

GENDER ANALYSIS TOOLKIT FOR HEALTH SYSTEMS



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 **Jhpiego**

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ABBREVIATIONS

ADS	Automated Directive System
ANC	Antenatal Care
CCT	Conditional Cash Transfer
CEDAW	United Nations Convention on the Elimination of All Forms of Discrimination against Women
FP	Family Planning
GAF	Gender Analysis Framework
GBV	Gender-Based Violence
IGWG	Interagency Gender Working Group
KAP	Knowledge, Attitude, and Practice
KPC	Knowledge, Practices, and Coverage
MCSP	Maternal and Child Survival Program
M&E	Monitoring and Evaluation
PLHIV	Person Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
RH	Reproductive Health
RMNCH	Reproductive, Maternal, Neonatal, and Child Health
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

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INTRODUCTION

PURPOSE OF THE GENDER ANALYSIS TOOLKIT

The purpose of the Gender Analysis Toolkit is to provide research questions to guide data collection when performing a project-level gender analysis. The Toolkit provides illustrative questions related to the five domains described in United States Agency for International Development's (USAID) Automated Directive System (ADS) 205, which are: 1) Laws, regulations, and institutional practices; 2) Cultural norms and beliefs; 3) Gender roles, responsibilities, and time used; 4) Access to and control over assets and resources; and 5) Patterns of power and decision-making. The tool presents illustrative general and health area-specific questions organized in matrices related to different levels of the health system. This is to identify more precisely the evidence of gender inequalities relevant to programs focused on different levels of the health system.

The Jhpiego Toolkit is designed to guide staff in developing baseline or knowledge, attitude and practice (KAP) studies on what types of gender-related information should be included. It is also designed for those working at different levels of the health system. For example, it includes orientation on the type of gender-focused information relevant at the facility level for quality of care and work-related issues affecting health workers. At the district level, it provides guidance on questions about resource allocation, human resource

issues, referral, and logistics systems. At the national level, it focuses on questions relevant to policies, monitoring and evaluation (M&E), and information systems. All in all, the questions are much more specific than most gender assessment guides or checklists, which mostly ask about "gender inequalities/issues" more broadly. For example, we ask things such as what decisions do men/women make in the household with respect to family planning (FP), antenatal care (ANC), voluntary counseling and testing for HIV (VCT), prevention of mother-to-child transmission of HIV (PMTCT), and other types of interventions? These questions help to identify gender inequalities and constraints that affect the achievement of health program objectives and produce adverse health outcomes for women, girls, men, and boys.

The collection of resources annotated in Annex II is somewhat eclectic based on what is available and accessible online. It includes a variety of survey and participatory tools, as well as checklists, indicator guides, and training manuals that provide modules on gender analysis. Other gender integration resources are available at the Interagency Gender Working Group (IGWG) website (www.igwg.org) and at the K4Health IGWG Gender and Health website (<http://bit.ly/1PoAGzF>).

A focus on gender equality examines how differences in power relations result in differential risks, exposures, vulnerabilities, and outcomes in health for men and women.

INTENDED USERS

The Toolkit is intended for program officers, managers and technical staff that develop program objectives, design activities, formulate and monitor indicators, and support implementation. Although a staff member or consultant with gender expertise may conduct the gender analysis, the engagement of other project actors in development of the scope of work and review of findings from primary and secondary sources will improve the likelihood of addressing gender equality and determinants of health in project design, implementation, and M&E. The better a gender analysis is aligned with the objectives of the project and the local context, the more useful the findings and recommendations.

Gender refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women. (WHO 2013b)





Gender inequalities arise from differential and unequal treatment of women and men, articulated through economic, social, and political institutions that systematically reinforce unequal roles, decisions, rights, and opportunities. In most societies, structural inequalities cause a disadvantage to women relative to men who, as a whole, generally enjoy greater exercise of power and access to opportunities than women. Particular groups of women and men, based on wealth, education, race, caste, ethnicity, and age (among other social variables), may be more or less advantaged than others.

WHY FOCUS ON GENDER INEQUALITY IN HEALTH PROGRAMS?

Gender equality is widely recognized as a core development outcome in its own right (World Bank 2011). Institutions, program implementers, and policymakers increasingly acknowledge gender equality as critical to improving the health of populations around the world (Kim et al. 2013, Grépin et al. 2013, World Bank 2011, WHO 2011c, Sen and Östlin 2007, USAID 2012, Yamin 2013a, 2013b). However, while attention to gender equality is becoming more prominent in the global agenda, it is still absent or misunderstood operationally by many of the global players (Hawkes et al. 2013).

Gender integration in health is the process of creating knowledge and awareness of gender and responsibility for addressing gender in health systems and programs. Gender integration is now a policy of most major donors and governments around the world. Increased gender equality is firmly linked to enhanced productivity, better development outcomes for future generations, and improvements in the functioning of institutions (Grépin et al. 2013, World Bank 2011).

A health system that responds adequately to health conditions associated with gender inequality is a system that has the capacity to address gender norms, roles, and relations through policies, programs, and health services (WHO 2011). Gender integration is a strategy to ensure that both women and men's concerns and interests are reflected in health systems' operations and institutional structures. To make health systems responsive and accountable for gender equitable outcomes, it is necessary to integrate gender considerations into health policies, programs, and services from design through final evaluation.

A recent World Health Organization (WHO) and United Nations Children's Fund (UNICEF) publication on consultations on the post-2015 Health Agenda stated:

**Discrimination against women and girls, including gender-based violence, economic discrimination, reproductive health inequities, and harmful traditional practices, remains one of the most pervasive forms of inequalities and one of the most important underlying causes of poor health outcomes for women and children.
(UN 2013a: 36)**



A focus on gender equality examines how differences in power relations result in differential risks, exposures, vulnerabilities, and outcomes in health for men and women. Gender-integrated approaches treat women and men's relative social, political, economic, educational, and health status as interrelated, intersectional, and inter-dependent but also changeable. Consequently, to be successful, gender-focused health programs often have to be multi-sectoral and engage a wide variety of female and male stakeholders, regardless of whether the focus of the program is on women's, children's, or men's health.

USAID Global Health policies (<http://1.usa.gov/205mqxM>) and strategies are designed to ensure that health programs reduce gender inequalities as an integral part of improving access, utilization, and quality of health care. The Women, Girls, and Gender Equality Framework posits inter-related pathways to achieving improved health status and outcomes via intermediate health outcomes:

- » Reduced inequalities between men and women in access to and control over social and economic assets and resources
- » Increased capacity to make decisions free of coercion or the threat of violence
- » Increased adoption of gender norms that value men and women equally
- » More equal participation of women and men as decision-makers and shapers of their societies
- » Reduced gender-based disparities in men and women's rights and status.

To achieve these outcomes, USAID expects programs to implement a variety of strategies. For instance, the President's Emergency Plan for AIDS Relief (PEPFAR) Strategy (<http://1.usa.gov/1J7AByn>) specifies that its programs are required to:

- » Provide gender equitable HIV prevention, care, treatment, and support
- » Implement gender-based violence (GBV) prevention activities and provide services for post-GBV care
- » Implement activities to change harmful [and unequal] gender norms and promote positive [equal] norms
- » Promote gender-related policies that increase legal protections
- » Increase gender-equitable access to income and productive resources, including education.



WHAT IS THE DIFFERENCE BETWEEN A FOCUS ON WOMEN'S HEALTH AND ATTENTION TO GENDER EQUALITY IN HEALTH?

Typically, a focus on women's and girls' health examines health conditions and morbidities associated with women's reproductive roles, without examining the unequal social dynamics that also produce poor health outcomes. Programs that are designed to address women's and girls' health typically focus on their health needs without examining how their subordinate positions in households, communities, and the larger societies in which they live contribute to their health-related behaviors, health status, and outcomes¹.

A focus on gender equality examines and attempts to rectify how differences in power relations result in differential risks,

exposures, vulnerabilities, and outcomes in health for men and women. Gender integrated approaches treat women and men's relative social, political, economic, educational, and health status as interrelated, intersectional, interdependent, and changeable. Consequently, to be successful, gender-focused health programs often have to be multi-sectoral and engage a wide variety of male and female stakeholders, regardless of whether the focus of the program is on women, children, or men's health.

Although attention to gender inequalities in health programs is linked to other types of concerns, such as socioeconomic equity, human rights, and respectful, quality care, it is not synonymous with nor superseded by these other issues. Table 2 highlights some key differences in focus between gender equality, human rights, and quality of care.

¹ A focus on women's health does not necessarily include examination of how women's health is affected by inequalities in the division of labor, allocation of resources, decision-making, or mobility. Men and boys are rarely engaged as part of women-focused health activities. As a result, differences in health outcomes between women and men are often essentialized in so far as they are perceived and treated as fundamentally related to differences in sex-linked physiological differences that by nature align with men's and women's different roles. For example, women are regarded as the primary caretakers of children because of their physiological capacity.



TABLE 2: COMPARISON OF APPROACHES BASED ON ATTENTION TO GENDER, HUMAN RIGHTS, AND QUALITY OF CARE

	GENDER	HUMAN RIGHTS	QUALITY OF CARE
OBJECTIVE	Equality of opportunity for men, boys, women, and girls	Realization of human rights as laid out in the Declaration of Human Rights and other international human rights instruments	Achieve application of clinical standards based on evidence and best practice
OUTCOME	Equitable policies and interventions reduce discrimination and expand opportunities for women, men, girls, and boys	Duty bearers meet their obligations and rights holders are able to exercise rights	Application of protocols and standards
PROCESS	Findings from context-specific analysis are applied to the design, implementation, monitoring, and evaluation of programs	Raise awareness about universal human rights principals and standards through programs. Seek more effective legal frameworks, implementation, and enforcement to guarantee rights, and education to make individuals aware of their rights	Evidence-based standards are transferred through pre-service and in-service training, supervision, and written policies and protocols for clinical care
FOCUS	Socially constructed categories of people (men, women, boys, and girls). Gender is relational and involves examining how power relations facilitate or restrict opportunities for women and men	Individuals' capacity to exercise their rights and the duty bearers responsible for guaranteeing rights	Individual clients and health care providers



All three of these approaches are important and complementary for a well-functioning health system. Although they are overlapping approaches, they often address different levels of the health system, with quality of care focused principally on health care delivered through health services. Human rights approaches focus principally on policy and policy implementation. Gender integration approaches focus on all levels of the health system. Attention to gender inequality in combination with a human rights perspective results in an approach that focuses on structural discrimination and deprivation of rights of women and girls (Yamin 2013a). In focusing on women's and girls' rights, human rights-based approaches also seek to address the underlying inequalities that deny women and girls their rights, including gender inequality.

Although this may not be the case with all human rights based approaches, it is true regarding women's and girls' rights because of the commitments made by most countries in the International Conference on Population and Development Program of Action and in Beijing at the International Conference on Women, which, in combination with the International Conference on Population and Development, stipulated empowering women in their relationships, and through policies, laws, and health services (Yamin 2013, IIMMHR 2010). When women and girls are able to exercise their rights to health care unencumbered by gender discrimination, they are able to demand quality health care. Similarly, health workers who experience gender discrimination and are not able to exercise their own rights are unlikely to be able to deliver quality health care.





GENDER INTEGRATION

GENDER INTEGRATION REFERS TO STRATEGIES APPLIED IN PROGRAM ASSESSMENT, DESIGN, IMPLEMENTATION, AND EVALUATION TO TAKE GENDER NORMS INTO ACCOUNT AND TO COMPENSATE FOR GENDER-BASED INEQUALITIES.

Gender integration supports the development and implementation of gender-transformative health programs, policies, and services. Gender-transformative approaches seek to change gender norms that restrict women and men's access to health services and realization of good health. They question and challenge the unequal distribution of power, lack of resources, limited opportunities and benefits, and restrictions on human rights.

Operationally, gender-transformative approaches support changes in socially prescriptive roles for men and women, greater equality in the distribution of goods and services, and sharing power and decision-making at home, in politics, and in economic activities. They also translate into engaging men more actively in women's and children's health programs and into giving women a greater say over health care investments.

Gender integration in health is the process of creating the knowledge and awareness of—and responsibility for—addressing gender in health systems and programs. Gender integration is now USAID policy and that of most other major donors and governments around the world. Increased gender equality is firmly linked to enhanced productivity, better development outcomes for future generations, and improvements in the functioning of institutions (Grépin et al. 2013, World Bank 2011).





GENDER ANALYSIS

GENDER ANALYSIS IS THE CORNERSTONE OF GENDER INTEGRATION. IDEALLY, IT IS THE FIRST STEP IN A GENDER INTEGRATION PROCESS.

WHAT IS GENDER ANALYSIS?

Gender analysis is a systematic methodology for examining the differences in roles and norms for women, men, girls and boys; the different levels of power they hold; their differing needs, constraints, and opportunities; and the impact of these differences in their lives.

GENDER ANALYSIS: USAID WORKING DEFINITION

Gender analysis, as defined by USAID, is an analytic, social science tool that is used to identify, understand, and explain gaps between males and females that exist in households, communities, and countries, and the relevance of gender norms and power relations in a specific context. Such analysis typically involves examining differences in the status of women and men and their differential access to assets, resources, opportunities, and services; the influence of gender roles and norms on the division of time between paid employment, unpaid work (including subsistence production and care for family members), and volunteer activities; the influence of gender roles and norms on leadership roles and decision-making; constraints, opportunities, and entry points for narrowing gender gaps and empowering females; and potential differential impacts of development policies and programs on males and females, including unintended or negative consequences. (USAID 2013, p. 24)



IS A GENDER ANALYSIS REQUIRED FOR ALL PROJECTS?

Donors are increasingly asking programs to conduct a gender analysis. For example, the USAID Global Health Bureau's custom indicator for reporting on progress on Gender Equality and Female Empowerment Policy is "[t]he proportion of global health projects with a gender strategy implemented in project activities." To design a well-informed gender strategy that is tailored to the local and project-related gender constraints and opportunities, a gender analysis is highly beneficial and essential when gender is a key component of the project activities or outcomes. The Canadian Department of Foreign Affairs, Trade and Development requires funding recipients to conduct a gender analysis as part of its program design phase. Increasingly, other donors are as well.

WHY SHOULD WE DO A GENDER ANALYSIS?

Beyond meeting donor requirements, the purpose of the gender analysis is to answer the following key questions:

- » How will anticipated results of the work affect women and men differently?
- » How will the different roles and status of women and men affect the work to be undertaken?

Ultimately, conducting a gender analysis entails understanding and addressing gender inequalities in power and privileges, and the use of tactics, including violence, to uphold inequitable rights and privileges. By understanding how these disparities affect health and pose constraints for reaching project objectives, it will help us attain and sustain project impacts. It also helps staff to understand the projects' contributions to promoting gender equality.

HOW DO WE DO A GENDER ANALYSIS?

At a minimum, projects should collect secondary information on the gender context of the country to do a basic gender analysis. Often, USAID missions have commissioned gender assessments, which are available on the Development Experience Clearinghouse (<http://1.usa.gov/1RLUpdl>). In addition, the Demographic and Health Survey modules (<http://bit.ly/1noESDE>) are often a good source of quantitative data about women's autonomy, economic status, and attitudes and experience related to gender-based violence. [The WomenStats Project](http://bit.ly/1RqHwVR) (<http://bit.ly/1RqHwVR>) also houses the largest online compilation of quantitative and qualitative data on the status of women, including women's political participation, land ownership, and domestic violence, in 173 countries.



In addition, many countries that are signatories to the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) submit periodic country reports to report on their status of progress on the commitments in CEDAW. Similar reports are often prepared by women's rights organizations in the country.

These sources of information provide a general picture on the status and rights of women. To understand in more detail how gender relations and norms affect the individual, household, community, facility, and health policy level dynamics that affect uptake and delivery of health services in a given community or region, it may be necessary to collect primary data, when it is not already available from other sources, to answer gender-focused questions tailored to the project interventions and directed at project actors and beneficiaries, provided that this information is not already available from previous assessment.

For example, some key questions across the levels of health intervention are:

- » Individual: What knowledge do women or men have about reproductive, maternal, neonatal, and child health (RMNCH)?
- » Household: Who decides whether a woman is able to seek care for herself or her child?
- » Community: What roles do men and women play in allocating community resources to facilitate men and women's access to health care (e.g., roads, transportation, blood and drug supplies, and oversight of health facilities)?
- » Health facility: How is the delivery of care organized to meet the different needs of men, women, boys, and girls?
- » Health system governance/policy: How do health policies and resource allocations support gender equality at different levels of the health system?





Gender analysis uses standard social science quantitative and qualitative data collection and analysis methods to respond to research questions about how gender differences and inequalities will affect project outcomes and how the project will differentially affect men and women's health, opportunities, and status. As gender analysis is comparative and relational, the main difference between a gender analysis and other types of operational and formative social research is that gender analysis requires that men, boys, women, and girls participate equally in the research by answering surveys, and participating in focus groups, interviews, and other qualitative data collection exercises. Quantitative methods are best suited for generating information on measurable gaps and disparities between men and women regarding health status and access to care. Quantitative research is also useful for identifying patterns of inequality and for generating the evidence of strong associations and correlations between gender inequalities and limited access and utilization of health resources and services. Qualitative methods provide greater insight into how men and women experience gender inequalities in different contexts and how these affect their capacity to adopt healthy practices and negotiate the health system to obtain services when needed. Participatory research methods are useful for engaging men and women directly in assessing, questioning, and identifying solutions to gender-related health challenges. These include mapping, decision trees, ranking, or other action research tools that can be used to directly involve local men and women in the research process as participants and partners.

WHEN DO WE DO A GENDER ANALYSIS?

Ideally, a gender analysis is conducted before or at the start of a project to inform the design of the project. The findings of a gender analysis provide the basis for developing gender-sensitive or responsive indicators, which can be used to follow reductions or increases in gender disparities in women and men's decision-making, resource control, and leadership, along with disaggregated by sex health indicators to monitor any differences in health outputs and outcomes for men, boys, women, and girls. If it is not possible to conduct the gender analysis at the beginning of a project, it can be useful to do one as a special study or part of a midterm evaluation. In fact, whether or not a gender analysis is conducted at the start of the project, it is important to disaggregate data by sex and track all monitoring data where people are the unit of measure to see if they indicate potential increases or decreases in gender disparities in participation, access to and control over resources, exercise of rights, and benefits.

A positive or negative trend may prompt a project to focus data collection during the course of the project to understand what, how, and why gender-based constraints are affecting unequal treatment and outcomes. When instruments designed to measure empowerment are applied at baseline, it is useful to measure the same indicators at endline to evaluate how the project affected the relative status of men and women.



WHO SHOULD DO THE GENDER ANALYSIS?

If doing primary data collection, it is important to have trained researchers with strong research skills overseeing the process as well as the data collection. Data collectors that have good facilitation skills are best. If relying on secondary data analysis, it is important to have a gender specialist or someone with some experience or training in gender analysis and integration to analyze the data. [The Manual for Integrating Gender into Reproductive Health and HIV Programs](http://bit.ly/1UVJgV7) (<http://bit.ly/1UVJgV7>) also provides step-by-step guidance on using a gender analysis framework (GAF) to summarize and analyze the data to help inform program design. Support and discussion with gender specialists and other technical experts on the project will still be necessary to help prioritize strategies and interventions to integrate into the project to address the gender issues identified in your analysis.

HOW TO CONDUCT A GENDER ANALYSIS?

A gender analysis has two parts. The first part is a process to identify inequalities, gaps, and disparities in a particular context. It consists of collecting information and data on gender roles, relations, and identities related to specific health problems to identify gaps and disparities based on gender differences. The second part of the analysis entails analyzing the information collected on gender differences to determine and prioritize gender-based constraints and opportunities and their implications for the achieving health objectives and equal status of women and men (Caro 2009).





1

GENDER ANALYSIS: PART ONE

Describes existing gender relations in a particular context, ranging from individuals within households to a larger scale of community, health facility, ethnic group, district, or nation. It involves collecting and analyzing not only disaggregated by sex data but also other qualitative and quantitative information that explains these gender relations. The tables in **Section 5** starting on page 30 of this Toolkit provide key questions for a range of Jhpiego health areas that can help with designing studies and assessments to collect this information.

2

GENDER ANALYSIS: PART TWO

Organizes and interprets, in a systematic way, information about gender relations to make clear the importance of gender differences for achieving development objectives. **Section 6** starting on page 64 of this Toolkit provides further guidance on how to analyze the data collected, with a particular focus on how to identify gender-based constraints and opportunities, which will inform the project design and M&E processes. To understand more fully how to apply the findings, consult **[A Manual for Integrating Gender into Reproductive Health and HIV Programs](http://bit.ly/1UVJgV7)** (<http://bit.ly/1UVJgV7>) from Commitment to Action, which provides guidance on how to apply the findings to policy formulation and program design, implementation, and M&E.



GENDER ANALYSIS FRAMEWORK

A gender analysis framework (GAF) provides a structure for organizing information about gender roles and relations. Figure 1 is one example of a GAF². It provides a way to systematize information about gender differences across different domains of social life and examine how these differences affect the lives and health of men, women, boys, and girls.

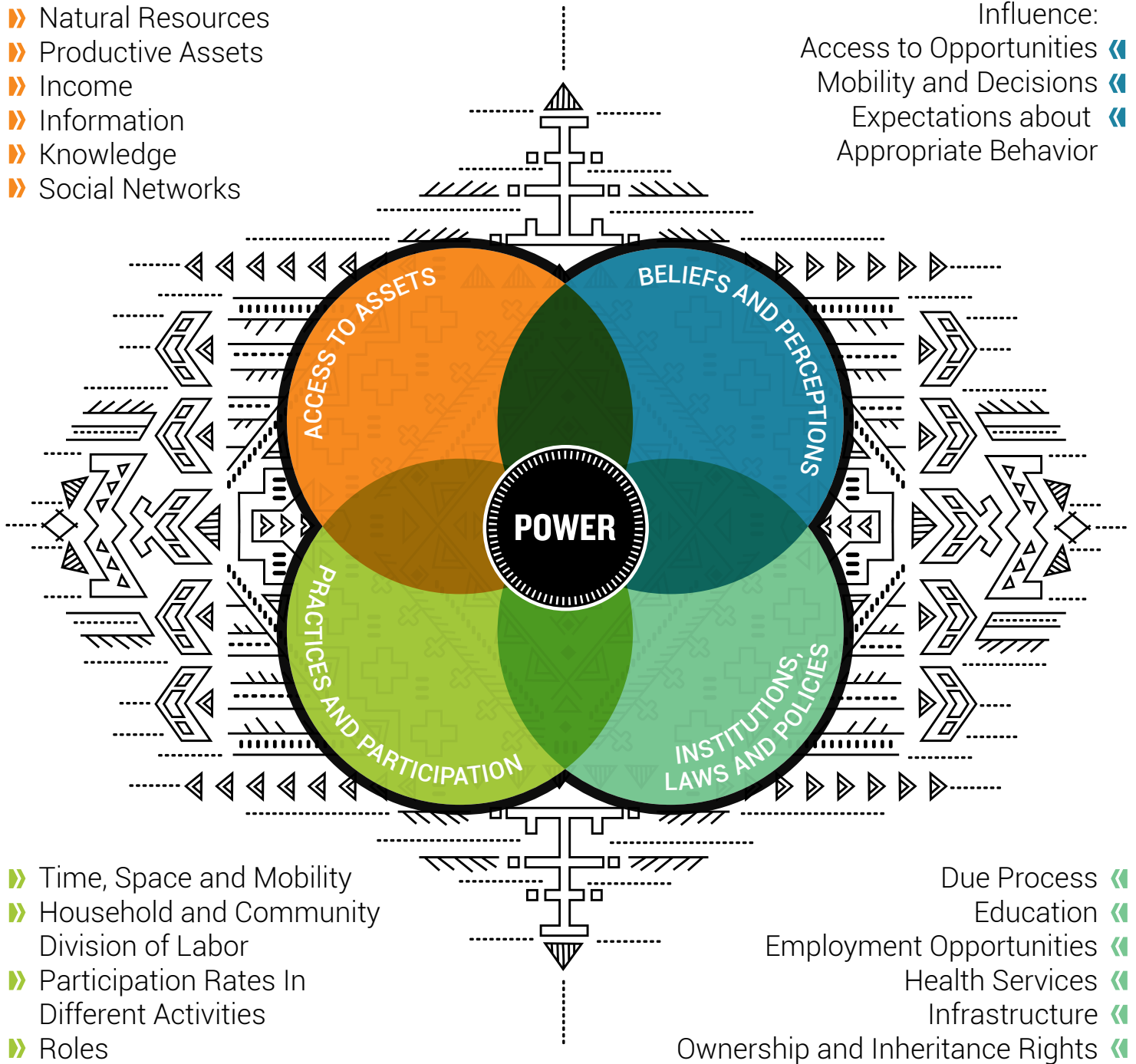
THE FOUR DOMAINS OF THE FRAMEWORK:

- ▶ **ACCESS TO ASSETS:** how gender relations affect access to resources necessary for a person to be a productive member of society and includes tangible assets (land, capital, and tools) and intangible assets (knowledge, education, and information).
- ▶ **BELIEFS AND PERCEPTIONS:** draws from cultural belief systems or norms about what it means to be a man or woman in a specific society. These beliefs affect men and women's behavior, dress, participation, and decision-making capacity. They also facilitate or limit men and women's access to education, services, and economic opportunities.
- ▶ **PRACTICES AND PARTICIPATION:** The norms that influence men and women's behavior also structure the type of activities they engage in and their roles and responsibilities. This dimension of the framework captures information on men and women's different roles, the timing and place where their activities occur, their capacity to participate in different types of economic, political, and social activities, and their decision-making.
- ▶ **INSTITUTIONS, LAWS, AND POLICIES:** This dimension focuses on information about men and women's different formal and informal rights, and how they are dissimilarly affected by policies and rules governing institutions, including the health system.
- ▶ **POWER** pervades all domains and informs who has, can acquire, and can expend assets and decisions over one's body and children. It determines if an individual can take advantage of opportunities, can exercise rights, move about and associate with others, enter into legal contracts, and run for and hold office. Power also determines the way men and women are treated by different types of institutions, policies, and laws. Providers' discriminatory attitudes, for instance, reinforce and deepen inequalities. Providers, particularly lower-level female providers, may also experience discrimination and mistreatment in their workplaces as a result of gendered hierarchies.

FIGURE 1 | THE GENDER ANALYSIS FRAMEWORK

- » Natural Resources
- » Productive Assets
- » Income
- » Information
- » Knowledge
- » Social Networks

- Influence:
- Access to Opportunities <<
 - Mobility and Decisions <<
 - Expectations about <<
 - Appropriate Behavior <<



- » Time, Space and Mobility
- » Household and Community Division of Labor
- » Participation Rates In Different Activities
- » Roles

- Due Process <<
- Education <<
- Employment Opportunities <<
- Health Services <<
- Infrastructure <<
- Ownership and Inheritance Rights <<

² Other gender analysis frameworks are structured similarly but may vary the grouping of content and labels for the domains. Some examples include: Canadian International Development Agency (2007); Danish International Development Agency (2008); Food and Agriculture Organization Socioeconomic and Gender Analysis; (Liverpool School of Hygiene and Tropical Medicine (1995).

FIGURE 2 | SEVEN STEPS TO A GENDER ANALYSIS

The key steps to a gender analysis are described in detail in Figure 2. The Jhpiego Gender Analysis Toolkit focuses principally on Steps 4 and 5 below—the identification of critical information gaps and the development and implementation of a data collection plan. The Toolkit uses the GAF to organize questions for collecting information on gender relations and roles in the context of health programming. The questions that appear in the tables are illustrative of the types of information collected as part of a gender analysis. They are not meant to be a comprehensive set of questions.

1

A SECONDARY DATA COLLECTION PLAN

Develop a data collection plan linked to project objectives to answer the questions:

- » How will anticipated results of the work affect women and men differently?
- » How will the different roles and status of women and men affect the work to be undertaken?

The plan should include a data collection matrix, which includes the gender-related research questions to be asked, the data to be gathered, source of the data, who will collect it, methods for data collection and analysis, and how the information will be used.

2

REVIEW OF SECONDARY DATA SOURCES

Conduct a search for gender-focused published and unpublished studies and disaggregated by sex databases related to the objectives of the project.



3

ANALYSIS OF SECONDARY DATA

Use the GAF, which is composed of four domains (access to assets, beliefs and perceptions, practices and participation, and institutions, laws, and policies, with power cross-cutting the four domains), to organize information about gender differences from existing sources. Assess whether the existing information is adequate for the project context to understand how health program objectives may be affected by gender difference and inequalities in the following areas:

- » Differences in women and men's access to assets, resources, and health services.
- » Differences and inequities in women and men's use of time between paid, unpaid, and volunteer labor and care-taking responsibilities in the household and community.
- » Differences and inequalities in leadership roles, decision-making, and legal status.

And, assess how potential differential effects of health policies and programs on women and men, including those that are unintended, may negatively or positively impact women and men's opportunities, health, socioeconomic status, and wellbeing.



4

IDENTIFICATION OF CRITICAL INFORMATION, GAPS AND CONTRADICTIONS

If the initial review does not satisfy the criteria in Step 3, identify what information is lacking and develop a data collection plan. In addition to gaps in the available information on gender issues related to the project, there may be contradictory findings that require further investigation. The choice of methods and the number of topics explored may be constrained by the available budget. It will require prioritization of topics based on an assessment of their relevance and potential impact on the project's objectives.



5

DEVELOPMENT OF A PRIMARY DATA COLLECTION PLAN AND INSTRUMENT

The current toolkit provides a guide for developing research questions and selecting research methods. The illustrative questions by domain indicate the type of information that needs to be collected, although the project objectives and focus will determine which of the illustrative questions are most pertinent. Some of the questions are more appropriate to investigate through quantitative methods and others through qualitative methods. The annotations of different quantitative and qualitative methods are included to provide assistance with the selection of methods appropriate to the task. Gender focused questions can be incorporated into existing instruments (see Yemen Knowledge, Practices & Coverage (KPC) examples in Annex IV) or applied in complementary qualitative or quantitative research.



6

DATA ANALYSIS

Gender-focused data can be analyzed using standard quantitative and qualitative analytical methods. What distinguishes the analysis is the focus on data linked to the GAF domains. The analysis should be designed to compare information about men and women, and about different categories of women and men (e.g., by ethnicity, sexual orientation, age, class, caste, residence, and race). These comparisons should reveal where there are gaps and inequalities that are likely to affect women or men's participation rates, leadership, access to services, uptake of healthy behaviors, or treatments, or that subject men or women to differential risks and vulnerabilities affecting their health. The analysis should also provide an understanding of why these gaps and disparities exist and how they affect men and women's opportunities and aspirations.



7

CONSTRAINTS ANALYSIS

The final step in the gender analysis examines how the identified gender differences limit or facilitate desired changes in health knowledge, practices, and access to care from the user's perspective.

The analysis serves to identify gender-based constraints and opportunities that have the potential to either impede or facilitate (also referred to as gender determinants of health) achievement of health objectives. For example, in many places, women are constrained in receiving skilled care in delivery because they do not have power to make autonomous or joint decisions about their health care.





More specifically, to make the GAF more accessible, in [Section 6](#) of this toolkit starting on page 30, we provide topical questions to guide the content of research questions for each domain at each level of the health system for gender analysis.

For each level of the health system, 1) individual and household; 2) community; 3) health facility; 4) district; 5) national, we provide illustrative questions for each of the four domains.

Each section contains general topical questions that pertain to that level of the health system, and topical questions, and the second table contains topical questions pertinent to a specific area of health (e.g., HIV, FP). The topical questions are both illustrative and descriptive and offer a set of key questions for a range of Jhpiego health areas. They should inform what kind of information should be gathered using a combination of qualitative and quantitative methods, but are *not intended to be directly transferred to a survey or interview guide*. Instead, the questions should be further adapted for a specific purpose, to a particular context, and to the type of data collection tool.

RESEARCH QUESTIONS (BY DOMAIN)	TOPICAL QUESTIONS
1. What sociocultural norms and practices related to sex may contribute to increased risk of HIV transmission among women, girls, men, boys, and transgender persons?	1. What do men know about sex? 2. What do women know about sex? 3. Can a woman discuss sex with her partner? Can a man discuss sex with his partner? 4. Can a woman refuse sex with her partner? 5. If a woman knows or suspects her husband has other sex partners, can she insist that her husband use a condom when having sex with her? 6. Do women initiate sex? 7. Do men initiate sex? 8. Can a woman (unmarried or married) refuse to have sex with a partner? 9. Do men and women discuss sex? [table continued on next page]



Sample data collection tools and resources that pertain to each level are also provided. Annotations of the data collection and analysis resources listed appear in [Annex II](#). The citations contain a hyperlink to the full document of each resource. To keep the size of the tool manageable, we focused questions on one health area per level of the health system.

The table below illustrates the level of questions that this Toolkit aims to provide using HIV-related gender analysis and assessment questions. The topical questions in the GAF tables are more specific than broader research questions and less specific than the types of questions that would appear on a survey or as part of a qualitative interview guide, which would have to be adapted and tested prior to their application for the setting and type of tools to be used.

QUANTITATIVE DATA COLLECTION QUESTIONS*	QUALITATIVE DATA COLLECTION QUESTIONS*
<p style="text-align: center;">FOR MEN AND WOMEN</p> <ol style="list-style-type: none"> 1. Men don't talk about sex <ul style="list-style-type: none"> » Totally agree? » Partially agree? » Disagree? 2. Men need more sex than women do <ul style="list-style-type: none"> » Totally agree? » Partially agree? » Disagree? 3. Men are always ready to have sex <ul style="list-style-type: none"> » Totally agree? » Partially agree? » Disagree? 4. I would be outraged if my wife/husband asked me to use a condom <ul style="list-style-type: none"> » Totally agree? » Partially agree? » Disagree? 	<p style="text-align: center;">FOR WOMEN:</p> <ol style="list-style-type: none"> 1. If your husband asked you to have sex after you suspected he was having sex with another woman, what would you do? 2. Under what circumstances can a woman refuse to have sex with her partner? 3. Who decides when you and your partner have sex? <p style="text-align: center;">FOR MEN:</p> <ol style="list-style-type: none"> 1. If your wife asked you to use a condom, what would you think? What would you do? 2. Who decides when you and your partner have sex? 3. When you need information about your sexual health or encounter a problem, who do you ask? <p style="text-align: center;">[table continued from previous page]</p>



THE GENDER ANALYSIS TOOL WITH TOPICAL QUESTIONS

LEVELS OF THE HEALTH SYSTEM

-  **INDIVIDUAL & HOUSEHOLD**
-  **COMMUNITY**
-  **FACILITY**
-  **DISTRICT & PROGRAM**
-  **NATIONAL**

DOMAINS

-  **ACCESS TO ASSETS**
-  **BELIEFS & PERCEPTIONS**
-  **PRACTICES & PARTICIPATION**
-  **INSTITUTIONS, LAWS, & POLICIES**



ILLUSTRATIVE GENERAL QUESTIONS AT THE INDIVIDUAL AND HOUSEHOLD LEVELS

ACCESS TO AND CONTROL OVER ASSETS

1. What kind of resources do women and men have access to, respectively?
 - » Financial
 - » Natural
 - » Services
 - » Information
 - » Social capital
 - » Knowledge
2. What do women own? What do they do with what they own to improve their own health? Their children's health?
3. What do men own? What do they do with what they own to improve their own health? Their children's health?
4. What do they own together?
5. Respectively, are women and men's assets equally liquid and transferrable?

BELIEFS AND PERCEPTIONS

(NORMS)

1. What is appropriate behavior for a man or a woman? What is an ideal woman? What is an ideal man? How do these beliefs influence health behaviors?
2. What are the social beliefs and perceptions that condition women and men's expectations and aspirations? For education, for employment, for marriage and family?
3. How might men or women interpret new experiences or information differently based on their gender identities, level of education, and different types of knowledge that men or women may have?
4. Who should make decisions? What decisions do women make in the household? What kind of decisions do men make in the household? Which kinds of decisions are made jointly?
 - » When and with whom to have sex
 - » Safe sex
 - » Use of FP, ANC, skilled delivery care, postpartum care?
 - » VCT, PMTCT, voluntary medical male circumcision (VMMC)
 - » Children's health and nutrition
 - » Management of the household

5. Schooling for boys and girls
6. What are men and women's different experiences with violence—as victims, survivors, or perpetrators?
7. Who decides at what age a boy or girl marries? Whom they marry?
8. Who decides whether or not a boy or man is circumcised, or whether or not a girl or woman undergoes female genital mutilation?
6. Spatially, within the community and beyond, where are men and women's activities located?
7. What are men and women's different skills and capabilities?
8. What are men and women's different experiences with violence—as victims, survivors, or perpetrators?
9. Who decides at what age a boy or girl marries? What are the reasons for getting married at younger/older ages?

PRACTICES AND PARTICIPATION

(ROLES & RESPONSIBILITIES)

1. What is the gendered division of labor: roles, activities, work, and responsibilities of women and men in the house?
2. Do men or women have restrictions on their mobility? What restrictions? How do they influence women's access to services? To supportive social networks?
3. What types of activities, meetings, associations, and groups do they engage in?
4. What types of leadership roles do men and women play?
5. Respectively, how do men and women spend their time?
10. Who decides whether or not a boy or man is circumcised, or whether or not a girl or woman undergoes female genital mutilation?
11. Does a man or a woman in a couple decide when to have sex and when to have a child? Under what circumstances do they decide jointly? How do they communicate their preferences?

LAWS, POLICIES, AND INSTITUTIONS

1. How do inheritance laws treat men and women respectively? What about children, boys, and girls?
2. How does the legal system treat men and women (i.e. due process and recognition of rights)?
3. What employment opportunities are open to men? What employment opportunities are open to women?
4. How do men's wages compare to women's?
5. How does men's access to resources from the state or private companies (e.g. health, education, basic infrastructure, and public goods) compare to women's?
6. Do men and women have equal status under all national, regional, and local laws?





ILLUSTRATIVE QUESTIONS SPECIFIC TO HIV AND AIDS

ACCESS TO AND CONTROL OVER ASSETS

1. What kind resources do women and men have access to, respectively?
 - » Financial
 - » Natural
 - » Services
 - » Information
 - » Social capital
 - » Knowledge
2. How do differences in men and women's ownership of assets affect their different risks and vulnerabilities to HIV transmission?
3. How do men and women's access to and control over assets and resources affect their decision to get tested? Their access to treatment? Their ability to follow treatment protocols? Their ability to afford or use condoms or avoid high-risk behavior, such as transactional sex?
4. How do differences in men and women's social capital affect their risk for HIV transmission and their care and support if they find out they are HIV positive?
5. Respectively, are women and men's assets equally liquid and transferrable? How do differences in men and women's inheritance of assets affect men and women's health and wellbeing after a divorce or being widowed, (e.g. due to HIV)?

BELIEFS AND PERCEPTIONS

(NORMS)

1. What are the social beliefs and perceptions that shape what it means to be a man or a woman, for dating, courtship, marriage, and sex? What is appropriate behavior for a man or a woman, for dating, courtship, marriage, and sex? What is an ideal woman? What is an ideal man? How do these beliefs affect women and men's respective capacity to follow safe sex practices?
2. What are the social beliefs and perceptions that condition women and men's expectations and aspirations for dating or courtship relationships? For marriage? For multiple partners?
3. How might men or women interpret information about HIV prevention differently based on their gender identities?
4. How do beliefs about who should make decisions in the household affect a woman's ability to influence her and her partner's decisions to get tested? What kind of decisions do men make in the household?

5. Which kinds of decisions are made jointly?
 - » When and with whom to have sex
 - » Safe sex
 - » Use of FP, ANC, skilled delivery care, postpartum care
 - » VCT, PMTCT, VMMC
 - » Children's health and nutrition
 - » Management of the household
 - » Schooling for boys and girls
6. What are men and women's different experiences with violence—as victims, survivors, or perpetrators? How does the fear of and/or experience of violence by an intimate partner affect a woman's risk of contracting HIV? Her willingness to get tested? Her ability to disclose her status to her partner?
7. What types of beliefs about men's "ideal" behaviors put men at risk of HIV or increasing the risk for their intimate partners?
8. Who decides at what age a boy or girl marries? How does early marriage affect the risk of HIV infection and the likelihood of accessing services?
9. Who decides whether or not a boy or man is circumcised, or whether or not a girl or woman undergoes female genital mutilation?

PRACTICES AND PARTICIPATION

(ROLES & RESPONSIBILITIES)

1. What is the gendered division of labor: roles, activities, work, and responsibilities of women and men. How might these affect the burden of care they assume for family members living with HIV?
2. Do men or women have restrictions on their mobility that may increase or decrease their vulnerability and access to care?
3. What types of activities, meetings, associations, and groups do they engage in? How do these different patterns of association affect men and women's respective access to information and capacity to understand and protect themselves from HIV?
4. What types of leadership roles do men and women play? To what extent can men and women influence HIV prevention, treatment, and care policies?
5. Respectively, how do men and women spend their time? Are men or women forced into or prone to economic activities that may put them at greater risk of HIV infection (e.g. sex work, migrant work)?

6. Spatially, within the community and beyond, where are men and women's activities located? How does the different location of men and women's activities put them at greater or lesser risk of HIV infection or affect their exposure to other diseases that may adversely affect their health, especially if they are HIV positive?
7. What are men and women's different experiences with violence—as victims, survivors, or perpetrators?
8. Who decides at what age a boy or girl marries?
9. Who decides whether or not a boy or man is circumcised, or whether or not a girl or woman undergoes female genital mutilation?
10. Does a man or a woman in a couple decide when to have sex; when to have a child? Who decides about PMTCT?



LAWS, POLICIES, AND INSTITUTIONS

1. How do inheritance laws treat men and women respectively?
2. Are there laws around HIV? What are they? How might they affect HIV protection or risk?
3. Is sex work illegal?
4. Is homosexuality illegal?
5. What employment opportunities are open to men? What employment opportunities are open to women? How are men and women's respective employment opportunities affected by their HIV status?
6. How does men's access to state resources (e.g. health, education, basic infrastructure, and public goods) compare to women's?
7. Do men, women, and those of other gender identities have equal status under all national, regional, and local laws?
8. Are there laws and policies preventing stigma and discrimination based on HIV status? Are they enforced?



USEFUL TOOLS AND OTHER RESOURCES INDIVIDUAL & HOUSEHOLD

1. **Demographic Health Survey Program.** 2013. [Demographic and Health Survey Modules](#). Washington DC: ICF for USAID. <http://bit.ly/1R9d0yw>
2. **Fulu, Emma and Rachel Jewkes n.d. The Core Men's Questionnaire.** Bangkok, Thailand: Partners for Prevention. <http://bit.ly/1Oj7GI3>
3. **Garbarino, Sabine and Mary Strode.** 2010. [Using Household Surveys for Gender Analysis in Developing Countries](#). London: Oxford Policy Management. <http://bit.ly/1MGpmuQ>
4. **Garcia-Moreno, Claudia, Henrica A.F.M. Jansen, Mary Ellsberg, Lori Heise, Charlotte Watts.** 2005. [WHO Multi-country Study on Women's Health and Domestic Violence](#). Geneva: World Health Organization. <http://bit.ly/1ldj5b4>
5. **International Community of Women Living with HIV/AIDS (ICW).** 2008. [Positive women monitoring change: A monitoring tool on access to care, treatment and support, sexual and reproductive health and rights and violence against women created by and for HIV positive women](#), Swaziland and Lesotho: ICW. <http://bit.ly/21iCX2Z>
6. **Institute for Reproductive Health (IRH).** 2008. [Tékponon Jikuagou \(TJ\) Project: Baseline Household Survey](#), accessible in Baseline Household Survey Report Tékponon Jikuagou Project: Addressing Unmet Need for FP through Social Networks in Benin. Washington DC: IRH. <http://bit.ly/1PQYPyL>
7. **Promundo and International Center for Research on Women.** 2011. [International Men and Gender Equality Survey \(IMAGES\) Survey Questionnaires](#). Washington D.C.: ICRW. <http://bit.ly/21iD3HT>
8. **Quisumbing, Agnes R. and Bonnie McClafferty.** 2006. [Food Security in Practice: Using Gender Research in Development](#). Washington DC: International Food Policy Research Institute. <http://bit.ly/1PdQOZu>



ILLUSTRATIVE GENERAL QUESTIONS AT THE COMMUNITY LEVEL



ACCESS TO AND CONTROL OVER ASSETS

1. How do men and women's access to and control over community resources affect their ability to:
 - » Decide to seek care?
 - » Reach the right level of care?
 - » Access transport to care?
 - » Access health information?
 - » Get appropriate care?
2. Do men/boys and women/girls have equal chance of choosing any health occupation?
3. Do men and women have equal access to the resources necessary to study health careers that may take longer or require specialized training?
4. Who decides about the deployment of community resources for health?
 - » Transport
 - » Infrastructure



BELIEFS AND PERCEPTIONS

(NORMS)

1. What are beliefs about:
 - » Age of marriage for boys, men, girls, and women?
 - » Female genital mutilation for girls and women?
 - » Circumcision for boys and men?
 - » Sex work for women and men?
 - » Adolescent boys and girls' use of condoms and other contraceptives?
 - » Sex for girls prior to marriage or women outside of marriage?
 - » Sex for boys prior to marriage or men outside of marriage?
 - » Homosexuality?
 - » Polygamy for men? Polygamy for women?
2. How does the community enforce gender norms and punish people when they do not conform to appropriate gender norms? How does this kind of social control affect men? How does it affect women? What are the ways in which communities discriminate against women? How do these practices also stigmatize some men?

PRACTICES AND PARTICIPATION

(ROLES AND RESPONSIBILITIES)

1. How many and what percentage of women and men serve on the community health committee?
2. How is the burden of care for the young and old distributed between men and women?
3. Who does what kind of health work? Men? Women?
4. How is health work organized? Are men and women treated equally regarding:
 - » Formal/informal care?
 - » Paid/unpaid care?
 - » Full-time/part-time work?
 - » Skilled/unskilled work?
5. What kinds of social groups do men and women participate in, respectively? What kind of leadership positions do men and women occupy? How do men and women's participation in social groups affect their access to health information? Their access to health services? Care and support from other community members?

LAWS, POLICIES, AND INSTITUTIONS

1. What kinds of groups and associations do men and women participate in?
2. Are there groups that bar women from membership?
3. Are there groups that bar men from membership?
4. Are women and men represented in leadership of:
 - » the community
 - » health committees
 - » producer's associations
 - » other civil society organizations



ILLUSTRATIVE QUESTIONS SPECIFIC TO ADOLESCENT REPRODUCTIVE HEALTH AND FAMILY PLANNING AT THE COMMUNITY LEVEL



ACCESS TO AND CONTROL OVER ASSETS

1. What kind of assets do adolescent girls have access to?
What kind of assets do adolescent boys have access to?
 - » Schooling
 - » Vocational training
 - » Mentors
 - » Employment
 - » Peer groups
 - » Money for school supplies
2. How do these assets influence their dating and sexual behavior (e.g. the role of peer groups)?
3. Do adolescent girls have access to reproductive health (RH)/FP services and information, such as about contraceptives, sexually transmitted infections (STIs), and HIV? What kinds of financial and social barriers impede their access?
4. Do adolescent boys have access to RH/FP services and information, such as about contraceptives, STIs, and HIV? What kinds of financial and social barriers impede their access?
5. How do adolescent girls gain access to financial assets for food, shelter, school materials, and clothing?
6. How do adolescent boys gain access to financial assets for food, shelter, school materials, and clothing?
7. How do adolescent girls gain access to condoms and other contraceptives?
8. How do adolescent boys gain access to condoms and other contraceptives?
9. What kind of social networks do adolescent boys have? What is the average number of people in boys' networks?
10. What kind of social networks do adolescent girls have? What is the average number of people in girls' networks?
11. Until what age respectively do girls and boys stay in school? What is the average year of completion for girls? For boys?
12. Respectively, what kinds of media do adolescent boys and girls have access to?
13. How do boys and girls learn about sex and from whom?
14. How do boys and girls obtain information about contraception and from whom?

BELIEFS AND PERCEPTIONS

(NORMS)

1. Are girls expected to abstain from sexual relations until marriage? What is the reason? Are girls able to do this?
2. Are boys expected to abstain from sexual relations until marriage? What is the reason? Are boys able to do this? Are boys expected to be sexually experienced before getting married? What is the reason?
3. What are local beliefs about adolescent boys or girls having sex with a non-married partner?
4. What are local beliefs about adolescents' use of contraceptives?
5. What are men and women's beliefs about contraceptives?
6. Are some contraceptives believed to be only for use by married couples or have side effects that affect fertility or women's or men's health? Do men and women hold these beliefs equally?
7. For married adolescents, how do beliefs about son or daughter preference influence women's use of contraception?
8. Are there beliefs held by men and/or women that discourage the use of contraceptives at particular times or for particular women (e.g. adolescents, breastfeeding women, women without children)?
9. Are there beliefs held by men and/or women that discourage adolescent girls or young women from getting a Pap smear or receiving a human papilloma virus vaccine?
10. What are men and women's perceptions of young men or young women who enter into relationships with the expectation of receiving money or other gifts? With someone of the same sex?
11. What are community attitudes toward adolescent girls or boys having access to cell phones?

PRACTICES AND PARTICIPATION

(ROLES & RESPONSIBILITIES)

1. Respectively, at what age do boys and girls have their first sexual experience? Is it prior to or after marriage (for girls/boys)?
2. Respectively, are boys and girls allowed to influence or discuss with their parents when or whom to marry, or if to marry? Who decides?
3. Do parents discuss with or educate their children about sex?
4. Do girls or boys experience sexual abuse or harassment at: school, water source, market, friends' or relatives' houses, home, or health services? When? By whom? At what ages?
5. Can adolescent girls use health services without the permission of parents, partners, or in-laws?
6. Do adolescent girls or boys engage in sexual or romantic relations in the expectation of receiving money or other gifts? With their peers? With older men or women?
7. Do adolescent boys or girls engage in sex work? How are girls recruited? How are boys recruited?
8. Do adolescent boys or girls experience violence from an intimate partner? What effect does this have on girls and boys' schooling? To what extent is violence associated with early pregnancy and early marriage?
9. Do adolescent boys or girls participate in community government, producer associations, or other civil society organizations? What determines if they participate or not—family position or wealth, educational attainment, or other factors?
10. Respectively, for what activities or tasks are girls and boys responsible? Are these by choice or prescribed by the community? What happens when individual boys or girls don't follow these norms of behavior?

LAWS, POLICIES, AND INSTITUTIONS

1. What kinds of services exist in the community tailored for youth (e.g. health, education, employment, digital)?
2. At what age do boys attain adult legal status? At what age do girls attain adult legal status? What does this mean for boys in terms of political participation, ownership of property, decisions about marriage? What does this mean for girls and boys in terms of political participation, ownership of property, decisions about marriage?
3. What is the age of marriage for girls? For boys?
4. What is the age of sexual consent for girls and boys?
5. Is comprehensive sexual education taught in schools?





USEFUL TOOLS AND OTHER RESOURCES COMMUNITY

1. **CARE and The International Center for Research on Women.** 2007. [Inner Spaces Outer Faces Initiative \(ISOFI\)](#)
Toolkit: Tools for Learning and Action on Gender and Sexuality. Washington, DC: CARE and ICRW.
<http://bit.ly/1IkwGI>
2. **CARE USA.** 2014. [Women's Empowerment—Multidimensional Evaluation of Agency, Social Capital & Relations \(WE-MEASR\): A Tool to Measure Women's Empowerment in Sexual, Reproductive, and Maternal Health Programs](#). Atlanta, GA: CARE.
3. **Doggett, Elizabeth and Tanya Medrano.** 2012. [Integrating Gender in Care and Support of Vulnerable Children: A guide for program designers and implementers](#). Chapel Hill, NC: FHI 360.
<http://bit.ly/10j9Nvx>
4. **Institute for Reproductive Health.** 2013. [The Gender Roles, Equality and Transformations Project \(GREAT\) Activity Cards: for Married and/or Parenting Adolescents](#). <http://bit.ly/1IkIJ4i>
5. **Instituto Papai, Promundo, Ecos, and Salud y Género.** 2002. [Program H Working with Young Men Series](#). Rio de Janeiro: Promundo.
<http://bit.ly/1NaIY7s>
6. **Loewenson, Rene, Asa C. Laurell, Christer Hotstedt, Lucia D'Ambruoso, and Zubin Shroff.** 2014. [Participatory Action Research in Health Systems: A Methods Reader](#). Ottawa, Canada and Harare, Zimbabwe: Training and Research Support Centre, Alliance for Health Policy and Systems Research, World Health Organization, International Development Research Centre Canada, and Regional Network for Equity in Health in East and Southern Africa.
<http://bit.ly/1MU4yhn>
7. **Michau, Lori et al.** 2008. [SASA! Activist Kit for Preventing Violence Against Women and HIV](#). Kampala, Uganda: Raising Voices.
<http://bit.ly/10j9TTR>
8. **Nanda, Geeta.** 2011. [Compendium of Gender Scales](#). Washington, DC: FHI 360/C-Change.
<http://bit.ly/1IMWisE>
9. **Underwood, Carol and Hillary Schwant.** 2011. [Go Girls! Vulnerable Girls Indices: Data from the 2009 Baseline and 2010 Endline Survey in Botswana, Malawi, and Mozambique](#). Baltimore: JHU/CCP.
<http://bit.ly/1Pduz0Y>



ILLUSTRATIVE GENERAL QUESTIONS AT THE FACILITY LEVEL

ACCESS TO AND CONTROL OVER ASSETS

1. What is the average amount of time health care providers spend explaining procedures and treatment regimens to men vs. women?
2. What amount of time do providers spend with women and men for the same or comparable conditions? Are men and women treated by the same category of health care provider for comparable conditions?
3. What is the amount of time men and women spend in the hospital for similar conditions? Do men or women spend less time, and why? For example, do women leave the health facility sooner than expected after giving birth? Why?
4. How and when is information about men and women's access to services collected and analyzed?
5. Are there male and female health care providers to fulfill the client's preferred sex of provider?
6. Are commodities available for both female and male health needs, according to demand?
7. Are there equal opportunities for men and women health care workers to be employed and promoted?
8. Do men and women receive equal pay for equal work, equitable fringe benefits, preferred postings, and equal opportunity to work the same number of hours and shifts?
9. Do male or female health care providers have the same opportunities for training in ANC, FP, emergency obstetric and newborn care, active management of the third stage of labor, postpartum care, and other skills, locally, nationally, and internationally?
10. Do either male or female health care providers report that there was training on these or other topics that they wanted to attend but were not able to? Why couldn't they attend (e.g. given on a day off when they had family or other obligations, not selected, too far away, couldn't afford the cost of the course, or other associated costs)?
11. Are there enough female midwives and physicians to care for women who prefer female health care providers?
12. Are there enough male nurses and physicians to counsel women's partners on FP and HIV should they desire a male to speak to instead of a female?
13. Are women or men denied promotions or other benefits because of assumptions about competing household obligations or lack of autonomy?

BELIEFS AND PERCEPTIONS

(NORMS)

1. How do ideas about men and women's proper behavior affect their access to services and treatment by health care providers? How do these attitudes affect how they interact with men, women, boys, and girls?
2. How do the attitudes of health care professionals differ toward women vs. men?
3. What are providers' beliefs about gender differences and equality? In general? In the health care work place? For their patients? How does this affect their treatment of patients?
4. What are supervisors and administrators' attitudes about sending male and female providers for training? In the district? Outside the district? Overseas?
5. Do factors related to gender influence promotion decisions?

PRACTICES AND PARTICIPATION

(ROLES & RESPONSIBILITIES)

1. Are men or women's health needs prioritized or disregarded? Is triage affected by the sex of a person? For example, are women with obstetric complications treated with the same speed as men with injuries from car accidents or occupational injuries?
2. How well do health workers respond to men and women's different health needs?
3. Are men and women treated differently by:
 - » Providers who are women?
 - » Providers who are men?
4. Do women or men experience harassment and assault at their workplaces, and in what form and frequency?
5. How and when is information about men and women's different experiences with the services collected and analyzed?
6. What is the proportion of men and women in management? Supervisors of each category of health workers, staff, and volunteers?

7. How does counseling promote or discourage men and women's personal choices about uptake of services, compliance with treatment, or use of contraceptive methods?
8. How are male and female health care workers involved in planning and policy formulation in the facility? Do men and women with equal training and seniority have equal decision-making and influence?
9. What would a nurse or midwife do if s/he observed a doctor's error or failure to follow biosecurity protocols? If the nurse is a woman and the doctor is a man? If the nurse is a man and the doctor a man? If both the nurse and the doctor are women? If the nurse were a man and the doctor a woman?



LAWS, POLICIES, AND INSTITUTIONS

1. Does the organization, spatial arrangement, and client flow in the facility affect men and women differently, making them more or less likely to use the services? Provide them more or less privacy?
2. Is health information at the facility level disaggregated by sex and age and comparatively analyzed for decision-making?
3. Is there any difference in availability of drugs and supplies (e.g. vasectomy vs. oral contraceptive pills) that are routinely used for men's health compared to women's health?
4. Are men and women treated equally with regard to confidentiality (nondisclosure) of health information?
5. Does the health facility have a code of conduct and reporting mechanisms for sexual harassment and assault? Disrespectful treatment?
6. As a consequence of facility protocols and procedures, do men or women experience stigma around different diseases? What about differences between groups of men and women, based on things like marital status or sexual orientation?
 - » HIV
 - » Malaria
 - » TB
 - » STIs
7. How many women and men on staff at the facility have the power to shape policies?
8. Which of the facility-level policies promote or discourage male and female clients' personal choices about about uptake of services or compliance with treatment? How do they affect men and women's choices and access to services or treatment? For example, do policies state that tubal ligation is only available to women with at least two children? Do facility policies support the disclosure that a woman is using contraception to her husband without first consulting her?
9. Are staff trained on gender equality and human rights, and how is the training often offered?
10. Is there a national policy on gender equality?
11. Is there a human resource policy at the district and facility levels on gender equality and/or non-discrimination based on gender?
12. Are any of the workplace policies discriminatory against men or women?



ILLUSTRATIVE QUESTIONS FOR MATERNAL & NEWBORN HEALTH AT THE FACILITY LEVEL (CLIENT-PROVIDER INTERACTIONS)



ACCESS TO AND CONTROL OVER ASSETS

1. Are information, education, and communication (IEC) materials equally accessible to male and female clients? Why or why not (i.e. low literacy levels of women, illustrations do not include men and women equitably, or sex-specific pronouns are used in exclusionary ways)?
2. Do the illustrations stereotype men and women's roles (i.e. women are caregivers; women are portrayed as responsible for illness of other family members, men are only portrayed as those in need of care or as doctors and administrators)?
3. Do men have access to health education and at times they are available?
4. During ANC, do providers ask a woman if there are any reasons that would prevent her from delivering at a health facility; if she is able to decide for herself where to deliver; and if not, whether she can bring the decision-maker to her next appointment?



BELIEFS & PERCEPTIONS

1. Do men and women have a preference for a health care practitioner of the same sex?

2. What are the beliefs held by women that prevent a woman from:
 - » Using FP?
 - » Attending ANC?
 - » Delivering at a health care facility?
 - » Breastfeeding?
3. What are the beliefs held by men that prevent a woman from:
 - » Using FP?
 - » Attending ANC?
 - » Delivering at a health care facility?
4. Are there beliefs that would discourage men from getting an HIV test, seeking services for an STI, agreeing to use condoms, or supporting his partner to use other types of FP?
5. What is considered respectful treatment, respectively, by male and female health workers of:
 - » Female clients or companions?
 - » Male clients or companions?
6. Do providers believe that a woman should not receive FP until she has a boy child, or that she should not receive a FP method without her husband's consent? Do health care workers believe men/boys and women/girls should receive the same attention and quality of care? Do health care workers believe men/boys and women/girls should receive the same attention and quality of care?

PRACTICES AND PARTICIPATION

(ROLES & RESPONSIBILITIES)

1. Do health workers ask women who decides:
 - » If she can go to the health facility?
 - » To bring her child to a health facility for a well child or sick care?
 - » Where she will deliver?
2. Are there incidents of disrespectful care by male or female providers in the facility toward:
 - » Female clients or companions?
 - » Male client or companions?
 - » Female health workers?
3. Are women discriminated against for being poor, of a particular ethnic group, for being young or old, for the timing of her arrival (too early or too late in labor), or for coming in with a miscarriage or abortion?
4. Do health care providers explain to the woman and her companion progress and procedures during labor, delivery, and postpartum?
5. Do health care providers treat women who give birth to a boy differently than those who give birth to a girl?
6. How does counseling promote or discourage men and women's personal choices about uptake of services or compliance with choices of method?

LAWS, POLICIES, AND INSTITUTIONS

1. Is there a national policy on gender equality?
2. Are there guidelines for the health sector response on GBV?
3. Are there protocols at the facility level about screening for and responding to GBV?
4. Are there policies and guidelines for inviting women's partners for:
 - » ANC
 - » HIV counseling and testing during ANC
 - » FP
5. Are there guidelines for inviting a woman to bring a companion during delivery at the health facility?
6. Do hours or the layout of services exclude women, men, or adolescent boys or girls from attending ANC, FP, delivery, or postpartum care?



USEFUL TOOLS AND OTHER RESOURCES HEALTH FACILITY

1. **CARE International.** 2013. [The Community Score Card \(CSC\): A generic guide for implementing CARE's CSC process to improve quality of services](http://bit.ly/1PdB2Ji). Atlanta: CARE: <http://bit.ly/1PdB2Ji>
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10. **World Health Organization.** 1995. [Health Workers for Change: A Manual to Improve Quality of Care](http://bit.ly/1MGBLz0). Geneva: World Health Organization.



ILLUSTRATIVE GENERAL QUESTIONS AT THE DISTRICT & PROGRAM LEVELS



ACCESS TO AND CONTROL OVER ASSETS

1. Are ambulances deployed equitably to meet the different needs of men and women?
2. Are fees for transport applied equitably and without discrimination?
3. Is there any difference in budgets for drugs and supplies (e.g. vasectomy vs. oral contraceptive pills) that are routinely used for men's health compared to women's health?
4. Are district budgets analyzed and appropriated according to gender equity principles?
5. Are employment and training opportunities for male and female health care workers allocated equitably?



BELIEFS AND PERCEPTIONS

(NORMS)

1. Are health messages, illustrations, and other media presentations free of gender stereotypes and biases?
2. Are district authorities knowledgeable of national gender equality policies? To what extent do they implement and enforce the policies?
3. Is there equal concern for disseminating health information to men and women?



PRACTICES AND PARTICIPATION

(ROLES & RESPONSIBILITIES)

1. Are men and women equitably involved in program planning?
2. Do men and women working at the same level of care and in the same cadres receive equal support and opportunities in terms of benefits, training, promotions, and leadership opportunities?
3. Are men and women's different health needs taken into consideration in district planning, program design and budget development?
4. Are measures taken to address women and men's different constraints in accessing services, for example:
 - » Hours health services are open
 - » Educational materials, messages, and health outreach activities
 - » Balance of men and women in the health work force
5. Are male and female health care workers trained on gender equality?
6. Where do men and women seek care for themselves and their children and why: traditional healer, local drug shop, community health worker, formal health clinic, or a combination of the above?

LAWS, POLICIES, AND INSTITUTIONS

1. Do referral systems treat men and women equitably?
2. What is the likelihood of women being appropriately referred and reaching the facility in a timely fashion?
3. What is the likelihood of men being appropriately referred and reaching the facility in a timely fashion?
4. Are there family-friendly policies in place? Does the organization of health work take into consideration women's disproportionate responsibilities for childcare, food preparation, and other family care?
5. Are the differential effects on men and women taken into consideration regarding different forms of cost recovery, such as fees and insurance?
6. Are there mechanisms in place for registering and addressing practices that are gender discriminatory or inequitable?
7. Are their gender equitable workplace policies?
8. Do supervision guidelines incorporate attention to gender equality?
9. Are men and women represented equally in district health care leadership posts?
10. Are men and women represented equally in positions as health care trainers?





ILLUSTRATIVE QUESTIONS SPECIFIC TO MALARIA AT THE DISTRICT & PROGRAM LEVELS



ACCESS TO AND CONTROL OVER ASSETS

1. Do women and men and boys and girls under five years old have equal access to malaria bed nets?
2. Do men and women have equal opportunity for employment on indoor residual spray teams?
3. Does information about malaria prevention and control reach both men and women?
4. If delivery of malaria services is provided principally through ANC and child health services, how are non-pregnant woman, men, and adolescent boys and girls provided access to care?
5. Who pays for treatment and how does this impact the time it takes to seek treatment?



BELIEFS AND PERCEPTIONS

(NORMS)

1. Are there beliefs about what it means to be a man that may deter men who are sick from seeking or receiving care at health centers?
2. Are there beliefs about what it means to be a woman that may deter women who are sick from seeking or receiving care?

3. Do health workers believe that men should receive preferential treatment over women? How does this affect delivery of care?
4. Are these attitudes and beliefs addressed through district-level supervision and training?



PRACTICES AND PARTICIPATION

(ROLES & RESPONSIBILITIES)

1. Has the division of labor between men and women been taken into consideration for planning and monitoring to address issues such as exposure risk (times of day when men and women work outside) and biological vulnerability (e.g. pregnancy)?
2. Are women restricted from moving on their own outside of their households or communities that may restrict access to services?
3. Do women or men face time constraints that may limit their ability to get to services when they are open?
4. Are there times during the malaria season when men or women may be sleeping outdoors?
5. Are nets adequately allocated and distributed in communities where women and men sleep in separate houses at times? Are there sufficient nets allocated to polygamous households?

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6. Are new drugs tested on both men and women of different ages?
 7. Are there outreach activities to adolescent girls living with HIV and affected by malaria? How are they identified?
 8. Are services for HIV and malaria co-located to minimize the time, effort, and expense that persons living with HIV have to exert to get care, especially young and pregnant women?
 9. Does the fulfillment of other household or social roles impede treatment seeking?
 5. Do district policies about location of health services and times they are open take into consideration men and women's different time constraints and mobility restrictions?
 6. Do research protocols include both women and men of different ages?
 7. Are there gender equitable policies that guide the allocation of malaria resources within the district?
 8. Is there research underway or planned to support delivery of home-based and door-step care?

LAWS, POLICIES, AND INSTITUTIONS

1. Are data on prevalence disaggregated by sex and analyzed for sex-specific patterns?
2. Are data on utilization of health services disaggregated by sex and analyzed for disparities in utilization of services by men and women according to prevalence rates?
3. Do district plans for net distribution take into consideration who in the household controls financial resources and who might control use of nets?
4. In the case of indoor residual spraying, do district plans and policies support equal employment opportunities for men and women in all positions on spray teams?



USEFUL TOOLS AND OTHER RESOURCES DISTRICT & PROGRAM

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2. **Health Policy Initiative.** 2010. [Gender Integration Index](http://bit.ly/1YwOWaX). Washington, DC: Futures Group for USAID.
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3. **Quinn, Sheila.** 2009. [Gender Budgeting: Practical Implementation Handbook](http://bit.ly/1IN8NVf). Strasbourg, France: Directorate General of Human Rights and Legal Affairs, The Council of Europe.
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<http://bit.ly/1Q1sPpY>
6. **World Health Organization.** 2011. [Gender Mainstreaming for Health Managers: A Practical Approach](http://bit.ly/1Xuhrnk). Geneva, Switzerland: World Health Organization.
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ILLUSTRATIVE GENERAL QUESTIONS AT THE NATIONAL LEVEL (POLICIES, RESOURCES, AND SYSTEMS)



ACCESS TO AND CONTROL OVER ASSETS

1. Proportionately, how do health budgets for programs, drugs, supplies, infrastructure, and human resources benefit men vs. women?
2. Who decides how these resources are allocated?



BELIEFS AND PERCEPTIONS

(NORMS)

1. Is political leadership committed to gender equality in the health system?
2. Do national health leaders understand their legal and political obligations for responding to women's health issues? Men's health issues? GBV?



PRACTICES AND PARTICIPATION

(ROLES & RESPONSIBILITIES)

1. Are proposed health reforms and new policies assessed for their potential differential impact on men and women, and on male and female health workers? How?
2. Are national budgets for health assessed for whether they are gender equitable?
3. How does the design of health research take into consideration:
 - » Differential risks and vulnerabilities of men and women?
 - » Differential biological and social impacts of disease on men and women?
 - » Involvement of men and women in treatment and control groups in research studies?
4. How is the health system leadership accountable for implementing existing gender equality policies? Do they conduct periodic assessments, issue reports, or measure performance on a regular basis?

LAWS, POLICIES, AND INSTITUTIONS

1. Does the country have policies on gender equality, and are any of them specific to health?
2. Is health information disaggregated by sex?
3. Are statistics on the health workforce disaggregated both by sex and type of professional (e.g. nurse, doctor, etc.)?
4. Are there national gender equality in health indicators, such as age of marriage, GBV, son preference?





ILLUSTRATIVE QUESTIONS SPECIFIC TO GENDER-BASED VIOLENCE AT THE NATIONAL/POLICY LEVEL

ACCESS TO AND CONTROL OVER ASSETS

1. What kind of health, legal, and social services are available to GBV survivors?
2. Who has access to these services and who does not?
3. Have health care providers had access to GBV pre-service training? In-service training?
4. Have providers been trained on how to:
 - » Screen for GBV?
 - » Detect GBV?
 - » Provide counseling?
 - » Conduct safety planning and referrals?
 - » Perform forensic exams?
5. Do women throughout the country have local access to health services with rape kits, post-exposure prophylaxis, and emergency contraception?
6. What is the budget for GBV services?
7. What is the budget for GBV monitoring?
8. What is the budget for GBV prevention?

BELIEFS AND PERCEPTIONS

(NORMS)

1. Is GBV regarded as a public health problem?
2. Which forms of GBV are considered health problems?
3. Is GBV considered a private matter?
4. Is GBV considered a multi-sectoral issue?

PRACTICES AND PARTICIPATION

(ROLES & RESPONSIBILITIES)

1. Where are programs for survivors located? In cities? In rural areas?
2. Where are programs for perpetrators located? In cities? In rural areas?
3. How many complaints of health care workplace sexual harassment and assault have been reported? What percentage has reached the attention of a supervisor? The health center or hospital administrator? The district health administrator? National attention? What percentage has been adjudicated?

4. What percentage of sexual violence cases reported to health facilities has been properly referred? What percentage of sexual violence cases that have been adjudicated have resulted in the prosecution of the perpetrator?
5. Has the Ministry of Health (MOH) committed to ending GBV, and how public are those commitments?
6. What laws/policies define GBV? Is rape illegal? How is rape defined? Is there such a thing as marital rape in the law? Is domestic violence illegal? How is it defined?
7. Does the law recognize GBV against women, men, and other gender identities?

LAWS, POLICIES, AND INSTITUTIONS

1. Does the MOH have policies on gender equality?
2. Does the MOH have policies and protocols and referral procedures on intimate partner violence, sexual violence, or other forms of GBV history and intake (e.g. regarding Post-Exposure Prophylaxis and emergency contraception)?
3. Are there GBV indicators in the health management information system, and are data disaggregated by sex?
4. Are there national gender equality in health indicators, such as age of marriage, GBV, son preference?
5. What policies exist for prevention and response to sexual harassment and assault in health facilities? What are the procedures for someone to file a complaint? Are policies enforced? How?



USEFUL TOOLS AND OTHER RESOURCES NATIONAL

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<http://bit.ly/1kVYcHp>
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<http://bit.ly/1jmuFVx>
8. **Perez Fragoso, Lucia and Rosalio L Rangel Granados.** 2004. [Guide for the Formulation of Public Budgets in the Health Sector Using a Gender Perspective](http://bit.ly/1Hr4skw). Mexico City: Ministry of Health.
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3. **United Nations Development Fund for Women (UNIFEM)/ United Nations Entity for Gender Equality and Empowerment of Women (UN WOMEN) and United Nations Population Fund (UNFPA).** 2006. [Gender-responsive Budgeting in Practice: A Training Manual.](#) New York: UNIFEM and UNFPA.
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4. **World Health Organization.** 2011. [Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence.](#) Geneva: World Health Organization.
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◆ CONSTRAINTS ANALYSIS: EXAMINATION OF HOW GENDER INEQUALITIES AFFECT HEALTH OUTCOMES

Although the domains of the GAF (i.e., access to and control over assets and resources; beliefs and perceptions; practices and participation; and laws, institutions, and policies) do not encompass all facets of human life, they provide a conceptual frame of reference, especially when considered along with the unequal use of power, for being able to identify the information necessary to address three key questions:

- » What are the different gender-based constraints and opportunities faced by women, men, boys and girls that affect their health behaviors, access to health care and health?
- » How will the anticipated results of health policies, programs and services affect women, men, boys, and girls differently? And what impact will they have on women and men's relative status?

Disparities and inequalities that are a consequence of some of these gender-linked differences determine differential health outcomes for men, women, boys, and girls. These gaps and disparities form constraints when they become a barrier to using a service or taking advantage of an opportunity presented by a health intervention.

After collecting information about gender relations at the levels of the health system in which you plan to intervene, the second step in the gender assessment process is to analyze how the identified gender differences limit or facilitate desired changes in health knowledge, practices, and access to care from the user's perspective. The constraints analysis serves to identify gender-based constraints and opportunities that have the potential to either impede or facilitate (also referred to as gender determinants of health) achievement of health objectives. For example, in many places, women are constrained in receiving skilled care in delivery because they do not have the power to make autonomous or joint decisions about their health care.



The constraints analysis begins with a process to uncover gender-based constraints. The first step is to identify the condition(s) of inequality. For example, unequal access to services or delay in receiving care are inequalities that act as constraints to health. The second step is to identify the gender-based factors that contribute to the condition(s) of inequality. For instance, disparities in women and men's control over resources needed to pay for transportation to get to care or the inequalities in decision-making that impede women's capacity to decide and act on the decision to seek care. The constraint is articulated by linking the constraining factors to the outcome, for example:

"Women in labor who experience complications are often delayed in seeking care because they are unable to make the decision themselves to seek care, without permission from someone else, usually their partner or husband, mother-in-law, or father-in-law."

Once the constraint is identified, among others, the next step is to prioritize those constraints which are most likely to affect program outcomes, are feasible to address within the mandate of the project, and, when addressed, will contribute to greater gender equality.

Upon completion of the constraints analysis, staff are ready to begin the design of the project.



[The Manual for Integrating Gender into Reproductive Health and HIV Programs \(http://bit.ly/1UVJgV7\)](http://bit.ly/1UVJgV7): From Commitment to Action, it provides a sequential process for applying the findings of the gender and constraints analyses for project design, implementation, and M&E.

LIST THE MOST IMPORTANT GENDER-BASED CONSTRAINTS FOR THE PROGRAM	WHAT ACTIONS MIGHT ADDRESS THE CONSTRAINTS TO ACHIEVE MORE EQUITABLE OUTCOMES?	MODIFY OR CONSTRUCT A GENDER-SENSITIVE INDICATOR TO MEASURE SUCCESS
Women's restricted mobility outside the household limits their access to FP and ANC services	Home-based ANC services	% increase or decrease in number of pregnant women receiving four ANC visits after offering home-based ANC
	Cash paid to women who attend ANC services at health center	Number and % of pregnant women receiving cash payments compared to % women who do not receive conditional cash transfers (CCT) who attend four ANC visits at a health center
		Number and % of men whose pregnant partners receive CCT compared to men whose partners do not who agree that their partners can go to ANC services at the health center unaccompanied by a male relative



The project team designs activities to reduce or remove the identified constraints. This can be accomplished by developing activities to get around the constraint. For example, if women's mobility limits their access to clinic-based services for ANC, the project could offer home-based services. Another approach is to directly address women's lack of mobility by working with both women and other powerful stakeholders to increase women's mobility outside the home. For example, economic incentives, such as a CCT program, may encourage men who restrict women's access to health services to change their minds for the family to benefit from the additional financial resources.

Once the project team develops activities to overcome the constraints, the next step is to develop indicators that measure the reduction in or removal of the constraint or that measure women's empowerment relative to men's. In the first example in the table, the indicator demonstrates whether the provision of ANC services through home-based care increases the number of pregnant women who receive four ANC visits. For the CCT program, the indicator measures whether CCT increases women's ability to independently access ANC at the health center compared to women who are not in the program. The second CCT indicator measures changes in men's attitudes regarding women's mobility by comparing men whose partners are in the program with men whose partners are not in the program. Although all three indicators measure a reduction in barriers and access to health care, the CCT indicators also measure potential changes in a woman's status relative to men by measuring her expanded mobility and men's changes in attitudes about women's mobility.





ILLUSTRATIVE GENDER INTEGRATION PATHWAY

Although health care professionals generally are comfortable addressing biological differences, they are not always as attentive to social inequalities that differentially affect men and women's health risks and vulnerabilities, capacity to seek and utilize care, comply with medical advice, and the magnitude of the burden of the health problem. The gender integration pathway, developed for USAID's Maternal and Child Survival Program (MCSP), facilitates visualization of these differential effects and some potential responses, based on information collected in response to questions posed in the GAF.



	ASSESSMENT	ANALYSIS	INPUT	OUTPUT	OUTCOMES	IMPACT
HEALTH SYSTEM	Identify Evidence Base and Gender Context in: <ul style="list-style-type: none"> » Access to assets » Knowledge, beliefs, and perceptions » Practices, roles, participation » Legal rights and status 	Analyze the impact of gender constraints and opportunities on program objectives	Gender Integration in Program Design and Implementation Activities are designed to: <ul style="list-style-type: none"> » reduce/overcome gender-based constraints » increase gender equality 	Monitoring, Evaluation, and Learning	Changes in Behavior	Normative and Structural Changes
INDIVIDUAL	<ul style="list-style-type: none"> » Men less likely to be educated about RMNCH due to gender roles » RMNCH perceived as a woman's domain » Having children as a defining character of womanhood or manhood 	<ul style="list-style-type: none"> » Men may hinder RMNCH prevention and treatment practices » Men do not participate in RMNCH » Prevention of early marriage and pregnancy is inhibited 	<ul style="list-style-type: none"> » Educating and engaging men (with women) about RMNCH at all entry points » Adolescent reproductive life skills education that addresses gender norms that contribute to early marriage/pregnancy 	<ul style="list-style-type: none"> » Disaggregated by sex data where relevant » Gender-based constraints are reduced: <ul style="list-style-type: none"> • Number of countries where the program supported a gender analysis • Number of districts with a gender strategy • Number of people who have completed gender norms changing activities • Percentage of women allowed a companion at birth • Percentage of women who experienced disrespectful care or abuse during their most recent delivery in MCSP-supported areas • Number of countries that have integrated GBV screening/ services into ANC services with MCSP support <ul style="list-style-type: none"> » Gender equality has improved: <ul style="list-style-type: none"> • Percentage of currently married women who participate in decisions about their own health care in the program supported areas » Increased knowledge of effective gender integrated programming 	<ul style="list-style-type: none"> » Men and women identify equitable responsibilities in RMNCH » Equal education about RMNCH in men and women » Increased use of FP 	Improved RMNCH outcomes measured by Reduction in: <ul style="list-style-type: none"> » Maternal mortality ratio » Neonatal mortality ratio » Under five mortality rate » Unmet need for FP » Total fertility rate » Adolescent birth rate » Stunting » Anemia Increase in: <ul style="list-style-type: none"> » Proportion of births attended by skilled health personnel » Contraceptive prevalence rate » ANC coverage » Proportion of children fully immunized Increased gender equality: <ul style="list-style-type: none"> » Education » Opportunities » Access to assets » Decision-making and power
HOUSEHOLD	<ul style="list-style-type: none"> » Women lack decision-making power to access or utilize services » Women's lack of control over resources » Gender-based mistreatment—GBV, heavy household work burden, less food distribution » Women as caretakers and men not 	<ul style="list-style-type: none"> » Women are not able to access RMNCH services » Women are not able to pay for RMNCH services » Gender-based mistreatment and heavy workload contributes to poor health in women » Men are less capable of facilitating child health care 	<ul style="list-style-type: none"> » Promoting gender equality through social and behavior change communication to facilitate healthy practices and uptake of services » Educating men and families about effects of gender-based mistreatment and violence on maternal and child health outcomes » Offering parenting courses for mothers and fathers that promote positive fatherhood, joint birth planning, and delaying and spacing pregnancy 		<ul style="list-style-type: none"> » Adult and adolescent women and men freely access services » Reduced gender-based mistreatment and violence » Men's participation in fatherhood and caregiving 	
COMMUNITY	<ul style="list-style-type: none"> » Women's lack of leadership in the community » Acceptance of early marriage » Low value placed on women's lives » Women's limited mobility due to gender norms » Harassment and abuse of women in the community » Low social capital for women 	<ul style="list-style-type: none"> » Women's RMNCH needs are not prioritized in the community » Prevention of early marriage and pregnancy is inhibited » Women are not able to seek services » Community health workers may have difficulty mobilizing in the community 	<ul style="list-style-type: none"> » Community mobilization and advocacy on safe motherhood, women's health and rights (not just child's) » Training and deploying skilled female birth attendants to homes » Supporting community transport systems for accessing maternal health services » Women's/mother's care groups 		<ul style="list-style-type: none"> » Female birth attendants are empowered to attend to mothers in the home » Community leaders and resources prioritize women's health and safe motherhood 	
HEALTH FACILITY	<ul style="list-style-type: none"> » Disrespectful, gender discriminatory, and abusive attitudes of health workers » Lack of recognition of GBV and services » Health providers and facilities unwelcoming to men in RMNCH setting » Female health workers disempowered or face gender discrimination in the workplace » Infrastructure, staffing, commodities not responsive to women's/men's needs 	<ul style="list-style-type: none"> » Women may not want to seek services at the health facility, e.g. for labor and delivery » Men do not receive the same counseling on RMNCH and, thus, inhibit healthy practices » Female health workers less able to give quality care 	<ul style="list-style-type: none"> » Training and guidelines for health providers on gender and human rights and respectful care » Strengthen GBV detection and services » Facilitating couples' counseling and communication on ANC, birth planning and postpartum FP » Promoting gender equity in clinical governance and allocation of health facility resources 		Services are: <ul style="list-style-type: none"> » Accessible » High quality » Efficient » Non-discriminatory » Promote gender equity 	
LAWS & POLICIES	<ul style="list-style-type: none"> » Laws that support early marriage » Lack of laws and policies on GBV/ gender in health sector » Lack of guidelines on responding to GBV in the health sector » Lack of guidelines on engaging men in RMNCH and HIV services 	<ul style="list-style-type: none"> » Girls marry and get pregnant at an early age » GBV contributes to pregnancy complications and may inhibit FP » Health providers have no guidance or capacity to respond to GBV » Health facilities do not know how to engage men in services 	<ul style="list-style-type: none"> » Participate in national dialogue on impacts of early marriage and GBV on RMNCH » Integrate gender issues into RMNCH national action plans » Support the development and/or implementation of gender into service delivery guidelines and quality improvement tools 		<ul style="list-style-type: none"> » Policies and guidelines support equal rights, choice, access, participation, and non-discrimination. 	



ANNEXES

View the most up-to-date version of this document online at:
<http://gender.jhpiego.org/analysistoolkit>

ANNEX I GENDER CONCEPTS AND DEFINITIONS



Sex refers to biologically defined and genetically acquired differences between males and females, according to their physiology and reproductive capabilities or potentialities. It is universal and mostly unchanging without surgery.

Gender refers to the economic, social, political, and cultural attributes and opportunities associated with being women and men. The social definitions of what it means to be a woman or a man vary among cultures and change over time. Gender is a sociocultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality.

Gender Analysis is a methodology that both:

- » Describes existing gender relations in a particular environment, ranging from within households or firms to a larger scale of community, ethnic group, or nation. It involves collecting and analyzing disaggregated by sex data and other qualitative and quantitative information.
- » Organizes and interprets, in a systematic way, information about gender relations to make clear the importance of gender differences for achieving development objectives.

Gender Assessment examines how a program or project addresses and responds to gender disparities and inequalities through its objectives, activities, and policies. It responds to two key questions:

1. How will the different roles and status of women and men within the community, political sphere, workplace, and household affect the work to be undertaken?
2. How will the anticipated results of the work affect women and men differently? And their relative status?



Gender Equity is the process of being fair to women and men. To ensure fairness, measures must be taken to compensate for historical and social disadvantages that prevent women and men from operating on a level playing field.

Gender Equality is the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources.

Gender Integration refers to strategies applied in program assessment, design, implementation, and evaluation to take gender norms into account and to compensate for gender-based inequalities.

Gender Mainstreaming is the process of incorporating a gender perspective into policies, strategies, programs, project activities, and administrative functions, *as well as into the institutional culture of an organization.*

Gender Stereotypes are ideas that people have about masculinity and femininity, what men and women of all generations should be like and are capable of doing. (e.g. girls should be obedient and cute or are allowed to cry, and boys are expected to be brave and not cry; women are better housekeepers and men are better with machines; or boys are better at mathematics and girls are more suited to nursing).

Gender-Based Violence is violence derived from gender norms and roles as well as from unequal power relations between women and men. GBV is specifically targeted against a person because of his or her gender, and it affects women disproportionately. It includes, but is not limited to, physical, sexual, and psychological harm (including intimidation, suffering, coercion, and/or deprivation of liberty within the family or within the general community). It includes violence perpetuated by the state.

Agency is a person's capacity to set goals and act on them. It may entail bargaining, negotiation, and resistance (*Adapted from Naila Kabeer's definition of agency*).

Empowerment 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. (*Adapted from Naila Kabeer's and Ruth Alsop's definition of empowerment.*)



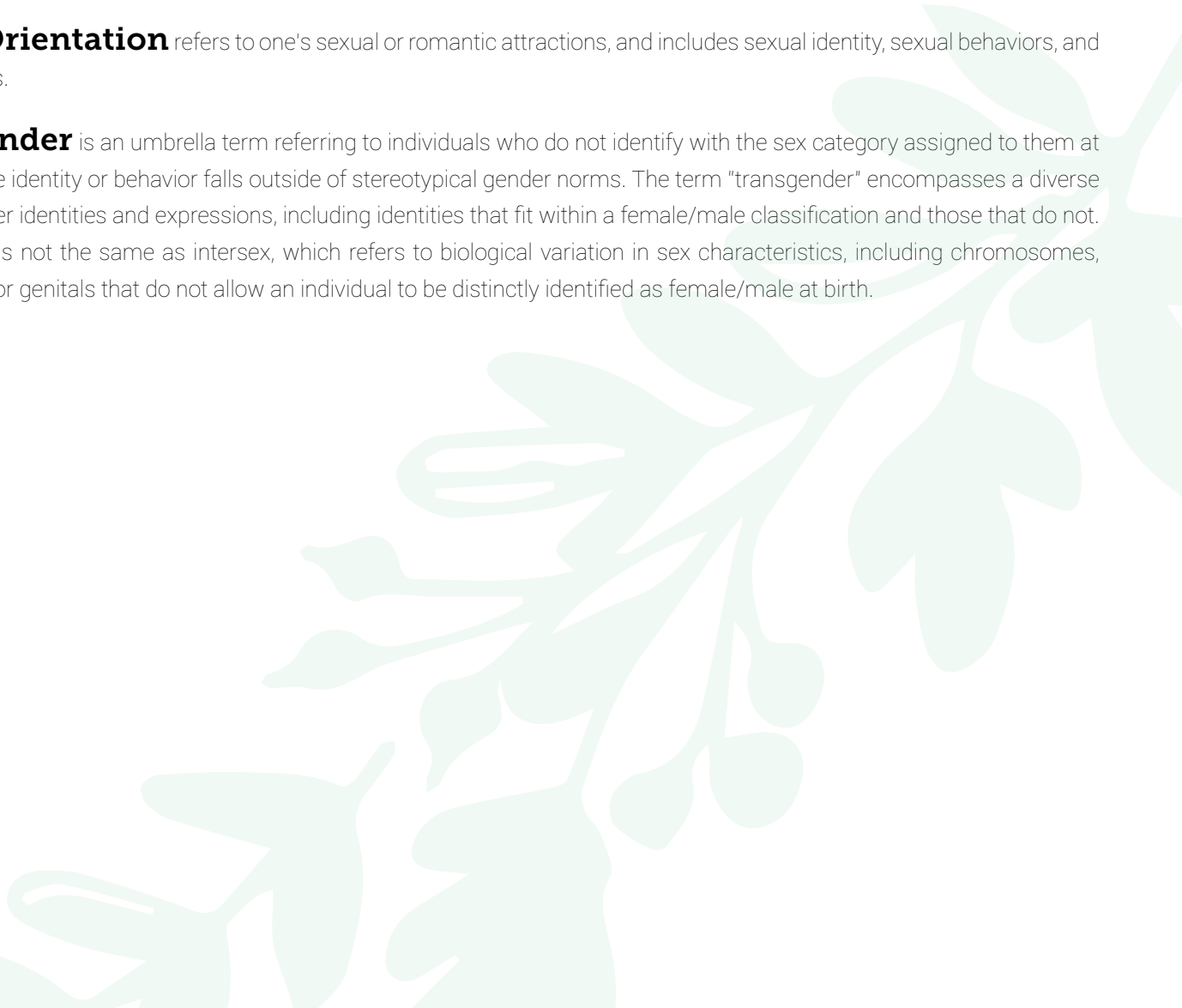
Homophobia is the irrational fear of, aversion to, or discrimination against homosexuals or homosexual behavior or cultures. Homophobia also refers to self-loathing by homosexuals, as well as the fear of men or women who do not live up to society's standards of what it is to be a "true man" or "true woman."

Heterosexism is the presumption that everyone is heterosexual and/or the belief that heterosexual people are naturally superior to homosexual and bisexual people.

Men's Engagement is a programmatic approach that involves men and boys a) as clients and beneficiaries, b) as partners, and c) as agents of change, in actively promoting gender equality, women's empowerment and the transformation of inequitable definitions of masculinity. In the health context, this comprises engaging men and boys in addressing their own and supporting their partners' reproductive, sexual, and other health needs. Men's engagement also includes broader efforts to promote equality with respect to caregiving, fatherhood, and division of labor, and ending gender-based violence.

Sexual Orientation refers to one's sexual or romantic attractions, and includes sexual identity, sexual behaviors, and sexual desires.

Transgender is an umbrella term referring to individuals who do not identify with the sex category assigned to them at birth or whose identity or behavior falls outside of stereotypical gender norms. The term "transgender" encompasses a diverse array of gender identities and expressions, including identities that fit within a female/male classification and those that do not. Transgender is not the same as intersex, which refers to biological variation in sex characteristics, including chromosomes, gonads, and/or genitals that do not allow an individual to be distinctly identified as female/male at birth.



ANNEX II
*ANNOTATED
DATA
COLLECTION
AND ANALYSIS
TOOLS*





DEMOGRAPHIC AND HEALTH SURVEY MODULES

AUTHORS: Demographic Health Survey Program

DATE: 2013

ORGANIZATION: ICF International

URL: <http://bit.ly/1PYtlyA>

HEALTH AREA: National health statistics

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): In addition to the standard DHS, which questions the health status of women of reproductive age and their children, the women's module includes questions designed to measure the status of women relative to men. The questionnaire asks about different areas of women's lives related to empowerment, including decision-making, autonomy, ownership of houses and land, barriers to accessing medical care, and attitudes toward intimate partner violence. A parallel men's questionnaire probes areas of men's knowledge of reproductive health and includes questions about men's health. In addition, it inquires about men's employment and attitudes related to women's empowerment, such as decision-making, childbearing, women's autonomy, and intimate partner violence.

The Domestic Violence module supports a more extensive examination of intimate partner and sexual violence. It is administered to women only. The module interviews a subset of the women interviewed for the main DHS household and women's modules. Information on men who experience intimate partner violence comes from the men's module of the standard DHS and not from the Domestic Violence module.

TARGETED USERS: Policymakers, researchers, and health system administrators and planners.

HOW TO APPLY THE TOOL? These instruments were developed to use for national level surveys. They are lengthy and expensive to administer and not appropriate for project level data collection. Nevertheless, they are useful as a reference when developing surveys at the local or regional levels within countries as the questions have been tested and validated across a number of different contexts. The results of the DHS surveys in individual countries are also a good starting point before designing and conducting gender data collection and analysis. National findings may not capture local variations in key gender indicators. In most countries, there is considerable variation across different regions and ethnic groups. When working in different areas of the country, a project may find it useful to use some standard DHS-like questions to capture this variation in a comparable form.



WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE

AUTHORS:**DATE:** 2005

- » Claudia Garcia Moreno
- » Henrica Jansen
- » Mary Ellsberg
- » Lori Heise
- » Charlotte Watts

ORGANIZATION: World Health Organization (WHO)

URL: <http://bit.ly/1KdVRgK>

HEALTH AREA: Violence against women and girls

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

This resource reports on the findings of a multi-country study of intimate partner violence. Its objectives were to: 1) estimate the prevalence of violence against women; 2) assess the extent to which intimate partner violence is associated with different types of health outcomes; 3) identify factors that are either protective or subject women to risk of partner violence; and 4) document the strategies and services that women use to deal with intimate partner violence. The full version of the report includes the data collection instruments used in the survey in Annexes 3-4.

TARGETED USERS: Researchers, M&E specialists, and program managers who are interested in researching or evaluating intimate partner violence.

HOW TO APPLY THE TOOL? The tool was developed to be used at a population level but the questions are designed to collect data from individuals at the household level.



TÉKPONON JIKUAGOU PROJECT: BASELINE HOUSEHOLD SURVEY

AUTHORS: Institute for Reproductive Health

DATE: 2014

ORGANIZATION: Institute for Reproductive Health, Care International, Plan International

URL: <http://bit.ly/1PQYPyL>

HEALTH AREA: FP

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): The Tékponon Jikuagou project focused on reducing unmet need for FP. This survey, developed by the Tékponon Jikuagou project, can be used to collect data on women's attitudes and behaviors related to fertility, child spacing, and FP, and to learn more about individuals' social networks. The survey provides interviewers with information about the individuals' key demographic information, women's beliefs and attitudes about FP (for women in polygamous marriages), couple communication and gender norms, and experience with FP interventions. To learn more about the project that initially used this survey in Benin click here: <http://bit.ly/1HyPjOa>

TARGETED USERS: This survey is designed to assess women's unmet needs in FP interventions.

HOW TO APPLY THE TOOL? This survey can be used by organizations implementing projects focused on FP.



POSITIVE WOMEN MONITORING CHANGE: A MONITORING TOOL ON ACCESS TO CARE, TREATMENT AND SUPPORT, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS, AND VIOLENCE AGAINST WOMEN CREATED BY AND FOR HIV-POSITIVE WOMEN

AUTHOR: International Community of Women Living with HIV/AIDS (ICW)

DATE: 2005/08

ORGANIZATION: International Community of Women Living with HIV/AIDS (ICW)

URL: <http://bit.ly/1PsjfZA>

HEALTH AREA: HIV

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

The positive women monitoring change (PWMC) tool provides organizations working with HIV-positive women tools for monitoring HIV-positive women's barriers in access to care and treatment and support and their sexual and reproductive rights (SRR). Section One is an advocacy framework which includes definitions of key terms (p. 7), positive women's health and rights indicators (p. 8), and questionnaires for HIV positive women, service providers, and governments in the three key areas: access to care and treatment, sexual and reproductive rights, and violence against women (p. 9-29). The third section includes the training curriculum (p. 30-39). Section four includes fact sheets on STIs, thrush, and motherhood; pregnancy, childbirth, and feeding; access to care and treatment; sexual and reproductive rights; and violence against women (p. 30-51). The last section includes a feedback form on the positive women monitoring change tool (p. 52-53).

TARGETED USERS: HIV-positive women and service providers working with HIV-positive women.

HOW TO APPLY THE TOOL? The positive women monitoring change tool can be used for advocacy and monitoring.



THE CORE MEN'S QUESTIONNAIRE

AUTHORS: Emma Fulu and Rachel Jewkes

DATE: n.d.

ORGANIZATION: Partners for Prevention

URL: <http://bit.ly/1Oj7GI3>

HEALTH AREA: FP, gender-based violence

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

This survey was developed for the United Nation's Partners for Prevention initiative focused on building evidence and theory-based approaches to prevent violence. This survey can be used to gather information about men's FP practices and sexual relationships. The survey includes sections on sociodemographic characteristics and employment, childhood experiences, attitudes about relations between men and women, intimate relations, fatherhood, health and well-being, and policies. A self-administered section of the questionnaire allows participants to answer questions about their sexual relations with partners privately and anonymously. It has been used by UNFPA in Bangladesh, UN Women in Cambodia and Indonesia, UNFPA and Institute of Sexualities and Gender Studies in China, United Nations Development Programme in Papua New Guinea, and CARE International and CPA Social Indicator in Sri Lanka.

TARGETED USERS: Organizations focused on assessing men's attitudes and experiences related to FP and GBV.

HOW TO APPLY THE TOOL? This tool can be used by organizations working on interventions related to FP and GBV.



INTERNATIONAL MEN AND GENDER EQUALITY SURVEY SURVEY QUESTIONNAIRES

AUTHOR: International Center for Research on Women and Instituto Promundo

DATE: 2011

ORGANIZATION: International Center for Research on Women and Instituto Promundo

URL: <http://bit.ly/21iD3HT>

HEALTH AREA: Men's engagement

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

The International Men and Gender Equality Survey questionnaire developed under the Men and Gender Equality Policy Project can be used to assess men's attitudes and practices and women's opinions of men's practices related to several key topic areas, including gender-based violence, health and health-related practice, household division of labor, men's participation as caregivers/fathers, attitudes about gender-related policies, transactional sex, criminal behavior, and quality of life. The tool includes one questionnaire for men and one for women. These questionnaires include sections focused on sociodemographic information, childhood experiences, attitudes about relations between men and women, sexual diversity, household dynamics, policies, parenting, relationships and violence, and health and quality of life.

These questionnaires were used in Latin America, South Asia, and sub-Saharan Africa with more than 8,000 men and 3,500 women ages 18-59.

TARGETED USERS: Project staff working with men and women involved in projects addressing gender equality.

HOW TO APPLY THE TOOL? This tool can be used to interview men and women about attitude and practices related to gender equality issues. The tool authors recommend that organizations interested in using the survey in new locations should contact Gary Barker at Instituto Promundo (g.barker@promundo.org.br) and/or Ravi Verma (rverma@icrw.org) and Manuel Contreras (mcontreras@icrw.org) at ICRW. It has been used in Brazil, Chile, Croatia, India, Mexico, and Rwanda.



USING HOUSEHOLD SURVEYS FOR GENDER ANALYSIS IN DEVELOPING COUNTRIES

AUTHORS: Sabine Gabarino and Mary Strode

DATE: 2010

ORGANIZATION: Oxford Policy Management

URL: <http://bit.ly/20155p0>

HEALTH AREA: General

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

This brief outlines recommendations to improve household survey design and data collection to conduct a gender analysis. It provides an overview of key gender analysis terms. It includes an overview of how to avoid gender bias when carrying out fieldwork using household questionnaires and combining qualitative and quantitative methods in gender analysis.

TARGETED USERS: Organizations developing household surveys that will be used in gender analysis of an intervention.

HOW TO APPLY THE TOOL? Used to design household surveys to create a good base for gender analysis.



FOOD SECURITY IN PRACTICE: USING GENDER RESEARCH IN DEVELOPMENT

AUTHORS: Agnes R. Quisumbing and Bonnie McClafferty

DATE: 2006

ORGANIZATION: International Food Policy Research Institute

URL: <http://bit.ly/1SOY2hW>

HEALTH AREA: Nutrition

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

Using empirical evidence on how gender and intra-household issues affect development interventions, this tool guides users on how to incorporate research findings into development projects and policy. Findings are presented on International Food Policy Research Institute gender and intra-household research program and guides users on how to use project and policy cycles as frameworks for incorporating gender research. For example, this guide examines how to address gender throughout the project cycle for a needs assessment, project design, project implementation, and M&E.

TARGETED USERS: Project implementers and policymakers.

HOW TO APPLY THE TOOL? This tool can be used to incorporate gender throughout each stage of the project cycle and to increase attention to gender in policies.



INNER SPACES OUTER FACES INITIATIVE TOOLKIT

AUTHORS: CARE and International Center for Research on Women

DATE: 2007

ORGANIZATION: CARE and International Center for Research on Women

URL: <http://bit.ly/1kwGII>

HEALTH AREA: Maternal and Reproductive Health/FP

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

This training module is designed for project staff to use internally or with communities to examine their personal beliefs and attitudes about gender and sexuality; to explore organizational values and approaches to addressing inequities in gender and sexuality in health programs; to allow staff to explore their own values as they relate to gender and sexuality; and to improve organizational processes and practices.

TARGETED USERS: Health and development organizations and practitioners.

HOW TO APPLY THE TOOL? This toolkit can be used by health and development organizations to increase community members' and staff's understanding of gender and sexuality issues and how those issues relate to reproductive health.



WE-MEASR: A TOOL TO MEASURE WOMEN'S EMPOWERMENT IN SEXUAL, REPRODUCTIVE, AND MATERNAL HEALTH PROGRAMS

AUTHORS: CARE

DATE: 2014

ORGANIZATION: International Food Policy Research Institute

URL: <http://bit.ly/1jsxYul>

HEALTH AREA: Maternal and reproductive health/FP

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

The tool was developed to measure women's empowerment in domains of their lives that are important for improving sexual, reproductive, and maternal health outcomes. It is composed of 20 short scales designed to measure women's agency, social capital, and relations with their partners. It was tested in both matrilineal and patrilineal communities in Malawi. CARE is using local adaptations in several other countries to test the applicability of the scales in different contexts.

TARGETED USERS: Researchers, M&E staff, and gender advisors.

HOW TO APPLY THE TOOL? The tool is applied through interviews using the questionnaire developed by CARE. Answers are given a numeric value and scored on a scale adapted from other tools developed by Measure Evaluation, Population Council, Promundo, International Center for Research on Women, and others.



THE SASA! ACTIVIST KIT

AUTHORS: Lori Michau (Lead Writer)

DATE: 2008

ORGANIZATION: Raising Voices

URL: <http://bit.ly/21nS773>

HEALTH AREA: HIV

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

The SASA! Toolkit aims to empower community members to take action on the interconnected issues of violence against women and HIV/AIDS through a multi-phase process. The toolkit aims to introduce community members to violence against women and HIV/AIDS as interconnected issues and encourages community member activism around those issues. The second phase aims to raise community members' awareness of how power and gender roles influence violence against women and the occurrence of HIV/AIDS. The third phase of the toolkit provides resources to help community members support activists as well as women and men affected by these issues. The final phase provides resources that empower community members to take action to prevent violence against women and HIV.

TARGETED USERS: Activists working on violence against women and HIV/AIDS and community members affected by violence against women and HIV/AIDS.

HOW TO APPLY THE TOOL? This tool can be used by activists to raise community awareness of violence against women and HIV/AIDS, provide them with the tools to support those affected by these interconnected issues, and take action to prevent violence against women and HIV. Activists can use these resources, including monitoring and assessment tools, media and advocacy tools, communication, and training materials, in their work.



EVALUATING STEPPING STONES: A REVIEW OF EXISTING EVALUATIONS AND IDEAS FOR FUTURE M&E WORK

AUTHORS: The Wallace for ActionAid International

DATE: 2006

ORGANIZATION: ActionAid International

URL: <http://bit.ly/1XCdAEA>

HEALTH AREA: HIV

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

Although this is not specifically a data collection tool, it provides insights into how to conduct evaluations of gender-focused projects. The review examines M&E data from ActionAid's tool Stepping Stones, an HIV/AIDS prevention tool, a tool for gender equality, and a community mobilization tool. It provides an overview of Stepping Stones (p. 6-10); methods used to evaluate Stepping Stones (p. 11-19); key findings (p. 20-25); relevance of findings for future evaluation work (p. 26-29); and an example of the adaption and spread of SS (p. 30-32). The appendix includes Joint United Nations Programme on HIV/AIDS education and HIV/AIDS behavior benchmarks (p. 37) and a proposed list of process indicators for Stepping Stones (p. 38).

TARGETED USERS: This review can be used by programs using the Stepping Stones tool in their HIV programming.

HOW TO APPLY THE TOOL? The review provides M&E staff with tools for evaluating the Stepping Stones tool in their programs aimed at preventing HIV/AIDS and promoting gender equality.



COMPENDIUM OF GENDER SCALES

AUTHORS: Geeta Nanda

DATE: 2011

ORGANIZATION: FHI 360/C-Change

URL: <http://bit.ly/1IMWisE>

HEALTH AREA: FP and reproductive health

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

This tool provides scales for measuring the extent to which gender is integrated into programs. Scales aggregate multiple indicators on particular topics. The gender scales in this compendium include: 1) couple and communication on sex (p. 5-6); 2) women's empowerment (p. 7-10); 3) gender beliefs (p. 11-12); 4) gender equitable men (p. 13-16); 5) gender norms and attitudes (p. 17-20); 6) gender relations (p. 21-24); 7) household decision-making (p. 25-26); and 8) sexual relationship power (p. 26-29). These scales include specific information on the scale of the objective, types of behavior predicted, number of items and subscales, scoring procedures, psychometrics used, statistics used to test validity, who and where it has been used, and other additional relevant information such as definitions.

TARGETED USERS: Health and development practitioners measuring gender-related attitudes in their programs.

HOW TO APPLY THE TOOL? Users can use one or more of the scales to measure gender norms, gender attitudes, and women's empowerment in eight different topic areas.



INTEGRATING GENDER IN CARE AND SUPPORT OF VULNERABLE CHILDREN: A GUIDE FOR PROGRAM DESIGNERS AND IMPLEMENTERS

AUTHORS: Elizabeth Doggett and Tanya Medrano

DATE: 2012

ORGANIZATION: FHI 360

URL: <http://bit.ly/1Oj9Nvx>

HEALTH AREA: Adolescent boys

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

This tool provides step-by-step guidance on how to integrate gender into programs designed to address the needs of vulnerable children. It guides users through the gender analysis process and provides a number of tools for collecting data for an initial gender analysis for program design, monitoring, and evaluation. Although it is not designed as a data collection tool, it does have a checklist in the annex that is useful in indicating the steps that should be followed when conducting a gender analysis prior to the design of a new program.

TARGETED USERS: It is designed as a support material for program staff who want to create new programs and integrate gender and to train participants.

HOW TO APPLY THE TOOL? This document was designed to help program staff integrate gender into new programs that serve vulnerable children, and it is also a training source that contains training activities on gender analysis and integration.



THE GREAT ACTIVITY CARDS: ACTIVITY CARDS FOR MARRIED AND/ OR PARENTING ADOLESCENTS

AUTHORS: Institute for Reproductive Health

DATE: 2013

ORGANIZATION: Institute for Reproductive Health

URL: <http://bit.ly/1TfwCiV>

HEALTH AREA: Adolescent FP and reproductive and maternal health, with a focus on married and parenting adolescents.

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

This is a participatory method designed to use with married and/or parenting adolescents. It contains a series of interactive activities and exercises designed to elicit participants' perspectives on a host of gender and reproductive health related topics. It provides instructions for facilitators to guide the exercises and discussions about equality, health, and safety resulting from the interactive game. There are cards to provide the content and structure for a variety of games; discussions; debates; community interviews; and music, drama, and dance. These cards focus on reproductive health, healthy pregnancies, planning for the future, alcohol abuse, and relationships.

TARGETED USERS: Community health educators with married or parenting adolescents.

HOW TO APPLY THE TOOL? This tool is aimed to be applied to married and/or parenting adolescents to discuss and understand equality, health, and safety.



GO GIRLS! VULNERABLE GIRLS INDICES GUIDE: DATA FROM THE 2009 BASELINE SURVEY AND 2010 ENDLINE SURVEY IN BOTSWANA, MALAWI, AND MOZAMBIQUE

AUTHORS: Carol Underwood and Hilary Schwandt

DATE: 2011

ORGANIZATION: JHU/CCP

URL: <http://bit.ly/1Pduz0Y>

HEALTH AREA: Adolescent girls' health, education, and livelihoods

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

The Go Girls! Initiative, a component of the PEPFAR-funded Project SEARCH, was implemented in four communities each in Botswana, and Malawi and in eight communities in Mozambique. It was designed in response to the persistent evidence that adolescent girls in sub-Saharan Africa are more vulnerable to HIV/AIDS than are boys who are their peers. The purpose was to define and test indices that could be standardized for Go Girls! Initiative to assess girls' vulnerability to HIV/AIDS and to measure the degree of protective factors extant in a given community.

TARGETED USERS: Researchers, evaluators, evaluator managers, health providers.

HOW TO APPLY THE TOOL? This tool can be used as a reference for future research and program monitoring. The indicators that make up the indices are explained, and the annex provides a detailed description of the type of information collected. The data collection instruments are not included in the publication.



PROJECT H WORKING WITH YOUNG MEN SERIES

AUTHORS: Instituto Papai in collaboration with Promundo, Ecos and Salud y Genero

DATE: 2002

ORGANIZATION: Instituto Papai in collaboration with Promundo, Ecos and Salud y Genero

URL: <http://bit.ly/1NalY7s>

HEALTH AREA: Adolescence (Sexual and Reproductive Health, HIV/AIDS)

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

This manual presents information on masculinities and reproductive health topics related to young men. It provides a collection of participatory tools for programming and research to engage young men and support more equitable gender relations.

TARGETED USERS: Young fathers, young men, adolescents, sexually active individuals.

HOW TO APPLY THE TOOL? This tool can be implemented for participatory research or program implementation.



PARTICIPATORY ACTION RESEARCH IN HEALTH SYSTEMS: A METHODS READER

AUTHORS: Rene Loewenson, Lucia D'Ambruoso, Zubin Shroff, Asa C. Laurell, Christer Hogstedt

ORGANIZATION: International Development Research Centre, World Health Organization, Regional Network on Equity in Health in East and Southern Africa (Equinet), Training and Research Support Centre, and Alliance for Health Policy and Systems Research.

URL: <http://bit.ly/1MU4yhn>

HEALTH AREA: All

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): To make participatory action research understandable and accessible for health policy and systems research. It explains how these implementation research methods can be useful for improving health and health systems. The reader seeks to clarify the key elements of participatory action research and the social science theories underlying it. It explains how to use the process and methods used in participatory action research, including recent innovations and developments in the field. The reader also learns how the findings can be communicated, reported, and applied to improve health systems. Although the resource is not specifically focused on gender analysis, it provides a good introduction to tools that are useful for conducting a gender analysis, as long as they are used to both engage men and women equitably in the research and to gather comparative information.

TARGETED USERS: The reader is intended for use by researchers in academia and health policy and systems communities. It is also intended for community level and program implementing organizations, and policymakers.

HOW TO APPLY THE TOOL? The reader provides five distinct resources. Part I provides an overview of the key concepts underlying participatory action research. Part II introduces different methods for gathering and analyzing information. Part III addresses some of the challenges in applying the methods and some of the analytical issues related to comparability, selection bias, causality, validity, and generalization of results. Part IV discusses how to communicate and apply the results and how to form communities of practice in support of PAR. Part V provides access via electronic links to 21 published papers based on the application of PAR methods for health system research.



THE COMMUNITY SCORE CARD (CSC): A GENERIC GUIDE FOR IMPLEMENTING CARE'S CSC PROCESS TO IMPROVE QUALITY OF SERVICES

AUTHORS: CARE International

DATE: 2013

ORGANIZATION: CARE International

URL: <http://bit.ly/1PdB2Ji>

HEALTH AREA: General

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): The toolkit provides guidance on how to use the Community Score Card, a participatory tool for assessing, monitoring, and evaluating services. In particular, it will allow users to measure the quality, efficiency, and accountability of their services. It is intended to stimulate discussions between users and service providers. Communities using this tool are engaged through focus groups that are highly interactive.

TARGETED USERS: This tool can be used by government institutions, nongovernmental organizations, community-based structures such as health centers and village committees, and community-based organizations.

HOW TO APPLY THE TOOL? This tool allows service users to provide feedback on the performance of systems. It also gives service providers the opportunity to learn from beneficiaries about how services can be improved in a way to meet the beneficiaries' needs.



THE GENDER AUDIT HANDBOOK

AUTHOR: Patricia Morris

DATE: 2010

ORGANIZATION: InterAction

URL: <http://bit.ly/21iJc6U>

LEVEL OF HEALTH SYSTEM: Multiple

HEALTH AREA: All

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): The handbook offers a step-by-step process for conducting a gender audit of an organization. It provides the tools, resources, and information needed to conduct each step of the gender audit. The audit examines gender integration in the policies, social relations, leadership, and procedures of an organization, as well as attention to gender inequalities in the organization's programs.

HOW TO APPLY THE TOOL? The tool was developed to be used at an organizational level. The questions relate both to gender integration in programs and in the organization's policies and procedures. The tool provides the necessary instructions and data collection instruments to conduct a gender audit. The questions on the questionnaire and for the focus group discussions can be adapted for other types of gender analyses.



HEALTH WORKERS FOR CHANGE

AUTHORS: World Health Organization

ORGANIZATION: World Health Organization

URL: <http://bit.ly/1njuNb9>

HEALTH AREA: Women's health

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This manual is a facilitation guide for a series of six workshops designed to help health workers examine the way they relate to women and clients and the factors that influence this relationship. It uses participatory methods to help health workers themselves identify causes for the way they relate to clients and ways to improve their interaction and support for clients, both through improving their own job satisfaction and the quality of services.

TARGETED USERS: The manual is intended for health managers to use with health workers through the guidance of a trained and experienced facilitator to improve services. Researchers may also use the manual to gather information about how health workers and clients relate.

HOW TO APPLY THE TOOL? The tool is broken into three parts. Part 1 gives an overview to allow one to decide whether it is appropriate to meet the needs of the user. Parts 2 and 3 give a step-by-step guide on how to organize the workshops.



UNDERSTANDING MATERNAL HEALTH FROM A GENDER AND RIGHTS PERSPECTIVE

AUTHOR: Renu Khanna

DATE: 2013

ORGANIZATION: CommonHealth, SAHAJ, and RUWSEC

URL: <http://bit.ly/1NaNWB8>

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This four-day module can be used to build staff's skills and capacities to approach maternal health programming through a gender perspective. The training module is broken up into 12 sections outlined below. Through this tool, facilitators can provide greater clarity on how to incorporate a gender perspective into policies and maternal health program. The topics include Section 1: Overview of Maternal Health, Globally and in India (p.4-5); Section 2: The Concept of Maternal Health (p. 6-8) ; Section 3: Gender Issues in Maternal Health (p.9-42); Section 4: Maternal Health as a Human Rights Issue (p. 44-47); Section 5: Maternal Deaths and their Measurements (p. 48-50); Section 6: Prevention of Maternal Deaths -1 (p. 53-55); Section 7: Prevention of Maternal Deaths -2: Emergency Obstetric Care (p. 56-61); Section 8: Prevention of Maternal Death – 3: Importance of ANC and PNC (p. 63-64); Section 9: Maternal Morbidities as a Maternal Health Issue (p. 65-68); Section 10: Abortion as a Maternal Health Issue (p. 65-67); Section 11: Maternal Health Policy in India (p. 76-79); and Section 12: Addressing Maternal Health from a Gender and Rights Perspective (p. 80-96). On page two, a schedule for the sessions outlines the learning objectives for each session, methodology outlining the learning objectives for each session, methodology, and the amount of time required.

TARGETED USERS: Mid-level managers of maternal health programs.

HOW TO APPLY THE TOOL? This tool can be used for training mid-level managers on ways to integrate gender into their programming.



HOW GENDER-SENSITIVE ARE YOUR HIV AND FAMILY PLANNING SERVICES?

AUTHORS: International Planned Parenthood Federation, Western Hemisphere Region

DATE: 2002

ORGANIZATION: International Planned Parenthood Federation, Western Hemisphere Region

URL: <http://bit.ly/1TgVN5q>

HEALTH AREA: HIV

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): The HIV/Gender continuum self-assessment tool is designed to help organizations incorporate gender sensitive approaches into their HIV programs through a rights-based approach to sexual and reproductive health. It is designed to address specific issues such as social and biological factors that put women at risk for contracting HIV, women's decision-making and negotiation skills on condom use with their sexual partners, providers and counselors' ability to articulate connections between HIV and gender-based violence, and the extent to which providers and counselors refer women to women's rights groups. It includes a series of score cards that organizations can use to assess if their organization falls into a non-gender-sensitive program, a somewhat gender-sensitive program, or an ideal gender-sensitive program.

TARGETED USERS: This tool is aimed at organizations implementing HIV programs.

HOW TO APPLY THE TOOL? Organizations implementing HIV programs can use this tool to assess and then develop an action plan for increasing the gender-sensitivity of their program.



APPENDIX A: REPORT ON THE SOCIETY FOR FAMILY HEALTH GENDER ASSESSMENT

AUTHOR: C. Newman, M. Mwanamwenge, and K. Peterson

DATE: 2013

ORGANIZATION: IntraHealth International

URL: <http://bit.ly/1TWbkHW>

HEALTH AREA: Reproductive health with a focus on human resources

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?):

This resource is an adaptation of InterAction's Gender Audit Tool for health care facilities (<http://bit.ly/1Zvn0YP>). The body of the report presents findings of a gender audit conducted at the Society for Family Health in Zambia. Appendix A includes the data collection instruments, including a questionnaire for a survey and guides for focus group discussions. It also includes instructions for the facilitators and note takers on how to conduct the focus groups, informed consent forms for the focus group discussion participants, and surveys.

TARGETED USERS: M&E staff, researchers, and gender advisors.

HOW TO APPLY THE TOOL? These tools, along with the InterAction Gender Audit Manual, can be used by anyone who is interested in conducting a gender audit of their organization. The body of the report provides an example of a completed audit and how to present the findings, analysis, and recommendations.



MANUAL TO EVALUATE QUALITY OF CARE FROM A GENDER PERSPECTIVE

AUTHOR: International Planned Parenthood Federation/Western Hemisphere Region

DATE: 2000

ORGANIZATION: International Planned Parenthood Federation/Western Hemisphere Region

URL: <http://bit.ly/1lkoToG>

HEALTH AREA: Reproductive health/FP

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This manual will assist reproductive health institutions to evaluate the quality of care of their services from a gender perspective. This manual provides guidance on assessing the level of gender integration in the institution, identify ways to better integrate gender into the institutions, and build staff's capacity to use a gender perspective in their delivery of reproductive health services. This manual can be used to identify the extent to which gender is integrated into the system and then develop a plan of action to better integrate gender into identified areas. The annexes of this manual includes six tools: 1) a client exit interview guide; 2) a service provider interview guide; 3) a service provider document review guide; and guides for 4) observation of physical aspects of the clinic; 5) client reception; and 6) consultation and counseling. Annex 8 includes a list of indicators that can be used to assess the quality of care in a reproductive health institution from a gender perspective.

TARGETED USERS: Evaluation teams can use this manual to conduct an assessment of a reproductive health institution.

HOW TO APPLY THE TOOL? This tool can be used to evaluate the quality of care of a reproductive health institution from a gender perspective and identify resources and a plan of action to better integrate gender in the institution.

'MEN-STREAMING' GENDER IN SEXUAL AND REPRODUCTIVE HEALTH & HIV/AIDS: A TOOLKIT FOR DEVELOPMENT POLICYMAKERS

AUTHOR: International Planned Parenthood Federation

DATE: 2008

ORGANIZATION: International Planned Parenthood Federation

URL: <http://bit.ly/1jmgbVH>

HEALTH AREA: HIV

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This tool is designed to assist organizations developing policies promoting men's engagement in improving their own, women's, and children's sexual and reproductive health. It includes three parts. The first section reviews the rationale for engaging men and boys in sexual and reproductive health and HIV/AIDS policies (p.4-9). The second part, the toolkit (p. 10-32), includes six modules on developing policies on engaging men in sexual and reproductive health and HIV/AIDS, including Module A: Understanding the policy context; Module B: Institutional commitment; Module C: Developing a policy statement: engaging men and boys; Module D: Reviewing existing policies; Module E: Working with stakeholders; and Module F: Making policy work in practice. Lastly, the annexes review International Planned Parenthood Federation's policies, a glossary of terms, and a case study on male involvement in sexual and reproductive health programs.

TARGETED USERS: For organizational staff responsible for developing organizational policy on men's engagement in sexual and reproductive health and AIDS.

HOW TO APPLY THE TOOL? This tool can be used to review existing policies, develop new policies, or include men in existing policies focusing on sexual and reproductive health and HIV/AIDS.

REFERENCE GUIDES: FOR HEALTH CARE ORGANIZATIONS SEEKING ACCREDITATION FOR HIGH-QUALITY, GENDER-SENSITIVE REPRODUCTIVE HEALTH SERVICES

AUTHORS: Patricia Riveros, Erica Palenque, Ricardo Vernon, Ignacio Carreño, John Bratt

DATE: 2009

ORGANIZATION: Population Council and PROCOSI

UR FOR MANUAL: <http://bit.ly/1P1lqrP>

URL FOR APPENDIX: <http://bit.ly/1W8MB4m>

HEALTH AREA: Reproductive health and FP

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This reference guide provides guidance on how to implement high quality, gender-sensitive standards in health care organizations and nongovernmental organizations' member clinics and administrative centers through a process developed by PROCOSI. The guide includes four different guides focused on the formal certification process. The procedures guide contains information on strategy behind certification (p. 1-13). The self-training guide can be used by staff to build their capacity to understand definitions and concepts and comply with them (p.14-65). The assessment guide outlines steps in the assessment process (p. 66-83). Lastly, the costing guide outlines a methodology for analyzing the costs of integrating a gender perspective into system standards (p.84-108). The appendices include useful tools assessment tools such as a survey guide, an interview guide, and costing guides.

TARGETED USERS: Health care organizations and nongovernmental organization member clinics implementing gender-sensitive standards in member clinics and administrative centers to achieve certification.

HOW TO APPLY THE TOOL? This tool can be used to evaluate gender-sensitive standards in clinics and administrative centers. This approach can be adjusted by the evaluators to meet their specific needs.



NIGERIA: ACCESS TO HEALTH CARE FOR PEOPLE LIVING WITH HIV AND AIDS

AUTHOR: Chen Reis

DATE: 2008

ORGANIZATION: Physicians for Human Rights in coordination with Futures Group (USAID Policy Project)

URL: <http://bit.ly/1Xu6Ys1>

HEALTH AREA: HIV

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This is a report based on three surveys 1) of health care providers, 2) about the health facility, and 3) of people living with HIV/AIDS, all of which are available in the annex. The survey of health care providers included questions on respondent demographics, practices on informed consent, testing, disclosure of HIV status, treatment and care of people living with HIV, and attitudes and beliefs about treatment treatment and care of male and female HIV/AIDS patients. A separate survey instrument was used to assess each facility's capacity, resources, and policies from the person in charge of the facility.

The men and women living with HIV/AIDS survey included questions on respondent demographics, experiences regarding informed consent, testing, and disclosure, treatment and care, and attitudes and beliefs about treatment and care. Treatment and care practices of HIV/AIDS patients used Likert-type scales (e.g. always, most of the time, sometimes, rarely, never). Questions on attitudes and beliefs were probed by a response of "agree" or "disagree" to statements about testing, treatment, and care of HIV/AIDS patients and perceptions of gender roles and women's rights. It is possible to disaggregate by sex the data from both the health care provider and person living with HIV (PLHIV) surveys. In addition, there are gender-specific questions on both the providers and persons' living with HIV/AIDS questionnaires.

TARGETED USERS: For organizational staff responsible for developing organizational policy on men's engagement in sexual and reproductive health and AIDS.

HOW TO APPLY THE TOOL? This tool can be used to examine differential treatment and attitudes toward men and women seeking HIV services. It has the advantage of providing information from both the providers and users' perspectives and examines gender issues with regard to HIV status disclosure, premarital testing, women's decision-making, and women's legal rights.



GENDER BUDGETING: PRACTICAL IMPLEMENTATION HANDBOOK

AUTHORS: Sheila Quinn

DATE: 2009

ORGANIZATION: Council of Europe, Directorate General of Human Rights and Legal Affairs

URL: <http://bit.ly/1N8NVf>

HEALTH AREA: General

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): The handbook provides guidance on how to do gender budgeting. It provides an overview of prerequisites for gender budgeting (p.11-13); the three stages of gender budgeting (p.16-22); and useful tools for gender budgeting (p. 22-30). The handbook also outlines how to do gender budgeting at different levels including the central government, sectoral/departmental, regional/local government, and program level. An annex of key terms, additional resources, and websites is also provided. This handbook assumes prior knowledge of and the rationale for gender mainstreaming.

TARGETED USERS: It is intended for practitioners responsible for gender budgeting.

HOW TO APPLY THE TOOL? This handbook can be used to assist with developing a budget at different levels, including central government, sectoral/departmental, regional/local government, and the program level.

GENDER INTEGRATION INDEX

AUTHOR: Health Policy Initiative

DATE: 2010

ORGANIZATION: Futures Group (USAID Policy Project)

URL: <http://bit.ly/21nZKuo>

HEALTH AREA: General

LEVEL OF THE HEALTH SYSTEM: District

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This Gender Integration Index was developed by USAID's Health Policy Initiative to assess how gender is integrated into policy, management, and technical components of a project. The tool is organized around three different components that project staff can use to better integrate gender into the design and evaluation of a project. Component 1: Assessing Gender Equity of Project Management Practices features organizational policies and procedures for integrating gender into the workplace and guidelines for assessing staff's technical competency around gender (p. 4-7). Component 2: Designing and Implementing Activities includes guidelines on conducting a gender analysis to assess the ways in which gender is considered in the design and anticipated outcomes of a project (p. 8). Component 3: Achieving Gender-Equitable Results includes a table for assessing the ways in which activities outlined in an annual report integrate gender (p. 11). A glossary of terms (p. 12) includes key gender-related terms.

TARGETED USERS: This tool is targeted to project managers and staff involved in design and monitoring of project results.

HOW TO APPLY THE TOOL? This tool can be used to assess how gender is integrated into the policy, management, and technical components of a project. The results of the assessment can be used to facilitate dialogue among staff about gender issues within a project.





INTEGRATING GENDER INTO HIV/AIDS PROGRAMMES IN THE HEALTH SECTOR: TOOL TO IMPROVE RESPONSIVENESS TO WOMEN'S NEEDS

AUTHORS: World Health Organization

DATE: 2009

ORGANIZATION: World Health Organization

URL: <http://bit.ly/20170Q8>

HEALTH AREA: HIV

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This field-tested tool was developed as a response to a global consultation on Integrating Gender into HIV/AIDS programs. This tool examines the ways gender inequalities impact women's access to and their experience of HIV programs and services. It also provides program managers with steps to create gender-responsive HIV/AIDS programs and services. For example, it includes guidance on basic steps in gender-responsive programming (p. 1), addressing gender inequalities in programs testing for HIV and providing counseling (p. 31), prevention of mother-to-child transmission of HIV (p. 49), HIV/AIDS treatment and care (p. 57), and home-based care for people living with HIV (p. 67). The annexes provide both manager and provider checklists for assessing the extent to which a program or service is gender-responsive.

TARGETED USERS: This tool is intended for program managers and health care providers responsible for designing, implementing, and evaluating HIV/AIDS programs.

HOW TO APPLY THE TOOL? This tool should be used to complement existing guidelines for national, regional, district, public, private, and donor-supported HIV/AIDS programs. It can be used to conduct training on building a gender-responsive HIV/AIDS program in order to better integrate gender into existing HIV/AIDS programmatic guidelines, strategic plans, and management plans and teams.



THE THEORY OF CHANGE OF GENDER-RESPONSIVE BUDGETING

AUTHOR: Niseen Alami

DATE: 2010

ORGANIZATION: UNIFEM

URL: <http://bit.ly/1Ojk0lj>

HEALTH AREA: General/Gender-responsive budgeting

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This report provides insight into the how gender-responsive budgeting relates to implementation of projects committed to gender equality and areas for intervention. It outlines key challenges behind policy commitments to gender equality, who is accountable, the ways gender-responsive budgeting can influence implementation of gender equality commitments, standards for defining if a budget is responsive to gender equality demands, and the theory of change in the context of gender-responsive budgeting.

TARGETED USERS: Organizations developing a gender-responsive budget in support of projects committed to gender equality in their programs.

HOW TO APPLY THE TOOL? This tool can be used to develop gender-responsive budgets to support gender equality in project interventions.



GENDER-BASED ANALYSIS IN GOVERNMENT PRACTICES AND THOSE OF LOCAL AND REGIONAL DECISION-MAKING BODIES

AUTHORS: Secrétariat à la condition féminine du ministère de la Culture et al.

DATE: 2008

ORGANIZATION: Government of Quebec

URL: <http://bit.ly/1PslyMp>

HEALTH AREA: Multisectoral

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This guide outlines the advantages of conducting a gender analysis throughout the life of a project in response to Quebec's Turning Equality in Law into Equality Policy. As a governance tool, this guide provides background on what a gender-based analysis is, a rationale for using it, and when it is appropriate to use it.

TARGETED USERS: Project staff and managers.

HOW TO APPLY THE TOOL? This tool can be used to apply a gender-based analysis of projects and integrate gender analysis into any phase of a project.



GENDER MAINSTREAMING FOR HEALTH MANAGERS: A PRACTICAL APPROACH

AUTHOR: World Health Organization, Department of Gender, Women and Health

DATE: 2011

ORGANIZATION: World Health Organization

URL: <http://bit.ly/1Xuhrnk>

HEALTH AREA: General

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This tool is designed to provide guidance to facilitate and participate in workshops focused on concrete ways to integrate gender into public health projects. It is divided into three modules to build knowledge on key concepts for integrating gender in public health (Module 1); conduct a gender analysis (Module 2); and to assess policies and programs to develop gender-responsive activities (Module 3). It also includes two booklets for participants and facilitators. The participant notes provide guidance for participation in gender and health workshops based on the three modules. The booklet includes background reading, WHO gender analysis tools, exercises, and activity sheets. The facilitator's guide provides guidance on moderating a workshop.

TARGETED USERS: This tool can be used by public health managers at international, national, and community-based institutions.

HOW TO APPLY THE TOOL? The three different modules can be used by facilitators to lead a workshop that builds participants' knowledge and skills on key gender concepts, conduct a gender analysis, and assess and develop gender-responsive programming.

GENDER RESPONSIVE BUDGETING IN PRACTICE: A TRAINING MANUAL

AUTHORS: UNIFEM/UN WOMEN AND UNFPA

DATE: 2006

ORGANIZATION: UNFPA and UNIFEM/UN WOMEN

URL: <http://bit.ly/1Hr6ukK>

HEALTH AREA: General

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This manual provides an overview of gender-responsive budgeting applied to national budget cycles through five modules that outline key concepts and technical and political aspects of gender-responsive budgeting. Module 1 focuses on key concepts in gender-responsive budgeting (p. 13-15). The second module seeks to enable participants to differentiate between various budget classifications and how to apply a gender lens to those different types of classifications (p. 19-24). Module three provides an overview of Diane Elson's gender budget analysis tools and how to apply those to tools to develop a gender-responsive budget (p. 29-37). Module four reviews experiences in gender budget initiatives (p. 43-45). The final module examines gender budget initiatives within the government (p. 51-54). The Annexes include an outline of the suggested workshop program, the workshop evaluation form, and a list of the handouts referenced in the various modules (p. 61-65). This publication is available in English, French, and Spanish.

TARGETED USERS: This manual is aimed at UNFPA and UNIFEM staff and partners who are supporting gender-responsive budgeting at the country level.

HOW TO APPLY THE TOOL? Facilitators with experience using gender-responsive budgets and doing gender analysis can use this tool to conduct workshops with staff to build their knowledge and skills to use, develop, and understand the applications of gender-responsive budgets.

TOOLKIT ON GENDER EQUALITY RESULTS AND INDICATORS

AUTHOR: Juliet Hunt

DATE: 2013

ORGANIZATION: Asian Development Bank and Australian Agency International Development

URL: <http://bit.ly/1MGSF0q>

HEALTH AREA: Multi-sectoral

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This tool is intended as a reference manual for the formulation of gender sensitive or responsive indicators. It is multi-sectoral, covering the sectors of health, education, energy, environment, finance and enterprise development, humanitarian response, law and justice, gender-based violence, public sector management and reform, rural development, agriculture and food security, urban development, WASH, and transport.

TARGETED USERS: Development practitioners and policymakers.

HOW TO APPLY THE TOOL? The tool aims to improve national M&E of gender integration. The chapter on health provides indicators to measure gender equality in human capital, economic empowerment related to employment in health care, voice and rights, and capacity-building. Users can consult the illustrative indicators and apply or adapt them as appropriate. It is an especially useful resource for those undertaking multi-sectoral gender integration activities.

GUIDELINES FOR GENDER-BASED ANALYSIS OF HEALTH DATA FOR DECISION-MAKING

AUTHORS: Margaret Haworth-Brockman and Harpa Isfeld

DATE: 2010

ORGANIZATION: Pan American Health Organization

URL: <http://bit.ly/1RfVkkX>

HEALTH AREA: General

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This tool provides guidance on how to conduct a gender analysis using health surveillance data and data from surveys or other sources to develop, change and improve national and regional health policies, planning and programs. It discusses the use of quantitative and qualitative data for gender analysis and provides case studies to illustrate what can be learned from conducting an analysis of disaggregated by sex data in health to enhance health systems response to men and women's different health needs.

TARGETED USERS: Researchers, policymakers, and program managers.

HOW TO APPLY THE TOOL? This is an excellent place to start when embarking on an analysis of secondary data sources. It demonstrates that gender analysis is built on a series of questions used to query data that are continuously refined to move from identification of sex differences in health risks, vulnerabilities, and outcomes to ascertain contributory factors based on gender.

GENDER-SENSITIVE INDICATORS FOR MEDIA

AUTHOR: UNESCO

DATE: 2012

ORGANIZATION: United Nations Educational, Scientific and Cultural Organization

URL: <http://bit.ly/1XCoVEJ>

HEALTH AREA: General

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): The Gender-Sensitive Indicators for Media examines the intersection between women's empowerment and media development. The gender indicators presented provide guidance on how to monitor the gender-responsiveness of their organizations and activities. Indicators are listed under two categories: A) Actions to foster gender equality within media organizations and B) Gender portrayal in media content. Section A includes indicators for 1) Gender balance at the decision-making level (p. 22-23); 2) Gender equality in work and working conditions (p. 24-28); 3) Gender equality in unions, associations, clubs, and organizations of journalists, other media professionals, and media self-regulatory bodies (p. 29-32); 4) Media organizations' promotion of ethical codes and policies in favor of gender equality in media content (p. 33-34); and 5) Gender balance in education and training (p. 35-38). Section B includes indicators on 1) Balanced portrayal of men and women in news and current affairs (p. 40-46) and 2) Fair portrayal of women and men in commercial messages in the media in advertising (p. 47-48). A gender glossary is also available on page 53. This tool is linked to Media Development Indicators available here: <http://bit.ly/1OufPHU>

TARGETED USERS: Citizen media groups and organizations using media in development interventions.

HOW TO APPLY THE TOOL? Organizations using media in their projects can use the indicators presented in the Gender-Sensitive Indicators for Media to measure the gender-responsiveness of their organizations and activities.

GENDER, WOMEN AND PRIMARY HEALTH CARE RENEWAL: A DISCUSSION PAPER

AUTHORS: World Health Organization

DATE: 2010

ORGANIZATION: World Health Organization

URL: <http://bit.ly/230b54D>

HEALTH AREA: General

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This report features how the World Health Organization has integrated gender into recent primary health care reforms including universal coverage reforms, service delivery reforms, public policy reforms, and leadership reforms. Secondly, it features ways to measure gender equality in the six building blocks of the health system and larger policy reforms. Chapter 1 outlines the primary health care approach, reforms, gender concepts, and a rationale for integrating gender into primary health care (p. 11-17). Chapters 2 (p. 21-42) and 3 (p. 45-60) review the universal coverage reforms, and public and leadership reforms. Chapter 4 (p. 63-67) provides recommendations to the World Health Organization to better integrate gender into policies and programs. A number of key concepts are referenced in boxes throughout the report, notably developing gender-sensitive indicators (p. 47) and applying sex and gender-based analysis in health research.

TARGETED USERS: Policymakers focused on primary health care.

HOW TO APPLY THE TOOL? This tool can be used to assist organizations that are integrating gender into primary health care policies.

COMPENDIUM OF GENDER EQUALITY AND HIV INDICATORS

AUTHOR: Shelah S. Bloom and Svetlana Negroustoueva

DATE: 2013

ORGANIZATION: Carolina Population Center/PEPFAR, UNAIDS, USAID, UN Women

URL: <http://bit.ly/1LHQLbZ>

HEALTH AREA: HIV/AIDS

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): The Compendium provides a menu of M&E indicators to be used by program managers, organizations, and policy-makers to measure gender equality and HIV/AIDS outcomes. It provides relevant indicators for use at different levels of programming and measurement from individual to population level measurement. The tool provides an approximate determinants framework that is used for organizing the indicators into five groups: societal context, intervention programs, populations warranting special attention, behavior and knowledge, and disease prevalence/reproductive health.

TARGETED USERS: Researchers, program planners and managers, and M&E professionals .

HOW TO APPLY THE TOOL? The tool is a resource for identifying gender relevant indicators. It can be used in the context of designing M&E plans or to identify what kind of information is important to collect for a gender analysis or baseline and endline studies.

VIOLENCE AGAINST WOMEN AND GIRLS: A COMPENDIUM OF MONITORING AND EVALUATION INDICATORS

AUTHORS: Shelah S. Bloom

DATE: 2008

ORGANIZATION: Population Reference Bureau and Carolina Population Center

URL: <http://bit.ly/1ldsfo6>

HEALTH AREA: Gender-based violence with a focus on violence against women

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): The guide is a compendium of indicators intended to contribute to improved M&E of violence against women and girls in USAID health programs. The indicators have been designed to be used by people who need information obtained through quantitative methods on program performance at the community, regional, and national levels. All the indicators presented in the compendium conform to technical and ethical standards. The indicators are organized in four chapters, where each indicator is described and explained. The chapters cover indicators that measure: 1) Magnitude and characteristics of different forms of violence against women and girls; 2) Programs addressing violence against women and girls by sector; 3) Under-documented forms of violence against women and girls and emerging areas; and 4) Programs addressing the prevention of violence against women and girls.

TARGETED USERS: Researchers, program planners and managers, and M&E professionals.

HOW TO APPLY THE TOOL? The tool can be used to identify indicators on violence against women and girls and to guide the type of information to be included on violence against women and girls in gender analysis.

GUIDE FOR THE FORMULATION OF PUBLIC BUDGETS IN THE HEALTH SECTOR USING A GENDER PERSPECTIVE

AUTHOR: Lucia Pérez Fragoso and Rosalío L. Rangel Granados

DATE: 2010

ORGANIZATION: UN WOMEN

URL: <http://bit.ly/1Hr4skw>

HEALTH AREA: General

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): The purpose of this tool is to guide ministries of health through a process to incorporate a gender equality perspective in their programming and budgets. The tool includes a series of gender-focused questions to facilitate policymakers and planners' reflections and actions on the allocation of health resources in a gender equitable manner. The tool offers a comprehensive explanation of what a gender budgeting process is and how to do it. The tool was developed by a team in Mexico that undertook the entire process there.

TARGETED USERS: Policymakers and planners in ministries of health, planning, and finance. It can also be used by donors to examine their own budget allocations. This is an essential and valuable tool for anyone who works on health financing and program planning and design.

HOW TO APPLY THE TOOL? Application is most useful when starting a new strategy to develop an accompanying gender equitable budget but can also be applied yearly as a monitoring and re-planning tool.

POLICY REPORT: ENGAGING MEN IN HIV AND GBV PREVENTION, SRHR PROMOTION AND PARENTING/ZAMBIA

AUTHORS: Sonke Gender Justice

DATE: 2012

ORGANIZATION: Sonke Gender Justice

URL: <http://bit.ly/1OjmRkt>

HEALTH AREA: HIV/AIDS, gender-based violence, and reproductive and sexual health

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This is one of several reports based on the application of a policy tool. The policy tool is contained in each report (in the Zambia report it appears on page four). The tool provides a practical framework for conducting an analysis of the strengths and weaknesses of policies, laws, and plans supportive of the engagement of men and boys in four areas related to gender equality: HIV/AIDS; gender-based violence; sexual and reproductive health and rights; and parenting.

TARGETED USERS: Policymakers and planners in ministries of health and advocates for policy change.

HOW TO APPLY THE TOOL? The tool uses a four-point scale to assess the enabling environment: satisfactory, room for improvement, inadequate, and relevant documents not available. These criteria are applied to each of the four areas of HIV/AIDS: gender-based violence; sexual and reproductive health and rights; and parenting.

UNAIDS GENDER ASSESSMENT TOOL: TOWARDS A GENDER-TRANSFORMATIVE HIV RESPONSE

AUTHOR: UNAIDS

DATE: 2014

ORGANIZATION: UNAIDS

URL: <http://bit.ly/1kVYcHp>

HEALTH AREA: HIV/AIDS and TB

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): This tool is designed to support countries' assessment of gender issues that affect and are affected by their HIV epidemic, context, and response. The tool was developed to formulate or review national strategic plans and to support development of requests for funding from Global Fund to Fight AIDS, Tuberculosis and Malaria. It is also intended to serve the gender analysis requirements of other stakeholders, such as those involved in the President's Emergency Plan for AIDS Relief (PEPFAR) programming.

TARGETED USERS: Policymakers and planners in ministries of health, donors, and implementing partners

HOW TO APPLY THE TOOL? The tool provides a step-by-step approach, with instructions on how to prepare for a gender analysis and where to find relevant documents to review (Stage 1). In Stage 2, the tool provides guiding questions appropriate to different types of stakeholders. Stage 3 provides questions for assessing the policy context, and Stage 4 provides a framework for analysis of the data collected. The annexes provide a list of additional resources and model scopes of work for conducting a gender assessment.

HUMAN RIGHTS AND GENDER EQUALITY IN HEALTH SECTOR STRATEGIES: HOW TO ASSESS POLICY COHERENCE

AUTHORS: World Health Organization

DATE: 2011

ORGANIZATION: World Health Organization

URL: <http://bit.ly/1PmCNnF>

HEALTH AREA: General

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): The purpose of the tool is to:

- » Assess the extent to which health sector strategies are consistent with and promote human rights standards and principles, including gender equality;
 - » Identify gender equality and human rights-related gaps and opportunities in national commitments and health sector strategies to facilitate effective, relevant, and strategic health sector interventions; and
 - » Engage stakeholders in multiple disciplines to address human rights and gender equality in relation to health.
-

TARGETED USERS: Ministries of health and other sectors, national human rights institutions, development partners, and civil society organizations

HOW TO APPLY THE TOOL? The tool offers practical guidance on planning, data collection, analysis, and dissemination for identifying whether gender has been adequately addressed in national policy instruments, particularly health policies. It offers three instruments for assessing:

- » A country's compliance with its obligations and commitments in accord with international treaties, agreements, and consensus documents;
 - » A country's fulfillment of its own legal, policy, and institutional frameworks that promote human rights and gender equality; and
 - » The extent to which principles of human rights and gender equity have been incorporated in national health sector strategies.
-

TAKING THE PULSE OF POLICY: THE POLICY IMPLEMENTATION ASSESSMENT TOOL

AUTHOR: A. Bhuyan, A. Jorgensen, and S. Sharma

DATE: 2010

ORGANIZATION: Futures Group

URL: <http://bit.ly/1Hz7pPV>

HEALTH AREA: General

TOOL OBJECTIVES (WHAT IS THIS TOOL DESIGNED TO HELP YOU DO?): The purpose of the tool is to help government civil society advocates to “take the pulse” of policies in their appropriate areas, given the issues to be addressed.

TARGETED USERS: Government and civil society advocates

HOW TO APPLY THE TOOL? The tool is applied through a step-by-step approach, which typically takes about four to six months: (1) select the policy; (2) form a core country team; (3) make decisions about study parameters; (4) adapt the interview guides; (5) identify interviewees and/or focus group discussion participants; (6) conduct the interviews/focus group discussions; (7) analyze data; and (8) share findings and discuss next steps.

ANNEX III

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ANNEX IV

YEMEN

KNOWLEDGE, PRACTICES, & COVERAGE (KPC) EXAMPLES



1. Who usually makes decisions about what food to buy for family meals?
 - you..... 1
 - your husband..... 2
 - you and your husband jointly 3
 - you and someone else jointly 4
 - other (specify: _____)..... 5
 - decision not made/not applicable..... 9

2. Who usually makes decisions about whether to purchase small household materials, such as utensils?
 - you..... 1
 - your husband..... 2
 - you and your husband jointly 3
 - you and someone else jointly 4
 - other (specify: _____)..... 5
 - decision not made/not applicable..... 9

3. Who usually makes decisions about what gifts to give when relatives marry?
 - you..... 1
 - your husband..... 2
 - you and your husband jointly 3
 - you and someone else jointly 4
 - other (specify: _____)..... 5
 - decision not made/not applicable..... 9

4. Who usually makes decisions about inviting guests to your home?
 - you..... 1
 - your husband..... 2
 - you and your husband jointly 3
 - you and someone else jointly 4
 - other (specify: _____)..... 5
 - decision not made/not applicable..... 9

5. Who usually makes decisions about your going and staying with parents and siblings?
 - you..... 1
 - your husband..... 2
 - you and your husband jointly 3
 - you and someone else jointly 4
 - other (specify: _____)..... 5
 - decision not made/not applicable..... 9

6. Who usually makes decisions about whether to purchase major goods for the household, such as a TV?

- you..... 1
- your husband..... 2
- you and your husband jointly 3
- you and someone else jointly 4
- other (specify: _____)..... 5
- decision not made/not applicable..... 9

7. Who usually makes decisions about whether to purchase or sell animals?

- you..... 1
- your husband..... 2
- you and your husband jointly 3
- you and someone else jointly 4
- other (specify: _____)..... 5
- decision not made/not applicable..... 9

8. Who usually makes decisions about how you spend your own money?

- you..... 1
- your husband..... 2
- you and your husband jointly 3
- you and someone else jointly 4
- other (specify: _____)..... 5
- decision not made/not applicable..... 9

9. Please answer yes or no to the following questions.

- a.** If you wanted to buy yourself a piece of cloth to make clothes, would you feel free to do it?
 - Yes 1
 - No..... 2
 - I don't know..... 8
- b.** If you wanted to buy yourself a small item of jewelry, such as a pair of earrings, would you feel free to do it?
 - Yes 1
 - No..... 2
 - I don't know..... 8

- c.** If you wanted to buy a small gift for your parents or other family members, would you feel free to do it?
 - Yes 1
 - No..... 2
 - I don't know..... 8

10. Please answer yes or no to the following questions.

- a.** Are you allowed to have some money set aside that you can use as you wish?
 - Yes 1
 - No..... 2
 - I don't know..... 8
- b.** When you get money, do you usually give all of it to your husband?
 - Yes 1
 - No..... 2
 - I don't know..... 8
- c.** Do you you and your husband ever talk alone with each other about what to spend money on?
 - Yes 1
 - No..... 2
 - I don't know..... 8
- d.** Do you have a say in how the household's overall income is spent?
 - Yes 1
 - No..... 2
 - I don't know..... 8
- e.** Do you get cash in hand to spend on household expenditures?
 - Yes 1
 - No..... 2
 - I don't know..... 8

- 11. Who usually makes decisions about healthcare, such as going to the doctor, for yourself?**
- you..... 1
 - your husband..... 2
 - you and your husband jointly 3
 - you and someone else jointly 4
 - other (specify: _____)..... 5
 - decision not made/not applicable..... 9

- 12. Who usually makes the decision to seek health care for a child, such as to go see a doctor?**
- you..... 1
 - your husband..... 2
 - you and your husband jointly 3
 - you and someone else jointly 4
 - your mother..... 5
 - your mother in-law 6
 - your father in-law..... 7
 - other (specify: _____)..... 8
 - decision not made/not applicable..... 9

- 13. Who usually makes decisions regarding child-feeding practices and when to start feeding the child food?**
- you..... 1
 - your husband..... 2
 - you and your husband jointly 3
 - you and someone else jointly 4
 - your mother..... 5
 - your mother in-law 6
 - your father in-law..... 7
 - other (specify: _____)..... 8
 - decision not made/not applicable..... 9

- 14. Who usually makes decisions regarding child breastfeeding practices?**
- you..... 1
 - your husband..... 2
 - you and your husband jointly 3
 - you and someone else jointly 4
 - your mother..... 5
 - your mother in-law 6
 - your father in-law..... 7
 - other (specify: _____)..... 8
 - decision not made/not applicable..... 9

- 15. Who usually decides to have the baby immunized?**
- you..... 1
 - your husband..... 2
 - you and your husband jointly 3
 - you and someone else jointly 4
 - your mother..... 5
 - your mother in-law 6
 - your father in-law..... 7
 - other (specify: _____)..... 8
 - decision not made/not applicable..... 9

- 16. Who usually makes the decision about where you should deliver?**
- you..... 1
 - your husband..... 2
 - you and your husband jointly 3
 - you and someone else jointly 4
 - your mother..... 5
 - your mother in-law 6
 - your father in-law..... 7
 - other (specify: _____)..... 8
 - decision not made/not applicable..... 9

- 17. If you were to have complications during a pregnancy, who would mainly decide where you should go to take care of them?**
- you..... 1
 - your husband..... 2
 - you and your husband jointly 3
 - you and someone else jointly 4
 - your mother..... 5
 - your mother in-law 6
 - your father in-law..... 7
 - other (specify: _____)..... 8
 - decision not made/not applicable..... 9

- 18. In your opinion, do you need to get approval from your husband before using FP?**
- yes..... 1
 - no..... 2
 - I don't know 8

19. During your pregnancy with your youngest child, did your husband accompany you to at least one antenatal counseling visit?

- yes..... 1
- no..... 2
- I don't know..... 8

20. In the last 12 months, have you received family planning services at a health facility?

- yes..... 1
- no..... 2
- I don't know..... 8

21. IF YES, when you visited the health center to obtain a method to delay or avoid pregnancy, did your husband go with you?

- yes..... 1
- no..... 2
- I don't know..... 8

22. IF YES, did your husband participate in family planning counseling with you?

- yes..... 1
- no..... 2
- I don't know..... 8

23. In the last 12 months, have you discussed whether to use a family planning method with your husband?

- yes..... 1
- no..... 2
- I don't know..... 8

24. Who decides whether money can be spent on healthcare for your children?

- you..... 1
- your husband..... 2
- you and your husband jointly 3
- you and someone else jointly 4
- your mother..... 5
- your mother in-law 6
- your father in-law..... 7
- other (specify: _____)..... 8
- decision not made/not applicable..... 9

25. Do you eat at the same time as the male members of the family?

- yes..... 1
- no..... 2
- I don't know..... 8

26. IF NO, when do you eat?

- before the male members eat..... 1
- after the male members eat 2
- after the children eat 3

27. Did you eat less, the same, or more food during your last pregnancy than when you were not pregnant?

- less food when pregnant..... 1
- same amount of food as when not pregnant.. 2
- more food when pregnant..... 3
- don't know/not applicable..... 8

28. Do you have to ask your husband or senior family members for permission to go to:

a. Any place outside your house?

- Yes 1
- No..... 2
- I don't know..... 8

b. The market?

- Yes 1
- No..... 2
- I don't know..... 8

c. The health center?

- Yes 1
- No..... 2
- I don't know..... 8

d. Homes of relative or friends?

- Yes 1
- No..... 2
- I don't know..... 8

e. Nearest village?

- Yes 1
- No..... 2
- I don't know..... 8

29. Can you go to any of these places without your husband?

a. Market?

- Yes 1
- No..... 2
- I don't know..... 8

b. Health center?

- Yes 1
- No..... 2
- I don't know..... 8

c. Homes of relatives or friends?

- Yes 1
- No..... 2
- I don't know..... 8

d. Nearest village?

- Yes 1
- No..... 2
- I don't know..... 8

30. Now I am going to ask your opinion about women's interactions at health facilities.

- Yes, I feel it is OK 1
- No..... 3
- Don't know..... 4

31. Do you feel comfortable receiving reproductive health care or treatment from a male health worker?

- Yes, I feel it is OK 1
- No..... 3
- Don't know..... 4

32. A woman who comes to the health clinic for services without a companion should be treated equally as any other patient.

- strongly agree 1
- agree..... 2
- neutral 3
- disagree 4
- strongly disagree..... 5



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