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A LITERATURE REVIEW ON DETERMINANTS OF GENDER SENSITIVITY WITHIN THE AFGHANISTAN HEALTH SYSTEM

This publication was prepared by Laili Irani, Sara Pappa, Rahila Juya, Meghan Bishop, and Karen Hardee of the Health Policy Project.

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Contents

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EXECUTIVE SUMMARY

Introduction

International agencies such as the United Nations (UN) and World Health Organization (WHO) as well as governments recognize the need to address gender-sensitive norms that affect access to and use of a country's healthcare system. Several international agreements and health policies have called for gender mainstreaming within healthcare systems. These agreements and policies state that a gender-sensitive health system should ensure that men and women have equal access to health services, and that healthcare providers are aware of gender differences and pay special attention to gender norms when making clinical decisions.

There is limited evidence and guidance on how gender mainstreaming is translated at the facility level. This literature review identifies the determinants and characteristics of a gender-sensitive health facility, with special attention to the documentation of tools and checklists that measure gender integration within a health facility. The purpose of this review is to inform the Afghanistan Ministry of Public Health (MOPH) of existing best practices and successful gender mainstreaming activities being conducted in Afghanistan and abroad. It also highlights existing tools and checklists that measure the integration of gender within a health facility so they can be adapted to create a tool for monitoring gender integration in Afghanistan's public health facilities.

Methodology

This literature review was conducted in three stages between October 2012 and May 2013. First, a search was conducted to retrieve peer-reviewed articles that describe gender barriers to accessing and using healthcare and interventions that addressed any of these barriers. Second, relevant documents from the MOPH were reviewed to learn about interventions that had been conducted to integrate gender into Afghan health services. Third, the peer-reviewed and gray literature was searched for tools used to measure the gender sensitivity of a health facility.

Findings

The findings have been divided into three categories: overall evidence, with a focus on developing countries; a summary of specific evidence from Afghanistan; and an overview of existing tools that measure gender sensitivity within healthcare systems.

Gender sensitivity within health systems

Limited evidence exists in the literature describing the gender sensitivity of health systems. This evidence, from data gathered worldwide, shows that gender-sensitive health systems are far more effective at serving women than healthcare systems that are not gender sensitive. At the facility level, gender sensitivity ensures that both male and female healthcare providers are sensitive to the local gender norms, female healthcare providers are available to examine women in a society where women do not/cannot see male healthcare providers, female patients receive respectful treatment, and the facility is appropriately structured and adequately equipped. Health service providers are introduced to the importance of gender sensitivity within healthcare settings during their medical training and through continued medical education. The contribution of community health workers to gender sensitivity should not be underestimated. They can be the lifeline to providing basic and sometimes urgent care in circumstances where women's movement is restricted or there is a shortage of health workers.

Gender mainstreaming within the Afghanistan health system

The MOPH has begun taking concrete steps to improve the mainstreaming of gender sensitivity. Community midwifery education and community nursing education programs are now in place. Adapted from a program in Pakistan, the Lady Health Worker Program, a network of community health workers, has expanded across Afghanistan. The Gender Directorate of the MOPH has conducted gender-awareness and gender-based-violence workshops for healthcare providers and postgraduate medical students.

Tools that measure gender sensitivity within healthcare systems

Afghanistan does not have a tool to measure whether a healthcare facility conforms to the prevalent gender norms and is providing equitable management to men and women. This literature review was conducted to determine if such a tool exists elsewhere. The review identified examples of and guidelines for making a health system more gender sensitive by addressing various aspects of a health facility, such as the presence of gender-sensitive policies, equitable distribution of health personnel, collection of sex-disaggregated data, and factors affecting access to healthcare. This evidence can guide the development of a tool to measure the gender sensitivity of a health facility in Afghanistan.

Discussion

Despite the efforts of the MOPH to mainstream gender sensitivity in the delivery of health services, much remains to be done to analyze whether a current health facility is gender sensitive and determine what steps need to be taken to make a facility more gender integrated. The current literature provides examples of indicators that can be adapted to the local setting. This will provide the ministry with a standardized tool to monitor the progress of all facilities over time and compare this progress across facilities. Continued efforts are needed to address gender mainstreaming and thus improve the quality of healthcare.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
CHW	community health worker
FP	family planning
GBV	gender-based violence
HIV	human immunodeficiency virus
HPP	Health Policy Project
HQI	harmonized quality improvement
HSSP	Health Services Support Project
LHW	Lady Health Worker
LHWP	Lady Health Worker Program
MMR	maternal mortality rate
MOPH	Ministry of Public Health (Afghanistan)
NGO	nongovernmental organization
QA	quality assurance
RH	reproductive health
SBA	skilled birth attendant
STI	sexually transmitted infection
UN	United Nations
UNDP	United Nations Development Programme
USAID	U.S. Agency for International Development
WHO	World Health Organization

INTRODUCTION

A gender-sensitive health system ensures that men and women have equal access to health services and, as a result, equal opportunities for a better quality of life. In addition, gender sensitivity in a health system implies that service providers are aware of the specific healthcare needs of men and women, recognize the impact of those specific needs on the presentation of health complaints and health outcomes, and incorporate those needs into their decisions and actions (H. Celik, et al., 2008; H. Celik, Lagro-Janssen, Klinge, van der Weijden, and Widdershoven, 2009; H. Celik, et al., 2011). A health system that is truly gender sensitive acknowledges that the social roles and positions of men and women determine their health-seeking behavior and their specific needs, rather than differences that are inherently biological (H. Celik, et al., 2011; Gijsbers van Wijk, van Vliet, and Kolk, 1996).

The focus on gender sensitivity and "gender mainstreaming" was initially spurred by several international agreements on population and development and women (H. Celik, Lagro-Janssen, Klinge, van der Weijden, and Widdershoven, 2009; H. Celik, et al., 2011). The Program of Action of the International Conference on Population and Development in Cairo in 1994 and the Beijing Platform for Action in 1995 argue for the integration of gender analysis into all health and development activities (Vlassoff and Garcia Moreno, 2002). Furthermore, since these agreements were made, the concept of gender mainstreaming has been adopted and promoted by a number of international organizations including the United Nations (UN), the European Union, and the World Health Organization (WHO) (Payne, 2011; WHO, 2009).

Despite notable international agreements and commitments, and the establishment of gender-sensitive health policies at the country level, many studies regard existing policies as either inadequate or failing to be implemented at the local level (Lin, 2000; Payne, 2011; T. K. Ravindran and Kelkar-Khambete, 2008; Theobald, Tolhurst, Elsey, and Standing, 2005). Yet little has been done to address gaps in the implementation of policies at the local level (T. K. Ravindran and Kelkar-Khambete, 2008). Identification of gender gaps at the policy level should be seen as an impetus by various stakeholders, such as policymakers, governments, civil society, and donors, to address these gaps and use them to inform intervention design and program implementation.

This literature review aims to identify determinants of gender sensitivity within the Afghanistan healthcare system and document examples of best practices and successful programs from surrounding regions and countries. Furthermore, it documents the steps that Afghanistan's Ministry of Public Health (MOPH) has taken to integrate gender into its many activities. This review further highlights existing tools and checklists that are used worldwide to measure gender integration in various aspects of healthcare systems, with the ultimate goal of guiding future gender integration activities in the Afghanistan healthcare system.

METHODOLOGY

This literature review was conducted between October 2012 and May 2013 by the USAID-funded Health Policy Project (HPP) to guide the gender-integration activities of the Afghanistan MOPH. The peer-reviewed literature was searched using PubMed and Google Scholar to identify gender barriers to healthcare and interventions that addressed gender inequity in Afghanistan. The search was expanded to include countries in the adjoining Middle East, North Africa, and Asia regions due to limited literature on Afghanistan. In addition to peer-reviewed journal articles, several pertinent MOPH documents were reviewed and institutional knowledge was sought from MOPH Gender Directorate staff to better understand the steps that have been taken to address gender barriers and integrate gender sensitivity into health facilities. Finally, peer-reviewed journals and the gray literature were searched for tools and

checklists that have been used and tested in other environments to measure the gender sensitivity of a healthcare facility.

FINDINGS

The findings are divided into three sections. The first section highlights the factors that characterize a gender-sensitive health system and is based on evidence and best practices in the Middle East, North Africa, and Asia regions, excluding Afghanistan. The second section reveals gender-related barriers in the allocation of human resources and the infrastructure of facilities that are pertinent within the context of Afghanistan. Furthermore, this section highlights the many interventions that have been carried out in Afghanistan to address gender barriers within the healthcare system. The third section is an overview of the tools identified in the literature that have been used to measure gender sensitivity within healthcare systems.

Identifying and Addressing Gender Sensitivity within Various National Health Systems

A number of factors influence and determine the level of gender sensitivity in health systems and among healthcare providers. Gender-sensitive healthcare ensures that both male and female health professionals are aware of existing gender norms within the culture and incorporate this knowledge when making clinical decisions that will eventually guarantee better health outcomes (H. Celik, et al., 2011). Gender sensitivity includes factors such as ensuring the availability of female healthcare providers to examine female clients where women are not permitted to be seen by or are not comfortable with male providers, reducing service providers' apathy toward female clients, improving provider-client interactions and communication, and ensuring high-quality services and comprehensive care for women (Qureshi and Shaikh, 2007; Vlassoff and Garcia Moreno, 2002). In addition, sex-disaggregated data is heavily emphasized as a vital tool for monitoring gender sensitivity in health systems (Khoury and Weisman, 2002; Standing, 1997; Vlassoff and Garcia Moreno, 2002).

Availability of female healthcare providers

Ensuring the availability of female healthcare providers, especially in areas where women are not comfortable with or cannot be seen by a male provider, is essential to achieving gender sensitivity in healthcare programming (Qureshi and Shaikh, 2007; Vlassoff and Garcia Moreno, 2002). Female providers are considered to be more sensitive to women's health needs and a lack of female providers can be a point of contention in a woman's healthcare-seeking behavior (H. Celik, et al., 2011; Mobaraki and Soderfeldt, 2010; T. S. Ravindran, 2012; B. T. Shaikh, Haran, and Hatcher, 2008; B.T. Shaikh, Reza, Afzal, and Rabbani, 2007). A study in rural Australia found that compared to male providers, female providers' personal breastfeeding experience equipped them with better knowledge and skills, and greater confidence to assist breastfeeding women (Brodribb, Jackson, Fallon, and Hegney, 2007). Similarly, Cowan et al. (2003) found that female clinicians were more attentive to providing alcohol and drug treatment to their female clients than were male clinicians. In the same study, female clients reported a greater appreciation for female clinicians and preferred them over male clinicians. It is important to note, however, that although the gender of a healthcare provider is an integral component of ensuring gender-sensitive healthcare (Verdonk, Benschop, De Haes, and Lagro-Janssen, 2008), it is not the only guarantee (Gijsbers van Wijk, et al., 1996).

Contributions of community health workers

The use of community health workers (CHWs), in particular female CHWs, is a common strategy to address a shortage of health workers while improving access to and the quality of basic health services (Liu, et al., 2011). There are examples of successful programs using female CHWs in India, Ethiopia, and Pakistan, to name just a few (GHWA and WHO, 2008a; Gopalan, Mohanty, and Das, 2012; Liu, et al., 2011). These programs deliver vital and comprehensive health services to women, while empowering the CHWs to play an integral role in improving the country's healthcare delivery system.

Gender-sensitive medical curricula

A number of studies highlight the need to integrate gender into medical training and education (H. Celik, et al., 2009; Gijsbers van Wijk, et al., 1996; Risberg, Johansson, Westman, and Hamberg, 2008; Verdonk, et al., 2008; Verdonk, Benschop, de Haes, and Lagro-Janssen, 2009). A gender-sensitive medical curriculum is necessary to establish a gender perspective in medical education and ensure that gender awareness is heightened among future doctors. Integrating gender into medical curricula transforms norms, knowledge, and skills, and can aid the achievement of gender equity in health further down the line (H. Celik, et al., 2011). Teacher attitude is a crucial component to successful implementation of a gender-sensitive medical curriculum (T. K. Ravindran and Kelkar-Khambete, 2008; Risberg, et al., 2008). Therefore, gender-sensitization efforts geared toward medical educators are vital to creating an enabling environment. One study showed that as a result of advocacy efforts, medical educators in India and South Africa were trained on the need and strategies to sensitize the medical curriculum on gender issues (T. K. Ravindran and Kelkar-Khambete, 2008). Challenges to these efforts included institutional resistance and lack of support from key faculty and male educators to modify the curriculum. Moreover, very few faculty members in each institution were equipped with the expertise required to teach gender and women's health issues.

Training of healthcare providers

Achieving gender-sensitivity in health services involves overcoming considerable challenges. In some cases, healthcare providers admit that it is difficult to change ingrained habits and routines, while others feel overwhelmed by the complexities of gender and view attention to gender as an addition to their already heavy workloads (H. Celik, et al., 2009). In addition, many healthcare providers do not feel that efforts toward gender sensitization will pay off. They often view gender issues as being simple to address, believing that rational thinking and common sense are sufficient to address gender-related issues in health service delivery.

Therefore, in addition to the need for a gender-sensitive medical curriculum, a number of studies support gender training of healthcare providers within the workplace (Brodribb, et al., 2007; H. Celik, et al., 2009; H. Celik, et al., 2011; H. H. Celik, et al., 2008; Qureshi and Shaikh, 2007; T. K. Ravindran and Kelkar-Khambete, 2008; Vlassoff and Garcia Moreno, 2002). It is essential for healthcare providers to be sensitized to women's health issues, and while gender sensitivity can be fostered among trained professionals, a one-time training is not enough (H. Celik, et al., 2009; Qureshi and Shaikh, 2007). Incorporating gender sensitivity into performance appraisals is one way to develop and sustain an understanding and appreciation of gender differences in men's and women's healthcare-seeking behavior and the implications of these differences on their health (Vlassoff and Garcia Moreno, 2002). It also ensures that gender sensitivity is taken seriously and translated into everyday decisions and actions, such as an employee's participation in a gender training course, his or her performance in the course, use of gender-sensitive language, and the application of gender sensitivity to the employee's work.

At the facility level, gender-sensitive actions involve efforts to bring minority employees into mainstream activities within the health facility. Workplace training programs can also be valuable to gender-sensitization efforts and contribute to changing social norms among healthcare providers (H. Celik, et al., 2011). Both male and female providers should receive training on gender-sensitive topics. For example,

the Australian study on breastfeeding found that male healthcare providers in the facility felt excluded from learning more about breastfeeding or developing practical skills to assist female clients with breastfeeding (Brodribb, et al., 2007). As a result, they became distant and detached from further involvement in breastfeeding issues. Other healthcare personnel excluded the male providers because they assumed the male providers were unlikely to assist breastfeeding women. This study highlights the need to encourage gender training for both female and male providers across all types of medical practice.

Other training programs and tools have been documented worldwide. The ANEW program in Australia is an example of a gender training program aimed at professionals working in a hospital obstetric ward. This program focuses on enhancing the knowledge and skills of midwives and doctors to identify and support women dealing with psychosocial issues in pregnancy (Gunn, et al., 2006). Health Workers for Change is a WHO/World Bank/United Nations Development Programme (UNDP) training tool that has been adopted in various settings, including South Africa, Kenya, and Pakistan. It uses a series of participatory workshops conducted with healthcare providers to sensitize them to customers' needs and women's health, thus improving provider-client relationships (Fonn and Xaba, 2001; Onyango-Ouma, Laisser, et al., 2001; Onyango-Ouma, Thiongo, Odero, and Ouma, 2001; B. T. Shaikh, Rabbani, and Rahim, 2006; Vlassoff and Fonn, 2001). A study conducted in Pakistan documented the experience of using the model with male and female health workers. Through six workshops covering various themes, health workers were sensitized to gender issues and together identified solutions to improve the quality of health service delivery (B. T. Shaikh, et al., 2006).

It is also important that health providers be trained to recognize and deal with instances of gender-based violence (GBV). Health facilities are in a key position to break the silence and offer critical care to women in need (Ashford and Feldman-Jacobs, 2010). However, further training and guidance are needed to better diagnose and manage victims of domestic violence within the local context. For example, a recent study in Malaysia found that healthcare providers often received very little training on how to recognize and effectively treat victims of GBV. To effectively respond to GBV in a community, healthcare providers must be trained to assist victims and facilities should be equipped to manage these victims (Colombini, Mayhew, Ali, Shuib, and Watts, 2012).

Provider-client interaction and communication

The relationship between a healthcare provider and his or her female client is a significant determinant of the client's future healthcare-seeking behavior (T. S. Ravindran, 2012). If women experience physical and verbal abuse in health facilities when they are in labor, seeking abortion, or receiving treatment for sexually transmitted infections (STIs), they are discouraged from returning for future care. The relationship between providers and clients should be respectful, private, and non-discriminatory (Gijsbers van Wijk, et al., 1996). A number of studies emphasize the importance of the provider-client relationship and suggest that healthcare providers should focus on developing better interaction with clients through improved quality of communication, greater sensitivity, and improved problem-solving skills (Kaartinen and Diwan, 2002; T. K. Ravindran and Kelkar-Khambete, 2008; B. T. Shaikh, et al., 2008; B.T. Shaikh, et al., 2007).

Structural constraints of health facilities

Structural factors—the way health facilities are set up and operate—are also vital to ensuring gender sensitivity in services offered. These may include shortening waiting times and lengthening health facility hours, ensuring privacy for examinations, equipping health facilities with separate waiting rooms and toilets for men and women, providing separate lines for men and women to collect tuberculosis treatment, guaranteeing the availability of contraceptives during immunization days, and ensuring that labor wards are in a private location within facilities (Qureshi and Shaikh, 2007; T. K. Ravindran and Kelkar-Khambete, 2008; Vlassoff and Garcia Moreno, 2002). Hence, these structural factors should be addressed

and accounted for by hospital administrators and donor agencies, especially in societies where the structure of health facilities may prevent the population from seeking care.

Factors Determining the Gender Sensitivity of Health Systems Based on Evidence from Afghanistan

In recent years, Afghanistan has made strides in developing a policy environment that is conducive to delivering gender-equitable health services. Most important is the MOPH Gender Directorate's *National Gender Strategy 2012–2016*, which outlines four strategic directions to improve the health and nutrition status of Afghan women and men, and improve gender equity for staff working in the health sector. The strategic directions include efforts to incorporate a gender perspective and implement gender-sensitive activities in all MOPH programs; advocate for gender-sensitive MOPH administrative policies and procedures; ensure equal access to health services that are non-discriminatory and address GBV; and create gender-sensitive indicators for all health programs to guide monitoring and evaluation efforts (MOPH, 2012a, 2012b).

Gender-related barriers in human resource allocation and facility infrastructure

National health policymakers in Afghanistan recognize that there is a need to sensitize healthcare providers and health facilities on gender-related barriers to improve health service delivery. Despite this, gender barriers persist and influence the effective delivery of health services (Acerra, Iskyan, Qureshi, and Sharma, 2009; Huber, Saeedi, and Samadi, 2010; Kaartinen and Diwan, 2002; Khan and Juya, 2012; MOPH and WHO, 2009; USAID, 2010). At the service-delivery level, two studies assessing gender barriers to health service utilization in Afghanistan found that provider-client relationships and the availability of female healthcare providers are essential to healthcare utilization among Afghan women (MOPH and WHO, 2009; USAID, 2010). Female healthcare providers tend to be less available in rural areas. The Afghan women in the studies reported that they often lack 24-hour maternal health services provided by female staff, face long waiting times, and that facilities do not have separate waiting areas for men and women. This trend is echoed in other studies. A lack of empathy and providers' poor communication skills are highlighted as common reasons women do not visit health facilities (Kaartinen and Diwan, 2002), as is the shared notion that male providers are less attentive than female providers (USAID, 2010).

Interventions Addressing Gender Inequity in Afghanistan

A number of interventions that are currently underway in Afghanistan aim to achieve greater gender equity and/or sensitivity in the delivery of health services. Some of these are outlined below.

Availability of female healthcare providers

Due to Afghanistan's high maternal mortality rate (MMR) (327 maternal deaths per 100,000 live births), in the last decade, the MOPH has prioritized improvements in maternal and child health services (Afghan Public Health Institute, Ministry of Public Health (APHI/MOPH) [Afghanistan], Central Statistics Organization (CSO) [Afghanistan], ICF Macro, and World Health Organization Regional Office for the Eastern Mediterranean (WHO/EMRO) [Egypt], 2011; USAID and Johns Hopkins University, 2003). One of the key factors contributing to the high MMR is a shortage of skilled birth attendants (SBAs) at the facility level, especially in rural areas (MOPH, 2012c). To address this, the MOPH collaborated with development partners to establish community midwifery education and community nursing education programs. Between 2003 and 2012, the number of graduated midwives in Afghanistan increased from 467 to 3,001, according to the Afghan Midwifery Education and Accreditation Board report (Jhpiego, n.d.). As a result, the number of births attended by SBAs has gradually increased: a 2006 household survey showed that 19 percent of deliveries in Afghanistan were attended by SBAs; by 2010, more than one-third (34%) of deliveries were attended by SBAs (MOPH, 2012c).

Contributions of community health workers

In the context of gender-sensitive healthcare, CHWs have played a pivotal role in improving access to healthcare in Pakistan and Afghanistan. The network of CHWs in Pakistan, called the Lady Health Workers Program (LHWP), reaches out to remote, tribal communities where strict adherence to social and religious customs greatly impedes a woman's ability to seek healthcare and/or work as a healthcare provider (Garwood, 2006; GHWA and WHO, 2008). The LHWP is one of the largest CHW programs in the world, with over 90,000 Lady Health Workers (LHWs) in Pakistan alone (Garwood, 2006; Hafeez, Mohamud, Shiekh, Shah, and Jooma, 2011; Mobaraki and Soderfeldt, 2010; PRIME II and USAID, 2003). This program has been operating in Afghanistan since 2005. After completing a 15-month training course, each LHW serves 1,000 people in her designated community and extends her services to people who need them through monthly home visits. LHWs perform more than 20 tasks, covering all aspects of maternal, neonatal, and child healthcare. Health indicators in areas covered by the LHWP are significantly better than those areas not covered by the program (GHWA and WHO, 2008; Hafeez, et al., 2011). The program also demonstrates a phased scale-up process and can be implemented in both rural areas and urban slums (GHWA and WHO, 2008; Hafeez, et al., 2011).

The LHWP is a success story in that it has essentially broken the cycle of poor healthcare-seeking behavior among Pakistani, and now Afghan, women (Garwood, 2006; Hafeez, et al., 2011). By training and managing female CHWs, the program compensates for gender inequalities and is therefore a "gender-accommodating" approach to gender-sensitive healthcare (Feldman-Jacobs, Yeakey, and Avni, 2011). In countries such as Afghanistan, where firmly entrenched societal norms restrict women's access to health services, gender-accommodating interventions are often a necessary first step in reducing gender barriers to effective health service delivery.

Other community-based healthcare approaches include Family Health Action Groups that increase people's awareness of health programs and healthy behaviors. They also work to increase women's access to health facilities and services.

Gender-sensitive medical curricula

In 2006, 2009, and 2010, the Gender Directorate conducted one-day gender-awareness workshops with Kabul Medical University's postgraduate students that exposed the new cadre of doctors to the need for gender sensitivity. The Gender Directorate also plans to work with medical universities and training programs to advocate for and design trainings to integrate gender sensitivity into pre-service education curricula.

Training of healthcare providers

The MOPH has undertaken several initiatives to improve the health status of women and children by increasing awareness of gender among policymakers; healthcare providers, administrators, and staff at private health clinics and hospitals; and community leaders at the central and provincial levels. This is accomplished through in-service trainings, workshops, and national conferences on topics such as gender mainstreaming, GBV, gender and reproductive rights, and gender in disaster management.

A gender and reproductive rights curriculum was developed by the WHO and the Gender Directorate of the MOPH. The curriculum includes modules on defining gender, the social determinants of health, reproductive rights, and evidence and policies in support of gender and reproductive rights. The WHO also coordinated with relevant partners to develop training curricula covering gender mainstreaming and gender in disaster management.

In 2010, the USAID-funded Health Services Support Project (HSSP) worked with the Gender Directorate to develop the training manual *GBV for Health Providers*. The GBV topics covered in the manual include

defining gender and related concepts, defining GBV, the life cycle of violence against women, the concept of human rights, causes of GBV, and the roles and responsibilities of healthcare providers.

HSSP also developed a gender-awareness training that focuses on defining gender, evidence of how gender sensitivity leads to improved health outcomes, equality, gender sensitivity in health communication, advantages and disadvantages of different family planning (FP) methods, women's and men's engagement in health decision-making processes, and key issues to address in counseling couples.

Annex A is a list of gender-related trainings that have been conducted in collaboration with the MOPH Gender Directorate in Afghanistan, including the estimated number of sessions for each, and the estimated number of people reached through the training. The MOPH prioritizes the attendance of women at the workshops, as well as at conferences inside and outside the country.

Provider-client interaction and communication

HSSP developed quality assurance (QA) standards to assess health facilities and their providers' knowledge and application of skills in different contexts (such as use of counseling techniques with clients, provision of client-friendly services, and human resources). Gender standards were initially developed separately, but were integrated into an overall QA tool. A report by the MOPH Quality Improvement (QI) Unit and HSSP found that health providers' communication skills improved slightly with training. A revised Harmonized Quality Improvement (HQI) Package integrates gender indicators into 5 of the 21 health facility assessment areas. This package will be used in selected facilities from 2013 onward and is pending implementation and expansion dependent upon funding.

Communication interventions, led by the MOPH Gender Directorate, include the development and dissemination of brochures, posters, and TV spots related to gender and reproductive rights. Approximately 760 posters have been distributed to healthcare facilities: one poster for each CHW, two posters for each Basic Health Center (BHC), and five for each Comprehensive Health Center (CHC). To date, 25,000 brochures have been disseminated to CHWs, community leaders, and members of Health Shura (tribal/village level health councils) at the BHC and CHC levels.

Structural constraints of health facilities

Routine data are collected from all Basic Primary Health Services and Essential Primary Health Services facilities through the Health Management Information System and National Monitoring Checklist on whether health facilities are equipped with separate waiting rooms and toilets for men and women, and whether labor wards are in a private location. These data are disseminated among the nongovernmental organizations (NGOs) serving the facilities, other implementing partners, the MOPH provincial offices, and the funding agencies. Decisions to improve upon the structural constraints are left to individual facilities and their funding agencies. Hence, no clear evidence exists on what steps have been taken to improve the structure of health facilities.

Existing Tools that Measure Gender Sensitivity within the Health System

The evidence suggests that many gender-related barriers prevent equitable access to and use of the healthcare system, especially when considering the allocation of human resources and facility infrastructure. Efforts are being made to improve the situation in Afghanistan. However, much remains to be done. The first step to improving gender equity within the health system is to collect data on the gender sensitivity of a health facility. Afghanistan does not currently have a tool to assess whether a health facility conforms to the prevalent gender norms, so there is no means to identify challenges to ensuring gender-equitable care and address them at the policy and program levels. The 21 HQI standards developed by the QI Department of the MOPH and University Research Co. to measure the quality of a

facility were recently revised to integrate gender. However, these are not currently being rolled out to all the hospitals and need further revision. A tool must be developed that can appropriately measure the gender sensitivity of healthcare services, identify barriers, and address them on a regular basis. Guidance on the components of HQI standards and tools noted in the literature could serve as a useful starting point.

A review of the literature shows that several organizations and institutions have provided examples and guidelines on how healthcare services can be made gender sensitive while addressing the various components of the healthcare system, such as the presence of gender-sensitive policies, equitable distribution of health personnel, collection of sex-disaggregated data, and factors affecting access to healthcare (African Development Bank Group, 2009; Canadian International Development Agency [CIDA], 1997; European Commission, 2008; MEASURE Evaluation, 2013; MercyCorps and USAID/Sudan; UNDP and UNIFEM, 2009; WHO, 2011; Women's Centre for Health Matters, 2009) . Furthermore, the USAID-funded PRIME II project created a checklist to assess the gender sensitivity of family planning and reproductive health (FP/RH) services (PRIME II and USAID, 2003). A detailed description of the guidance and tools for measuring the gender sensitivity of health facilities is presented in Annex B. The evidence presented in this literature review can guide the process of developing a relevant tool for measuring gender sensitivity at health facilities in Afghanistan.

DISCUSSION

The recognized need for gender sensitivity in the health system of Afghanistan is still a relatively new concept. This is evident in the establishment of the Gender Directorate within the MOPH in 2010, and the endorsement of the *National Gender Strategy* by the Minister of Public Health in March 2012. Therefore, it is vital to implement, support, and monitor the translation of the strategic directions outlined in the strategy into actual programs and interventions. Although Afghanistan has implemented a number of interventions aimed at improving gender sensitivity related to the accessibility and delivery of healthcare, many challenges remain. For example, an analysis of community-based interventions based on the earlier version of the QA standards found that female participation in the Health Shura is very low, although women occupy one-third of the membership of the local Shura-e-Sehi (community-level health council/committee). Areas that require greater attention include counseling on FP methods and the benefits of attending a health facility for delivery, increased male involvement in FP, and improved access to health services for women, among others.

Recommendations

Based on the evidence presented above, the following recommendations can help to achieve a gender-sensitive health system:

- Health facilities should have an adequate number of female healthcare providers, especially in areas with restrictive social norms that dictate a woman’s ability to access and use health services;
- Healthcare providers, both male and female, should undergo structured gender-sensitization training so they are better equipped to respond to women’s complex health needs;
- Healthcare providers should be trained to recognize signs of abuse and treat victims of GBV;
- Gender-sensitive medical curricula should be put in place at the national level to train future healthcare providers;

- Gender-sensitive research must be conducted and gender-disaggregated data collected to better inform healthcare decisions and actions at the policy level and ensure better health service delivery for women; and
- Positive provider-client relationships should be encouraged so that women are motivated to utilize health services.

Conclusion

In summary, to sustain gender-sensitive healthcare delivery, gender should be integrated into medical curricula along with regular gender-awareness and GBV trainings for healthcare providers. Additionally, the gender sensitivity of healthcare facilities should be regularly monitored so that efforts can be made to address gender mainstreaming and ensure that the men and women of Afghanistan receive equitable care in health facilities.

ANNEX A. GENDER-RELATED TRAININGS CONDUCTED IN AFGHANISTAN IN COLLABORATION WITH THE MOPH GENDER DIRECTORATE

Implementer	Topics Covered	Number of Trainings Conducted	Number of Participants Reached	Timeline	Location
WHO	Gender mainstreaming, gender awareness, GBV	22	560	2007–present	Central, provincial
UNFPA	Gender mainstreaming, gender awareness, GBV	8	170	2007–2009	Central, provincial
Afghan Family Guidance Association (AFGA)	Gender mainstreaming, gender awareness, GBV	8	220	2007–2012	Central, provincial
Swedish Committee for Afghanistan (SCA)	Gender awareness, GBV	2		2007–2009	
Marie Stopes	Gender mainstreaming, gender awareness	2		2008	
HSSP	Gender awareness	23	514 healthcare providers (233 female, 281 male)	2007–2010	Central, provincial
HPP	Gender awareness, GBV	8	177 healthcare providers (42 female, 95 male)	2011–present	Central, Provincial

Note: This list includes an estimated number of trainings conducted and participants reached.

ANNEX B. CRITERIA AND EXAMPLES OF TOOLS FOR MEASURING GENDER SENSITIVITY

Purpose and audience for the tool	Indicators or items in a checklist mentioned

A webpage owned and managed by MEASURE Evaluation includes a menu of indicators from which the most applicable indicators for a given service-delivery environment can be selected.
 	
These data can be collected by an external team or internally for self-assessment, based on international standards adapted to the local setting (MEASURE Evaluation, 2013).
	Gender-sensitive indicators in a service-delivery environment
	• Availability of services to adolescents, single women, widows, homosexuals
	• Absence of requirements that a client has permission from her husband or mother-in-law (for married women) or parents (for adolescents) to access health services
	• Availability of condoms to both women and men
	• Percent of providers in the health facility who are female
	• Availability of a full range of services whatever the sex of the provider (e.g., male doctors provide intrauterine devices [IUDs] for female clients)
	• Percentage of physicians who are women
	• Availability of female physicians for women who prefer them
	• Non-stigmatizing attitudes toward clients (e.g., unmarried female clients with STIs, sex workers, homosexuals, postabortion-care clients, adolescents)
	• Number of referrals to other programs that empower women (e.g., related to literacy, income generation, microcredit, domestic violence)
	• Percentage of personnel (including supervisors of service programs) who receive training in gender sensitivity
	• Use of gender-sensitive protocols for counseling (e.g., non-discriminatory language, two-way communication, paying equal attention to women in counseling sessions for couples)
	• Percentage of facilities that, with the permission of the female client, encourage men to visit/attend (to accompany partner, obtain information, or use services)
	• Equal treatment (e.g., waiting time, courtesy, privacy, information given) for male and female clients
	• Avoidance of gender stereotyping in behavior change communication materials
	• Percentage of facilities that are "male-friendly"
	  • Hours are convenient for men
	  • Staff members are receptive to men being in the clinic

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	• Materials (posters, pamphlets) directed at men are visible and available • Percentage of FP service providers who are trained to detect, discuss, and refer clients to services that handle sexual and gender-based violence • Services focused on health outcomes for both the child and mother (safe motherhood services) • Description of female and male sterilization as equally desirable, when appropriate (FP only)
CIDA developed a guide to gender-sensitive indicators. The project, based in Egypt, aimed to promote women's access to essential health services so that infant, child, and maternal mortality and morbidity rates were reduced compared to the national average within five years. The population the project targeted lived in an isolated area where child and female mortality and morbidity rates were about 50 percent higher than in the rest of the country (CIDA, 1997).	**Gender-sensitive indicators** *Input indicators* • Number of health workers trained • Number of buildings used as clinics, and their condition • Instructional material and its gender makeup • Amount of medical supplies and equipment provided • Provision of mobile clinic *Process indicators* • Regular meetings of women and healthcare workers • Degree of education, counseling, and information provided; women's feedback on this information • Number of visits to mobile clinic, by sex of child; parents' views of health workers' activities and clinic • Periodic data collection on health status *Output indicators* • Number of immunizations and vaccinations • Satisfaction with services among mothers, and satisfaction with training among healthcare personnel *Outcome indicators* •Infant, child, and maternal mortality and morbidity rates reduced compared to the national average within five years • Improved status of women through better female health

Purpose and audience for the tool	Indicators or items in a checklist mentioned
The Women's Centre for Health Matters (WCHM) in Australia established the following set of principles to guide gender-sensitive health service delivery: • Women and men are not the same; factors such as age, race, disability, language, sexual orientation, education, and access to resources influence an individual's capacity to achieve optimal health and well-being. • Health service delivery should strive for equity. This does not mean that each individual should receive the same treatment and access to services, but rather that each person receives the access and treatment necessary to realize equal health outcomes between women and between women and men. • Women must be involved in decision making about policies and programs surrounding health service delivery. • Health practitioners should reflect on their own experience of gender and use this to facilitate their understanding of others; never losing sight of the fluidity of gender across time, culture, and social position. • Gender-sensitive health service delivery acknowledges the role that health practitioners can play in empowering or disempowering those in their care.	**Gender-sensitive health services are likely to have the following characteristics** • They offer women choices about the type of support they receive, and who provides it (i.e., a male or female doctor). This is of particular importance for some Culturally and Linguistically Diverse (CALD)/Aboriginal and Torres Strait Islander women, women who have suffered trauma, and/or women who may feel uncomfortable disclosing personal information to a male practitioner. • They provide women with opportunities to be actively involved in their own care and treatment, including service planning and delivery. • They offer women choice in treatment options, which may include medication, alternative therapy and/or other community-based services like peer support. • They treat women with respect, give them time to talk and listen to what they have to say, including the provision of longer consultations and more preventative health measures and counseling where needed. • Their staff members and practitioners have qualifications in women's health and/or are trained to understand the impact of gender on health and well-being. • They are culturally sensitive. • They understand that all health issues and life events may affect men and women differently across their lifespan and use a life course approach in service planning and delivery. • They take into account the social determinants of health—they acknowledge that women's personal circumstances and socioeconomic status affects health. For example, a woman's child and/or other caring responsibilities, her relationships, housing status, income, age, sexuality, ethnicity, religion, and cultural and linguistic background all have the potential to negatively affect her health and well-being. • The service adapts to the social reality of women's lives and its impact on their health. • They employ a holistic, individual approach to service delivery which recognizes that women often have a multitude of concurrent challenges that often lead into a cycle of difficulties (i.e., chronic pain may lead to unemployment, mental health issues and/or alcohol and drug abuse). • They have "women only" spaces within their buildings where it is required. • They provide family-friendly and, more specifically, child-friendly environments (i.e., affordable childcare and/or supervision). • They keep clients' personal information confidential at all times. • Services are community-based, located near where women live and/or public transport routes, or offer an outreach program in most localities.

Purpose and audience for the tool	Indicators or items in a checklist mentioned
• Men and women do have typical rates of morbidity and mortality, but these should be understood in the context of individual experiences (Women's Centre for Health Matters, 2009).	• Pathways of care are easy to navigate, information is provided in preferred formats, and assistance is provided for those who experience difficulty in understanding and/or navigating the health system. • Established and effective services are able to provide continuity of care through a stable and secure funding base.
UNDP and UNIFEM developed a guide that outlines the characteristics of gender-sensitive basic service delivery. The document states that to improve delivery of public services to women and girls and ensure the realization of their human rights, four Key Questions need to be answered: 1. To what extent do available services reach women and girls? 2. Which women/girls are being reached and which are missing out? 3. Why do women and girls miss out on basic services? • Lack of demand? • Lack of access? • Lack of supply? • Inappropriate supply? • Inefficient or ineffective delivery mechanisms? • Lack of voice and participation in decision making? • Lack of accountability? • Other factors? 4. What must be changed to make basic service delivery more gender-sensitive to meet the needs of, and ensure accessibility to, women and girls?	**Indicators that can be used to measure gender-sensitive delivery of basic services** *Service-related indicators* • Gender databases do not include direct indicators of service delivery. Most service-related indicators in these databases measure inputs or outputs of basic services in education, health, water supply, and sanitation. Education and health indicators are usually measured at the individual level and disaggregated by sex. • Indicators on violence against women and women's rights (in the OECD database and specialized assessments) relate more directly to the provision of governance services. Women's right to a life free of gender-based violence depends on governance services provided by the police and the justice system, as well as NGOs and social agencies providing preventive, protective, or counseling services. *Service-related governance indicators* • Governance indicators on the participation of women (and by inference, of men) in political decision making are included in both gender and general governance databases. • Service delivery is a significant governance issue in poor countries where governments are not yet able to provide adequate basic services to a major part of the population. • Some governance assessments provide indicators of public or experts' perceptions about service delivery. • Some provide indicators of users' actual experiences of service delivery. • Governance assessments of specific issues such as corruption, elections, and the rule of law are more closely linked to the provision of governance services and may include indicators of service delivery. • Some governance surveys (e.g., social audits of the delivery of public services in Pakistan, and the Good Urban Governance Report Card, an evaluation tool introduced by The Urban Governance Initiative (TUGI)-United Nations Development Program (UNDP) and designed to assess the level of good governance in cities) focus specifically on, and provide indicators of, service delivery.

Purpose and audience for the tool	Indicators or items in a checklist mentioned
The mapping of gender-related databases and assessments includes: 1. UN databases, which are largely organized around monitoring the implementation of the Millennium Development Goals 2. Databases maintained by the World Bank and the Organization for Economic Co-operation and Development (OECD) 3. Composite indicators of gender equality or women's empowerment developed by the UN system or by major civil society research groups Very few indicators in these databases are gender-sensitive or focus directly on the delivery or accessibility of basic services. Without new approaches to data collection, the Key Questions will remain unanswered and women and girls will continue to be deprived of basic services and their human rights (UNDP and UNIFEM, 2009).	**Examples of data sources that can be used to measure gender-sensitive delivery of basic services** *Public Expenditure Tracking Surveys (PETS) data and indicators* • Gender-sensitive design that records the sex of respondents, seeks to include women and men, and conducts gender-sensitive analysis of the results, can provide useful information on women's access to services. • The public expenditure management issues that PETS focuses on are often major supply-side obstacles to basic service delivery. Where they lead to the imposition of unofficial fees and user charges, the negative impact on access is likely to be greater for women and girls. *QSDS (Quantitative Service Delivery Surveys) data and indicators* •The focus on the frontline service-providing unit, the health facility, creates a challenge for gender analysis. • Since the unit of data collection is an institution, the data cannot be easily disaggregated by sex. • Many of the data also have a gender dimension and can provide some answers on the supply side.

Purpose and audience for the tool	Indicators or items in a checklist mentioned
MercyCorps and USAID/Sudan developed a guide for program staff on how to mainstream gender across various components of a program. The guide states that gender equality is no longer viewed as a "separate question," but becomes a concern for all programs and policies. The following fundamental principles of gender mainstreaming govern their approach: • A gender mainstreaming approach does not look at women in isolation, but looks at women and men. • A gender mainstreaming approach does not necessarily make obsolete the need for specific policies, programs, or projects on gender equality. The level of intervention (from basic "gender sensitivity" to comprehensive, targeted gender programs) will depend on the specific needs and priorities revealed by a gender-sensitive situation assessment (MercyCorps and USAID/Sudan).	**Related questions and possible strategies across various program components** *Access to healthcare services* - Related Questions • Are there differences in access to health services between women and men, girls and boys? (Consider factors such as timing of services, lack of time for women, distance, lack of money for transportation, restrictions on movement, lack of female staff in clinics, lack of privacy for examination, stigma toward men/boys and young girls seeking reproductive health assistance, etc.)? • Is the location of the facility safe for both women and men? - Possible Strategies for gender mainstreaming • Ensure opening hours do not clash with household function, water collection times, and school times. • Locate health centers where they are conveniently and safely accessible to women. • Provide childcare support to enable women and men—especially those from single-parent households—to participate in program-related meetings. • Ensure maximum protection for people visiting health facilities (e.g., lighting and paths leading to buildings; provision of transport and/or escorts where possible). • Introduce special services for men, such as "exclusive" clinic hours and husbands' day at the clinic. • Offer a range of services in the health facility so that young boys and men, who may feel that the facility is only for women, will be able to access services. • Ensure privacy for health consultations, examinations, and care. *Equal and meaningful provision of health services* - Related Questions • Does the project target women, men, or both genders? • Are reproductive and sexual health projects considered a "woman's issue"? Is there a need for a broader focus on women's health? • Does the project mainly emphasize women's health in terms of their role as mothers? - Possible Strategies for gender mainstreaming • Ensure that the project objectives explicitly address the different health needs of males and females.

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	Ensure that men are not overlooked. • Consider networking with civil society organizations to promote men's involvement in RH. • Promote the concept of men and women sharing responsibility for family and community health by training men in parenting, child health, and reproductive health. • Offer women training in areas other than RH, such as literacy, employment skills, legal rights, and social mobilization to increase their capacity to make decisions about their own health. *Health sector reform* - Related Questions • Is there a sufficient number of female and male care providers? • What are the constraints preventing more women from being trained or being appointed as healthcare providers? • What is the yearly average amount of government money spent by the government on healthcare for men versus that for women? - Possible Strategies for gender mainstreaming • Collect and analyze male/female ratio in the health profession at the following levels: top-level managers and administrators, other administrative personnel, primary care doctors, specialists, nurses • Set quotas for the number of female health workers to be trained by a project • Adjust the time, location, and logistics of training to increase female participation • Provide childcare or family support to enable women's participation. • Include a gender-awareness component in training • Ensure equal pay and opportunities for women and men in the health sector *GBV* - Related Questions • Are healthcare providers aware of relevant laws and policies governing their legal obligations to report cases of sexual violence to the police? • Are health staff members sensitized to sexual violence and aware of medical confidentiality? Do they abide by it?

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	• Do health staff members have the knowledge and equipment to record forensic evidence of rape or physical assault, in case the survivor wants to report the case? • Is GBV prevalent in the area that the health facility caters to? • What community or health services are offered to abused women and men in the area? - Possible Strategies for gender mainstreaming • Health workers must possess a clear understanding of principles such as confidentiality, rights, and the country's GBV legal framework, as they often may be the only point of contact in case of GBV. • Identify and liaise with GBV activists and advocacy groups to coordinate on GBV cases and issues. *Governance – Service delivery* - Related Questions • Do women and men have equal access to public services? • Does the institution keep sex-disaggregated data on access to livelihoods, education, housing, health and transport? • Does the institution take steps to ensure that women benefit equally from service-delivery opportunities? • Does the institution monitor the usage pattern of public services? • Are both women and men consulted regarding their specific needs in all sectors? - Possible Strategies for gender mainstreaming • Conduct a gender analysis to examine women's, men's, boys' and girls' access to and control over resources. • Consult both women and men about their needs.

Purpose and audience for the tool	Indicators or items in a checklist mentioned
Gender mainstreaming can help identify differences and disparities and change 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 (WHO, 2011).	**Institutional gender mainstreaming** This approach looks at how organizations function: policy development and governance, agenda-setting, administrative functions, and overall system-related issues. Institutional gender mainstreaming acknowledges that an institution must be equipped with mechanisms to create an enabling environment for programmatic approaches to succeed. It also ensures that organizational procedures and mechanisms do not reinforce patterns of gender inequality in staffing, functions, or governance. Institutional gender mainstreaming seeks structural changes, calling for a transformation of the public health agenda to include the participation of women 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 organizational policies 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 the reflection of gender equality dimensions in strategic agendas and policy statements as well as monitoring and evaluating organizational performance by: • Developing tools and processes to address gender in planning activities (both institutional and programmatic planning) • Establishing mechanisms of accountability on gender and health via advisory bodies, steering committees, etc. • Building staff capacity to implement the gender analysis methods required by programmatic approaches
The purpose of the gender mainstreaming checklist developed by the African Development Bank Group is to provide Bank staff members and consultants with a tool to facilitate effective analysis and identification of gender issues in the health sector, to design appropriate gender-sensitive strategies/components, allocations of resources, and definition of monitoring indicators through all stages in the cycle of a project/program (African Development Bank Group, 2009).	**Gender issues in health delivery systems** *Key questions* • How effective are health services for women and men in the client population? At the primary level? Secondary level? Tertiary level? Are primary levels being bypassed for higher levels of care? • What socioeconomic or cultural constraints do people face in accessing health services at each level? Are there differences in access between women and men? • What access to associated health services (water supply and sanitation improvement, other disease control measures) do women and men in the client population have? To what extent do women and men actively participate in planning and managing such programs? • Are changes being proposed in the provision of health services that will change gender relations? How will the changes affect women? Will the changes be acceptable to women/men?

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	• What formal health service delivery systems are available to the client population, both clinical and nonclinical? To what extent do women use them? What is the ratio of female users to male users? • Are there women health workers in the community? What are their roles? • Is recourse to traditional medicine and traditional healers common in the project/program area? Are traditional practitioners mainly male or female? Are there female traditional birth attendants? • What traditional health measures are practiced locally? Do health delivery systems make use of traditional knowledge? Would an inventory of traditional notions and practices assist the program? • What are the constraints preventing more women from being trained or appointed as healthcare providers? • What factors reduce women's access to health services? Consider factors such as the timing of services, women's lack of time due to household responsibilities, distance, lack of money for transportation, restrictions on women's movement in public, lack of female staff in clinics, lack of privacy for examination, complicated or intimidating procedures, and poor facilities. *Key strategies to address gender issues in health service delivery* • Collect sex-disaggregated data on the use of formal and informal/traditional health services and access to medicine. • If the intention is to strengthen basic health services, then focus on supporting primary healthcare units. • Locate health centers where they are conveniently accessible to women. Ensure that the hours of service delivery fit in with women's work schedule. • Improve the client population's knowledge of health matters so people can participate in improving health and associated services. • NGOs or community-based organizations may be involved in such initiatives. • Establish an emergency transport system in communities by supporting the most feasible methods of emergency transport and community commitment to transport women to hospitals. • Ensure that the executing agency places sufficient emphasis on and devotes adequate resources to training women as healthcare providers at all levels of the health delivery system. • Consider assisting the executing agency in recognizing the need and taking action to increase the number of female health service providers by recruiting women for all areas of health delivery, as CHWs, health educators, doctors, health administrators and managers, nurses, midwives, and paramedics.

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	Common gender dimensions in the health sector • Locations and timings selected for health centers and health posts: User's problems are not always taken into consideration. • Health personnel: Men are often chosen as health workers because requirements for training include basic literacy, if not a few years of basic education, and in more isolated or rural areas relatively few women are eligible. Male workers cannot always provide healthcare to women in the community, particularly in relation to childbearing, but also in societies where segregation is practiced. • Health education: health messages in facilities are often communicated to women. However, women are seldom able to transmit hygiene and health-related messages to the community with authority. As a result, there can be gender differences in awareness of health risks, and gender-based barriers to implementing adequate preventive health measures. • Biological aspects of women's health: Differences between men and women in personal autonomy and bargaining power within relationships put women at risk of physical and sexual abuse and limit their ability to negotiate sexual practices that protect against STIs, including HIV. • Cultural practices: Cultural practices observed in some areas, such as female genital mutilation and child marriage, seriously affect women's sexual and reproductive health (e.g., an increased risk of pregnancy-related complications), as well as limiting socioeconomic opportunities for girls. • Son preference: In some societies, a preference for male children often leads to a tendency to invest more family resources in the prevention and treatment of illness for sons than daughters. It may, for example, result in preferential allocation of food to boys and lead to nutritional deficiencies and poor physical development in childhood for girls, and a higher risk of complications during childbirth. • Work allocation; Women's heavy workloads and multiple responsibilities for productive and household/childcare activities mean that the opportunity costs for seeking healthcare may be high, particularly where distances, transport, or health center hours are problematic. **Gender issues in health sub-sectors** *Gender issues in primary healthcare* • Unavailability of women-to-women services in maternal and child health programs (including RH and FP) • Lack of decision-making power, particularly on sexual and reproductive health issues • Religious or cultural restrictions that prevent women from leaving their homes and from receiving healthcare from male providers • Prevalence of unfriendly environments that do not respond to the sexual and reproductive health rights and special needs of women, further impeding their access to healthcare

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	• Lack of women's input on the distribution of family resources inhibits them from meeting the cost for healthcare • Negative attitudes among providers toward clients seeking reproductive health services, providers' inadequate knowledge of how to manage and counsel clients on sexual and reproductive health (SRH) issues, unfavorable facilities for provision of high-quality SRH services, unfriendly client-provider relationships, inadequate supplies, and lack of participatory gender-sensitive approaches in planning • Lack of self-esteem and knowledge that results in women denying the existence of a health problem and/or hesitating to complain about ill-health • Inability to obtain healthcare or reach a service delivery site due to obstacles such as distance from the health center, lack of time and money, lack of childcare during visits to the health center, the hours of operation and long queues at the health center, and the possibility of losing a day's work and wages • No female health staff in attendance, and limited services (e.g., only maternal and child healthcare aimed specifically at women); RH problems are many and varied, and women may not find a facility that is equipped for screenings, or personnel who have the appropriate skills to perform screenings • High opportunity costs of follow-up health services, which prevent women from continuing and completing recommended treatment *Gender issues in reproductive health* • Cultural and socioeconomic factors may result in high incidences of maternal deaths • The percentage of births that are assisted by medically trained midwives is low • Health services to treat illnesses related to violence against women or abused women are unavailable • Societal attitudes that constrain the population from recognizing or reporting occurrences of STIs • Female poverty and lack of access to resources contribute to the low level of access to reproductive health services (e.g., the high cost of contraceptives may restrict access for women and men) • Women's lack of decision-making power within couples or among extended families • Sex-based differences in knowledge and attitudes regarding fertility decisions • Insufficient legal instruments to promote women's access to contraceptives regardless of age, marital status, and number of children (e.g., women may require the permission of males to obtain contraceptives or an abortion) • Lack of culturally appropriate information/education programs on FP that are adapted for low-literacy populations and programs which target women, men, or both sexes

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	Gender issues in health delivery systems • Ineffective health services for women and men at all levels of healthcare (primary, secondary, and tertiary) • Socioeconomic or cultural constraints affect women's and men's access to health services at each level • Lack of associated health services (water supply and sanitation improvements and other disease control measures) that may be inaccessible by the client population • Inadequate participation by women and men in the planning and managing of health service programs • Lack of recognition by the formal health delivery systems of traditional health knowledge, notions, and practices
Gender mainstreaming is reinforced in the European Pact for Gender Equality that was adopted by the European Council in March 2006. The pact encourages member states to • promote women's employment, reduce gender gaps, and asks them to consider how to make welfare systems more friendly for women's employment; • adopt measures to promote a better work-life balance for all; • reinforce governance through gender mainstreaming, notably by encouraging the member states to include a perspective of gender equality in their National Reform Programs. In light of this guidance, the European Commission has developed a manual for gender mainstreaming of employment, social inclusion, and social protection policies (European	**Sample questions to guide Member States in assessing the gender impact of their ongoing or future health and long-term care reforms** • Are there existing or planned initiatives to improve the collection of sex-disaggregated data on women's and men's access to, use of, and participation in health and long-term care? • Are available sex-disaggregated statistics analyzed with a view to identifying health inequalities between the sexes? • To what extent and how do health and long-term care systems take into account existing inequalities between women and men? • Do policies of prevention target both women and men, taking account of their specific needs? Are there specific screening programs for women and men? • Are there any specific programs for pregnant women/new mothers? • Women and men in low-income or disadvantaged groups face different challenges with regard to their access to healthcare and long-term care (women being more exposed to poverty and, on average, earning less than men).Does the policy design take these differences into account? • Are there any specific measures for ethnic minority and immigrant women? • Does atypical/part-time work influence insurance coverage? • Are there initiatives to assess if older women encounter more financial hardship than older men in making use of formal institutional or home long-term care (given women's higher exposure to poverty and average lower income compared with men)? • Can policies promote the equal participation of women and men in training and lifelong programs for staff members in the health and long-term care field?

Purpose and audience for the tool	Indicators or items in a checklist mentioned
Commission, 2008).	• Can initiatives be targeted at improving the working conditions and remuneration of staff in the health and long-term care sector to attract more people, both young women and men, to the profession? • Are there initiatives to support informal careers?
Under the USAID-funded PRIME II project, gender-sensitivity assessment tools were developed for RH and service providers and managers. The FP/RH service manager's assessment tool helps managers of primary-level FP/RH services assess, monitor, and improve the gender sensitivity of service delivery on an ongoing basis. The gender-sensitivity assessment checklist analyzes the gender sensitivity of the following components of FP/RH services: • Service provider values and comfort in providing FP/RH services to women and men • Making RH and information, education, and communication (IEC) services accessible to both male and female clients • Men's participation in reproductive health and safe motherhood • Reproductive and sexual rights • Client-provider interaction that accords respect and full decision making power to female clients regardless of marital status or age • Confidentiality and privacy as gender issues	**A program manager's checklist to assess the gender sensitivity of FP/RH services** 1. Reproductive health services are usually guided by service policies that promote making the maximum number of choices available to men and women in contraceptive method mix, regardless of age or marital status, to allow for all reproductive health intentions. The health service site offers a. a range of user-controlled methods (pills, spermicides, condoms) b. a range of provider-controlled methods (e.g., Depo Provera, voluntary surgical contraception, Norplant) c. a range of male and female methods d. methods which can be used without the spouse/partner's knowledge e. emergency contraception f. dual protection against unwanted pregnancy and STIs, including HIV g. referral to other sources when a preferred safe method is unavailable 2. All clients receive ***information*** on their sexual and reproductive ***rights*** that is understandable regardless of educational level. These rights are: a. the right to choose the number and timing of children, b. the right to live without sexual harassment or forced sexual relations c. the right to be free from violence 3. Access to ***information*** about reproductive health services is ***equitable*** for men and women (e.g., information is on display where both men and women can see it). 4. ***FP*** services are available for both ***male and female*** clients, regardless of age or marital status. Services include: a. education and counseling for informed choice b. provision of an FP method c. referral for preferred safe methods that are not available at the site

Purpose and audience for the tool	Indicators or items in a checklist mentioned
• Gender-based violence, including rape and female genital cutting • Power dynamics in negotiating condom use and other contraception • Gender issues in infertility and postabortion care • Adolescent reproductive and sexual health for young women and men • Screening and counseling around STIs and HIV/AIDS • Gender-sensitive safe motherhood services (PRIME II and USAID, 2003).	5. Service providers respect and maintain ***confidentiality*** regarding a female client's use of an FP method. 6. The service site offers other basic reproductive health ***services to both male and female clients***, regardless of age or marital status. These services are: a. screening of both male and female clients for STIs, including HIV b. treatment of both male and female clients for STIs c. clinical examination for cancer detection (breast, cervical, prostate) d. safe motherhood services addressing the needs and roles of both women and men during pre- and postpartum and delivery phases 7. ***Safe motherhood*** services are available through the clinic/hospital. These include: a. outreach with community groups to provide information on the recognition of danger signs of a complicated pregnancy or obstetric emergency. b. outreach with community groups to arrange rapid transport from the village to the health center c. safe delivery in obstetric emergencies d. birth preparedness planning with the pregnant woman, her spouse/partner, and her family (stressing recognition of danger signs, the importance of financial savings, rapid transport, and the presence of a skilled attendant at delivery) e. counseling the pregnant woman, spouse/partner, and family on nutrition during pregnancy, f. voluntary counseling on and testing (VCT) for HIV for men and women, or VCT referral 8. The health center offers postpartum services to the new mother and her spouse or partner. Services include the following: a. care throughout the recovery process, including counseling on postpartum sexual practices/customs b. counseling and methods for birth spacing, prevention of unwanted pregnancy, and protection against STIs , including HIV, for both men and women c. detection/treatment of postpartum depression d. counseling related to the mother's and child's nutrition, breastfeeding, and hygiene 9. Clients are encouraged to make their own ***reproductive choices*** regardless of their age, marital status, or sex.

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	10. The staff is able/trained to provide ***gender-sensitive counseling***. Training topics include: a. strategies to improve women's and adolescents' negotiating skills for FP/RH decision making b. counseling clients of the opposite sex 11. The clients' rights to ***privacy, confidentiality and comfort*** are respected in the delivery of FP/RH services. The provider: a. assures the client that the conversation will remain confidential b. arranges for counseling and the physical exam to occur in a private setting c. encourages the client to ask questions during an examination d. allows the client to undress and dress in private e. allows the client to dress as soon as an examination is over f. asks the client if he or she would like his or her spouse/partner to participate in future visits 12. Clinic staff offer reproductive health ***services*** to all ***clients***. This means that: a. staff members appear comfortable serving both male and female clients b. staff members show no preferential treatment of one sex over the other c. staff members demonstrate comparable treatment of clients regardless of age, marital status, or level of education 13. Clinic staff members help clients and the community deal with ***gender-based violence*** (e.g., physical aggression, rape, incest, etc.) or other practices that are harmful to physical, psychological, sexual and reproductive health. Staff members will: a. identify cases of gender-based violence during reproductive health service consultations (e.g., ante- and post-natal, HIV/AIDS/STIs, FP, etc.) b. provide appropriate treatment c. provide psychological support d. document instances of gender-based violence in the client's medical record, including details of findings of the physical exam, consistent with local policy e. assure strict confidentiality and privacy with regard to client-provider discussions and documentation f. prescribe emergency contraception, when needed

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	g. screen for HIV and other STIs h. refer women who are at risk for gender-based violence to community-based assistance programs i. organize awareness-raising activities in the community that promote/advocate for the elimination of sexual or other types of gender-based violence j. advise a woman at risk of gender-based violence about actions she can take to increase her protection and safety 14. Clients receive information from the service provider and through IEC materials. Topics include: a. existing ***laws*** that protect against sexual or other gender-based violence b. existing ***services*** for women who are at risk for gender-based violence 15. Clients and clinic staff members discuss the client's or couple's ***sexual health***. Discussions should address: a. the risks (for the client her/himself or others) of contracting an STI, including HIV, and means for preventing them b. possible feelings of guilt or embarrassment in discussing sexual matters c. possible difficulty in expressing needs or wishes d. the possibility that both men and women may occasionally experience sexual problems 16. Service providers take into account the ***unequal power*** in decision making between men and women when counseling clients. They help women and adolescents who face opposition to condoms or other contraception (from male partners or from family members) to develop safe strategies to prevent pregnancies or STIs. 17. Services related to the prevention and treatment of ***HIV*** are offered. These include: a. explaining of how HIV is transmitted b. helping the client determine his/her own individual risk with regard to specific sexual practices and preferences, including (as locally relevant): multiple partners, same-sex partners, unprotected sexual relations, "dry" sex, nonconsensual sex, sex with a partner who has (an)other partner(s), and sex with a partner(s) who is an injecting drug user c. helping female clients recognize the economic, social, and physical factors that increase women's vulnerability to HIV

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	d. helping clients explore strategies to prevent HIV e. explaining the advantages of abstinence and dual protection, including the use of the male or female condom, where feasible f. strengthening clients' negotiation and decision-making skills based on the realities of their sexual relations, and their personal needs g. helping clients make fully informed choices about their reproductive and sexual lives regardless of HIV status h. helping clients make independent choices about their reproductive and sexual lives regardless of HIV status i. exploring GBV with all women who come to the clinic for HIV counseling and testing j. offering support or services (if they exist) to women identified as victims of violence k. organizing awareness-raising activities for men, women and/or adolescents that: promote/advocate the prevention of HIV, promote/advocate for sharing in the care of persons living with AIDS l. collaborating with women's groups to create conditions that reduce women's economic and social vulnerability to HIV m. offering support to clients who suffer stigma associated with seropositivity n. offering support to women who suffer gender-based stigma associated with seropositivity 18. ***Postabortion care*** services are offered, as needed. Clients receive: a. emergency treatment (with prompt pain management) b. counseling and psychological support c. contraceptive services d. referrals to and information on other RH services (safe motherhood, HIV/ STI screening, etc.) 21. Clinic staff members offer ***postabortion care*** services. Staff members will: a. provide services in a non-judgmental way b. explore whether the pregnancy was the result of unwanted or forced sex c. refer a woman for assistance if she says the pregnancy was a result of unwanted or forced sex

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	22. Services are available to individuals or couples who suffer from ***infertility***. These include: a. simultaneous investigation of both male and female infertility b. individual or couple's counseling and education c. referral to a support group (if available) of women who experience blame and guilt due to infertility 23. ***Adolescent sexual and reproductive health*** is promoted through the education of girls and boys. Students (and their families) learn about: a. sexual development in adolescence (including values clarification and self-esteem) b. the right to say no to unwanted sex c. negotiation skills for condom and contraceptive use to protect against HIV and other STIs, and unwanted pregnancy d. male and female anatomy and physiology and reproduction e. the shared responsibility of men and women for childbearing and raising children f. GBV, gender inequities, and other practices or attitudes that are harmful to health and well-being g. the physical and emotional issues and needs related to adolescence (including the need to speak freely and the importance of interaction between the adolescent and parents/guardians) 24. Clinic staff members support ***men's positive participation*** in reproductive health with male clients and men in the community. Staff members will: a. encourage men to support their spouse's/partner's reproductive health needs (e.g., FP, nutrition, pre- and postpartum care, safe delivery) b. encourage dialogue between spouses/partners c. encourage men to share decision making related to the conception and raising of children (including education, nutrition and discipline) with spouses/partners d. explain male and female anatomy and physiology, indicating that it is an error to believe that a woman determines the sex of her child e. help men identify behaviors that have a negative impact on their own and on women's physical, reproductive, sexual, and psychological health (e.g., domestic violence, multiple partners, unprotected sexual relations, nonconsensual sex)

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	Characteristics of Gender Sensitive Services (Organizational Functioning) 25. Strategies exist to improve the gender-sensitivity of services. These are evident in: a. the involvement of women's and men's groups in the definition of what/how services are offered b. the involvement of women's and men's groups in the evaluation of services c. the existence and use of a mechanism to obtain client feedback d. efforts to involve men as partners in safe motherhood and other reproductive health services e. services whose costs are affordable to male clients f. services that are offered at convenient times for male clients g. services that are affordable to female clients h. services that are offered at convenient times for female clients i. services that are offered in places that are convenient for men j. services that are offered in places that are convenient for women k. outreach provided to those with limited access to services or to vulnerable groups (e.g., adolescents, sex workers, HIV+ persons) through mobile clinics or another approach l. integration of FP/RH and maternal and child health services (or creating links with other services) 26. Where feasible, clinic staff members respect the clients' preferences for having either a male or female service provider. 27. Equity for women in service management/decision making is promoted in various ways. Among these are: a. Asking qualified female candidates to fill vacant posts b. Training women in management and supervision c. Training women in negotiation and advocacy techniques d. Training women in interpersonal communication e. Training men in gender sensitivity and gender equity 28. There are policies that prohibit the abuse of power and sexual harassment in the workplace. Staff members, including healthcare workers and other hospital staff, know about policies that prohibit abuse of power and sexual harassment in the workplace, and are protected by them.

Purpose and audience for the tool	Indicators or items in a checklist mentioned
	29. There are policies that prohibit gender-based discrimination in hiring. Staff members ***know*** about policies that prohibit gender-based discrimination in hiring, and are ***protected*** by them. 30. There are policies that guarantee ***gender equity regarding salary***. Staff members ***know*** about policies that guarantee gender equity regarding salary and are ***protected*** by them. 31. There are policies that guarantee ***gender equity regarding promotion***. Staff members ***know*** about policies that guarantee gender equity regarding promotion, and are ***protected*** by them. 32. Staff members state that the organization or site in which they work is sensitive to the "double burden" carried by some female staff. Flexible time is allowed to female staff members who have childcare or other family responsibilities. 33. Staff members state that the organization or the site in which they work has a gender equitable work environment.

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