Oxford Policy Management

GENDER & HEALTH GLOSSARY

About Oxford Policy Management

Our vision is for fair public policy that benefits both people and the planet. Our purpose is to improve lives through sustainable policy change in low- and middle-income countries.

Through our global network of offices, we work in partnership with national stakeholders and decision makers to research, design, implement and evaluate impactful public policy. We work in all areas of economic and social policy and governance, including health, finance, education, climate change and public sector management. We have cross-cutting expertise in our dedicated teams of monitoring and evaluation, political economy analysis, statistics, and research methods specialists. We draw on our local and international sector experts to provide the very best evidence-based support.

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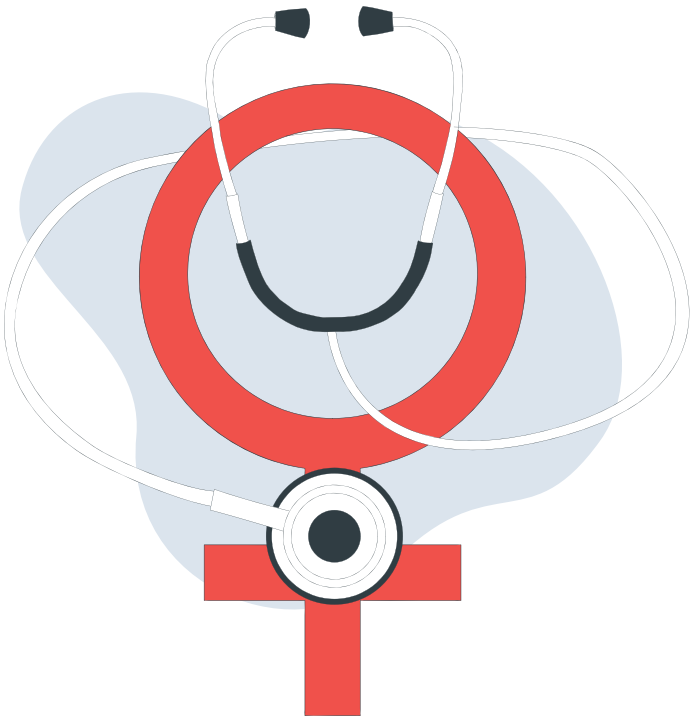
List of Abbreviations

ADB	Asian Development Bank
EIGE	European Institute for Gender Equality
GBV	Gender-based violence
GEDSI	Gender equality, disability, and social inclusion
GESI	Gender equality and social inclusion
ILO	International Labour Organization
IPV	Intimate partner violence
JHPIEGO	John Hopkins Program for International Education in Gynaecology and Obstetrics
ICRW	International Center for Research on Women
OPM	Oxford Policy Management
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technology in Health
SRHR	Sexual and reproductive health and rights
TDR	The Special Programme for Research and Training in Tropical Diseases
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNESCWA	United Nations Economic and Social Commission for Western Asia
VAWG	Violence against women and girls
WASH	Water, sanitation, and hygiene
WHO	World Health Organization



Introduction

Vocabulary plays a crucial role in shaping language and forming a shared understanding of different topics. Language is used to communicate effectively but it can also be alienating if it is not used optimally and accurately. It is important to understand clearly what words, concepts, and terms mean in specific domains. This glossary is an attempt to identify the right language to communicate gender and its role in health programming and research. It aims to equip readers with an understanding of all the relevant conceptual words used in the gender and health space, and to provide them with examples, tools, and resources to further their understanding.

Purpose of the document

This document fills an important gap by providing a contextual glossary for gender and health that has been developed in the global South. Most of the glossaries reviewed during the process of developing this document were conceptualised and developed in the global North. This glossary presents concepts and terms that are used within the health programming and research, with a focus on low- and middle-income countries.

Developing the glossary

Existing glossaries published by globally renowned organisations specialising in gender and health were examined and data were synthesised by the team. Some of the organisations whose publications were considered were UN Women, World Health Organization (WHO), Asian Development Bank (ADB), International Labour Organization (ILO), United Nations Children's Fund (UNICEF), John Hopkins Program for International Education in Gynaecology and Obstetrics (JPHEIGO), among others.

Definitions were judiciously chosen based on the following criteria:

Preference was given to organisations primarily focusing on gender and health issues.

Definitions from organisations involved in gender-related work, beyond health, were also considered in the selection process.

The clarity and ease of comprehension of definitions were considered.

The following steps were followed by the team:

The team created a data abstraction table containing specific items, including the name of the published glossary, the publishing organisation, the year of publication, gender and health-related concepts/terminologies, definitions, and additional information.

Two reviewers extracted the data, which were recorded and organised in an Excel spreadsheet.

Following this, the team extracted essential information and selected items to be included in the final list.

Who is the glossary for

This glossary can be used by any individual, organisation, technical partners of governments, or government functionaries working in or interested in gender integration in health. Specifically, it serves as a reference guide to help programme partners identify and acquire the right vocabulary relating to integrating gender into health programming and research.

How to use the glossary

The glossary is divided into three sections as follows

01
A list of concepts related to gender as a social determinant of health

02
A list of terms related to gender and health programming.

03
A list of terms related to gender and health research.

Annexures

Explanations of selected concepts, as well as additional supplementary resources.

01 Each entry provides links to the original website/ glossary that was reviewed and synthesised to develop it. Some entries provide multiple reference links.

02 Concepts and terms also include an appropriate illustration or example, to facilitate comprehension.

Prepared by

This glossary was developed by Oxford Policy Management (OPM), with funding support from the Bill & Melinda Gates Foundation, as part of the project 'Adaptive Learning Towards Gender Integration in Health Systems'. The key purpose of this project is to provide robust learning exchange opportunities and need-based technical support to the foundation and its Technical Support Unit partners in their gender intentional programming efforts in Uttar Pradesh and Bihar, through two key components: i) a Gender Support Desk that provides on-request/on-demand technical and advisory support to the foundation, Technical Support Unit partners, and government stakeholders; and ii) an active gender and health system learning network.

Note: The glossary is meant to be a living document, and it does not claim to be exhaustive. Rather, the team has sought to ensure that all concepts and terms that are most commonly in circulation at the time of its drafting are included. Entries will have to be updated periodically.

Few things to bear in mind:

#1: OPM recognises and acknowledges that gender is not a binary concept, and that it exists along a spectrum. The glossary contains definitions and references relevant for all genders but these may not be as comprehensive as desired. Readers are pointed to additional resources mentioned in the relevant sections.

#2: Please note that gender and gender-related terms and concepts are not mutually exclusive but rather are interrelated: that is, the understanding of one contributes to understanding the other. The glossary has been designed in such a way that the understanding of each concept leads to and strengthens the understanding of the subsequent ones. For this reason, the glossary will be most useful when read in the order in which it is presented.

#3: OPM acknowledges that there are several definitions of gender-based violence (GBV). However, in the interests of simplicity and readability, the glossary relies on a limited number of sources to explain the concept. It is important to note that this means that it does not provide a comprehensive or exhaustive explanation of GBV.

01 Gender as a Social Determinant of Health

Gender critically affects health outcomes. It influences, for instance, who has (more) control over resources, who has better access to healthcare, who bears a disproportionate load of providing care, and who is left out of health programming and research. Gender intersects with each layer of the health system, and gender-based inequities translate into health inequities. WHO recognises the crucial role of gender in health systems and recommends integrating gender into health systems and health programming and evidence-building. To this end, Section 1 forms the foundation of this glossary as it takes the reader through the basics and basis of gender and related health concepts.

1.1 Sex and Gender

A. Sex

Sex, also called 'sex assigned at birth' by healthcare professionals, is based on both primary and secondary **biological characteristics,** including genitalia, hormones, and chromosomes (Gender Equity Unit, WHO).

How is 'sex assigned at birth' in healthcare settings?

At birth, a sex of an infant is determined by a combination of bodily characteristics, including chromosomes, hormones, internal reproductive organs, and genitalia (PATH). However, sex assignment is often done on the basis of external genitalia and not necessarily chromosomes or hormones. The doctor usually looks at the genitals of the baby and declares whether it is a boy or a girl. If the baby has a penis, it is declared a boy and if it has a vulva and vagina, it is declared a girl. Apart from the genitals, it is extremely difficult to differentiate between two newborn children (see Figure 1).

Figure 1: Understanding biological characteristics, from the YP Foundation's handbook 'Understanding Gender Beyond the Binaries'

It is important to note that many of the characteristics listed above are not visible at the time of birth, so it is most often the external genitalia that determines what sex is assigned.

B. Intersex

Closely associated with the understanding of sex is the understanding of intersex persons. Intersex is an umbrella term that describes persons with bodies that fall outside of the male/female binary. There are a variety of intersex bodies. The term is used to denote people with anatomical variations, especially in regard to the sexual organs, that fall outside the boxes of male and female organs. It is important to note that intersex variations occur naturally, and are not an abnormality (Planned Parenthood). Sometimes people are born with genitals that fall outside the category of male and female, such as 'ambiguous' genitalia, enlarged clitorises, clinically designated 'micro-penises', and undescended testes, to name a few. In other words, sex can be described as a biological distinction between male, female, and intersex individuals (The YP Foundation).

If a person's genitals look different at the time of birth, the doctors may label them as intersex right then or they may try to surgically change them to conform to the binary sexes. it is important to take into account the fact that gender-affi¬rming surgeries, when undertaken with the consent of an individual, can help them in coping with the struggle that they face with their gender identities and sexuality.

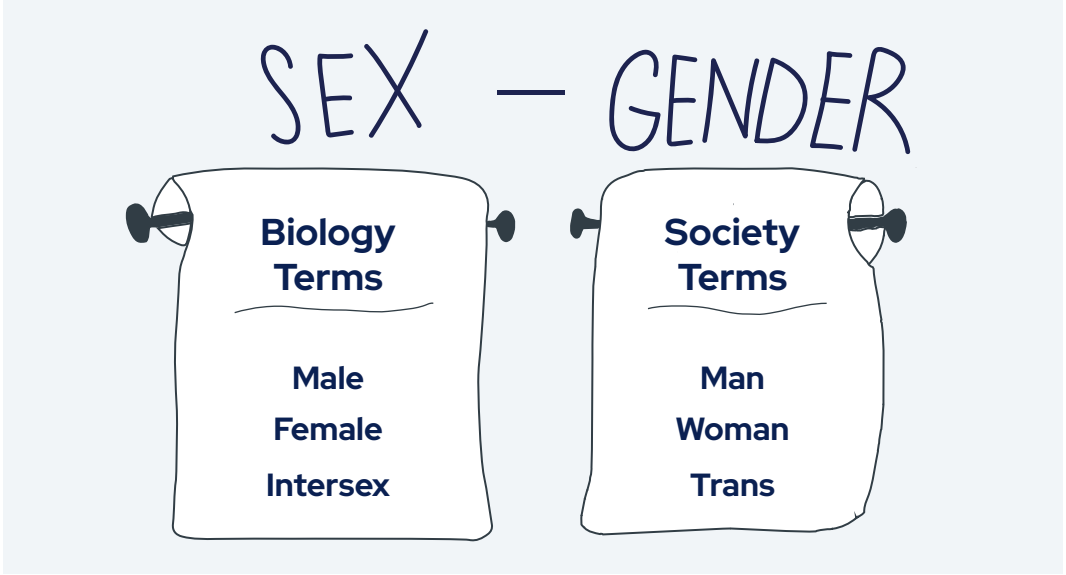
C. Gender

Gender refers to socially constructed identities, roles, and expectations assigned to a specific biological sex, which create differential power relations. Some important things to know about gender include the following:

Gender, as a social construct, is also culturally specific and hence is also a cultural construction. Gender is not who we are but what we do, and in that sense, it is also performative.

Gender is a social and cultural construction of identity, at a given point of time. It is important to consider that gender constructions are often subject to time and change. Thus, for example, construction of gender can be influenced by the media and by capitalist markets.

Figure 2: Understanding sex and gender, from OPM's 'Gender Made Simple'



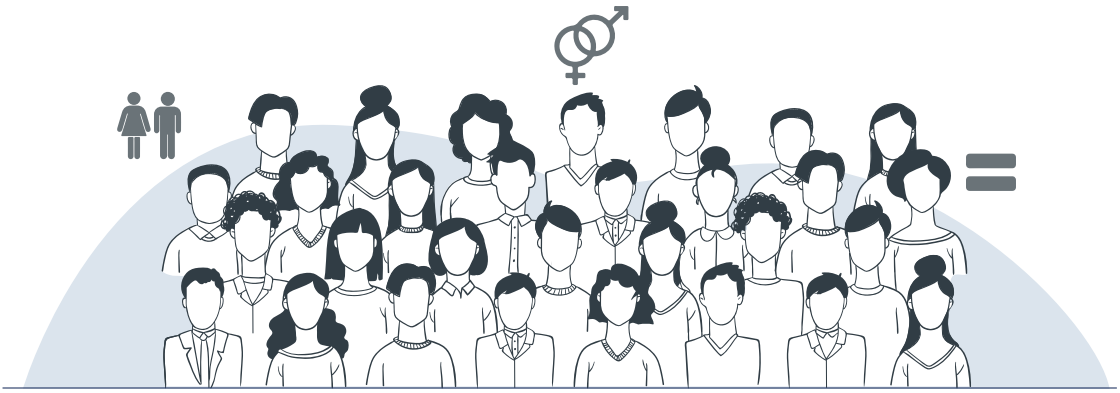
What is gender not?

Before we can understand the meaning of gender, it is important to establish what gender is not about (Gender Made Simple, OPM):

- **Gender is not only about women's issues:**
  Gender is often misunderstood as a women's problem or as relating to women's issues, or as a discourse that pertains to women alone. However, gender encompasses an understanding of power and hierarchy experienced equally by men and women and a range of other identities.

- **Gender is not about two sexes, i.e. male and female.**
  It is important to recognise that gender is a complex and multifaceted concept that encompasses a range of identities and experiences beyond the traditional understanding of male and female. Even though gender is not a binary, the binary serves as a reference point to illustrate different gender identities and expressions.

- **Equality and discrimination are not gender – they are the implications of gender:**
  When talking about gender, people often start talking about inequality, discrimination between men and women, violence, and/or injustice. However, these are all implications of gender, rather than gender itself. Due to a lack of clear understanding of gender and related concepts people often use their own experiences of gender to give meaning to it and to make sense of it, which also leads to people using such terms interchangeably.



1.2 Gender identity

Gender identity refers to a person's understanding of their own gender, and how they express that understanding. Clothing, appearance, and behaviours can all be ways of expressing one's gender identity. Gender identities exist on a continuum. The various case

scenarios of gender identity are set out below (note that this terminology is continuously being revised so the wording here may differ from other resources (The YP Foundation).

01

When an individual's assigned sex and gender identity are the same, or are in line with each other, they are called **cisgender.**

02

When an individual feels that their assigned sex is of the other gender from their gender identity (i.e. assigned sex is female but gender identity is male) they are called **transgender or trans.** (expanded in section 1.3)

03

When an individual falls into neither of the above categories, they are called **non-binary** (for example, genderqueer, genderfluid).

04

Gender non-conforming refers to individuals with a range of identities and expressions that are different from the conventional understandings of masculinity and femininity.

Note that it is impossible to look at someone and tell their gender identity.

Not all gender non-conforming people identify as transgender, nor are all transgender people gender non-conforming. Many people have gender expressions that are not entirely conventional – that fact alone does not make them transgender.

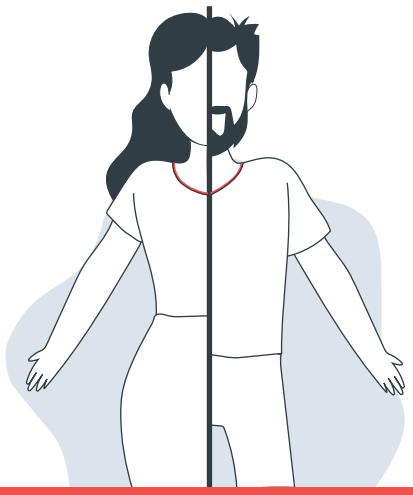
Many transgender men and women have gender expressions that are conventionally masculine or feminine. Simply being transgender does not make someone gender non-conforming.

Resources

- Understanding Gender Beyond Binaries
- Terminology Related to Gender and Sexuality
- Transgender and Non-binary Identities

1.3 Transgender and transitioning

Transgender refers to the situation in which an individual's gender identity is different, or their expression and behaviour does not align with what a doctor assigned them when they were born, based on the way their body looked at that time (their 'sex assigned at birth', which will usually be 'male' or 'female'). For example, a transman is a man who was assigned female gender at birth. A transwoman is a woman who was assigned male gender at birth.



Note that while transgender is used widely as an identity marker, it is essential to remember that this label might or might not cover the identities of local Indian communities, such as hijras, kinnars, and jogis. It is important to take the unique needs and identities of all of these groups into account when discussing the rights of transgender persons in India.

What do we mean by 'transitioning'?

Transitioning is an umbrella term that refers to the various social, legal, as well as medical processes a person undergoes to affirm their gender identity (United Nations). Since transitioning is a very broad term, it can mean different things to different people (OHCHR).

From a medical point of view, it can include medical, surgical, and hormonal treatment. A specific medical part of this may be a gender-a¬ffirming surgery that involves surgical procedures or hormonal treatment.

From a social point of view, it can include changing one's name and chosen pronouns and changing one's gender expression.

From a legal point of view, it can include changes in social documents, such as a driver's licence or passport.

Note that all persons who identify themselves as transgender and all gender identities are valid irrespective of whether they have undergone a transitioning process.

Medical transitioning resources

- Born Free and Equal
- Trans-affirmative Medical Education in India
- What do I need to know about transitioning?

1.4 Gender norms and gender socialisation

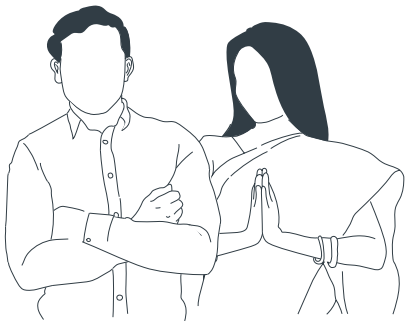
UNICEF describes gender norms as being a part of social norms and defines them as 'informal, deeply entrenched and widely held beliefs about gender roles, power relations, standards or expectations that govern human behaviours and practices in a particular social context and at a particular time'. UNICEF also refers to gender norms as ideas or 'rules' about how girls and boys and women and men are expected to be and to act that are internalised at an early stage in life.

The YP Foundation resource provides a lucid categorisation:

Norms of gender expression

include ways in which an individual is expected to express themselves because of their gender. This includes how they dress, how they behave, what they are supposed to do with the hair on their body, and more.

For example, depending upon the prevalent culture, a woman is supposed to wear clothes such as a saree or a skirt, and a man is supposed to wear a shirt and trousers (largely). While it is easier to make this comparison in regard to clothing, it is relatively difficult to do so in regard to other forms of gender expression involving behaviour, body language, and manner of speaking. For instance, men are supposed to have a huskier voice, a baritone, while women's voices are supposed to be much softer, while in terms of body language, how men and women sit, walk and stand is closely observed.



Norms of gender attributes

are the qualities that are associated with masculinity (tough, carefree, risk-taking, dependable, aggressive) and femininity (soft, caring, nurturing, dependent, submissive). These attributes are not set in stone, and are being questioned by increasing numbers of men and women.

Norms of gender roles

include the kind of work that a person is supposed to do. Gender roles also include rules and regulations which are imposed on people because of their gender.

Women working and earning is still a relatively recent development. However, even within that there are aspects which are usually gender stereotyped, with limitations and challenges. For example, in healthcare, most community health workers and nurses are women. Some exceptions are made to these norms: for example, women working may be tolerated, and even celebrated, if they are supplementing the household income while also balancing their domestic duties as wife and mother, but it may not be so acceptable for them to earn more than their husband (see Figure 3).

Norms of gender identity

demand that throughout their lives people continue to identify with the sex and/or gender they were assigned at the time of their birth. However, gender identities are fluid and can change over an individual's course of life.

Please also refer to the International Center for Research on Women's (ICRW's) Stories of Change: An illustrated Guide to understand norms and what reimagined gender roles look like.

Figure 3: Reimagined gender roles from ICRW's stories of change.

A. Gender socialisation

The social construction of gender happens through gender socialisation, the process through which individuals learn and internalise gender norms and expectations from an early age, based on their assigned sex. UNICEF defines gender socialisation as the process whereby 'individuals develop, refine and learn to "do" gender through internalising gender norms and roles as they interact with key agents of socialization, such as their family, social networks, and other social institutions' (including educational and religious institutions, workplaces, mass media and others). Socialisation begins early, and involves the constant reinforcement and ascribing of roles and expectations, including attributes of sexuality.

For example, as children, girls are told repeatedly to not go outside and play as their place is in the home, that they cannot run outside errands but rather must help with household chores. By contrast, boys are asked to go outside and fend for themselves and spend time with other boys outside. This consistent and repeated messaging socialises children into being adults who refer to these codes of conduct as their framework for living life, and even transfer them to their own children, thereby ensuring that norms are followed.

1.5 Gender power relations

Gender norms sustain a hierarchy of power and privilege that typically favours what is considered male or masculine over that which is female or feminine, reinforcing a systemic inequality that undermines the rights of women and girls and restricts opportunity for women, men, and gender minorities to express their authentic selves (UNICEF).

A. Gender and patriarchy

This structured system of power which favours men is what we call patriarchy. Patriarchy is a system that upholds and perpetuates male dominance, power, and privilege within societies. It operates through social, cultural, economic, and political structures, norms, and beliefs that privilege men over women and over other marginalised genders.

Critical aspects of understanding gender power relations include examining who has what (access to resources); who does what (the division of labour and everyday practices); how values are defined (social norms); and who decides (rules and decision-making) (as explained more fully here).

Patriarchy manifests itself in people's daily lives in various subtle and not so subtle ways. For example, in many cultures, daughters do not inherit land but sons do, while daughters get a dowry (but they may not have control over it) but sons do not; women do household work, with most domestic workers and home cooks being women, while most highly paid chefs are men. Patriarchy also plays out in the decision-making for girls on whom to marry and when to marry.

Note that even though patriarchy favours men, men are not alone in practising patriarchy: even women can be enablers and upholders of patriarchy. The intersections of age, position, and class also influence the practice of patriarchy. The discussion of intersectionality (below) will make it clearer how some positions are more favoured than others.

1.6 Intersectionality

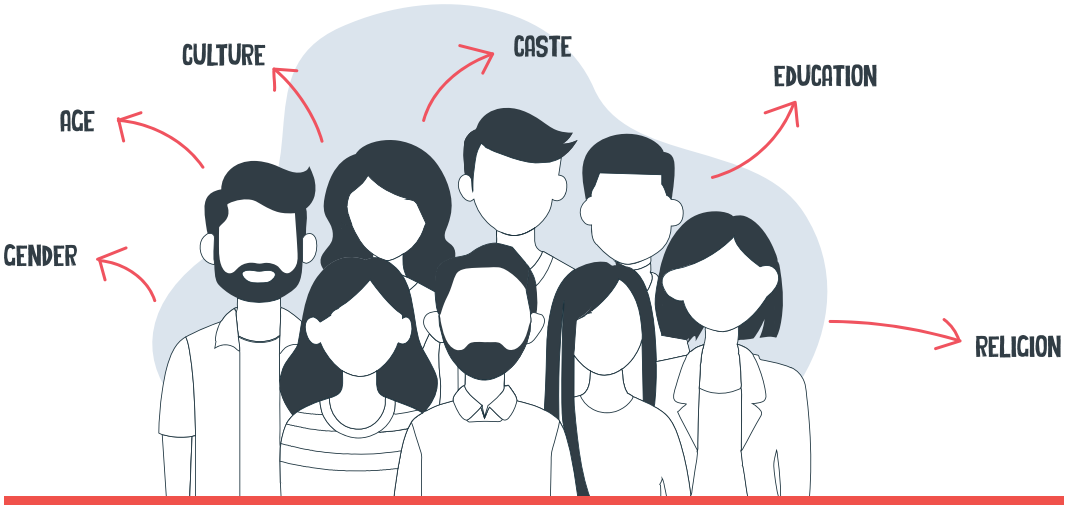
Understanding gender power relations is imperative in order to understand intersectionality. Intersectionality describes how multiple, interdependent identities interact in different ways to put individuals (or groups) in different positions within a system of power. Important identities to consider typically include race, class, religion, age, disability, ethnicity, and gender (see Figure 4). These identities create interconnected systems of discrimination, disadvantage, or relative privilege, and affect each person's lived experience, health, and behavioural outcomes (Social Norms Lexicon, ALIGN).

A. Gender, intersectionality, and intersecting identities

To understand intersectionality it is important to know about intersecting identities. The inequities and inequalities people experience are never the result of a single, distinct factor. Rather, they are the outcome of the intersection and overlap of different social identities enmeshed in power dynamics and contextual factors in a given environment (YW Boston Blog). The term 'intersectionality' was first coined by Kimberlé Crenshaw in 1989. It expands our understanding of social oppression and how it operates in a given society, culture, or environment.

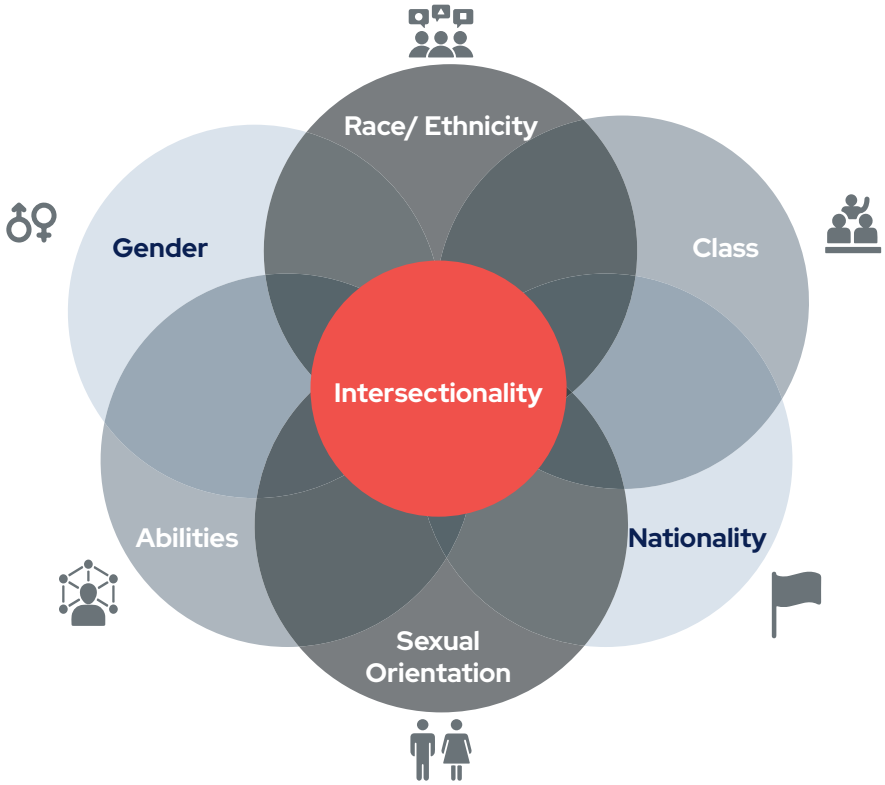
Hence, intersectionality is a way of understanding social relations by examining intersecting forms of discrimination. This means acknowledging that that many forms of oppression, like racism, sexism, and ageism, might be present and active at the same time in a person's life. Intersectionality is about understanding and addressing all potential roadblocks to an individual or group's well-being (The Compass for SBC). Intersectionality accounts for gender and its interaction and overlap with other social identities. Gender is only one source of power among others: all of which are imbued in any individual identity (see Figure 4). However, gender as a source of power cuts across all other sources of power.

In the Indian context, age, education, caste, and religion also play an important role in a person's identity and lived experience, and contribute to increased vulnerability. It is important that we account for intersectional vulnerabilities when designing health policies and programmes.



In India, who does what is determined by the caste system. This intergenerational caste-based occupational segregation (refer to Section 2) leads to the exclusion and stigmatisation of, and discrimination against, certain caste groups, and amplifies their vulnerabilities. Sanitation workers and waste-pickers belong to the Dalit community, which is considered to be the lowest caste in the caste hierarchy. While all Dalits are marginalised, Dalit women face more marginalization, because they are both Dalit and women. Thus, along with facing occupational risks (refer to Section 2) and illnesses (including TB, asthma, and eye infections), women sanitation workers also face multiple marginalisations, in the form of untouchability and gender-based violence (GBV) from other caste groups, receive lower wages than Dalit men in the community, and have limited access to health and other services (ICRW).

Figure 4: Various intersecting identities leading to intersecting forms of discrimination



Adapted from Womankind Worldwide, https://www.womankind.org.uk

1.7 Gender empowerment

Gender empowerment is a form of social empowerment: it refers to the expansion of people's capacity to make and act upon decisions (agency) and to transform those decisions into desired outcomes, affecting all aspects of their lives, including decisions related to health. It entails overcoming socioeconomic and other power inequalities in a context where this ability was previously denied. Programmatic interventions often focus specifically on empowering women because of the inequalities in their socioeconomic status and historical disadvantages. (This paragraph was adapted from Naila Kabeer's and Ruth Alsop's definition of empowerment; and from JHPIEGO).

Gender empowerment is a process that aims to change people's degree of access to available means and resources, and to build capacity such that it alters the positioning of those in a lesser position due to their gender (including women, girls, and transgender individuals) to allow for greater autonomy and self-determination (GEH and UCSD).

Empowerment of women (and girls) is achieved through the expansion of choice and the strengthening of voice, aimed at transforming power relations so that women and girls have more control over their lives and futures. Simply put, empowerment is a process of ongoing change through which women and girls expand their aspirations, strengthen their voice, and exercise more choice (Bill & Melinda Gates Foundation).

In gender and health research, there are indicators that can be used to measure gender empowerment and its various components. These will be elaborated in Sections 2 and 3.

A. Agency

Agency is a core attribute of empowerment. It refers to a person's capacity to set goals and act on them (UN Women). It may entail bargaining, negotiation, and resistance (adapted from Naila Kabeer's definition of agency and JHPIEGO). Women and girls exhibit agency in decision-making when they influence and make decisions, and when they establish and act on goals. Key decisions that affect women and girls' lives and futures occur in both the private and public spheres and often entail a process that includes negotiation and compromise. A woman or girl exercises empowered decision-making when she uses her voice to influence key decisions and is aware of, and can act upon, a full array of choices (Bill & Melinda Gates Foundation).

Agency means that empowerment cannot be given to people or done to people but rather comes from processes whereby people empower themselves. Agency involves people creating their own momentum, gaining their own skills, and advocating for their own changes.

B. Gendered access to and control over resources

Central to the definition of empowerment of women and girls is whether they have access to and control over resources. Traditional gender roles restrict women's mobility and decision-making power and they may face barriers to access, including timely access to healthcare facilities, which can lead to delayed or inadequate treatment.

In this context, equal access to and control over resources for men and women means that all genders have an equal opportunity to use and benefit from various resources, including material, financial, human, social, and political assets. While access is important, it is equally important that women have control over the resources, i.e. both men and

women possess an equal say and decision-making power in how these resources are utilised and distributed, ensuring a fair distribution of resources between genders. Below, we cite the definitions of UN Women and WHO for these two concepts:

Access to resources
for UN Women refers to the ability to use and benefit from specific resources (material, financial, human, social, political, etc.). WHO defines access as 'the availability of a resource that includes several components such as geographic or physical accessibility, financial and social accessibility'.

Control over resources
for UN Women entails being able to make decisions over the use of that resource. WHO defines 'The ability to decide when, how and who can use a resource'.

1.8 Violence against women and girls (VAWG)

Closely associated with the understanding of gender is the issue of VAWG. VAWG is defined by WHO as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.'

> Note that this includes violence against cisgender and transgender women. This term should not be used to describe violence against transgender or non-binary people assigned female sex at birth who do not currently identify as women.

A. Gender-based violence (GBV)

According to UNHCR, 'Gender-based violence refers to harmful acts directed at an individual based on their gender. It is rooted in gender inequality, the abuse of power and harmful norms.'

GBV is often understood to be driven by socially (and sometimes legally) codified gender roles and rules about what is and is not acceptable behaviour. The term GBV acknowledges that violence may be used to perform and reinforce gender-related social norms in a given context and to sanction or victimise people who deviate from them.

Usage of VAWG and GBV

While the terms 'gender-based violence' (GBV) and 'violence against women' and 'violence against women and girls' (VAWG) are frequently used interchangeably in literature and by advocates, the term GBV highlights the gender dimension: in other words, the relationship between

(1) subordinate status (of women, queer/trans people, and others who do not occupy the dominant identity of cisgender heterosexual males) in society; and

(2) increased vulnerability to violence because of unequal power relations and gender roles.

Note that GBV disproportionately affects women and girls, but men also experience GBV (SVRI).

Types of GBV

United Nations Population Fund (UNFPA) defines various types of GBV:

01 Physical violence

'Physical violence' refers to the intentional use of physical force with the potential of causing death, injury, or harm.

02 Sexual violence/abuse

Sexual violence refers to any sexual act or attempt to obtain a sexual act, or unwanted sexual comments or acts to traffic, that are directed against a person's sexuality using coercion by anyone, regardless of their relationship to the victim, in any setting, including at home and at work.

03 Psychological violence/abuse

'Psychological violence' (often also referred to as 'emotional violence') refers to any act or omission that damages the self-esteem, identity, or development of the individual. It includes, but is not limited to, humiliation, threatening loss of custody of children,

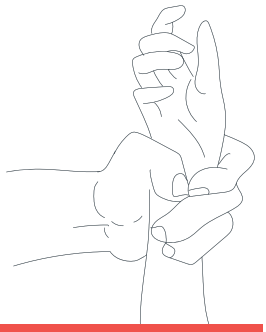
forced isolation from family or friends, threatening to harm the individual or someone they care about, repeated yelling or degradation, inducing fear through intimidating words or gestures, controlling behaviour, and the destruction of possessions.

04 **Economic violence/abuse**

'Economic violence' includes denying a person access to and control over basic resources. It causes, or attempts to cause, an individual to become financially dependent on another person, by obstructing their access to or control over resources and/or independent economic activity. It includes acts such as the denial of funds, refusal to contribute financially when obligated to do so, denial of food and basic needs, and controlling access to health care or employment.

B. Domestic violence

Domestic violence refers to abusive behaviour (physical, sexual, and emotional violence and neglect) that occurs within the private, domestic sphere, generally between individuals in the same household who are related through blood or intimacy. In most contexts, 'intimate partner violence' (IPV) – further explained below – is the main type of domestic violence, but in some societies violence by in-laws can also be a dominant form (UNFPA).



The term 'domestic violence' should be used carefully to avoid confusion, since
(1) it overlaps with IPV, VAWG, and GBV; and
(2) experience of domestic violence is not confined to women.
Domestic violence also includes child abuse and elder abuse in the domestic sphere.

Please note that legal definitions of domestic violence vary among countries; they often include violence against domestic workers who live in the same household.

C. IPV

IPV is violence against a current or former spouse or other sexual/romantic partner. The overwhelming majority of IPV cases affect women (WHO). IPV includes a range of assaultive and coercive behaviours, including physical, sexual, emotional, and psychological attacks, as well as economic coercion, by a current or former intimate partner. IPV often involves multiple overlapping violent behaviours that occur repeatedly over time (SVRI).

D. Sexual violence

Sexual violence occurs when someone is forced, coerced, and/or manipulated into any unwanted sexual activity. It includes rape, attempted rape, and sexual assault; child sexual abuse and incest; intimate partner sexual assault; any unwanted sexual contact or touch; sexual harassment; sexual exploitation; showing one's genitals or naked body or masturbating in front of another person without their consent; and watching someone in a private act without their knowledge or permission. Sexual violence can be perpetrated by anyone regardless of their relationship to the victim, and in any setting, including at home, at work, or in a public space. While sexual violence most often occurs within – or reinforces – gendered power dynamics and/or other social hierarchies, the term 'sexual violence' includes all acts listed above, regardless of the perceived gender, gender identity, sexual orientation, or other personal characteristics of either the victim or the perpetrator (NSVRC).

The terms 'sexual violence', 'sexual assault', and 'sexual abuse' are sometimes used interchangeably, though it may be more common to hear one term versus another in certain circumstances.

Role of the health sector in addressing GBV and VAWG

WHO considers GBV to be a public health issue. The role of healthcare providers in addressing GBV is crucial to ensure life-saving care is provided to women, girls, and other at-risk groups. Healthcare providers are often among the first – and only – points of contact for GBV survivors. Healthcare providers not only offer immediate medical attention and first-line support but they can also link survivors to other needed assistance, including mental health and psychosocial support, social services, legal aid, shelter/housing services, and livelihood support.

Resources on VAWG, GBV, and the role of the health sector

- Gender based violence is a public health issue: using a health systems approach: WHO
- Role of health sector in addressing IPV in India: ICRW
- Strengthening the medico-legal response to sexual violence: United Nations Office on Drugs and Crime (UNODC), WHO
- Enhancing the Quality of Response of the Health Care System to Sexual Assault: ICMR

1.9 Equality, equity, and substantial equality

Equality is the idea that, for anything to be fair, people must always be given equal opportunity (see Figure 5). **Gender equality** implies that the interests, needs, and priorities of both women and men are taken into consideration, recognising the diversity of different groups of women and men. Gender equality is not a women's issue: it should concern and fully engage men as well as women. Equality between women and men is both a human rights issue and a precondition for, and indicator of, sustainable people-centred development (UN Women).

However, equal opportunities given to people who are unequally positioned in society may not lead to equality of outcomes. **Substantial equality** goes beyond equal opportunity and focuses on equal outcomes. Equality might enable equal participation for all, but it does nothing to ensure equal distribution of results or outcomes for all (Gender Made Simple, OPM).

Equality indicates uniformity, where it is assumed that everything is evenly distributed among people when in fact it is not

Equity represents impartiality, whereby the distribution is made in such a way to even out the opportunities available for all, i.e. levelling the playing field.

Equity as a concept relates to adoption of a strategy or an affirmative action to achieve substantial equality.

Equity ensures that individuals are provided with the resources and support they need to have access to the same opportunities as the general population (see Figure 5). Gender equity refers to the fair distribution of benefits and responsibilities between women and men according to their respective needs. This may involve equal treatment or treatment that is different but considered equivalent in terms of rights, benefits, and opportunities. In the development context, a gender equity goal may introduce special measures (also referred to as affirmative action) to compensate disadvantaged women and men, to end inequality and foster autonomy (ADB).

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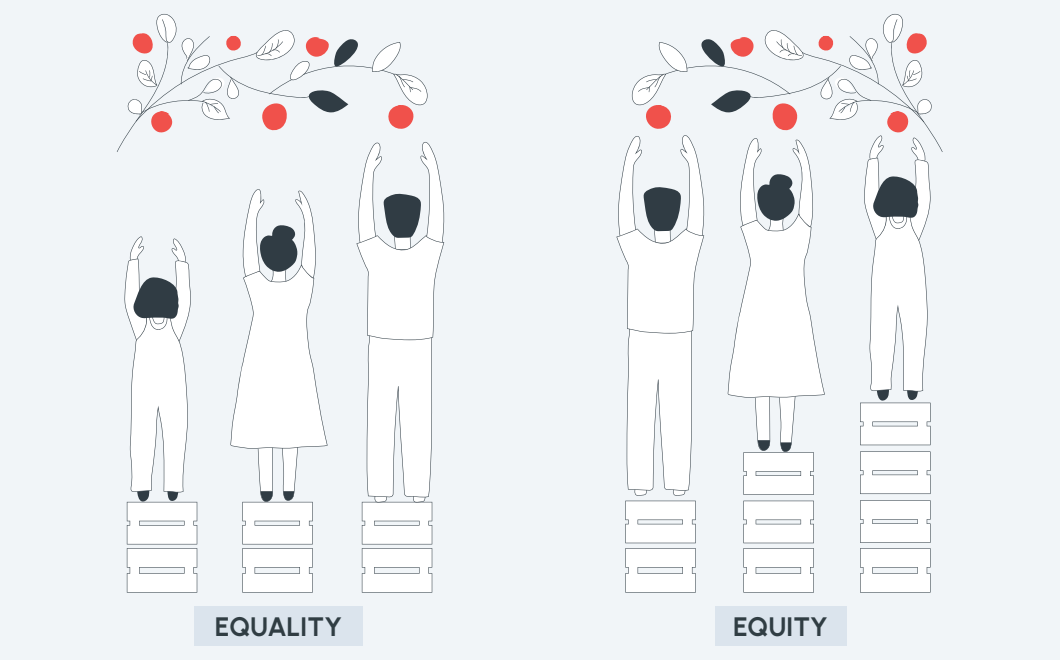
Figure 5: Understanding gender equity and equality (Feminism in India)



Gender equality in health
implies that women and men have equal conditions in which to realise their full rights and potential to be healthy, contribute to health development, and benefit from the results. Achieving gender equality requires specific measures that are designed to support groups of people with limited access to such goods and resources.

Gender equity in health
refers to the process of being fair to women and men with the objective of reducing unjust and avoidable inequality between women and men in health status, access to health services, and their contributions to the health workforce (refer to gender and human resources in health in Section 2).

Gender inequality disproportionately affects women and girls, and people of other genders. In most societies, these individuals have lower status and have less control over decision-making about their bodies, in their intimate relationships, families, and communities, which exposes them to violence, coercion, and harmful practices. Women and girls face high risks of unintended pregnancies, sexually transmitted infections (including HIV), cervical cancer, malnutrition, and depression, amongst others health issues. Gender inequality also poses barriers to women and girls accessing health information and critical services, including restrictions on mobility, lack of decision-making autonomy, limited access to finances, lower literacy rates, and discriminatory attitudes of healthcare providers (WHO).

1.10 Health equity

Health equity refers to the absence of unfair, avoidable, or preventable differences in health among populations or groups, defined socially, economically, demographically or geographically (WHO). Health equity is achieved when everyone can attain their full potential for health and well-being.

Health and health equity are determined by the conditions in which people are born, grow, live, work, play, and age, as well as by biological determinants. People's living conditions are often made worse by discrimination, stereotyping, and prejudice based on sex, gender, age, race, ethnicity, or disability, among other factors. Discriminatory practices are often embedded in institutional and systems processes, leading to groups being under-represented in decision-making at all levels, or underserved (WHO).

1.11 Gender-affirming care

Gender-affirming care refers to the provision of high-quality, compassionate care irrespective of an individual's gender identity. This care includes using gender-neutral language, validating and affirming patients, and applying appropriate mental and physical health screenings to enhance patient experience, health outcomes, and quality of life (see here).

While gender-affirming care is for everyone, it is most needed for lesbians, gays, queer transgenders, and intersex individuals who face exacerbated health disparities. These patients experience drastic disparities in rates of suicide, depression, anxiety, substance use, malignancy, sexually transmitted disease, and violence (see here).

For transgender patients, every encounter in the healthcare space can be either gender-affirming or gender-denying, depending on the way they are addressed and provided with healthcare and services, and their experience of visiting a health facility. They may feel their gender is denied if they are subject to microaggressions, misgendering, and harassment, and if they experience transphobia[1] from providers, medical staff, and fellow patients. Hence, healthcare providers have a critical role to play in ensure patients receive gender-affirming care (see here).

[1] Transphobia is the belief that gender and sex are binary, and thus that transgender identity is a medical pathology.

How can providers ensure patients receive gender-affirming care?

Providers have the opportunity to intervene and positively impact patient experiences through providing gender-affirming care, but they first require an adequate knowledge base and understanding of the importance of sensitive and inclusive care. Gender-affirming care goes beyond the application of these treatment modalities. For this reason, this broader understanding of the term 'gender-affi¬rming' care includes the attitudes and behaviour of the care provider as regards quality and dignity in care provision.

An inclusive and gender-affirming healthcare atmosphere necessitates appropriate and inclusive education for all staff and employees, not only for healthcare providers and physicians. Gender-neutral language should be encouraged, and gender-neutral restrooms should be clearly available and easily accessible. Diversity and inclusion statements, and non-discrimination statements should be clearly posted in the lobby or waiting room; use of inclusive or minority logos, such as the pride flag or transgender flag or colours, can further encourage comfort and establish inclusive care.

Resources on the provision of gender-affirming care:

- Gender affirming care toolkit for providers and educators
- Gender-affirming Paediatric Care Toolkit

1.12 Sexual and reproductive health and rights (SRHR)

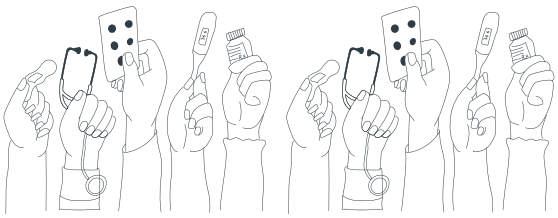
SRHR can be understood as the right for all – whether young or old; women, men, or transgender; straight, gay, lesbian, or bisexual; HIV positive or negative – to make choices regarding their own sexuality and reproduction, providing they respect the rights of others to bodily integrity. This definition also includes the right to access the information and services needed to support these choices and optimise health (UN Women).

A. Sexual health

Sexual health includes fertility regulation, the prevention and management of sexually transmitted infections (including HIV), sexual violence prevention, and sexual functions (including sexual desire and arousal) (Lancet). WHO defines sexual health as a state of physical, emotional, mental, and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction, or infirmity.

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled.

Sexual health and reproductive health are closely linked, but crucial aspects of sexual health can be overlooked when grouped under or together with the domain of reproductive health.



B. Reproductive health

Reproductive health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the ability to reproduce and the freedom to decide if, when, and how often to do so (Pan American Health Organization (PAHO)). It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion, and violence.

Components of reproductive health include sexual health, family planning, antenatal and postnatal care, safe delivery, and abortion services (UNFPA) (PAHO). Infertility care is also now considered a part of reproductive health (WHO).

C. Gender norms and reproductive health

Gender norms, especially those around marriage and fertility, restrict the agency of women and girls, and promote early marriage, resulting in adolescent and young women being unable to complete their education, or to participate in family planning decisions. Limited

agency often restricts women's ability to receive antenatal care, which negatively impacts their health and the health of the newborn (ICRW).

1.13 Gender-based discrimination

Gender discrimination, also referred to as sexual discrimination, encompasses any action that deliberately withholds opportunities, benefits, or rewards from an individual or group based on their sex or gender. Gender-based discrimination takes place due to society's expectations regarding how men and women should behave or what work they should do etc., and it can lead to people being denied their rights and opportunities, and the chance to fully participate in society (UNODC).

A. Gender-based discrimination as a structural barrier to health

The concept of gender-based structural barriers refers to gender inequalities in social structures, based on institutionalised conceptions of gender differences. Conceptions of masculinity and femininity, expectations of women and men, judgements regarding women's and men's actions, prescribed rules about the behaviour of women and men – all of these, and more, create and maintain gender inequality in social structures. Social and cultural environments, as well as the institutions (i.e. family, religion, education etc.) that structure them and the individuals that operate within and outside these institutions, are engaged in the production and reproduction of gender norms, attitudes, and stereotypes (UNICEF).

Health systems and health actors are also influenced by gender norms, which impacts the delivery and quality of health, especially for women and girls, and other gender identities. It is important to recognise and address gender-based discrimination in the delivery of healthcare.

> COVID-19 inflicted additional layers of stigma and isolation on transgenders engaged in sex work – more so because they fall outside the traditional binary segmentation of male and female. As the mainstay of their work is physical contact, these people were also looked upon as high-risk transmitters of the infection and were termed 'super-spreaders'. Moreover, their social status made it impossible to access healthcare during the pandemic (ICRW).

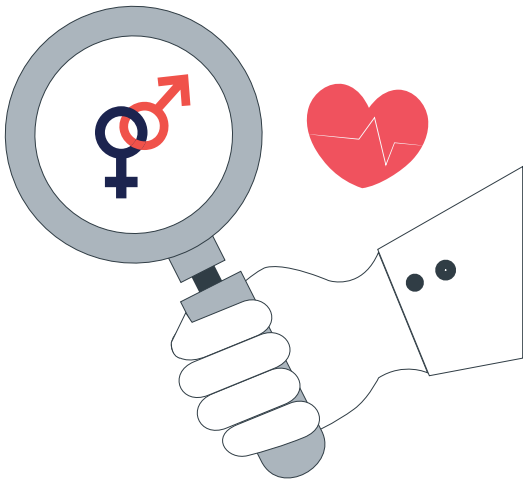
02 Gender and health programming

In the previous section, we defined and discussed various concepts relating to gender and its influence on health; we gave some examples and provided links to additional resources.

In this section, we detail the different aspects of gender and health programming: we discuss what a gender lens in health means; various types of gender assessments; the gender integration continuum; as well as gender and human resources in health. This section aims to equip the reader with a comprehensive understanding of gender-focused health programming.

2.1 Gender lens/ gender perspective in health

Applying a gender lens or perspective means having an awareness of existing differences between women and men, and the importance of taking this difference into account when analysing a situation or when developing specific approaches or programmes (UNFPA, as cited in United Nations Economic and Social Commission for Western Asia (UNESCWA)).



Having this awareness enables an individual to carry out gender analysis and subsequently to mainstream a gender perspective into a proposed programme, policy, or organisation (UN Women).

Applying a gender lens or perspective is imperative in all health programming; whether or not this takes place is a key indicator of where the programme lies on the gender-integration continuum.

2.2 Gender equality/ gender equitable programming

Gender equality/gender equitable programming is an umbrella term that refers to programmes that aim to create gender equality or remove gender inequality. It encompasses a wide range of programmes that aim to create opportunities, improve access to resources, build agency, and remove barriers for women, to address the gender-based inequalities they face (UNICEF).

This type of programming purposefully addresses inequities that are strongly influenced by cultural and socially defined expectations, roles, responsibilities, norms, and power relations based on sex, gender identity, and gender expression that impede the individual from achieving gender equal outcomes (PATH).

For example, gender mainstreaming, gender analysis, prevention of and response to GBV and sexual exploitation and abuse, promotion and protection of human rights, empowerment of women and girls and gender balance in the workplace can all be counted under the umbrella term of gender equality programming.

2.3 Gender mainstreaming

Gender mainstreaming is the process of integrating a gender lens into all aspects of an organisation's strategies and initiatives, and into its culture, systems, and operations. It is a strategy for making the needs and interests of all genders an integral part of the design, implementation, and monitoring and evaluation of programmes, policies, and organizational processes, so that everyone has the opportunity to benefit equally, and to ensure inequality is not perpetuated. Gender mainstreaming requires building relevant capacity and accountability across an organisation. The ultimate goal of mainstreaming is to achieve gender equality for all (Bill & Melinda Gates Foundation).

The Gender and Health hub report categorises gender mainstreaming into two categories:

1. **Programmatic gender mainstreaming**
in health refers to achieving gender equality by putting in place policies, programmes, and interventions that aim to achieve better health outcomes for all through advancing gender equality in health

2. **Institutional gender mainstreaming**
involves addressing gender equality through internal organisational changes, such as resource allocation, strategic planning, policies, culture,

human resources, staff capacity, leadership, management, accountability, and performance management.

Example of programmatic gender mainstreaming
While violence against women has long received attention, mainly from women's movements, framing violence against women as a health issue and eliciting a health sector response to it has been a long struggle. Following two decades of persistent and sustained work across networks of feminists internal and external to WHO, GBV is now recognised as a global health priority. In 2016 the World Health Assembly passed Resolution WHA67.15 on 'Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children' (UNU-IIGH).

Example of institutional gender mainstreaming
Integration of gender into the Special Programme for Research and Training in Tropical Diseases (TDR) (WHO). TDR formally adopted its intersectional gender research strategy in 2020, with precise mechanisms for performance accountability through monitoring and evaluation indicators and a clear pathway to mainstream gender dimensions throughout TDR's work. Part of TDR's commitment to equality, includes a gender balance on advisory committees, grantees, and authorship lists, as well as increasing the number and proportion of peer-reviewed publications that explicitly consider gender and women's issues (UNU-IIGH).

Resources

- BMGF Gender Equality toolbox
- ILO Gender Mainstreaming tools
- Oxfam Gender Mainstreaming Tools: Questions and checklists to use across the programme management cycle Gender Mainstreaming Tools: Questions and checklists to use across the programme management cycle

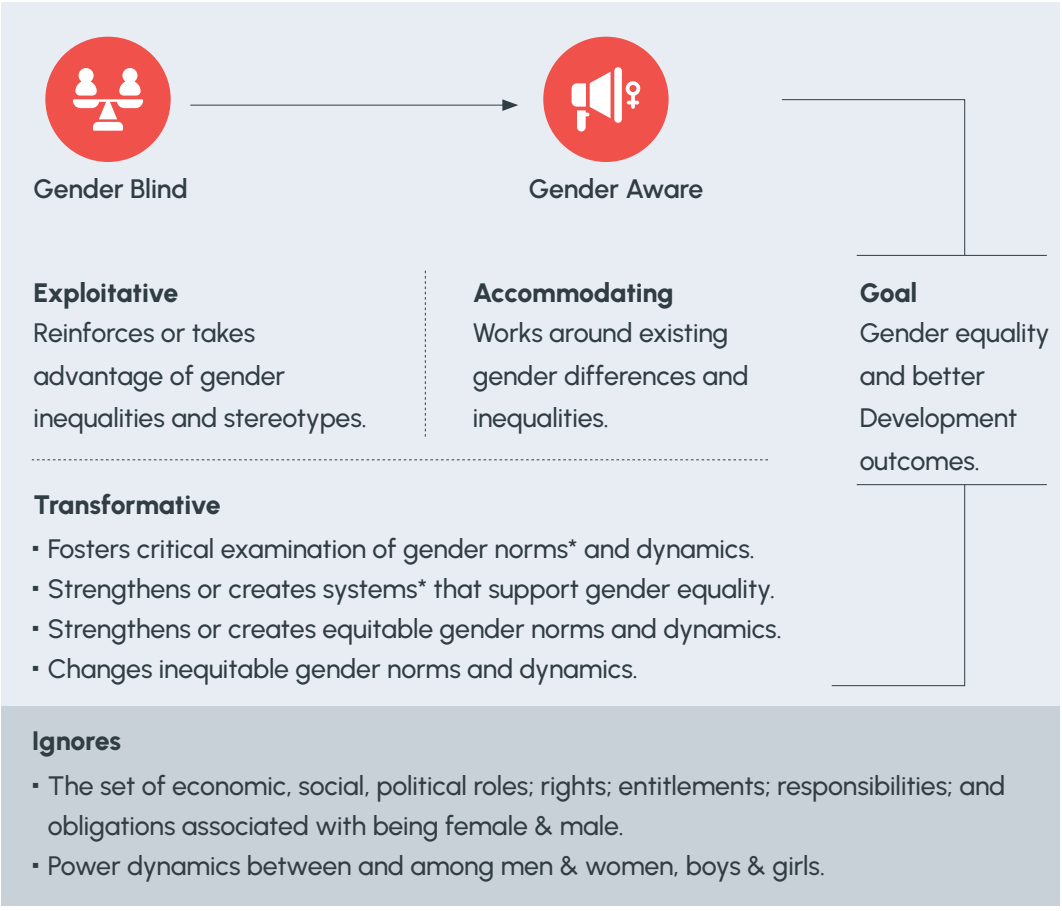
2.4 Gender integration continuum and scale

Gender integration refers to strategies applied in programme assessment, design, implementation, and evaluation to take gender norms into account and to compensate for gender-based inequalities (JHPIEGO). Gender integration is also sometimes referred to as gender mainstreaming, with the two terms used interchangeably. 'Gender integration', 'advancing gender equality and women's empowerment', and, more recently, 'gender-transformative programming', are some of the emerging terms used in United Nations agency documentation, and gender strategies, and by staff engaged with gender mainstreaming (UNU-IIGH).

Gender integration in programmes and policies operates along a continuum of degrees of integration that can range from complete absence of integration to a level of integration that is designed to achieve gender transformative changes. The gender integration continuum serves as a tool for designers and implementers to use in planning how to integrate gender into their programmes/policies. It takes users from gender-blind to gender-aware programmes, towards the goal of equality and better development outcomes.

Below we share some examples of the Gender Integration Continuum tool (IGWG, Bill & Melinda Gates Foundation), developed by different organisations.

Figure 6: Gender Equality Continuum Tool by Interagency Gender Working Group



*Norms encompass attitudes and practices.
*A system consists of a set of interacting structures, practices, and relations.

Figure 7: Gender Integration Marker in Bill & Melinda Gates Foundation Gender Integration Guide

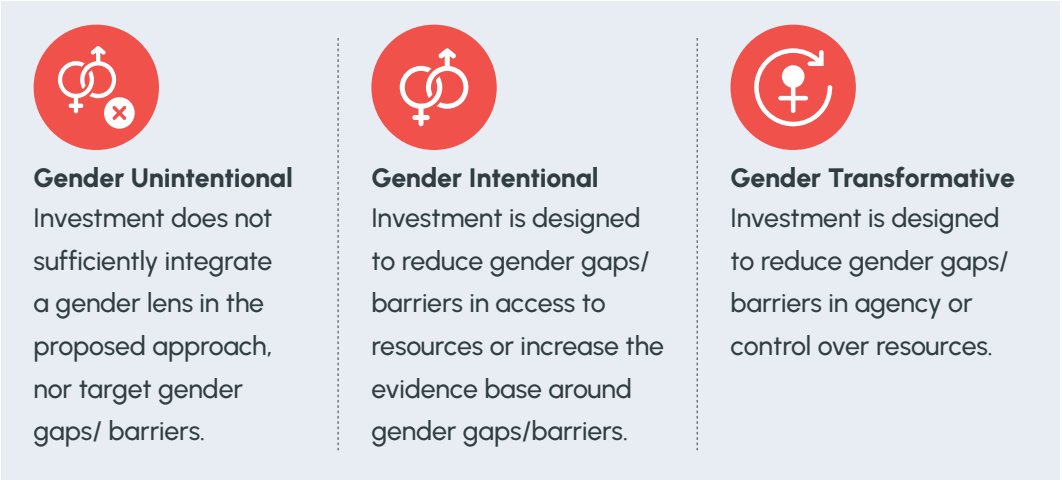


Figure 8: Gender Equity Continuum by UNICEF

Note that these terms are commonly used and defined across organisations, sometimes interchangeably and with varying meanings, including meanings that are contradictory. In the following sections we draw on the definitions used in existing tools and scales of gender integration continuum.

More examples of gender integration continuum

- UNICEF Guidance on Gender
- FHI 360 Gender Integration Framework
- Understanding and applying Gender Equality Continuum in SBCC

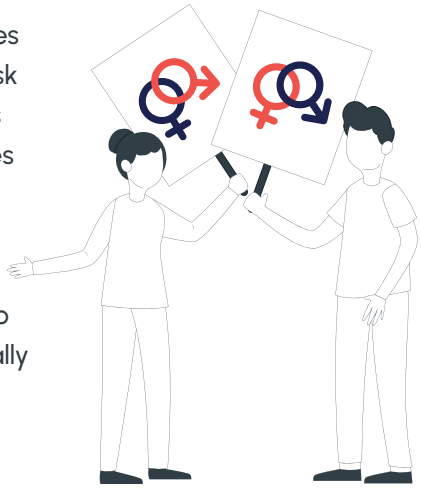
A. Gender exploitative

Gender-exploitative approaches take advantage of inequitable gender norms and existing imbalances in power to achieve programme objectives. Using a gender exploitative approach may seem expeditious in the short run, but this approach is unlikely to be sustainable, and it can result in harmful consequences and can undermine the programme's intended objectives. Gender-exploitative approaches are unacceptable in regard to integrating gender and programme designers and implementors should ensure that their programmes are not gender exploitative (FHI 360).

In some gender norms, men are seen as protectors and providers: these roles not only limit women's agency but also put a burden on men in regard to playing these roles throughout their lives. Given this understanding, if a family planning programme's core messaging is that, as protectors and providers, it is important for men to take the decision regarding planning children responsibly then that programme is 'gender exploitative'. The programme may still end up engaging men in family planning but the messaging is not around being an 'equal partner' and of 'joint decision-making' but reinstates those gender norms that need to be challenged (ICRW).

B. Gender blind/gender blindness

Gender-blind programming fails to recognise the gendered social context in which individuals live and interact with each other, and the gendered roles and inequities that exist in any context, and thus do not consider different roles and diverse needs. Consequently, gender-blind programmes tend to perpetuate, and can even exacerbate, gender inequities by ignoring the gender-based differences in disease risk and burden, power dynamics, decision-making, access to resources and services, and more, in the communities where they are implemented (PATH).



Projects that are gender-blind risk violating the 'Do No Harm' programming principles since lack of attention to gender dynamics in a specific context can unintentionally exacerbate inequities through, for example, reinforcing existing unequal power relationships and inequitable gender norms (PATH).

Family planning is considered to be a woman's domain even though family planning decisions are taken by men or other older members in the household: for example, the mother-in-law. Considering this, programmes and interventions that do not consider the interpersonal dynamic within a household can potentially put women and girls at risk. Direct engagement of women on sexual health and family planning, while hiding this from other family members, can potentially do more harm than good.

C. Gender neutral

Gender neutral refers to anything – a concept, an entity, a style of language – that is not associated with either the male or female gender. However, the nature of systemic and embedded or internalised bias is such that what is perceived to be gender neutral is in fact often gender-blind (UNICEF).

Gender-neutral activities are activities in which gender is not considered relevant to the development outcome but where the process and the outcomes do not worsen or improve gender norms, roles, and relations (USAID). Gender-neutral (programming) policies are policies that do not centre gender concerns or distinguish between genders

in their design, interventions, and monitoring (UNICEF), and that often use gender-neutral language that avoids bias towards a particular sex or gender, and therefore is less likely to convey gender stereotypes (UNESCO).

An example of a gender-neutral health programme is a public health campaign aimed at promoting healthy lifestyle behaviours, such as encouraging regular physical activity, a balanced diet, and quitting smoking. This type of program does not specifically target or differentiate its interventions based on gender but aims to benefit the health and well-being of all individuals, regardless of their gender.

D. Gender-aware and gender-sensitive programming

Gender-aware programming refers to programmes where gender norms, roles, and inequalities are considered and there is stated awareness of these issues, although appropriate actions may not necessarily have been taken.

An example of a gender-sensitive programme is a programme working on the prevention of mother-to-child transmission of HIV in which there is explicit acknowledgement that women may not have the status, rights, and decision-making power to practice safer sex and adopt safer infant-feeding practices (WHO, as cited in NCBI), but which does not address the reasons for women's lack of decision-making.

Gender aware, often used interchangeably with gender sensitive, refers to the ability to recognise gender issues, and especially the ability to recognise women's different perceptions and interests arising from their different social locations and different gender roles.

Gender sensitivity is considered to be the beginning stage of gender awareness. Gender awareness is distinguished from 'gender sensitivity' in terms of being more analytical, more critical, and more 'questioning' of gender disparities. Being gender aware means having the ability to identify problems arising from gender inequality and discrimination, even if these are not very evident on the surface or are 'hidden' (i.e. not part of the general or commonly accepted explanation of what and where the problem lies) (USAID).

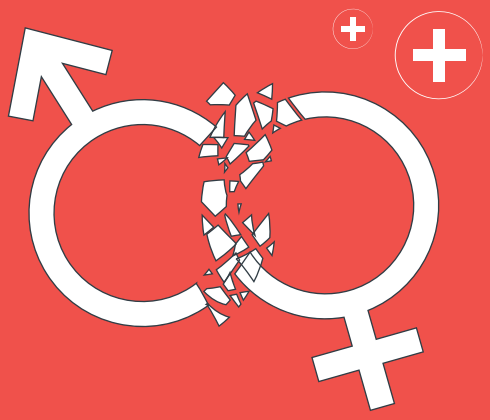
A policy on women's safety in public places would be gender sensitive if it focused on the provision of street lighting in darker areas, establishing a women's helpline that is connected to the police and hospitals, and providing emergency alarms in all public transport. It would not be gender sensitive if it focused on restricting women's mobility during certain hours (for example, in the evening or at night) or introduced a dress code for them.

E. Gender accommodating

Gender accommodating means not only being aware of gender differences but also adjusting and adapting to those differences. However, gender accommodation does not address the inequalities generated by unequal norms, roles, and relations (i.e. no remedial or transformative action is developed) (UNICEF).

Gender-accommodating policies and programmes acknowledge – but work around – gender differences and inequalities to achieve project objectives. Although this approach may result in short-term benefits and realisation of outcomes, it does not attempt to reduce gender inequality or address gender systems that contribute to differences and inequalities (IGWG).

For example, a health education project is being implemented in a community with wide gender inequalities in regard to accessing information and education. This project would be called gender accommodating if it included messages emphasising the importance of education for girls and their health issues but did not directly confront the underlying gender-related challenges that prevent women and girls from accessing education and health information and services.



F. Gender intentional/intentionality

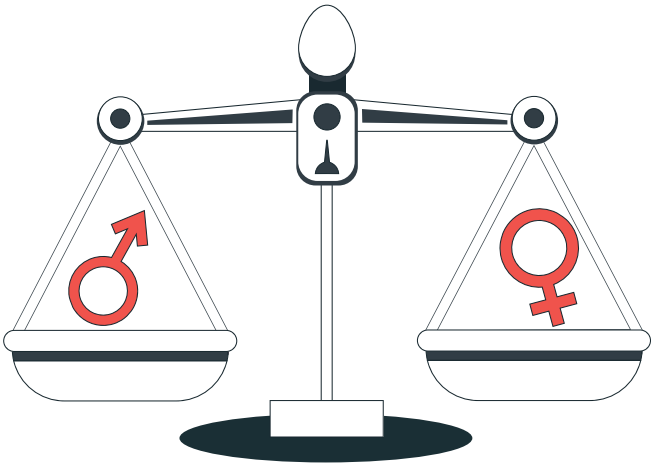
Gender intentional/intentionality means identifying and understanding gender inequalities, gender-based constraints, and inequitable norms and dynamics, and taking steps to address them (McKague et al., 2021). It is an approach in which an understanding of gender roles, inequalities, gaps, and barriers is intentionally placed at the forefront of all decisions related to the design and investment in a programme (Bill & Melinda Gates Foundation).

Gender intentionality refers to the deliberate and conscious effort to increase access to resources. Access to a resource implies the ability to obtain and use it and is limited to that (Gender Made Simple, OPM).

An example of a gender-intentional maternal health programme is one that focuses on enhancing healthcare access and services for pregnant women, encompassing safe deliveries, prenatal care, and maternal nutrition, but which does not actively challenge broader gender norms and inequalities, like abuse at home, the burden of domestic work, and societal disrespect for women, which can hinder quality care and impact their well-being. Despite its gender-intentional approach, such a program does not aim to transform the larger structural barriers perpetuating gender disparities in healthcare access and decision-making.

G. Gender-responsive programming

Gender-responsive approaches actively attempt to examine, question, and change harmful gender norms and the imbalance of power between women and men as a means of achieving development and gender equality objectives. Gender-responsive approaches encourage men's and women's critical awareness of gender roles and norms; promote the status of women; challenge the distribution of resources and the allocation of duties between boys and girls and men and women; and address the power relationships between women and others in the community, such as service providers and traditional leaders (FHI 360).



For example, a gender-responsive family planning programme is one that goes beyond simply increasing women's access to family planning services and also addresses women's limited decision-making power by involving men, husbands, and mothers-in-law. This inclusive approach aims at enabling women to adopt family planning through joint decision-making at the household level. It aims to enable better access to family planning in a context where women have little bodily autonomy and independent decision-making on their reproductive roles.

H. Gender-transformative programming

A gender-transformative approach or process is one which challenges norms and processes underlying unequal gender relations to promote shared power, control of resources, decision-making, and support for women's empowerment (UN Women). It refers to programming that focuses on addressing the unequal resources and power within a programme.

Gender-transformative policies and programmes seek to transform gender relations to promote equality and achieve programme objectives by doing the following:

01
fostering a critical examination of inequalities and gender roles, norms, and dynamics

02
recognising and strengthening positive norms that support equality and an enabling environment

03
promoting the relative position of women, girls, and marginalised groups,

transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities (IGWG). Gender-transformative policies and programmes are designed to reduce gender gaps/barriers in agency or control over resources (Bill & Melinda Gates Foundation). They try to increase access to, and enable control and authority over, resources by addressing the underlying power dynamics and working towards achieving more equitable distribution and management of resources.

In Somalia, the Communities Care Programme has helped to reduce sexual violence through changing harmful norms. Its goal is to create safer communities for women and girls by challenging social norms that sustain GBV, and spur new norms that uphold women and girls' equality, safety, and dignity (UNICEF).

The programme commences with a mapping of survivor response services for the referral of women and girls experiencing violence, as a matter of ethical priority. The peer-facilitated dialogues between young people (15 years+) and adults support the community group to identify harmful social norms that lead to GBV, and explore the benefits of change.

This is followed by a series of structured, facilitated dialogues with influential community members to examine social norms that cause and perpetuate GBV, and the pathways for transforming them.

It provides compassionate, survivor-centred care for women and girls, and it forms partnerships with local communities to address the underlying drivers of sexual violence.

The final stage in the process is to make new behaviours and norms visible through social and traditional media.

2.5 Gender-responsive budgeting

Gender-responsive budgeting, or gender budgeting, is a public policy tool that involves analysing central and local administrative budgets to assess gender funding gaps, identify actions to close them, and ensure that national and local commitments to gender equality and women's empowerment are adequately funded (UN Women).

Gender budgeting is the application of gender mainstreaming in the budgetary process. Since the budget is central to resource allocation and significantly influences public policy formulation, it is crucial to assess its potential impact on promoting gender-responsive public governance. An established definition of gender budgeting refers to 'a gender-based assessment of budgets, incorporating a gender perspective at all levels of the budgetary process and restructuring revenues and expenditures in order to promote gender equality' (Council of Europe, 2009) (OECD).

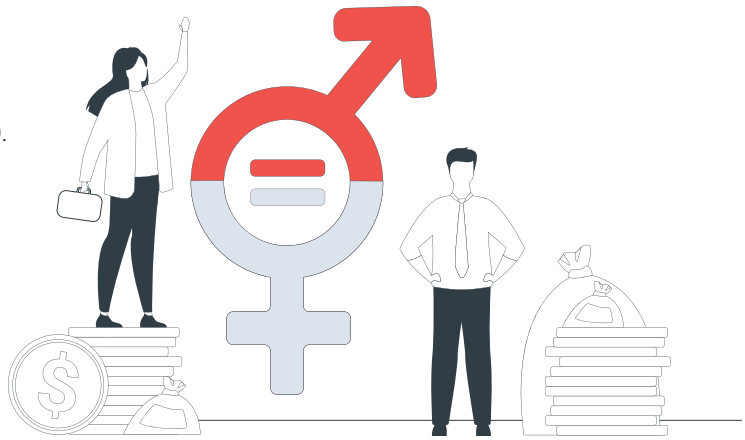
Gender-responsive budgeting in India has been applied in Andhra Pradesh, Himachal Pradesh, Madhya Pradesh, and Manipur. It first traces if any gender budgeting institutional mechanisms are in place, followed by state-level consultations with experts and then designing a tailored gender budgeting state action plan. Capacity building of government officials is an essential element that is required for the successful implementation of State Action Plans. Uniform parameters are used to assess, measure, and strengthen procedures for ensuring gender responsiveness in policies, programmes, and schemes that directly or indirectly benefit women and girls.

Resources

- India: Advancing Gender Budgeting in Select States
- Gender Responsive Budgeting: Good Practices from Select States
- Budgeting for Gender Equality: A Practical Guide to Gender Budgeting

2.6 Gender-sensitive budgeting

Gender sensitive budgeting integrates a gender perspective in budgeting and tracks how budgets respond to gender equality commitments and targets. It considers equality during budget planning and assesses the impact of budget decisions on the situation of men, women, and other genders (IPPF). Gender-sensitive budgeting is not about whether an equal amount is spent on women and men, but whether the spending is adequate to address women's and men's needs.



Resources

- Understanding Gender Sensitive Budgeting: International Organization for Migration

2.7 Gender audits

A gender audit is the process of conducting a gender assessment and is aimed at assessing the extent to which gender equality is effectively institutionalised in policies, programmes, organisational structures, and proceedings (including decision-making processes), and in the corresponding budgets (European Institute for Gender Equality (EIGE)).

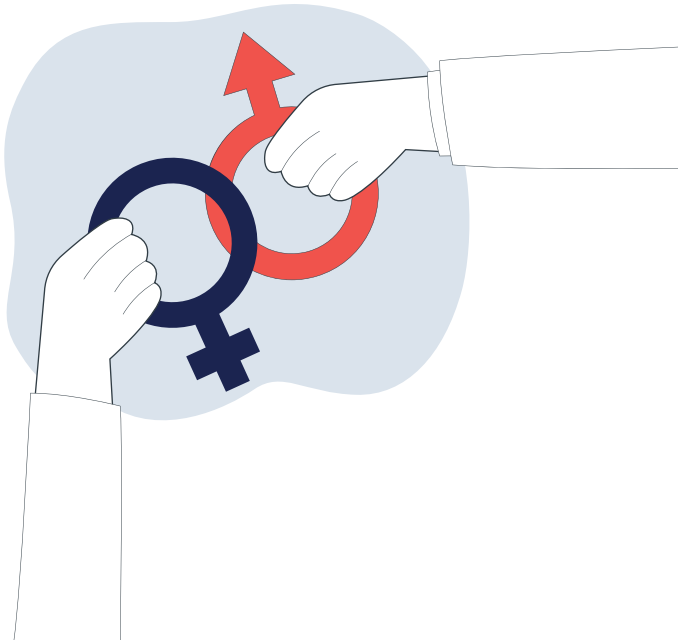
A gender audit involves a self-assessment methodology that focuses on improving the performance of an organisation with regard to the promotion of gender equality and women's empowerment. It is a tool for enhancing peoples self-reflection in people's daily lives and working environment in relation to the promotion of gender equality. A gender audit is a participatory process aimed at measuring the level of gender input, language, sensitivity, and awareness in an organisation. It is also a learning process, which involves the sharing of experiences, information, knowledge, and best practices (USAID).

Resources

- UN Women Gender Audit Guide

2.8 Gender and human resources for health

Human resources for health are defined as 'the stock of all individuals engaged in the promotion, protection or improvement of population health'. This includes both public and private sectors and different domains of health systems, such as personal curative and preventive care, non-personal public health interventions, disease prevention, health promotion services, research, management, and support services (see here) (WHO, 2007).



WHO's Global Strategy on Human Resources for Health: Workforce 2030 lays down a commitment to achieving

universal health coverage through its vision for human resources for health: 'To improve health, social and economic development outcomes by ensuring universal availability, accessibility, acceptability, coverage and quality of the health workforce through adequate investments to strengthen health systems, and the implementation of effective policies at national and regional and global levels.'

Gender inequality and gender-based discrimination in relation to human resources for health is manifested in a variety of ways, including the lack of women leadership, occupational segregation, a gender pay gap, and poor working conditions (as explained in the subsequent sections).

With this understanding, it is pertinent to understand some concepts that are integral to human resources in health and that lead to this differential power.

A. Gender (or sexual) division of labour

The concept of division of labour has its basis in economics: the division of labour is expected to increase productivity. In the words of economist Adam Smith, the division of labour involves assessing the production process and allocating tasks to individuals to enhance productivity. The gendered division of labour, also commonly referred to as the sexual division of labour, refers to the way each society divides work among men and women, boys and girls, according to socially established gender roles or what is considered suitable and valuable for each sex (UN Women).

Related concepts

Productive roles are aligned with the economics point of view and are activities carried out in order to produce goods and services either for sale or exchange, or to meet the subsistence needs of the family.

Reproductive roles are activities needed to ensure the reproduction of society's labour force and are more care-based. This includes housework like cleaning, cooking, childbearing, rearing, and caring for family members.

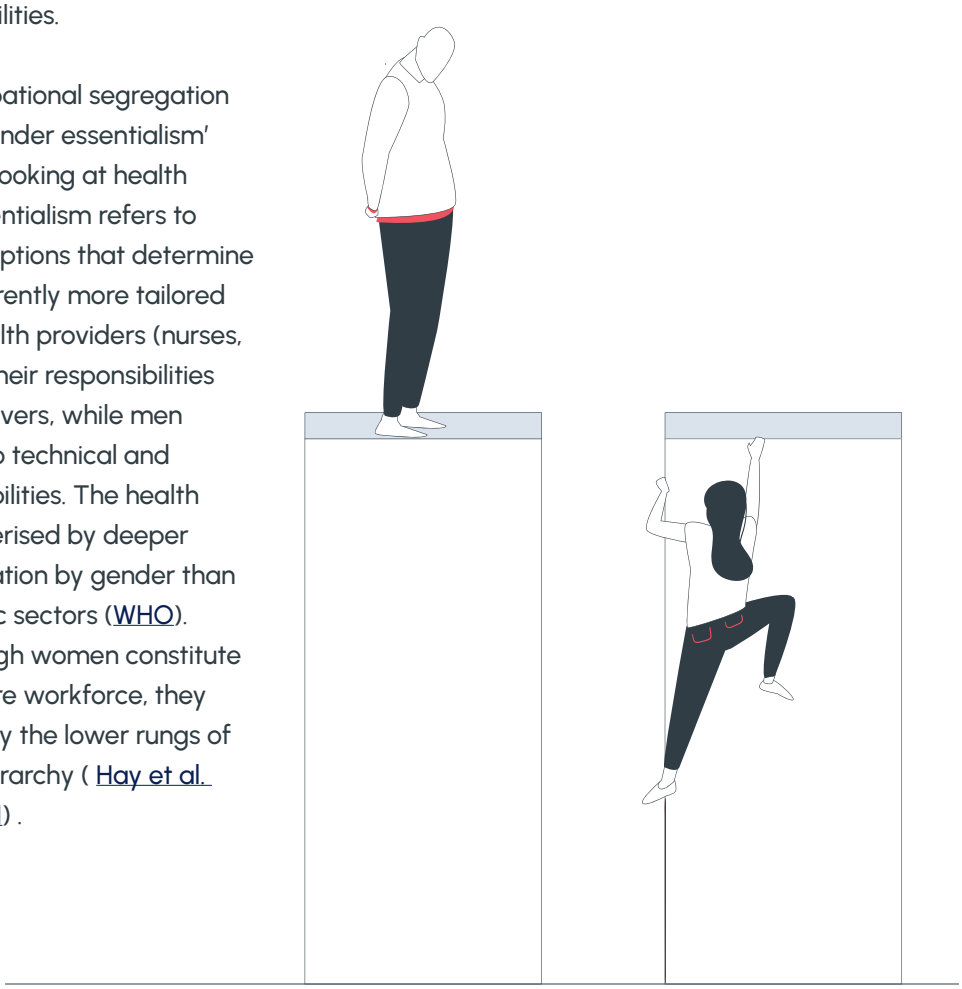
Gender-norm based sexual division of labour is how roles were defined and assigned traditionally but as more have women joined the workforce, things have changed. Women now bear what we call the 'triple' burden or roles, which means they tend to work longer and more fragmented working days than men as they are usually involved in three different roles: reproductive, productive, and community work.

Care work responsibilities have long been gendered across cultures and geographies, with domestic unpaid care – and even more formal paid care responsibilities – falling disproportionately on women and girls (ICRW). Domestic unpaid work is usually invisibilised in the form of household labour, childcare, and elderly care. Formal paid care work can be seen as care work provided within formal spaces: for example, there is a heavy concentration of women in beauty parlours, working as nurses and midwives, and working as domestic help.

B. Gender-based occupational segregation

Rooted in a gendered division of labour is gender-based occupational segregation which is work or labour segregation within the same sector or occupation. Gender-based occupational segregation refers to the differential distribution of female and male workers across and within job types, often reflecting the norm-based sexual division of labour. Such segregation often takes place alongside unequal remuneration and work advancement possibilities.

Gender-based occupational segregation is underpinned by 'gender essentialism' and 'male primacy'. Looking at health systems, gender essentialism refers to gender-biased perceptions that determine that women are inherently more tailored to caring roles as health providers (nurses, midwives) owing to their responsibilities as nurturers or caregivers, while men are naturally suited to technical and managerial responsibilities. The health workforce is characterised by deeper occupational segregation by gender than many other economic sectors (WHO). Therefore, even though women constitute most of the healthcare workforce, they predominantly occupy the lower rungs of the health system hierarchy (Hay et al. 2022; Ayaz et al.2021) .



Related concepts

Vertical occupational segregation
refers to the under- or over-representation of women and men workers in senior roles in occupations with higher status, better wages, more managerial responsibilities, or greater potential for promotion and growth. An example of vertical segregation is the over-representation of men in surgery and top leadership positions.

Horizontal occupational segregation
refers to the under- or over-representation of women or men in occupations or sectors characterised by lower pay, lower status, and flexible roles with a higher workload and no clear pathway for growth or promotion. An example is the over-representation of women as nurses, community health workers, and lower-level admin positions with a low status.

The huge deficit in regard to women leadership in the health sector and in health systems across the globe is an indicator of the prevalence of vertical occupational segregation. Women hold around 70% of health worker jobs globally, over 80% of nursing jobs, and over 90% of midwifery roles. If leadership roles were allocated proportionally (assuming that women and men have equal merit) then, since women account for 70% of health workers, 70% of health sector leaders would be women. This is the opposite of the current situation where men make up less than 30% of the health workforce but hold 75% of leadership roles (WGH). Moreover, most incentive-based volunteer positions within the health sector are held by women, making their employment and earnings more insecure.

C. Gender pay gap

The gender pay gap can be defined as the difference between what men and women are typically paid (UN Women) and is a direct manifestation of the gendered division of labour and occupational segregation previously discussed. A range of both individual and institutional factors are at play and contribute to this gap, the basis of which lies in the gender norms discussed in the last section. It can be seen that the labour of women is undervalued as well as typified, who are still largely employed in informal sectors, unpaid domestic work, and in reproductive roles, accompanied with lesser bargaining power (WHO).

Within the health sector, occupational segregation contributes to a considerable gender pay gap biased against female health workers, even after controlling for factors such as education, years of experience, speciality etc. Furthermore, women are more likely than men to work in unpaid health roles, such as working as unremunerated community health workers. The gender power imbalances resulting from occupational segregation create an enabling environment for sexual harassment at work, which is reported to be a major problem for women health workers but rarely recorded or sanctioned (WGH).

D. Right to decent work

Decent work involves creating conducive work environments built on the principle of equal opportunities for all, free of discrimination, bias, or harassment, including sexual harassment (Kahsay et al. 2020). This is an important goal that is a cross-cutting theme across other forms of inequalities, including occupational segregation and the gender pay gap (WGH, WHO).

2.9 Sexual exploitation, abuse, and harassment (SEAH)

SEAH commonly takes place in work environments or work-related settings, including programme settings and during work travel.

The impact of work-related SEAH in healthcare may include the following (WGH):

01 Unsafe work environment.

02 Workers (especially women) leaving the health sector and fewer professionals joining the job market.

03 Deterioration of physical and mental health of staff.

04 Increase in healthcare costs.

05 Deterioration of the quality of care provided by professionals.

Sexual exploitation

Defined as 'any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, threatening, or profiting monetarily, socially or politically from the sexual exploitation of another' (WHO; United Nations).

Sexual abuse

Defined as 'the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions' (WHO).

Sexual harassment (at work)

Defined as 'any unwelcome sexual advance, request for sexual favour, verbal or physical conduct or gesture of a sexual nature, or any other behaviour of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation to another, when such conduct interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment. Sexual harassment may occur in the workplace or in connection with work' (United Nations).

Addressing SEAH in the workplace is crucial and is a key part of ensuring the right to decent work.

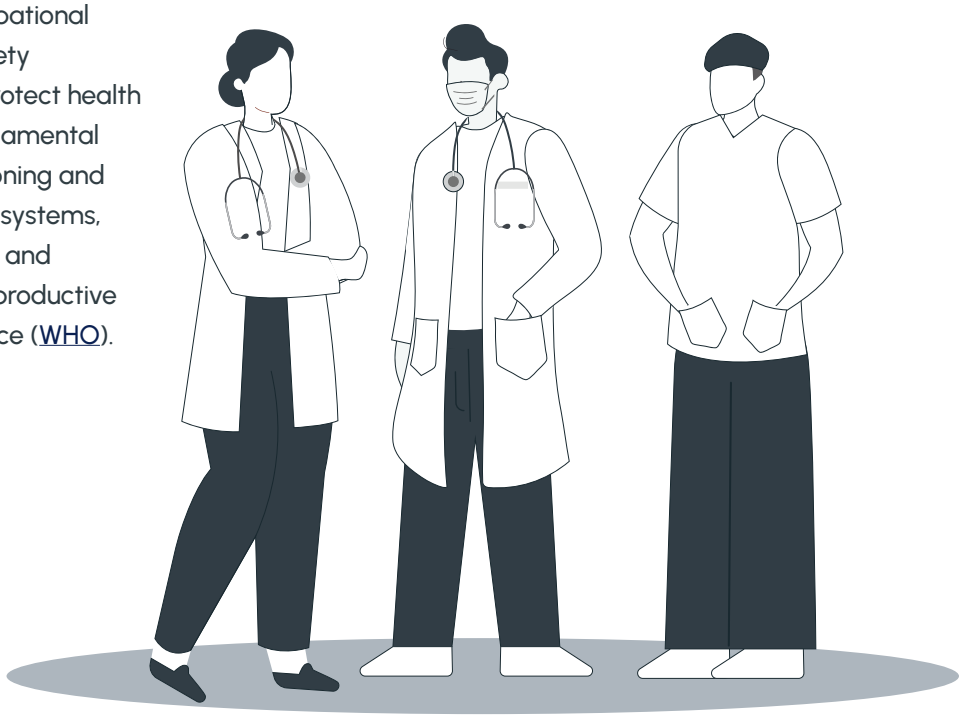
2.10 Safeguarding the health, safety, and well-being of health workers

Health workers face a range of occupational risks associated with biological, chemical, physical, ergonomic, and psychosocial hazards affecting the safety of both health workers and patients. Occupational risks exists for both men and women but are considerably heightened for women healthcare workers as they have comparatively lesser negotiating power than their male counterparts and are at the frontline, engaging directly with the community.

Additionally, they also face sexual harassment and violence in the workplace. Violence in the workplace is defined as 'Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health (George et al.,2020). Workplace violence affects all health workers, but is particularly harmful to women.

During the COVID-19 pandemic, incidents of violence, harassment, and stigmatisation were reported for women community health workers. Women healthcare workers were found to experience a higher risk of exposure and infection; barriers to accessing personal protective equipment; increased workloads; and decreased leadership and decision-making opportunities in general but especially during disease outbreaks.

Providing occupational health and safety measures to protect health workers is fundamental for well-functioning and resilient health systems, quality of care, and maintaining a productive health workforce (WHO).



WHO's work on protecting health and safety of health workers includes:

01
Developing norms and standards for the prevention of occupational risks in the health sector

02
Advocacy and networking to strengthen the protection of health and safety of health workers

03
Supporting countries to develop and implement occupational health programmes for health workers at the national level and in all healthcare facilities.

The ILO also stresses the safety of health workers, especially after COVID-19. Additionally, women face more sexual harassment and violence in the workplace compared to men. Moreover, with the increase in conflicts around the world, in which the well-being of health workers is critically compromised, safeguarding their health and safety is crucial to ensure achievement of the goal of universal health coverage.

Addressing SEAH in the workplace is crucial and is a key part of ensuring the right to decent work.

Resources

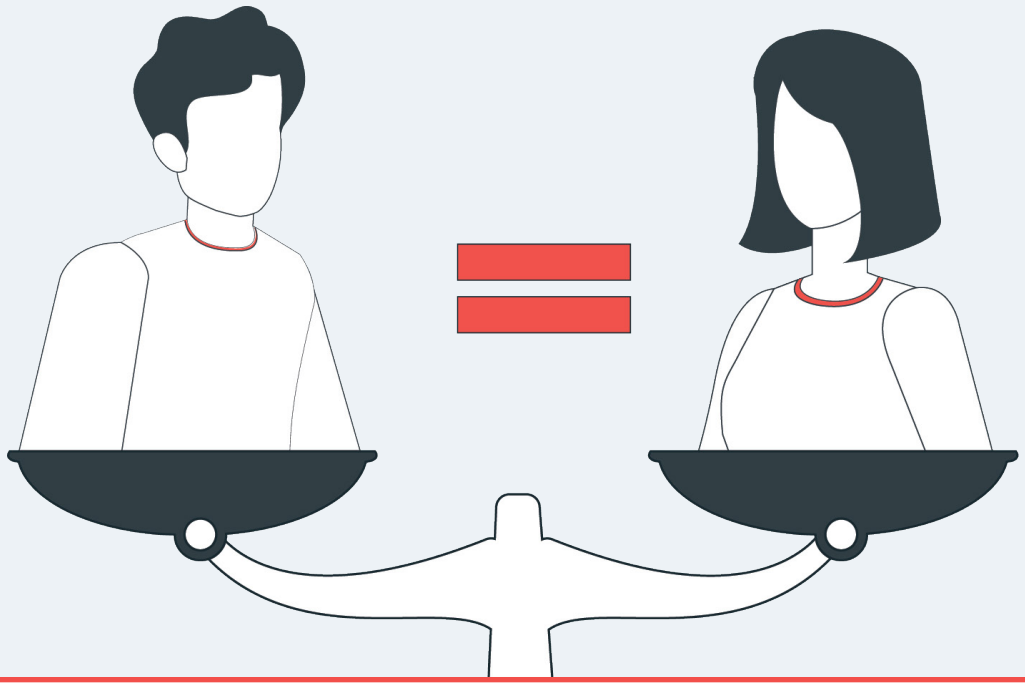
- Caring for those who care – Guide for the development and implementation of occupational health and safety programmes for health workers (ILO/WHO)

03 Gender and health measurements

This section of the glossary elaborates on gender and health measurements and on 'how' to do gender-based health research. Programmes, interventions, and policies on gender are incomplete where accurate data are unavailable. Policymakers, government stakeholders, and donors all require reliable data to pursue their objectives. Without data, it is hard to take the conversation on gender forward – and even to measure where we are on the road to gender equality. This section provides a detailed understanding of what each of the concepts at the intersection of gender and health research refers to and provides tools and resources to strengthen this understanding.

3.1 Gender data

Measuring gender has always been complex. Existing measures tend to conflate the constructs of sex and gender, typically by asking a single question that attempts to reflect one or the other or perhaps some combination of the two (Becker, T.et al. 2022). In the preceding section we established that sex and gender are different and that the two words do not mean the same thing. We will now explore what gender data means and how these data can be used to conduct health research.



A. Sex-disaggregated data

This refers to data collected on two biological categories, males and females. These data are often used to develop programmes and policies to improve health outcomes. Sex-disaggregated data tell you the numbers of men and women affected by a particular disease, condition, or cause of death. Sex-disaggregated data do not consider gender identity, or gender roles, norms, and relations, all of which we have discussed in the previous sections and are known to affect health outcomes. Sex is not a proxy for gender (Gender Equity Unit).

B. Gender-disaggregated data

This refers to data that consider other gender identities as well, beyond the binary of men and women. For example, in India, the Census collects data on the 'other' category, which includes individuals who do not identify as male or female.

Different organisations working on gender have different ways of selecting what gender data include. Most organisations – like World Bank, UN Women, ADB, and even national surveys – collect data that are disaggregated by sex, i.e. in the binary of men and women. This is also a more standardised and accepted way of collecting data considering that not all countries and regions recognise other identities.

According to UN Women, gender-disaggregated data are:

01
Data that are collected and disaggregated by sex

02
Qualitative data on gender issues (e.g. gender roles, relationships, causes of inequalities, women's participation and leadership)

03
Data that adequately reflect diversity within subgroups and capture all aspects of their lives

To make programme and policies more gender responsive, it is important that a more comprehensive approach towards gender data is taken. Such an approach is called gender-specific data or gendered health data.

C. Gendered health data

Also referred to as gender statistics, these types of data consider the 'who' questions – who does the household work, who has a higher prevalence of a particular disease, and who is accessing the healthcare system – to understand the root causes of health inequities in a population. Gender health data account for the power relations and gender norms that exist between and among males, females, and people with other gender identities, including the cultural and systematic disparities that exist. Gendered power relations have a significant influence on data collection efforts, health-seeking behaviours, vulnerability to risk factors for non-communicable and other diseases, and the impact of health policies. Sex and gender have independent and interactive consequences for individuals' health, illness, and healthcare experiences (Gender Equity Unit).

Ideally, a combination of gender-disaggregated and gendered health data is required to provide accurate and comprehensive evidence around gender and health issues.

Data about the effect of COVID on gender-diverse people was absent in most countries. Gendered data analysis and discussion are likely to confirm that gender-diverse people are a marginalised population that suffered more severe outcomes during the pandemic.

3.2 Gender assessment

A gender assessment is a review of current programming to ensure that it aligns with the goal of promoting gender equality, to achieve effective and sustainable development. A gender assessment combines:

01 A gender analysis of the situation in a given setting

02 A review of current programmes

03 The identification of programming gaps and opportunities

04 Recommendations for future programming (IGWG).

A gender assessment of a health programme examines the ways gender realities affect health, and then translates this understanding into health programming that promotes gender equality and improves health outcomes. It provides an overview of gender equality and women's empowerment issues in a particular setting and analyses the various challenges for achieving gender equality, and their impact on development outcomes (ADB).

Examples of gender assessments

- Pakistan: Country Gender Assessment - Overall Gender Analysis
- Gender Equality and Women's Rights in Myanmar: A Situation Analysis

3.3 Gender analysis

Gender analysis, which is enabled by adopting a gender lens (refer to Section 2), is a critical and systematic examination of differences in the constraints and opportunities available to an individual or group of individuals based on their sex and gender identity (Bill & Melinda Gates Foundation). It also enables us to understand differential impacts of planned interventions on men, women, and other genders. Gender analysis uses sex- and gender-disaggregated quantitative and qualitative data to understand men's and women's different roles, responsibilities, decision-making power, incentives, and access to productive resources and basic services. Gender analysis includes contextual analysis of the socioeconomic, legal, and political environment as they affect gender-based roles and constraints in society (ADB). Triggered by the results of sex-disaggregated data and informed by gender frameworks, gender analysis questions help researchers move beyond detailing differences between females and males to further examine why and how power relations cause inequities between males and females in health (Morgan et al.2016).

This approach to analysing a situation can establish a more complete and less biased standpoint from which to understand the context of an investment or project, and leads to the identification of those who may be included and who may be excluded from an investment or project on the basis of their sex or gender identity (Bill & Melinda Gates Foundation). A gender analysis should be integrated into all sector assessments or situational analyses to ensure that gender-based injustices and inequalities are not exacerbated by interventions, and that, where possible, greater equality and justice in gender relations are promoted (UN Women).

A gender analysis is the first step in designing gender equality programmes

It is a critical step towards gender-responsive and gender-transformative planning and programming (UNESCO).

Gender equality and social inclusion (GESI) analysis and gender equality, disability and social inclusion analysis (GEDSI) analysis are different intersectional lenses that are applied in a gender analysis.

Examples of gender analysis toolkits

- JHPIEGO's gender analysis toolkit
- USAID's gender analysis toolkit

A. GESI analysis

GESI analysis refers to the identification of vulnerable and excluded people (or persons or groups) in different geographies (for programme or project designs) and the systematic examination of

01 their conditions (in regard to social, economic, and political issues)

02 the barriers to their access to and control over social, economic, and political resources, assets, and opportunities

03 their collective agency and capacity (i.e. to claim their rights, access available development resources and opportunities, and link to service providers)

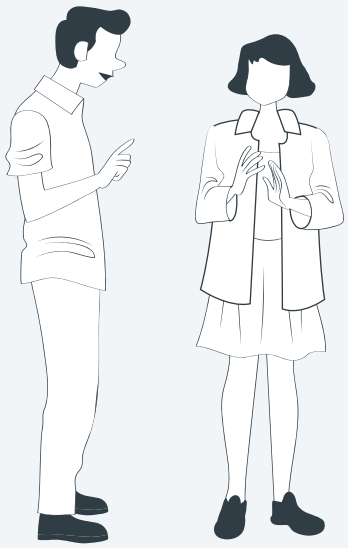
04 the initiatives – e.g., policies, structures, programmes, projects, and activities – to address these issues and barriers, unleash their agency, and develop their capacity (ADB).

A GESI approach is rooted in intersectionality, acknowledges the ways that gender intersects with other social identities and characteristics, and recognises important differences between equality, equity, and social justice (BEI). It focuses on the need for action to re-balance these power relations, reduce disparities, and ensure equal rights, opportunities, and respect for all individuals regardless of their social identity (UN Women).

Figure 9: Example of GESI Analysis to Inform ADB's Country Partnership Strategies and Project Designs in South Asia

Table 1: Guide for Analyzing Issues and Designing Actions

Understand for action



Purpose

Identify barriers to GESI and analyze the capacities of women and excluded and vulnerable groups to claim their rights and promote GESI based on disaggregated data and evidence

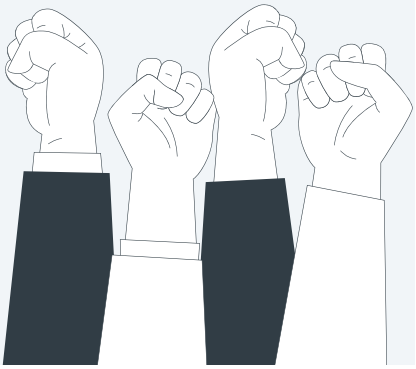
Questions for Analysis

- Who is excluded and vulnerable?
- Why are they excluded and/or vulnerable?
- What are the barriers to their access to services, resources, and opportunities?
- What are their resources and capability in removing these barriers?

Empower for Change

Purpose

Promote the livelihood, voice, and social empowerment of women and excluded and vulnerable groups



Questions for Analysis

What laws, policies, institutional arrangements, strategies, programs, and projects contribute or can contribute to:

- Livelihood and/or resource empowerment
- Voice empowerment
- Social empowerment (improving individual and collective social capital)

Include for Opportunity

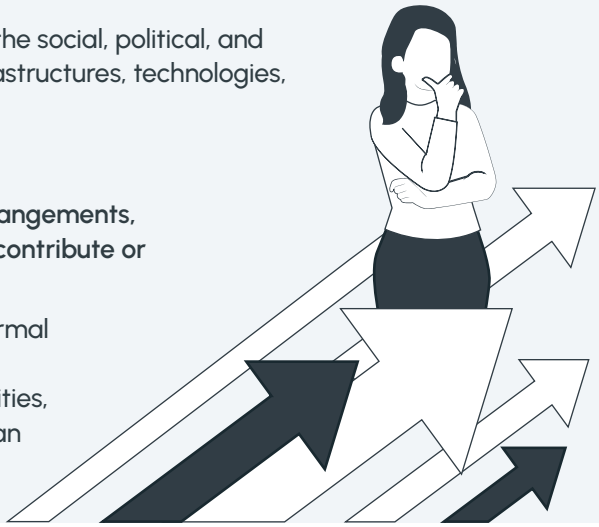
Purpose

Ensure the GESI-responsiveness of the social, political, and physical environment, including infrastructures, technologies, resources, and services

Questions for Analysis

What laws, policies, institutional arrangements, strategies, programs, and projects contribute or can contribute to:

- Changing harmful formal and informal norms and practices
- Making public infrastructures, facilities, spaces, workplaces, and services an enabling environment for GESI



Resources:

- Conducting GESI Analysis in South Asia: A Guidance Note
- Communities Ending Gender-Based Violence: GESI Analysis

B. GEDSI analysis

GEDSI analysis assesses and seeks to understand differences in social norms, relations, and power dynamics experienced by individuals as a result of their social identities, including gender, age, disability, income, education, faith, race, ethnicity, sexuality, and migration status; and explores how these identities intersect to create diverse experiences of exclusion and marginalisation (DFAT).

WHO's work in Sri Lanka on the integration of GEDSI into water, sanitation, and hygiene (WASH) practices within healthcare facilities provides a detailed example of promoting GEDSI analysis. The GEDSI training included sessions on identifying and addressing barriers to access, understanding the specific WASH needs of diverse populations, and developing strategies to ensure that WASH facilities are safe, clean, and accessible to all. The training emphasised the importance of creating environments where GEDSI are not just mere afterthoughts but are integral components of ongoing and future WASH programmes.

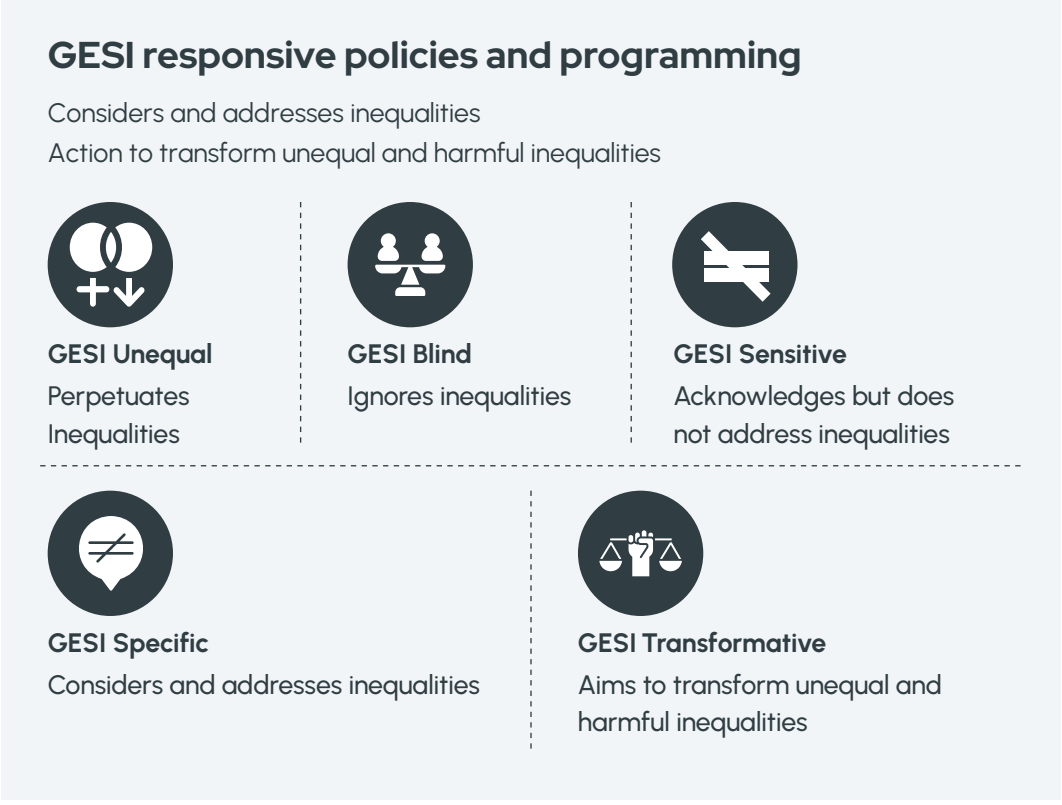
Resources:

- GEDSI Analysis Good Practice Note
- Toolkit on mainstreaming GEDSI in WASH in healthcare facilities

3.4 GESI integration continuum

As gender integration continuum is used to mainstream gender in health programming, there are GESI integration continuum measures and scales for health research. The GESI-responsive assessment scale (WHO) (see Figure 10) provides a GESI integration continuum which outlines the extent to which GESI considerations can be incorporated into projects and policies. The scale acts as a roadmap, so that the incorporation of GESI into project activities and processes can be considered along a continuum: from GESI sensitive to GESI specific to GESI transformative.

Figure 10: Example of a GESI-responsive assessment scale from WHO's Gender Mainstreaming for Health Managers: A Practical Approach



3.5 Gender indicators and gender-sensitive indicators

A gender-sensitive indicator (or gender indicator) is simply an indicator that captures and measures gender-related changes in projects or interventions, or at the population level, over time. Using gender-sensitive indicators can also help us to understand how effectively desired changes in gender relations are occurring, which enables more astute planning of gender equality work in the future and the delivery of future work (Oxfam).

The indicators can be qualitative or quantitative and are developed through testing across settings and contexts, with negotiations then leading to some of these indicators becoming global standards that are used to assess the achievement of global goals, such as gender equality goals within the Sustainable Development Goals. Gender-sensitive indicators vary by sector (EU Gender). Gender indicators should be specific, measurable, achievable, relevant, and time-bound (SMART). Baselines and targets should be included to capture the expected level of achievement (ADB).

The first step in developing gender-sensitive indicators is ensuring that programme or project objectives have clearly defined gender goals, based on a gender analysis. These might be measures to raise the status of women or an explicit statement of how the programme will ensure that it benefits women and men equally. The next step is to look at each of the key objectives and to ask what success would look like.

Annex A provides some examples of illustrative questions that can be reformulated into gender-sensitive indicators that are relevant to the health system from a provider perspective.

Resources:

- Guide to Gender Sensitive Indicators
- How can gender-sensitive and responsive measurement improve primary health care?
- Quick Guide to Gender Sensitive Indicators

3.6 Gender frameworks

Gender frameworks serve as analytical guides, and help researchers organise their thinking, research questions, data collection, and data analysis. They are particularly useful in helping to focus their thinking on the key aspects of gender power relations which are most relevant. Over time, such frameworks have identified how gender norms, beliefs, roles, time allocation, division of labour, access to resources, and rules and decision-making constitute gender power relations (refer to Section 1).

Examples of gender frameworks in health (Morgan et al., 2016)

- Guide for analysis and monitoring of gender equity in health policies (PAHO, 2009).
- Addressing Gender and Women's Empowerment in mHealth for MNCH: An analytical Framework (Deshmukh and Mechael, 2013).
- Guidelines for the Analysis of Gender and Health (LSTM, 1996).
- A Manual for Integrating Gender Into Reproductive Health and HIV Programs (Caro, 2009).

3.7 Gender action plans

A gender action plan lays out the action points regarding how a programme will achieve the target gender indicators. A gender action plan focuses on how gender issues, concerns, and constraints identified through the gender analysis have been addressed in the project design. Such a plan is mostly presented in a table format that corresponds to each project output, with targets and responsibilities specified (ADB).

A gender action plan may include strategies, mechanisms, project components, budget provisions, and other measures identified to address gender concerns. This includes clear targets, quotas, gender design features, and quantifiable performance indicators to ensure women's participation and benefits (ADB).

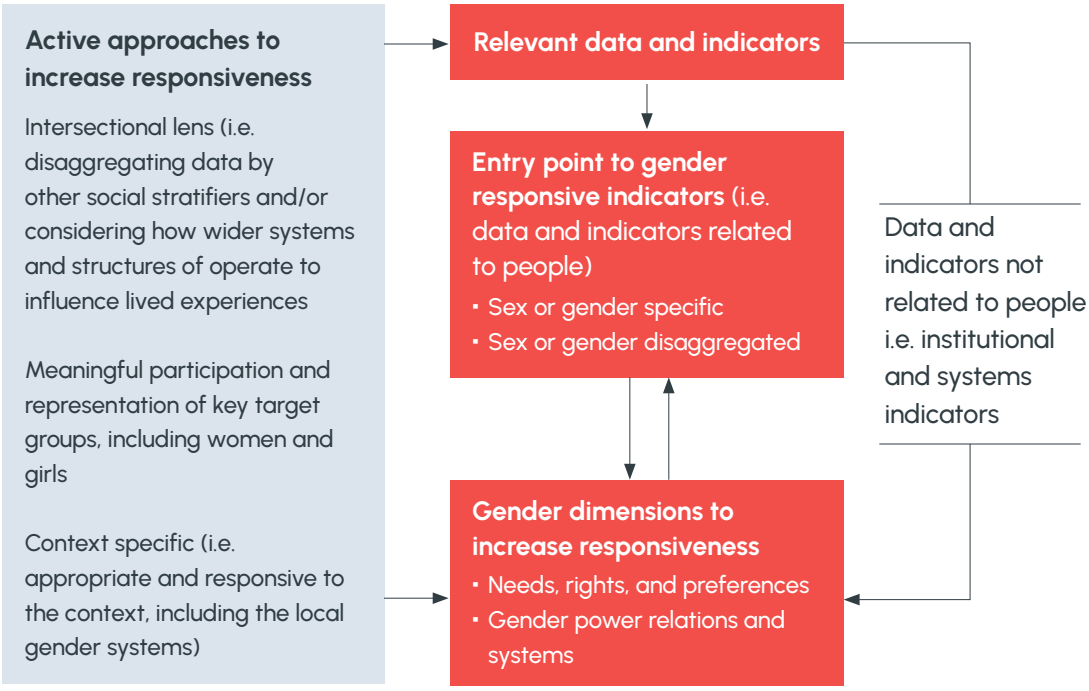
Resources:

- Maharashtra Tertiary Care and Medical Education Sector Development Program: Gender Action Plan
- Combating Domestic Violence Against Women and Children - Additional Financing: Gender Action Plan

3.8 Gender-responsive monitoring and evaluation

Gender-responsive evaluations assess the extent to which an intervention has resulted in progress (or lack thereof) towards intended and/or unintended results regarding gender equality. They assess any changes related to gender equality – such as changes to cultural values, norms, attitudes, social behaviours and power relations; the participation and representation of women and men in all their diversity; access to and control over opportunities and resources; and shifts in policies, legislation, and organisational rules (EIGE).

Figure 11: Actions that can be taken to increase gender-responsiveness of health programmes and policies through relevant data and indicators



In other words, gender-responsive monitoring and evaluation is defined as intentionally integrating the needs, rights, preferences, and power relations among women and girls, men and boys, and gender minority individuals, as well as across social, political, economic, and health systems, in monitoring and evaluation processes (Morgan et al.2024) (shown in Figure 11).

EIGE defines the aims of gender-responsive evaluation as:

01

Independently measuring progress towards achieving intended gender-related objectives and goals set out in policies, programmes and projects

02

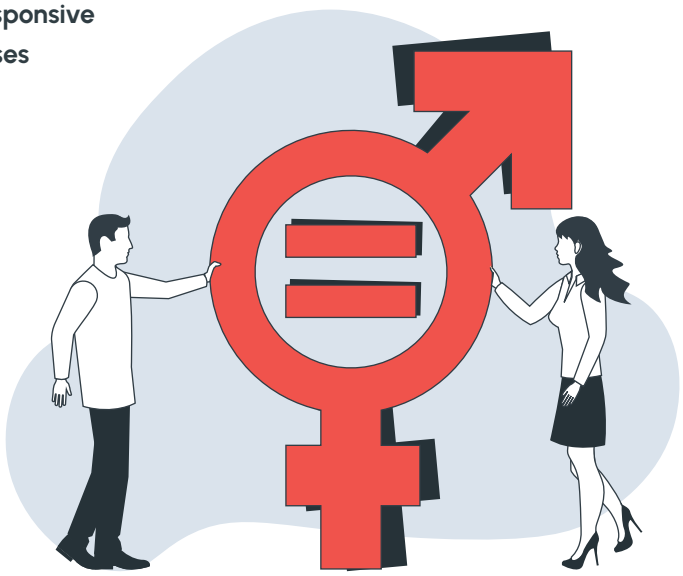
Evaluating from a gender perspective the relevant processes, activities, outputs, outcomes, and impacts of an intervention.

According to UN Women, a gender-responsive evaluation serves the following purposes

01 Demonstrates accountability to stakeholders

02 Provides credible and reliable evidence for decision-making

03 Contributes important lessons learned about normative, operational, and coordination work.



Resources:

- Gender Empowerment Measures Repository
- A Tool for Strengthening Gender-Sensitive National HIV and SRH monitoring Systems
- Gender equality toolkit by Gates for MNC
- Gender equality toolbox, Gates Foundation

Annex A

Gender-sensitive indicators relevant to health systems, from a provider perspective

Gender issue	Illustrative questions	Reformulated as an indicator	Qualitative or quantitative	Source
Gender deficit in leadership and management	What is the representation of women and men on boards, panels, working groups, and other decision-making bodies, and in supervisory and management positions?	Percentage of men and women on boards, panels, working groups, and other decision-making bodies, and in supervisory and management positions.		Morgan et al. (2016)
Poor work environment	Are there female members and workers from across the health workforce hierarchy on committees that adjudicate on sexual harassment in the health workforce?	Proportion of women members and workers across the health workforce hierarchy on committees that adjudicate on sexual harassment in the health workforce.		Morgan et al. (2016)
Access to resources and amenities	Are there infrastructure conditions that favour breast-feeding by women who work in the health sector?	Proportion of healthcare facilities with infrastructure conditions that favour breast-feeding by women who work in the health sector.		PAHO

Gender issue	Illustrative questions	Reformulated as an indicator	Qualitative or quantitative	Source
Poor access to training, education, and career progression	What are supervisors and administrators' attitudes towards sending male and female providers for training? In the district? Outside the district? Overseas?	Changes in attitudes of supervisors and administrators towards sending male and female providers for training in the district/ outside the district/ overseas.		Caro et al. (2013)
Gender-based occupational segregation	To what extent are women more or less likely to work in frontline service delivery in poorly compensated (including volunteer) or less supported positions than men?	Percentage of men/ women in frontline service delivery in poorly compensated (including volunteer) or less supported positions.		Morgan et al. (2016)
	What sex differences exist with respect to remuneration, job security, working hours, and benefits?	Average remuneration, job security, working hours, and benefits provided to women healthcare providers versus male healthcare providers.		Caro et al. (2013)
	Do performance-based incentives mean the same thing for female and male health workers across and within cadres?	Difference in the meaning of performance-based incentives between male and female healthcare workers across cadres.		Morgan et al. (2016)
Gender biases and norms within health systems	What are providers' beliefs about gender differences and equality? In general? In the healthcare workplace?	Differences in male and female healthcare providers' beliefs about gender equality in general and in the workplace.		Caro et al. (2013)

Annex B

Gender-sensitive indicators relevant to health systems, from a user perspective

Gender data and indicators	Description	Examples	Examples with a needs, rights, and preferences lens
Sex- or gender-specific	Sex- or gender-specific data and indicators focus only on one sex or gender group, such as women, men, or gender minority individuals, or on subgroups within them.	Percentage of women receiving antenatal care. Percentage of family planning facilities offering women a contraceptive method. Teen girls aged 15–19 who are mothers. Percentage of rural vs urban pregnant women assisted by a skilled birth provider during delivery. Percentage of transgender women aged 15–49 who received an HIV test in the past 12 months and know their results.	Percentage of women receiving antenatal care that meets quality of care standards. Percentage of family planning facilities offering women contraceptive methods of choice. Incidents involving disrespectful, neglectful and/or abusive treatment from healthcare providers towards female/women patients. Percentage of transgender women aged 15–49 who received hormone replacement therapy when they wanted it.

Gender data and indicators	Description	Examples	Examples with a needs, rights, and preferences lens
Sex- or gender-disaggregated	Sex- or gender-disaggregated data and indicators explore differences between different sex or gender groups (and subgroups within them), such as between women and men, in relation to a particular metric.	Percentage of girls vs boys aged 15-19 with HIV/Aids. Percentage of men and women accessing primary healthcare. Percentage of women and men who are beneficiaries of health insurance. Percentage of key populations, including transgender and gender-diverse individuals (disaggregated by gender), reached with HIV prevention programmes.	Percentage of family planning facilities offering women and men contraceptive methods of choice. Percentage of health facilities managed by women vs men supervisors. Access to and cost coverage for support services for pre-puberty transgender and gender-variant children (disaggregated by gender) is ensured. Incidents involving disrespectful, neglectful, and/or abusive treatment from healthcare providers towards transgender and gender-diverse individuals (disaggregated by gender).
ender power relations and systems	Gender power relations and systems data and indicators focus on the ways in which gender power relations and systems manifest as inequities that affect differences in health and health system outcomes and experiences, such as through inequitable access to resources; roles and practices; norms, values, and beliefs; and decision-making power and autonomy (both formal and informal).	Control over own earnings. Percentage of health facilities managed by women supervisors. Coverage of reproductive and maternal health services in health insurance schemes. Coverage of gender-affirming care in health insurance schemes.	Access to diverse banking systems. Women's ability to visit preferred healthcare centre without asking permission. Coverage of reproductive and maternal health services which meet essential needs in health insurance schemes.

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