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Handbook for Mainstreaming

A Gender Perspective in the Health Sector

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SWEDISH INTERNATIONAL DEVELOPMENT
COOPERATION AGENCY

Department for Democracy and
Social Development
Health Division

This handbook has been developed for Sida by a team of consultants – Johanna Schalkwyk, Beth Woroniuk and Helen Thomas – in close consultation with the Health Division and the Gender Equality Unit at Sida.

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Preface

In May 1996 the Swedish parliament established equality between women and men as an overall goal for Swedish development cooperation. The Action Programme being developed by Sida focusses on the mainstreaming strategy. A gender perspective shall be mainstreamed into all policy development and dialogue and all development interventions.

The Platform for Action agreed upon in Beijing in 1995 gave a great deal of attention to the importance of mainstreaming a gender perspective in health development. A particular focus was placed on sexual and reproductive rights and health including the roles and responsibilities of men and the needs and rights of adolescents.

Over the past 10 years considerable efforts have been made to promote gender equality in the health sector development cooperation. However the approach has been ad hoc and unstructured. It has become increasingly evident that a clear understanding of the linkages between gender equality and the goals of the health sector is essential. Understanding why and how gender is important and relevant to health development is crucial for developing concrete, measureable goals and indicators for gender equality.

Our experience is that development cooperation planners, administrators and consultants need considerable assistance to identify and understand these linkages in order to carry out adequate sector analyses and to mainstream a gender perspective in the policy dialogue as well as in the planning and development of different types of health sector support.

Sida will now support the development of new strategies to improve the focus on gender equality in development cooperation policies and programmes in the health sector. This handbook was therefore developed by the Health Division in close collaboration with the Gender Equality Unit to further the development of awareness and capacity for working with a gender perspective in the health sector. A team of gender specialists, Johanna Schalkwyk, Beth Woroniuk and Helen Thomas, were responsible for producing the handbook in consultation with Sida personnel and consultants.

The handbook has been developed in accordance with Sida's new policy documents:
- Policy for Development Cooperation in the Health Sector;
- Strategy to promote Sexual and Reproductive Health and Rights;
- Position Paper on Population, Development and Cooperation.

The handbook is composed of three parts:

i) An analysis of the linkages between gender equality and health sector development which should guide sector analysis and policy development and help set concrete measureable goals for the sector.

ii) Talking points to guide policy dialogue on gender in the health sector taking the starting point in both social justice and effectiveness rationales.

iii) Guidance for mainstreaming gender in different parts of the planning cycle: appraisals, sector reviews and evaluations. This part of the handbook has not been developed as a conventional checklist. It is comprised of a series of questions which should be asked at different phases of the planning cycle as well as comments on why these questions are relevant and possible actions to be taken. It aims to develop awareness of the questions that need to be asked rather than to attempt to give answers.

It is not possible to develop generic guidelines which are competely adapted to all national and institutional contexts. While this handbook was developed specifically to stimulate further development within Sida, it is hoped that they will also prove useful to other actors, for example to national partners and NGOs.

Eva Wallstam
Head of the Health Division

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How to use this Handbook

What Is This Handbook? This handbook is a reference tool to assist staff to mainstream a gender equality perspective in the Health sector. They build on Sida's work to date and incorporate insights from development programming around the world, academic research, and international agreements (such as the Beijing Platform for Action).

It is meant to stimulate thinking and to provoke discussion. **Not all questions are relevant at all times.**

Why Has It Been Prepared? The handbook has been prepared in response to requests from staff for further assistance in applying a gender equality perspective in specific sectors and at different stages of the programme cycle.

Who Should Use It? The handbook can be used by Sida staff at headquarters and country offices. Some of Sida's partners (government ministries, implementing agencies and contractors) may also find them useful particularly as a means of better understanding Sida's approach to gender equality.

When Is It Useful? The different components of the handbook should be useful at different times. The **Overview: Gender Equality and Health** provides an introduction to key issues in the sector from a gender equality perspective. This should help to introduce key insights and arguments.

The **Talking Points** summarize arguments that support the consideration of gender issues and the inclusion of gender equality objectives in health programming. They are accompanied by **Key Citations** from international agreements that can also be used in policy dialogue.

The four sections in the table format (**sector analysis, project formulation/appraisal, annual review/monitoring, and evaluation**) can be used at the corresponding stages of the programming cycle. The general **overview** complements each of these sections.

How Might It Be Used? This handbook is designed to be a working document. Ideally, staff will consult it as they move through the programming cycle.

This handbook does not provide a set recipe to be followed at all times. It is designed to raise issues and promote active learning and thinking on the relevance of a gender perspective and the goal of gender equality to different types of programming.

Staff may find it useful to review specific sections from time to time, rather than working through the entire handbook in one sitting.

Staff may also find it useful to add specific examples of best practices, case studies or terms of reference, so that the handbook becomes increasingly useful.

1 Basic Questions

What is meant by "gender"?

The term *gender* refers to the economic, social and cultural attributes and opportunities associated with being male and female. In most societies, being a man or a woman means not only having different biological characteristics, but facing different expectations about the appearance, qualities, behaviour and work appropriate to being male or female. Relations between women and men – whether in the family, the workplace or the public sphere – also reflect understandings of the talents, characteristics and behaviour appropriate to women and men. *Gender* thus differs from sex in that it is social and cultural in nature rather than biological. Gender attributes and characteristics vary among societies and change over time.

Why is gender a development issue?

From a development perspective, gender is important not only because of *differences between women and men in what they do, but also because of inequality between women and men.* Women's personal autonomy is more limited than men's; women have less access to economic resources; and women are systematically under-represented in decision-making processes that shape their societies and their own lives. There are differences among women (and among men) in interests and needs, as factors other than gender influence social identity. Nevertheless, there are clear patterns of lesser access by women to resources, opportunities and decision-making. This pattern of inequality is a constraint on development because it limits the ability of women to develop and exercise their full capabilities, for their own benefit and that of society as a whole.

What is meant by "gender equality"?

Gender equality, or *equality between women and men,* consists of equal enjoyment by women and men of socially-valued goods, opportunities, resources and rewards. As what is valued differs among societies, a crucial aspect of equality is the *empowerment of women* to influence what is valued and to share decision-making about societal priorities and development directions. Equality will not mean that men and women become the same but that their opportunities and life chances will not depend on their sex.

Why do gender strategies focus on women?

Organisations such as Sida and many partner countries have formulated gender equality policies and strategies precisely because gender equality does not exist. Since it is *women* who are generally excluded or disadvantaged in relation to social and economic resources and decision-making, efforts to identify and redress imbalances have focused on women's situation and women's views. But it is increasingly recognised that strategies must focus on men as well as women, and on the relations between men and women, in order to achieve real change.

What is the role of men in achieving gender equality?

The achievement of equality implies changes for both men and women. More equal relationships will need to be based on a redefinition of the rights and responsibilities of women and men in all spheres, including in the family, the workplace and society at large. One of the challenges in moving forward will be to motivate more men to participate as partners in the process of defining the visions and strategies for a more gender-equal society.

Don't men have gender too?

Gender is often overlooked as an aspect of men's social identity. This stems from a tendency to consider male characteristics and attributes as the norm, with those of women being a variation on the norm. But the lives and activities of men as well as women are strongly influenced by gender. Cultural norms and practices about "masculinity" and expectations of men as leaders, husbands, sons and lovers – in other words, gender – are important in shaping the demands on men and their behaviour. In many societies, they mean that men are expected to bear arms and fight in defense of the nation or community. They shape the expectation that men will concentrate on the material needs of their families, rather than the nurturing and care relationship assigned to women. There are thus disadvantages and costs to men in patterns of gender difference.

How does a gender perspective help understand men's situation?

The recognition of men's gender identity is part of a broader perspective on equality issues that has evolved through two decades of experience. This perspective on gender equality is concerned not only with the roles, responsibilities and needs of women compared to men but with the inter-relationships between men and women. This has led to a recognition of men's specific health problems and needs and on the conditions that shape them. For example, men are often exposed to greater risks than women of morbidity and mortality related to accidents, violence, and alcohol consumption. A gender perspective also highlights the rights and responsibilities of men in relation to child health, fertility regulation and safe sexual practices.

How does a gender perspective help understand women's situation?

This Handbook focuses on the ways in which gender – the socio-economic aspects of being male or female – is relevant to health analyses and strategies Much of the discussion and most examples focus on women. This is because women bear the most direct negative consequences of inequality between women and men. These are evident in women's lower health status and in their access to and use of health services. At the same time, the visibility of women in the health care system as both clients and caregivers has led to a widespread perception that equality issues have been addressed. The Handbook thus aims to illustrate that a gender perspective is not mainly concerned with women as a target group but with analysing how gender identities shape the health conditions of women and men and their possibilities for action.

Is equal treatment of women and men a sufficient strategy for gender equality?

Equal treatment and equal opportunities for women and men is an important goal. This is often interpreted to mean equal numbers of women and men participating in a programme or initiative. However, a lesson from experience is that equal participation at this level is not always the most relevant or effective means of ensuring that an initiative supports the achievement of equality. Equality strategies are incorporating this lesson in two related ways:

> *focusing on impact rather than activities/inputs* – looking at how the overall initiative will affect women and men and gender equality, either directly or indirectly;

> *focusing on equality as an objective rather than on women as a target group* – considering how to select and design initiatives that can support equality as an objective, which may include, for example, changes in institutional practices, legislation, and planning methodologies, and include both men and women.

Mainstreaming as a strategy for gender equality

The strategy adopted by the world community at the UN Fourth World Conference on Women (1995) is *mainstreaming. The Platform for Action* emphasised two aspects of a mainstreaming strategy:

> Equitable distribution of the resources, opportunities and benefits of the mainstream development process. This requires the integration of equality concerns into the analyses and formulation of policies, programmes and projects, with the objective of ensuring that these have a positive impact on women and reduce gender disparities.

> The inclusion of the interests, needs, experiences and visions of women in the definition of development approaches, policies and programmes and in determining the overall development agenda. This requires strategies to enable women to formulate and express their views and participate in decision-making across all development issues.

A mainstreaming strategy does not preclude initiatives specifically directed toward women or toward equality between women and men. Such positive initiatives are necessary and complementary to a mainstreaming strategy.

Health strategies in a local context

Sida's development cooperation policies and strategies place special emphasis on women's health needs and access to services as women's health problems are often the most urgent. However, each country and each local context requires its own culture-specific gender analysis as a basis for the development of balanced and appropriate policies and programmes.

2 Overview: Gender Equality, Health and the Health Sector

This overview is intended as a starting point or stimulus for consideration of gender issues in relation to health and the health sector. It does not aim to be comprehensive but to suggest ways in which gender-based differences and inequalities are relevant to health status and access to health care. The implications of these factors are briefly explored in relation to broad themes in health sector programming.

1. What is meant by a gender perspective in health?

Women are visible in the health sector, but...

Women are very visible in the health care system as both caregivers and clients. Most of those working in the health care sector are women. Women have been identified as major resources for primary health care and for measures to improve the health status of families and communities. Many primary health care programmes focus on maternal and child health and family planning and are targeted to women. As a result, it is sometimes suggested that gender issues are already being dealt with in the health sector. However, consider the following:

... not as decision-makers

> Women may predominate among health care workers in the formal health care system (as nurses, midwives, community health workers, etc.) but they are under-represented at policy, management and decision-making levels. Women also provide most of the (unpaid) health care in families and communities, but are under-represented in community level decision-making processes and may also have limited influence over the allocation of household resources to health. Thus women's extensive experience and responsibilities in health care are not reflected in opportunities to shape priorities and choices.

... not as non-mothers

> Although women have been targeted in maternal and child health (MCH) and family planning programmes, this has largely focused on them in relation to children and child-bearing functions. Even with the "M" back in "MCH" – a relatively recent shift that is often mentioned as a significant advance – this focus on mother and child coincides with neglect of both the health needs of women independent of their children and neglect of men as fathers with responsibility for children and as partners in fertility regulation.

... not in research and knowledge

> Research on health issues and problems has neglected both physical and socio-economic differences between women and men. There are information gaps on gender differences in causes, contributing factors, disease course, and appropriate treatment for

health problems such as heart disease and AIDS/HIV. Women's health advocates also point to the limited knowledge about women-specific health problems, such as cervical and breast cancer, and osteoporosis.

The gender-based inequalities that exist in society also influence health and the health sector – they are evident in the health status of individuals, in social behaviours and practices that affect health and well-being, in access to and use of health care services, and in the structure of health care institutions, employment and services. **Applying a gender perspective to health policy and services requires attention not only to the different needs of women and men based on their biology, but taking account of the broader socio-economic and cultural context that shapes possibilities and actions of different groups of women and men.**

2. What are gender aspects of health and health care?

2.1 Gender and the health/ill-health of individuals –

Women have significant and specific health concerns and needs in relation to the reproductive cycle. This is reflected in services for pregnancy and childbirth, but continuing high rates of maternal mortality suggest the need to improve the availability and quality of antenatal, obstetric and post-natal services. There are other health conditions associated with reproductive biology that merit further attention, including women's greater susceptibility to iron-deficiency anaemia, and pregnancy-related exacerbation of malaria, tuberculosis and anaemia. Women are also biologically more susceptible than men to contracting sexually-transmitted diseases (STDs), with more severe consequences such as infertility and cervical cancer, particularly where treatment is delayed.

Gender influences health through...

These biological aspects to women's health are also influenced by the socio-economic and cultural context. There are various different ways in which the health risks faced by individuals are influenced by their gender – by the socio-economic and cultural aspects of being male or female. For example:

... differences in personal autonomy

> Differences between women and men in personal autonomy and bargaining power within relationships puts women at risk of physical and sexual abuse and limit their ability to negotiate sexual practices that protect against STDs including HIV/AIDS.

... cultural practices > There are a number of cultural practices observed in different areas that have negative consequences for women. Female genital mutilation, which occurs in various parts of the world, seriously affects women's sexual and reproductive health. Child marriage and early childbearing increases the risk of pregnancy-related complications as well as limiting the social and economic opportunities of girls.

... work allocation > Men and women generally do different types of work and are thus exposed to different risk factors. In the household, smoke and gases associated with indoor cooking are serious hazards for women in many countries. In agriculture the division of labour may result in greater exposure by women to toxic substances such as pesticides. In the formal sector, women tend to be clustered in particular industries, such as garment factories and electronic assembly, which are also associated with specific risk factors that are different to those related to male-dominated sectors.

... risk of poverty > Women face a higher risk of poverty than men, due to lack of access to economic resources (credit, land, inheritance, education, etc.) and lower remuneration for women's activities and occupations. Within households, poverty places a particularly heavy burden on women because of the time and energy demands of managing family consumption and welfare in the context of scarcity. Poverty and health have clear inter-relationships through impacts on nutrition, exposure to risks of unhealthy housing and unsafe water and sanitation, higher workloads, and generally on vulnerability to illness. Poverty is also a major contributor to sexual and reproductive ill-health.

... biases in food allocation > In some societies, son preference (or daughter neglect) is associated with preferential allocation of food to boys and a tendency to invest more family resources in the prevention and treatment of illnesses of sons than of daughters. For girls, nutritional deficits in childhood can result in poor physical development and a higher risk of complications during childbirth. Unequal allocation of food can also be a factor in the health of adult women, with particularly negative effects during pregnancy and lactation when women's nutritional requirements increase.

Many of the above factors are symptoms of broader problems for which full solutions cannot be found in the health sector. However, they clearly have consequences for the health sector – for the problems that present themselves and for strategies to address them. Thus, for example, tackling nutritional deficiencies among pregnant women through health

education targeted to women may have limited effect in altering gender biases within the household in the allocation of food unless health messages are targeted to men as well as women.

Gender mediates access to health services through...

2.2 Gender and access to health services –

Access to health services is also mediated by gender. For example,

...financial costs

> Families may be less willing to invest in obtaining health care for girls and women, as is suggested by some studies of the use of services for malnutrition and malaria by women and men in comparison with the incidence of these conditions by gender. The lower average earnings of women may also limit their use of health services. Where health care costs increase due to a decline in the availability or quality of public services or the imposition of user fees, the problem of inequitable access by women and girls may be exacerbated.

... opportunity costs

> Women's heavy workloads and multiple responsibilities for productive and household/childcare activities mean that the opportunity costs of seeking care may be high, particularly where services are distant, transport is problematic, or health centre hours are not structured to take account of women's schedules. Where services are perceived to be unresponsive to women's needs and concerns, or the quality of care is perceived to be low, the opportunity costs are correspondingly higher.

... social costs

> Socio-cultural constraints can include barriers to women travelling alone to health centres or being treated by male health care workers.

These are factors that need to be taken into account in structuring health care services. Issues that can be considered include the location and hours of services in relation to women's schedules, and the possibility of outreach services to reach women and girls who might otherwise have little access to care. Where user fees are introduced or increased, use of services should also be closely monitored by gender to identify whether the increased costs are decreasing access and equity in health services.

2.3 Gender and health in households and communities –

Women are major contributors to health at household level...

Under the gender division of labour prevailing in most countries, women's activities have a major impact on family health. It is generally women who have responsibility for food preparation and storage, for

fetching and storing water, for household hygiene, for care of children, for transmitting health-related values and practices to children, and for care of the ill. Women also produce many of the food and subsistence crops that are critical to family health and welfare.

... and have been targeted as health sector resources

Women have been targeted as resources for primary health care and health education because of the close link between their household and community activities and health. However, there are limits to what can be achieved if planners do not take account of the context in which the activities are undertaken. In particular,

... but there are opportunity costs

> The adoption of different health practices at the household level and participation in community activities have opportunity costs (in time, energy, material resources, and other activities) that are significant due to women's already heavy workloads. Asking that additional tasks be undertaken may result in further increasing women's workloads or cause trade-offs to be made against other activities necessary to family health and well-being – or in no action being taken at all.

... and men must also play a part

> Gender-related factors in access to household and community resources and in decision-making about these resources mean that health messages must also be targeted to men. Health and well-being at the family and community level can be supported through measures that encourage men to value and contribute to initiatives taken by women in relation to health and that encourage men to include women as partners in decision-making about the allocation of community and household resources related to health. Equally important are steps to encourage men to assume more responsibility for their children.

Such concerns are particularly important as pressures on health care budgets increase and services decrease in quantity and quality. While the numbers of health facilities and health workers may diminish, the number of those ill and in need of care do not – the costs of care are thus transferred to communities and households and generally to women. This represents another increase in the demands on women's time and energy, another increase in overall workloads with implications for their own health as well as their health-supporting activities for other family members. Where communities are called on as part of a health care strategy to take on additional responsibilities for organising and financing health care services, concerns with both equity and effectiveness underline the need to ensure that women are part of local and community decision-making.

Women's position in the health system can be supported through...

2.4 Gender and employment in the health care sector –

A large proportion of health care workers are female. This includes nurses, midwives, and community health care workers – but notably not doctors, technical specialists, and planners. Thus the structures of recognised expertise and power in the health sector reflect those in other sectors and in local communities, with men at the top and women at the lower-paid and less influential levels.

... better representation at senior levels

The issue of women's representation at policy, management and decision-making levels is related not only to equal opportunities concerns but to the ability of the health system to incorporate women's priorities and needs as both consumers of health services and as health care providers.

... and management and training strategies

For the lower-paid categories that are predominantly female, including community health workers and traditional birth attendants, investments in training can be an important means of enhancing capacity and effectiveness. In addition, the inclusion of these workers in human resource development strategies and investments in training for them can enhance their legitimacy and their status in local communities.

3. Mainstreaming gender equality in health sector programming – examples of issues to be considered

Mainstreaming gender equality includes attention...

There are two dimensions to a strategy of mainstreaming gender equality in health sector programming:

... to women's needs

> recognising the specific needs of women for health care and services that arise from both physiology and socio-cultural circumstances and seeking to address those needs through the services provided; and

... and to reducing gender disparities

> recognising the implications of inequalities in power and decision-making relationships between women and men for health status, health behaviours and the delivery of health services, and seeking to move to more equal gender relationships.

Different initiatives and areas of programming offer different opportunities for action. The examples below illustrate some possible approaches.

Questions for health policy and management:

3.1 Gender issues in health sector policy and management

Health sector reform is being pursued in many countries in response to budget pressures and the need to make more effective use of scarce resources.

Types of issues that might be considered in relation to health sector reform and health policy and management are suggested below.

... what gets resources?

> **Priorities in sectoral allocations and investments** – What are the implications of the allocations of health sector investments for availability of care in rural areas and among poorer socio-economic groups? Is there adequate provision for primary health care and prevention? And for services required to treat complications in childbirth? Such questions are particularly important because the decisions about priorities and sectoral allocations set the framework for the sector as a whole and the scope of possibilities within particular services and programmes.

... who pays?

> **Financing of health care** – In considering different financing mechanisms such as user fees, insurance, community contributions, has consideration been given to equity in the allocation of costs between different income groups and between women and men? Has the potential impact of user fees on access to health services by girls and women been considered? Or the possibility of mitigating measures such as exemptions from fees for certain social groups or certain categories of services (such as basic health care related to childbearing, contraception and STDs)?

... who delivers?

> **Role of local communities** – Where strategies rely on community mobilisation, have the specific requirements of labour and time that are expected from communities been analysed by gender? To what extent do these strategies rely on women's unpaid labour? Can modifications be made to promote a more equal sharing of labour and responsibility between women and men at the community level? Does the strategy incorporate measures to ensure equal representation by women in community-level decision-making?

... are women's health advocates recognized?

> **Role of women's organisations and clinics** – Do health policies and strategies support the role that has been played by women's organisation in policy advocacy on women's health and in the provision of services to women?

... are decision-makers informed?

> **Policy, planning and management skills at national and district levels** – Do staff development and training programmes include components on gender issues in health status, health services, health services management, and the evaluation of health services? Will they increase the capacity of decision-makers to incorporate a gender perspective in policy and planning? Do programmes also include measures to increase the representation of women at policy, planning and management levels?

... are health workers supported?

> **Training and supervision of health workers** – Do human resource management and training policies recognise the role and needs of community-level workers, such as health visitors, community health workers and traditional birth attendants? Are these workers trained, supervised and supported in addressing all family members (rather than women specifically) on issues such as fertility, nutrition, child health, and STDs?

... are data systems appropriate?

> **Health and management information systems** – Have steps been taken to ensure that data collection on health/ill-health and use of health services is disaggregated by gender? Are personnel trained in the interpretation and use of gender-disaggregated data for policy, planning and management purposes?

... is regulation used effectively?

> **Regulatory and supervisory mechanisms** – In setting standards of service (for government, private sector and NGO providers), has attention been given to factors that affect access to care by girls and women (including hours, gender of personnel, privacy, etc.)?

3.2 Gender issues in sexual and reproductive health

Questions related to SRH services:

New perspectives on sexual and reproductive health highlighted at the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995), and the commitments made by national governments in the declarations of both conferences, provide opportunities to rethink and reorient health sector strategies. They provide a basis for reconceptualising traditional maternal-child health and family planning programmes within a framework that links sexual and reproductive health to human rights, and that is concerned with the situation and needs of both men and women. Such a framework differs from many existing approaches, which have been criticised for having a narrow focus on women as childbearers and mothers that ignores women's independent health needs as well as men's rights and responsibilities as fathers and sexual actors.

Some of the gender issues that might be considered under this broader approach are suggested below.

... are new perspectives incorporated?

> **Orientation** – Does planning of services reflect the broad concept of reproductive and sexual health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" that was emphasised in the Beijing and Cairo conferences? Does this approach acknowledge the reproductive and sexual rights of both women and men, and recognise the link between gender equality and the exercise of these rights?

... how are services provided?

> **Integration of services** – Can the various types of services (child health and immunisation, ante-natal, fertility regulation, STD treatment, general health issues, etc.) be accessed in one place? Or do they require separate trips and appointments, which may limit access and use?

... to whom are they available?

> **Clientele for services** – Do the services provided respond to the needs for sexual and reproductive health care of women who are not married (adolescent, single, widowed) or not fertile (infertile, beyond reproductive years)? Does it respond to the needs of men at various stages of the life-cycle? Or are there complementary services to ensure that men have access to contraceptive information and products, information and treatment for STDs, etc.?

... how well are staff equipped?

> **Staff training and support** – Are staff trained, supported and rewarded on aspects of quality of service such as responsiveness to individual concerns of clients, to social and cultural aspects of the use of fertility decisions and sexual behaviour, to privacy requirements? Are they able to identify and respond to the health and emotional consequences of sexual and physical violence against women?

... are men as well as women targeted?

> **Targets of health promotion** – Are efforts made to target boys and men (through school groups, work sites, sports associations, etc.) with health education messages concerned with sexual behaviour and STD prevention? How can these messages promote healthy sexuality, more equitable gender relations, and sexual behaviour that takes account of the health risks or consequences for sexual partners? How can they encourage men to take more responsibility for the children they father?

... is gender equality promoted?

> **Content of health promotion messages** – Do health promotion messages reflect and support equality between women and men? Do they promote understanding of the extent and value of

women's contributions to family health and the legitimacy of their role in decision-making within families and communities, both generally and specifically on nutrition, fertility, sexual behaviour, etc.? Do they promote an increased role by men in assuming responsibility for fertility control, health of their partners, care of children? Do these messages counter cultural practices harmful to women, such as female genital mutilation, discriminatory allocation of food, taboos depriving women of nutritious foods particularly during pregnancy? Do they promote equal treatment of girls within families?

4. What might a health strategy with a gender perspective seek to achieve?

Possible themes of a health strategy with a gender perspective

In summary, some of the main themes that might be pursued in applying the above perspectives include:

> **clear recognition that gender-based discrimination and inequality are contributing factors to women's health needs and problems** and that an effective and equitable health strategy must therefore respond to the manifestations and consequences of these social patterns and support women's empowerment;

> better **gender-disaggregated data and research** to provide a more accurate assessment for planning purposes of health problems, needs and use of health services;

> strategies for health care delivery that **respond to gender-based differences in health problems and access to health services,** and that consider **women's concerns and needs as individuals** as well as in relation to children and childbirth;

> **strategies that target men as well as women** for activities related to child health, fertility regulation and safe sexual practices, and that recognise men's rights and responsibilities in these areas;

> recognition that women provide most of the paid and unpaid health care in society by **expanding women's role in decision-making about policies and priorities** at national level and within communities;

- health sector policies that result in an **equitable distribution of the costs and benefits** of investments and approaches to health care provision at both national and community levels;

- identification of ways in which the health authorities can **support the initiatives of other agencies that create the conditions for health, with particular benefit to women:** such as investments in water and sanitation; food security policies that target women's food crops for extension services and productivity enhancement; legislative and policy changes that support women's access to productive resources such as land, credit, and extension services; legislation and inspection of employment standards that cover sectors in which women work (and cover hours of work, protection of equipment, air quality, protection from toxins, etc.); public awareness campaigns on women's social, political and economic rights...

3 The Rationale for taking a Gender Perspective in the Health Sector: Some Talking Points

- **The right to health is a basic human right of both women and men.** The right to health is cited as a basic human right by the WHO constitution and by the International Covenant on Economic, Social and Cultural Rights. More recently, at the International Conference on Population and Development, sexual and reproductive health have also been linked to human rights issues. The commitments made by governments in these areas include attention to the specific health needs and problems of women and to linkages between health rights and other human rights such as gender equality.

  If health sector programming does not recognise existing inequalities between women and men in health status and access to health resources, and does not seek strategies to address them, it can reinforce or exacerbate these inequalities and thus undermine commitments to both health and gender equality. On the other hand, initiatives for gender equality and health can be mutually supportive. Health messages and services that encourage an increased role by men in assuming responsibility for fertility control, care of their children and the sexual health of partners, for example, serve both health and equality objectives.

- **Individual health and well-being of both women and men is integral to development.** The achievement of individual health and well-being is not only a major goal in itself – part of the definition of "development" – but serves to support the achievement of other development objectives. Those whose physical and mental energies are sapped by illness and malnutrition cannot contribute their potential to social and economic development. The low health status of women is a cost to society as a whole as it limits women's productivity. In addition, health problems faced by women have an impact on the health and productivity of the next generation.

  Investments in women's health benefit women by improving their well-being and quality of life, but also benefit families, communities and the broader society.

- **Gender inequality and health are inter-related.** Gender-based discrimination and inequality are contributing factors to women's health problems and needs. This includes, for example, injury due to domestic violence, risk of contracting STDs and HIV/AIDS due to the lack of personal autonomy and bargaining power in relationships, nutritional defiats due to unequal allocation of food in households. It also includes reluctance by families to seek health care for girls and women, and the lower average earnings of women that limit their ability to finance health care for themselves. While full solutions to these problems do not lie within the health sector, the recognition of such inequalities and their health consequences must be a factor in designing effective health services.

  Analysis of gender inequalities and discrimination can result in more effective health programming through identifying particular health risks faced by women, women's constraints in accessing health services, and the role of men in decision-making about health-related behaviours.

Key Citations

Platform for Action, Fourth World Conference on Women, Beijing, September 1995, para. 89:

Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology.

Platform for Action, Fourth World Conference on Women, Beijing, September 1995, para. 105:

In addressing in equalities in health status and unequal access to and inadequate health-care services between women and men, Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes, so that, before decisions are taken, an analysis is made of the effects for women and men, respectively.

Platform for Action, Fourth World Conference on Women, Beijing, September 1995, para. 92.:

Good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.

Platform for Action, Fourth World Conference on Women, Beijing, September 1995, Strategic objectives related to women and health (paras. 106–110):

1. Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services.

2. Strengthen preventive programmes that promote women's health.

3. Undertake gender-sensitive initiatives that address sexually-transmitted diseases, HIV/AIDS, and sexual and reproductive health issues.

4. Promote research and disseminate information on women's health.

5. Increase resources and monitor follow-up for women's health.

United Nations Convention on the Elimination of All Forms of Discrimination Against Women, Article 12:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Programme of Action of the International Conference on Population and Development, Cairo, 1994, Principle 4:

Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights...

Programme of Action of the International Conference on Population and Development, Cairo, 1994, para. 7.2:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease of infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so... Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually-transmitted diseases.

Programme of Action of the International Conference on Population and Development, Cairo, 1994, para. 4.24:

Changes in both men's and women's knowledge, attitudes and behaviour are necessary conditions for achieving the harmonious partnership of men and women. Men play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of Government. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life.

Programme of Action of the International Conference on Population and Development, Cairo, 1994, para. 4.27:

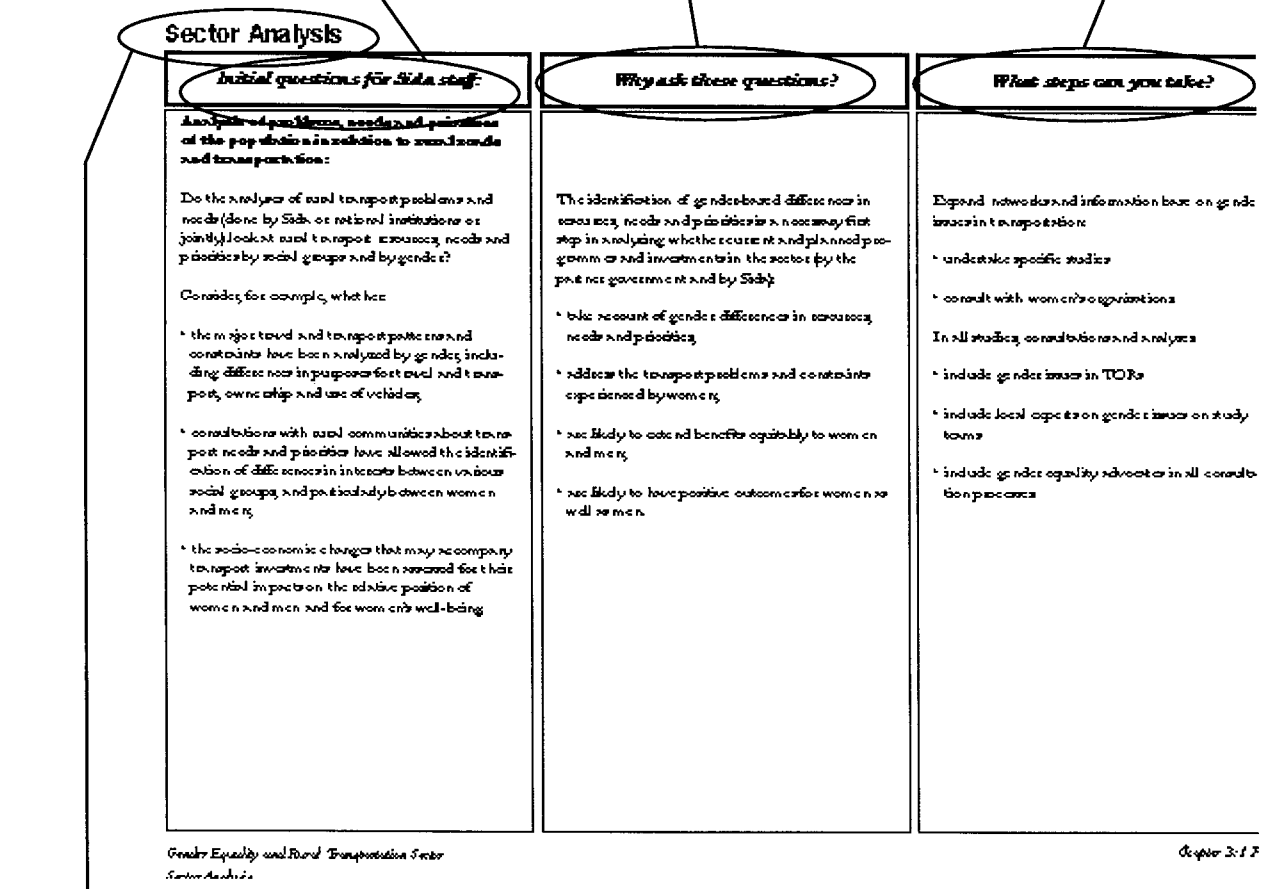
Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children.

4 An Explanation of the Handbook Structure

This column contains questions for Sida staff to ask themselves (WHAT?)

This column explains why these questions are relevant and important (SO WHAT?)

This column provides advice on what to do with the answers to the questions in the first column (NOW WHAT?)



This indicates the moment or stage in the programming cycle to ask these questions:

- sector analysis
- project formulation/appraisal
- annual review/monitoring
- evaluation

4:1 Sector Analysis

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Analysis of problems and needs of the population in relation to health and health services: Has the analysis of the country situation assessed health status, problems and needs by social groups and by gender? Consider, for example: • Is the analysis of health status and health problems (of both adults and children) based on gender-disaggregated data (separate information for males and females)? Is there such data on, for example, the incidence of malnutrition, infectious diseases, malaria, STDs and HIV/AIDS? Is there adequate information on maternal mortality and morbidity? • Does the analysis assess differences by gender in use of health services? Are there differences in the numbers of boys and girls taken to health centres for immunisation, or treatment of malnutrition? Or in the numbers of women and men seeking treatment for malaria or infectious diseases? • Does the analysis take account of socio-economic and cultural influences on health status and access to health services? Have any practices detrimental to the health of women, such as female genital mutilation or food taboos, been identified? Has attention been given to the incidence of physical and sexual violence against women and the health implications? • Have consultations about concerns and priorities included both women and men?	The health status, problems and needs of women and men differ because of socio-economic and cultural factors as well as biology. Men and women also take on different gender-assigned roles in health related activities at the household and community levels. Gender-based differences and gender-specific needs and priorities can be addressed most effectively if they are taken into consideration at the beginning of programme planning. The sector analysis provides the basis for selecting programme emphases and partners. It is therefore a critical stage for raising questions to ensure that an accurate assessment is available for planning purposes.	Sida may need to expand its networks and information base on gender issues in the health sector by, for example: • undertaking specific studies, • consulting with women's organisations and NGOs concerned with the position of women. Sida can ensure that any studies, consultations and analyses undertaken for programme planning purposes considers gender differences and women-specific concerns by, for example: • including these issues in terms of reference, • including local experts on gender issues in health sector study teams; • ensuring that all consultation processes include gender equality advocates.

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Analysis of existing national policies and programmes in the health sector: The types of questions that might be asked about national policy and programmes in light of the analysis of problems and needs above include: • What types of services are priorities for investment (hospitals? rural health posts?)? What are the implications of these priorities for the availability of care in rural areas and for poorer socio-economic groups? And for the availability of services for complications in child-birth? • How is sexual and reproductive health (SRH) defined by national authorities? Are men as well as women targeted for initiatives related to child health, fertility regulation, STD prevention, and health education/promotion? Do policies address women's health needs as individuals as well as mothers? • Are there any differences by gender in the impact of expenditure constraints in the health sector – e.g., in relation to the services provided, costs and access to care, the proportion of care provided at household level? • Do strategies take account of the capacity of communities and particularly women to respond to expectations of community participation? Is there a government policy statement on women's position, and does it include references to women's health? Are any efforts under way to implement the Beijing Platform for Action and its sections on women's health? Is the country a signatory to the UN Convention on the Elimination of All Forms of Discrimination Against Women (which also includes references to women's health)? What is being done about the ICPD declaration?	This step in the analysis is concerned with assessing the extent to which gender perspectives are currently incorporated in national policies and programmes in the sector, and to identify starting points and allies in raising these issues. Dialogue on these issues can be assisted by reference to national commitments to improving the position of women. In many of Sida's partner countries, the national constitution and the adoption of international conventions provides a basis and a justification for pursuing women's rights and gender equality issues. Many have national policies on the position of women or gender equality that state general principles as well as objectives in specific sectors such as health. Many countries have also established government ministry or office of women's affairs that acts as an advocate for gender equality and gender responsiveness in the programmes of sectoral ministries. National and local women's health advocacy organisations and women's studies centres are other resources that could support the development of gender-aware policies and programmes.	Sida can draw on all these resources (the Beijing Platform for Action, the ICPD declaration, national polices, gender equality experts and advocates) to develop and strengthen its programme and to underpin its policy dialogue with governments. A national policy on women's position or gender equality can serve as an important starting point in policy dialogue. The government ministry or office for women's affairs can be a useful partner in policy dialogue. Sida can consult with national institutions such as the government ministry or office for women's affairs, women's organisations, and women's studies centres about issues and experiences concerning women's health and can also encourage its sectoral partners to undertake such consultations. Sida can also support linkages with other sectors and ministries working on complementary issues, such as water supply and food security.

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Analysis of the health ministry and other government institutions: Do the national and local institutions responsible for health policy, planning and services have the capacity to identify and address gender issues in the sector? For example: • Do they have access to **information and research** on women's health and on gender issues in health and health services? • Do they have access to **gender-disaggregated data** (for both children and adults) on health status and the use of health services? • Do planners and managers have the **skills** to formulate and analyse questions on the gender aspects of health status and health services? • Do the **political will and resources** exist to respond to women's health issues and gender equality goals? Have any women's health and gender equality advocates within these institutions been identified? • Are health sector planners and decision-makers knowledgeable about the **Beijing Platform for Action and the ICPD declaration** and their commitments on sexual and reproductive health, women's health and gender equality? • Have the health ministry and other institutions developed **processes for public participation** in planning for health policy and services that seek the views of both women and men? • Have any **links** been established between health sector institutions and women's organisations or women's studies centres concerned with women's health and gender equality?	If these national and local institutions lack the capacity to identify and address gender issues in planning or implementing policies and programmes, donor action within projects will remain isolated initiatives with limited long-term impact. Analyses of how organisations adopt new perspectives, including gender perspectives, have identified the importance of policy advocates. These are people within the organisation (i.e., the Ministry of Health, district health council) who are willing and able to promote a gender perspective, who have the knowledge and skills to demonstrate its relevance to the organisational mandate and goals, and can identify opportunities and allies to push the issue forward. The identification of individuals who are taking on this role, or potentially could do so, is a means by which to support processes already under way and to assist Sida staff in developing their analysis and strategies in the sector.	Consider how Sida initiatives to strengthen planning and management in the sector could contribute to building institutional capacity for gender-aware health planning at the national or local level. For example, Sida could: • assist with the identification of gaps in data and information and possible strategies, either in the short-term (through undertaking a special study) or in the longer-term (through a review of data sources and the identification of possible modifications to methods of data collection or presentation); • support the development of health information systems that generate gender-disaggregated data, including assistance in the definition of categories for data collection, and training of staff in the interpretation and use of gender-disaggregated data for policy and planning purposes; • build skills relevant to gender analysis by including components on gender issues in training programmes for planning and management in the health sector; • support current or potential advocates of a gender perspective within partner organisations, through providing moral support, training, access to national or regional networks, etc.; • assist in the development of effective processes for public participation that ensure that the views of both women and men are expressed; • support research by national institutions or women's organisations on sexual and reproductive health concerns, women's health needs, access to health care, etc. in order to provide a stronger basis of information.

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Analysis of employment and training in the sector: Do the employment and training strategies being pursued by national partners such as the Ministry of Health and district health authorities incorporate gender perspectives and promote gender equality? With respect to equal employment opportunities: • Have efforts been made to increase the representation of women at planning, management and decision-making levels in these institutions? (Through recruitment, promotion, training?) • Are there policies to address concerns with personal security that are mainly faced by women staff (in relation to concerns such as travel requirements for health care workers, sexual harassment of health care workers)? • What has been the impact of restructuring and reduced public expenditure in health on workers at the lower levels of the health-delivery hierarchy, most of whom are women? With respect to gender awareness and competence: • Do training and staff development activities for policy and management staff include components on women's health and gender issues in health to increase their ability to respond to these concerns? • Do programmes include training, supervision and support of community-level health workers, such as nurses, community health workers, birth attendants, most of whom are women?	In most countries, women are the majority of health workers (both paid and unpaid), but they remain under-represented at management, planning and decision-making levels. Women are also under-represented among the doctors and medical specialists who have the most authority in the sector. In addition to human rights justifications for increasing women's access to these levels of employment, it has been argued that higher representation of women at planning and decision-making levels is a necessary step toward ensuring that health policy and health services reflect women's perspectives and needs. As well as increasing the representation of women at management, planning and decision-making levels (and the representation of men among community-level care givers and health promoters), it is important to ensure that all policy and service delivery staff (both men and women) are aware of gender issues relevant to their functions and are able to address them. An issue relevant to both employment opportunities and quality of service is the position of workers at the lower levels of the health services hierarchy, who may be decreasingly able to function effectively as budget constraints leave them without adequate resources and supervision and without a viable income.	Consider the opportunities through which Sida can address these issues in institution-strengthening and training activities undertaken with partner institutions. For example, with respect to equal opportunities for women, Sida could: • assist partner institutions to analyze the structure of employment in the sector in order to identify patterns by gender in decision-making/management levels, supervisory relationships, participation in training, pay grades and the valuation of women's work; • identify barriers to equal participation by women at management, planning and decision-making levels and encourage partners to formulate objectives concerning recruitment, training and advancement; • ensure that any managerial and policy-level training financed by Sida for personnel in the health sector includes measures to ensure equitable participation by women. With respect to increasing awareness and competence on gender issues, possible steps could include: • ensure the dissemination of information about the ICPD declaration and the Beijing Platform for Action through training courses supported by Sida; • assist partners in designing and implementing training or staff development initiatives that introduce gender perspectives to staff (as appropriate to staff with different types of responsibilities).

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Analysis of opportunities: Generally with respect to the health sector, where are the possibilities for change or for development cooperation to have a positive impact on women's health and gender equality? Do the ICPD declaration or the Beijing Platform for Action offer opportunities to raise new issues or start a broader dialogue with partner governments – on the conceptualisation of traditional MCH and family planning programmes under the framework of sexual and reproductive health, or on the link between gender equality and health policy objectives? What are the constituencies that support gender equality, and what programme elements can be built around them?	In considering the situation overall, it is important to have a sense of where possibilities for change and impact exist, given the situation in the country, the priorities of partner organisations, and the areas of Sida expertise. Neither Sida nor its sectoral partners will be able to immediately and simultaneously address all the gender issues in the sector, particularly if they are only beginning to take up these issues. Rather than being overambitious and accordingly unfocussed it is better to begin with a clear focus and specific objectives that can be revisited and revised in the light of changing circumstances and opportunities. Changes must have a domestic resonance and "demand". Sida programming will have a greater chance of success if it supports the demand for gender equality that already exists in the country.	Sida can seek out women's organisations and other advocates of gender equality and solicit their views on priorities and on the opportunities and constraints in their pursuit. An important part of policy dialogue is the identification of those gender issues on which Sida can work fruitfully with its national partners, and the joint determination of feasible medium-term objectives.
Initiatives of other donors: Are their other donor initiatives in this area that Sida could complement and build on?	Consultations with other donors is another means of gaining further information as well as for identifying possible areas of complementary or collaborative action to maximize collective impact.	Network and share information with other donors. Project Formulation/appraisal

4:2 Project Formulation/appraisal

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Consultation: Is there a process for consultation with organisations and communities about the objectives and activities of the project? Is the process structured to ensure that the views of women as well as men will be identified? Consider, for example: • Were both women and men consulted? • Which women/ which men were consulted? (staff in the bureaucracy? members of the target group/clientele of the ministry? other stakeholders?) • How were they consulted – through meetings? interviews? surveys?	Consultation and participation are themes emphasised by Sida in all aspects of development cooperation. In considering these processes from a gender perspective, it is important to ask who has been consulted and whose needs have been identified as important, and whether the methodology of consultations influenced women's participation and the findings. For example, if consultations are mainly with village and district authorities, or through general village meetings, it may be mostly the views of men that are heard. Ensuring that women are included in consultations about health sector initiatives is important for several reasons: • women may have different health concerns and priorities than men (due to the social or economic context of their lives, or specific to reproductive health); • where initiatives anticipate community input or participation, the capacity of these communities to respond should be explored with women (as well as men): this would allow a better assessment of the actual costs and feasibility of the initiative and would provide a basis for developing strategies for increased male support of women's health activities and increased female involvement in decision-making; • women predominate among workers in health services delivery, and any initiative should draw on their knowledge and experience.	In addition to any consultations undertaken by Sida itself in the initial planning stages, Sida can include a specific requirement to consult with women and women's organisations in its contracts and terms of reference with consultants. It can also assist its national sectoral partners to understand the rationale for such consultations and assist partners to develop methods for undertaking consultations that ensure that the views of women as well as men are heard. Consultations with local communities or members of organisations directly targeted by a project can be supplemented with consultations drawing on the views of experts and activists from women's health advocacy groups and women's studies centres. These can assist in identifying who to consult, how to consult, what to consult about and how to interpret the findings of the consultations. A gender analysis, as suggested below, is another input to this process.

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Gender analysis: Does the initial analysis for project planning include gender perspectives? That is, • Is project planning based on an understanding of gender differences in health status, needs, constraints and priorities? • Does project planning reflect the perspectives of the ICPD declaration and the Beijing Platform for Action on sexual and reproductive health issues and on the relationship between women's empowerment and women's health? • Did project planning include an assessment of community contributions anticipated (labour, time, resources), who (men or women) would make these contributions, and their capacity to respond to the expectations? • Do institutional assessments consider institutional capacity on women's health and gender-equality issues?	A gender analysis is an important basis for specifying objectives and strategies, which otherwise may be based on (implicit or explicit) assumptions that may not turn out to be valid. Although the analysis and design of programmes and projects may be prepared by national partner organisations rather than Sida, Sida can provide assistance and support to partners in undertaking such an analysis and also review the issues in its own appraisal process.	Sida can provide assistance to partners in undertaking gender analyses for programmes and projects by identifying and/or financing the requisite expertise. Willingness to do this can be suggested at an early stage of dialogue on programme and project possibilities and can be justified by national commitments to women's health and gender equality in health such as the Beijing Platform for Action. In project appraisal by Sida, the team undertaking the appraisal (whether of Sida staff or consultants) should include a member with expertise on gender issues in the health sector; where the appraisal is contracted to consultants, their responsibility to consider gender factors can be included in terms of reference.
Project objectives: Do the project objectives specify what the project seeks to achieve in relation to women's health and gender equality? Have the gender equality concerns been considered in relation to the main issues the project was established to address? Have targets and indicators been established to clarify these objectives and to allow them to be monitored?	Strategic choices linked to the opportunities identified through the analysis and consultations above can be made at the stage at which project objectives are specified. Gender-based differences in the situation of women and men mean that a "gender-neutral" or "gender-blind" project may fail to consider gender-specific needs and constraints and gender-equality issues relevant to the project. This is best avoided by ensuring that the project objectives make specific reference to women's health and gender equality.	The consultations and analysis discussed above should provide the basis for identifying the women's health and gender equality objectives that contribute to the overall project goals. Consultations with women's health experts and equality advocates may also assist in identifying objectives, targets and indicators relevant for a particular project.

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Implementation strategy: How will objectives for women's health and gender equality be pursued in the project? • Have specific strategies been identified to pursue these project objectives? • Have the constraints that may keep women from benefiting or participating been identified and appropriate strategies developed? • Have the budgetary implications of the gender-specific elements of the project been anticipated? • Does the project management strategy and budget provide for the necessary expertise on women's health and gender issues?	Often, gender-related provisions are left to be "self-implementing" and the resources required to carry them out are often not specifically dedicated. In other cases, the project design provides for exploration of possible strategies on gender equality issues as part of project implementation, without providing a contingency fund or flexibility to finance the strategies identified. In both cases, good intentions are frustrated. The need for technical expertise is often under-estimated. Specific skills and expertise are required for high-quality project design and implementation.	Review project plans and contracts to ensure that they give explicit consideration to the means of implementing women's health and gender-related objectives and provide for the technical expertise and budgetary resources required. Realism in estimating the resources required to achieve these components is vital to retain respect from partner and contracted organisations.
Expectations of the implementing agency: Does the implementing institution or agency have a commitment to gender equality and to achieving positive outcomes for women through the project? Indications of such a commitment might include: • serious engagement by senior officials in discussions on gender equality issues • willingness to dedicate their own resources to action in this area (financial resources and staff time, including willingness to send senior staff on training) • a current set of guidelines on women's health or gender equality that are used by staff • an action plan to implement the Beijing Platform for Action and the ICPD declaration • ongoing links to women's health advocates and researchers.	The implementing institution's understanding of and commitment to achieving project objectives on women's health and gender equality, and its ability to be flexible and innovative in pursing these objectives, will be an important factor in the project's success in this area. Accountability on these issues is facilitated when responsibilities are clearly specified in each agreement and contract.	Discuss objectives relating to women's health and gender equality with national partners, implementing agencies and contractors. These discussions can assist Sida to identify areas in which it can work constructively with national partners on women's health and gender equality issues; such discussion will also assist Sida in identifying ways in which it can support national partners to develop their own capacity on gender equality issues. When definitions and expectations are agreed on, the responsibilities of each party can be clearly stated in agreements, with measurable indicators for monitoring.

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Reporting and monitoring: Does the reporting and monitoring system for the project provide for gender-disaggregated data collection on participation in various aspects of the project and on the indicators selected to monitor change and impact? For example, will child immunisation rates be identified separately for boys and girls? Will those reached by health promotion activities be identified by gender? Will both women and men be involved in identifying indicators to monitor change and impact, and will both be involved in providing feedback? For example, will monitoring processes seek the views of both women and men on concerns such as accessibility, affordability and quality of service?	The collection of gender-disaggregated data is essential for monitoring changes brought about by the project and for identifying both achievements and issues of concern. Gaining feedback from both women and men on changes and impacts associated with the project is important for the same reasons that consultations with both are important in project planning: gender differences in activities and resources may result in differences in impacts.	Achieve agreement with the partner or implementing institution on the key variables appropriate to the project for which gender-disaggregated data will be collected – for example: • on participation in project activities, e.g., in consultations, planning and implementation, training, services and benefits received; • on indicators for monitoring change and impacts, e.g., indicators of health status, knowledge and practices affecting health; • on indicators for monitoring related changes, e.g., indicators of time devoted by women to health-related activities, overall workloads, and trade-offs against other activities.

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Revision and renewal of projects: Have the objectives and design of a programme or project being considered for renewal been assessed from a gender perspective? That is, are questions being asked in the review and renegotiation process about: • project efforts and achievements to date in addressing women's health and gender equality concerns; • whether the project objectives and implementation strategy require modification to reflect concepts and approaches agreed in the International Conference on Population and Development and the Beijing Platform for Action (such as the more comprehensive approach to human sexuality and women's health now conceptualised as Sexual and Reproductive Health); • whether the partner or implementing agency has developed an awareness or commitment to women's health and gender equality concerns.	The questions in this section are most effectively raised at the initial design stage of a project, but can also guide thinking when a programme or project is in progress or will be continued in a new phase. While options may be more restricted where the main elements of project design and objectives are already in place, small changes at this stage could still have important impacts.	Possible steps include: • review the programme or project in light of the preceding pages to determine the extent to which a gender perspective has been applied and to identify potential opportunities for positive action; • if an evaluation is to be undertaken as part of the assessment and project extension process, identify the information required to address gender issues in the project and ensure this is included in evaluation terms of reference (see section below on Evaluation); • seek out individuals in partner institutions and on project staff who would be internal allies in identifying and advocating project modifications to address issues of women's health and gender equality; • seek out other potential sources of ideas and support such as the government office or ministry of women's affairs, or women's health advocacy organisations; • build on recent commitments to women's health and gender equality – such as the Beijing Platform for Action and the ICPD declaration – in dialogue with partners.

4:3 Annual Review

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Preparation for the review: Have there been important changes within the country that are relevant to women's health and gender issues within the health sector? For example, • have there been changes in major trends in the health of the population, such increases in HIV/AIDS incidence among women and men? • have there been changes to legislation or government policies that affect health conditions and services, such as a shift toward community-based health approaches, or a change in policy on abortion? • have there been events affecting food availability, food prices or incomes that affect living standards and health? what are the effects on women's health and access to health care? • are there opportunities arising from recent international commitments such as those made in the International Conference on Population and Development and the Beijing Platform for Action? • are there any new women's networks and organisations that could become allies on women's health issues? • is there new information or knowledge arising from research or ongoing projects that suggest promising approaches or strategies? • are there new initiatives by major donors such as the World Bank?	These questions assist in assessing whether the original analysis is still valid and in identifying whether programme modifications should be made. Such modifications might address problems and issues identified in the course of programme implementation, or might be proposed to take advantage of new opportunities that have arisen.	Preparations for the Annual Review could include: • consultations with women's advocacy organisations (both state and non-state) to identify changes or concerns that should be considered in preparation for the annual review; • inclusion of these issues in the terms of reference of any background studies or analyses to be undertaken for the Annual Review; • discussion by Sida staff of programmes and projects in light of this analysis, and identification of possible programme modifications or additions; • preliminary discussions with partners on these possible modifications; • identification of gender-related issues that should be formally discussed during the annual review, and the results that Sida would like to achieve through those discussions (what outcomes or agreements on programme modifications or new initiatives).

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Analysis of projects: In the analysis of each project: • Have short-term targets relating to women's health and gender equality been reported on and met? • What has supported the achievement of these targets? Can lessons be drawn for other projects? • If they have not been met, why not? Can measures be taken to address obstacles encountered? • Are the original targets still relevant? If not, what modification might be made?	This is an essential step in monitoring project implementation. It is an opportunity to assess progress to date and decide whether or not changes in basic project design are required. Although the best moment to integrate a gender perspective is during programme or project design, adjustments can still be made in the course of implementation.	The analysis may reveal a need to rethink project strategies where the project falls short of anticipated objectives, or to develop new targets and indicators. The Annual Review process also provides the opportunity and mechanisms to achieve agreement with national partners on any changes to project strategies that may be required. However, satisfactory discussions resulting in agreements on new or revised strategies will be more likely to occur if the groundwork has been done in the quarterly meetings leading up to the Annual Review.
Approaches taken by partners: Do the implementing organisations and contractors (including Swedish organisations) have a clear understanding of the gender-related issues and objectives in the project?	This is a moment to review whether all stakeholders are on the same path with respect to project objectives and strategies concerning women's health and gender equality, and whether Sida needs to provide additional assistance to its partners to ensure objectives in this area will be met.	Sida can also consider how it could assist national partners and implementing institutions to be more responsive and innovative on gender issues in health policy and planning and the participation of women in health sector programmes and services. Sida could, for example, provide gender training, or facilitate the establishment of linkages between the implementing institution and other actors (such as the national office for women's affairs, women's organisations or NGOs that have experience with women's health and gender equality issues, other projects or institutions that have been innovative in addressing gender issues or in reaching women).

4:4 Evaluation

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Terms of reference: Do the evaluation terms of reference clearly specify the issues and questions concerning women's health and gender equality to be addressed? Do they clearly identify what Sida and its partner want to learn about gender issues from this evaluation? For example, in an assessment of a health reform initiative in which user fees were introduced, information useful to Sida and its partners for future planning might include: how user fees affected demand and use of services by types of services and by gender.	A conclusion from past experience is that evaluation terms of reference must include explicit and feasible directions for the analysis of gender issues in order to produce a report that is helpful for future planning purposes. The long-standing policy of integrating a gender perspective in all Sida projects provides a rationale for including related issues in evaluations, even if specific objectives on women's participation or gender equality are not included in project documents. Given that evaluations often provide the basis for an extension or further phase of cooperation, they provide a critical opportunity to identify what can be learned from past efforts and achievements and to build on this in accordance with Sida's gender equality policy.	Discussions between Sida and its national partner should seek to identify the type of information or analysis that each requires to address women's health and gender equality issues more effectively and how the evaluation could contribute to this. Clear and specific terms of reference can be formulated once Sida and its partners have identified what they want to learn. This could include a range of issues, as suggested below.

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Project design and implementation: Will the evaluation review the process of project design and implementation? Is it clearly specified that this review should consider the extent to which Sida's gender equality policy has been followed?	This is important to specify as evaluations are frequently limited to assessing objectives stated in the project documents rather than broader issues of Sida policy such as gender equality objectives (which are not explicitly stated or interpreted in the documentation of many projects). Thus opportunities to learn from past experience about what works and what is necessary for successfully integrating a gender perspective are missed.	Some of the basic questions about the process of project design and implementation that could be included in the evaluation relate to: • *initial analysis:* Was project planning based on an understanding of gender differences in health status, needs, constraints and priorities? Did project planning include an assessment of community contributions anticipated (labour, time, resources), who (men or women) would make these contributions, and their capacity to respond? • *baseline data:* Was project planning based on gender-disaggregated data? Were adequate data collected at the planning stage to allow an assessment of change or improvement on the basis of gender at the evaluation stage? • *consultation and decision-making:* Did women participate to the same extent as men in decision-making in project planning and implementation? • *gender equality objectives and strategies:* Did the project plan specify objectives and strategies with respect to women's health and gender equality? Were project implementors able to respond to issues that arose in the process of implementation or as a result of experience gained?

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Project resources and activities: Will the evaluation review resources and activities directed to target groups? Is it clearly specified that this analysis should identify the extent to which women as compared with men benefited from project inputs or participated in project activities? Is it clearly specified that the analysis should consider the appropriateness and implementation of initiatives to address gender equality objectives?	These concerns are omitted surprisingly often if the requirement is not specified in directions to the evaluation team.	The types of questions to address to evaluators varies with the types of inputs and activities of a particular project. Thus for example, • *in a project that provided health services:* How many women compared to men received or used the services provided? How do these figures compare for adults? for children? for those bringing dependants to service providers? for different types of services? Who provided the services (what was the proportion of women among project staff and volunteers)? Were the services relevant to women's needs? • *in a project that provided health information at community-level:* were men as well as women targeted in delivering health messages aimed at changes in community, household or individual in relation to, e.g., child health and nutrition, maternal health, community and household sanitation, sexual behaviour? • *in a project that provided training:* How many women relative to men received training supported by the project, and in what areas? How many women participated in training for policy, planning and management staff of national and district health authorities? • *in a project that aimed to strengthen skills in health policy analysis and health planning:* Did the project include activities to enhance skills in gender analysis in the health sector, or to improve the data base and training in this area?

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Project outcomes with respect to health: Will the evaluation consider project outcomes with respect to health status and the adoption of health practices? Do directions to the evaluators clearly specify that the analysis should consider outcomes by gender? Or will the evaluation consider project outcomes on institutional capacity in the health sector? Do directions to evaluators specify that this should include capacity with respect to women's health and gender issues in the sector?	These questions assist in developing a better understanding of the effectiveness of particular interventions, and are therefore important for future projects and for project planning.	Pertinent questions for an evaluation can only be formulated in light of the scope and type of a particular intervention. Examples of the types of questions that might be relevant, depending on the nature and objectives of the project, include: • Have there been changes in health indicators for children or adults? Are these similar for males and females? • Have there been changes in health-related behaviours as a result of the project (e.g., in relation to fertility regulation, prevention of STDs)? What are the patterns of change by gender? • Have there been changes in the health services available to the community? What are the patterns by gender in use of these services? • Has the intervention met the health services requirements of women as well as men (regarding type of service, quality, accessibility, etc.)? • Has the intervention enhanced capacities for generating gender-disaggregated data? for developing research agendas that are responsive to gender issues? for policy analysis that incorporates gender perspectives?

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Socio-economic impacts: Will the evaluation consider the project's broader socio-economic impacts, such as impacts on the responsibilities, workloads, livelihoods, opportunities of women and men and on relations between women and men?	Community-level health initiatives can generate other changes within communities, particularly when participatory approaches are pursued. These might include mobilising various groups within the community to take greater control over their health and health conditions; they might also entail increased responsibility for communities to devote time, energy and material resources to health care. Analysis of the impact of interventions on activities of women and men and on the disparities between women and men are an important source of information for future projects and for policy planning.	Particular questions need to be formulated in light of the particular project. Types of questions that might be asked include, for example: • has the project made similar demands for inputs (of time, labour, resources) from women and men? and have the opportunities for participation in decision-making at the community been similar for women and men? • if an initiative has relied on women's time and labour, what has this meant for their overall workloads, or their other domestic and income-earning work? • has the project resulted in a greater capacity at the household and community level to deal with health issues or meet health needs with their own resources?
Evaluation process/methodology: Does the evaluation process/methodology outlined provide for the types of information and data-gathering and that would allow a gender analysis? Does the evaluation plan provide for consultations with women and men on their views about project results and impacts? Is it specifically required that the data collected (from project records, surveys, consultations with communities, etc.) be disaggregated by gender? Do the terms of reference provide that the evaluation team will include a member with the requisite skills to undertake the gender analysis and provide leadership on this issue?	These processes for ensuring that the views of both women and men are obtained and that gender-disaggregated data is collected must be built into the planning of the evaluation if it is to be done in a cost-effective manner. Past experience indicates that an adequate gender analysis requires that the evaluation team must include a member with specific and demonstrated expertise on gender analysis who is in charge of that aspect of the work.	Review the evaluation terms of reference and the evaluation plan.

Initial questions för Sida staff:	*Why ask these questions?*	*What steps can you take?*
Lessons learned: Does the evaluation call for the identification of specific "lessons learned" about gender equality issues in any of the areas above and recommendations for future projects?	This may seem very obvious – given that the task is an evaluation – but it is often not done even where data has been gathered. Thus, to avoid losing an opportunity to learn from experience, the evaluation terms of reference should specify a requirement to discuss lessons learned with respect to gender equality issues through the project and the evaluation.	This is a consideration in both reviewing the terms of reference and judging whether the report received is complete and adequate. The impact of the "lessons learned" through an evaluation is, of course, increased when steps are taken to disseminate the analysis and conclusions to staff, partners and consultants.

5 Best Practices

6 Own Notes

List of Health Division Documents

Strategies/Policies

1997:1 Policy for Development Cooperation
Health Sector

1997:2 Política para la Cooperación para el Desarrollo
Sector Salud

1997:3 Position Paper
Population, Development and Cooperation

1997:4 Positionspapper
Befolkning, utveckling och samarbete

1997:5 Marco de Referencia para la Cooperación para el Desarrollo
Población, Desarrollo y Cooperación

1997:6 Strategy for Development Cooperation
Sexual and Reproductive Health and Rights

1997:7 Estrategia para la Cooperación para el Desarrollo
Salud y Derechos Sexuales y Reproductivos

1997:8 Handbook for mainstreaming
A Gender Perspective in the Health Sector

1999 Investing for future generations.
Sweden's International Response to HIV/AIDS

2000:2 Guidelines for Action – Illicit Drugs and Swedish International Development Cooperation

2001:1 Hälsa & Utveckling,
Fattigdom & Ohälsa – ett folkhälsoperspektiv
by Göran Paulsson, Ylva Sörman Nath and Björn Ekman

Issue Papers

1998:1 Maternal Health Care, by Staffan Bergström

1998:2 Supporting Midwifery, by Jerker Liljestrand

1998:3 Contraception, by Kajsa Sundström

1998:4 Abortion, by Kajsa Sundström

1998:5 Female Genital Mutilation,
by Beth Maina-Ahlberg

1998:6 Adolescent Sexuality Education, Counselling and Services, by Minou Fuglesang

1998:7 Discrimination and Sexual Abuse Against Girls and Women, by Mary Ellsberg

1998:8 Health Care of the Newborn,
by Ragnar Thunell

1998:9 Men, Sexuality and Reproductive Health,
by Beth Maina-Ahlberg, Minou Fuglesang and Annika Johansson

1998:10 Illicit Drugs and Development Cooperation,
by Niklas Herrmann
– Replaced by 2000:2 –

1999:3 Socio-economic Causes and Consequences of HIV/AIDS
by Stefan de Vylder

2000:1 HIV/AIDS in the World Today – a Summary of Trends and Demographic Implications
by Bertil Egerö and Mikael Hammarskjöld

2001:2 Health and Environment
by Marianne Kjellén

2001:3 Improving Access to Essential Pharmaceuticals, by IHCAR

2001:5 A Development Disaster: HIV/AIDS as a Cause and Consequence of Poverty
by Stefan de Vylder

2001:6 National Health Accounts – Where are we today?
by Catharina Hjortsberg

2001:7 Ideas work better than money in generating reform – but how?
by Alf Morten Jerve

2002:2 Health and Human Rights
by Birgitta Rubenson

Continues

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www.sida.se, e-mail: info@sida.se

Facts and Figures

1995/96	Facts & Figures 95/96 Health Sector Cooperation
1997	Facts & Figures 1997 Health Sector
1999:2	Facts & Figures 1998 Health Sector
2000:3	Facts & Figures 1999 Health Sector
2001:4	Facts & Figures 2000 Health Sector
2002:1	Facts & Figures 2001 Health Sector

Country and Regional Health Profiles

1995	Angola
1995	Bangladesh
1995	El Salvador
1995	Ethiopia
1995	Guatemala
1995	Guinea Bissau
1995	Honduras
1995	India
1995	Kenya
1995	Laos
1995	Nicaragua
1995	Vietnam
1995	West Bank/Gaza
1995	Zambia
1995	Zimbabwe'
2000:4	Uganda
2000:5	West Africa

Fact Sheets

1997	Hälso och sjukvård
1997	Reformer inom hälsosektorn
1997	Rätten till sexuell och reproduktiv hälsa
1997	Befolkning och utveckling
1997	Ungdomshälsa
1997	Handikappfrågor
1999	Aidsbekämpning i Uganda
1999	Förebyggande insatser mot drogmissbruk
1999	Insatser mot familjevåld i Centralamerika
1999	Bättre mödrahälsovård i Angola
1999	Utbildningssamarbete Kenya-Linköping
2001	Sveriges stöd till Hiv/Aids-insatser – 2001
2002	Fler välutbildade barnmorskor ger tryggare förlossningar
2002	Femina skapar het debatt om sex och hiv
2002	Rent vatten ger bättre hälsa och ökad jämställdhet

Sida Evaluations

98/14	Expanded Programme on Immunization in Zimbabwe
99/10	Working with Nutrition. A comparative study of the Tanzania Food and Nutrition Centre and the National Nutrition Unit of Zimbabwe
99/11	Apoyo de Asdi al Sector Salud de Nicaragua. Prosilais 1992–1998
99/36	Support to Collaboration between Universities. An evaluation of the collaboration between MOI University, Kenya, and Linköping University, Sweden
01/03	Tackling Turmoil of Transition. An evaluation of lessons from the Vietnam-Sweden health cooperation 1994 to 2000
01/32	Review of PAHO's project. Towards an integrated model of care for family violence in Central America. Final report
02/13	Sida's Support to the Reproductive Health and TANSWED HIV Research Programmes in Tanzania

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Other documents

1999:1	Report on: World Youth Conferences in Portugal August 1998, by Wanjiku Kaime-Atterhög and Anna Runeborg
2000:6A	Framtid Afrika – Huvudrapport
2000:6B	Annex to Framtid Afrika – Health Support in Africa – Country Reports
1998	Gender and Tuberculosis
2000	Webs Women Weave
2001	Hälsa – en nyckel till utveckling
2001	Jord för miljarder
2001	Aids: The Challenge of this Century
2002	Health Sector Reforms: What about Hospitals?

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