Workshop on Gender Mainstreaming in Health

Facilitated by Warda Batool

ROYAL COMMONWEALTH SOCIETY

CYGEN

Hi!

I am a **health policy analyst and health services researcher** specialising in equity and **gender-responsive approaches in global health**.

Research interests:

- Integrating gender perspectives into health policy and systems
- Addressing how societal determinants shape access to care for women and marginalised communities
- Policy analysis, evidence synthesis, and interdisciplinary research across global contexts, including health systems strengthening, adolescent health, NCD care, and health workforce optimisation.

As a facilitator, I bring a strong focus on **translating evidence into actionable strategies, supporting stakeholders to embed gender mainstreaming into policies, programmes, and health system practice**.

Agenda

- Module 1: **Awareness** – building blocks to address gender inequality in health
- Module 2: **Analysis** – conducting gender analysis
- Module 3: **Action** - developing Gender Responsive Actions

Module 1: Awareness – building blocks to address gender inequality in health

Let's start from the basics[1]

Sex is about **biological and physiological differences** between women and men such as hormones, genitalia or chromosomes. Sex is usually **difficult to change** – except through surgical intervention.

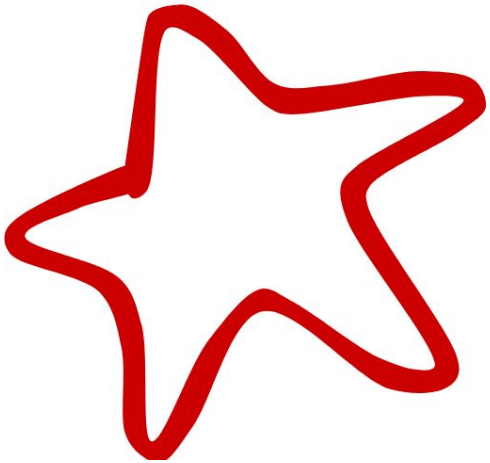
Gender refers to the characteristics of women and men that vary from society to society and are **socioculturally, economically, and politically constructed**. → gender learning

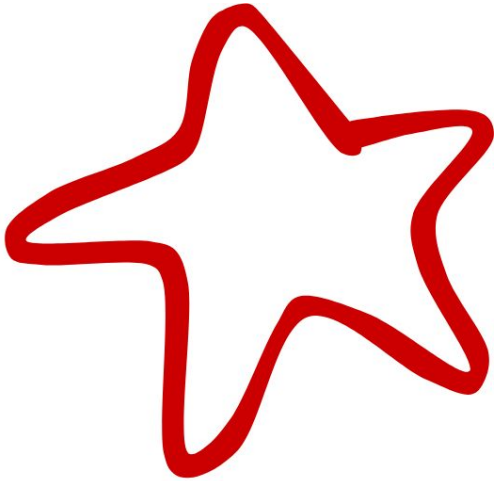
While gender can be changed, it **requires long-term strategies** and the right local partners and stakeholders to do so.

How does gender impact health?[1]

- Sex and gender are **not the same, but are interrelated**
- People are born **female or male** but are taught what appropriate **behaviour and roles** are expected of them
- Biology (sex) cannot explain all the **different disease patterns between women and men**
- Many differences in health outcomes between women and men can be attributed to **differences in life circumstances and norms (gender)** and can therefore either be **mitigated or prevented altogether.**

Yes or No?





Does gender really matter in health?

Q: Can household responsibilities, such as food preparation, pose a risk to health?[2]

YES **NO**

Yes. The fact that women tend to be in charge of cooking in most contexts puts them at **higher risk of respiratory illness than men** as a result of their household responsibilities. Acrid smoke deposits are responsible for 39% deaths due to chronic obstructive pulmonary disease (COPD) among women worldwide per year

Q: Do more men than women die from road traffic injuries?[3,4,5,6,7]

YES **NO**

Yes. Almost **three times as many** men die from road traffic injuries as women. This is true especially for men younger than 25 years. In fact, a study in Pakistan found **22.4 road crashes per 1000 men** versus 6.9 per 1000 women. In Tehran, a hospital-based study of road traffic victims found the male-to-female ratio for road crash victims was **4.2:1,** while a survey of road traffic victims treated in a hospital in Saudi Arabia showed a male-to-female ratio of **9:1**.

Q: Do boys and girls have the same access to high-quality health care?[8]

YES **NO**

Not always. Boys and girls do not always have the same access to high-quality health care. For example, surveys conducted in Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand found that, **even when girls were vaccinated at comparable rates to boys, they were often not taken to a health provider or care facility for illness episodes.**

Do men and women experience violence in the same places, by the same types of perpetrators?[9]

YES **NO**

No. Women experience **physical, sexual and psychological violence** in their homes, often from intimate partners, in conflict settings and in communities, **often by people they know.** Sometimes they die from these situations; sometimes they remain in unsafe settings. Men who experience violence, in contrast, often experience violence at the **hands of strangers** and tend to die as a result of **homicide** by unknown perpetrators

Q: Do males and females differ in mortality related to lung cancer?[10]

YES **NO**

Yes. More men than women die of lung cancer. GLOBOCAN 2000 data reveal gender differences in lung cancer incidence, prevalence and mortality, with about 10 female deaths and 31 male deaths per 100 000 population being attributed to lung cancer, more than a threefold difference!

Q: Do women generally live longer than men?[11,12]

YES **NO**

Yes. In most countries **women do live longer than men** but have **higher levels of disability or illness.**

Q: Do men and women differ in the prevalence of depression?[13]

YES **NO**

Yes. In the Islamic Republic of Iran, the prevalence of mental disorders was **1.7 times higher among women** than among men: 29% versus 15%. A population-based study in Rawalpindi, Pakistan estimated that **24% of women and 10% of men** had depressive disorders.

Q: Does male involvement influence maternal and child health outcomes?[14,15]

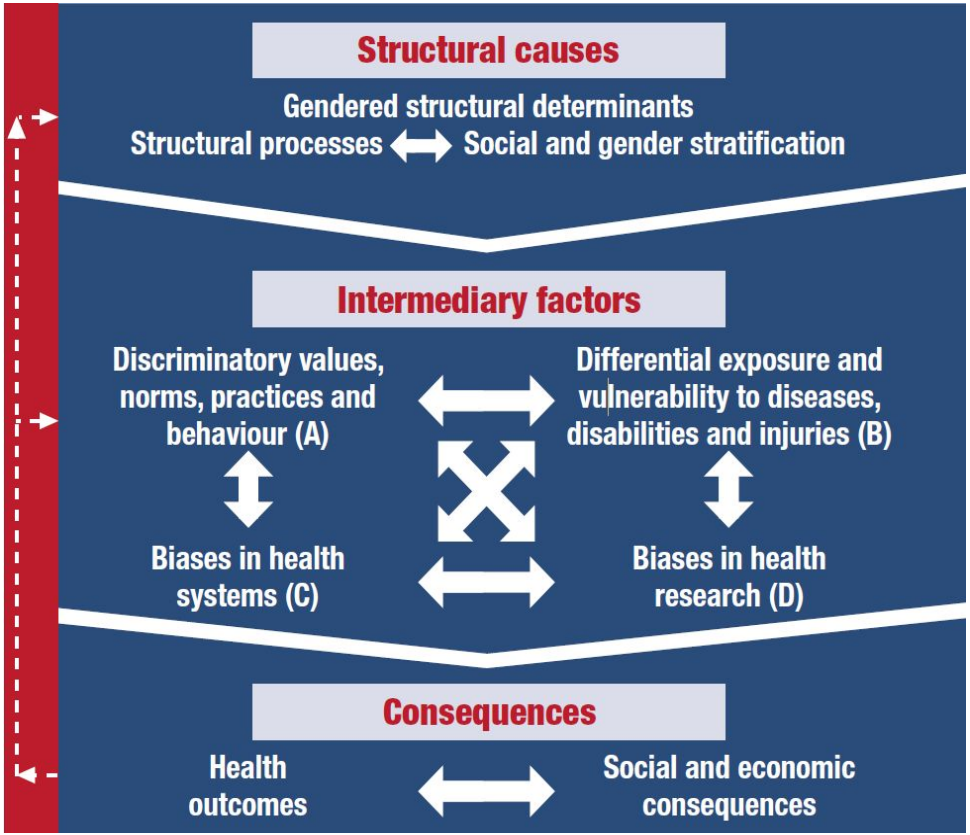
YES

NO

Yes. Male involvement **improves physical and psychosocial maternal and child health outcomes.** It also leads to **positive social outcomes for men.**
Studies in Scandinavia have shown that men's involvement in maternal and child health programmes can **reduce maternal and child morbidity and mortality, such as:**

- **fewer low-birth-weight infants in low-income families**
- **improved cognitive outcomes for preterm and low-birth-weight babies**
- **shortened labour time and rate of epidural use**
- **obstetric emergencies may be alleviated.**

Framework for the role of gender as a determinant of health[16]



Understanding the difference between equity and equality[1]

The hosts created equality of opportunity by making food available. However, they failed to pay attention to the needs of their guests to ensure they could actually benefit from the dining opportunity.

THE FOX AND THE STORK

At a dinner party hosted by the fox, the stork was invited to enjoy a bowl of soup. The soup was served in a wide, flat bowl and the stork could eat very little – simply wetting the tip of its long beak. The stork watched as the fox, able to fit its snout in the bowl, gobbled up the soup with ease.

Days later, the stork hosted a dinner party – and served rice. The rice was served in a long, thin urn that the stork could easily dip its long, thin beaks in and peck away at the delicious rice. The fox, hard as it tried, could not get its snout past a certain point on the urn.

What does this tale tell us about **equality and equity**?

Gender equality, gender equity and health equity[1]

- Gender equality → women and men have **equal conditions to realize their full rights and potential** to be healthy, contribute to health development and benefit from the results

- Gender equity → goes beyond equality of opportunity with the objective of **reducing avoidable inequality in health status, access to health services and their contributions to the health workforce**.

How does this matter when trying to achieve health equity?[1]

- **Equality of opportunity (gender equality)** helps ensure that women have the same opportunities as men to access social, economic and political resources.
- Recognition of **different needs to redistribute social, economic and political resources (gender equity)** addresses inequality between groups of women and men so that they can benefit from the above resources (or equality of outcomes).
- **Reducing avoidable health differences (or achieving health equity)** can only occur by addressing both equality of opportunity and equality of outcomes.

Gender Norms, Roles, and Relations[16]

- puts the health of **millions of women and girls at risk** globally
- led to **deprivation of rights** faced by women and girls in households, communities, workplaces and health care settings
- needs to be addressed to **ascertain equitable accessibility, availability, and affordability** of healthcare services

How do gender norms, roles, and relations impact health?

Impact of Gender Norms on Health[17, 18]

- Low **social status, health literacy, and autonomy** leads to adverse health effects
- Depriving girls of **education opportunities** can damage their health
- Teaching boys to be men according to **harmful norms and rites of passage** encourages them to put their lives and those of others at risk

Impact of Gender Roles on Health[19, 20, 21]

- Domestic tasks can increase **women's risk and vulnerability to illness and poor health** → risk for schistosomiasis, chronic obstructive pulmonary disease

- **Higher reports of injury** among men of working age → occupational and road traffic injuries

- Men who are equally involved in all aspects of domestic life are **less likely to engage in risky behaviour and demonstrate better health outcomes**

Impact of Gender Relations on Health[22, 23, 24]

- **Unequal power relations** between women and men contribute to gender-based violence
- **Early and/or forced marriage** places young girls at risk for early pregnancy and unsafe, coerced sex ➜ HIV, STIs, removal from schools, lack of social support and networks
- Heterosexual norms can lead to discrimination that adversely affects the health of LGBTQIA+ communities ➜ **social exclusion, marginalisation, stigmatisation**

Gender-based discrimination in health[1]

- Any **distinction, exclusion or restriction based on gender norms, roles and relations** that prevents women or men of different groups and ages from enjoying their human rights
- Health programmes and policies must respond to instances of gender-based discrimination when they **pose potential or real harm to health**
- Public health workers must understand how gender-based discrimination may influence health to be able to **develop sound responses.**

Gender Mainstreaming[25]

- a process of **assessing the implications of any planned action within a health system**, including legislation, policies, programmes or service delivery **at all levels** for women, men and gender diverse people

- a pathway to make the concerns and experiences of diverse women and men an **integral dimension of the design, implementation, monitoring and evaluation of policies and programmes** in all spheres so that they benefit equally

- is not an end in itself but a means to **achieve the goal of gender equality** → a long-term process, and its results will be seen progressively

Gender Analysis [26,27]

- utilised to identify, assess and inform actions to **address inequality and inequity**

- **systematically identifies differentials between groups of women and men**, whether related to sex or gender, in terms of risk factors, exposures and manifestations of ill-health, severity and frequency of diseases, health seeking behaviours, access to care and experiences in health care settings, as well as outcomes and impact of ill-health

- collecting and analyzing **data disaggregated by sex** and additional factors such as age, ethnicity, socio-economic status and disability, is critical.

Progress Check

I know or understand	Not at all	Somewhat	Well
Why gender matters in public health			
The difference between sex and gender.			
What gender norms, roles and relations are.			
What the difference between gender equality and gender equity is.			
What gender mainstreaming is.			

5 minute break

Module 2: Analysis – conducting gender analysis

Guiding Principles for Gender Analysis[1]

- Sex is not gender.
- Women and men are different.
- Policies and programmes do not affect men and women in the same ways.
- Diverse types of evidence are needed to understand how gender operates as a determinant of health.
- Sustained commitment is necessary.

Guiding Principles for Gender Analysis[1]

- Sex is not gender.
- Women and men are different.
- Policies and programmes do not affect men and women in the same ways.
- Diverse types of evidence are needed to understand how gender operates as a determinant of health.
- **Sustained commitment is necessary.**

Why is gender analysis in health crucial?

- Informs **actions to address inequality** that stems from[28,29]:
  a. gender **norms, roles and relations**;
  b. unequal **power relations** between and among men and women; and
  c. the **interaction of other determinants of health with gender,** such as sexual orientation, ethnicity, education or employment status.

It is a core gender mainstreaming skill that generates processes and information needed for health planning and programming.[1]

What does gender analysis help in?

- Understanding **health differences and disparities among and between** groups of women and men in the following areas:[30,31,32]
  a. risk factors and vulnerability;
  b. patterns of disease, illness and mortality; and
  c. the health effects of policies, legislation or programmes.

- Highlighting differences in access to: [31]
  a. **health services and resources** for preventing disease and promoting health
  b. **decision-making processes** related to health and the organization of health systems.

Where can gender analysis be applied?[32,33,34]

- health policies, legislation, programmes, services and research;
- specific health conditions and problems; and
- human resource planning, budgeting and operational planning.

Gender analysis increases health sector effectiveness by:[1,31]

- ensuring the **right to health** of different groups of men and women;
- identifying **practical and strategic gender needs** in health;
- recognising and **reducing the constraints** women face in promoting their health;
- addressing how male gender norms, roles and relations may have **adverse health effects**
- reducing **inadequate, ineffective services, programmes or policies**
- identifying and **reducing gender bias** in the health system;
- developing and implementing **gender-responsive policies, laws and services and programmes**; and
- improving **health information, documentation and use**.

Gender analysis increases health sector effectiveness by:[1,31]

- ensuring the **right to health** of different groups of men and women;
- identifying **practical and strategic gender needs** in health;
- recognising and **reducing the constraints** women face in promoting their health;
- addressing how male gender norms, roles and relations may have **adverse health effects**
- reducing **inadequate, ineffective services, programmes or policies**
- identifying and **reducing gender bias** in the health system;
- developing and implementing **gender-responsive policies, laws and services and programmes**; and
- improving **health information, documentation and use**.

What are practical and strategic gender needs?[1,28]

Practical gender needs → necessities such as adequate living conditions, drinking-water, health care and employment. Meeting these needs is essential to improving women's status in society.

- **short-term**, such as health care, food, shelter and income;
- **basic needs** that are easily identifiable; and
- require **direct, tangible action** such as installing water pumps and building schools or health facilities can address these needs.

Strategic gender needs → refer to women's unequal status relative to men and are usually identified by analysing gender norms, roles and relations.

- **Long-term**, such as changing laws and policies related to gender-based violence;
- **difficult to identify** as they are less tangible;
- usually common across groups, as they relate to **vulnerability** to physical violence, restricted legal protections and other **social resources** such as education.

Caution![1]

- **Gender analysis alone does not address practical or strategic gender needs.**
- To avoid sprinkling gender salt on top of existing efforts, **information from gender analysis should inform every stage of health planning and programming.**
- Actual work of addressing gender inequality in health **begins with analysis but requires action.**

No more gender words without gender action!

It's time to stop adding gender salt on top of health programmes and actually integrate gender throughout!

Gender Analysis Tools

- Indicators to assess women empowerment
- Gender Analysis Questions (GAQ)
- Gender Analysis Matrix (GAM)
- Gender Responsiveness Analysis Scale (GRAS)

Gender Analysis Tools

- **Indicators to assess women empowerment**
- Gender Analysis Matrix (GAM)
- Gender Analysis Questions (GAQ)
- Gender Responsiveness Analysis Scale (GRAS)

Examples of indicators used to assess women's empowerment[35]

Features to be examined	Yes	No	Partly
Individual level			
Capacity to participate in decision-making at the household level			
Access to health information			
Membership in any association			
Ability to participate in or attend women's empowerment workshops or meetings			
Ability to move around outside the household within the community (mobility)			
Community level			
Community tolerance and support for women's leadership			
Ability of women to make decisions within local committees			
Availability of community leaders sensitive to women's issues			
National level			
Existence of laws and regulations enhancing women's health, empowerment and participation			
Existence of active women's movements and institutions			
Existence of a gender policy			

Gender Analysis Tools

- Indicators to assess women empowerment
- **Gender Analysis Matrix (GAM)**
- Gender Analysis Questions (GAQ)
- Gender Responsiveness Analysis Scale (GRAS)

Gender Analysis Matrix (GAM)[1]

Factors that influence health outcomes: *Health-related considerations*	Factors that influence health outcomes: *Gender-related considerations*		
	Biological factors	Sociocultural factors	Access to and control over resources
Risk factors and vulnerability			
Access and use of health services			
Health-seeking behaviour			
Treatment options			
Experiences in health care settings			
Health and social outcomes and consequences			

Risk factors and vulnerability 36-38

Risk factors → associated with the development of disease or illness, or the underlying causes of disease and Illness. Exposure is often linked to **gender norms, roles, and relations**

Examples:
Socioeconomic status: income, age, ethnicity and gender
Geographical location: rural or urban, including housing, working conditions and physical access to services
Psychosocial factors or lifestyle: tobacco or alcohol consumption, nutrition and physical activity
Physiological factors: sex, body type, genetics, blood pressure and serum cholesterol

Vulnerability refers to the degree to which individuals, communities and systems are susceptible, or have diminished capacity, to cope with exposure to risk factors.

Risk factors and vulnerability 36-38

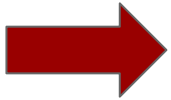
Risk factors → associated with the development of disease or illness, or the underlying causes of disease and Illness. Exposure is often linked to **gender norms, roles, and relations**

Examples:
Socioeconomic status: income, age, ethnicity and gender
Geographical location: rural or urban, including housing, working conditions and physical access to services
Psychosocial factors or lifestyle: tobacco or alcohol consumption, nutrition and physical activity
Physiological factors: sex, body type, genetics, blood pressure and serum cholesterol

Vulnerability refers to the degree to which individuals, communities and systems are susceptible, or have diminished capacity, to cope with exposure to risk factors.

Differences in access to and control over resources may increase vulnerability to illness and disease.

Gender Analysis Matrix (GAM)



Factors that influence health outcomes: *Health-related considerations*	Factors that influence health outcomes: *Gender-related considerations*		
	Biological factors	Sociocultural factors	Access to and control over resources
Risk factors and vulnerability			
Access and use of health services			
Health-seeking behaviour			
Treatment options			
Experiences in health care settings			
Health and social outcomes and consequences			

Access to and use of health services[39]

- **Availability** → existence and sufficiency of needed health services
- **Affordability** → patients' ability to pay for services, including free services and other coverage issues
- **Accessibility** → location of population and services, transport and other related costs to access and use health services
- **Accommodation** → compliance of health services with the time and communication needs of patients, which contributes to the perceived quality of the services received
- **Acceptability** → fit between services and the community or individual, based on cultural understandings

Gender Analysis Matrix (GAM)

Factors that influence health outcomes: *Health-related considerations*	Factors that influence health outcomes: *Gender-related considerations*		
	Biological factors	Sociocultural factors	Access to and control over resources
Risk factors and vulnerability			
Access and use of health services			
Health-seeking behaviour			
Treatment options			
Experiences in health care settings			
Health and social outcomes and consequences			

Health-seeking behaviour [1, 40-43]

- Refers to actions carried out by a person with a perceived need for health services in order to address a given health problem.
- In addition to sex and gender, influenced by **socioeconomic status; education; proximity to health facilities; type, duration and perceived severity of illness; long waiting times; unsatisfactory or negative staff attitudes and adequate health education**

What has influenced your health-seeking behaviour?

Gender Analysis Matrix (GAM)

Factors that influence health outcomes: *Health-related considerations*	Factors that influence health outcomes: *Gender-related considerations*		
	Biological factors	Sociocultural factors	Access to and control over resources
Risk factors and vulnerability			
Access and use of health services			
Health-seeking behaviour			
Treatment options			
Experiences in health care settings			
Health and social outcomes and consequences			

Treatment options[1]

- Many prevention programmes are community-based and therefore **influenced by sociocultural norms.**
- Treatment and rehabilitation options are often institutionalized ➔ depend on the **availability of resources.**
- Healthcare providers should **address both sex and gender in suggesting treatment options** so as to fully respond to the health needs and realities of women and men from different populations.

Gender Analysis Matrix (GAM)

Factors that influence health outcomes: *Health-related considerations*	Factors that influence health outcomes: *Gender-related considerations*		
	Biological factors	Sociocultural factors	Access to and control over resources
Risk factors and vulnerability			
Access and use of health services			
Health-seeking behaviour			
Treatment options			
Experiences in health care settings			
Health and social outcomes and consequences			

Experiences in healthcare settings[44]

- Previous experiences in health care settings positive or negative, **influence future health-seeking behaviour**
- Health care provided in a **discriminatory, harmful or ineffective manner** may discourage women and men from seeking treatment.
- Healthcare settings that do not address gender norms, roles and relations in **culturally sensitive, appropriate ways** may perpetuate inequalities and fail to reach those in greatest need of health services

Gender Analysis Matrix (GAM)

Factors that influence health outcomes: *Health-related considerations*	Factors that influence health outcomes: *Gender-related considerations*		
	Biological factors	Sociocultural factors	Access to and control over resources
Risk factors and vulnerability			
Access and use of health services			
Health-seeking behaviour			
Treatment options			
Experiences in health care settings			
Health and social outcomes and consequences			

Health and social outcomes and consequences[1,44]

- Health outcomes relate to disease or illness manifestation and associated **recovery, disability or death**.
- Gender considerations often influence how these outcomes influence a family or individual.
- Factors that affect health and social outcomes and consequences include:
  - monetary costs
  - duration and severity of a health problem
  - type of care needed, its availability and accessibility
  - available social networks
  - stigma

Gender Analysis Matrix (GAM)

Factors that influence health outcomes: *Health-related considerations*	Factors that influence health outcomes: *Gender-related considerations*		
	Biological factors	Sociocultural factors	Access to and control over resources
Risk factors and vulnerability			
Access and use of health services			
Health-seeking behaviour			
Treatment options			
Experiences in health care settings			
Health and social outcomes and consequences			

Gender-related considerations of the GAM[1,27]

Biological factors: Refers to those factors only related to physiology such as: reproductive and/or conditions related to physiological and/or hormonal changes; genetic or hereditary conditions (or those transferred from parent to child through chromosomes).

Sociocultural factors: Factors related to gender norms, roles and relations that may result in gender inequality.

Access to and control over resources: control does not mean owning a resource. Access is the availability of a resource (the resource exists and can be used), whereas control implies the ability to make decisions on how and when a resource can be used and by whom

Gender Analysis Tools

- Indicators to assess women empowerment
- Gender Analysis Matrix (GAM)
- **Gender Analysis Questions (GAQ)**
- Gender Responsiveness Analysis Scale (GRAS)

Gender Analysis Questions[1]

WHO Gender Analysis Questions	Corresponding GAM health-related considerations
What is the illness, disease or health condition of interest?	
• Is it an acute or chronic condition? • Is it a communicable or a noncommunicable condition? • What are the risk factors for this condition? – Are they different for women and men, boys and girls?	Introductory information on the health condition in question (not included in GAM) Risk factors and vulnerability
When does this condition occur?	
• Does it occur at any specific time in the life course? – Can biological factors explain increased vulnerability of the affected individual and/or group during this period? Which ones? – Can sociocultural factors explain increased vulnerability of the affected individual and/or group during this period? Which ones? – Which gender norms, roles and relations during this period may explain increased vulnerability?	Introductory information on the health condition in question (not included in GAM) Risk factors and vulnerability Health and social outcomes and consequences
• Is vulnerability increased at any specific time of the year? – Around or during a particular season (that is, related to climate)? Around crop time? – Are there any particular activities that men or women carry out at this time that may increase their vulnerability?	

Gender Analysis Questions (contd.)

Where does this condition occur?	
• Is it in rural or urban contexts? – Does this have different implications for groups of women or men, boys or girls?	Introductory information on the health condition in question (not included in GAM) Risk factors and vulnerability
• Is it linked to any particular factor in the social or physical environment? – Does it occur in the workplace, school settings, in the field or at home? – Do cases occur in places where either women or men tend to go or may be more numerous? – Do these women or men belong to a particular sociocultural group (economic, political or otherwise)?	
Who gets ill?	
• Can biological factors explain why women, men, girls or boys are affected differently by this condition? – Does the sex of the individual increase the risk for or vulnerability to this condition? How? – Do age or other physiological factors, such as hormone levels, matter? How?	Risk factors and vulnerability Health and social outcomes and consequences
• What are the specific gender norms, roles or relations of the community in question that may increase the risk for or vulnerability to this condition? – Do these norms affect men and women similarly or differently? – Does the affected group belong to a particular socioeconomic, ethnic or marginalized group? – Do the daily activities of women or men affect the risk for and vulnerability to this condition? If so, what kind of activities (paid or unpaid) increase risk, and who is responsible for carrying these out? – Do access to and control over resources affect the risk of and vulnerability to this condition? – Does the level of individual or community empowerment influence the risk for and vulnerability to this condition? ◦ Is this different for women, men, boys and girls? – Do educational opportunities influence the risk for and vulnerability to this condition? ◦ Is this different for boys and girls in the target population? How? – Do paid employment opportunities influence the risk for and vulnerability to this condition?	

Gender Analysis Questions

What are the people affected by the condition doing about it?	
• Are both women and men seeking services appropriately for this condition? – Who is attending health services for treatment? Women? Men? Certain age groups? Certain socioeconomic groups? – Who is consulting traditional healers or seeking alternative therapies for this condition? Women? Men? Certain age groups? Certain socioeconomic groups? ◦ Why these groups?	Access and use of health services Health-seeking behaviour
• Do biological factors affect health-seeking behaviour related to this condition? How? – Are these factors different for men and women? How?	
• Do sociocultural factors affect health-seeking behaviour related to this condition? How? – Are these factors different for women and men? How?	
• Do gender norms, roles or relations affect women's or men's willingness or ability to recognize that they are ill and/or to seek treatment? How? – How do women's and men's access to and control over resources affect their willingness or ability to recognize that they are ill and/or to seek treatment? – Do women have the ability to decide to seek treatment on their own?	

Gender Analysis Questions

How do access to and control over resources affect the provision of care?	
• Are health services facility-based or provided in the community? Or both? – Does the site of service delivery exclude any particular group? Which one? For what reasons?	Access and use of health services Experiences in health care settings
• Does access to and control over resources affect the type of health services received for this condition? How?	
• Do women and men have the resources necessary to seek and use available health services for this condition? – Do they have access to these resources to seek health services? Is access different for women and men? – Can they make or influence decisions about the use of these resources to seek health services? Is decision-making different for men and women? – If women and men have different access to and control over resources, how does this affect their experiences with health services? Does such a difference affect the quality of care received? – Does access to and control over resources affect treatment options? How? Is this different for women and men?	
• Do women or men in the affected group have specific types of financial or social vulnerability that may affect their ability to access and use health services? – Is this vulnerability worsened by age, ethnic or religious affiliation, sexual orientation or other factors?	
• If the affected population does not have the resources necessary, what networks or facilities are available to them for support? – Do these differ for women and men?	
• Are user fees affordable for this condition? – Do they differ for men and women of different groups? How?	

Gender Analysis Questions

How do health services meet the needs of the men and women affected by this condition?	
• Do biological factors influence treatment options, uptake and adherence? – Do these differ for women and men of different groups (including age)? How?	Treatment options Experiences in health care settings
• Do sociocultural factors influence treatment options, uptake and adherence? – Are these different for women and men of different groups (including age)? How?	
• Are women's and men's different roles considered in treatment options for this condition? – Are gender norms and relations considered? How? – What consequences may be incurred in treating this condition if gender norms, roles and relations are not considered?	
• Are health workers generally aware of the different ways men and women of different ages can express their symptoms when suffering from this condition?	
• Do women and men have different experiences with health services for this condition? What kinds? For what reasons? – Do experiences in health care settings differ by age, marital status, sexual orientation, ethnic or religious affiliation, socioeconomic status or other factors? How and for which groups?	
What are the predominant health and social outcomes of this condition?	
• As a result of this condition, are there differences (between women, men, girls and boys), in recovery, disability or mortality? – Are these outcomes influenced by sex or age? – Are these outcomes influenced by gender norms, roles or relations? Are the influences different for women and men? – What are the broader social effects of these outcomes?	Health and social outcomes and consequences
• Who (other than the immediate patient) is also affected? Children? Partners? Families? Communities? In what ways? – How do these effects vary if the affected person is a woman or man?	

Gender Analysis Questions

What are the predominant health and social outcomes of this condition?	
• As a result of this condition, are there differences (between women, men, girls and boys), in recovery, disability or mortality? – Are these outcomes influenced by sex or age? – Are these outcomes influenced by gender norms, roles or relations? Are the influences different for women and men? – What are the broader social effects of these outcomes?	Health and social outcomes and consequences
• Who (other than the immediate patient) is also affected? Children? Partners? Families? Communities? In what ways? – How do these effects vary if the affected person is a woman or man?	
• Do the sociocultural characteristics and consequences of the condition differ for women and men, such as the division of responsibilities in the household, employability, stigma or divorce?	
• Who else provides care (outside the health care system) for this condition? – What are the opportunity costs for this caretaking work? • Do these differ for men and women?	
• How are men and women coping with the effects of this condition? – How does sex, or other biological factors, affect the coping strategies for this condition? – How do gender norms, roles and relations affect the coping strategies for this condition? – Do access to and control over resources matter when coping with this condition? • Do these differ for men and women? How?	

How do we answer Gender Analysis Questions?[1]

- data from **secondary and published sources**
- **rapid appraisals** using both quantitative and qualitative methods such as gathering health services data or **interviewing major stakeholders**
- **condition-specific expertise** on epidemiology and ways of getting, preventing and treating the disease
- studies of **knowledge, attitudes and practices**
- **consultations** with local women, men and health care providers
- reports from **NGOs**
- data from regions or countries with **similar demographic, cultural, political and economic contexts**

Gender analysis is..[31,32,45,46]

... Purposeful

When public health actors engage in gender analysis, it is to:
- **address harmful gender norms** that increase health risks for women or men; and
- **transform institutional mechanisms** to promote gender equality in the way public health activities are developed, delivered and monitored

... Participatory

Addressing harmful gender norms, roles and relations requires **understanding the reasons** why certain practices or beliefs are upheld. This requires **working in collaboration with women and men in communities** to develop acceptable responses and solutions.

... Partnership-based

Working with partners from other sectors to achieve common goals of social justice and improved health outcomes for men and women is crucial. Working **across departments, offices and sectors** is the only way to ensure sustainable success.

Progress Check

I know or understand	Not at all	Somewhat	Well
What a gender analysis is and what its benefits are in public health work.			
What gender and health-related considerations are in a gender analysis of a health problem.			
How to answer Gender Analysis Questions (GAQ)			
The components of Gender Analysis Matrix (GAM)			

5 minute break

Module 3: Action-Developing Gender Responsive Actions

Gender Analysis Tools

- Indicators to assess women empowerment
- Gender Analysis Questions (GAQ)
- Gender Analysis Matrix (GAM)
- **Gender Responsiveness Analysis Scale (GRAS)**

Gender-Responsive Policies and Programmes[1]

- Ensuring that existing policies and programmes can **reduce gender-based health inequities** requires assessing them for their degree of gender-responsiveness.
- For a policy or programme to be gender-responsive, it must fulfil two basic criteria:
  - Gender norms, roles and relations are considered; and
  - Measures are taken to actively reduce the harmful effects of gender norms, roles and relations – including gender inequality.

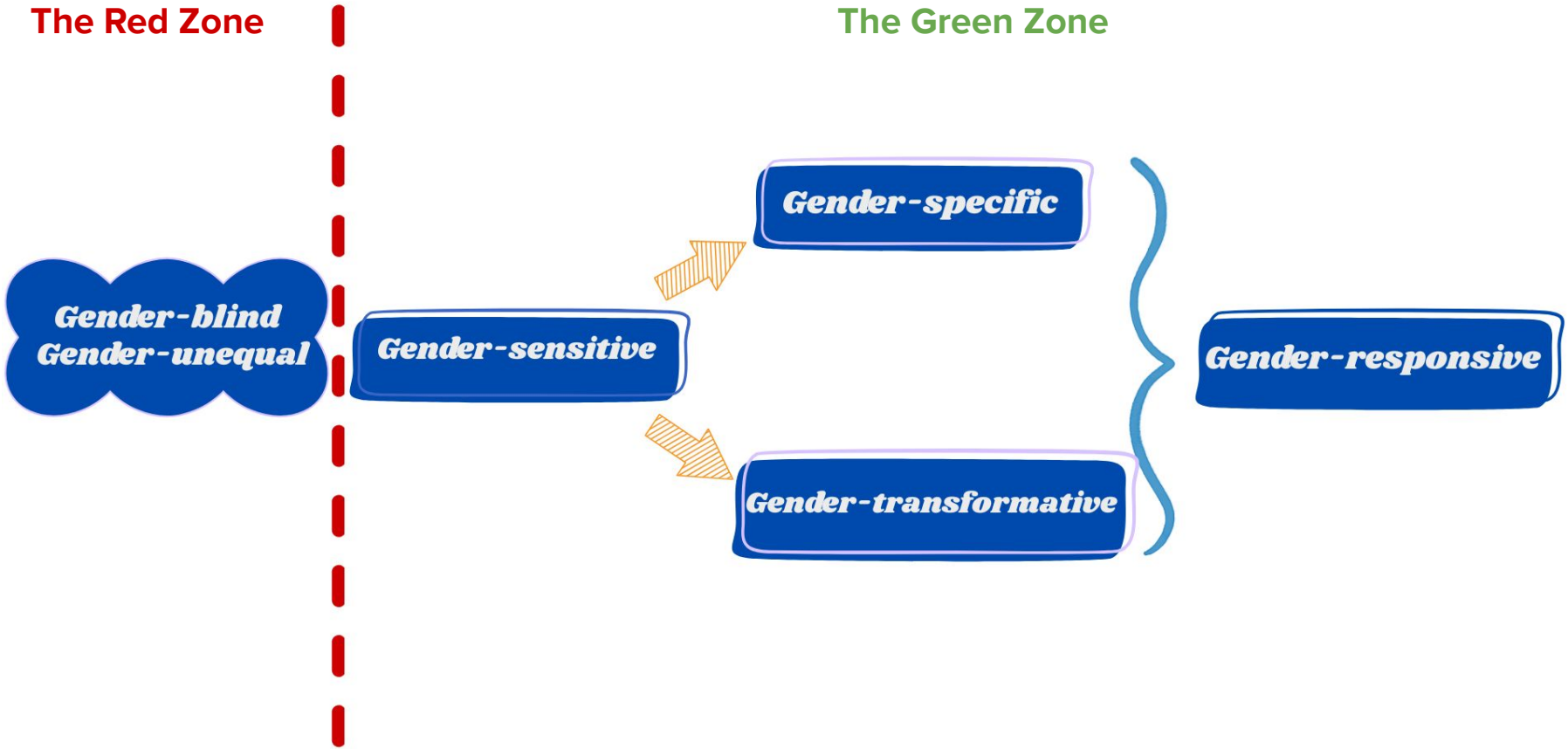
Gender-Responsive Policies and Programmes[1]

- Ensuring that existing policies and programmes can reduce gender-based health inequities requires assessing them for their degree of gender-responsiveness.
- For a policy or programme to be gender-responsive, it must fulfil two basic criteria:
  - **Gender norms, roles and relations are considered**; and
  - Measures are taken to actively reduce the harmful effects of gender norms, roles and relations – including gender inequality.

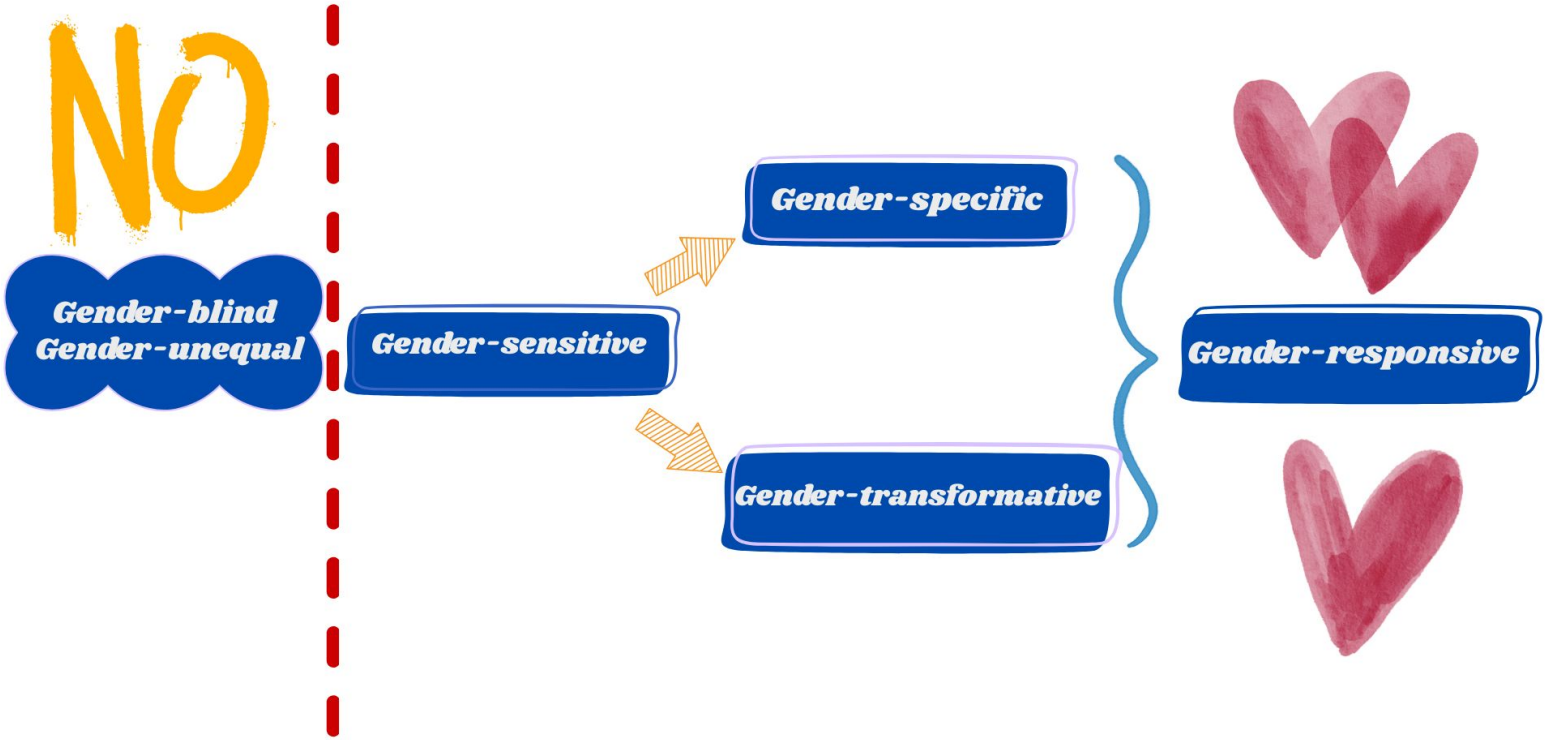
Gender-Responsive Policies and Programmes[1]

- Ensuring that existing policies and programmes can reduce gender-based health inequities requires assessing them for their degree of gender-responsiveness.
- For a policy or programme to be gender-responsive, it must fulfil two basic criteria:
  - **Gender norms, roles and relations are considered**; and
  - Measures are taken to **actively reduce the harmful effects of gender norms, roles and relations** – including gender inequality.

Gender Responsive Assessment Scale



Gender Responsive Assessment Scale



The five levels on the gender responsiveness scale[1]

- Level 1: Gender-unequal
  - **Perpetuates gender inequality** by reinforcing unbalanced norms, roles and relations
  - Privileges men over women (or vice versa)
- Level 2: Gender-blind
  - **Ignores** gender norms, roles and relations
  - Often **reinforces gender-based discrimination**
  - Ignores differences in opportunities and resource allocation for women and men
  - Often constructed based on the **principle of being "fair"** by treating everyone the same

The five levels on the gender responsiveness scale[1]

- **Level 1: Gender-unequal**
  - **Perpetuates gender inequality** by reinforcing unbalanced norms, roles and relations
  - Privileges men over women (or vice versa)
- Level 2: Gender-blind
  - **Ignores** gender norms, roles and relations
  - Often **reinforces gender-based discrimination**
  - Ignores differences in opportunities and resource allocation for women and men
  - Often constructed based on the **principle of being "fair"** by treating everyone the same

The five levels on the gender responsiveness scale[1]

- Level 1: Gender-unequal
  - **Perpetuates gender inequality** by reinforcing unbalanced norms, roles and relations
  - Privileges men over women (or vice versa)
- **Level 2: Gender-blind**
  - **Ignores** gender norms, roles and relations
  - Often **reinforces gender-based discrimination**
  - Ignores differences in opportunities and resource allocation for women and men
  - Often constructed based on the **principle of being "fair"** by treating everyone the same

The five levels on the gender responsiveness scale

- Level 3: Gender-sensitive
  - Considers gender norms, roles and relations, but **doesn't address the resulting inequalities**
  - Indicates gender awareness, although often **no remedial action is developed**
- Level 4: Gender-specific (The Green Zone)
  - Considers gender norms, roles and relations and how they affect access to and control over resources
  - Considers women's and men's specific needs
  - Intentionally targets and benefits a specific group to achieve certain policy or programme goals or meet certain needs
  - Makes it easier to fulfil duties that are ascribed based on gender roles

The five levels on the gender responsiveness scale[1]

- **Level 3: Gender-sensitive**
  - Considers gender norms, roles and relations, but **doesn't address the resulting inequalities**
  - Indicates gender awareness, although often **no remedial action is developed**
- Level 4: Gender-specific (The Green Zone)
  - Considers gender norms, roles and relations and how they affect access to and control over resources
  - Considers women's and men's specific needs
  - Intentionally targets and benefits a specific group to achieve certain policy or programme goals or meet certain needs
  - Makes it easier to fulfil duties that are ascribed based on gender roles

The five levels on the gender responsiveness scale[1]

- Level 3: Gender-sensitive
  - Considers gender norms, roles and relations, but **doesn't address the resulting inequalities**
  - Indicates gender awareness, although often **no remedial action is developed**
- **Level 4: Gender-specific (The Green Zone)**
  - Considers gender norms, roles and relations and how they affect access to and control over resources
  - Considers women's and men's specific needs
  - Intentionally targets and benefits a specific group to achieve certain policy or programme goals or meet certain needs
  - Makes it easier to fulfil duties that are ascribed based on gender roles

The five levels on the gender responsiveness scale[1]

- Level 5: Gender-transformative **(The Absolute Best)**
  - Considers gender norms, roles and relations and that these affect access to and control over resources
  - Considers women's and men's specific needs
  - Addresses the causes of gender-based health inequities
  - Includes ways to transform harmful gender norms, roles and relations
  - The objective is often to promote gender equality
  - Includes strategies to foster progressive changes in power relationships between women and men

The five levels on the gender responsiveness scale

- **Level 5: Gender-transformative (The Absolute Best)**
  - Considers gender norms, roles and relations and that these affect access to and control over resources
  - Considers women's and men's specific needs
  - Addresses the **causes of gender-based health inequities**
  - Includes ways to **transform harmful gender norms, roles and relations**
  - The objective is often to **promote gender equality**
  - Includes strategies to **foster progressive changes in power relationships** between women and men

Summary of GRAS[1]

- Gender-transformative strategies require **equalizing current power relationships among women and men** and among various types of decision-makers, as well as involving local populations and a range of stakeholders.
- **Meaningful participation** is needed in developing policies and programmes to ensure sustainable outcomes.
- Fully implementing gender-transformative strategies is an important **goal of gender mainstreaming** – and is best conceptualized in the **long-term**.
- Nevertheless, success often requires **complementary short- and medium-term strategies** – which need to be gender-specific.

Summary of GRAS[1]

- Gender-specific strategies acknowledge the differences in norms and roles for women and men and any associated differential access to and control over resources.
- These strategies accommodate women's and men's different roles, norms and responsibilities and their specific needs within a programme or policy.
- **In summary, people who work in public health should aim for gender-specific and gender-transformative strategies. The two are complementary, progressive steps towards mainstreaming gender into public health activities.**

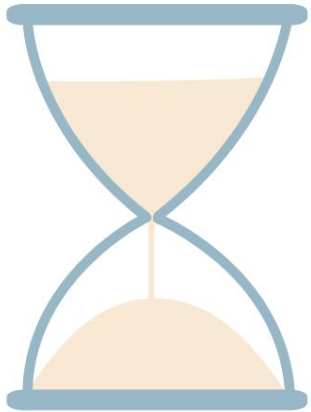
Summary of GRAS[1]

- Gender-specific strategies acknowledge the differences in norms and roles for women and men and any associated differential access to and control over resources.
- These strategies accommodate women's and men's different roles, norms and responsibilities and their specific needs within a programme or policy.
- **In summary, people who work in public health should aim for gender-specific and gender-transformative strategies. The two are complementary, progressive steps towards mainstreaming gender into public health activities.**

Final Check

I know or understand	Not at all	Somewhat	Well
What GRAS is			
What are the five levels on GRAS			
What are gender responsive policies and programmes			
How to analyse a health policy or intervention using GRAS			

Let's apply our learnings!



20 - 30 mins

Workshop Activity: Analysing the level of a health intervention or policy on the Gender Responsive Assessment scale[1]

Can you identify the GRAS level for the following example?

Mr and Mrs ABC live in country P, in which residents need private health insurance or pay out of pocket to get health care. Mr ABC is unemployed, but his wife works as a primary school teacher. However, in country P, the national policy entitles men but not women to include dependents on employment benefits such as health insurance.

Therefore, the only person in the ABC household who has health insurance is Mrs ABC. Her husband and children are not covered. If Mrs ABC were a man, a wife or children would be covered under his health insurance. But since she is a woman, no one in the household (besides herself) has any health insurance through employment benefits. **Is this policy gender-responsive?**

Exercise 1: Solution

Is this employment policy gender-responsive?
Which GRAS level is this employment policy?
Why?

Exercise 1: Solution

Is this employment policy gender-responsive? No
Which GRAS level is this employment policy?
Why?

Exercise 1: Solution

Is this employment policy gender-responsive? No
Which GRAS level is this employment policy? Gender-unequal or gender-blind.
Why?

Exercise 1: Solution

Is this employment policy gender-responsive? No
Which GRAS level is this employment policy? Gender-unequal or gender-blind.
Why? Gender-unequal: the policy privileges men's access to health insurance over women's through employment-based benefits.

Exercise 1: Answers[27]

Is this employment policy gender-responsive? No.
Which GRAS level is this employment policy? Gender-unequal or gender-blind.
Why? Gender-unequal: the policy privileges men's access to health insurance over women's through employment-based benefits.
Gender-blind: the policy assumes that men are the main income earners for the family. It follows, then, that their families (wife and children) are protected under their benefits. **The assumption follows that women do not engage in paid employment** and are not responsible for providing social benefits for family members such as dependent benefits, including health insurance coverage.

Case Study: Yari Dosti, India [47]

Yari Dosti, conducted over a six-month period between 2005 and 2006 in Mumbai, aimed to **improve gender-equitable attitudes** to prevent HIV transmission and **reduce sexual health risk** among low-income men 18–29 years old. The men were encouraged to explore the effect of gender norms on themselves, their partners and women and men in general and how these influence sexual health.

The project began with formative research in the study area to determine the **effect of prevalent gender norms on men's behaviour and attitudes and the risks for sexual health**. Men from local communities who expressed opposition to prevalent sexist norms and beliefs were chosen to act as "peer leaders". They received training and conducted qualitative interviews with men in the target age group with the support of the researchers. Peer leaders also conducted focus group discussions with young women and local leaders.

The intervention was designed based on this formative research and involved a series of participatory sessions in which peer leaders acting as facilitators encouraged exploration, critical thinking and debate on topics related to gender norms and sexual health: negotiation around condom use, preventive and risky behaviour for transmission of HIV and STI, violence between intimate partners and others, sexuality, gender and reproduction. Sessions were weekly and lasted for several hours each.

Qualitative interviews, focus group discussions and surveys using a scale to **assess gender-equitable attitudes** were conducted before and after the intervention. The participants reported **more gender-equitable beliefs** after the intervention.

Most participants were drawn to the educational sessions because they wanted to learn about disease risk and reproductive biology. However, over time, the men found the discussions on **gender dynamics and power imbalances** between men and women engrossing and informative. The peer leaders felt that most participants denied the often negative effects of prevailing gender norms, roles and relations when the programme started, but eventually most men accepted the importance of change and **wanted to challenge aspects of gender socialization**.

Some participants expressed difficulty at integrating their new, more gender-equitable ideas into their lives and relationships. For example, one participant who dropped out of the programme stated the following: **"I have lost intimacy with friends [because of the change in my attitudes] .... Losing friends makes me unhappy".**

Case Study: Yari Dosti, India [27]

GRAS level	Your assessment	Comments and insights
Gender-unequal		
Gender-blind		
Gender-sensitive	✓	The programme **acknowledges the influence of gender norms, roles and relations** on men's and women's sexual and reproductive health
Gender-specific		
Gender-transformative	✓	Although the participants were all men, it **addresses underlying causes of gender differences**: attitudes that perpetuate inequality. The programme's goal was to **transform men's attitudes** to achieve better relations between men and women. Yari Dosti intended to benefit both men and women by **addressing harmful gender norms, roles and relations**


Thank you!

Connect with us!

CYGEN: https://www.instagram.com/cygenetwork/

RCS: https://linktr.ee/royalcwsociety

Warda Batool: linkedin.com/in/wardabatool-health
wbatool.substack.com

References

1. World Health Organization. Gender mainstreaming for health managers: a practical approach: participant's notes. Geneva: World Health Organization; 2011.
2. World Health Organization**.** *Fuel for life: household energy and health.* Geneva: World Health Organization; 2006.
3. Ghaffar A, Hyder AA, Masud TI. The burden of road traffic injuries in developing countries: the 1st national injury survey of Pakistan. *J R Inst Public Health.* 2004;118:211–217.
4. Moutaery KA, Akhdar F. Implications of road accidents in Saudi Arabia. *Pan Arab J Neurosurg*. 1998;2:2.
5. Roudsari BS, Sharzei K, Zargar M. Sex and age distribution in transport-related injuries in Tehran. *Accid Anal Prev.* 2004;36:391–398.
6. Toroyan T, Peden M, editors. *Youth and road safety.* Geneva: World Health Organization; 2007.
7. World Health Organization. *Gender and road traffic injuries.* Geneva: World Health Organization; 2002.

References

8. World Health Organization Regional Office for South-East Asia. *Women of South-East Asia: a health profile.* Delhi: WHO Regional Office for South-East Asia; 2000.

9. García-Moreno C, et al. *WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses.* Geneva: World Health Organization; 2005.

10. Payne S. *Gender in lung cancer and smoking research.* Gender and Health Research Series. Geneva: World Health Organization; 2005.

11. Sen G, George A, Östlin P. *Unequal, unfair, ineffective and inefficient: gender inequity in health. Why it exists and how we can change it.* Final report to the WHO Commission on Social Determinants of Health. Geneva: World Health Organization; 2007.

12. World Health Organization. *Gender, health and ageing.* Geneva: World Health Organization; 2003.

13.Noorbala AA, et al. Mental health survey of the adult population in Iran. *Br J Psychiatry.* 2004;184:70–73.

14. Mumford DB, et al. Stress and psychiatric disorder in urban Rawalpindi community. *Br J Psychiatry.* 2000;177:557–562.

References

15. World Health Organization Regional Office for Europe. *Fatherhood and health outcomes in Europe.* Copenhagen: WHO Regional Office for Europe; 2007.

16.Sen G, George A, Östlin P. *Unequal, unfair, ineffective and inefficient: gender inequity in health. Why it exists and how we can change it.* Final report to the WHO Commission on Social Determinants of Health. Geneva: World Health Organization; 2007.

17. Temin M, Levine R. *Start with a girl: a new agenda for global health. A girls count report on adolescent girls.* Washington (DC): Center for Global Development; 2009.

18. World Health Organization. *Policy approaches to involving men and boys in achieving gender equality and health equity.* Geneva: World Health Organization; [in press].

19. Watts S. The social determinants of schistosomiasis. In: Report on schistosomiasis. Report of the Scientific Working Group Meeting on Schistosomiasis; 2005 Nov 14–16; Geneva. Geneva: World Health Organization on behalf of the Special Programme for Research and Training in Tropical Diseases; 2006.

20. Messing K, Östlin P. *Gender equality, work and health: a review of the evidence.* Geneva: World Health Organization; 2006.

References

21. World Health Organization Regional Office for Europe. *Fatherhood and health outcomes in Europe.* Copenhagen: WHO Regional Office for Europe; 2007.

22. García-Moreno C, et al. *WHO multi-country study on women's health and domestic violence against women.* Geneva: World Health Organization; 2005.

23. Douglas Scott S, Pringle A, Lumsdaine C. *Sexual exclusion – homophobia and health inequalities: a review. A review of health inequalities and social exclusion experienced by lesbian, gay and bisexual people.* London (UK): Gay Men's Health Network; 2004.

24. Temin M, Levine R. *Start with a girl: a new agenda for global health. A girls count report on adolescent girls.* Washington (DC): Center for Global Development; 2009.

25. United Nations. *Review of the implementation of the Beijing Platform for Action and the outcome documents of the Special Session of the General Assembly entitled "Women 2000: Gender equality, development and peace for the twenty-first century".* New York: United Nations; 2004. Report No.: E/CN.6/2005/2.

26. World Health Organization. Gender and health. Geneva: World Health Organization; 2021 May 24 [cited 2026 May 7]. Available from: WHO Gender and Health

27. World Health Organization. *Gender mainstreaming for health managers: a practical approach*. Geneva: World Health Organization; 2011

References

28. Oxfam Williams S, Seed J, Mwau A. *The Oxfam gender training manual*. Oxford: Oxfam UK and Ireland; 1994.

29. Reeves H, Baden S. *Gender and development: concepts and definitions* [Internet]. Brighton: BRIDGE, University of Sussex; 2000

30. World Health Organization. *Gender analysis in health: a review of selected tools* [Internet]. Geneva: World Health Organization; 2002

31. Medical Women's International Association. *Training manual for gender mainstreaming in health*. Burnaby (Canada): Medical Women's International Association; 2002

32. Health Canada. *Exploring concepts of gender and health*. Ottawa: Health Canada; 2003.

33. Status of Women Canada. *Gender-based analysis: a guide for policy-making*. Ottawa: Status of Women Canada; 1996.

34. Health Canada. *Health Canada's gender-based policy*. Ottawa: Health Canada; 2000.

35. World Health Organization Centre for Health Development. *A toolkit for women's empowerment and leadership in health and welfare*. Kobe: World Health Organization Centre for Health Development; 2006.

References

36. Bonita R, Beaglehole R, Kjellström T. *Basic epidemiology*. 2nd ed. Geneva: World Health Organization; 2006

37. Farah Fikree, Omair Pasha. Role of gender in health disparity: the South Asian context. *BMJ*. 2004;328:823-826.

38. Rachel Jewkes, Jonathan Levin, Loveday Penn-Kekana. Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study. *Soc Sci Med*. 2003;56:125-134.

39. Hartigan P. The importance of gender in defining and improving quality of care: some conceptual issues. Health Policy and Planning, 2001, 16(Suppl. 1):7–12.

40. Ahmed S. Differing health and health-seeking behaviour: ethnic minorities of the Chittagong Hill Tracts, Bangladesh. Asia Pacific Journal of Public Health, 2001, 13:100–108.

41. Ahmed S et al. Changing health-seeking behaviour in Matlab, Bangladesh: do development interventions matter? Health Policy Planning, 2003, 18:306–315.

42. Ali M, De Muynck A. Illness incidence and health seeking behaviour among street children in Rawalpindi and Islamabad, Pakistan – a qualitative study. Child: Care, Health and Development, 2005, 31:525–532.

43. Giao PT et al. Early diagnosis and treatment of uncomplicated malaria and patterns of health seeking in Vietnam. Tropical Medicine and International Health, 2005, 109:19–25

References

44. Cottingham J et al. Transforming health systems: gender and rights in reproductive health. Geneva, World Health Organization, 2001

45. Gender analysis in health: a review of selected tools. Geneva, World Health Organization, 2002

46. March C, Smyth I, Mukhopadhyay M. A guide to gender-analysis frameworks. London, Oxfam GB, 1999.

47. Verma RK et al. Challenging and changing gender attitudes among young men in Mumbai, India. Reproductive Health Matters, 2006, 14:135–143.