can range from self-care to alternative(such as local healers) to allopathic treatment delivered inhealth facilities, the community or at home.
Healthcare providers shouldaddress both sex and gender in suggesting treatment options soas to fully respond to the health needs and realities of womenand men from differentpopulations.

Previous **experiences in health care settings** positive or negative, influence future health-seeking behavior. Experiencesmay be those of individuals or of others in the household or community. If the head of household, for example, experienced poor quality of services, he or she may be more likely to discourage (even forbid) household members from attending the health facility – especially in the face of user fees. In such a situation, women who have limited decision-making power in the household may never experience poor-quality services themselves but still cite this as a reason for not accessing and using health services.Thus, the context in which care is provided can influence health-seeking behavior, treatment adherence and the overallperceived quality of services. Health care provided in a discriminatory, harmful or ineffective manner may discouragewomen and men from seeking treatment. Furthermore, health care settings that do not address gender norms, rolesand relations in culturally sensitive, appropriate ways may perpetuate inequalities and fail toreachthose in greatest needof health services.

Health and social outcomes and consequences refer to what happens to the person with poor health. She or he may recover, become disabled or die. The consequences of a health problem generally include economic and social changes for both the sick individual and their social network (family or household members, friends and/or broader community members). Health outcomes relate to disease or illness manifestation and associated recovery, disability or death. Genderconsiderations often influence how these outcomes influence a family or individual. Health problems or conditions haveeconomic, social and attitudinal consequences that can reach everyone in the social network – placing increased burdenson some more than others.

Factors that affect health and social outcomes and consequences include:

- monetary costs
- duration and severity of a

Important things about treatment options

- In many settings, prevention programmes are community-based and therefore influenced by sociocultural norms.
- Treatment and rehabilitation options are often institutionalized and therefore depend on the availability of resources.

health problem
- type of care needed, its availability and accessibility
- available social networks
- stigma.

Gender analysis can be applied to

- health policies, legislation, programmes, services and research;
- specific health conditions and problems; and
- human resource planning, budgeting and operational planning.

Gender analysis can increase health sector effectiveness by:

- ensuring the right to health of different groups of men and women;
- identifying practical and strategic gender needs in health;
- recognizing and reducing the constraints women and girls face in protecting and promoting their health;
- considering and addressing how male gender norms, roles and relations may harm the health of men and boys;
- reducing inappropriate, ineffective services, programmes or policies that ignore the realities of women's and men's health needs and life conditions;
- identifying and reducing gender bias in the health system;
- developing and implementing gender-responsive policies, laws and services (primary, secondary and tertiary) and programmes; and
- improving health information, documentation and use.

2. **Gender Audit**:is part of a social program audit that assesses the progress achieved so far and the gaps that need further interventions. Although its applicability depends on various factors such as financial and time, gender audit is a holistic approach to examine organization as it is (how things are done, by whom, who decide, etc.) and how the organization work to actualize its mission i.e. its programs and projects. Therefore, enhance the gender responsiveness of programs and operations. Gender Audit has various tools to obtain an insight of whether the health policies, programs, and operations has institutionalized gender mainstreaming to ensure equity and equality between men and women. The success of health programs is highly dependent on the effective application of different strategies and interventions provided to women and men, girls and boys. Thus, any efforts to ensure gender equality is based on needs to reach out to the end-users will be subject for audit.

3. **Gender budgeting:** "Gender budgeting is an application of gender mainstreaming in the budgetary process. It means a gender-based assessment of budgets, incorporating a gender perspective at all levels of the budgetary process and restructuring revenues and expenditures in order to promote gender equality".An important aspect of the gender

budgeting approach to gender mainstreaming is that it allows an examination of the impact of budgets on a number of demographic groups and, as such, can address disadvantage associated with ethnicity, class, geographical factors, age or disability, for example.The approaches taken may vary, both in terms of the gender budgeting techniques used and also the level (national, regional or local) at which such budgeting measures have been taken up. The goals of gender budgeting may be varied but, in general, objectives include improved gender disaggregated data, explicit recognition of the gender impact of policies, andmovement towards gender equality.

There is no single model for gender budgeting. A variety of approaches have been adopted, reflecting different contexts, political systems, local versus regional versus national policy machinery, and also stages of economic development. Key principles for the implementation of gender budgeting in most settings include the need for transparent procedures and decision-making, participation by the different stakeholders, sustainability and a long-term perspective. Gender budgeting can be focused on specific policy issues, the budgetary process as a whole, or both; the key is that spending choices – and their gender impact – should be explicit. A number of specific instruments have been associated with gender budgeting, including gender-sensitive policy processes, gender-disaggregated analysis of benefits and beneficiaries, gender-disaggregated data, gender auditing of expenditure and revenue to explore differences between women and men, gender impact assessment and gender equality targets.

For instance, to use gender budgeting approaches at local level – for example, in the planning of local health services. Plans for a new hospital can be evaluated in terms of the different services to be offered to women and men and the likely uptake, reflecting not only population needs but also barriers to the use of existing services (and how new services might overcome them). Such an analysis would be a cross-service one, in the sense that the availability of public transport, the local employment opportunities and the educational and child-care facilities (and the availability of care for otherdependents) might also be considered.

2.3. GENDER MAINSTREAMING AND SOCIAL DETERMINANTS OF HEALTH

Gender mainstreaming provides tools to reduce the harmful effects of the determinants ofhealth.Specific strategies are required to address gender-based health inequities. Gender mainstreaming is an internationallyaccepted strategy that aims to institutionalize gender equality across sectors. Given the powerful impact that genderhas on the health of women and men, it is imperative that gender be mainstreams in the health sector functions and policies to addressgender-based health inequities.

Gender is one of these broader determinants of health. Gender interacts with a range of other determinantsto produce differential health outcomes for women and men. Being female or

male significantly influences health behavior,status, access and use of health services. Women and men differ in terms of power, status, biological make-up,socialization and roles in society, and these differences must be acknowledged, analyzed and systematically addressed.

Gender mainstreaming in health generally takes three principalmethods for implementation at

1. Institutional, programs and operation level
2. Household and individual level
3. Multi-sectoral level through the social determinants for health of humankind (Health and Well-being, WASH, Environment, Education, Wealth, Protection, Nutrition, regional residence, age …).

2.4. GENDER MAINSTREAMING A MEANS OF NEW WAY OF DOING BUSINESS IN THE HEALTH SECTOR

The steps towards achieving health equity goals, such as *health for all*, must begin from the basic acknowledgement that"all" are not the same. Differences and disparities in health between countries and regions are widely recognized and recorded in health statistics and profiles. Public health workers at all levels need to recognize and identify differences withinpopulations in their countries and address these differences systematically and appropriately. As such, it may requirevarious interventions to facilitate the attainment of the highest possible level of health across groups within the population.It also often means that business-as-usual procedures are not the most effective ones. New ways of thinking and new ways of doing business are needed to move beyond rhetoric to address global health inequities and the different health needs and challenges facing men and women across the life course.

Gender mainstreaming can help in identifying differences and disparities – and in changing how the health sector operates to achieve its objectives. It does this through two contiguous approaches: programmatic (or operational) gender mainstreaming and institutional gender mainstreaming.

1. Programmatic (or operational) gender mainstreaming

Based on human rights principles of equality, participation and nondiscrimination, programmatic approachessystematically apply gender analysis methods to health problems to better understand how gender norms, roles and relations affect the health of women and men across the life course.

Programmatic gender mainstreaming can do the following:

- address how health problems affect women and men of all ages and groups differently;

- focus on women's empowerment and women-specific conditions to address historic and current wrongs womenand girls face;
- examine how gender norms, roles and relations influence male behavior and health outcomes and how these shapes the role of men in promoting gender equality;
- adopt a broad equity approach to look at issues of age, socioeconomic status, ethnic diversity, autonomy, empowerment, sexuality, etc. that may lead to inequities; and
- provide an evidence base to enable appropriate, effective and efficient health planning, policy-making and service delivery.

2. Institutional gender mainstreaming

This aspect looks at how organizations function: policy development and governance, agenda-setting,administrative functions and overall system-related issues. Institutional gendermainstreaming acknowledges that an institution must be equipped with mechanisms to createan *enabling environment* for programmatic approaches to succeed. It also ensures thatorganizational procedures and mechanisms do not reinforce patterns of gender inequalityin staffing, functions or governance. Institutional gender mainstreaming seeks structural changes,calling for a transformation of the public health agenda so as to include the participation ofwomen and men from all population groups in defining and implementing public health priorities and activities.

Institutional gender mainstreaming addresses the alignment of human and financial resources and organizationalpolicies, which include recruitment and staff benefit policies, such as:

- establishing work-life balance;
- sex parity and gender balance in staffing;
- equal opportunities for upward mobility; and
- mechanisms for the equal participation of male and female staff in decision-making procedures.

Institutional gender mainstreaming also addresses gender equality dimensions in strategic agendas and policy statements as well as monitoring and evaluation of organizational performance, via:

- developing tools and processes to address gender in planning activities (both institutional and programmatic planning);
- mechanisms of accountability on gender and health via advisory bodies, steering committees, etc.; and
- building staff capacity to implement the gender analysis methods required by programmatic approaches.

Therefore, mainstreaming gender and health focus on both institutional and programmatic gender mainstreaming through the global and national health policy approaches to integrate gender consideration in all aspects of its work and in building national-level capacity to address gender-based health inequalities.

2.5. APPROACH TO GENDER MAINSTREAMING IN HEALTH

- **Regulatory approach:**at national level might address patients' rights or create a duty for public-sector organizations to address gender equality. Such a duty would require health ministries to consider the ways in which health systems can reinforce inequality, and to work towards the promotion of gender equality

- **Organizational approach**:designed to address gender equity focus on the use (in health systems) of various tools to highlight gender inequalities and pinpoint solutions. For example, gender budgeting is an organizational approach that focuses on government expenditure and makes the gender impact of budgetary decisions explicit

- **Informational approach:**focus on the role of data in providing knowledge about gender inequities. For example, gender-sensitive health indicators are intended to identify key differences between women and men in relation to health and in the social determinants of health, in order to support policy change.

2.6. MAINSTREAMING GENDER IN THE PERSPECTIVE OF NATIONAL HEALTH SECTOR TRANSFORMATION PLAN II

Based on the vision and mission of MOH, the main objective of HSTP II is to improve the health status and well-being of people living in Ethiopiaensuring no one is left behind through the four strategic pillars.

1. ***Accelerate progress towards Universal Health Coverage***

This strategic objective builds on previous gains of quality and equitable health service delivery without financial hardship. This could be achieved through the strategic intervention in three focused areas

1. Ensuring essential service availability close to the population mainly at primary health care level with standard quality of care.
2. Ensuring that essential service coverage is met that individuals and community receive health services based on needs which in turn have three widely used components, need analysis utilization, and quality of healthcare interventions that can be put into actionable measure for tracking progress towards achieving UHC.
3. Ensuring that people are protected from financial hardship i.e. financial risk protection**.** In other words, HSTP II intends to ensure that the essential health care package service components are accessible and utilized by the community without causing financial hardship to service users.

How to mainstream gender in the Universal HealthCoverage is fundamental question to be addressed.

Biologically, men and women have different health needs, but lifestyles and socially ascribed roles arising from prevailing social and cultural patterns also play a part in the health picture. Thus, obtaining health information disaggregated by sex is the first step for applying gender analysismethod to design the strategic interventions of programmatic and institutional planning.

Although analysis of health equity typically focuses on socioeconomic disparity andresponses, applying gender analysis methods to public health programmes, research and policiesaddresses unnecessary,avoidable and unfair differences in health status beginning from the interaction of sex and gender as core determinantsof health inequity. This means that thedifferences between and among groups of women and men (age, ethnicity,socioeconomic status, region of residence etc.) are incorporated into a systematic gender analysis,thereby operationalizing approaches to health equity.

For example, men are more likely to be the victims of occupational diseases, accidents at work, smoking, alcohol and other forms of substance abuse. Men have a higher incidence of cardiovascular lesions and diseases (the principal cause of male mortality). Women's health risks, which are mainly linked to reproduction, make them more vulnerable during pregnancy to anemia, malnutrition, hepatitis, malaria, diabetes and other illnesses.Therefore, users of the essential health care package services with different needs in terms of gender specific health care and information could benefit from and result in the desired target of service availability and coverage without financial hardship.

2. Protect people from health emergencies

This strategic objective refers to improving health security through protecting the public from the impact of public and medical (routine) health emergencies caused by human made and natural disasters, conflicts, recurrent and unexpected disease outbreaks and epidemics, accidents, emergencies due to infectious or non-infectious causes and new health threats. It also includes safeguarding the public from cross-border health problems and ensuring the health security of the population.

Public health emergency services mainly focus with the preparedness, prevention, detection, management and recovery of all public health emergencies, including disease outbreaks, nutritional emergencies and health consequences of natural and human made disasters. Medical emergencies include any medical problems that could cause death or permanent injury if not treated quickly.

Men and women also differ in their vulnerability to the indirect and long-term effectsof climate-related hazards. For example, droughts imply reduced water availability fordrinking,

cooking, hygiene, and also food insecurity, especially in developing countries like Ethiopia,which in turn results in health hazards.

Health consequences resulting from food insecurity and nutritional deficienciesdisproportionately affect women and girls compared to men and boys. Additionally, women and girls often have the responsibility of water collection for the family, and droughts increase their burden as they would need to travel further to collect water. The workload of women increases in response to climate change variation, such as droughts or low rainfalls, not only because of the increased burden of collecting water, but also collecting firewood, in addition to having to work casual jobs to make ends meet.

Changing weather patterns may also increase the geographical range and seasonalityof certain vector-borne diseases, with some groups more vulnerable than others[2].

The roles of women caring for the sick families increase the risks of vulnerability of illnesses and conditions. Therefore, integrating gender with sound analysis into the protection and emergency services becomes compulsory.

3. *Woreda transformation:*

Sex and gender are important determinants of health. Both influence the exposureof men and women to the risk factors for ill-health, access to health information andservices, health-seeking behavior, treatment options, and experience in health-care settings.These factors in turn can lead to differences in health outcomes for women and men.

Programmatic and institutional gender analysis is importantto guide through a systematic process of examining theinfluence of gender-based differences and inequality on health. The reasons behind gender-based differences inhealth are often difficult to uncover by using traditional health analysis methods. Conducting gender analysis is, in manyways, similar to tending a garden. What appears on the surface neither adequately reflects the complexity of the intertwiningroots beneath nor reflects the stronghold these roots may have in the soil.As each programmatic intervention must be examined in a bottom-up manner, understanding the realities of local populations before moving upto the regional and national levels to understand the root causes of how and why power, rights and access to importanthealth-related resources are distributed unequally among internal groups. Therefore, gender sensitive Woreda level implementation of health actions will not only lead to changes from gender blind to gender accommodative but also as the house-hold and individual are the agent of changes and so gender transformative actions will be realized.

4. *Improve health system responsiveness*

[2] *Climate change and health. Fact sheet N°266.* Geneva, World Health Organization, 2010 (http://www.who.int/mediacentre/factsheets/fs266/en/, accessed January 1, 2012).

Gender has also to be integrated in all the health system components:

Leadership & governance: The country has made notable progress towards women empowerment in making the ministerial cabinet 50% female in 2019, and 38.8 % of the parliament seat occupied by female. The ministry of health is one of the cabinet members with female minister leading the sector. Education is major power to balance the *gender parity* in decision making positions and the essence to build self-confidence importantly for female. *Life-work balance* is important for women to advance with career particularly during pregnancy, and child care. The legal proclamation that oblige each institution to establish a child-care center empowers women and single parent men to advance in their professional job. The enabling environment of the health sector has much to do in analyzing and ensuring gender parity at higher level of technical management in different directorial position of programs;as well asthe political leadershipof health at regional health bureauand the federal health agencies level that disproportionally favormenduring the HSTP I cycle.Therefore, the *organizational culture* is expectedto undertake institutional transformation regarding gender-related issues and gender parity within the sector to address gender equality in workplace, discrimination and personal safety, and work-life balance at the minimum in the second cycle of HSTP. Furthermore, the ***gender architecture and capacities*** that refer to gender coordination mechanism and gender capacities across the health sector will be strengthened to mainstream gender across programs/operation and institutions through collaborative work and partnership mechanism to ensure gender capacity development.

Finance and budget:Public goods are consumed by men and women to different degrees and "women and men benefit differently from social transfers".Gender budgeting is one way of recognizing, and attempting to redress, these differences. The term gender budgeting, or gender-responsive budgeting, includes a number of different approaches that focus on government expenditure. Gender budgeting does not refer to resources allocated specifically for either sex, such as budgets for women's programmes, but calls for a gender analysis of the impact of fiscal and monetary measures on both men and women.A country's national annual budget is a statement of government priorities overthe next year, including financial allocations in relation to competing prioritiesand also the manner in which revenue is to be raised. With gender budgeting,gender differences in relation to needs and experiences in the context of publicsectorexpenditure are explicitly considered in this process. Thus, genderbudgeting aims to determine the following: the specific needs of men andwomen; whether current measures and policies meet the needs of men andwomen; and how any failure to meet the needs of men and women should beaddressed. In addition, an objective of gender budgeting is to increasegovernment accountability for gender-based differences in terms of the impactof public-sector health expenditure and revenue measures.Gender budgeting has less often been explicitly applied to health policy, although some of the requirements of the approach – gender disaggregated data and gender indicators – have been extended to questions of health policy.

Human resource for health:

The MOH has been monitoring its staffing policies and recruitment practices from a gender perspective to ensure progress towards gender parity across all programs and entities and at all levels.In addition to applying corrective measures to achieve gender balance and fill gaps especially in senior positions, the data on gender parity encourages further improvement in staffing policies. It means creating a safe and respectful work environment, zero tolerance for sexual harassment and abuse, work life policy, maternity/paternity leave, day care facilities, spouse employment and many similar measures.The staff development policy that set age limit as criteria for selection process has been annulated in HSTP II through the gender advocacy efforts and in turn the constitutional rights of affirmative actions for women candidate to be explicitly strengthen.

Pharmaceutical, supplies and technologies:

The strategic shift of pharmaceutical supplies and technologies from product-oriented services to patient-oriented services have great differential impact in the process of *procurement*, *storage, distribution in time sensitive manner* to both male and female end users. This shift in approach is a step to mainstream gender along the logistic and supply chain management. The pharmaceutical, supplies, and diagnostic & treatment technologies differ for women and men, girls and boys. Thus, gender and age tailored needs should be entrenched in programming.The Ethiopian Pharmaceutical and Supply Agency has an ambitious vision statement to be responsive and efficient pharmaceutical supply chain agency in Africa. This vision could only be observed if twinned in a gender responsive planning, implementation and monitoring.

The precious gift of humankind, which is not synthesized, is blood and blood products that saves lives of both women and men. The blood safety program collects and donates blood from people to people where both women and men are engaged in voluntary renumeration of blood donation and benefit from receiving safe blood and blood products as needed. Thus, gender mainstreaming approach in this program becomes inevitable. Equitable access to safe blood services takes gender as a prime determinant for equity analysis to improve the supply (donors pool) as well as the demand side (gender-based needs).

Apart from the allopathic medicine, traditional medicines are used & provided both by women and men in the country for physical, mental, social and spiritual well-being. Ensuring the safety and efficacy of traditional medicine efforts through research is one of the priority programs in HSTP II. Therefore, theproduction of quality-assured traditional medicine needsa gender-based analysis due to the powerful impact of gender for better outcomes of health and reduce harmful effect on users.

Health information system including researches:

Health communication, messages and various types of mass media are important in public health work to raise awareness of health conditions or preventive measures, promote healthy behavior (both health interventions and advocacy campaigns) and establish commitments to achieving health goals (these could be policies or speeches). Either type of communication must avoid the reinforcement of gender stereotypes as well as harmful gender norms, roles and relations. On the contrary, language, images and the type of media used to communicate health messages can and should be used to challenge gender-based stereotypes that may harm health. For example, some communication messages and interventions can reinforce stigmatization that is usually a result of gender-based discrimination or stereotypes.

This could include depictions of:men as aggressive, promiscuous or unemotional; women only in the context of motherhood; women as passive bystanders in household or community activities etc. Therefore, messages or images that reinforce gender stereotypes could compromise the outcomes of communication interventions aimed at raising awareness and building knowledge about specific health topics. Thus, the process of achieving gender equality need to consider gender at all stages of communication.

The basic requirement for planning and programming are the ***sex-disaggregated data and gender-sensitive indicators*.** Though gender and health data are broad area to cover, key points to consider are the following:

- Analysis frameworks must allow for the selection of indicators that facilitate gender analysis of health data.
- Generating and analyzing sex-disaggregated health data is a core requirement of gender analysis. When possible, other forms of stratification are strongly encouraged such as ethnic origin, education level, etc.
- Health indicators should be gender-sensitive. They should have relevant disaggregation and capture key gender and health issues for specific groups of men or women.
- Having health data is often insufficient to conduct gender analysis. Integrating gender into health planning and programming may require gender statistics.

Analysis frameworks are important in health planning and programming, especially for situation analysis, developing activities and monitoring and evaluation. Various framework could be applied but all points to the same conclusion that relevant health information focuses on more than the burden of disease. It includes for example, determinants of health, health status and outcomes etc. Therefore, health data moves beyond simply counting bodies or diseases to address broader public health issues such as gender equality.

Gender research is important for the following reasons: (1) It often uncovers patterns of discrimination – either against women or men; (2) It aims to identify the structural causes of

inequalitybetween men and women; (3) It is more likely to reflect a broader range of experiencesin society, and therefore has the capacity to more comprehensively addresssociety's interests and needs**;** and (4)Mandateexists in international conventions and agreements (CEDAW, Beijing Platform for Action).

Therefore, promoting the integration of the gender perspective in ***research and innovation*** (R&I) so that gender as cross-cutting issue is mainstreamed in each part of the study process is important. Research programs under the health sectorneed to foster equal opportunities and a balanced participation of women and men at all levels in R&I teams and management structures, and the gender dimension must be included in the research content. However, in spite of legal duties and recommendations, gender biases persist in research and technological developments in all fields of knowledge, which maintain androcentric perspectives and discriminatory power structures that perpetuate social inequalities. Every research and surveys should integrate a gender dimension in the hypothesis, formulation, research design, methodology, research processes of the dissemination and publication results. Teaching and research institutionsincludingacademia should bring more visibility to the gender research and teach on how to manage and introduce a gender perspective in their teaching activities. Research application for grant, for example, should mandate the inclusion ofa gender perspective in all proposals.

Health infrastructure is more and more close to the end-users for the geographic access to health services. The structural layouts of some health facilities are not only sub-standard but also unfriendly both for the health workers as well as male and female service utilizers. Different facilities like electricity, toilets, communication and water supplies that are critical to consider and serve as clinical health facilities as women and men, girls and boys need varies.

2.6. PRACTICAL STEPS IN MAINSTREAMING GENDER

Gender mainstreaming is essential to realizing the right to health and it puts ***people*** *at thecenter of public healthprogrammes and policies!*

Gender-based differences and inequalities influence the health of women and men (knownas gender analysis). These are generically referred to as gender analysis tools. Usually formulated as questions, gender analysis tools guide one through a systematic process of examining the influence of gender-based differences and inequality on health. The reasons behind gender-based differences in health are often difficult to uncover by using traditional health analysis methods. The tool assists to detect where and why gender inequality has harmful effects on health in order to develop adequate and appropriate interventions. Thus, must be examined in a bottom-up manner, understanding the realities of local populations before moving upto national levels to understand the root causes of how and why power, rights and access to important

health-related resources are distributed unequally among internal groups.

The **programmatic gender mainstreaming analysis** outlines concrete ways to uncover how biological factors interact with gender norms, roles and relations (or sociocultural factors) to affect the health of women and men and that of their communities. On the other hand, it has also impact on **institutional issues** for consideration – especially in health planning and programming. Although analysis of health equity typically focuses on socioeconomic disparity and responses, applying gender analysis methods to public health programmes, research and policies addresses unnecessary, avoidable and unfair differences in health status beginning from the interaction of sex and gender as core determinants of health inequity. This means that the differences between and among groups of women and men (age, ethnicity, socioeconomic status, region of residence etc.) are incorporated into a systematic gender analysis, thereby operationalizing approaches to health equity.

Steps in Gender mainstreaming

Step 1: The social construction of gender

Knowledge on the definition of sex, gender, gender equity, equality and discrimination help to understand how gender is constructed, maintained and reinforced

Gender equality, gender equity and health equity

When gender equality and gender equity are applied to health, the following distinctions are important:

- Gender equality does not mean making sure that disease burden is evenly distributed among women and men.
- Gender equality in health means that women and men have equal conditions to realize their full rights and potentialto be healthy, contribute to health development and benefit from the results.
- Achieving gender equality will require specific measures designed to support groups of women and men with limitedaccess to such goods and resources.
- Gender equity in health refers to a process of being fair to women and men with the objective of reducing unjust andavoidable inequality between women and men in health status, access to health services and their contributions to thehealth workforce.

Step 2: Concept and tool for gender analysis

Define gender analysis and present different rationales, tools and concepts for analyzing gender.It identifies, assesses and informs actions to address inequality that stems from:

- gender norms, roles and relations;
- unequal power relations between and among men and women; and
- the interaction of contextual factors with gender, such asethnicity, education or employmentstatus.

Gender analysis is a core gender mainstreaming skill that generates, processes and information needed for healthplanning and programming. It includes critical questions that dig forinformation where it is often not easily found. It also follows core principleslike:

i. sex is not gender
ii. women and men are different
iii. policies and programs do not affect men and women the same way
iv. diverse types of evidence are needed how gender operates as determinant of health
v. sustained commitments are necessary

Women empowerment is part of gender analysis: a process of strengthening the capacity of marginalized groups to enjoy and realize their right to health. (See Annex 2).for gender analysis questions on how empowerment can be woven into gender analysis of a health problem W.H.O suggested measures of empowerment relevant to health and indicators used to assess women's empowerment (which could be used as a guide to develop measures with and for other groups) is annexed(annex 2)

Step 3:Gender-based inequalities the evidence

Explain how gender norms and values of gender roles are related to gender-based inequalities in workload, and to unequal access to education, and access to and control over the economic and social resources and access to power. Familiarizes with evidence from international and national data set on gender-based inequalities /gaps.Source of evidence could be obtained from range of data sourcesthat can contribute to gaining insight into the health issue being analyzed. For example, data from secondary and published sources; or rapid appraisals using both quantitative and qualitative methods such as gathering health service–based data or interviewing major stakeholders;studies of knowledge, attitudes and practicesetc.

Step 4: Mainstream gender in institution

This introduce the concept of "gender mainstreaming" and the tools for gender analysis. It also introduces a range of actions and strategies for gender mainstreaming.

Step 5: Linking gender and health

Help to apply the tools of gender analysis to specific health conditions to understand how gender impacts on health status and on access to health care.Start with the process of questioning with the help of gender analysis questions (annex 2) and use gender analysis matrix (annex 1) that contains important factors that interact with the horizontalaxis (gender-related considerations). The intersection of the horizontal and vertical axes provides a frameworkfor conducting gender analysis in health and helps to recognize differences and disparities as to who gets ill, when,where and why – and what the health sector is doing about thisto organize answers from GAQ.

In summary gender analysis is…

…**Purposeful**

Conducting gender analysis is not just a politically correct phrase to add to reports. It is also not about undoing tradition or cultural or religious institutions just for the sake of doing so.

When public health actors engage in gender analysis, it is to:

- address harmful gender norms that increase health risks for women or men; and
- transform institutional mechanisms to promote gender equality in the way public health activities are developed, delivered and monitored.

… Participatory

Addressing harmful gender norms, roles and relations requires understanding the reasons why certain practices or beliefs are upheld. This requires working in collaboration with women and men in communities to develop acceptable responses and solutions.

Consulting and involving women and men from different groups and areas ofspecialization is crucial to determining the best ways to address gender equality in health programs.This also applies tocompleting the Gender Analysis Matrix and to the ways human resource policies, for example, can be enhanced to promote

… **… Partnership-based**

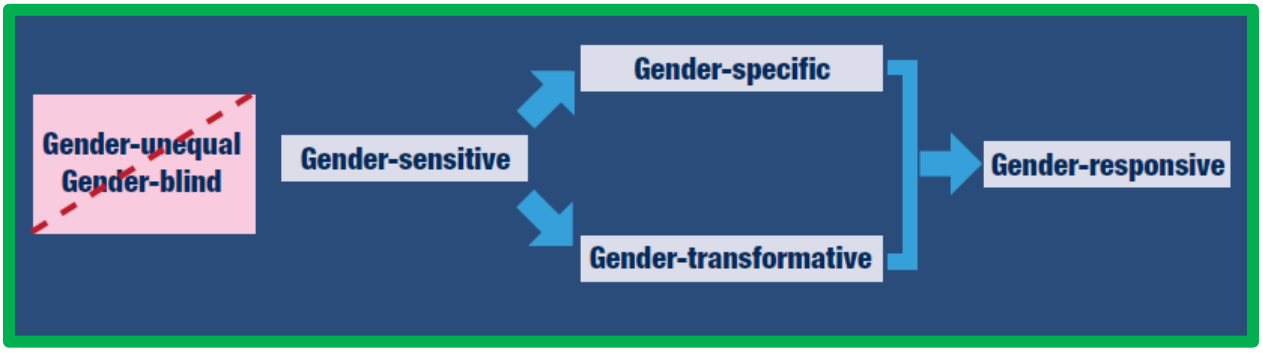
Working with partners from other sectors to achieve common goals of social justice and improved health outcomes for men and women is crucial. When compiling information for the Gender Analysis Matrix, be a leader in your work and use health as a platform and entry point for addressing social inequality. For institutional mechanisms, no department or office in MOH can effectively address gender inequality on its own. Working across departments, offices and sectors is the only way to ensure sustainable success.

SECTION THREE: GENDER MAINSTREAMING MEASURES

Data to support the advancement of gender mainstreaming efforts as well as methods to comprehensively evaluate theirimpacts are lacking.In addition to the challenges of measuring gender norms, roles and relations across programme areas and operation, the struggle to obtain adequate sex- and age- disaggregated data persists. Despite this evidence gap, gender-based health inequities can – and must – be addressed and alleviated. Existingevidence is sufficient to know that gender inequality is an important determinant of health. However, while data sets and methodologies are strengthened, men, women, girls and boys should not continue to suffer the health consequences of harmful gender norms, roles and relations.

Gender is one of the broader determinants of health. Gender interacts with a range of other determinantsto produce differential health outcomes for women and men. Being female or male significantly influences health behavior,status, access and use of health services. Women and men differ in terms of power, status, biological make-up,socialization and roles in society, and these differences must be acknowledged, analyzed and systematically addressed.

The WHO's Gender Responsive Assessment Scale (GRAS), based on other frameworks, includes five levels, two of which hinder the achievement of gender equality and health equity. The third level, gender sensitivity, is the turning-point – when policies or programmes recognize the important health effects of gender norms, roles and relations (annex 3). Only when a policy orprogramme is gender-sensitive can it be either gender-specific (level 4) or gender-transformative (level 5) –where the real action begins.



The Gender Assessment tool (GAT) (see annex 5) can help to rapidly assess the gender-responsiveness (gender-sensitive, -specific or -transformative) ofhigh-level activities of a given programme. It indicates where gender-responsiveness can be improved.

Policy approaches to women's health:this can be seen in two approaches in the gender assessment tool.

1. *Women health needs* which this approach focuses on epidemiological differences to highlight the specific health needs of women and girls. It includes sexual and reproductive

health issues but encompass a holistic understanding across the life course. *Strategic gender and health needs* are also incorporated in the women's health needs approach. Yielding many women-focused initiatives, this approach has emphasized women's human rights with respect to health choices and opportunities. Such strategic interventions have empowered women to enjoy their human rights. By focusing on women's *practical gender and health needs*, this approach deals with women's health within the context of existing gender norms, roles and relations – without directly addressing inequalities.

Therefore, adopting a women's health needs approach is predominantly *a gender-specific strategy* as it targets specific health needs of women while acknowledging things such as differences in access to and control over resources.

2. Gender Equity and gender inequality approach: This approach broadens the scope of analysis from epidemiological differences to include the effects of harmful or unequal gender norms, roles and relations on women's health. To understand these effects on women's health and to understand why health conditions, services, programmes or policies affect women and men differently, the gender equity and gender inequality approach emphasizes the determinants of health and enables the effects of gender norms, roles and relations on the health of men and boys to be analyze as well.
   Primarily addressing *strategic gender and health needs*, this approach can propose women- or men-focusedprogrammes. For either sex, however, the gender equity and gender inequality approach targets the harmful gendernorms, roles andrelations that contribute to health inequities.

   Adopting a gender equity and gender inequality approach to women's health is a *gender-transformative strategy –even if it focuses on one sex or the other*. It is gender-transformative because it aims to achieve gender equality.This approach is predominant across a range of actors and follows the broader international move towards gendermainstreaming.

The GAT is not a detailed programme analysis; this would require each question to go into further detail. For example,many may have to answer *no* to the question "Is the evidence generated by or informing my programme collected andreported by sex?" due to poor availability of sex-disaggregated data. However, a follow-up question could be "What isyour programme doing to facilitate the generation, analysis and reporting of data by sex?"

The generic WHO GAT comprises of 23 questions which yes and no answers are expected. if the answer isyes to the majority of questions 1 – 18, one can consider that the programme is gender-responsive and therefore either gender-sensitive, gender-specific or gender-

transformative. If the answer isyes to the majority of questions 19 – 23, the programme may be either gender-blind or genderunequal– and is therefore not gender-responsive.

W.H.O gender-response assessment scale adapted from WHO gender mainstreaming for program managers- practical approach, 2011

Gender and health planning and programming checklist (adopted from WHO)

Gender issues can be addressed at various stages in the process of developing a programme or policy. The checklist, attached in annex 6,assists in integrating gender into health planning and programming activitieshighlighting key questions (as per gender analysis methods).

Monitoring and Evaluation

*Sex-disaggregated data and gender-sensitive indicators are basic requirements for health planningand programming.*Ensuring that health policies and programmes address gender norms, roles and relations requires basing the information used to guide their development (or the process of evidence-based planning) on a gender analysis of health data that are sex-disaggregated at the very minimum. Attention should also be paid to the types of indicators selected so that key gender and health issues are adequately captured for situation analysis (as a source of evidence for health planning or programming), surveillance or monitoring and evaluation activities.

The *selection of indicators* that facilitate gender analysis of health data need in place appropriate indicators to include adequately disaggregated, that can reflect gender and health considerations. Broader determinants of health data – may not be adequate for conducting gender analysis in health. However, may require drawing on gender statistics or data from other

sectors. Two examples below show how disaggregated data can identify and monitor gender-based health inequities.

Access to health services: more than just sex disaggregation

***Indicator*:** number (%) of people or households covered by health insurance by sex, population group and specifically for low-income andvulnerable groups.

insurance coverage can be understood as a proxy measure for access to health services, as it can both facilitate access to fee-basedservices and serve as a protective factor against catastrophic health expenditure. 152 However, in many contexts, most of the population doesnot have access to health insurance, and this plays out differently for women and men of different population groups.

Disaggregated by sex, this indicator makes it possible to identify which groups of women and which men are not covered by health insurance.With this basic information, it is possible to ask critical questions (as in gender analysis) about why some women or some men are morevulnerable than others.

In this indicator example, the data are disaggregated not only by sex but by population group. This enables finer analysis of how different lifecircumstances for groups of women and men may affect access to health services – and avoids binary oppositions between women and mentreated as homogeneous groups. For example, inequity in access to health services can be exacerbated when health insurance schemes arelinked to formal labor activities. Women in many settings have less access to employer-based health insurance schemes, as their labor maybe concentrated in informal market activities (including domestic work such as home-based child care, commercial sex work and subsistencefarming), employee benefits may be compromised due to adjusting working hours to accommodate household responsibilities (such as parttimework) – or women are excluded from market activities altogether. Without adequately disaggregated data, this important informationon gender-related factors that increase vulnerability with respect to health insurance coverage (whether provided by the public sector or not)is missed.

Health services coverage: making the most of sex-disaggregated data

Indicator: percentage of women and men with a health problem or injury having used health services.

Health service delivery is an important building block in any health system. Components of health service delivery include issues of access to and use of health services. Health service coverage, which looks specifically at the number of people who receive services when they need them, relies heavily on service delivery issues.

The decision to seek and use health services can depend on many factors. Such factors include the perceived salience of the health problem or injury (including recognition of symptoms), available resources within the household and the availability, affordability, accessibility, accommodation and acceptability of health services. Gender norms, roles and relations influence this decision-making process in various ways. In situations of poverty, women's health may be undervalued if they are not contributing to household income. This can be understood as giving priority, for economic reasons, to the health of those bringing income to the household. Other ways that gender can affect health seeking behavior (and hence health service utilization) include:

- restrictions on the physical mobility of women; known as chaperoning for women in some contexts outside the household;
- decreased decision-making power and autonomy for women or permission-seeking requirements; and
- daily tasks (paid or unpaid) of men and women restricting their ability to effectively access and use health services. This may include, for women, a focus on the health and well-being of others in the household (children or older people), which can lead to neglect of their own health.

This indicator does not encompass all these elements. However, when it is based on sex-disaggregated data (as above), there is potential to at least identify different patterns of health service utilization and dig deeper into the reasons why such differences exist, whether they are unfair and whether they can be avoided to ensure that health needs are met through both existing services and appropriate health-seeking behavior.

Notes on health service coverage indicators

Most but not all health service coverage indicators can be disaggregated by sex. Births by caesarean section (percentage) and other health service coverage indicators may deal with a condition that affects only one sex – having sex disaggregation irrelevant. Such indicators could benefit from other forms of disaggregation to better identify vulnerable groups within the same sex group. An example of such an indicator is pregnant women living with HIV receiving antiretroviral therapy for preventing vertical transmission. Other forms of disaggregation could age, region of residence (urban or rural) and level of education.

Gender mainstreaming indicators

Remember that gender mainstreaming is about both process (institutional mainstreaming) and outcome (programmaticmainstreaming). This means that indicators are needed to observe changes and progress in both areas. Process indicators are important to monitor progressive, institutional change.

The ministry of health could adapt the four strategic direction to monitor gender mainstreaming in health

Strategic direction 1: Building MOH capacity for gender analysis and planning

1. Percentage of all MOH staff members (by sex, category, level and regions) who have a basicunderstanding of gender and health.
2. Percentage of all MOH staff members who are at least moderately applying gender analysis and actions in their work (disaggregated by sex, category, level and region).
3. Percentage of MOH staff members who report at least some institutional support for integrating gender into their work (disaggregated by sex, category, level and region).

Strategic direction 2: Bringing gender into the mainstream of MOH's management

1. Percentage of planning focal points whose responses reflect strong integration of gender during the operationalplanning process, disaggregated by sex, category, level and whether or not there was collaboration withthe gender, women and health network.
2. Number of health programs, agencies and bureaus adopted the revisedgender mainstreaming in their programto strongly integrate gender.
3. Percentage of all professional and administrative posts by sex and grade level (cumulative).

Strategic direction 3: Promoting use of sex-disaggregated data and gender analysis

1. Number of new MOH publications of those sampled that promote and/or use sex-disaggregated data.

Strategic direction 4: Establishing accountability

1. Number of speeches by the Minister of health and the regional health bureau heads of thosesampled that include at least onereference to gender.

Therefore, in summary monitoring and evaluation of the gender mainstreaming approaches in health should factor in the following:

- Gender-sensitive qualitative and quantitative indicators are identified;
- Use and analysis of sex-disaggregated data is ensured;
- Achievement of gender related objectives, results and different impact the project may have had on women and men, and on the power relations between them is evaluated;
- Gender balance of staff at different categories

ANNEXES:

Annex 1: WHO Gender Analysis Questions

The following Gender Analysis Questions (GAQ)* are useful for filling out the GAM. Use this tool together with the GAM and the checklist for gender and health planning and programming to enhance attention to gender issues in your area of work

WHO Gender Analysis Questions	Corresponding GAM health related considerations
What is the illness, disease or health condition of interest?	
Is it an acute or chronic condition? • Is it a communicable or a noncommunicable condition? • What are the risk factors for this condition? – Are they different for women and men, boys and girls?	Introductory information on the health condition in question (not included in GAM) Risk factors and vulnerability
When does this condition occur?	
Does it occur at any specific time in the life course? – Can biological factors explain increased vulnerability of the affected individual and/or group during this period? Which ones? – Can sociocultural factors explain increased vulnerability of the affected individual and/or group during this period? Which ones? – Which gender norms, roles and relations during this period may explain increased vulnerability?	Introductory information on the health condition in question (not included in GAM) Risk factors and vulnerability Health and social outcomes and consequences
• Is vulnerability increased at any specific time of the year? – Around or during a particular season (that is, related to climate)? Around crop time? – Are there any particular activities that men or women carry out at this time that may increase their vulnerability?	
Where does this condition occur?	
• Is it in rural or urban contexts? – Does this have different implications for groups of women or men, boys or girls?	Introductory information on the health condition in question (not included in GAM) Risk factors and vulnerability
• Is it linked to any particular factor in the social or physical environment? – Does it occur in the workplace, school settings, in the field or at home? – Do cases occur in places where either women or men tend to go or may be more numerous? – Do these women or men belong to a particular sociocultural group (economic, political or otherwise)?	
Who gets ill?	
• Can biological factors explain why women, men, girls or boys are affected differently by this condition? – Does the sex of the individual increase the risk for or vulnerability to this condition? How? – Do age or other physiological factors, such as hormone levels, matter? How?	Risk factors and vulnerability Health and social outcomes and consequences
• What are the specific gender norms, roles or relations of the community in question that may increase the risk for or vulnerability to this condition? – Do these norms affect men and women similarly or differently? – Does the affected group belong to a particular socioeconomic, ethnic or marginalized group? – Do the daily activities of women or men affect the risk for and vulnerability to this condition? If so, what kind of activities (paid or unpaid) increase risk, and who is responsible for carrying these out? – Do access to and control over resources affect the risk of and vulnerability to this condition? – Does the level of individual or community empowerment influence the risk for and vulnerability to this condition? ° Is this different for women, men, boys and girls? – Do educational opportunities influence the risk for and vulnerability to this condition? ° Is this different for boys and girls in the target population? How? – Do paid employment opportunities influence the risk for and vulnerability to this condition? ° Is this different for women and men in the target population? How? • Do women's and men's household, community and workplace responsibilities influence the risk for and vulnerability to this condition?	

What are the people affected by the condition doing about it?	
• Are both women and men seeking services appropriately for this condition? – Who is attending health services for treatment? Women? Men? Certain age groups? Certain socioeconomic groups? – Who is consulting traditional healers or seeking alternative therapies for this condition? Women? Men? Certain age groups? Certain socioeconomic groups? ° Why these groups?	Access and use of health services Health-seeking behavior
Do biological factors affect health-seeking behavior related to this condition? How? – Are these factors different for men and women? How?	
• Do sociocultural factors affect health-seeking behavior related to this condition? How? – Are these factors different for women and men? How?	
• Do gender norms, roles or relations affect women's or men's willingness or ability to recognize that they are ill and/or to seek treatment? How? – How do women's and men's access to and control over resources affect their willingness or ability to recognize that they are ill and/or to seek treatment? – Do women have the ability to decide to seek treatment on their own?	
How do access to and control over resources affect the provision of care?	
Are health services facility-based or provided in the community? Or both? – Does the site of service delivery exclude any particular group? Which one? For what reasons?	Access and use of health services Experiences in health care settings
Does access to and control over resources affect the type of health services received for this condition? How?	
Do women and men have the resources necessary to seek and use available health services for this condition? – Do they have access to these resources to seek health services? Is access different for women and men? – Can they make or influence decisions about the use of these resources to seek health services? Is decision-making different for men and women? – If women and men have different access to and control over resources, how does this affect their experiences with health services? Does such a difference affect the quality of care received? – Does access to and control over resources affect treatment options? How? Is this different for women and men?	
Do women or men in the affected group have specific types of financial or social vulnerability that may affect their ability to access and use health services? – Is this vulnerability worsened by age, ethnic or religious affiliation, sexual orientation or other factors?	
If the affected population does not have the resources necessary, what networks or facilities are available to them for support? – Do these differ for women and men?	
Are user fees affordable for this condition? – Do they differ for men and women of different groups? How?	
Are there any individual, indirect costs related to accessing health services, such as transport? or child care, that may affect women and men differently?	
Do health insurance schemes have different eligibility criteria for women and men? – Do health insurance schemes include the services necessary to address this condition? Are there differences according to employment, marital or other status? If so, how does this affect women and men? – Do health insurance schemes include coverage for medicines and access to additional services, such as mammography or voluntary HIV counselling and testing? Are there essential services for this condition that health insurance does not cover? – If health insurance schemes do not exist and health services are not offered free of charge, how are low-income women and men accessing health services? ° What individual or community strategies are used? ° Are these different if the patient is male or female? How?	
What are the opportunity costs (such as lost opportunities for income generation) for seeking and accessing care? – Are these different for women and men?	

Gender Analysis Questions	Corresponding GAM health related considerations
How do health services meet the needs of the men and women affected by this condition?	
Do biological factors influence treatment options, uptake and adherence? – Do these differ for women and men of different groups (including age)? How?	Treatment options Experiences in health care settings
Do sociocultural factors influence treatment options, uptake and adherence? – Are these different for women and men of different groups (including age)? How?	
Are women's and men's different roles considered in treatment options for this condition? – Are gender norms and relations considered? How? – What consequences may be incurred in treating this condition if gender norms, roles and relations are not considered?	
Are health workers generally aware of the different ways men and women of different ages can express their symptoms when suffering from this condition?	
Do women and men have different experiences with health services for this condition? What kinds? For what reasons? – Do experiences in health care settings differ by age, marital status, sexual orientation, ethnic or religious affiliation, socioeconomic status or other factors? How and for which groups?	
What are the predominant health and social outcomes of this condition?	
As a result of this condition, are there differences (between women, men, girls and boys), in recovery, disability or mortality? – Are these outcomes influenced by sex or age? – Are these outcomes influenced by gender norms, roles or relations? Are the influences different for women and men? – What are the broader social effects of these outcomes?	Health and social outcomes and consequences
Who (other than the immediate patient) is also affected? Children? Partners? Families? Communities? In what ways? – How do these effects vary if the affected person is a woman or man?	
Do the sociocultural characteristics and consequences of the condition differ for women and men, such as the division of responsibilities in the household, employability, stigma or divorce?	
Who else provides care (outside the health care system) for this condition? – What are the opportunity costs for this caretaking work? • Do these differ for men and women?	
How are men and women coping with the effects of this condition? – How does sex, or other biological factors, affect the coping strategies for this condition? – How do gender norms, roles and relations affect the coping strategies for this condition? – Do access to and control over resources matter when coping with this condition? • Do these differ for men and women? How?	

Annex 2: Gender Analysis Matrix tools

The WHO Gender Analysis Matrix (GAM) *

Factors that influence health outcomes: *Health-related considerations*	Factors that influence health outcomes: *Gender-related considerations*		
	Biological factors	Sociocultural factors	Access to and control over resources
Risk factors and vulnerability			
Access and use of health services			
Health-seeking behaviour			
Treatment options			
Experiences in health care settings			
Health and social outcomes and consequences			

Annex 3: WHO Gender Responsive Assessment Scale: criteria for assessing programmes and policies

Level 1: Gender-unequal

- ***Perpetuates gender inequality*** by reinforcing unbalanced norms, roles and relations
- Privileges men over women (or vice versa)
- Often leads to one sex enjoying more rights or opportunities than the other

Level 2: Gender-blind

- ***Ignores gender norms, roles and relations***
- Very often reinforces gender-based discrimination
- Ignores differences in opportunities and resource allocation for women and men
- Often constructed based on the principle of being "fair" by ***treating everyone the same***

Level 3: Gender-sensitive

- ***Considers gender norms, roles and relations***
- Does not address inequality generated by unequal norms, roles or relations
- Indicates gender awareness, although often ***no remedial action is developed***

Level 4: Gender-specific

- ***Considers gender norms, roles and relations*** for women and men and how they affect access to and control over resources
- Considers women's and men's specific needs
- Intentionally ***targets and benefits a specific group of women or men to achieve certain policy or programmegoals or meet certain needs***
- Makes it easier for women and men to fulfil duties that are ascribed to them based on their gender roles

Level 5: Gender-transformative

- ***Considers gender norms, roles and relations*** for women and men and that these affect access to and control over resources
- Considers women's and men's specific needs
- ***Addresses the causes of gender-based health inequities***
- ***Includes ways to transform harmful gender norms, roles and relations***
- ***The objective is often to promote gender equality***
- Includes strategies to foster ***progressive changes in power relationships between women and men***

Source: *WHO Gender Mainstreaming Manual for Health Managers, 2011*

Annex 4: Examples of indicators used to assess women's empowerment

Features to be examined	Yes	No	Partly
Individual level			
Capacity to participate in decision-making at the household level			
Access to health information			
Membership in any association			
Ability to participate in or attend women's empowerment workshops or meetings			
Ability to move around outside the household within the community (mobility)			
Community level			
Community tolerance and support for women's leadership			
Ability of women to make decisions within local committees			
Availability of community leaders sensitive to women's issues			
National level			
Existence of laws and regulations enhancing women's health, empowerment and participation			
Existence of active women's movements and institutions			
Existence of a gender policy			

Source: WHO gender mainstreaming practical guide for health managers, 2011

Annex 5: WHO Gender Assessment Tool (GAT)

QUESTION	YES	NO
1. Do the vision, goals or principles have an explicit commitment to promoting or achieving gender equality? Scoring hints: No may indicate gender-blindness. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
2. Does the policy or programme include sex as a selection criterion for the target population? Scoring hints: No may indicate gender-blindness. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
3. Does the policy or programme clearly understand the difference between sex and gender? Scoring hints: No may indicate gender-blindness. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
4. Does the target population purposely include both women and men? Scoring hints: No may indicate gender-blindness. No may also indicate the programme is gender-specific if either sex is addressed in the context of broader gender norms, roles and relations. Yes, may indicate that the programme is gender-sensitive or gender-transformative.		
5. Have women and men participated in the following stages? • design • implementation • monitoring and evaluation. Scoring hints: No may indicate that the programme or the specific stage of programming is gender-blind or gender-unequal. Yes, may indicate that the programme or the specific stage of programming is gender-sensitive, gender-specific or gendertransformative		
6. Have steps been taken to ensure equal participation of women and men? Scoring hints: No may indicate that the programme is gender-blind or gender-unequal. No could also indicate gender-specificity if one sex is targeted in the context of broader gender norms, roles and relations. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
7. Do both male and female team members have an equal role in decision-making? Scoring hints: No may indicate that the programme is gender-unequal or gender-blind. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
8. Does the policy or programme consider life conditions and opportunities of women and men? Scoring hints: No may indicate that the programme is gender-blind. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		
9. Does the policy or programme consider and include women's practical and strategic needs? Scoring hints: No may indicate that the programme is gender-blind or gender-unequal. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
10. Have the methods or tools been piloted with both sexes? Scoring hints: No may indicate that the programme is gender-blind, gender-unequal or gender-specific. Yes, may indicate that the programme is gender-sensitive or gender-transformative.		
11. Does the policy or programme consider family or household dynamics, including different effects and opportunities for individual members, such as the allocation of resources or decision-making power within the household? Scoring hints: No may indicate that the programme is gender-blind or gender-unequal. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
12. Does the policy or programme include a range of stakeholders with gender expertise as partners, such as government affiliated bodies, national or international non-governmental organizations or community		

organizations? Scoring hints: No may indicate that the programme is gender-blind. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
13. Does the policy or programme collect and report evidence by sex? Scoring hints: No may indicate that the programme is gender-blind or gender-unequal. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
14. Is the evidence generated by or informing the policy or programme based on gender analysis? Scoring hints: No may indicate that the programme is gender-blind or gender-unequal. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
15. Does the policy or programme consider different health needs for women and men? Scoring hints: No may indicate that the programme is gender-blind, gender-unequal or gender-specific (if one sex is targeted). Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		
16. Does the policy or programme include quantitative and qualitative indicators to monitor women's and men's participation? Scoring hints: No may indicate that the programme is gender-blind or gender-unequal. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
17. Does the policy or programme consider gender-based divisions of labour (paid versus unpaid and productive versus reproductive)? Scoring hints: No may indicate that the programme is gender-blind or gender-unequal. Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		
18. Does the policy or programme address gender norms, roles and relations? Scoring hints: No may indicate that the programme is gender-blind or gender-unequal. Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
19. Does the policy or programme exclude (intentionally or not) one sex but assume that the conclusions apply to both sexes? Scoring hints: No may indicate that the programme is gender-sensitive, gender-specific or gender-transformative. Yes, may indicate that the programme is gender-blind or gender-unequal		
20. Does the policy or programme exclude one sex in areas that are traditionally thought of as relevant only for the other sex, such as maternal health or occupational health? Scoring hints: No may indicate that the programme is gender-sensitive, gender-specific or gender-transformative. Yes, may indicate that the programme is gender-blind or gender-unequal		
21. Does the policy or programme treat women and men as homogeneous groups when there are foreseeable, different outcomes for subgroups, such as low-income versus high-income women or employed versus unemployed men? Scoring hints: No may indicate that the programme is gender-sensitive, gender-specific or gender-transformative. Yes, may indicate that the programme is gender-blind or gender-unequal.		
22. Do materials or publications portray men and women based on gender-based stereotypes? Scoring hints: No may indicate that the programme is gender-sensitive, gender-specific or gender-transformative. Yes, may indicate that the programme is gender-blind or gender-unequal.		
23. Does the language exclude or privilege one sex? Scoring hints: No may indicate that the programme is gender-sensitive, gender-specific or gender-transformative. Yes, may indicate that the programme is gender-blind or gender-unequal.		

Annex 6: Gender and health planning and programming checklist

Situation Analysis
Have gender analysis methods been used in conducting the situation analysis? ✓ Use the GAQ and GAM to highlight gender-based health inequities that require attention.
Have knowledge and information that exist on gender and health from sources other than health indicators and/or reports been used as part of the evidence base? ✓ Use data disaggregated by sex and age from multiple sources of data as well as information on mortality, morbidity, survival, disability and determinants of health. ✓ Use existing knowledge on gender norms, roles and relations to inform data analysis
Does the country have a legal and policy framework on gender equality and women's health? ✓ Review international commitments and obligations such as the Beijing Platform for Action, national MDG plans, signature and/or ratification of core human rights treaties - and relevant reservations (e.g. CEDAW). ✓ Assess national and/or district health sector policies for their attention to gender equality and women's health issues. ✓ Compile an inventory of programmes and policies on the topic in question – and then use the GRAS to assess them
Do national and health sector processes include mechanisms on gender equality and human rights, such as a desk or unit on gender and/or health in the health ministry or elsewhere in the government sector, a focal point system or network of non-governmental organizations? ✓ Compile a list of health stakeholders working on health to identify partners that will enhance programme outcomes. ✓ Include women's non-governmental organizations; lesbian, gay, bisexual and transgender organizations; human rights groups; women's affairs ministries; community leaders; health professionals, etc.
Designing Programmes and Policies: Define the Scope, Vision and Target Audience
Are core gender issues in this area reflected in the scope and vision? ✓ Explore how sex and/or gender differences affect the health issue at hand. ✓ Address gender and gender inequality as determinants of health. ✓ Identify key gender issues and articulate them within statements of scope and vision. ✓ Involve women and men equally in design phases, as beneficiaries and as programme staff members. Does the target population purposely include both women and men? If not, why? ✓ Pay attention to diversity among women and among men when determining target audience(s). ✓ Use gender analysis methods and tools to identify key population groups that may require specific attention. • Adopt either a gender-specific or gender-transformative approach based on the defined objectives and target audience(s).

Designing Programmes and Policies: Set Goals or Objectives
Does at least one goal or objective explicitly address gender equality or gender as a determinant of health? ✓ Based on use of GAM and GAQ, reflect men and women's different health needs in goals and objectives. ✓ Pay attention to diversity among women and among men when determining goals and objectives. ✓ Have other stakeholders or partners participated in setting goals or objectives? ✓ Choose partners with the right skills and capacity to address gender inequality in health: Note that these partners could be selected from the list of stakeholders compiled during the situation analysis. If this was not done at the time of the situation analysis, it can be done at any point to ensure the involvement of relevant partners. • Remember to equally involve women and men in goal setting activities.
Designing Programmes and Policies: Developing Activities
Was the context of men's and/or women's lives and their different health needs considered? ✓ Consider the different effects or implications the activities will have on different groups of women and men in the target population. ✓ Include women and men and girls and boys when determining the feasibility and appropriateness of the activities selected: o Be innovative when determining methods of consultation to ensure diverse input from women and men and girls and boys. o Ensure that the programme will not interfere with their daily tasks (and thereby affect participation and benefits). o Consider how or if sociocultural norms may impede the participation or benefits of women or men - and address them appropriately. Does addressing gender inequality require specific activities for women or men of a particular group? ✓ Identify similar and different needs of men and women and girls and boys – and target activities towards the particular needs of the groupthat may have a higher burden of illness or whose health may be more vulnerable. ✓ Remember that women and men are not homogeneous groups and consider the vast diversity among them in developing activities. Do methods and activities include ways to identify or address gender norms, roles and relations that are harmful for health? ✓ Use the GAM and GAQ to identify and address the gender norms, roles and relations that hamper healthy outcomes. ✓ Ensure that activities, by their methods or through their assumptions, do not reinforce or uphold existing stereotypes in their targetsor planned outcomes. Have other stakeholders or partners participated in discussions on activities? ✓ As feasible, address both individual groups and broader communities in moving towards sustainable interventions. ✓ Ensure that stakeholders have the opportunity to provide meaningful input on the feasibility and appropriateness of the activities developed. ✓ Ensure that women and men have participated equally in developing activities – both as beneficiaries and as programme staff members

Designing Programmes and Policies: Preparing a Budget
Do budget lines exist for work on gender equality or women's health initiatives? ✓ Allocate specific funds towards activities and objectives addressing gender inequality in health: • This requires explicitly allocating and costing all activities and not simply higher-level objectives. ✓ Hire or allocate dedicated staff members to work on gender equality and women's health - with an appropriate staff time allowanceto implement and monitor activities. Are male and female staff members entitled to equal benefits? ✓ Ensure that the implementation of activities does not reinforce or uphold existing inequalities among different groups of men and womenthrough unequal incentives or benefits paid. Have women and men – from communities and partner organizations – been consulted to identify planned costs? ✓ Include budget allocations for stakeholder consultation and involvement. This includes local non-governmental organizations as well aswomen and men and boys and girls: • This could include financial support to compensate for staff time, transport costs, child care, etc. ✓ Apply explicit strategies to mobilize resources for gender and health activities.
Designing Programmes and Policies: Team Composition
Does the team have both male and female team members at all decision-making levels? ✓ Make sex parity an explicit recruitment criterion. ✓ Encourage the equal and meaningful participation of men and women as project staff. ✓ Strive for a balance between women and men in decision-making positions in the project. ✓ Include experience in gender (analysis or equality) or women's health as a core competency in the team. ✓ Include experience with gender and health in the terms of reference for consultants, project staff and other contractors. ✓ Map skills, knowledge and experience to specific activities and objectives for addressing gender inequality in health. ✓ Ensure gender and health expertise in senior positions and in implementing roles. ✓ Identify and address capacity-building needs within the team on gender analysis or raising gender and health awareness within the scopeof the project; provide training as necessary. • Training sessions should build skills and address staff beliefs and attitudes around gender towards common understandings and approaches. Does the team have an established mechanism for reporting and sharing information on gender equality or women's health activities? ✓ Establish clear lines of accountability for the gender aspects of the programme. Do team members differ in terms of pay scales or other benefits? For whom? Why? ✓ Establish equal pay rates between women and men performing the same responsibilities. ✓ Ensure that the incentives provided to staff are equal for men and women. ✓ Ensure that the terms and conditions for staff members and contractors are not more difficult for one sex to meet than the other becauseof structural or familial constraints. • If postings are in rural or high-security areas, ensure that such constraints for men and women are addressed to facilitate equal accessto these posts.

Implementing Activities
What mechanisms are put in place to ensure that programme implementation will uphold the principles of gender equality and health equity? ✓ Develop gender-sensitive codes of conduct for working within the programme and in-field activities. Do programmatic materials or publications reinforce gender-based stereotypes? ✓ Ensure that methods or strategies for delivering programmes, including communication, do not reinforce or uphold existing stereotypesabout different groups of men and women. ✓ Ensure that the language of the programme does not exclude or privilege one sex over the other. Are programme delivery sites in places that both women and men can access? ✓ Consider constraints women or men may face in accessing selected sites of programme delivery. Choose sites that are accessibleto all – even if this means multiple programme delivery sites. Have women and men participated equally in the implementation stage – both as beneficiaries and as programme staff members? ✓ Establish a two-way system of information sharing about the programme, outcomes and impact: from you to the community andfrom the community to you. • Develop community-based strategies for sharing information about the programme, its progress and outcomes. • Include community members (men and women) and other local stakeholders/partners in analyzing data and interpreting results asfeasible and relevant. • Do not limit communication to national or international decision-makers, the academic community or written mass media. • Create mechanisms for stakeholder participation throughout the implementation of the policy or programme.
Monitoring and Evaluation
Have process and outcome indicators been included in monitoring and evaluation frameworks and activities? ✓ When selecting or creating indicators, ensure that they are disaggregated by sex and age (as a minimum and where appropriate). ✓ Ensure that the health status indicators used in both monitoring and evaluation and situation analysis development include morbidity andmortality trends, disaggregated by sex and age at the very minimum. What are the sources of information for monitoring and evaluation? ✓ Rely on a mix of indicators from various sources to analyze the social, economic, political and cultural influences on health. Does the programme monitor progress on gender equality and health equity? ✓ Ensure that measures are included and analyzed on empowerment (of women and of the community). ✓ Use progressive measures of gender equality and health equity as evaluation criteria. ✓ Include both process and outcome indicators for gender mainstreaming. ✓ Socioeconomic measures should include both the productive and reproductive roles of women. ✓ Examine the differential impact of the programme or policy outcomes on both women and men – of different ages and across othersocioeconomic and sociocultural stratifiers as feasible. ✓ Use the information collected from monitoring and evaluation activities to inform amendments, corrective action or subsequent cycles ofprogrammes or policies. Have women and men participated equally in the monitoring and evaluation stages – both as beneficiaries and as programme staff members? ✓ Include community members (men and women) and other local stakeholders in designing the monitoring and evaluation strategy and activities

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