

Purpose of the checklist

The checklist is meant to assist staff and consultants in implementing the Bank's policy and strategic objectives on gender and development (GAD) (see the Bank's Policy on Gender and Development, May 1998). It guides users through all stages of the project/program cycle in identifying the main gender issues in the health sector and in designing appropriate gender-sensitive strategies, components, and indicators to respond to gender issues.

ADB staff should use the checklist in identifying gender issues in the initial social assessment (ISA) during the fact-finding phase of project preparatory technical assistance (PPTA). Consultants should use it in carrying out more detailed social analysis during the PPTA. It should be emphasized, however, that not all questions are relevant to all projects, and the staff or consultant must select the questions that are most relevant in the specific context.

Guidelines on the preparation of gender-sensitive terms of reference for the ISA and the social analysis are also included, as are case studies from ADB's project portfolio, to demonstrate good practices in mainstreaming gender in health projects.

For project preparation, the checklist may be used together with the Bank's *Handbook for Incorporation of Social Dimensions in Projects* (1994), *Guidelines on Benefit Monitoring and Evaluation*, and *Briefing Papers on Women in Development* series. Other useful references are listed at the back of this brochure.

The checklist was prepared by Susanne Wendt and Shireen Lateef using preliminary work by a staff consultant, Penelope Schoeffel. Mary Ann Asico edited the text and Jun dela Cruz prepared the final layout. Marivic Guillermo provided production assistance.

Why is gender important in health projects?

Women have the right to enjoy the highest attainable standard of physical and mental health. Their enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. Because women are visible in the health-care system both as caregivers and as clients, there is a widespread misperception that health projects automatically address women's empowerment. Gender gaps in health status, in access and use of health services, and in health outcomes persist, signifying a need to address gender inequality in health sector reforms.

Women's health depends on economic and social improvements—in education, working conditions, and standard of living

In many developing countries the availability and quality of health care has been further reduced because of the deterioration of public health systems and the privatization of health-care systems without appropriate guarantees of universal access to affordable health care. This situation not only directly affects the health of girls and women, but also places disproportionate responsibilities on women. Their multiple roles, including their roles within the family and the community, are often not acknowledged; hence, they do not receive the necessary social, psychological, and economic support.

There is a widespread misperception that health projects automatically address women's empowerment

Human capital is the primary asset of the poor. Its development is of fundamental importance in reducing poverty. Every person must have access to primary health care and other essential services. Without such access the poor and their children will have little opportunity to improve their economic status or to participate fully in society. Poverty and gender are also interrelated factors underlying women's vulnerability to mental illness, to violence, and to stigmatization due to health problems, leading in some cases to their exclusion from society. However, the preva-

lence of violence against women across all social groups and its health consequences, dramatically illustrate that a focus on poverty alone is insufficient.

Health and well-being are also dependent on health-seeking behavior, and poor women and girls are least likely to have access to appropriate care or to seek adequate treatment.

Key issues

The Bank, in its health sector projects, seeks to promote primary health care strategies and to provide assistance to high-risk populations, particular the poor, children, and women of reproductive age. These principles favor projects that will include women, but care must be taken to get women actively involved in the planning and delivery of health interventions. Women's health is affected by their economic and social status;

therefore improving women's health depends, among other factors, on improving their standard of living, education, and working conditions. Planners should recognize women's role as providers and promoters of preventive as well as curative health care within the household and the community. Women must be seen as agents of change, and not only as beneficiaries of development interventions.

One area in which there should be a strong focus on women is the promotion of effective woman-to-woman services for maternal and child health. This area encompasses prenatal and postnatal monitoring and care, family planning information and resources, and general reproductive health care, including information about the risks and treatment of sexually transmitted diseases (STDs). The services should also cover child health, including immunization, infant growth monitoring, and advice about nutrition, hygiene and disease prevention, oral rehydration therapy, and so on. In many DMCs, unless the health-care providers are female, accessible, and culturally sympathetic, women will not take advantage of the services that are available or obtain information to improve their health and that of their families. A key gender and development (GAD) strategy for the health sector should therefore consist of training women in the health professions and encouraging the growth of participatory, community-based women-to-women health services.

But while there are important reasons to focus on women-to-women services, men must not be overlooked. Men may play key decision-making roles in

Health projects need to focus on women-to-women services—but men must not be overlooked

Promote the concept of men and women sharing responsibility for family and community health

the allocation of household resources, in decisions about family planning, and in community organizations. Both women and men must therefore be fully involved in projects that are aimed at improving family, reproductive, and community health. An effective public health program will combine woman-to-woman services with a family health approach and programs targeted at the men in all aspects of family, reproductive, and community health.

Box 1

Key Gender Issues for the Initial Social Assessment (ISA) in PPTA Fact Finding

- Identify and describe the target population. Disaggregate demographic data by gender. Consider how women and men differ in their roles and their economic, educational, and health status.
- Examine the differences between subpopulations. Point out differences in the roles, status, and well-being of women and men within these groups.
- Assess the target population's needs and demands in relation to the project. Consider whether women and men have different priorities and how these differences might affect the proposed project.
- Assess absorptive capacity. Consider how women and men will participate in the project—their motivation, knowledge, skills, and organizational resources—and how the project will fit into their culture and society.
- Identify government and non-government agencies and organizations with a focus on women or interest in improving the status of women that might contribute to the project.

Key questions and action points in the project cycle

This checklist follows a gender analysis framework and is flexible and adaptable. The premise of gender analysis is that women and men have different roles and status in the household, the community, and society, and therefore have different needs and priorities. Gender-differentiated data are collected to identify those different needs and priorities, as well as different knowledge, attitudes, and practices in the prospective project area. The information from the gender analysis will inform the design of the project and contribute to its efficiency and effectiveness. In examining the feasibility of a project and designing the project, two questions arising from the gender analysis should be asked:

- What are the practical implications of the different roles and status of women and men in the project area for the feasibility of the project and for the effective design of the project? How will the project recognize and accommodate the different roles of women and men?
- What is the strategic potential of the project for improving the status of women? How will the project affect women and men? How can the project contribute to long-term strategies for the empowerment of women?

Planners should recognize women's role as providers and promoters of preventive as well as curative health care within the household and the community

The checklist should be used in the initial social assessment (summarized in Box 1) during the fact-finding phase of project preparatory technical assistance (PPTA) and in the social analysis (summarized in Box 2) during the PPTA.

The ultimate purpose of the gender analysis is to assist in the design of development projects that will maximize the participation of both female and male beneficiaries and the benefits to them. The checklist is not all-inclusive. It is meant to be used in addition to general data necessary for project design.

Gender analysis will be carried out in two steps. Background data on gender-differentiated characteristics of the client population will be collected and analyzed in relation to the socioeconomic and cultural characteristics of the project area. The analysis will be used in planning projects and in all stages of the project cycle.

Box 2

Key Gender Issues for the Social Analysis and Design in PPTA

Participatory approach: Consult and involve women and men in project design and implementation.

Gender analysis

- Record the activities of women and men, and their respective access to and control of resources
- Analyze this information against the demographic, economic, cultural, social, legal, and institutional context.
- Apply the information and analysis to all phases of the project cycle.

Benefit monitoring and evaluation: Develop indicators that define the benefits to women and men.

Social analysis: On the basis of the gender analysis, establish the needs, demands, absorptive capacity, and institutional arrangements of the target population, and the potential adverse effects of the project on vulnerable groups in the population.

Cooperation with nongovernment organizations (NGOs), including those for women or with a focus on WID.

Gender issues in the health sector

Key questions

Household activities

- What is the gender division of labor among the client population? How are productive and reproductive roles (such as sexual division of labor within households, production of goods and services, and income earning) interrelated? Data should show differences in roles between older and younger women and men, and between boys and girls. In other words, who does what, where, how, when, and for how long?
- What are the broad income levels of the client population? Are there differences in income between females and males?
- Identify key facts about the social structure and organization (community organization, cultural perception and attitudes, marriage rules, land ownership pattern, etc.), by gender and socioeconomic status.
- What services (health, education, water and infrastructure, agricultural extension, law and justice) are provided in the project area and to whom? Consider differences in socioeconomic status as well as gender.
- What is the legal status of women? Do women have rights to self-determination (e.g., divorce, property rights, custody of children, decisions about reproductive matters)?

- Are divorced women socially stigmatized among the client population? Is sex segregation a norm? Are there restrictions on male/female interaction? Is there any reluctance on the part of women to consult male health-care providers?

Health status of the project population

- What are the most serious illnesses in the project area(s)? Are there gender differences in the incidence of particular diseases? What are the main causes of these illnesses (consider sanitation, diet, activity patterns)? What factors, other than reproductive, contribute to gender differences in the incidence of disease?
- What are the occupational health hazards in the targeted community? Consider exposure to pesticides, harmful chemicals from textile dyeing, toxic waste materials from electronics industries, etc. Are there gender differences? Are there particular risks to pregnant or lactating women?
- What is the extent of women's workload, and are patterns of sickness among women (malnutrition, anemia, and other diseases) explained by their occupational context?
- What information exists and can be collected regarding the mental health of women and men? Are there gender-related differences in incidence?
- What roles do women and men play in community health care?
- How do women and men explain common diseases and health problems?
- Who makes decisions in families about taking children to a health-care provider for treatment? Who decides whether medicine will be purchased?

TIP

Promote effective woman-to-woman services for maternal and child health



- Does the project mainly emphasize women's health in terms of their role as mothers? Is there a need for a broader focus on women's health?

Diet

- What type of diet is common in the client population? Do women and men, girls and boys have different access to food?
- Is food bought or grown? Are changes from subsistence to cash production affecting food supply or changing dietary patterns? What is the significance for the health status of women and men?
- For how many months do women usually breast-feed their children? Is there a difference in the duration of breast-feeding for girl and boy children? What are the cultural attitudes toward the duration of breast-feeding? Is bottle-feeding a common practice? What socioeconomic factors contribute to decisions to bottle-feed infants?
- According to cultural beliefs, is breast-feeding during pregnancy an acceptable practice?
- Are there food taboos for women during pregnancy and lactation?
- Are there differential patterns of growth between boys and girls in the same age group? Different diseases? Are these differences related to differential feeding patterns of girls and boys or other factors?
- What is the incidence of anemia among pregnant women in the target population?

**Make
primary
health
services
more
accessible
to poor
women by
lowering
their cost**

Gender issues in reproductive health

Key questions

Maternal risk factors and women's health

- What is the incidence of maternal deaths? What are the main maternal risk factors? What are the major clinical, environmental, and socioeconomic causes? Which age groups are the most at risk? What percentage of births are assisted by medically trained midwives?
- What are the childbearing years for women?
- What health problems among the client population predominantly affect women or are female-specific?
- Is violence against women prevalent in the project area? What community or health services are offered to abused women?
- Are there women-to-women services in maternal and child health programs (including reproductive health and family planning)? Does lack of women-to-women maternal and child health services constrain women from using health services?

Some strategies for gender-sensitive health projects

- Distribute relevant information on food and nutrition to improve the diet of women, children, and men in the client population.
- If violence against women is prevalent in the area, initiate measures to prevent violence against women. For example, wage campaigns to ensure that abused women have access to health centers and crisis centers.

Sexually transmitted diseases

- Are sexually transmitted diseases (STDs) a problem in the targeted community, for men? for women? Are there societal attitudes that constrain the population from recognizing or reporting such occurrences? Are there cultural constraints on measures to protect against the spread of STDs?
- How prevalent is HIV/AIDS among the client population? Is heterosexual transmission common?
- Is there a relationship between poverty and female sexuality that may contribute to the transmission of HIV/AIDS?
- If HIV/AIDS is a serious health problem, who care for AIDS sufferers?

Key strategies

Objectives and target groups

- Ensure that project objectives explicitly address inequality in access to health care and inadequate responses of health systems.

→ Ensure that the project objectives explicitly address the different health needs of males and females.

→ Ensure a broad focus on women's health, and not a limited focus on motherhood.

→ Ensure that the target groups identify their own health needs, by involving them in the design of the project. Also consider involving nongovernment or community-based organizations.

- Promote men's responsibility for sexual practices, domestic work, and child rearing, and decrease violence against women, by focusing on male behavior patterns (fertility decisions, reproductive practices, sexual behavior, violence), sexuality, and life skills.
- Promote women's autonomy in decisions about their sexuality and fertility, decision making in marriage, and sexual practices.

Data collection

- Collect sex-disaggregated data on health standards of males/females, women's/men's role in the health sector, the numbers and training levels of male and female health workers, preferences for male or female health workers, women's/men's use of and capacity to benefit from health-care services, etc.
- Collect sex-disaggregated data on decision-making patterns for family health needs, particularly for reproductive health.

Institutional strengthening

- Integrate in the project capacity-building activities in management and human resource development for women in the health sector.
- Assist the executing agency in recognizing the need and taking action to increase the number of female health service providers by recruiting and training women for all areas of health delivery, as village and community health workers, health educators, doctors, health administrators and managers, nurses, and midwives.
- Provide medical training to traditional birth attendants.
- Train schoolteachers working in the project area, as part of the project, to support initiatives aimed at changing food, hygiene, and sanitation habits, and attitudes regarding family planning that are detrimental to women or their families.

Ensure a
broad
focus on
women's
health
and not
just on
motherhood

- Refocus the staff and services toward client needs. Train health personnel to provide integrated services (e.g., family planning, safe abortion, violence, TB immunization).
- Provide training in gender sensitization and in gender planning and participatory approaches for the executing agency.
- Facilitate trust and partnership building between the communities and the formal health system. Improve the organization and training of local health services by establishing small projects to facilitate joint actions by communities and the health system.
- Link the health project to related policies and sectors, e.g., water and sanitation, education, agriculture.

Participation

- Improve the knowledge of the target groups about health matters, to enable them to participate in the improvement of health and associated services. Nongovernment or community-based organizations may be involved in such initiatives.
- To draw more women into the project, use interpersonal communication and the services of local women field workers. Engage NGOs to facilitate the involvement of women in project design and implementation.
- Ensure that women have access to all training activities provided by the project, by setting a quota for their participation.

Monitoring and evaluation

- Promote the development of qualitative and process-oriented gender-sensitive indicators of inputs, outputs, and outcome for program design and for monitoring and evaluation.

TIP

Train women in the health professions and encourage participatory, community-based health services



Gender issues in family planning

Key questions

What factors affect women's use of the available health facilities?

- Among couples or extended families, who makes fertility decisions?
- Are there sex-based differences in knowledge and attitudes regarding fertility decisions?
- What traditional methods, if any, do local women/men use to control fertility?
- Is the use of contraceptives legal in the country? Do women have access to contraceptives regardless of age, marital status, and number of children? Do women require the permission of males to obtain contraceptives or an abortion? What is the cost of contraceptives? How accessible are contraceptives to women and men?
- What is the family planning acceptance rate in the target population? What is the percentage of new acceptors each year? Which methods are most widely accepted?
- Are there information/education programs on family planning? Who offers them in the project area—NGOs and/or public-sector programs? Are they adapted for low-literacy populations? Do the programs target women or men, or both genders? Are the female and male users aware of the pros and cons of each method?

Design messages about population strategies, health and fertility for both women and men

- How acceptable are the family planning messages to women? to men? Are the messages culturally appropriate?
- Does family planning emphasize sterilization? Are there social or cultural problems associated with sterilization for women or men?
- Are there “quality of care” issues associated with the promotion of family planning? How do these affect women and men?
- How common is infertility? Which main groups suffer from infertility? What are the main causes and effects?
- How common is abortion (legal or nonlegal)? Is it legal? Which groups are primarily concerned? What are the effects on women’s health?
- Is sonar scanning or amniocentesis used in association with abortion for the sexual selection of offspring?
- What are the cultural and social attitudes toward unmarried mothers? toward children classified as “illegitimate”?

**Women are
agents of
change,
and not
merely
project
beneficiaries**

Key strategies

- Design separate gender-appropriate communication strategies for women and men.
- Design messages about development and population strategies, health, and fertility that are acceptable to both women and men.
- Develop curriculum guidelines and instruction materials for school programs on nutrition, hygiene, and family planning for boys and girls. Nutrition and reproductive health education for

Introduce special services for men, such as “exclusive” clinic hours and husbands’ day at the clinic

adolescent girls, in particular, will reduce maternal risk factors when they grow up.

- Use the mass media to provide follow-up information on project activities for nutrition, health, and family planning that will reach and be interesting to women.
- Involve women’s organizations, women’s groups or clubs, schools, unions, neighborhood associations, cooperatives, etc., to reach as many women in the project area as possible.
- Initiate information and education campaigns to promote the idea that men and women share equal responsibility for health in the family.
- Design communication strategies that target men with messages about birth spacing, family health, and family planning.
- Promote the responsibility of men as husbands and fathers in family planning and family health, through focus group discussions with health and family planning workers, community and religious leaders, NGOs, etc.
- Introduce special services for men, such as “exclusive” clinic hours and husbands’ day at the clinic.
- Consider networking with NGOs to promote men’s involvement in reproductive health.
- Assist women and men, in a gender-sensitive and culturally sensitive manner, in learning about their reproductive systems and functions, and obtaining accurate information about the different techniques, advantages, and disadvantages of contraception. Provide alternative means of contraception to women and men.
- Ensure that health practitioners are assisted in monitoring any possible side effects and problems arising from the use of contraceptives.

Gender issues in health delivery systems

Key questions

- How effective are health services for women and men in the client population? At the primary level? Secondary level? Tertiary level? Are primary levels being bypassed for higher levels of care?
- What socioeconomic or cultural constraints do people face in accessing health services at each level? Are there differences in access between women and men?
- What associated health services (water supply and sanitation improvement, other disease control measures) do women and men in the client population have access to? To what extent do women and men actively participate in planning and managing such programs?
- Are changes being proposed in the provision of health services that will change gender relations? How will the changes affect women? Will the changes be acceptable to women/men?
- What formal health delivery systems are available to the client population, both clinical and nonclinical? To what extent do women use them? What is the ratio of female users to male users?
- Are there women health workers in the community? What are their roles?
- Is recourse to traditional medicine and traditional healers common in the project area? Is traditional medical knowledge mainly the province of men or women? Are traditional practitioners mainly male or female? Are there female traditional birth attendants?

TIP

Design public health strategies that involve men as well

What health problems are female-specific?

- What traditional health measures are practiced locally? Do health delivery systems make use of traditional knowledge? Would an inventory of traditional notions and practices assist the program?
- What are the constraints preventing more women from being trained or being appointed as health providers?
- What factors reduce women's access to health services? Consider factors such as timing of services, lack of time for women, distance, lack of money for transportation, restrictions on women's movement in public, lack of female staff in clinics, lack of privacy for examination, complicated or intimidating procedures, poor facilities.

Key strategies

- Collect sex-disaggregated data on the use of formal and informal/traditional health services and access to medicine.
- If the intention is to strengthen basic health services, then focus on supporting primary health care units.
- Locate family planning clinics or health centers where they are conveniently accessible to women. Ensure that hours of service delivery fit in with women's work schedule.
- Improve the knowledge of the client population about health matters, to enable them to participate in improving health and associated services. NGOs or community-based organizations may be involved in such initiatives.
- Establish an emergency transport system in communities by supporting the currently most feasible methods of emergency transport and community commitment to transport women to hospital.

**Build
partnerships
with women's
and
community
organizations**

- Lower the cost of primary health services for poor individuals.
- Discuss gender issues, particularly the need for active participation by women as health providers and recipients of health services, with the executing agency/government ministry.
- Consider how women's groups and networks can be encouraged to assist women in learning about health issues and supporting one another.
- Consider whether the executing agency can link up with NGOs for service delivery, such as for the training of field workers, to involve men and women in the community. Provide enough funds for this.
- Ensure that the executing agency places sufficient emphasis and devotes adequate resources to training women as health providers at all levels of the health delivery system.
- Consider assisting the executing agency in recognizing the need and taking action to increase the number of female health service providers by recruiting women for all areas of health delivery, as community health workers, health educators, doctors, health administrators and manager, nurses, midwives, and paramedics.
- Encourage the executing agency to make use of the services of community groups or NGOs in the delivery of health-based services and family planning.

Ensure that women are trained as health providers at all levels of the health delivery system

Locate family planning clinics or health centers where they are conveniently accessible to women

Expose decision makers to gender issues

- ➔ If necessary, ensure that women are trained as health providers at all levels of the health delivery system.
- ➔ Set quotas for the number of women to be trained by the project and/or to be appointed to positions in the project, including supervisory positions.
- ➔ Train health workers to treat and support preventive measures for the health problems that primarily afflict women (such as backaches caused by carrying heavy loads on the head, anemia from poor diet or frequent childbirth, eye and lung diseases caused by cooking smoke, lack of rest during pregnancy).

Box 3

Population and Family Health in Viet Nam, 1994

Access to health-care services is a particular problem for women who are part of an ethnic minority, especially in remote mountainous areas. Special efforts need to be made to reach them. Ethnic minorities, for example, account for more than half of the population in three of the provinces served by the Population and Family Health Project in Viet Nam. To ensure that women members of these groups in remote mountainous areas have access to the improved health and family planning services provided under the project, two model outreach programs are being tested.

Village-level health posts are being established together with a hamlet-based "collaborator" network. Locally selected collaborators are being provided with bicycles to ensure that health care is available to the settlements when they need it. Paramedic staff trained within the ethnic communities supplement the collaborators. If successful, these outreach programs will be replicated in the other 12 provinces, where the project is upgrading and expanding health and

CASE STUDY

family planning services. Improved clinical training is also being provided to women health and family planning workers. More women are being trained as health workers, nurses, midwives, and doctors' assistants. To reach women unfamiliar with the services being offered, the project includes the use of innovative social marketing methods. Nontraditional outlets are being used to promote the new services, including the

tea shops widely frequented in rural areas. Well-known individuals in the communities, such as birth attendants and healers, are mobilized to complement more traditional approaches, such as in the sale of medicines. Through the project, thousands of Vietnamese women are starting to experience improved care in pregnancy and during deliveries. There is now access to a wider range of contraceptives for both women and men. As their health improves and they are able to control the birth spacing of their families, women are becoming better equipped to move out of poverty and into a productive life.

Strategies for gender mainstreaming in health projects

Analyze and understand how inequality between women and men affects their health

Initiatives that start with an appropriate understanding of gender inequality—the different ways in which the socioeconomic and cultural aspects of being male or female affect the health risks of individuals and their access to health services—are generally better able to promote and mainstream gender issues.

Address gender inequality in access to health care and responses of the health system

All good practices in regard to gender mainstreaming in health projects show that gender inequality in access to health care and the responses of the health system need to be addressed. It is important to recognize that women are barred from access not simply by limited or nonexistent services. Other socioeconomic and cultural factors prevent access, e.g., women's heavier workload, their lack of independent income, the unwillingness of families to invest in women's health, and cultural attitudes. In addition, the responses of the health system can be improved not just through more facilities, drugs, and staff but through a health system that has been reorganized and reoriented to promote access and client focus.

Facilitate
joint actions
by
communities
and the
health
system

Planners should recognize women's role as providers and promoters of preventive as well as curative health care in the household and the community. Women must be seen as agents of change, and not only as beneficiaries of development interventions.

Consult with all stakeholders, including women, and build partnerships with women's organizations

Consultation with all stakeholders is critical because it leads to a better understanding of issues and therefore a better identification of needs. Consultation and dialogue make the process transparent, valid, and credible, and thus help build consensus. The process itself can raise awareness about health and about the need to address aspects of gender inequality that affect women's health. All categories of stakeholders need to be identified and women's representation must be ensured. Women's organizations can play an important role in this respect.

Promote gender equality in strengthening national capacity

Capacity strengthening is needed in different places (e.g., government, NGOs, women's organizations) and at different levels (local, regional, and national). Capacity needs to be developed for different kinds of activities: from policy development by the national government and sector programs to management and administration, human resource planning, service delivery, management information system, and support for authentic consultation with civil society. The capacity to refocus services to client needs and manage change at all levels is critical. There is a need to expose decision makers at the highest level to gender-equality objectives and dialogue with stakeholders.

Recognize that men and women have different health needs

Box 4

Urban Primary Health Care Project, Bangladesh, 1997

Attention to women's health obviously needs to focus on the major concerns associated with pregnancy and childbirth. But there are other concerns, too. Domestic violence, for example, brings its own major health problems, which are starting to be tackled in health projects. In Bangladesh, for example, the project includes special measures to assist women victims of violence.

While 25 percent of female deaths in Bangladesh are maternity-related, nearly 29 percent are due to homicide or violent accidents, with the latter probably including some concealed homicides. The maternal mortality rate is estimated at 550 per 100,000 live births, and the country is one of only a few in the world where men have a longer life expectancy than women. High maternal mortality rates relating to inadequate medical services are a major factor, but there are also other contributing factors related to gender inequality. These include nutritional inadequacies among adolescent girls and young mothers, 70 percent of whom suffer from anemia; lack of access to the basic health services available to men; and violence against women either at home or in the community. Women compose more than 75


**CASE
STUDY**

percent of the estimated project beneficiaries, and assistance for women victims of violence is an important project component. Health centers being established in four cities are providing medical treatment for women victims of violence, referrals to legal counseling, and places of refuge. Health center staff are being trained to investigate cases of rape. The project also

includes a community education campaign to prevent violence and raise community consciousness about violence against women. To facilitate working women's access to the services, the health facilities remain open at hours convenient for them, including evenings, weekends, and holidays. The facilities are designed to ensure sufficient privacy for female patients, and are providing preventive, promotive, and curative health services, including immunization, micronutrients, family planning, prenatal, and basic curative, obstetrical, and other gynecological care, and health education. By improving family access to primary health care, the project is also expected to provide indirect benefits to women by reducing the amount of time they need to spend away from work looking after sick children and other family members.

Appendix

SAMPLE TERMS OF REFERENCE FOR GENDER SPECIALIST**Initial Social Assessment (ISA)
in PPTA Fact Finding**

- Identify and analyze poverty features and gender issues in the health sector, and suggest health sector instruments that will do most to reduce poverty.
- Identify and describe the target population. Disaggregate data by gender. Consider gender differences in access to health, health status, etc.
- Point out differences between subpopulations. Point out differences in health status and access to health facilities within these groups.
- Examine gender differences in knowledge, attitudes, practices, roles, constraints, need, and priorities in the health sector, and the factors that affect such differences.
- Examine the target population's needs and demands for the project: Consider, for example, whether females and males need different health facilities, and how this difference might affect the proposed project.
- Determine absorptive capacity. Consider how women and men will participate in the project—their motivation, knowledge, skills, and organizational resources—and how the project will fit into their culture and society. Identify constraints on women's/men's participation in health projects (fees, gender-based roles and responsibilities, etc.).
- Identify government agencies and NGOs, community-based organizations, and women's groups that can be used during PPTA and project implementation. Assess their capacity.
- Review the related policy and legal framework (abortion law, marriage law, etc.), as necessary.
- On the basis of the analysis, develop a gender-responsive and participatory project design and possible further sector work and policy/sector reform, if required.
- Development a gender-responsive M & E mechanism and indicators.

Social Analysis and Design in PPTA

- Ensure that women and men are consulted and involved in project design and implementation.
- Conduct gender analysis:
 - Identify the health of men and women and factors affecting their health, e.g., differences between men and women in degree of autonomy over their own bodies, higher risk of poverty among women, cultural practices, division of labor, workload or length of working day.
 - Identify men's and women's roles and responsibilities in the household and the community.
 - Identify differences in access to health services.
 - Assess the response structure of the health system (e.g., analyze the resources, attitudes, number of women employed, etc., of institutions).
- Examine the proposed institutional and organizational framework in relation to women's participation in the proposed intervention and their representation in the management of the project.
- Examine the proposed project with respect to its capacity to increase access and participation for major target groups, particularly the poor.
- Appraise the relevance of the proposed monitoring and evaluation system, including the availability and use of gender-disaggregated data and gender-sensitive indicators suitable for measuring women's participation and empowerment.
- Examine possibilities for cooperation with NGOs, including those for women or with a focus on GAD.
- Develop specific strategies and actions for inclusion in the project design to ensure that women participate in the project and benefit from it.

Selected References

- Australian Agency for International Development. 1997. *Guide to Gender and Development*.
- Bridge, 1998. *Gender, HIV/AIDS Transmission and Impacts: A Review of Issues and Evidence*. International Development Studies.
- Family Health International. 1998. *Women's Choice, Women's Lives: The Impact of Family Planning*. A synthesis of findings from the Women's Studies Project.
- _____. 1998. *Men and Reproductive Health*.
- Organization for Economic Cooperation and Development, Development Assistance Committee. 1999. *Reaching the Goals in the S-21: Gender Equality and Health*. Vol. 2.
- Swedish International Development Cooperation Agency. 1997. *Handbook for Mainstreaming. A Gender Perspective in the Health Sector*.
- United Kingdom Department for International Development. 1997. *Lessons Learnt: A Decade of Measuring the Impact of Safe Motherhood Programmes*.
- World Health Organization. 1998. "Gender and Health." A technical paper.
- _____. 1998. *World Health Report*.