THEMATIC BRIEF

Gender and health

This Thematic Brief provides quick guidance on the most important issues relating to gender and health

This Brief is addressed to staff from development cooperation agencies who are involved in health-related programmes and projects.

Here they will find information on the most important gender issues at stake and how to address them, indicators that can be used to monitor whether a programme is integrating gender dimensions, examples of gender-sensitive development actions and references to further information and tools related to gender and health.

Contents

Gender issues in health 2
A roadmap for gender mainstreaming in health development programmes 10
Questions for gender analysis in Health 13
Macro level 15
Meso level 17
Micro level 19
Gender sensitive indicators for the health sector 21
Examples of gender-sensitive projects in health 22
Further References 25

Gender issues in health

Gender inequalities in health

Due to both their sexual and reproductive functions and to gender roles, women experience specific health issues and have particular needs and requirements in relation to access to and provision of healthcare (HOM, 2006). Social determinants of health are likely to affect men and women differently, resulting in inequalities in health outcomes. **Gender inequalities** have been observed in relation to **health status**, **access to healthcare** and **provision of health services**.

Inequalities in health status and needs:

- **Women have specific needs in relation to their reproductive functions.** At some points in their life, women are more at risk of being in poor health, such as during pregnancy and childbirth. In spite of global awareness on the issue of maternal mortality (Millennium Development Goal 5 focused on improving maternal health), childbirth is still one of the main causes of death for women living in developing countries. More than half a million maternal deaths occur every year and 99% happen in developing countries (WHO, 2009). Part of this problem is related to the lack or inadequacy of services to attend to women's specific needs. In 2004, it was estimated that more than 50% of births in developing countries were attended by traditional birth attendants only (those rates can reach 90% in some countries). Traditional birth attendants are often not properly trained to respond to complications during childbirth (WHO, 2004). Alcoholism and tobacco consumption are unhealthy behaviours that are harmful for both women and men, but they have different health consequences for each, particularly affecting pregnant women (PAHO, n.d.).
- **Women's health issues not related to reproduction have tended to benefit from less attention.** Cardiovascular problems have long been considered as a 'man's disease'. Women's symptoms tend to be more 'subtle' and were thus not identified early enough. However, globally cardiovascular diseases are one of the main causes of death among women over 49 years old (PAHO, n.d.).
- **Globally, mental health problems are a significant public health problem, especially among women and girls. Women's status in society, the gender division of work and vulnerability to violence are considered to be contributing factors** (WHO, 2009). Suicide is among the leading causes of death for women between 20 and 59 years worldwide, with variations between regions and countries. For instance, in low and middle-income countries of the Western Pacific Region, suicide is the second leading cause of death among women. It is the main cause of death for women living in rural China, where the number of women committing suicide outnumbers men (WHO, 2009). Globally, mental health problems (such as depression) are also a leading cause of disability for women.
- **In all regions of the world, women 15 years or older living with HIV outnumber men and HIV/AIDS has become the leading cause of death among women of reproductive age globally**. In 2006, it was estimated that 59% of people living with HIV in sub-Saharan Africa were women (PAHO, n.d.). In 2009, it was estimated that 5.4 million of young people between 15 and 24 years old were infected with HIV, with rates among young women increasing the fastest (IGWG,2011). In southern Africa, young women are infected six to ten times the rates of young men. It is now recognised that women are more vulnerable to infection (when

transmitted through heterosexual relations), due to a set of biological factors[1] and gender norms, particularly limiting women's capacity to acquire knowledge about HIV, to protect themselves and to negotiate safer sex (PAHO, n.d.; WHO, 2009).

- Due to a set of biological and social factors, women are more vulnerable to other sexually transmitted infections (STIs), such as chlamydia and trichomonas. STIs are often "asymptomatic" for longer periods in women, whereas physical symptoms are more likely to develop after a short period of infection in men (such as pain on urination in case of gonnorhea). Less obvious symptoms in women and limited access to sexual health services may be inaccessible result in late diagnostics and treatments in women. In Latin America and sub-Saharan Africa, approximately one out of four women was infected by one treatable infections, such as gonorrhoea, chlamydia, syphilis or trichomoniasis (WHO, 2009). STIs are more frequent among young people (globally, almost half of infected persons are between 15 and 24 years old) and younger women are the most at risk (WHO, 2009). STIs have more severe consequences for women, such as sterility, cancers and even death (e.g. in case of pelvic inflammation) and can provoke chronic infection (PAHO, n.d.; WHO, 2009). Globally, the death rate due to sexually transmitted infections is higher in women than in men. In low and middle income countries, lack of contraception and unsafe sex are the most important risk factors for death and disability among women of reproductive age (WHO 2009).
- Due to gender division of labour and women's and men's traditional activities, women and men are more prone to different types of health issues. For instance, women are usually in charge of washing clothes. They are thus more likely to be in contact with contaminated water and to develop schistosomiasis. Women are also traditionally in charge of food preparation at home. In developing countries, indoor air pollution provoked by the use of solid fuels for cooking affect higher rates of women and girls than men and boys. Indeed, globally, respiratory problems due to this indoor air pollution account for 641 000 of the 1.3 million women's and girls' deaths attributed to chronic obstructive pulmonary disorder (COPD) each year. The rate of women suffering from COPD caused by exposure to indoor smoke is over 50% higher than the rate of men (WHO, 2009).

Inequalities and issues in relation to healthcare access:

- Women and men do not always have the same access to healthcare. For instance, a survey conducted in East Asia countries (Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand) compared the care received by both girls and boys in case of illness. It showed that even when vaccination rates are comparable between girls and boys, girls are less likely to be taken to see a health provider or brought to a care facility in the case of illness (PAHO, n.d.). Even when healthcare is available, household responsibilities and cultural practices might prevent women from accessing it (WHO, 2009).
- Lack of access to healthcare facilities has consequences on women's entire life cycle and although women live longer than men, their last years of life are often spent in poor health. For instance, every year, more than 2.5 million older wom-

[1] These include a larger mucous membrane exposed during intercourse; a higher exposure to infectious fluids (length of time infected semen remain in the vaginal tract); changes that occur in the vaginal mucosa as a result of the reproductive cycle or age of the woman; increased friction during sexual intercourse which may lead to lesions or tearing of the vaginal mucosa.

en go blind, with consequences on their daily life. Many of the causes of this disability would be preventable if women had access to the necessary care (e.g. cataract surgery) (IGWG, 2011).

- **Women are also more affected by gaps in provision of healthcare services, especially in provision of sexual and reproductive health.** According to data available from 53 countries, one out of seven married women and one out of 13 never-married women have an unmet need for contraception, being thus at increased risk of unwanted pregnancy. Those unmet needs would be highest in sub-Saharan Africa, where one out of four married women would have an unmet need for contraception (IGWG, 2011). Recourse to unsafe abortion is one of the consequences of those unmeet needs for contraception and would cause approximately 70 000 deaths each year worlwide. Unmet needs in contraception and safe sex options are a specific burden for young people, especially for young women. In sub-Saharan Africa, one in four unsafe abortions is carried out among adolescents aged between 15 and 19 years old (WHO, 2009). Women are also receiving inadequate care in matter of contraception. For instance, women are more prone to choose sterilisation as a contraceptive method than men (a ratio of 300 women for one man), although men sterilisation is easier, cheaper and less invasive (PAHO, n.d.).

Impact of gender norms on women's health

- **Due to prevailing gender norms, women are also significantly affected by some gender specific health issues**. Social norms and traditions subject women to additional health risks. For instance, early marriage is linked to early childbearing, with negative consequences on both the mother's and child's health (IGWG, 2011). In developing countries, 38% of girls marry before the age of 18 and 14% before 14 years old (WHO, 2009). Worldwide, 10% of the births occur among girls between 15 and 19 years old, of whom the majority are already married. Research has shown that early childbearing contributes to increased rate of mortality and morbidity during pregnancy, labour, and childbirth, and to increased rates of premature births (IGWG, 2011). Complications during pregnancy and childbirth are the leading causes of death in girls aged between 15 and 19 years old living in developing countries and 15% of all maternal deaths occur among adolescent girls. In Africa, adolescent girls comprise 26% of the maternal deaths occuring every years (WHO, 2009). Early childbearing has also negative consequences on the children. Babies born to mothers under 20 years old are more likely to have low birth weight and perinatal mortality is 50% higher among babies born to mothers under 20 years old than among those born to mothers aged between 20 and 29 years old.

- **Harmful practices, such as Female Genital Mutilations (FGM) represent particular health risks for women and girls and significantly affect their sexual and health rights.** Worldwide, between 100 million and 140 million of women and girls are estimated to have been affected by the practice of FGM (IGWG, 2011) and research estimates that 92.5 million girls and women above the age of 10 years in Africa are living with the consequences of FGM. Of these people, 12.5 million are girls between 10 and 14 years of age. Although available data show small decreases in the extent of FGM in recent years, it also indicates a growing tendency for FGM to be carried out by health professionals. FGM would also be increasingly practised on girls before they reach the age of five years (WHO, 2009).

- **Gender-based violence worldwide is a public health problem, linked to a wide range of negative physical, psychological, social, and economic consequences for women and their children.** Women can experience physical, sexual and psychological violence in their homes, in conflict settings and in communities, often by people they know. Reported prevalence of intimate partner violence and sexual violence varies widely. A multi-country study carried out by the World Health Organisation reported rates varying between 71 % in rural Ethiopia and between 21 and 47 % in other countries. Globally, between 10% and 69% of women reported being physically assaulted by an intimate male partner at some point in their lives. In some countries, sexual violence by an intimate partner is reported by one woman out of four, and the first sexual experience of a large share of adolescent girls (up to a third) would have been forced (PAHO, n.d.).
- **Women and girls in situation of conflict, disasters and emergencies face additional issues in accessing health care**. Women and girls represent at least 65% of the millions of people displaced by conflict and wars. In addition to deprivation and insecurity, they face increased risks of violence, including sexual violence. In the absence of healthcare services, the physical and mental health consequences of that violence are often left unattended (such as depression or STIs) (PAHO, n.d.; WHO, 2009).

Inequality in participation in healthcare system

- **Although women are major contributors to and users of health systems, these are often unresponsive to their needs.** Women are primary caregivers in the family and thus are users of healthcare system both for themselves and for the people they care for. They are also healthcare providers in both the formal and informal health sectors. Women comprise the majority of the formal healthcare workforce globally. In many countries, women represent more than 50% of healthcare formal workers. Despite this, women are underrepresented in decision-making and management-level positions. They tend to be concentrated in lower-paid health care jobs (e.g. nurses, midwives and community health workers) and exposed to greater occupational health risks. Women also operate as the main informal providers of healthcare, providing healthcare services to their family or their community. However, although necessary to the well-being of the community, those functions remain unsupported, unrecognized and unremunerated (WHO, 2009).

Several structural and cultural factors can explain gender inequalities in health

Specific social, economic, cultural and institutional factors interact with biological factors and explain gender inequalities in health:

- **Social norms with regards to women's and men's roles place women in a situation of greater vulnerability of being in poor health.** This issue is particularly exacerbated in relation to sexuality. For instance, women are more susceptible to be infected by STIs and HIV due to gender norms limiting their power of decision and choices in matters of sexuality and sexual relations. Gender norms affect both women and men and determine the appropriate sexual behaviour they both can have. Research has shown that unequal gender relations are a key determinant in explaining the epidemic of HIV in a given country (WHO, 2009). In many contexts, men are essentially allowed multiple partners: a behaviour that increases risks of infection for their spouse. By contrast, women's lower status

and value make them particularly vulnerable to HIV, as they have little or no decision-making power in sexual relations and cannot impose the use of protection (WHO, 2009; African Development Bank, 2009). Social norms might also impede women from reporting or even recognising they might suffer STIs (African Development Bank, 2009). Young women or those not married might also be discouraged to request information about sexual matters or contraceptive methods, by fear of stigmatisation (IGWG, 2011).

- Discriminatory practices hinder women's access to and control over their health. For instance, in certain settings, women need their husband's permission before receiving health-related information or medical treatment and societal attitudes hinder women's access to those services, especially when they relate to sexual health (African Development Bank, 2009). Low levels of education among girls place them in a difficult position to access to information regarding health issues and rights and to learn how to protect them (PAHO, n.d.)
- The multiple roles that women perform affect their health and their access to healthcare. The gender-based division of labour impacts on responsibilities to take care of the sick and the elderly at home or in health facilities. Women are often in charge of providing the care that dependents cannot receive in the formal health system. Their contribution is not recognised nor valued and they do not receive sufficient social, economic, or psychological support (Asian Development Bank, n.d.). Research has shown that women's responsibilities in the household partly explain why women tend to wait longer than men before seeking medical care. Women often deny their health issues by fear of disrupting household functioning. This approach means they receive delayed treatment, or inadequate follow up, with disastrous consequences on their health (African Development Bank, 2009). For instance, women might not be willing to get to hospital if it is located far from their house and no childcare facilities are provided.
- Financial barriers can prevent women from accessing health care. Healthcare can be expensive, and its cost has specific repercussions for women, who are less likely to have paid work and to experience the health benefits linked to formal employment (HOM, 2006). When maternal healthcare services charge user fees, it has a substantial impact on the rate of women who make use of those services during pregnancy and childbirth, and can increase maternal mortality (WHO, 2009). The same is true of the high cost of contraceptives, which limits women's access to sexual and reproductive health services (African Development Bank, 2009). The costs of follow-up health services might also deter women from continuing treatment. Furthermore, as primary caregivers, women face higher health costs than men due to their greater use of healthcare for themselves and the people they care for. The negative impact of healthcare costs on women's health and their economic independence are reinforced by the deterioration of public health systems in developing countries and by privatisation, made without appropriate guarantees of universal access to affordable, quality health care services (Asian Development Bank, n.d.). Research has shown that healthcare privatisation is often associated with higher costs for basic services and that women and girls are most at risk of being excluded from treatment and care (Oxfam, 2009). Certain groups of women face additional difficulties to access healthcare due to its cost, including elderly women, young women, unwed women, etc.
- Institutional barriers, linked to the functioning of the healthcare system and services can be additional causes of gender inequalities in health. For instance, in cases of the absence of women from the healthcare workforce and the unavail-

ability of women-to-women services in local health facilities, women may be less willing to turn to formal health structures, especially if they face health issues related to reproductive health and family planning. The lack of qualified personnel might also be a deterrent for women to access healthcare (African Development Bank, 2009). The training curricula of healthcare workers and their promotion and remuneration systems can also cause women to receive inadequate treatment. For instance, a study into the causes of the high maternal mortality rate in Bangladesh found that the healthcare staff motivation system impacted directly on mothers' health. Indeed, health workers' remuneration was based on their success in reducing the number of pregnancies, not on the number of safe deliveries they performed. Health workers were thus encouraged to focus on contraception issues (HOM, 2006). Even if women have access to healthcare facilities, the lack of associated health services (such as water supply and sanitation improvements) can increase the risks for their health (African Development Bank, 2009).

- **Gender-blind health interventions can ignore and reproduce gender inequalities between women and men.** For instance, reproductive and sexual services targeting women only (due to their reproductive function) might be based upon the idea that family planning is a woman's issue, overlooking the reality that men are often the ones who take key decisions regarding family planning, with no knowledge of the consequences of their decision on women's health and well-being. Frequently, men are also the ones regulating women's access to reproductive health services, through control of women's mobility and economic resources to receive treatment (Asian Development Bank, n.d.; IGWG, 2011). Similarly, the absence of information or family planning programmes adapted to the different needs of the target population can render interventions to improve women's and girls' health useless (for example, failing to recognise the specific health needs of women and girls survivors of gender-based violence or to target the programme to populations with low literacy levels).

- **Structural gender inequalities in health sector interventions reinforce gender disparities in health status, access and use of health services** (African Development Bank, 2009). The power relations established in the relationship between the healthcare user and the healthcare provider is greater when the user is a woman and the provider a man, as there are socially pre-existing inequalities in women and men's social status and education (IGWG, 2011). Health care providers are not exempt from gender stereotypes and biases with regard to the respective roles of women and men in the household and the community. For instance, they might demonstrate negative attitudes towards users (and especially women) seeking reproductive health knowledge and advice, thus impeding their access to healthcare (African Development Bank, 2009).

- **Women's lack of decision-making power on the functioning of their healthcare system is a factor increasing the risk that they will receive inadequate attention and treatment,** especially when it comes to sexual and reproductive health issues (African Development Bank, 2009). For instance, in rural areas of Nepal, high rates of birthing issues amongst mothers and their children have been linked to women's lack of participation in the identification and implementation of health strategies (WHO, 2009).

- **Recourse to informal or traditional healthcare systems might also increase the risk of women receiving inadequate treatment**. Women might choose to refer to traditional health workers, who have not been properly trained to administrate care, due to a number of social reasons (for example, absence of women mid-

wives in local health facilities, cultural status of traditional birth attendants, etc.) and economic reasons (for example, fees to receive maternity care). Conversely, the lack of recognition of the importance of traditional health systems for women might lead to the implementation of inadequate strategies (African Development Bank, 2009).

How to address gender inequalities in health

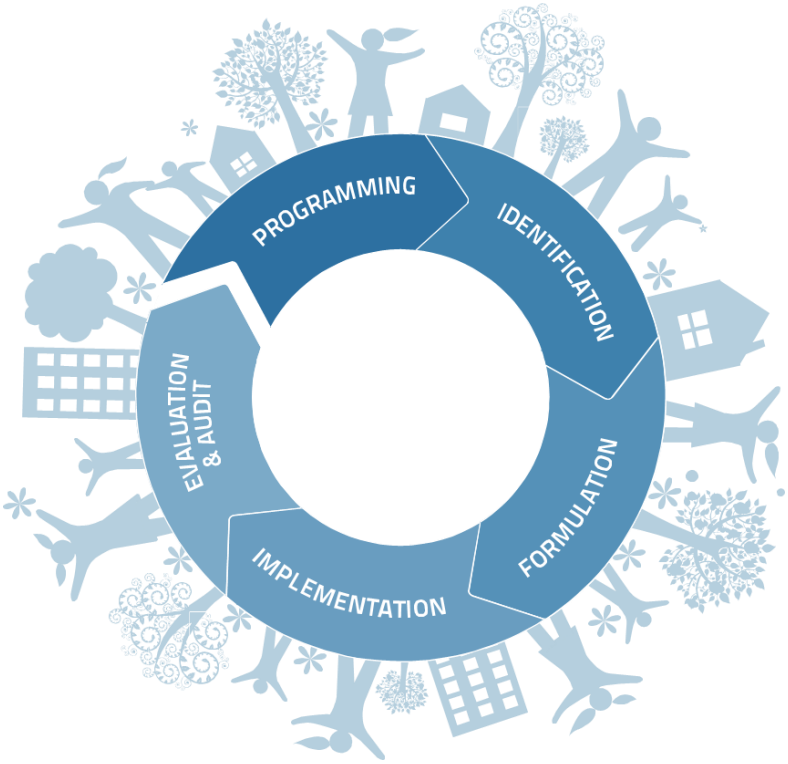
For health programmes to reach their potential, gender disparities must be addressed and effectively reduced. Health programmes need to be **gender-sensitive**, in the ways described below.

- Making use and creating demand for **sex-disaggregated data**, for example on women and men's health standards; roles in and access to the health care sector (both formal and informal) and services; their knowledge, needs and priorities, preferences with regards to health services; etc.
- **Ensuring that women's needs and priorities are voiced, understood and addressed**. For instance, women's lack of participation in the identification and implementation of health strategy can seriously hamper its success. This issue has been observed in Nepal, in relation to pregnancy and birthing problems. A community-based participatory intervention was implemented, involving women's groups in identifying the problems, their causes and formulating strategies to address them. This programme has succeeded in reducing maternal and infant mortality (WHO, 2009).
- **Avoiding reinforcing gender inequalities**, by ignoring the existing gender relations and power disparities between women and men. For instance, programmes aiming at improving women's access to health care services by developing locally-based facilities should make sure that women-to-women services will be available, with opening times adapted to women's needs and activities. Programmes addressing women's health issues should not be limited to motherhood but should strive to address inequalities in access to health care and inadequate responses of health systems to women's varied health needs.
- **Planning gender-specific actions**, to address problems relating more particularly to one or the other gender, either as separate initiatives or as part of larger programmes. For instance, programmes related to family planning and reproductive health should take into account the roles of both women and men. Men are often more reluctant to see their partner or wife attending information sessions addressing issues related to sexuality and contraception. Specific activities should thus target men and raise their awareness of the consequences of STIs, unplanned pregnancies and unsafe abortion on the health of both women and children. They should also aim at improving their understanding of sexual and reproductive rights and at promoting their responsibilities in sexual and reproductive health issues.
- **Adopting longer term "transformative" perspectives**, supporting women's participation in decision-making and changing prevalent negative attitudes on women's leadership capacities and social roles. For instance, women's roles and knowledge as providers and promoters of preventive and curative (health)care to the family and the community should be recognised and valued, by integrating women's groups (such as traditional birth attendants) in discussion regarding

the identification of health issues and the formulation of adapted strategies to solve them.

- Involving women's organisations, women's groups, unions, neighbourhood associations and cooperatives in problem identification, strategy formulation and implementation. For instance, women's organisations are likely to know which health problems women experience and which institutional, structural and cultural barriers impede their access to health care (e.g. in case of gender-based violence). They might also be a spread awareness of the programme and promote its objectives to other women.
- Engaging men, creating awareness on gender disparities and proving the benefits of gender equality in health for their families and their communities. For instance, programmes aiming to reduce the prevalence of harmful practices such as FGM or early marriages often require the buy-in of elderly men in charge of decision making in the community. Specific actions should aim at raising their awareness of the consequences of those practices on girls' and women's health and rights, and at engaging them to advocate against the practices to other men.
- When planning small sized women- or gender-equality specific projects, see them as part of larger scale programmes. For instance, projects aiming at improving women's health could be linked to policies and programmes aiming at improving environmental resources management in the community (e.g. water and sanitation). Programmes aiming at improving women and girls' health should recognise and adequately take into account the fact that their health (in term of their status, control and access to services) is affected by their economic and social status. Therefore combined efforts should be made to improve women's and girls' living conditions.
- Building actions to facilitate and improve the relation between the informal and formal health system. For instance, instead of devaluating their knowledge, traditional healthcare providers could be targeted by skills training programmes. Their participation in the development of health strategies should be sought.

A roadmap for gender mainstreaming in health development programmes



Gender equality considerations should be integrated throughout the whole cycle of development planning.

This Section proposes a roadmap for gender mainstreaming in the various phases of a programme – or project - lifecycle.

1. Analysis, programming and identification of country strategies

Programming and identification are strategic moments to promote health programmes which serve to redress gender inequalities in health status, access to healthcare, service provisions and control over healthcare system. The most essential steps are:

- To keep gender equality in the policy dialogue agenda;
- To carry out gender sensitive analysis for the diagnostic stage.

Dialogue and negotiations related to health should:

- Be grounded in the shared objectives of the global health agenda, and in the common respect of international human rights framework, including CEDAW, the International Conference on Population and Development (Cairo, 1994), the World Summit for Social Development (Copenhagen, 1995), the Beijing Platform for Action[2] (1995); the Millenium Development Goals (especially goal 3 promoting gender equality, goal 4 on the reduction of child mortality and goal 5 on im-

[2] Especially the objectives in relation to women and health (area C); violence against women (area D); women and armed conflict (area E) and the girl child (area L).

proving maternal health), the Declaration on the Elimination of Violence against Women (1993); the Declaration of Commitment on HIV/AIDS, 'Global Crisis-Global Action' (2001); the Declaration on the Right to Development (1993) (especially article 41 on women's health).

- Align with regional instruments relevant to women's health and rights, such as the African Charter on Human and Peoples' Rights (1981) and the Protocol on the Rights of Women in Africa (2003), especially the article 14 on health and reproductive rights; or the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women 'Convention of Belem do Para' (1994).
- Align with the country commitments (laws, policies, strategies) to promote gender equality and equal access to quality and inclusive healthcare.
- Analyse the different roles and take-off positions of women and men in relation to health (including status, access, needs, etc) and in the health sector (participation of women and men in the healthcare workforce, participation of women and men in decision-making positions, etc). Dialogues should also use sex-disaggregated data in diagnostic studies to assess how existing social and economic inequalities between women and men affect their health and determine their access to healthcare services. Gender country profiles or other sectoral studies should be used or commissioned.
- Systematically involve and support "gender stakeholders", from Government, donors and civil society, at all stages. This can include gender coordination groups, gender focal points in ministries (especially the health ministry and its decentralised agencies), gender experts, women's rights groups, representatives of healthcare workers' associations (such as midwives, doctors, nurses, health community workers), representatives of public and private healthcare service providers (hospitals, pharmacies, etc), and user and patient associations.
- Build on previous and current initatives to promote gender equality in the health sector or in contributing sectors, map existing needs and financing gaps, and avoid duplication of efforts. For instance, if family planning programmes have been carried out, part of the needs assessment should aim at looking if they also address issues related to sexual and reproductive rights.
- Assess whether institutions responsible for programme management and service delivery have resources and capacities to promote gender equality and plan for competence development initiatives, including at service delivery level. For instance, effort should be made to raise the awareness of healthcare providers.
- Assess if associated health services exist in the programme area and if gaps in services provision could impede the success of the programme (e.g. availability of emergency transport systems).

2. Formulation and budgeting

The results of gender analysis should be used to tailor the formulation of programmes and projects. The formulation phase is particularly important, as it affects all subsequent phases of the programme (implementation, monitoring and evaluation). To do, one must follow the steps described below.

- Design objectives and activities to address gender gaps identified in relation to health and access to healthcare and include them in programme documents, plans, logical frameworks, financing agreements and budgets.

- Include and budget for initiatives to address specific needs and constraints faced by women or men in accessing high-quality and inclusive healthcare, including long-term capacity building of women on sexual and reproductive rights and leadership and participation in decision-making training.
- Allocate resources for gender mainstreaming, capacity building and awareness raising at all levels of the healthcare system and in ways that are adapted to the needs of different target groups (E.g. programme staff, women and men beneficiaries, staff from relevant local institutions, service delivery institutions such as hospitals and health centres, midwives and community health workers young people, elderly women, indigenous women, single mothers). Capacity-building and awareness-raising activities should be planned to improve the knowledge of the target groups, to enable them to participate in the improvement of health and associated services. Resources should also be allocated for 'refresher training' over a period of time.
- Devote adequate resources to increase the number of women healthcare providers and promote the recruitment of women in all areas of the healthcare system (including community health workers, midwives, nurses, doctors, health administrators, etc.).
- Commit to pursue a strategy for continued gender mainstreaming in the programme (donor and country led processes). This may be formalized in an action plan which should then clearly assign responsibilities, resources and results to be achieved, as part of the broader programme's result chain.
- Establish formal mechanisms of consultation with gender stakeholders.
- Design and budget for participatory and gender-sensitive monitoring processess, particularly at service delivery level e.g. in assessments of women's and men's level of satisfaction with the new services introduced, including indicators to capture changes in power relations among the household and the community; change in family planning preferences; etc.
- Define performance monitoring frameworks and processes which can capture progress in gender-related objectives.
- In direct budget support initiatives, include gender indicators in financing agreements between donor and recipient countries (e.g. Percentage of government expenditure devoted to women's health needs; Implementation of programmes to combats AIDS with a gender perspective; Development of universal access to healthcare). Respect equal opportunity principles in management arrangements and establish accountability structures for gender mainstreaming at programme level. For instance, in programmes aiming to upgrade the skills of healthcare workers, it may be helpful to set a quota for the participation of women workers in training activities to ensure that women and men both have access to the the opportunities offered by the programme.

3. Implementation and monitoring

At this stage what is planned in relation to gender equality should be maintained, monitored and corrected as needed. The most important points to consider are:

- Continued coordination, dialogue and consultation on gender equality within working groups on health, with institutional stakeholders (such as the gender units of the health ministry) as well as with a broader range of actors from civil society.

- Effective monitoring of the progress of the various gender dimensions of the programme and sub-programmes, including at service delivery level, collecting opinions and experiences of women and men regarding their perception, valoration and access to new services. Confidentiality and sensitivity of the data collected as part of the monitoring process should be ensured by strict procedures.
- Integration of gender in joint sector reviews and policy dialogues (particularly at the level of the SWAP committee);
- Monitoring if resources planned for gender equality are spent, and if not, why.

4. Evaluation

- Terms of Reference of (mid-term) evaluations should require gender expertise in the evaluation team and take account of the differential impacts of a programme on women and men, identify potential negative impacts on women or men and offer recommendations and lessons learned useful to further pursue gender equality in the sector.
- Evaluators and monitors should be able to use participatory evaluation techniques and sex-disaggregated beneficiary assessments of service delivery.
- Evaluations should also build on past gender evaluations of programmes in the sector.

GENDER TOOLS FOR THE DIFFERENT AID MODALITIES

An ample selection of analytical and planning tools useful at each phase of the development cooperation cycle, according to the different aid modalities, is available in the "Aid Modalities" Section of the EU Resource Package on Gender Mainstreaming in Development Cooperation.

The following Section offers a list of gender-analysis questions that can be used in Programmes related to Health.

Questions for gender analysis in Health[3]

Gender analysis helps acquire a different perspective on the complexity of a development context, and understand how to better address other forms of social inequalities. It looks at how economic and social structures at multiple levels can reinforce, or help overcome, gender inequalities and imbalances in power relations between women and men.

[3] More on gender analysis is available in the EU Resource Package, Section "Building Blocks".

DIFFERENT LEVELS OF GENDER ANALYSIS

Macro analysis looks at national level law, policy and decision making, including trade and finance policies and national development plans. It helps identify how health programmes can contribute, or hamper, broader development strategies. It assesses whether health-related legislation or policies contribute to gender inequalities, or to their elimination. It is particularly useful when programming or identifying development cooperation strategies, programmes and projects.

For example:
Gender analysis at macro level will look at the national law and policies regulating sexual and reproductive rights. It can reveal that certain family planning services and reproductive health such as contraceptive are only available to married couples, thus difficulty the access to contraceptives and safe sex to young and unmarried people.

Meso level analysis looks at markets, institutions, services, infrastructures which serve as a link between laws/policies and people, enabling them to benefit (or be excluded) from policy effects: communication and transportation systems, health services, education, decentralized public services, credit institutions, markets and extension systems.

This is particularly useful at programme formulation, as it also assesses the extent to which gender roles relationships and cultural issues can influence the effectiveness of service delivery and other policy and programme implementation mechanisms.

For example:

A gender analysis at meso level should examine the institutional and structural barriers impeding women and men from having equal access to healthcare services. For example, lack of public transportation to healthcare facilities might be an issue affecting more women's health than men's. Women have usually less economic resources to bear the cost of private transport. If healthcare facilities are located far from their home, they might face childcare issues too.

Micro level analysis studies people: women and men as individuals, and the **socio-economic differences** between households and communities. It considers women and men's roles, activities and power relations within the household and the community, and how these influence their respective capacities to participate and benefit from development programmes. It is particularly useful at formulation, implementation and monitoring levels.

For example:

Gender analysis at micro level should look at the impact of gender norms and relations on women's and men's access to and use of healthcare services. It may enable to understand the social, economic and cultural factors influencing the implementation of a healthcare policy at local level. For instance, in Bangladesh, the policy to reduce maternal mortality focused on developing care for pregnant women in health facilities. However, for various socio-cultural reasons linked to their traditional activities, women had difficulty to reach a health facility and preferred to receive care at home. Thus, they were not benefiting from the improvements made to the formal health system.

The following section proposes guiding questions for gender analysis in health, at macro, meso and micro levels.

Macro level

Macro level. Policies and laws

- What gender equality commitments have been made by the government, for instance in the framework of the Beijing Platform for Action, CEDAW, the SDGs? Is there a law and/or a policy on gender equality in the country?
- Do national health policies reflect these commitments through awareness of inequalities between men and women, and do they outline the means to address them?
- Are there gender policies and action plans in health? Do national health programmes and sub-programmes align to and support these gender plans?
- Do policies and action plans in health focus on women's health in terms of their role as mothers only? Do they adopt a broader focus?
- Are there constitutional or legislative guarantees of the right to health, non-discrimination towards women, sexual and reproductive rights, etc.?
- Do current policies, laws and regulations address women's and men's needs in relation to healthcare separately? Do they have discriminatory provisions (e.g. requiring husband's approval to have access to contraceptives)? Do they have measures for equal opportunities and women's rights (e.g. mandatory sexual and reproductive rights education in school)?
- Is the social and health protection system inclusive of women (e.g. right to maternity care)? Are certain groups excluded (e.g. women in the informal economy)?
- Is the use of contraceptives legal in the country?
- Do informal or customary laws influence the health rights of women and girls?
- Is violence against women recognised as a public issue? Are there policies and programmes in place to tackle the issue of violence against women and its consequences on health?

Macro level. How are decisions made in national-level institutions?

- Are there decision makers (in Government, Parliament) who are ready to champion gender equality and women's empowerment in relation to health? For instance, are there (women and men) decision-makers voicing their opposition to harmful practices such as FGM or early marriage?
- Are governmental institutions responsible for women's and gender issues, involved in decision-making at national policy and planning levels?
- Are there gender thematic groups that could be involved in sector level consultations?
- How are relevant gender stakeholders, for example gender experts, women's rights groups, representatives of healthcare workers associations (such as midwives, doctors, nurses, health community workers), representatives of public

and private healthcare service providers (hospitals, pharmacies, etc.), user and patient associations)? How regularly?

- If a gender action plan in health exists, have the groups most affected by the issues participated in its development and implementation?

Macro level. Data and information

- Are there policy documents or agreed gender assessments that information and statistics on the gender gaps and priorities in health?
- Are sex-disaggregated data available on women and men's health issues, access to healthcare, participation in healthcare decision making institutions, provision of house-based care? Are sex-disaggregated data available of reproductive health needs and preferences of women and men?
- Are sex-disaggregated data available on recourse to informal health care system and medicine?
- Who is in charge of collecting this data? What reporting mechanisms are in place?
- Have similar programmes/projects been implemented in the country? Were gender-sensitive evaluations carried out? What are the good examples of women's empowerment in the study area? Which attempts to achieve gender equality were failures (e.g. because they were taken over by men or had adverse effects on women)?

Macro level. Monitoring frameworks

- How is the country faring on gender equality targets established at international level?
- Has the government developed indicators that allow for monitoring progress in health from a gender equality perspective? Which data exists to show the impacts of the programme/project for women and men?
- Has there been a gender analysis of government spending in the health sector and in the sub-sectors? Does the government have a system to track the gender sensitivity of development programmes?
- Is it possible to have a benefit incidence analysis by sex of beneficiaries? (Method of computing the distribution of public expenditure across different demographic groups, such as women and men.)
- In sector budget support modality, can payments be linked to progress made on the gender objectives and gender indicators? Is part of the budget earmarked for specific gender equality objectives (e.g. reduction of maternal mortality)?

Meso level

Meso level . Service provision

- What health related services are provided in the project area; to whom and by whom?
- Do formal health systems are available to the target population (both clinical and nonclinical)
- Is the recourse to informal health systems and medicines common in the community?
- Are there women traditional birth attendants? Do health delivery systems make use of their traditional knowledge?
- Is information on family planning available? Who is in charge of providing this information to the population (NGOs and/or public sector; religious authorities)? Does the programme target both women and men?
- Are there women-to-women services in healthcare facilities to provide women with maternal and child health; reproductive health and family planning?
- What is the cost of contraceptives? Or abortion?
- Are there access fees to care during pregnancy and childbirth?
- Are there specific services provided to women and men with HIV?
- Are health centres, hospitals and clinics accessible to women and men?
- Are there plans to improve the outreach capacity of local-level service delivery institutions to poor communities and in particular to women (E.g. mobile clinics to improve rural communities' access to healthcare)?
- If financial mechanisms or facilities are in place to facilitate access to certain healthcare services, are they accessible for women as well as for men?
- Have different communication strategies been developed for women and men? For different groups of people?
- What associated health services (e.g. water supply and sanitation improvement) do women and men in the target population have access to? To what extent do women and men actively participate in planning and managing such programmes?
- Does the timetable of services take into account women's and men's traditional roles and responsibilities?
- Are there specific health services for women survivors of gender-based violence?
- Do cuts in public expenditure affect women's and men's access to health differently?
- Are workers' organisations or NGOs able to promote the rights of women working in the healthcare sector?
- Is there a gender balance in programme and project implementation units? At which levels?

- Are there mechanisms to enable patients to complain about (the lack of) healthcare services (such as ombudsmen, patients' rights associations, complaint procedures, etc.)?

Meso level. Decision making and consultation

- If the programme envisages support to community-based organisations, are women represented and at which levels? Which women?
- Are gender equality institutions and structures at local level being involved?
- If there are mechanisms to increase access to healthcare, are there provisions to promote equitable access (E.g. guarantee of universal access to health care services)?
- Which groups have been consulted prior to the implementation of the programme (e.g. women's rights groups, religious representatives, healthcare representatives)?
- Where specific consultation mechanisms implemented to ensure that both women and men could participate in the discussions?

Meso level. Data collection and monitoring processes

- Which data can be collected throughout the programme to monitor the impacts for women and men? Who will be responsible for collecting this data, and how frequently? Will they be trained in participatory, gender-sensitive data collection techniques?
- How will consultation processes be organised at various levels? Will both women and men be involved in community level consultation processes? How are women's interests going to be represented? Is there a need to set up new fora?
- Are adequate resources allocated for participatory consultation, monitoring and sex-disaggregated beneficiary assessments of services?
- Are data collected at this level disaggregated by sex (for example, anonymised administrative data on patients and conditions)? What is the capacity of the national statistical office, and of enumerators, to collect sex disaggregated data and produce gender-sensitive statistics?

Micro level

Micro level. Gender division of tasks and labour

- What are women and men's traditional activities?
- What is the gender division of labour among the target population?
- What is the impact of women's (and girls') unpaid work on their opportunity to engage in paid work or education?
- What is the impact of women's (and girl's) unpaid work on their access to healthcare?
- Who is in charge of taking care of dependent persons in the community, including during times of illness?
- Are children involved in household work? Which different tasks are allocated to girls and boys?
- Are there difference between the tasks carried out by younger and older women?
- What are the occupational health hazards in the targeted community (e.g. level of exposure to pesticides or harmful chemicals from textile dyeing, etc)?
- Do women's and men's activities equally expose them to risks of illness?
- How women's workload impact on their risks of developing certain health issues (e.g. malnutrition, anemia and other diseases)?
- What is the prevalence of illness in the programme area? Are there gender differences in the incidence of particular diseases?

Micro level. Gender relations: Access and control over resources

- What are the general economic and demographic conditions of the household? Of the community? What are men and women's main sources of income?
- Which factors influence access to and control over resources (for example, age, sex, wealth, ethnicity, peri-urban versus rural locations, education level, networks and patronage)?
- Does unequal access to financial resources between women and men affect their ability to access healthcare (e.g. ability to pay user fees)?
- Are there gender inequalities in access to and control over health resources and benefits (e.g. health benefits linked to formal employment)?
- At the household level, who takes decisions about resources and access to healthcare?
- At the community level, how are decisions made about resources and types of health services that should be provided to the community?
- Do women and men have equal access to contraceptives?
- What type of diet is common in the target population? Do women and men, girls and boys have different levels of access to food?

- If community-based organisations exist, (e.g. traditional sociocultural organisation, religion-based etc.), are women members? Do they participate? At which level? If not, why?
- What roles do women and men play in community health care?

Micro level. Perceptions about gender equality

- What are women and men's perceptions on gender-based violence (domestic and in public spaces) and harmful traditional practices?
- What is the legal status of women? Do they have the rights to self-determination (e.g. divorce, property rights, custody of children, decision about reproductive matters?)
- Are women aware of their rights in relation to health? Are they able to voice them in the community or with service providers?
- What are women's and men's perceptions of sexual and reproductive rights?
- Are there societal taboos preventing women and men from reporting STIs?
- Do women require the permission of men to obtain contraceptives or abortion?
- Are men openly resistant to gender equality? Are there groups of men who are more supportive/resistant than others? Who can influence them?
- Are there restrictions on interactions between women and men?
- How do women's and men's perceptions of their health and illness affect their willingness and ability to seek and receive treatment?
- Are women reluctant to be cared for by a man health worker? Are men reluctant to be cared for a woman health worker?
- What is women's and men's perception of common health problems in the community?
- Among couples and families, who makes decision regarding fertility and family planning? Who makes decision about taking children to a healthcare provider for treatment? Who decides what medecine will be purchased and who will benefit from treatment?
- Are there sex-based differences in knowledge and attitudes regarding fertility decisions?
- What traditional methods do women and men use to control fertility?
- What is social and cultural attitudes toward unmarried mothers?

Gender sensitive indicators for the health sector

Gender sensitive indicators aim at 'creating awareness of the different impacts of a development intervention on men and women, taking into consideration their socio-economic and cultural differences.' (FAO, n.d. – Gender sensitive indicators for Natural Resources Management). Gender sensitive indicators reveal valuable information to identify the specific problems faced by women and men; to assess the extent of gender inequalities in access to and use of resources and services in health, and provide the basis for evidence-based policy-making processes (FAO, n.d.).

The table below provides some examples of gender sensitive indicators.

Area/Sub-sector	Indicator
Health issues	Maternal mortality ratio Mortality rate, female child (per 1,000 female children age one) Adult mortality by years and by cause Cause of death, by communicable diseases and maternal, prenatal and nutrition conditions (% of total deaths ages 15 and above) Cause of death, by non-communicable diseases (% of total deaths ages 15 and above) Adolescent fertility rate (births per 1,000 women ages 15-19) Women's share of population aged 15-49 living with HIV/AIDS Prevalence of HIV among women and men Smoking prevalence among persons aged 15 and over, by sex Prevalence of FGM/C (for relevant countries only) Malnutrition prevalence, weight for age, women and men (% of children under 5)
Access to healthcare and service	Contraceptive prevalence among women who are married or in a union, aged 15-49 Met need for contraception (% of married women ages 15-49) Access to anti-retroviral drug, by sex Antenatal care coverage, by numbers of visits Personally paid for health insurance, by sex (% age 15+) Outstanding loan for health or emergencies, by sex (% age 15+)
Provision of healthcare	Number of primary healthcare centres Number of visits to primary healthcare centres by sex Number of hospital beds as percentage of the population Proportion of births attended by skilled health professional Share of women and men aged 15-24 accessing sexual and reproductive rights and health or HIV/AIDS education inside school/outside school

Area/Sub-sector	Indicator
Gender mainstreaming in healthcare	Proportion of staff, by sex and grade having ever attended a Gender Training Module or session. Number of consultations (meetings, teleconference, documentary analysis) for gender issues. Proportion of research activities that include sex, or gender "stratifiers", as variables of analysis. Number of publications produced that highlight how women and men are differentially affected by the given condition.
Legal and institutional framework for gender sensitive healthcare	Percentage of budget allocated towards gender issues. Health expenditure, public (% of GDP) Percentage of planned versus actual costs allocated towards increasing gender skills of the department/ Ministry. Number of weeks of maternity leave Maternal leave benefits (% of wages paid in covered period) Women's organisation involved in national health strategy plan process

Source:
Beck T. (Commonwealth Secretariat) (1999), *Using Gender-Sensitive Indicators: A Reference Manual for Governments and Other Stakeholders*
CIDA (1997), *Guide to gender-sensistive indicators,* Annex 6
PAHO (n.d.), *Gender Mainstreaming in Health: A Practical Guide*
SIDA (2010), *Tool: Indicators for Measuring Results on Gender Equality*

Examples of gender-sensitive projects in health

Several development and cooperation programmes have successfully addressed the issue of gender inequalities in health. Some examples are provided in the table below, and additional documents gathering good practices are listed in the following page.

Programme/project	Challenges	Gender Strategy	Source
The Programme on Sexual Health and Human Rights (PROSAD), Burkina Faso	Burkina Faso is one of the poorest countries in the world. Several issues have been identified in relation to sexual and reproductive health, including: - The number of children per women is six and almost half women have children before they turn 18. - Early and forced marriages are frequent. - Rate of stunting and malnutrition are very high. - More than one-third of school-age boys and almost one-half of school-age girls are not in school and more than 80% of women are illiterate. - Men make most of the decisions regarding family planning. - Unsafe abortions account for 28% of deaths among young women aged between 15 to 24 years old. - 76% of women over the age of 15 have been subjected to FGM. - The rate of HIV prevalence is 1,8 %, with wide variations between the regions. - HIV rate among young women (15 to 24) is almost twice the rate among young men. -Rates of child trafficking are high.	The Programme on Sexual Health and Human Rights (PROSAD) was launched in 2004. It aims to protect and empower women, youth and children by raising their own and public awareness on human rights, including their sexual and reproductive rights, and by providing them with a range of services and mechanisms to access those rights. PROSAD focuses on the needs of three different target groups: - Youth people's needs in relation to family planning, sexual and reproductive health, and HIV infection. - Women's and girls' rights. - Children's protection from trafficking and child labour. Several activities have been implemented, including: - Capacity development activities provided to relevant ministries (e.g. health, welfare, education, women's rights, labour, etc.); their regional, provincial and local branches; NGOs; village councils; etc. Those trained professionals then share their new knowledge with people; - Behaviour change communications, relying on a range of interactive approaches, such as forum theatre presentations and animation techniques to support community self-development (GRAAP method); -School courses against FGM - 'Approche Famille' (Family approach), a method that uses the family unit as the setting for education and dialogue aimed at promoting women's rights and putting an end to FGM and violence against women. The programme showed positive results, including: - An increase in the percentage of couples using modern family planning methods; - A decrease in HIV prevalence among women between	GIZ, n.d., *Going all-out for human rights and sexual health. Aiming for results in Burkina Faso* http://health.bmz.de/good-practices/GHPC/Going_all-out_for_human_rights_and_sexual_health/index.jsp

Programme/project	Challenges	Gender Strategy	Source
		1999 and 2007 (from 6% to 2,1% in the region of intervention). - Rate of school enrolment rose for both girls and boys; - Substantial decreases in rate of prevalence of FGM in the region.	
IMAGE, South Africa	- High rate of violence against women, and especially intimate partner violence and sexual violence; - High rate of HIV; - Rigid gender norms that assign less economic power to women.	The Intervention with Microfinance for AIDS and Gender Equality (IMAGE) project addressed women's needs. The strategy combined several approaches, including: - A microfinance programme for economic empowerment; - Participatory training on understanding HIV infection, gender norms, domestic violence, and sexuality. One of the objectives was to transform trained women into agent of change, who would be able to promote wider community changes. Events inviting men to reflect on gender norms, their impact on violence and HIV rates were organised. Findings from evaluations of the programme showed that the programme was successful in decreasing by half the prevalence of intimate partner violence and sexual violence in the intervention villages. Women's who participated in the activities reported feeling more confident dealing with financial issues; having more autonomy in decision-making and positive changes in their relationships with men.	IGWG, (2010), *Synchronizing Gender Strategies. A Cooperative Model for Improving Reproductive Health and Transforming Gender Relations* http://www.prb.org/igwg_media/synchronizing-gender-strategies.pdf

Further References

About gender and health

BRIDGE (2007), *Gender and Sexuality - Overview Report*
http://www.bridge.ids.ac.uk/sites/bridge.ids.ac.uk/files/reports/CEP-Sexuality-OR.pdf

Dfid (2010), *Choices for women: planned pregnancies, safe births and healthy newborns. The UK's Framework for Results for improving reproductive, maternal and newborn health in the developing world*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67640/RMNH-framework-for-results.pdf

GIZ (2009), *Social marketing for health and family planning: Building on tradition and popular culture in Niger*
http://health.bmz.de/good-practices/GHPC/Social_marketing_for_health_and_family_planning/index.jsp

GIZ (n.d.), *Going all-out for human rights and sexual health. Aiming for results in Burkina Faso HIV/AIDS*
http://health.bmz.de/good-practices/GHPC/Going_allout_for_human_rights_and_sexual_health/index.jsp

GIZ (n.d.), *Boosting prevention: The Join-In Circuit on AIDS, Love, and Sexuality*
http://health.bmz.de/good-practices/GHPC/Join-In-Circuit/

GIZ (n.d.), *Responding to what Young People really want to know. Developing Question-Answer Booklets on Sexuality, HIV and AIDS with Young People*
http://www.stoyke.com/aids/dokumente/02/028_en_bmz_question.pdf

Humanist Committee on Human Rights - HOM (2006), *Health Rights of Women Assessment Instrument (HeRWAI)*
https://www.k4health.org/toolkits/igwg-gender/health-rights-women-assessment-instrument

ICRW (2014), *Advancing Reproductive Health and Rights Insights from Congressional Debates on the Mexico City Policy*
http://www.icrw.org/publications/advancing-reproductive-health-and-rights

ICRW (2014), *Understanding the Adolescent Family Planning Evidence Base (Review of Literature)*
http://www.icrw.org/publications/understanding-adolescent-family-planning-evidence-base-review-literature

ICRW (2014), *In Brief: How Have Fertility Declines Benefitted Women's Lives in Low- and Middle-Income Countries?*
http://www.icrw.org/publications/brief-how-have-fertility-declines-benefitted-women%E2%80%99s-lives-low-and-middle-income-countr

ICRW, STRIVE, UNDP (2013), *A Global HIV Stigma Reduction Framework Adapted and Implemented in Five Settings in India*
http://www.icrw.org/publications/global-hiv-stigma-reduction-framework-adapted-and-implemented-five-settings-india-0

ICRW (2014), *Prevention of HIV/STI Risk/Vulnerability Among Married Women Through Integration Within Primary Health Care in India*
http://www.icrw.org/publications/prevention-hivsti-riskvulnerability-among-married-women-through-integration-within-prim

IGWG (2010), *Synchronizing Gender Strategies. A Cooperative Model for Improving Reproductive Health and Transforming Gender Relations*
http://www.prb.org/igwg_media/synchronizing-gender-strategies.pdf

INTERAGENCY GENDER WORKING GROUP (IGWG) (2004), *The "So What" Report. A Look at Whether Integrating a Gender Focus Into Programs Makes a Difference to Outcomes*
http://www.prb.org/igwg_media/thesowhatreport.pdf

INTERAGENCY GENDER WORKING GROUP (IGWG) (2011), *A Summary Report of New Evidence that Gender Perspectives Improve Reproductive Health Outcomes*
http://www.prb.org/igwg_media/summary-report-gender-perspectives.pdf

Myra Betron and Lucía Fort for World Bank (2006), *Mainstreaming Gender in the Health Sector : Prevention of Gender-Based Violence and Male Involvement in Reproductive Health*
https://openknowledge.worldbank.org/handle/10986/10314

Oxfam (2009), *Blind Optimism : Challenging the myths about private health care in poor countries*
https://www.oxfam.org/sites/www.oxfam.org/files/file_attachments/bp125-blind-optimism-0902_14.pdf

Pan American Health Organization -PAHO (n.d.), *Gender Mainstreaming in Health: A Practical Guide*
https://www.k4health.org/toolkits/igwg-gender/gender-mainstreaming-health-practical-guide

UNAIDS (2014), *UNAIDS GENDER ASSESSMENT TOOL - Towards a gender-transformative HIV response*
http://www.unaids.org/sites/default/files/media_asset/JC2543_gender-assessment_en.pdf

World Health Organization (2004), *Health in the millennium development goals. Millennium development goals, targets and indicators related to health*
http://www.who.int/hdp/publications/mdg_en.pdf

World Health Organisation (2009), *Women and health: today's evidence tomorrow's agenda*
http://www.who.int/gender/women_health_report/full_report_20091104_en.pdf

On the planning cycle for gender-sensitive programmes in Health

Asian Development Bank (n.d.), *Gender Checklist: Health*
http://www.adb.org/publications/gender-checklist-health

African Development Bank (2009), *Gender Mainstreaming Checklist for the Health Sector*
http://www.afdb.org/en/documents/document/gender-mainstreaming-checklist-for-the-health-sector-14996/

National HIV programme Cambodia, WHO, UNAIDS and GIZ. (2012), *Addressing Gender Inequality in HIV: A Framework for Gender Sensistive Monitoring & Evaluation*

Pan American Health Organization (n.d.), *Gender Mainstreaming in Health: A Practical Guide*
https://www.k4health.org/toolkits/igwg-gender/gender-mainstreaming-health-practical-guide

UNICEF (2006), *Setting up a gender sensitive monitoring and evaluation system: the process*
http://www.unicef.org/lac/Setting_up_-_Book_2.pdf

WHO (2002), *Gender analysis in health- A review of selected tools*
https://extranet.who.int/iris/restricted/handle/10665/42600

On gender-sensitive indicators in Health

Beck T. (Commonwealth Secretariat) (1999), *Using Gender-Sensitive Indicators: A Reference Manual for Governments and Other Stakeholders*
http://www.aic.ca/gender/pdf/Commonwealth_GSIs.pdf

CIDA (1997), *Guide to gender-sensistive indicators,* Annex 6
http://www.acdi-cida.gc.ca/inet/images.nsf/vLUImages/Policy/$file/WID-GUID-E.pdf

PAHO (n.d.), *Gender Mainstreaming in Health: A Practical Guide*
https://www.k4health.org/toolkits/igwg-gender/gender-mainstreaming-health-practical-guide

SIDA (2010), *Tool: Indicators for Measuring Results on Gender Equality*