'Gender Tools' provide questions and guidance to assess whether policies, programmes or research initiatives take into account differences between women and men in roles and responsibilities, access to resources and decision-making power; and what to do to not exacerbate gender-based inequalities.

This critical review examines the content of 17 widely used gender tools and their usefulness for gender analysis in health. The review is an invaluable resource for those working on gender and health, and in particular, for WHO staff working on gender.

Department of Gender and Women's Health
World Health Organization
20 Avenue Appia
CH-1211 Geneva 27
Switzerland

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Gender Analysis in Health *A Review of Selected Tools*

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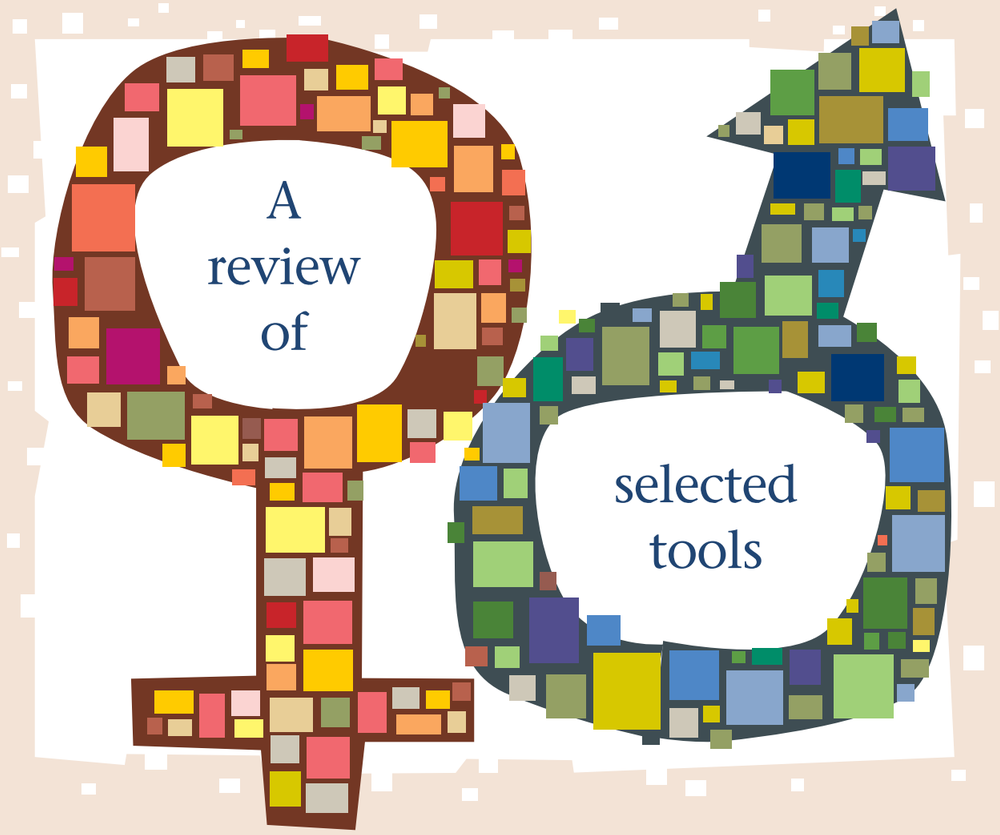

World Health Organization
Geneva, Switzerland

Gender analysis in health

A REVIEW OF SELECTED TOOLS

Department of Gender and Women's Health
World Health Organization

Tools are only useful when we know how to use them

—McDonald et. al. 1997:80

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Executive Summary

Purpose of the review

This critical review of tools for gender analysis and their application to health was carried out to support WHO's Gender Team in identifying possible strategies for implementing the Gender Policy for WHO. One component of implementation is providing WHO staff with support in a) understanding why it is necessary to address the impact of gender on health and health services and b) knowing how to address this impact as it pertains to their own field of work. Since many agencies facing similar tasks have developed tools for mainstreaming gender, it seemed appropriate for the Gender Working Group to consider their usefulness for health rather than immediately embarking on a process of developing its own tools.

This review is intended as background for use by anyone working on or interested in gender and health, and particularly by WHO staff working on gender issues. It assumes an understanding of the WHO Gender Policy for WHO, and of the challenges in mainstreaming gender. It is therefore written in a shorthand form, aiming simply to clarify the content of different tools, and to what extent they could be used in support of implementing WHO's Gender Policy. There is a complementary volume to this review which is designed as an educational tool for those not necessarily familiar with gender analysis, which provides an overview of gender tools that may be used for integrating gender issues in health.

Structure of the review

The introduction notes that institutions, and the tools they have produced, address gender issues from different perspectives and with different goals. Some aim to ensure women and men's equal participation in and benefit from social and economic development programmes. They do so with a view to ensuring maximum effectiveness of programmes. They usually also note the importance of ameliorating the negative impact of gender in-

equality. Others take as their starting point the goal of social justice. From this perspective, addressing gender aims not only to ensure that programmes are effective, but also ultimately to transform gender relations. There are two components to such transformation. Firstly, effort is made to ensure that women are no longer in a position of having lesser control over resources than men. Secondly, norms are changed such that women are valued equally to men, thus gaining the capacity to live their lives to their full potential.

The review is in two parts. After an introduction which describes the overall intention of gender mainstreaming tools, Part I presents an integrated review of tools. Part II gives a brief description of those aspects of the content of each tool that may be useful to WHO. This is followed by the list of full references for each of the tools reviewed and additional references made in the text. The framework developed and used for the analysis of these tools is included in Annex I. This framework, developed specifically for this review, shapes the structure of the review as described below.

Framework for analysis

The analysis of tools (Part I) is in two sections. The first section focuses on the general rather than health content of the tools under the categories of

- Gender analysis
- Situation analysis
- Research methods, monitoring and evaluation
- Strategies for programming
- Strategies for institutional change

This is because many of the tools are not developed specifically for health, but offer frameworks and explanations that can be applied to health. This analysis shows that the target of tools affects their level of analysis. Thus most tools developed by bilateral agencies focus on the macro-level of policy development. NGO tools and training tools tend to look more at implementation issues.

The second section of Part I looks at the extent to which each tool can contribute to understanding and addressing the impact of gender on the following dimensions of health and health care:

- Other social determinants of health and illness
- Health-seeking behaviour
- Quality of care
- Health promotion
- Impact of health financing
- Policy
- Consultation and Participation

Findings

In general the tools support problem identification through a series of questions that help detect manifestations of gender inequality or inequity. They assume the availability of data to provide answers to these questions. To the extent that such information exists, or that the user of the tool can apply these questions to gain insights from the field, the tools provide support in gaining an understanding of the problem. Moreover, the tools tend to stop there. Some tools provide examples of the sorts of activities that could be undertaken to address gender inequality and inequity. Others provide case studies that illustrate how a problem has been addressed in a specific place. The tools do not provide methodologies, details of how pilot interventions could be extended or other practical 'how to' guidelines for taking action.

Part I of the review ends by considering whether these tools can be useful to WHO. It concludes that most tools, and especially those that would give insights useful at the level of policy-making and programming, require prior skills in gender analysis. They also require the user to spend time focused on addressing gender alone, apart from the other dimensions of equity as well as the technical and organizational issues any intervention requires. From this perspective, the tools do not recognize the reality facing most users, which is that they are implementing interventions within a short time span, do not have gender and other social analysts at hand, and need to address a wide range of issues in an integrated way.

The framework for analysing the tools used in this review asks whether the tool provides information or asks questions in relation to a specific issue. It goes on further to ask whether the tool identifies actions, which the reader could take to address this

issue. It is this second dimension which is mostly missing from the gender tools reviewed here.

This raises some questions about both the nature of these tools and the role of tools in general. The review argues that many of these tools will not prove effective for implementers because they are too complex. They are, however, useful for training, to build the capacity of people in gender analysis. This is very helpful in an organization's strategies to mainstream gender. The methods and issues raised in the tools need to be taken up incrementally throughout the process of mainstreaming gender in any project or programme. That said, the review suggests that having a short tool can be one useful dimension of a broader intervention to mainstream gender in WHO. Such a tool would comprise of a few questions that can be used to screen ideas before they are taken up in action, and to alert officials to areas in which they may need to do further work. The broader mainstreaming approach will, however, have to take on long-term processes of changes in values and of skills building as no tool can overcome centuries of discrimination.

Tools assessed in this review

Part II provides a summary of those aspects of each tool that may be useful to WHO. In relation to each tool, it describes its purpose, content, and usefulness for analysis of health issues… as well as its limitations. It describes its analytical framework, lists the key questions it asks and notes the existence of, or actually includes checklists where they are not too large. The following is a list of tools which have been reviewed:

- ARROW (Asia-Pacific Resource and Research Organisation for Women): Women-centred and Gender-sensitive Experiences: Health Resource Kit
- AusAID (Australian Overseas Aid Program): Guide to Gender and Development
- CIDA (Canadian International Development Agency): Policy on Gender Equality
- CIDA (Canadian International Development Agency): Guide to Gender Sensitive Indicators
- Commonwealth Secretariat: Gender and Health: Curriculum Outlines
- DFID (UK Department for International Development): Gender Equality Mainstreaming (GEM) Information Resource
- DFID (UK Department for International Development): The Social Appraisal Annex for a Project Submission
- ECLAC (Economic Commission for Latin America and the Caribbean): Gender Indicators
- Elson and Evers: Sector Programme Support: The Health Sector. A Gender-aware Analysis
- Liverpool School of Tropical Medicine: Guidelines for the Analysis of Gender and Health
- OXFAM: Tool Kit: Concepts and Frameworks for Gender Analysis and Planning
- PAHO (Pan American Health Organization): Workshop on Gender, Health and Development: Facilitator's Guide
- Royal Tropical Institute, The Netherlands: Gender and Organizational Change
- Sida (Swedish International Development Cooperation Agency): Handbook for Mainstreaming. A Gender Perspective in the Health Sector
- UNFPA (United Nations Population Fund): Support for Mainstreaming Gender Issues in Policies and Procedures
- USAID (United States Agency for International Development): Gender Analysis Tool Kit (by the Futures Group)
- WHO (World Health Organization): Gender and Health Technical Paper

Recommendations

While the gender tools reviewed in this document help identify gender issues in health that need to be addressed, further work should be undertaken in support of WHO's Gender Policy in terms of identifying, evaluating, documenting and publishing useful methodologies on 'how to' go about addressing gender issues. These would be methodologies for integrating the processes required to integrate gender issues in health into the general process of policy development, programming and operational health systems research.

Gender tools may be helpful in supporting WHO staff mainstreaming gender at different levels. This

will, however, be but a small part of the overall process of operationalizing the Gender Policy. Substantial attention has to be given to building understanding of the need for, and commitment to, challenging gender inequities and inequalities within WHO and its programmes. In support of this process, WHO needs to build capacity both of management and programming staff in gender analysis, whilst also making it possible for them to draw upon expertise of gender analysts.

The Gender and Women's Health Department, the Gender Working Group and others employed as gender analysts to support implementation of the Gender Policy should have these tools and others, as they are developed, available for ongoing reference. Those responsible for building capacity of WHO staff in gender analysis should have access to the training-oriented tools for curriculum development purposes. In addition, some simple analytical tools should be developed for staff to take initial steps in integrating gender analysis into their ongoing work.

Tools are there to support broader processes undertaken at different levels in WHO, in line with its Gender Policy. The development of tools should therefore not become an end in itself, but should be followed by their successful application.

Introduction

THE DISADVANTAGED POSITION OF WOMEN in society is now internationally recognized as a breach of human rights and a barrier to development. It is now also recognized that women's subordination in society has been institutionalized through structures which organize social life in ways that marginalize women in important areas such as training, employment, policy-making, and planning, implementation and monitoring. This happens in various settings – within the family, in schools, and in commercial and political institutions. As a result, the content or priorities of such institutions reflect those of men, and in particular, of men from powerful and privileged social groups.

In the case of health, women's social, economic and political status undermine their ability to protect and promote their own physical, emotional and mental health, including their effective use of health information and services.

Expressions of gender inequity, whether in the relations between women and men or within institutions, need to be recognized and addressed. This is necessary both in order to redress discrimination on the basis of gender and to ensure that interventions in health involve and benefit those who have the least resources. In recognition of the role of gender-based inequities on the health of women and men, WHO has developed a Gender Policy 'to ensure that all research, policies and programmes/projects in WHO are designed from a gender perspective, and that this is accomplished in a systematic and sustainable manner. This will in turn increase their effectiveness and impact on equity of health interventions and contribute to achieving social justice, thus enabling WHO to carry out its mandate in providing global leadership in health' (1).

This critical review of tools for gender analysis in health was carried out to support those working on or interested in gender and health, and in particular, WHO staff working on gender issues. One component of implementation of WHO's gender policy is providing WHO management and staff with support in:

(a) understanding why it is necessary to address the impact of gender on health and health services and

(b) knowing how to address this impact as it pertains to their own field of work.

Since many agencies facing similar tasks have developed tools for gender analysis and mainstreaming gender, it seemed appropriate for WHO to consider their usefulness in health, before embarking on a process of developing its own tools.

The guidelines reviewed here were identified through two processes. Firstly, multilateral agencies were approached for copies of whatever guidelines or tools they currently use. Secondly, through a snowballing methodology, the author and a WHO counterpart sought to identify any tools currently being used by other agencies and by institutions in the field of health.

The guidelines reviewed are referenced in this document by agency rather than by author, except when they are not institutional products.

This review, although far from comprehensive, attempts to provide an understanding of the different types, scope and intentions of gender tools. In addition it provides a more detailed consideration of the extent to which health-specific tools might meet WHO's own needs.

The review is in two parts. After an introduction which describes the overall intention of gender mainstreaming tools, Part I presents an integrated review of the tools, and is divided into two sections. The first section focuses on the general rather than health content of the tools, because many of the tools are not developed specifically for health, but offer frameworks and explanations which can be applied to health. The second section of Part I looks at

Box 1
Definitions of 'mainstreaming gender' and 'gender analysis'

THE ECOSOC RESOLUTION DEFINES MAINSTREAMING GENDER AS:

"...the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres, such that inequality between women and men is not perpetuated. The ultimate goal is to achieve gender equality[1]".

"Mainstreaming gender is both a technical and a political process which requires shifts in organisational cultures and ways of thinking, as well as in the goals, structures and resource allocations .... Mainstreaming requires changes at different levels within institutions, in agenda setting, policy making, planning, implementation and evaluation. Instruments for the mainstreaming effort include new staffing and budgeting practices, training programmes, policy procedures and guidelines[2]".

Gender analysis, that is, an examination of the relationships and role differences between women and men, is the first step of a mainstreaming strategy. Gender analysis identifies, analyses and informs action to address inequalities that arise from the different roles of women and men, or the unequal power relationships between them, and the consequences of these inequalities on their lives, their health and well-being. The way power is distributed in most societies means that women have less access to and control over resources to protect their health and are less likely to be involved in decision-making. Gender analysis in health therefore often highlights how inequalities disadvantage women's health, the constraints women face to attain health and ways to address and overcome these constraints. Gender analysis also reveals health risks and problems which men face as a result of the social construction of their roles.

1. E/1997/L.30 Para Adopted by ECOSOC 14.7.97. (The WHO Technical Paper on Gender and Health provides more detailed information on mainstreaming gender in health).

2. Development and Gender, Issue 5: Approaches to institutionalising gender, Gender in Brief, Institute of Development Studies, University of Sussex, England, May 1997.

the extent to which each tool can contribute to understanding and addressing the impact of gender on specific dimensions of health and health care.

Part II provides a summary of those aspects of each tool that may be useful for application in the area of health. In relation to each tool, it describes its purpose, content, and usefulness for health as well as its limitations. It describes its analytical framework, lists the key questions it asks and notes the existence of checklists or actually includes these if they are not too large.

Annex I contains the framework developed and used for the analysis of these tools. This framework, developed specifically for this review, shapes the structure of the review.

Who are the targets and what are the purposes of different tools?

Although most donor tools express the hope that they will be useful to others, their primary concern is to ensure that their own staff and consultants address gender issues according to the organization's own policies and systems. These tools are usually addressed to their programme officers. Their intention is to orient programme officers engaged in negotiations with counterpart ministries or other implementing agencies to the issues surrounding gender relations and gender inequalities.

Some tools go beyond orientation. The handbook produced by the Swedish International Development Agency (Sida) is educational and serves to motivate programme officers. It presents 'Initial questions for Sida staff', followed by a column, 'Why ask these questions?' This second column provides a motivation in terms of Sida's own policies, the commitment to gender equality and the need for interventions to be effective, providing very concrete explanations as to why specific issues need to be explored (2).

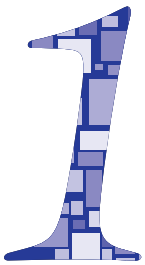
The Elson and Evers report (3), while not developed by donors, is likewise targeting the process of health sector programming undertaken by governments with donor consortia. The tools produced by 'NGO-donors', such as those published by the Royal Tropical Institute (4) and OXFAM (5) are likewise products of the donors' need to reflect on their own practice and to build a clear understanding of the methodologies which make greatest impact. Both of these are, however, created with the intention of being used by a greater range of users, including not only other donor organizations, but also NGOs and other development groupings.

The Liverpool School of Tropical Medicine (6) guidelines were produced for use by a broader target audience – researchers, donors, national governments and NGOs – as were the ARROW tools (7). They are less bound by the specific requirements or frameworks of donors.

Tools generally tend to be structured around planning cycles: country assessments followed by conceptualization of programming, followed by monitoring and evaluation. Since donor staff seldom become involved with the actual implementation process, the guidelines do not give the actual process of implementation as much attention. Following a logical framework, these guidelines remain at the levels of goals and purpose, rather than of specific objectives and activities.

Part I

Integrated Review of Tools



GENERAL CONTENT OF GUIDELINES, FRAMEWORKS AND TOOLS

TABLE 1 gives an overview of the different aspects addressed by gender tools examined in this review. It does not however tell us to what extent each of the aspects are dealt with in the different tools. Thus, both a tool which provides a two-page discussion on the role of research in policy development, and another which focuses extensively on research methods are represented equivalently in this table.

Table 1 What do different tools do?

Tools[1]	Clarifying concepts	Gender analysis (at context/policy/ institutional or programming levels)	Situation analysis/ policy analysis	Research methods/ M&E methods	Strategies for programming	Strategies for institutional change	Health focus	
							yes	Case studies or health 'sector' section
ARROW	◆	◆		◆	◆		◆	◆
AusAID	◆	◆		◆	◆			◆
CIDA Policy		◆			◆	◆		
CIDA Indicators				◆				◆
Commonwealth Secretariat	◆	◆			◆		◆	
DFID GEM	◆	◆		◆	◆	◆	◆	◆
DFID Annex			◆					◆
ECLAC				◆				◆
Liverpool School of Tropical Medicine	◆	◆		◆		◆	◆	
OXFAM	◆	◆	◆			◆		
PAHO	◆	◆			◆		◆	◆
Royal Tropical Institute	◆	◆				◆		
Sida	◆	◆				◆	◆	
UNFPA		◆			◆	◆	◆	
USAID	◆	◆	◆	◆	◆			◆
WHO	◆	◆		◆			◆	

1. See Part II for a detailed discussion of each of these tools

1.1. Gender analysis

WHO's Gender Policy 2000 includes as an objective 'to ensure that its policies, programmes and projects include analysis of gender issues in their activities in order to:

- increase the coverage, effectiveness and efficiency of WHO's programmes and projects;
- promote gender roles and relations that protect health, promote equality between women and men and contribute to the attainment of social justice; and
- provide information and policy advice to member States on the influence of gender on health and health care, based on both quantitative and qualitative data' (1, p.3)

Once organizations have committed themselves to promoting gender equity, or indeed, if evidence is required to convince an organization that it needs to promote gender equity, a gender analysis is a first step. It provides the information and interpretation of information that allows the institution to have an accurate understanding of the causes of the problem and the factors that would facilitate or constrain efforts to address inequities or inequalities in gender relations.

Most tools offer some methodology for gender analysis. All of the tools are framed within the 'gender' discourse – they are not about meeting women's needs specifically, but about addressing gender, that is the social construction of what it means to be a man or a woman. Beyond that, however, there are some differences in approach. The PAHO manual (8) describes these different approaches to enable a project planner to assess the nature of any project's approach to gender and the options for alternative approaches.

Some address 'gender' because it impacts on project effectiveness. Others want to address 'gender' because gender inequities are considered a social injustice. There is therefore a difference in intention. While all tools make some reference to the intention of improving women's lot, a social justice agenda – which is a transformative agenda – is much more explicitly articulated in some than in others.

The USAID tool (9.1), for example uses the concept of 'gender considerations in development', rather than, for example, 'mainstreaming gender'. The rationale given for this is that gender is a critical variable for sustainable socio-economic development. Efforts to identify gender differences and indeed gender inequality, are taken in order 'to ensure that women and men have an equal likelihood of benefiting from and contributing to sustainable development' (9.3). While some of the tools do suggest an intention of promoting equality, the overall focus is on effective development interventions.

Most tools, however, focus on gender in its own right and for its own sake. Tools with this perspective may point out that inattention to gender inequality and inequity could result in the failure of a policy or programme to meet the needs of those most in need. However, this critique is made from a social justice rather than an 'efficiency' perspective. For example, the CIDA Policy (10) offers guidelines on gender analysis, which cover 'what to ask' and then 'what to do'.

'What to ask' includes:

- who is the target, who will benefit and who will lose;
- have women been consulted and involved in development of the solution;
- does the intervention challenge the existing gender division of labour, tasks, responsibilities and opportunities;
- what is the best way to build on the government's commitment to the advancement of women;
- what is the relationship between the intervention and other action and organizations;
- where do opportunities exist for change;
- what specific ways can be proposed for encouraging and enabling women to participate despite their traditionally more domestic location and subordinate position; and
- what is the long-term impact in regard to women's increased ability to take charge of their own lives and to take collective action to solve problems (10).

'What to do' includes:

- gain an understanding of gender relations, the division of labour and who has access to and control over resources;
- include domestic (reproductive) and community work in the work profile;

- use participatory processes and include a wide range of female and male stakeholders at the governmental level and from civil society – including women's organizations and gender equality experts;
- identify barriers to women's participation and productivity; gain an understanding of women's practical needs and strategic interests and identify opportunities to support both;
- consider the differential impact of the initiative on women and men and identify consequences to be addressed;
- establish baseline data, ensure sex-disaggregated data, set measurable targets and identify expected results and indicators;
- outline the expected risks (including backlash) and develop strategies to minimize these risks (10).

Apart from differences in intention or purpose for which gender analysis is undertaken, the tools are also diverse in their approaches to 'gender' and to change. In relation to 'gender' some focus predominantly on roles – who does what. Others focus more on relations – the dynamic between women and men particularly as it pertains to control over resources. Resources are defined broadly to include information, decision-making (bargaining power), educational opportunities, time, income and other economic resources, as well as internal resources such as self-esteem and confidence. Tools which approach gender more in terms of the differences in power and in control over resources between women and men often consider gender relations at various levels – the home, community, national and international level. The focus on roles will support an understanding of who does what, and how this might impact on or should be taken into account for programme development. To promote changes in gender relations towards equity, however, a focus on gender relationships, and on access to and control over resources, is necessary. The balance between this differs across guidelines, rather than some guidelines taking exclusively one or the other approach.

The Sida handbook (2), drawing on the Platform of Action from the Fourth World Conference on Women, talks of strategies for 'mainstreaming gender', which implies going beyond the analysis to outlining strategies for dealing with the observed inequities. The handbook identifies two linked but different dimensions of gender mainstreaming. One dimension is to ensure 'equitable distribution of the resources, opportunities and benefits of the mainstream development process'. The second, and perhaps more central dimension of 'mainstreaming' is 'the inclusion of the interests, needs, experiences and visions of women in the definition of development approaches, policies and programmes and in determining the overall development agenda' (2).

While all guidelines and tools reviewed here make some reference to the importance of participation of women in problem identification, solution or policy development, implementation and evaluation, some give greater attention to the methodologies for this participation, the second dimension of gender mainstreaming mentioned in the Sida handbook.

However, a fundamental transformation of existing power relations may be necessary before women could reshape the policy agenda. Unfortunately, few guidelines examine the issue of transformation of existing gender power relations in a systematic way. Creating an opportunity for potential beneficiaries of a project to give input at each level is important, but it does not deal with the question of who decides on the nature of the project in the first place. It is at that initial level that the most insidious gender inequalities lie.

Those guidelines focusing specifically on institutional transformation such as MacDonald et al. (4) begin to consider fundamental questions of a reorientation in power relations. Fundamental questions are those related to the nature of gender relations – the allocation of power, responsibilities and resources – within academic institutions, departments of health and the like. It is only tools which address issues of gender power relations in society that have the potential to initiate a process of substantial changes in these, and in moving progressively towards gender equality.

In summary, all the tools aim to improve gender equity in society. Some intend to enhance project efficiency, while others are motivated by a social justice agenda. Within those motivated by a social justice agenda, again, some focus at the level of specific projects, aiming for women and men to benefit equally from an intervention, while others focus

more at the level of social transformation. Overall, most tools remain at the level of 'gender analysis', helping the user identify inequalities and inequities in the ways in which power relations exclude women. But few provide substantial support for the user in taking action to change current relations of power, or support a larger process of social transformation.

1.2. Situation analysis

A situation analysis is an analysis of the overall situation in which any policy or project is to take place. It considers international, national, community based, household and individual levels as well as specific institutions that relate to the problem concerned. In relation to these, it considers the impact of political, economic, social and cultural factors. It considers structural factors as well as circumstantial factors related to the particular moment in time. It identifies all of those affected by the policy or project, whether as decision-makers, as intended beneficiaries, as activists, or simply as people in the same space (whether geographical or in terms of interest) as the policy or project. It also outlines the extent to which they should be involved in the process, as well as the factors influencing their ability to be involved. A situation analysis should be framed within a social justice perspective, thus aiming to promote equity in relation to diverse issues which cause discrimination, and undermine health, access to health services and quality of health care. Gender inequalities and inequities should be included as one of these issues.

Many of the tools examined in this review identify gender issues in isolation. They function as additions to broaden processes of situation analysis and are intended to guide the user to insert key questions regarding gender into this broader process. In contrast, some donors, as reflected in the DFID Social Appraisal Annex (12), prefer to look at issues of human rights, poverty and vulnerability in a more integrated way. Their process of social analysis considers gender as one among several factors such as class, ethnicity or any other factors that limit a group's equal access to resources and opportunities. Other tools which follow an integrated approach, locating gender within the context of other social inequities, are the social relations approach developed by Kabeer in the OXFAM Tool Kit (5) and the USAID tools (9). These are described in greater detail in Part II below.

The advantage of an integrated approach is that it does not permit social justice issues to be treated as an 'add on'. Justice issues cannot be set aside to be dealt with after gender mainstreaming. Unfortunately, this is frequently the case in donor and government policy development and programming strategies. The integrated approach makes gender and social analysis a part of the problem analysis from the very outset.

1.3. Research methods, monitoring and evaluation

Research provides the basis from which a problem can be accurately understood. Research can also be used as a methodology for identifying solutions. Gender analysis tools help generate a 'gendered' research agenda through the questions they identify as necessary to ask when analysing a situation or planning a programme. In addition, they could help plan for a research process that allows for the voices of the women and men from the 'researched' group to be heard.

Gender analysis tools can help in assessing whether output and impact indicators, used for monitoring and evaluation of programmes and policies, are capable of identifying gender-gaps and differentials. They can also aid in the development of process indicators, which are capable of indicating how gender-sensitively the programme, or policy is being implemented.

Gender analysis tools identify questions that need to be asked to understand a given situation. In so doing they provide a research agenda. Some tools consider how the research process itself will influence findings The Liverpool School of Tropical Medicine guidelines (6), for example, provide a range of questions to consider in the formulation of research questions, the research process, and the analysis. These cover ethical issues, questions of study design, hypotheses and study groups, sampling, implementation and analysis.

A few tools give substantial attention to research methodology. The USAID tools (9), detailed

in Part II, explain some of the research methods necessary to undertake both situation analyses and monitoring and evaluation. They support the reader in considering the role of both quantitative and qualitative methods. The Tool for Development Project M&E Plans (9.4) in particular both provides an understanding of the role of different types of indicators and a discussion of what sorts of methodology can elicit these. It spells out the role of data gathering relative to the role of analysis.

Gender tools that are about indicators can help the user in working out how one would measure whether and how a project or programme had addressed gender issues. The CIDA Guide to Gender-sensitive Indicators (13) is very helpful on what constitute indicators, and in helping the user ensure realistic and measurable indicators. It could, through its case studies, spark ideas for the user as to project design, but it cannot of itself identify what constitutes gender-sensitivity, except in broad definitional terms. It also gives helpful inputs on indicators of participation and empowerment as key dimensions of mainstreaming gender.

Where these tools would be useful in identifying gender-related components of programming is for projects aimed at gathering of data, since they do identify some of the gender-related issues regarding how data is collected, such as the impact of having women enumerators on the sensitivity of data collected (13).

The ECLAC gender indicators (14) seek to measure government implementation of broad commitments, for example to implement the Platform of Action of the Fourth World Conference on Women. They provide guidance on how outcome indicators can help identify whether or not gender is being addressed. For example, birth rates among women below 20 years is an indicator of the situation of young women in a given country, and consequently, a rapid decline in birth rates in this age group may indicate that action has been taken in this regard. The indicator cannot, however, reveal whether the decline in birth rates among young women was achieved through gender-sensitive interventions.

The Women's Empowerment Framework, presented in the OXFAM Tool Kit (5) identifies different levels of equality: control, participation, conscientization, access, and welfare. It suggests evaluation of interventions to ascertain which level is being achieved, with the ultimate goal being that of control.

Elson and Evers (3) provide useful direction on the development of indicators which can assess the gender-sensitivity of various aspects of a programme process: in allocation of resources, in needs assessment at the community level, in programme management, in training, and in impact assessment of programmes.

1.4. Strategies for programming

The WHO Gender Policy cites the ECOSOC definition on mainstreaming gender as including 'the process of assessing the implications for women and men of any planned action'; 'a strategy for making women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes' (1, p. 2). Gender tools would therefore be expected to provide guidance of this process.

Programming issues are covered in many of the gender tools. This is usually at the level of asking questions to ensure that gender issues are identified in deciding on the programme content. Others deal also with addressing gender issues in programme design and strategies, such as ensuring that services are located in places and are scheduled for times such that they do not limit women's or men's access. Yet others start with an earlier step – of ensuring the participation of women and men in the processes and mechanisms through which programme content and strategies are decided upon, to ensure that issues of relevance to both genders are addressed.

The CIDA Policy, for example, has a simple listing of 'Good Practices to Promote Gender Equality' at the corporate level, in planning, during implementation and in performance measurement (10). They help guide programme content and process by providing questions that will help identify gender specific needs and gender differences in access to and control over resources and to use this in programme planning in terms of content and design.

The AusAID tool (15) too, offers broad questions, in relation to preparing of programmes, for example:

- Have constraints to women's and men's participation in the project been identified?
- Have strategies been identified to address these constraints?
- Have targets been set for women's and men's participation and benefits?

There are also questions in relation to health in particular, e.g.

- Is it socially acceptable for women to attend a health facility?
- Have constraints to women's and men's participation in project activities been identified? (both as health consumers and providers)

There are some very specific guidelines about programming content, such as those of UNFPA (16). These spell out what sorts of activities UNFPA can support in relation to its mandate regarding 'mainstreaming gender issues in population and development programmes', covering advocacy and 'action programmes'. Here it includes specific interventions such as 'training to ensure that all health service providers are gender sensitive' or 'assist in the reform of the school curricula to make them gender sensitive by removing gender stereotypes in language, messages and images'.

The Liverpool School of Tropical Medicine guidelines similarly ask questions, in some cases about whether specific actions have been taken, thus providing some direction regarding programme strategies and design (6). For example in relation to financing health care, 'Are financing options such as user fees assessed for their impact on different groups of women and men; what strategies to prevent any negative impacts could be devised' or in relation to service provision, 'Where is information about services available; Are these places equally used by women and men; How is information transmitted; Will this affect women and men differently. For example, are there differences in literacy rates' or 'Can people access services such as STD clinics without being noticed by community members'.

The DFID GEM Gender and Health Section (11.1) provides a 'Checklist for women's health and equity'. This has more detailed questions on 'Project Design' covering division of labour, decision-making, access, control, definition of key population (including differences between women from various social groups), current levels of knowledge on an issue among women and men; and process of deciding on project priorities. On 'Project Implementation/Monitoring' the questions are organized under structures for decision-making, service utilization, and service quality. Project Evaluation considers the process, impact on gender equity, impact on health and impact on policy. It serves as a helpful guide for the range of possible programming strategies.

The USAID Tool for Gender Informed Project Planning (9.4) offers steps, with analysis at each level, to inform the planning process. Once the steps are concluded, objectives will have been repeatedly reassessed on the basis of new information. This helps to bridge the gap between gender analysis and actual programming. For example, it explores the potential economic, technical and social gains and risks for the target population, and explicitly compares these for specific groups of women and men. It thus ensures that the steps taken have been interrogated in relation to their impact on women and men from different social groups. *It is the strongest practical programming tool of those reviewed for this report.* Its combination of participation and use of gender disaggregated information at each step of the planning process is central to the 'mainstreaming' approach.

Another programme planning model reviewed is the Moser Framework presented in the OXFAM Tool Kit (5). It has six components, which aim to ensure that gender is central to the planning process. The first tool, 'Gender roles identification/triple role' maps the gender division of labour. The second tool 'Gender needs assessment' identifies women's practical and strategic needs. The third, on 'Disaggregated data at the intra-household level', looks at who controls what within the household and who has what power of decision making. The fourth, 'WID/GAD policy matrix', is an evaluation tool for examining projects to determine which policy approach they take with respect to gender issues. The policy approaches presented in this framework are welfare, equity, anti-poverty, efficiency, and empowerment. Each of these approaches addresses gender issues differently, ranging from not taking them into account at all, to being committed to the transformation of gender power relations to

greater equality. Tool five, 'Linked Planning for balancing the triple role', assesses whether a project increases work in one of women's roles, to the detriment of another. Tool six, 'Incorporation of women, gender-aware organizations and planners into planning', argues for women's participation in order to ensure that real practical and strategic gender needs are addressed. These tools are applied to health in the PAHO manual, where provision of many case studies help the user to see how applying the tools generates insights about problems and opportunities for change (8).

The Sida handbook includes questions, which pertain to process, particularly to participation of various groups. It recommends "Consultations with women's health experts and equality advocates to assist in identifying objectives, targets and indicators relevant for a particular project" (2). The Gender Analysis Matrix described in the OXFAM Tool Kit offers a very specific method for bringing together communities who are affected by projects to collectively consider project impacts and how these should influence goals, in an ongoing monitoring process (5). Here the method itself helps to formulate the content of programming.

1.5. Strategies for institutional change

Institutional change to allow for mainstreaming gender is essential for WHO programming to achieve the goal of health equity. This issue needs to be addressed at two levels.

Firstly, for WHO's technical staff to address gender inequity in their activities they need to be based in an institution which promotes gender equality and equity in its own culture, management systems, priority setting and resource allocation. This requires WHO to ensure that its managers both understand and support the need for addressing gender relations. In addition, its staff have the capacity and resources to promote gender equity and equality in all of their work.

Secondly, institutional change issues need to be addressed in WHO's relationships with counter-part institutions – be they government departments of health, research institutions, or NGOs. The translation of a WHO intention for gender mainstreaming into practice will be affected by the extent to which the counterpart institution supports WHO's concern to address gender inequities. WHO may have to include as a criterion for selection of counterpart institutions for collaboration, the institutions' profile with respect to gender mainstreaming, or more proactively, help enhance the counterpart organizations' ability to address gender in their programmes and their institutional structures. This is particularly important in relation to health systems, since no new programme-specific intervention, whether on immunization, TB or violence against women, can be expected to address gender if the implementing organization does not have the resources or the policy commitment to do so.

Gender inequality is embedded in most institutions in society. This is for two reasons. Firstly men, usually those from educated, wealthy, and other privileged social groups, control most institutions. Over time, institutional goals, management styles, inter-personal culture, and in general, the 'way of doing business' is set according to male norms. When women take up leadership positions, it is this world that they enter and have to learn to work in. Secondly, institutions reflect the general social culture. If society does not value women's input, social institutions are unlikely to do so. If society does not give priority to women's health, health institutions are unlikely to do so. Yet many considerations of gender in relation to health tend to remain focused on women as users of services, or as service providers, rather than addressing the "health sector as a 'gendered structure'" (3).

Some tools provide pointers to the kinds of questions that need to be asked in order to ensure that the institutions, whether at a policy or programming level, take account of gender. The Sida handbook for example, provides a series of questions to ask during both project formulation and appraisal regarding the health ministry and other government institutions with which Sida is working (2). These range from the access of these institutions to sex-disaggregated data, and their political will and skills to formulate and analyse questions on the gender aspects of health status and health services, to whether they have processes for public participation in planning for health policy and services. In the evaluation phase, it includes questions such as 'will the evaluation consider project outcomes on institutional capacity in the health sectors; do direc-

tions to evaluators specify that this should include capacity with respect to women's health and gender issues in the sector'. Specific criteria the Sida handbook suggests in this regard include that an intervention should have enhanced capacity for generating sex-disaggregated data and for policy analysis that incorporates gender perspectives.

The DFID GEM Gender and Health Section's checklist for women's health and equity includes a series of questions on management issues (11.1). These include questions on the ratio of women and men staff at different levels; extent of staff training on gender-sensitive operating procedures, gender-sensitive research methodologies and service delivery practices; and gender-sensitive institutional arrangements to support change (e.g. transport, flexible working hours for parents, child care provision, sexual harassment complaint procedures, organizational objectives to achieve gender equitable representation). The checklist also has questions on commitment to gender equity. These questions explore knowledge levels of staff on gender issues. They also seek to find out whether there exist processes to build commitment to addressing gender inequities within the institutions concerned, and in the programming content they develop.

A few tools offer specific processes for institutional transformation. The CIDA Policy offers a series of actions for 'institutional strengthening and capacity development' (10). These include actions for promoting and supporting organizational change that contributes to gender equality; actively promoting positive images of women and their needs, interests and views; encouraging women's participation throughout the organization and developing strategies to increase their representation at decision-making levels. Further, the tools outline actions for supporting partners in developing their capacity to undertake gender analysis at the policy, program, and institutional levels. They also provide guidelines for programming that support gender equality; and for providing assistance for developing capacity at the national and sectoral levels to collect data and to make available sex-disaggregated data'. As this list indicates, the processes are inevitably from the position of a donor, but are nevertheless a useful basic guide as to what needs doing, as opposed to how to do it.

The Liverpool School of Tropical Medicine guidelines propose 'mainstreaming gender awareness in policy', and provide a list of enabling conditions for this. The guidelines also present a model 'the web of institutionalization' to alert the reader to the many dimensions which need to be addressed to mainstream a gender perspective in institutional policy and practice (6). The guidelines do not, however, go into much detail about how to address these dimensions. They also provide case studies of institutional transformation, which do outline to the reader the kinds of interventions that can be taken. Such information is helpful in alerting readers to the issues and may trigger ideas for their own area of interest.

The DFID GEM Health Sector Reform Section (11.2) includes a case study developed through a series of workshops amongst Commonwealth countries in four regions of the world. It uses the concept of a 'gender management system'. Essential resources for such a system include training in gender awareness, and in use of gender analysis in planning, design and implementation of health programmes; availability of staff time and expertise to co-ordinate, monitor and evaluate progress; and adequate administrative support. It provides the outline of what an action plan to mainstream gender should include and the roles of different stakeholders in managing it.

The Elson and Evers checklist identifies specific questions regarding the gender balance of the composition of the workforce in health institutions and particularly in policy-making posts (3).

Efforts to actually take on institutional change, however, would require more input than such guidelines can provide. There is substantial literature on organizational development and, likewise, on mainstreaming gender in institutions. For the purpose of guiding institutional change, tools specifically focusing on institutional transformation provide greater depth. The Royal Tropical Institute's book on 'gender and organizational change', for example, goes into much more depth, providing a rationale for addressing gender relations in institutions, questions to help analyse institutions and processes which can be undertaken to support institutional change (4).

Some of the frameworks presented in the OXFAM Tool Kit also provide specific methodologies for identifying the need for institutional transforma-

tion (5). The Social Relations Approach includes an accessible model for institutional analysis asking: who does what, who gains, who loses, which men and which women, in order to identify how institutions create and reproduce inequalities. The Social Relations Approach focuses on four sites: the state, the market, the community and family/kinship. The international community can be added. Within each institution, it considers five dimensions: rules (what is done, how, by whom and who will benefit); resources (what is used, what is produced including human resources, material resources and intangible resources such as information or political influence); people (who is in, who is out, who does what); activities (what is done, by whom, who gets what and who can claim what); and power (who decides; whose interests are served). Elson and Evers' report spells out some of this in relation to health institutions in their checklist for a Gender-Sensitive National Sector Framework (3).

Tools which address the issue of institutional transformation to promote equitable relationships and control over resources within institutions, are more likely to have a sustained impact on reducing gender inequity. They are more central to the proces of gender mainstreaming than other tools, which only help identify gender differences in needs and concerns.

2 APPLICABILITY OF GENDER TOOLS TO HEALTH

Some tools focus only on health. These are those produced by ARROW (7), the Commonwealth Secretariat (17), Elson and Evers (3), the Liverpool School of Tropical Medicine (6), PAHO (8), Sida (2), UNFPA (16) and WHO (18). The AusAID tool (15) is general but has a specific section on health. So do the ECLAC (14) and CIDA tools on indicators (13) and the DFID Gender Equality Mainstreaming tool (11) . The DFID Social Appraisal Annex (12) and USAID tools (9) are general but have the occasional case study on health, to illustrate a specific methodology or approach. The CIDA Policy (10) and the OXFAM (5) and Royal Tropical Institute (4) materials do not address health directly.

Table 2 Applicability of gender tools to health, health policy, standards and services

	Social construction of health & illness	Health seeking behaviour	Quality of care	Health promotion	Impact of health financing	Policy	Consultation & participation	Research & monitoring	Institutional management
ARROW			◆	◆		◆	◆	◆	
AusAID	◆	◆	◆		◆	◆	◆	◆	◆
CIDA Policy						◆			
CIDA indicators	◆	◆	◆				◆	◆	
Commonwealth Secretariat	◆	◆	◆	◆		◆	◆	◆	
DFID GEM	◆	◆	◆	◆	◆	◆	◆	◆	◆
ECLAC						◆		◆	
Liverpool School of Tropical Medicine	◆	◆	◆	◆	◆	◆	◆	◆	◆
OXFAM						◆	◆		◆
PAHO	◆			◆		◆	◆		
Royal Tropical Institute						◆	◆		◆
Sida	◆	◆	◆	◆	◆	◆	◆	◆	◆
UNFPA						◆			
USAID						◆		◆	
WHO	◆	◆	◆		◆	◆		◆	

In developing a framework for analysing gender tools for their applicability to health, the aim was to identify those dimensions of health and health systems and services that are gendered in some way. Ten dimensions were considered:

– Social determinants of health and illness, including gender relations;
– Health-seeking behaviour; quality of care in health services;
– Health promotion;
– Health care financing;
– Health policy;
– Research and monitoring;
– Consultation and participation of target groups; and
– Institutional management.

Details of the various components of each of these dimensions are presented in Annex 1.

All of these themes cut across WHO's areas of interest: policy development, programming, research and standard setting. The framework was developed to answer two questions in relation to the diverse areas of WHO's responsibility:

- What inputs would a person need in order to ensure that he or she identified how gender relations and gender inequalities impact on health and health systems and services?
- What inputs would that person need in order to be able to both take account of such gender differentials and to promote gender equity whether in policy development, programming or standard-setting?

This marks a very specific bias of this review: it is based on the assumption that guidelines, which help to make clear the 'gender problem', are not enough. Rather, these guidelines have to be used alongside tools for the task at hand, such as health policy-making, programming, research or advocacy.

2.1 Social determinants of health and illness

Understanding the causes of ill health or absence of well-being is fundamental to WHO's endeavour. Without understanding the cause of the problem, efforts cannot be made to address it. In many cases gender differences, whether in roles (division of labour) or in power (access to and control over resources) or other social differences, are central factors determining exposure to the risk of developing a specific health problem. Likewise, poverty or marginalization, for similar reasons, can increase vulnerability to health problems. WHO is committed, not just to a preventive and promotive approach, but also to address the symptoms of the problem. Hence the importance of understanding the underlying determinants.

Gender tools identify factors which make men and women's lives different, and hence are useful in identifying factors which potentially influence differences in their health. Different tools give greater or lesser attention to different factors. In general, gender differences are ascribed to:

– differences in roles (who does what);
– differences in the relationship of women and men to resources, both their access to and their control over resources (including information, decision-making, bargaining power, educational opportunities, time, income and other economic resources, and internal resources such as self-esteem and confidence); and
– social norms which value women and men differently and expect different behaviour from them.

Questions are asked in relation to gender differences in roles, access to and control over resources and in social norms within the household, the community, different levels of political authority (local government, national government etc.), the workplace, the market more generally, and international relations as they pertain to the issue being explored. This might refer to the impact of international treaties on national policy and programming, or of trade relations on access to drugs, or any other international policy or practice that may impact differentially on men and women.

Most of the tools describe the impact of gender on health. However, the Liverpool School of Tropical Medicine's (6) matrix (see Figure 1 on the following page) provides a tool for the users to carry out their own analyses.

The blocks provide a checklist for the user to systematically examine whether and how any dimension of gender may be impacting on health and on how men or women respond to ill/health. Figure 2, below, is an illustration of the kinds of questions the second row of this matrix might elicit.

Figure 1 Factors affecting who gets ill (6)

Why do different groups of men and women suffer from ill-health?	Household	Communities	Influence of States/markets International relations
How does the environment influence who becomes ill?			
How do the activities of men and women influence their health?			
How do the relative bargaining positions of women and men influence their health?			
How does access to and control over resources influence the health of women and men?			
How do gender norms influence health?			

Figure 2 Questions for gender analysis of factors affecting who gets ill (6)

How do the activities of women and men influence their health?	Do women's and men's work expose them to different hazards? Consider chemicals used, fuels used for stoves, times of day in sunlight, exposure to unsafe water etc. Do women and men have differential access to leisure time? How does this affect their exposure to risk of illness?	Consider women's and men's roles in agriculture and industry. Is there differential exposure to hazards? Consider impact of migrant labour on women and on men's health.	Is the establishment of tax free zones to attract industry to developing countries impacting on degree of legal protection of women and men's health in such zones? Do the cuts in public expenditure affect women and men's access to work differentially?

The columns on 'household', 'communities' and 'states/markets' may allow the user to ignore sexuality and sexual and reproductive behaviour despite the fact that these are central dimensions of gender relations. While analysis of the 'household' is likely to include analysis of domestic roles, it may not include broader sexual and reproductive health dimensions. Since it is this dimension of gender relations that people frequently avoid, tools need to alert the user to the importance of explicitly including this dimension.

One limitation of this kind of gender analysis is that it does not build in an awareness of other socio-economic factors which have an equal or greater impact on health, or consider the ways in which gender and socio-economic factors interact to intensify the disadvantages experienced by specific population groups.

One exception is the PAHO manual which considers gender within the context of other social determinants of health (8). It argues the importance of recognizing that the social construction of gender varies across age groups, cultures and socio-economic classes. All these factors need to be taken collectively into account when examining how gender influences health. The tool from this manual , shown in Figure 3 (see following page), emphasizes this dimension.

Here the user is reminded to analyse class, ethnic, cultural as well as age differentials, or any other differentials, in order to find out what is making women or men sick and why there may be differences between them. This analysis would, for example, note the greater vulnerability of poor women to HIV/AIDS. The example below (Figure 4) takes only the component of access to and control over

Figure 3
Needs in health (8)

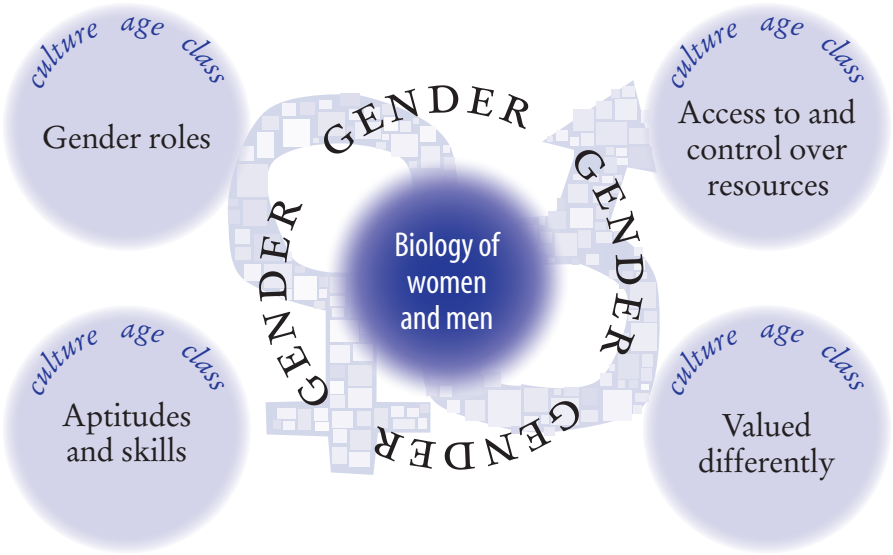


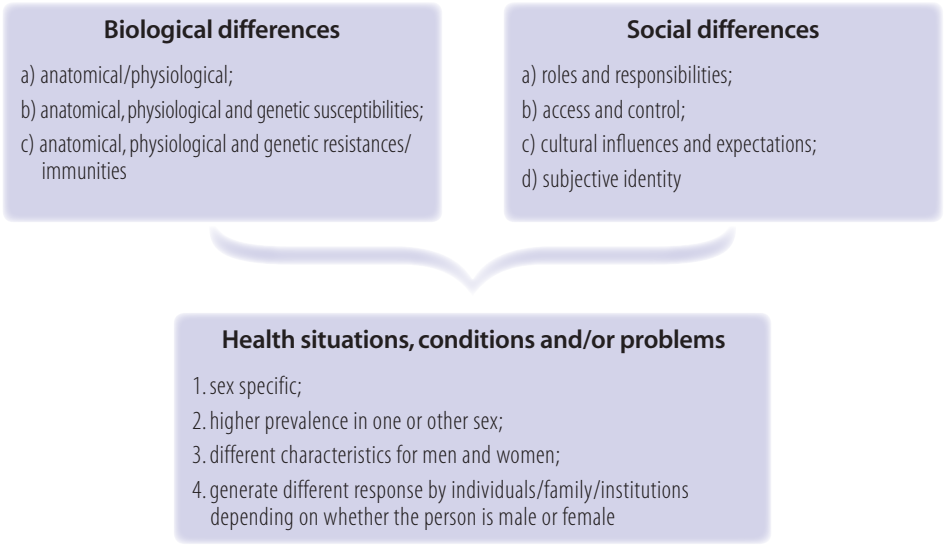
Figure 4 Questions for an integrated gender and social analysis of factors influencing health (8)

	Household	Communities	Influence of States/markets/ international relations
How do the activities of women and men influence their health?	**Consider class, age and culture in relation to the following questions :** Do women and men do the same work in the household? Does women's work expose them to different hazards than men's work? Consider chemicals used, fuels used for stoves, times of day in sunlight, exposure to unsafe water, etc. Do women and men have differential access to leisure time? **Consider in relation to:** Class: compare women who are middle class home-makers and women who are unskilled wage labourers Age: activities of young girls and of young boys in relation to exposure to unsafe water, leisure time, etc. Culture: divisions of labour often differ across countries and sometimes, across ethnicity, race and caste	**Consider class, age and culture in relation to the following questions:** Is there exposure to different hazards given the different types of work women and men undertake in agriculture and industry? Consider the impact of migrant labour on women and on men's health. **Consider these in relation to:** Class: Consider the class-based division of labour in the workplace – differential exposure to hazards of managers in relation to workers. Age: For example consider health risks to female and male youth in relation to schooling, such as sexual harassment in schools, dangers facing youth on the roads getting to and from school, drugs issues facing adolescents and how these might differ for girls and for boys. Culture: Consider how women and men in urban versus rural communities, or communities of different races may face different health risks because of the activities that they tend to be typically employed in.	**Consider class, age and culture in relation to the following questions:** Is the international trend of establishment of tax free zones to attract industry to developing countries impacting the degree of legal protection of women and men's health in such zones. Do the cuts in public expenditure affect women and men's access to work differentially? **Consider these in relation to:** Class: Are middle class people more likely to work in jobs which are protected by occupational health legislation? Age: Are such trading zones targeting particular age and sex groups such as young women? Culture: Are women and men of particular communities or ethnic groups more likely to be affected because of their social position or dependence on sources of employment?

resources used in Figure 3, and indicates what questions this figure might elicit more easily than the matrix in Figure 1 corresponding to row four, namely, How does access to and control over resources influence the health of women and men?

The USAIDS's Tool for Examining the Sociocultural Context of Sex Differences is a tool for combining quantitative and qualitative information for gender analysis 'to inform policy formulation and to ensure that women and men have an equal likelihood of benefiting from and contributing to sustainable development' (9.3b). It focuses on for-

Figure 5
Origin of male and female differences in health/illness profiles (8)



mulating questions on the different roles and responsibilities of women and men in society, why these roles persist and how policies could be formulated to take these differences into account.

For example, if one were studying the causes of death from violence in a given society, Step 1 would be to find out the proportion of women's deaths and of men's deaths that are the result of violence and to disaggregate this data in terms of types of violence. This might indicate, for example, that women are more likely to die from domestic or sexual violence whereas men are more likely to die from assaults as a result of alcohol consumption or crime. This disaggregation would elicit information for Step 2. This might lead in Step 3 to an analysis of domestic and spousal relations to identify what factors trigger domestic and sexual violence against women; and what factors lead to alcohol abuse amongst men. This information would inform programming priorities as Step 4.

Most health tools make some reference, in the conceptual definitions, to the differences between sex and gender. Some go on to identify the differences between biology and gender as a determinant of health and well being. But there is little investigation of the complexities of the interaction between biology and socially constructed roles except in the PAHO manual. Its model for the 'Origin of Differences in Health/Illness Profiles' (8) briefly explores the interaction of biological and social differences as presented in Figure 5.

The PAHO manual provides many examples of how the interaction between biology and gender impact on health. For example, while anaemia due to iron deficiency may be biological, linked to women's loss of iron during menstruation, pregnancy and lactation, it may be exacerbated by cultural practices that privilege men in intra-household distribution of iron-rich food (8).

This suggests that biology should be included in the matrices above so that users identify biological vulnerabilities, and then examine how these might interact with social phenomena.

Box 2

Basic Model for examining socio-cultural context of sex differences (9)

Step 1: examination of sex-disaggregated quantitative data to identify phenomena that are potentially indicative of gender issues in development.

Step 2: identification of the principal practices that are producing the phenomenon.

Step 3: analysis of the economic, political and cultural contexts in which the phenomena occur in order to understand the major underlying forces that motivate and sustain the practices in question.

Step 4: provision of general guidelines on how the knowledge gained from this process can be applied to development strategies.

2.2. Health-seeking behaviour

It may appear that a policy commitment and provision of a health service – whether immunization or emergency obstetric care – is the major challenge. However, sometimes a policy is in place but is not implemented, or a service is available, but is not used. Whether in developing norms or in piloting a specific intervention, WHO has to be aware of the social factors which may make this intervention inaccessible or inappropriate to certain members of the population, whether women, young people or a particular caste. This information would allow WHO to work out means of overcoming identified obstacles so that its activities can respond to and benefit those most in need.

The question is whether men or women give the same attention to their own illness, and what factors constrain or facilitate their use of health services. Is men's health-seeking behaviour different from women's? If there are differences, these may arise owing to social factors external to health services, or to factors related to how health services function.

The Liverpool School of Tropical Medicine guidelines provide a version of the matrix in Figure 1 for examining how gender impacts on health-seeking behaviour (6). This version replaces "states/markets international" in the last column with "available health services", and excludes the first row on "environment" as in Figure 6 below.

If one were to add in dimensions of class, age and culture more explicitly, the row on access to and control over resources would elicit the questions shown in Figure 7.

The tools do not give substantial attention to factors within the health service which may make

Figure 6 Factors affecting responses to ill/health (6)

Why do different groups of women and men suffer from ill/health?	Household	Communities	Available health services
How do the activities of women and men influence responses to illness?			
How do the relative bargaining positions of women and men influence responses to illness?			
How does access to and control over resources influence how women and men respond to ill health?			
How do gender norms affect responses to illness?			

Figure 7 Questions for gender analysis of factors influencing responses to illness (6)

	Household	Communities	Available health services
How does access to and control over resources influence how women and men respond to ill/health?	How does class, age or education influence the power to make decisions about one's own health care, within a household?	Do young women (culture) or poorer women (class) have the same access to information about health problems and services available as older women? As women from wealthier households? How does access to maternity services vary across class, ethnicity, education and age?	*Class*: Have policy changes on cost recovery impacted equally on middle class men/women as on working class or peasant men/women? *Culture*: Do global religious institutions impact in the same ways on women's and men's access to reproductive and sexual health services? On young versus older women?

them more or less attractive to men or women, beyond such issues as opening times and possible preference for a health worker of the same sex. While research shows that in many countries the quality of care received differs between women and men, with women more often receiving poorer quality of care, such as in waiting time, over medication, humiliating treatment (8) or that women might travel further in order to secure their privacy when using a health service, the tools do not provide substantive prompts to support the user in identifying such barriers to access.

2.3. Quality of care

An overall aim of WHO is to provide the standards that ensure good quality services for all and particularly for those most in need. While access to services is usually given priority, services that are not acceptable to clients are frequently poorly utilized. Acceptability may include issues such as inadequate facilities or drugs, or attitudes of health workers or lack of privacy. Good quality of care is an essential requirement for service provision, both to ensure that the health service addresses immediate health problems and that it offers an entry point for building the capacity of users to take control over their own health. Quality of care is affected by both gender and other factors, all of which have to be taken into account when developing policy, setting standards or making interventions.

All of the health guidelines and sector-specific health tools raise questions that fall in the sphere of 'quality of care'. The Sida handbook (2) for example offers a list of questions regarding health policy and management, but donor questions tend to focus on their own issues. Thus the issues identified are focused more at a policy level, as discussed above, than at the level of actual health service delivery.

Also at the level of design of sector reform, Elson and Evers' framework provides a list of possible gender-aware indicators, some of which pertain directly to quality of care. Some examples of these include 'meetings of health workers and women's groups; visits to health facility (by type) by 'gender', age; and women and men patients' views of health services' (3).

The DFID GEM Gender and Health Section presents three gender-related issues on quality of care:

- Women may receive worse quality of care;
- Women's priorities in terms of quality may differ from men's; and
- Poor quality may have a differential effect on women and men (11).

This tool uses two entry points for considering quality of care: the users' perspective or 'demand' side, and the providers' perspective, or 'supply' side. On the user side, the areas it identifies as having potential for problems with respect to quality of care, are: facilities and supplies; comprehensiveness of range of services; continuity of care; staff training and supervision; staff attitudes; staff explanations; waiting times; and preference for a particular sex of provider in certain cultural contexts. They provide less input regarding the providers' perspective. The main points they alert the reader to are that individual clinicians may refer to gender stereotypes in making a diagnosis, and that their knowledge about illness symptoms, progression of the illness and effects of treatment may be based on male norms, which they assume will apply also to women (11).

The ARROW Programmes for Change's 'Checklist for women-centred programme design' provides a series of questions which a programme designer could use to identify gender-related health issues. The questions deal with both the content and the process of service provision, which together determine quality of care. They are organized along the following categories: values, principles and philosophy; needs assessment; programme rationale; consideration of impact of context on women's health; resource requirements; mechanisms for community women's participation in programme review; documentation and dissemination of lessons learned. Its 'Checklist to determine how gender-sensitive is a health programme' likewise supports this goal (7).

Although they identify such categories as values, principles and philosophy, the tools do not provide more detailed content to these. They tend to focus on issues pertaining to health worker attitudes rather than other dimensions of quality of care. A better entry point to quality of care would be to begin with existing tools in use for assessing quality of care in health services, and improve their sensitivity to gender-related causes of poor

quality of care. This is an area which needs more research to inform tool development. For example, the Liverpool School of Tropical Medicine guidelines point out the importance of assessing whether men and women respond similarly to treatment (6). Trends and reasons for this would need systematic research in order to then provide a tool which asks appropriate questions.

The USAID Tool for Gender-Informed Project Planning (9.4a) offers a more concrete tool which could be applied to planning of health interventions. By filling in the matrices for both health providers (distinguishing between different levels of providers) and potential service users (distinguishing between women, men, adolescents and also across social groups) the tool would help identify issues which should be addressed in the planning process to ensure quality of care (see Figure 8).

For example, if the project was assessing the feasibility of introducing the community-based Directly Observed Treatment Strategy (DOTS) for TB, following the 'economic' row and column one, it might ask questions in relation to health providers and patients (and would ask these questions about other stakeholders too). (See Figure 9.)

There are two more matrices (see Part II, Figures 19 and 20) that take the user through further steps in planning, which may be similarly used to improve quality of health services in a gender-sensitive manner.

The Health Systems Assessment and Planning Manual (19) is presented here by way of illustra-

Figure 8 Tool for Gender-Informed Project Planning: Assessing people's motivation for project acceptance (9.4a)

Worksheet 1 Motivational analysis: assessing people's motivation for project acceptance			
Step 1: Preliminary objectives:			
	Step 1 (cont.).: Potential gains for target population	**Step 2**: Potential risks for target population	**Step 3**: Questions / Actions / Strategies
Economic			
Technical			
Social			
Potential others:			
Additional notes/comments			
Step 4: Modified objectives (according to findings from Steps 1–3)			

Figure 9 Questions for gender analysis of people's motivation for project acceptance (9.4a)

	Step 1 (cont.).: Potential gains for target population	
Economic	Health providers: *decrease numbers of repeat patients; release of hospital beds being used up for treatment monitoring; remove time spent in monitoring treatment* Men with TB: *may prevent men from having to take time off and lose pay when going for treatment* Women with TB: *may increase accessibility of treatment for women who cannot afford transport or clinic costs*	

tion of a health systems guideline which integrates gender in all its analysis. This manual contains the methodologies used for an intervention aimed at transforming reproductive health care services in three provinces in South Africa[2]. While focusing primarily on reproductive health, it provides detailed questions on different aspects of quality of care, using different tools in order to elicit information from different stakeholders. These are used to build up a coherent picture of the problems. The data-gathering and feedback process is used simultaneously as a mechanism for participatory solution-development. The majority of issues explored are not reproductive health-specific but relate rather to overall health service functioning and quality. The range of issues explored in detail include:

- the motivations and factors influencing the quality of service provided by individual health workers;
- existence and use of clinical guidelines;
- nature of supervision;
- content and value of in-service training;
- nature of service organization;
- nature of information systems and use of these;
- nature of monitoring systems and use of these;
- approaches to and implementation of patients' rights;
- community involvement;
- patient environment;
- staff and patient privacy;
- use of health education materials;
- existence and acceptability of basic facilities;
- staff workloads;
- waiting times relative to time spent with health worker;
- equipment and infrastructure;
- the distance between facilities and service users and;
- other logistics issues such as drug supply (19).

Within each of the above issues, detailed questions explore the nitty-gritty of service provision, which is a requirement if an accurate assessment of the problem is to be made and appropriate interventions worked out. For example, on physical access alone, one tool in the manual asks, with some specifications within each question: size of building vis-à-vis patient load; range of routine services; mobile services; frequency of mobile services; home visits; position of clinic in relation to community served; daily services; instructions for patients if the clinic is closed; and facility opening hours.

A number of the above incorporate specific women's health content, while some incorporate specific gender content. Opening hours, for example, can be a critical issue in the case of a specific health need for women: childbirth. Range of routine services, however, talks to the broader issue of women's gendered role as mothers, which may require them to have their own health need, as well as that of a child, addressed in one clinic visit. If different services are provided on different days, this may be inconvenient to all users, but it particularly discriminates against women, given their mothering role, and impacts on their time, funds for transport and, if services charge fees, the costs too. Size of the building housing the health facility has implications for privacy, and so on.

This example is intended to illustrate two points about gender-specific tools. Firstly, that identifying gender issues in health services requires a detailed and in-depth investigation. Exploring only the broad issues will not help obtain the information required to identify how gender differences and inequalities shape health service quality. Secondly, addressing gender-related issues alone is not enough. An overall aim of WHO is to provide the standards that ensure good quality services. A true 'mainstreaming' approach will therefore integrate considerations of gender into broader health service evaluations and interventions.

The need for an integrated approach holds also in situations where a specific health issue is under investigation. For example, in considering the implementation of the syndromic approach to sexually transmitted infections (STIs), there are obvious gendered issues. Some of these are: the possible impact of gender stereotypes on health worker's treatment of women with STIs as compared to men, or the question of how differently women or men patients might respond to a health worker's suggestion that they inform their partner about their STI. There are gender differences also in the meanings associated with and importance given to addressing STIs, not to mention the question of what to do

2. One of the methodologies in (19) is Health Workers for Change, which was initially developed by Fonn and Xaba, authors of this manual, but then tested both to see if it could be used and later for impact in two separate multi-country studies in Africa by WHO/TDR.

about asymptomatic STIs – experienced predominantly by women. Most of the above issues would probably be picked up by a good 'gender' guideline. However, clinical dimensions such as the issue of asymptomatic STIs, may not be identified. In addition, however, issues such as drug supply, and the systems for monitoring the nature of STIs in a particular community in order to ensure an appropriate drug regimen determine the effectiveness of the service. To separate these out will weaken the intervention – whether a 'gender' oriented intervention, or a 'health systems' oriented one. They need to be addressed simultaneously.

In some cases the 'gender-only' tools might alert the user to a problem. For example, they may ask whether patients have to wait excessively long times before being seen. A more substantial tool is required to identify the causes of the wait. Some of these causes may relate to easily identifiable gender issues such as priority being given to male patients, but others may relate to 'health-systems' issues such as staff workload, organization of staff breaks, physical organization of the clinic or extent of integration of services which may or may not have a gendered component. Thus, the more specific the tools (e.g. addressing any one health problem or one area of organizational management such as long waiting time) and the more the tool takes on not only other social justice questions, but also health system organizational questions, the more useful it will be.

Quality of health services is a field needing more research to inform tool development. For example, the Liverpool School of Tropical Medicine guidelines point out the importance of assessing whether men and women respond similarly to treatment (6). Trends and reasons for this would need systematic research in order to then provide a tool which asks appropriate questions.

2.4. Health promotion

Health promotion encompasses the principles that underlie a series of strategies that seek to foster conditions that allow populations to be healthy and to make healthy choices. Social mobilization, participation, and empowerment are central to its philosophy. This is particularly so because those who are marginalized or discriminated against tend to have the poorest health. Women are one such group. Ascertaining the specific dynamics of women's experience of a problem and their ability to act in relation to it, as well as addressing women's overall position in society is therefore central to many health promotion interventions. The health promotion approach is also essential in identifying why it is that technical interventions, whether TB treatment, contraception, or condoms to prevent spread of HIV, do not sometimes reach the intended target groups.

Some of the specifically gender-related issues in health promotion relate to the determinants of health and illness, as well as to the factors influencing health-seeking behaviour, both of which have been dealt with in sections 2.1 and 2.2 above.

The matrices of the Liverpool School of Tropical Medicine (6) and as applied in the DFID (GEM) Gender and Health section (11.1), as well as the PAHO manual (8), are the most useful in terms of identifying the problems which would need to be addressed. Elson and Evers' checklist, by incorporating macro, meso and micro considerations, in particular looking at the role of the household as both a producer and consumer of health, offers a very useful entry point for reorienting the approach to health promotion. It helps do this by considering the roles and responsibilities and access to resources of different members within a household, which helps assess both the potential and the limitations of each of these members as target audience for health promotion interventions (3).

Other gender issues in health promotion relate to questions of participation, which are dealt with in a separate section below, as are questions of financing priorities.

A number of manuals have case studies, most notably that of PAHO which offers an empowerment continuum to assess the extent to which a health promotion intervention was aimed to build individual capacity for change – a key dimension of health promotion (8). It has four health promotion case studies which illustrate how gender analysis tools can be used to identify strengths and weaknesses in health promotion efforts and to promote gender equity in health. For example, in relation to information and education resources on a campaign to stop tobacco addiction, they ask questions about

how a programme could incorporate a practical gender approach. They suggest, amongst others, the need for information to show the different factors which influence smoking initiation in girls and boys; that prevention campaign messages to women should convey independence from addiction as an image of the "woman in control of herself and her future"; to men that "real men who care for their family don't smoke"; and the need to work with religious groups to form youth groups particularly of boys and young men to focus on these issues. In relation to time resources, the suggestions for incorporating a strategic gender approach include that in countries where the data indicates an association between cigarette smoking in women and isolation and caring for children, an intervention could be to form support groups with women to review how they might work together to care for one another's children. "This would provide each with some free time during the week to pursue other interests. Additionally, the women could explore different ways of involving their male partners more in the caretaking of their children" (8).

Many tools avoid taking on board the issue of how to deal with the challenge and obstacle posed by powerful decision-makers opposed to specific health promotion interventions who may prevent the implementation of these interventions. Instead, they allude to the need to take into consideration and 'develop strategies' to deal with differentials and discrimination as it pertains to health promotion. For example the Sida handbook asks 'Have the constraints that may keep women from benefiting or participation been identified and appropriate strategies developed?' (2). The AusAID guideline asks if attention has been given to any cultural and religious practices which adversely affect women's, girls', boys' or men's health' and whether 'For projects which attempt to eliminate such practices, are there strategies to address any resistant attitudes of women and men' (15). It also asks 'Will there be adverse consequences for women who make decisions about their own health …needs as a result of the project?' (15).

As with quality of care, it may be useful to look for 'how to' materials which are written specifically for health promotion and which incorporate gender concerns, rather than broad guidelines on gender and health or gender analysis alone. The ARROW Programmes for Change booklet has a 'Material Production Pre-Testing Questionnaire' with a series of questions covering relevance, comprehension, translation/pitch, acceptability/believability and artwork. It provides a guide for the development of health information materials so that they take account of the different perceptions and experiences of the targeted women and men. This is the most concrete of the tools available, but limited to materials production rather than health promotion in general (7).

Although examining 'how to' materials is beyond the scope of this review, one example of a more concrete guide is given below as an illustrative example. The Healthy Women Counselling Guide (20), produced by WHO, is a case in point. While this is not about broad health promotion strategies, it is an excellent 'how to' guide on development of locally relevant health education materials. Its focus is on education materials for women, based on analysis of the negative impact of gender relations on women's ability to access information and sometimes to take health promotion actions proposed by policy makers who are at a distance from the realities of women's lives. It provides accessible explanations of why gender relations need to be addressed and a guide as to how to go about identifying women's health needs and developing materials to address these.

The specific health education materials developed as part of this intervention take into account the cultural and social causes of both ill health and of women's inability to access services. In addition, they challenge these, addressing both men and women. A book on prevention of vesicovaginal fistula (VVF) (21), for example, asks participants to consider what they can do to encourage parents to raise the age of marriage (while recognizing that it is frequently a decision made by the husband irrespective of his wife's views). It asks what men can do to prevent VVF. It asks what others can do when parents cannot be dissuaded from arranging marriages for their daughters at a young age. The material on malaria (22) explores the role of women friends and male relatives in particular, in challenging a husbands' failure to take his wife's malaria seriously and in ensuring she gets adequate treatment.

2.5. Impact of health financing

Health financing – having enough funds and ensuring that they are appropriately allocated and spent – is a requirement for meeting the basic right to health care. However, decisions on priorities for spending are frequently influenced by social, political and economic priorities that may not put meeting the needs of the poor, or meeting the needs of women, at the top of the agenda. In addition, in the current context of globalization, a key component of health sector reform has been to introduce health-financing systems, which include user-fees. User-fees could be a barrier to those most in need, including women, if men control their access to funds or if they are poor. Another specific financing issue relates to the way the services are organized, and the extent to which interventions rely on unpaid labour, such as that of community health workers, who are frequently women. WHO's role in health systems development as well as in standard setting for specific interventions, require it to ensure that health-financing recommendations redress gender inequities rather than reinforcing them.

Most of the gender tools alert the reader to the need to consider the costs of any intervention for individuals, both men and women, and for communities. Health-specific tools include more directed questions. The Sida handbook, for example, asks 'Are there any differences by gender in the impact of expenditure constraints in the health sector – e.g., in relation to the services provided, costs and access to care, and proportion of care provided at household level'; 'Have the budgetary implications of the gender-specific elements of the project been anticipated?' Its explanatory section includes financial issues that impact on health-seeking behaviour and health system financing issues, particularly laying out issues in relation to 'what gets resources' and 'who pays' (2).

Elson and Evers (3) provide checklists which are helpful in looking at the overall approach to health financing, in particular highlighting the need to incorporate the (unpaid) reproductive economy based on women's domestic work within the household and in caring and nurturing for children and older people, into the conceptualization of the health sector and hence the planned interventions and monitoring of impact.

These checklists provide guidance on how to translate priorities identified through gender analysis into financial information systems so that the budget process provides a means of translating goals into measurable deliverables (3) as shown in Box 3 below.

As with quality of care, it may be more helpful to look to materials on gender and financing in order to gain ideas for the health sector. For example, the manual, "How to do a gender-sensitive budget analysis" (23), drawing on the experiences of diverse countries in undertaking a 'gender budget', provides a series of tools. One tool explains how to undertake a gender-disaggregated public expenditure incidence analysis. It shows how such an analysis can help identify gender inequities in government spending. For example in Ghana, benefit incidence analysis found that poor women benefit as much as poor men from health spending, but women in all income quintiles benefited less from spending at all levels of education. The manual provides exercises to support gender-sensitive analysis of a budget in a particular sector (23).

Many gender issues in health financing go back to how priorities are determined. Thus the gender analysis of the determinants of health and illness, health-seeking behaviour, quality of care and health promotion would direct attention to financing issues. To what extent these are taken on board relates

Box 3

Components required for gender-aware financial systems (3)

- Identifying and costing gender priorities in health care delivery and monitoring;
- Expenditure through the management information system;
- Ensuring stakeholders know of these priorities in order to strengthen monitoring;
- Monitoring and evaluating the gender balance in use of services;
- Tracking information on gender balance in indicators of health status of non-users (thus requiring both facility-based and household information); and
- Evaluation of cost recovery.

also to gender issues in institutional management which is dealt with in section 2.10 below.

2.6. Policy

Policy, whether documented or implicit, forms the basis on which any institution's approach to gender is shaped. This is true also in the case of approaches that health institutions take with respect to specific programme issues. For this reason, it is essential that WHO is able to ensure that gender dimensions are taken into account in any policy development or standard setting in which it engages, and any support it provides to governments. It also requires WHO to promote institutional willingness to address gender dimensions. Further, the processes followed in policy development should ensure that priority setting; policy design, implementation and monitoring involve and are informed by the perspectives of women and other marginalized groups in society.

All donor tools considered in this review give attention to the information required for policy development, particularly in donor-government interactions. Regarding counterpart agencies, AusAID's general section on gender asks about the recipient government's strategy for incorporating gender issues into various sectors (15). In relation to health it asks whether they 'have national policy or other statements promoting the importance of girls' and women's health'. The Sida handbook alerts the reader to the critical issues of political will and resources in ensuring that policies are gender mainstreamed (2).

The Liverpool School of Tropical Medicine's guidelines provide a series of questions regarding the policy environment (6). These include questions on the status of gender in policy, policy debate and in policy content; and the extent to which policymakers understand gender issues in health.

ARROW's Policies for Change (7) provides a checklist which would allow policy makers to use the Australian Women's Health Policy as the basis for reflecting on what would be appropriate in their context. While this is a women's health policy rather than a gender policy, it may be useful because it addresses gender inequality in both its goals and content. Further, it provides a comprehensive picture of the range of components that would need to be addressed in overarching health policy – from preventive, promotive and curative care, to resource mobilization and participation of beneficiaries in decision-making.

A number of the tools offer categorizations of policy which are used in gender and development theory. These alert the user to the level of transformation intended by specific policies. These are summarized in the description of the Social Relations Approach within the OXFAM Tool Kit (5) as shown in Box 4 below.

This categorization helps the user to think about the goals of policy from a gender perspective. It does not, however, give enough detail to actually assess individual policies.

The USAID's booklet on Gender and Policy Implementation (9.3a) provides a rapid appraisal tool, called 'the gender policy inventory', for mapping the policy and institutional environment and for developing hypotheses about how policy (laws, procedures, etc.) impacts differentially on diverse

Box 4

Describing the approach of different policies to gender (5)

- *Gender-blind policies*: recognize no distinction between the sexes, thus incorporating existing gender inequalities.
- *Gender-aware policies*: recognize that both men and women are involved in activities and often on the basis of inequality as a result of which projects may impact differentially on them. Within this there are three categories:
  - *Gender neutral policies*: attempt to target and benefit both men and women effectively, working within existing gender divisions of resources and responsibilities.
  - *Gender specific policies*: respond to the practical gender needs of a specific gender, again working within existing gender divisions of resources and responsibilities.
  - *Gender redistributive policies*: intend to transform existing distributions to create a more balanced relationship between men and women.

populations, especially on women and men (see Figure 10). It was developed in recognition that policy can have unintended impacts and that it is important to analyse the sequence of events from the formulation of policies to their ultimate consequences for both women and men 'at the firm and household level.' It points out that this information is needed because without understanding the factors that produce differential impacts, it is not possible to identify or implement corrective actions. In the case of health, the tool would be used to see how a health policy impacts differentially on women and men as well as on different groupings within these two categories (Figure 10).

An example of the kinds of information this matrix might elicit on one health intervention, following the 'administrative issues' row, is shown in Figure 11.

The USAID booklet (9) also presents principles guiding implementation of the Gender Policy Inventory: bottom-up vs. top-down; integrated (into preparation of overall country strategy) versus stand-alone; focusing on gender – noting that the inventory is most powerful as a diagnostic tools at the micro-level; and analytical resources. It motivates the value of the inventory in that it requires moving beyond a single discipline or ministry. There are concrete examples to make the use of this tool easier for the user.

The last section of the USAID booklet notes that a team undertaking such an inventory requires extensive knowledge of the country, skills in economic and social analysis, interviewing experience, familiarity with sectoral development and expertise in gender analysis (9).

Some tools provide relevant quotes from in-

Figure 10 Policy Impacts (9.3a)

	Policy or Action	Purpose	Implementing Institution	Impact on the Economy [1,2]	Impact on small business [1,2]	Impact on women's economic position [1]	Descriptive Analysis of Impact on Target Groups	Possible Actions
Macro Policy Issues								
Legal Issues								
Regulatory Issues								
Administrative Issues								

1. These titles and the content of these columns will vary with the types of policies being analysed so in health they could read: 'Impact on the health sector'; 'Impact on district health services'; 'Impact on women's health' or 'on delivery of women's health services', etc.

2. Impact is assessed under each of these columns as: -2 = very negative impact; -1 = negative impact; 0 = neutral impact; +1 = positive impact; +2 = very positive impact.

Figure 11 Illustration of the application of the policy impacts matrix for a health intervention (9.3a)

	Policy or Action	Purpose	Implementing Institution	Impact on the Health System	Impact on private sector providers	Impact on women's health
Administrative Issues	Introduction of syndromic approach for management of STIs	To simplify treatment protocols; to limit the need for laboratory testing	All health facilities backed up by research institutions monitoring incidence of range of STIs. Is monitoring system in place?	Change in range of drugs supplied. Reduction in costs as a result of less use of laboratory services	May reduce income. May be difficult to communicate policy direction unless closer regulation of private sector providers.	How to address problem of asymptomatic STIs, which disproportionately affect women?

ternational consensus documents but they do not provide information on how to use international treaties to support development of national policy. None of the tools provide support to the user in how to influence policy processes to support gender aware policy development. It may be more beneficial to draw on policy analysis tools in this regard, strengthening their gender content, rather than starting with tools on mainstreaming gender. Likewise, tools on advocacy and gender would provide a stronger basis for supporting users in identifying how to support policy change. Tools regarding participation (in section 2.9 below) would also be helpful.

Clearly no general gender and health guideline can provide policy content to specific programmes. This has to be done by, or with technical support from people with expertise in relation to a specific health issue as well as gender and social analysis skills.

2.7. Consultation and Participation

Consultation and participation are requirements for the achievement of social justice. They are central components to all approaches to promoting gender equity and equality. They are also central to the Primary Health Care approach. This approach held that health services could not meet people's needs without people's participation in identifying those needs, and without an understanding of their perceptions of their health status and their expectations from health services. Solutions developed without such input may well not be successful. In addition, if those involved in any activity shape the activity, they are likely to feel ownership over it, protect and promote it. Collective action often helps to build the confidence and competence of participants. It is one of the key factors in building people's ability to take control over their lives, something frequently described as 'empowerment'. Finally, consultation with and participation of individuals from organizations involved in advocacy for gender equality and women's rights can bolster WHO's own capacity for gender mainstreaming.

A number of gender tools reviewed here assert the importance of participation of women and men and provide a few questions in this regard. In relation to policy, for example, the Sida handbook asks 'have the health ministry and other institutions developed processes for public participation in planning for health policy and services that seek the views of both women and men?' and 'have any links been established between health sector institutions and women's organizations or women's studies centres concerned with women's health and gender equality?' (2).

The USAID's Tool for Gender-Informed Project Planning described in section 2.4 above assumes participation through each step of the process (9.4 a). The OXFAM Tool Kit (5) provides a method for ongoing and participatory project monitoring in which the community involved in the intervention can surface and assess gender-related issues (see Figure 12 below). It is used with groups of community members, with women and men in equal numbers, who assess the impact of the project on each category on a monthly basis for the first three months and thereafter every three months. Once the matrix is completed, participants consider if each of the potential or actual changes is consistent with project goals or not.

For example, applying the above matrix would

Figure 12 Matrix: Gender Analysis (5)

	Labour Changes in tasks, skills, capacity	*Time* Changes in amount of time it takes to do the task	*Resources* Changes in access to capital or control over resources	*Culture* Changes in social aspects of participants' lives, including in gender roles or status
Women				
Men				
Household				
Community				

imply asking what changes have resulted from the implementation of the project in the labour of women and men, in the demands made on their time, in the resources accessible to them as a result of changes caused by the project, and the social consequences of the project to women's and men's lives.

Other levels such as age, class etc. can be added to the rows, and the same questions asked for women and men from different age, class or ethnic groups for a more complex analysis.

The CIDA Guide to Gender Sensitive Indicators has sections on indicators of participation. These can be reshaped into a checklist to remind users of options and issues regarding both participation and empowerment. Box 5 below presents these indicators of participation (13).

In relation to programming, the AusAID tool, for example, asks 'Have targets been set for women's and men's participation and benefits' (15). The USAID tool for Gender Informed Project Planning, goes furthest in that it offers a 'how to' process. It requires involvement of the 'target group' in the entire conceptualization process, which is entitled 'Motivational analysis of key stakeholders',

Box 5

Checklist of examples of quantitative indicators of participation (13)

a) Identification and planning level

Risk indicators
Level of government support for local participation.
Level of support by different sectors of the local population to participation (e.g. men, women, local elites).
Project dominated by different sectors of the population.
Lack of long-term commitment by donor.

Input indicators
Levels of input of women / men at different levels (government departments, NGOs, local stakeholders) to identification and planning.
Numbers of identification and planning meetings held with local stakeholders.
Attendance by local stakeholders at identification and planning meetings by sex, socio-economic background, age and ethnicity.
Levels of contribution / participation by local stakeholders at identification and planning meetings.
Levels of participation by local stakeholders to baseline study.

b) Implementation level indicators

Input and process indicators (of sustainability)
Audit of resources or funds held regularly and openly.
Existence of a set of rules that were developed in a participatory fashion, and the extent of involvement of women and men in this.
Reduced reliance on external funds.

Input and process indicators (of control)
Frequency of attendance by women and men.
Number of women and men in key decision-making positions. Rotation of people in leadership positions.

Input and process indicators (of activities)
Project input take-up rates. These would be specific to the type of project and need to be monitored for gender sensitivity e.g. number of visits to the clinic and their increase or decrease since group formation started.
Levels of women's and men's inputs, in terms of labour, tools, money, etc.
Maintenance of physical installations by women/men.

Process indicators (of scale and make-up)
Number of local women's and men's groups established.
Membership of groups by sex.
Rate of growth or drop-out of membership by sex.
Socio-economic, age and ethnic make-up of women and men attending meetings.

c) Evaluation indicators

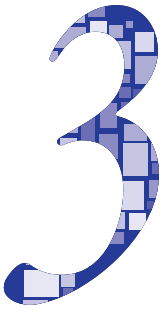
Output indicators (of benefit and returns)
Benefits going to men and women, by socio-economic class, ethnicity and age (e.g. increased employment).
Benefits to the "community" (e.g. community assets such as a clinic created to which all have access).

Outcome indicators (of evaluation)
Use of benefits to men and women, by socio-economic class, ethnicity and age.
Uses made of community benefits, by sex, class, ethnicity and age.
Levels of participation by different stakeholders in evaluation.
Degree to which lessons of evaluation are acted upon by different stakeholders.

and throughout the rest of the planning process. 'It is clear that consultation with the target group is the foremost prerequisite for laying the foundation for a solid project design and implementation plan' (9.4a). The entire model builds on this. The Gender Analysis Matrix presented in the OXFAM Tool Kit (5) also provides a method for ongoing project monitoring in which the community involved in the intervention can surface and assess gender-related issues. While it specifies both men and women's participation, it does point out that for women to be able to express themselves in this context would require good facilitation and possibly other back-up processes to build their capacity to represent their experience.

The PAHO manual's Module Four on practical and strategic gender approaches gives attention to the importance of people being able to take actions to improve their personal or collective quality of life. It argues that 'empowerment' is central to achieving this goal and presents four mechanisms of empowerment: interpersonal encounters, support groups, community organization and political action coalitions (8), providing an example of where each might fit into a health promotion strategy.

The final two columns in the 'Applicability to health' table are 'research and monitoring' and 'institutional management'. These are not addressed here since they have already been considered in Part I.



ARE THESE GENDER TOOLS EASY TO USE?

3.1. What assumptions do the tools make about the user?

The user has some social analysis skills

The tools do not all presume the same level of skills of the user. The Sida (2) and AusAID (15) tools are clearly for programme officers who are not expected to be social or gender analysts. The Sida handbook (2) goes as far as explaining why it is worth asking each question that it suggests. It thus offers a degree of training, through its layout and method. The WHO Gender and Health Technical Paper (18) likewise builds an understanding of the issues, as do the PAHO (8) and ARROW (7) manuals. The rest of the tools presume that gender analysts will use them or that the users can draw on the skills of gender analysts.

The DFID Social Appraisal Annex (12) and Commonwealth Secretariat Curriculum (17) are for people who are already skilled in social or gender analysis. The first simply spells out the specific approach required by DFID; the second provides a framework for course modules. But neither provides basic steps in gender analysis. The CIDA Guide to Gender-Sensitive Indicators (13) requires someone who is already gender aware to develop gender sensitive indicators.

The USAID tools (9) are much more detailed and hence give greater direction. They also provide built-in training on research methodology, processes for problem identification and programme design and the role and method of indicator development, monitoring and evaluation. Nevertheless, central to their method is the requirement that gender analysis is undertaken on the information gained through the methods and processes they propose – their tools do not replace the need for gender analysts.

The Liverpool School of Tropical Medicine guidelines (6) show the need for data gathering and for analysis of information. The guidelines are themselves analytical; that is they explain why certain questions are worth pursuing and they discuss how the methodologies used might impact on the results. They also focus on health and are therefore more accessible to someone in the health field. Someone less skilled in gender analysis is likely to get more direction from these guidelines than others. Someone with no skills in gender analysis will not, however, be able to use the guidelines to provide that training. The guidelines could be a useful textbook for someone already skilled in gender analysis, to frame a training programme on gender and health, because much, although not all, of the necessary content is there.

The user has time

Most of the tools are very dense. Whereas a basic donor tool such as the AusAID tool (15) provides a few simple questions, most of the tools require systematic reading and assessment by the user. They propose very complex methodologies and processes. WHO staff may not always have a large amount of time in which to plan a process, build relationships with stakeholders, commission research, analyse findings and so on. In reality, work is often done rapidly and the user may be overwhelmed by the apparent complexity of issues to take into ac-

count and processes to go through. While it is correct that processes of social transformation are not quick, one does not want a person to be intimidated by the complexity of tools.

The very simple list of questions developed by the Reproductive Health and Research Department of WHO to be included in their Guidelines and Forms for Preparing a Project Proposal is a practical example of an effort to raise priority gender-related issues without overwhelming the user. It requires all research proposals to address four questions, providing a brief explanation of the purpose of each. They are:

- 'Does the research question address a demonstrated public health need and a need expressed by women or men?';
- 'Will the research contribute to reducing inequities in health and health care?';
- 'Is there a plan for disseminating results and sharing knowledge with the research subjects and the non-scientific community?'; and
- 'What is the sex composition of the research team?' (24)

The obverse is also true – tools that provide a short checklist may give the impression that taking a few steps will be enough to overcome centuries of oppression.

In the process of identifying tools from different agencies for use in this review, as well as in prior work evaluating donor efforts at mainstreaming gender (25), programme officers who are themselves committed to gender mainstreaming have repeatedly argued that the tools their own organizations have produced, while well intentioned, are too complex to use in the conditions under which they work.

The user is only worried about gender relations; gender can be addressed in isolation

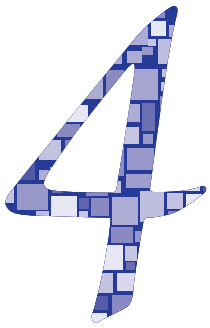
Related to the question of the user's time is the question of how many other social justice issues he or she needs to consider in policy development or programming. In addition to considerations of poverty or ethnic tensions, or the needs of specific groups such as disabled people, refugees, or people discriminated against on the basis of sexual orientation, there are other overarching issues, such as environmental impact. Yet in reality, it is often the same person who has to consider all of these dimensions. The less a tool integrates diverse considerations, the harder it is for the user. A methodology which is integrated, in which gender issues are embedded, rather than 'add-on' has a greater possibility of being effective. From this perspective, the USAID tools (9) or the institutional assessment tools such as the Social Relations Approach presented in the OXFAM Tool Kit (5), or even the Liverpool School guidelines (6) if their matrices are extended to consider other social justice dimensions, would all be preferable to gender-only tools.

On the other hand, in reality, people are often called in to assess gender-specific issues, in which case targeted gender tools give clear direction.

3.2. What assumptions do the tools make about information?

Most of the tools work by asking questions. This presumes that the user either has the answer or can get it. In some cases, discussions with the counterpart institution or with primary stakeholders would elicit such information, or there are functioning information systems that produce such information. But many tools call for information that is not easily available and requires the commissioning of various types of research. This arises in part because many of the gender planning tools are trying to make gender planning evidence-based in order to give it greater legitimacy. This is a good strategy, but it may not be necessary to conduct in-depth research before every process or intervention is undertaken. It may be adequate if an overall idea of the context and problem being addressed is available, either as input from stakeholders or from research in similar contexts.

The requirement of substantial research processes at every point may mean that the approach is simply ignored, in which case the gender tool will have set one up to fail.



VALUE OF TOOLS AS A SUPPORT FOR MAINSTREAMING GENDER: RECOMMENDATIONS

4.1. Problem identification or problem resolution?

Most gender tools give their primary focus to analysing the problem in order to identify issues, which need to be addressed in any specific project or intervention. They do not, however, provide the tools for addressing the issues. Thus a next level of tools is required – the 'how-to' tools. Whether these might be gender-sensitive operational research tools, advocacy tools, change-management tools or other interventions, they are not the primary focus of tools for mainstreaming gender. Some tools take some steps in this direction, but as the analysis above indicates, this is very limited.

There are however gender-sensitive tools for operationalizing gender mainstreaming in health being developed or being implicitly used throughout the world. Frequently those which are published, are not described as predominantly 'gender' tools. WHO materials such as Health Workers for Change (26) or the Healthy Women Counselling Guide (20), are cases in point. These are necessary to complement the problem identification tools (Baume et al., 2001) have compiled *Gender and Health Equity: A Resource Guide* which lists a wide range of tools, case studies and articles in relation to diverse aspects of gender and health which can also provide a reference (27).

Further work in identifying, evaluating and publishing useful 'how to' methodologies should be undertaken in support of the Gender Policy for WHO (1). These would be methodologies for integrating the processes required to mainstream gender in health into the general process of policy development, programming and operational health systems research.

4.2. The value of tools depends on the effectiveness of broader institutional processes

Related to this, it needs to be recognized that while tools can alert users to gender issues, they cannot make them go to the next stage of addressing the issues. To do this they need to have the will to do so. Their managers and their staff need likewise to be supportive in terms of the time, money and processes required to address gender issues every step of the way. The WHO Gender Policy (1) recognizes this. Its operational strategy covers many dimensions, from resource mobilization to capacity building, to ensuring gender parity in staffing and advisory groups, all with established mechanisms for ongoing monitoring and evaluation with agreed indicators.

All of this presumes will and commitment, backed by time and resources. As noted in the OXFAM Tool Kit, 'A framework will not do the work for you. It is only one step to help you understand the issues, facts and dynamics in your context; one step to help you plan the work that you need to do to confront women's subordination. The work still needs to be done' (5).

Processes of change are very complex, and seldom follow the order or logic of any framework. From this perspective people with good social analysis and activist skills are the greatest resource for gender mainstreaming.

As the WHO Gender Policy recognizes, wide-ranging processes are required in order to take on the problem of gender inequities both within who and in its approach to programming (1). With the professionalization of gender expertise and the acceptance by the international community that it has to address gender, the focus on tools is increasingly an attempt at a 'technical fix'. The Royal Tropical Institute's book spells this out as follows, 'this search for technical solutions – training, policy instruments, etc. – can also be seen as a retreat from the more emotionally demanding and less clear-cut questions of personal attitudinal change' (4). It further says that this 'cry for tools' is perhaps a result of the perception that gender equality in development is a technical issue which needs technical solutions (4).

However, gender inequality is an emotional and psychological issue. Technical tools can be used to change behaviour and practice, but a longer, more transformative, more diffuse and therefore less easily measurable process is necessary to achieve the changes in individual attitude and organizational culture without which more equal gender relations are impossible (4).

Thus while the gender tools may be helpful in supporting WHO staff at different levels, this will be but a very small part of the overall operationalization process. Substantial attention has to be given to building understanding of the need for, and commitment to, challenging gender inequities and inequalities within WHO and its programmes. In support of this process, WHO needs to build capacity both of management and programming staff in gender analysis, whilst also making it possible for them to draw upon expertise of gender analysts.

4.3. Taking forward gender tool development in WHO

In what ways might the gender tools reviewed in this report help in the process of gender mainstreaming in WHO? These tools can provide some input towards skills-building or conceptual support for those entrusted with the task of implementing the WHO Gender Policy. At every level of operationalization of the WHO Gender Policy there will be people responsible for specific actions. For each of them, some aspects of some tools may be useful. For example, those responsible for institutional transformation within WHO would certainly gain by examining the institutional change tools reviewed in this report, amongst others.

For those responsible for developing programme-specific tools for gender analysis, taking the 'core' questions from any one of the tools as a basis for approaching problem identification in their own programme would be useful. For example, the core concepts used by a number of the tools can provide such a basis: an analysis of the role of context/environment; activities/division of labour; bargaining positions/power; access to and control over resources; and gender norms/culture.

Alternatively one specific gender tool can be chosen for guidance, since the tools provide greater explanation of the thinking behind using these concepts. Once an individual or group has taken on the task of developing a basic analysis of how gender issues impact on their programme and what steps may need to be taken, this chosen tool can be used to orient the rest of the staff in that programme to gender issues. The individual or group given this task may need support from the Gender and Women's Health Department or some designated mentor within or outside of WHO to fulfil the initial task effectively. This is because, as already stated, tools do not necessarily work unless used by those with social analysis skills. This process could be a formal part of the skills development and attitude-change process undertaken within WHO.

For ideas on how to mainstream gender in programmes, those developing programme-specific tools might draw on the series of questions presented in the CIDA Policy (see Section 1.1 of this review) which provide a helpful starting point. Alternatively, the USAID Tool for Gender-Informed Project Planning (9.4a) could also give ideas about how to operationalize the findings of gender analysis in actual interventions. As this review has argued, however, there are stronger health specific implementation tools available. A search amongst existing WHO programmes for good materials would no doubt elicit these.

Tools can also be used in WHO's internal staff orientation and training processes. With regard to orientation, all staff entering into technical programmes, and possibly those currently in such pro-

grammes could be given a basic series of questions drawn from these tools. They could be asked to outline a simple situation analysis and identify a set of issues which would have to be addressed in their programme in order to meet WHO's Gender Policy requirements: of 'promoting gender roles and relations that protect health, promote equality between women and men and contribute to the attainment of social justice' (1:3).

Those responsible for any form of training of WHO staff, or for training project partners, could use the tools to guide them in curriculum development. The PAHO manual (8) could be used for initial training and then other gender tools could be used to deal with more complex issues such as health systems or specific health problems such as malaria or HIV/AIDS.

In addition, it should be noted that WHO is due to publish a curriculum on gender and rights in reproductive health, which provides already evaluated methodologies tested in five sites and content for more in-depth training. While its programme focus is reproductive health, an adaptation of case studies and readings would make its modules equally useful for other programme areas. It covers gender, social determinants of health and illness, human rights as foundation courses and policy, evidence and health systems as application areas (28).

In general, the original tools are likely to be most useful to those responsible for making the process of mainstreaming gender happen in WHO. While this may be seen as 'everyone's responsibility', a core group in WHO – probably The Department of Gender and Women's Health and the Gender Working Group – or team will have to have the conceptual and operational skills required to support all of the others trying to implement the policy. It is people with this level of expertise that will find the gender tools reviewed in this report most useful.

Thus, the Department of Gender and Women's Health and others employed as gender analysts to support implementation of the WHO Gender Policy (1) should have these tools, and others as they are developed, available for ongoing reference. Those responsible for building capacity of WHO staff in gender analysis should have access to the training-oriented tools for curriculum development purposes. In addition, some simple analytical tools should be developed for human resources and programme staff to provide an entry point for integrating gender analysis into their ongoing work.

4.4. Keeping the role of tools in perspective

Tools are there to support broader processes undertaken at different levels in WHO, in line with its Gender Policy. Any attempt to consider the use of these tools, or the development of health-specific and programme-specific tools as an end in itself, will defeat the purpose of the WHO policy. Having tools to facilitate gender analysis, however good, is not enough.

Part II

Review of Specific Policies, Tools and Guidelines

Introduction

This section provides a very brief description of each of the tools reviewed in this report. These descriptions are not comprehensive. They are intended to give the reader an idea of the overall approach and content of each tool, focusing on those dimensions that would be most relevant for health. In many cases, the descriptions use the language of the tools themselves, since this illustrates the discourse. Quotation marks are not used throughout, however, since this would make the text difficult to read.

In assessing the information provided in this section, it is important to keep in mind thatm the tools reviewed were developed by their sponsors to resolve specifically identified problems with specific target groups as their focus. Any limitations attributed to the tools in this review are therefore not aimed at the tools within the contexts for which they were developed. Rather, they aim to explain the limitations the tools would have if adopted and applied to WHO's efforts at mainstreaming gender in health. Part I provided an overview of the role of tools, without any detailed information about specific frameworks. This section is intended to complement Part I.

A label on the right hand side under each title gives an idea of the intention of the specific tool. The format of each section is to describe broadly the purpose of the tool and its content, followed by any comments on its value for health and its limitations. Note that page numbers within each section refer to the page number in the original tool unless otherwise specified.

1. ARROW: Women-centred and Gender-sensitive Experiences: Health Resource Kit (7)

This is a series of booklets which 'aim to share experiences, lessons learned and practical tools on the 'how' aspects of changing population, health and family planning policies and programmes'. It targets policy makers, programme managers, health care providers and trainers and educators of health care providers. Only those sections that could be used beyond reproductive health are covered here. Likewise training materials only pertinent to the training process are not covered. Each booklet has explanatory papers followed by a series of loose-leaf 'tools'.

1.1. Framework for Change

This booklet has a short article motivating the need for change in policies and services, which address women, outlining the required parameters of such change. It provides a series of 'tools'. Some of these tools are definitions of concepts and relevant quotes from the International Conference on Population and Development (1994) and the documents of the Fourth World Conference on Women in Beijing (1995), including a summary of 'Beijing recommendations on gender sensitivity' which outlines member states' commitments in this regard. Other tools provide conceptual frameworks. One is a map of determinants of women's health, linking biological, social, political and economic and cultural issues to factors influencing maternal mortality and morbidity. Another offers simple and accessible pointers to what is required for 'Gender-sensitive health and family planning policies and programmes'. These actions range from recognition of gender as a determinant of women's health in official documents and inclusion of gender equality as a goal in policy; to the need for analysing women and men's roles, responsibilities and authority in decision-making and how this affects health needs and behaviour. The next steps are for plans to redress gender issues and structures and mechanisms for women providers' and clients' input to planning, implementation and evaluation.

Its 'Women-centred and gender-sensitive programme management cycle' provides pointers to help workshop participants or users reflect on their own practice in relation to participatory planning and decision-making; research and evaluation; and training. The 'Deciding on action' tool offers concrete suggestions of actions to take in relation to identifying women's needs and experiences, extending services, modifying approaches and organizational structures. These tools serve to alert the reader to issues but do not have enough content to guide the reader on how to implement these actions.

Also in the booklet is a 'Framework for women-centred and gender-sensitive policies and programmes for women's health, post-Cairo and Beijing' which uses a chart format to contrast pre-Cairo and post-Cairo approaches to services which would be a useful prompt for those working on shifting the ideological assumptions underlying health systems. A similar framework in the following booklet 'A women-centred reproductive health framework' deepens this analysis and provides more concrete issues for monitoring health services.

1.2. Perspectives for Change

One of the papers in the booklet, 'Sensitizing health care practitioners and policy makers on gender and women's health' (15–20) describes the process of bringing together predominantly NGOs and Ministry of Health officials in Nepal to identify gender-related health concerns. The purpose was to jointly develop guidelines for gender sensitizing training programmes for government and NGO service providers. It describes how these decisions were implemented and their impact. This offers ideas for those responsible for implementing gender policies.

'Gender and women's health status: a conceptual framework' is a diagram showing that at each of the moments of a woman's life, a range of gender norms impact on health. The booklet also provides a range of research tools identifying essential steps in research to ascertain women's experience of their health and health services, including conducting interviews, transcription of these and analysis of findings to ensure both validity and ethics in this kind of research process.

1.3. Policies for Change

This booklet includes a description of the goals, principles and content of the Australian National Women's Health Policy and a checklist which would allow policy makers to use the Australian Women's Health Policy as the basis for reflecting on what

would be appropriate in their context. While this is a women's health rather than gender policy, it may be useful because it addresses gender inequality in both its goals and content. It also provides a comprehensive picture of the range of components that would need to be addressed in overarching policy – from preventive, promotive and curative care, to resource mobilization to participation of beneficiaries in decision-making.

1.4. Programmes for Change

This booklet is predominantly focused on reproductive health programming. Its 'Checklist for women-centred programme design', however, builds on the policy materials in the previous booklet. It provides a series of questions which a programme designer could use to alert them to gender-related health issues in both the content and process of service provision in the following categories:

- values, principles and philosophy;
- needs assessment;
- programme rationale;
- consideration of the impact of context on women's health;
- resource requirements (including resources to facilitate women's participation);
- mechanisms for community women's participation in programme review;
- documentation and dissemination of lessons learnt.

The booklet also has a 'Material Production Pre-Testing Questionnaire' with a series of questions covering relevance, comprehension, translation/pitch, acceptability/believability, and artwork. It provides a guide for the development of health information materials so that they take account of the different perceptions and experiences of the women and men they are meant to target.

1.5. Annotated Bibliography

This includes brief summaries of a range of materials on gender analysis and planning. The tools provided are simple. The conceptual assumptions behind the questions are not always detailed, relying on examples for illustration. This makes them user-friendly. Those not familiar with the issues could use them as guides for a step by step analysis of the problem and for ideas of what sorts of actions they could take to address these. The bibliography of materials in the field is useful.

Their focus on addressing population or family planning programmes limits their scope. The materials are useful for organizing training, but presume a trainer who has greater familiarity with the issues than the materials can provide.

2. AusAID Guide to Gender and Development (15)

The guide was developed 'to facilitate gender planning in AusAID's development programmes'; 'to help Activity Managers and contractors effectively implement AusAID's Gender and Development Policy'.

It is focused at the levels of country strategy formulation, activity identification and preparation, implementation and evaluation from the perspective of the donor. It raises issues the donor should consider in identifying an appropriate partner within the recipient government, for example, and raises questions about whether such institutions want assistance in strengthening their own capacity. It gives substantial attention to the need to support and build the capacity of counterpart institutions during project interventions in order to ensure sustainability of gender planning in development.

It opens with 'General Gender Questions' which, while not sector specific, provide a coherent overview as to the kinds of issues which should be considered in the planning, implementation, monitoring and evaluation processes. The primary focus is to ensure that differences between men and women in their ability to participate and in the benefits accrued from the project are identified and acted upon. Moreover, this section raises key questions regarding whether and how a project can promote women's status and build acceptance of any changes to gender roles or control over resources from men, from the counterpart agencies and from other social groups.

The third chapter provides 'Sectoral Gender

Questions' including a section on 'Health and population'. The categories under which it provides guiding questions for each sector are:

- project objectives and target group;
- gender division of labour;
- access to and control over resources and decision-making;
- access to and control over the benefits and project impact;
- social, cultural, religious, economic and political factors and trends;
- participation and consultation strategies;
- women's social status and role as decision-makers;
- counterpart agency capacity;
- project monitoring; and,
- project resources.

The guide is short and simple and easily accessible. On the other hand, since it is a donor tool, it remains at the level of overall policy and programme conceptualization, rather than detailed design, implementation and monitoring.

3. CIDA: Policy on Gender Equality (10)

This is CIDA's own policy on gender equality to guide its programming.

It lays out very clear principles. These include:

– the integration of gender equality into all policies, programmes and projects;
– recognizing that polices, programmes and projects affect men and women differently;
– the centrality of women's empowerment;
– promotion of equal participation of women and partnership between women and men; and,
– need for specific measures to eliminate gender inequalities.

It provides a table showing the value of linkages between gender equality and other CIDA programming priorities: poverty reduction; basic human needs; infrastructure services; human rights, democratization and good governance; private sector development; environment; and women in development.

The chapter on gender analysis as a tool argues for the use of gender analysis throughout the project cycle. This would help to provide information on differential perspectives, roles, needs and interests of women and men. It would also help understand differences in men's and women's access to and control over resources, and differential access to benefits and decision-making processes. Gender analysis would enable the identification of opportunities and entry points for reducing gender inequalities and promoting equality through the intervention, and to assess the capacity of institutions to programme for gender equality.

The next chapter offers strategies for CIDA, from policy dialogue to programme assistance, institutional strengthening and bilateral and multilateral programmes, so that it is only of direct interest to people in the donor cooperation field.

Following this is a chapter which provides a useful outline of 'good practices to promote gender equality' within the organization, in planning, implementation and performance measurement. It goes on to provide gender analysis guidelines: 'what to ask' and 'what to do'. Both of these are very brief and coherent memos, rather than detailed matrices or other more complex tools. They are intended to serve as prompts to remind the user of the issues to consider. The policy presumes that the user will have the understanding and skills to do as recommended. Understanding the nature of barriers to women's participation, for example, or being able to identify or find others to identify women's practical needs and strategic interests or to identify possible backlashes and develop strategies to minimize such a risk.

The CIDA policy document provides easy to follow questions which may be seen as essential steps in gender analysis, under the heading 'What to ask?' These are:

- who is the target, who will benefit, who will lose;
- have women been consulted on the problem and how have they been involved in the solution;
- does intervention challenge existing division of labour, opportunities etc.;
- what is the best way to build on government's commitment to advancement of women;

- what is the relationship between the intervention and other actions and organizations;
- where do opportunities exist for change;
- what can be proposed to encourage and enable women's participation; and,
- what is the long-term impact in regard to women's increased ability to take charge of their own lives and to take collective action to solve problems?

Moving from gender analysis to action, it asks 'What to do?' and provides the following directions:

- gain understanding of gender relations, division of labour and who has access to and control over resources;
- include domestic and community work in work profile;
- use participatory processes and include wide range of stakeholders from government and civil society including women's organizations and gender equality experts; identify barriers to women's participation and productivity;
- gain an understanding of women's practical needs and strategic interests and identify opportunities to support both;
- consider differential impact of the initiative and consequences to be addressed; establish baseline data, ensure sex disaggregated data, set measurable targets, and identify expected results and indicators;
- outline the expected risks, including backlash and develop strategies to minimize these risks.

The Policy is only one part of an overall strategy requiring institutional commitment, gender training and gender experts within the CIDA fold, so that the policy is not expected to stand-alone.

As a shortlist, it provides a simple orientation to a mainstreaming gender approach. It does not provide any methodologies for the actual operationalization.

4. CIDA: Guide to Gender Sensitive Indicators and The Why and How of Gender Sensitive Indicators – A Project Level Handbook (13)

This is an excellent guide as to the purpose of indicators, and issues to consider in developing indicators developed for CIDA staff so that they can choose and use indicators as an instrument of results-based management.

The chapter on 'What are gender-sensitive indicators and why are they useful' begins with an explanation of what indicators are and then differentiates qualitative from quantitative indicators. It argues for the value of both types of indicators, but notes that qualitative indicators give more opportunity to explore people's own perceptions of a situation. It sees the purpose of qualitative analysis as to 'understand social processes, why and how a particular situation that indicators measure came into being, and how this situation can be changed in future'. It further notes the need for such analysis alongside quantitative and qualitative indicators at each point of the project cycle (p. 12). At no point does it make explicit why qualitative indicators are helpful in drawing attention to achievements in promoting gender equality.

It goes on to outline the requirements for effective indicators. It argues that developing clear objectives (by involving all stakeholders) is important in order to be able to use indicators. It notes that objectives need to be explicit, clear, feasible, measurable (verifiable) and time bound.

It shows how indicators should be developed to 'feel the pulse of a project as it moves towards meeting its objectives' (p. 16) and offers a typology of a chain of indicators starting with risk /enabling factors and moving to input; process; output; and outcome indicators. It then considers the question of timeframes for indicators, as measures of sustainability.

The chapter ends with a list of criteria for the selection of indicators:

– developed with all stakeholders;
– relevant to the needs of the user and at a level the user can understand;
– sex disaggregated;
– both qualitative and quantitative,
– easy to use and understand;

– clearly defined;
– few in number – six per type of indicator, more of them outcome indicators;
– technically sound;
– measure trend over time.

Chapter 4 goes on to discuss indicators at region/ country level, using CIDA's own requirements as its orientation and considering the responsibilities of CIDA staff for developing indicators at this level. Chapter 5 discusses indicators at the project level, using a number of sectors, including health, as examples. The project objective is described. Then the indicators are developed within the risk/ input/ process/ output/ outcome model. Then the way in which project managers can use these indicators is described. The guide then provides a 'checklist' of examples of quantitative indicators of participation a described in Part 1 above (see Box 6 of this review).

The CIDA guide on gender-sensitive indicators notes that qualitative indicators and analysis of participation relate to three main areas: organizational growth, group behaviour and group self-reliance (p. 38). It identifies four components of empowerment. These are: women's and men's sense of internal strength and confidence to face life; the right to make choices; the power to control their own lives within and outside the home; and the ability to influence the direction of social change towards the creation of a more just social and economic order (p. 40). It notes that whereas indicators of participation have tended to reflect group and organizational dynamics, indicators of empowerment have tended to focus on 'changes in personal growth of participants, organizational and political change' (p. 45). It provides a similar 'checklist' to that on empowerment.

This section is very clear and particularly relevant to attempts to develop gender-sensitive indicators, although there is no theoretical or practical discussion as to why participation and empowerment are key components of strategies to promote gender equality in programming. The examples, however, measure issues to indicate gender inequality such as percentage of school goers who are female.

Despite its title, the guide does not explore what is meant by gender-sensitive indicators. It simply states that these are indicators '…. that have the function of pointing out gender-related changes in society over time'…. 'Their usefulness lies in their ability to point to changes in the status and roles of women and men over time, and therefore to measure whether gender equity is being achieved'. '… using gender-sensitive indicators will also feed into more effective future planning and program delivery' (p. 5). The guide identifies the need to recognize women as stakeholders in development and how this requires sex-disaggregated data.

There is not, however, any basic explanation as to what makes for a gender-sensitive indicator. The books do not use the process of thinking about indicators to guide the reader as to what makes an indicator gender-sensitive. They do not explain how indicators can be used to understand gender inequality. The only explanations regarding components of gender sensitivity include the need to examine gender roles, how these came into place and how they can be changed (p. 12).

If the reader did not think an issue was gendered, the guide does not help to identify how and why it may be so or how to go about finding out. The guide therefore requires someone who is already gender aware to develop gender sensitive indicators.

Although the sections on participation and empowerment are sophisticated, the overall lack of explanation as to the gender-specificity of indicators could result in users of the book using rather unsophisticated measures. Health sector staff may go no further than sex disaggregated data and fail to deal with the complexity of barriers to access, for example. CIDA does, however, have a Policy on Gender Equality (10), which would be guiding CIDA officers, as well as other strategies to build the capacity of CIDA staff in addressing gender inequality. As a result, the guide is adequate for its intended purpose of supporting CIDA in developing indicators. It cannot be used on its own, separately from other interventions, however, to ensure the user has the conceptual understanding of the causes, impact and means of addressing gender inequality. (For more specific examples, see the annex of this policy framework, points 3.9 and 5.4.)

5. Commonwealth Secretariat: Gender and Health Curriculum Outlines (17)

This document provides curriculum outlines 'defining a comprehensive and fully gendered approach to major health areas which are relevant across the Commonwealth'. The purpose is for these to be used to train health workers so that they can 'carry out a gender-based analysis of health issues' and 'identify and eliminate stereotypical attitudes, behaviour and approaches that lead to discrimination'.

The book contains material for fifteen 'courses'. For each course, the following categories of information are presented: introduction; aims; objectives; assessment; synopsis of course segments and readings. Each presentation is only a few pages, so that each 'course' provides only an idea of what issues should be covered under this topic with the rest left to the trainer to develop, using the readings as an entry-point.

The fifteen areas are: gender, health and society; gender and health care; culture, gender and health; community participation; gender and health promotion; gender, work and health; gender and mental health; gender violence and heath; gender and reproductive health; midlife and menopause: gender and health issues; gender-specific aspects of aging; understanding HIV and AIDS: a global, national and gender perspective; gender and health: bioethics; preparing a research project; and facilitating learning about gender and health.

A person newly working on one of the topics, for which a 'course' is provided, would benefit by reading the course in order to have a sense of the scope of this area and for initial ideas on readings. Were WHO supporting a training component, those developing the training might use it, taking into account the limitations.

The focus is on understanding the issues, with some sections considering strategies – although mostly at the level of how to build understanding – and less emphasis on how to address these problems in public health services or in society more generally.

There are not very many theoretical or case study readings from authors in developing countries, so the trainers would have to do more work to ensure that their course was place-specific. There is no methodology provided for how to train on each course, but there is a 'course' on 'facilitating learning', which might give trainers some ideas on how to conduct a course.

6. DFID: Gender Equality Mainstreaming (GEM) Information Resource (11)

This is for DFID officials, currently only available on the DFID Intranet but intended for publication at a later stage. It is included here because it is a comprehensive analysis of the interactions of gender and health and possibly entry points for action.

The resource follows the conceptual framework used by the Liverpool School of Tropical Medicine Guidelines (6). It is in four sections: Gender and Health (11.1), Health Sector Reform (11.2), and Specific Health Problems (11.3) and Reproductive Health (11.4). The four core texts are discursive, with tools such as checklists, case studies, resource lists including bibliographic material and 'facts and figures' all available in linked sections. The core text uses existing data and case studies to illustrate points throughout, thus making its content relatively concrete and hence useful to practitioners.

6.1. Gender and Health (11.1)

The Gender and Health core text provides a short and clear explanation of why it is important to consider gender in relation to health (p. 2), and what constitute equity and rights approaches (p. 3).

It then considers gender and patterns of health and illness internationally, observing the role of biology, social differences, differential risks of exposure to infectious diseases and changing living and working environments. As with other tools, it uses the gender analysis categories of access to and control over resources; decision-making power or bargaining position; and gender norms and identities, as entry points for exploring these categories (pp. 4–6). In relation to the health sector, it suggests actions for gender mainstreaming, given gender differences in patterns of health and illness and

the different impact of illness on women and men. These include: collecting and analysing sex disaggregated health information; challenging stereotypes in health and medical research; and taking gender into account in priority setting for health policy and services, and in community needs assessments (p. 7). Many of its proposed actions are beyond the health sector, such as considering legal changes, efforts to improve women's access to income and control over economic resources and improvements in occupational safety. It also offers suggestions in relation to environmental issues and the broader terrain of challenging gender norms (p. 8).

The text then considers gender and health care access, again using the categories for gender analysis described above and considering both 'demand side' or user factors. (pp. 9–12) and 'supply side' or health service factors: distance, cost, mix of services, quality of care. It provides practical examples of what has been done in relation to these issues in different contexts, providing references to the relevant journal articles in each case (pp. 13–15).

A section on quality of care identifies the main components of quality from the perspective of service users (p. 17), and then identifies how quality may be influenced by reliance on gender stereotypes by providers, and provides a list of possible actions to be taken.

'Gender issues in the health care workforce' notes pervasive discrimination against women in the formal health sector workforce.

Two checklists have been included in this section. One is the International Women's Rights Action Watch's 'Checklist for women's health and equity: Accountability and Implementation', a guide for assessing states' compliance with their obligations under the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) to ensure right to equitable health care. At a micro-level, the 'Checklist for women's health and equity, through a gender lens' produced by Family Health International in 1998 provides a series of questions to guide the user to identify gender and health issues at each stage of a project cycle. It is detailed and would serve as a helpful reminder of issues to consider in planning, implementing and evaluation.

6.2. Health Sector Reform (11.2)

This section provides categories through which to assess the possible gendered impacts of the diverse processes underway in health sector reform in different countries. It notes the paucity of research and the absence of sex disaggregated data which add to difficulties in drawing conclusions about whether or not health sector reform impacts differentially on men and women.

It asks how the following processes might reinforce gender inequities and how they might support gender and health objectives: human resources management and restructuring; decentralization; efforts to improve cost effectiveness of health interventions; different modes of cost recovery; working with the private sector; and donor sector-wide approaches. For each process it provides brief answers to these questions, as well as short examples from different countries and in-depth case studies. This section includes checklists from both the Liverpool School of Tropical Medicine (6) and the Elson and Evers materials (3) reviewed here as well as two case studies to illustrate efforts at addressing gender issues in different dimensions of health sector reform.

As a case study, there is a checklist on the process of institutionalizing attention to gender equity that would be useful for those developing a gender policy for a department of health or a university or, indeed, the WHO. It was developed through a series of workshops amongst Commonwealth countries in four regions of the world. It uses the concept of a 'Gender Management System'. The following items are presented as essential resources:

- gender awareness training;
- administrative support;
- training in use of gender analysis in planning, design and implementation of health programmes;
- staff time and expertise to coordinate, monitor and evaluation progress;
- promotional materials;
- need to address cultural factors which hinder the participation of women; and
- consultancy services.

This section thus provides the outline of what an action plan to mainstream gender should include and the roles of different stakeholders in managing it.

6.3. Specific Health Problems (11.3)

This section begins with occupational health, noting the focus on men's health in this sphere and the paucity of information on the health implications of domestic work and other types of work in which women predominate. It also notes the lack of research on the psychological impact of work and the physical consequences of this. Finally it points to the contradictions around the impact of paid work on women's lives and health . On the one hand, it offers women potentially greater access to and control over economic resources which should impact their health positively. Yet the opportunities for paid work remain shaped by gender norms – the division of labour and gender stereotypes – retaining women in insecure and poorly paid work. This, coupled with domestic labour, may mean that work has negative implications for women's health (p. 2). This section contains suggestions for short and medium term actions, which a DFID programme officer could support in this field and which are likewise useful for others working in occupational health (pp. 2–3).

The section then describes gender differentials in nutrition at different stages of the life-cycle. This is followed up with suggestions including food supplementation, identifying appropriate local food sources, state action for food subsidies to ensure food security for low-income families, reducing women's workloads, and public awareness and educational campaigns to promote an understanding of special nutritional needs of adolescent girls and pregnant women (pp. 3–6).

On mental health it offers a series of suggestions recognizing that many mental health problems arise from the social and economic context people find themselves in and a sense of disempowerment linked to social expectations of men's and women's roles and responsibilities (pp. 8–9).

It provides a list of the diverse ways in which gender affects the risk of HIV infection, the impact of HIV/AIDS, the quality of care for those with HIV/AIDS and suggests a range of short and longer-term strategies to address these (pp. 9–13).

6.4. Reproductive Health (11.4)

This section describes the gender issues pertaining to sexual and reproductive rights and health, providing suggestions regarding integration of services, training, participation, health promotion messages and multi-sectoral approaches (p. 4). It then identifies how gender norms impact on maternal health, family planning and prevention of unwanted pregnancy, adolescent sexual and reproductive health, and gender violence and harmful traditional practices. In each of these cases, it suggests how the orientation or content of policy and programmes can address these.

This section, like the earlier ones, has a series of checklists, one for 'social analysis' to understand the gender dynamics underlying sexuality and reproduction, one for 'client- exit interview' for monitoring purposes and one to identify gender-related sexual and reproductive health issues during the project cycle.

The DFID resource is helpful because, having been able to draw on the many tools in this field – of which it is the newest – it integrates several useful concepts and checklists. It also relies on research, particularly findings reported in journal articles, thus providing a helpful foundation of evidence for the importance of addressing gender in health, as well as concrete examples of efforts to address gender in health policy and programming.

Its disadvantage is that it is not yet published, but DFID officials would most likely be amenable to sharing the materials with others in the field until it is published.

7. DFID: Social Appraisal Annex for a Project Submission (12)

This annex is a guideline for DFID staff or consultants responsible for the social appraisal component of a project submission as well as for ongoing social appraisal.

The annex explains the reasons why a social appraisal, including a gender analysis, is needed in terms of DFID's priorities, notably its goal of contributing to poverty eradication.

The annex spells out requirements for addressing five specific issues. Firstly it requires an analysis of how a project will contribute to poverty elimination. In relation to this, the annex provides some

guidelines such as the need to assess how the intervention would affect different groups among the poor; the multi-dimensional character of deprivation (those who lack rights, voice, access to assets, income, information etc.); poverty./ vulnerability at different levels of social organization (individual, household, community); and identification of what particular threats apply to which groups (p. 5).

Secondly, it spells out the need to consider how a project design contributes to DFID's objective for equality between women and men. It calls for a gender analysis. In particular 'Any significant risks to the project achieving appropriate outcomes in terms of gender due to gender bias in the institutional culture or structures of key partners should be discussed' (p. 6).

The third requirement is an analysis of the structures and processes of social organization among 'primary stakeholders' at the community level and how these link with the 'political economy of the country'. This would ensure that issues of difference and of local level power structures are taken on board in the project design (p. 7).

The fourth focus is on the social policy environment. This means an analysis of the assumptions underlying social development policies, specifically to examine whether they favour particularly sections of the population; and whether the project outcomes 'can contribute to the development of a more pro-poor policy environment…' (p. 7).

The fifth requirement is an analysis of stakeholder participation. DFID has produced an additional annex on how to do this. This annex argues why such an analysis is essential: for ensuring effective participation by key stakeholders; for making visible important stakeholders and to 'contribute to identifying ways and means of empowering them to become more influential' and to identify potential risks to achievement of project purpose (p. 8).

This approach is linked to the Social Relations Approach described in the OXFAM Tool Kit (5). It is useful to consider because it looks at social relations generally, not requiring the user to undertake a slew of separate assessments – on gender, on ethnicity, on disability, on refugees etc. It provides a limited and therefore manageable minimum set of issues which should be explored and then addressed.

The annex guides the DFID Social Development Adviser or consultant as to what is expected in the social appraisal dimension of project design and monitoring, but presumes that the user is already skilled in social analysis.

8. ECLAC: Gender Indicators (14)

This document was developed in response to the need for 'accurate instruments to identify progress and reverses in the situation of women' in Latin America and the Caribbean.

Where relevant, indicators are formulated for both sexes and in some cases the emphasis is on the relative position of one sex as compared to the other. The availability of information and statistics guided the choice of the indicators, although in some cases they suggest new measuring instruments. The intention of using indicators both for national monitoring and for cross-country comparisons over time also limits the range of possible indicators.

There is one section specifically on women and health. The indicators presented here are useful for monitoring national commitments to implementation of the health aspects of the Beijing Platform of Action. As a result of its purpose, however, the indicators are all quantitative and 'outcome' rather than 'process' indicators. On preventing and dealing with teenage pregnancy, for example, they include: the existence of a national functional committee or norms and standards for reproductive health, including family planning and sexual health; and birth rate per thousand women aged 14 to 19.

While these are useful starting points for monitoring gender inequalities in health, there is need for developing process indicators which would help assess the gender sensitivity of the interventions and the processes through which women's health status is improved. In the example above, of teenage pregnancy, some of the following questions might elicit such information: Do interventions recognize that young men and women might require a different approach in order to encourage them to use health

services? Do they seek to change the existing sexual power relationships between young men and women? Do they build women's ability to exercise the right to reproductive decision-making and young men's ability to respect that right? Are they helping men recognize that they are responsible for the consequences of their sexual behaviour? Is there an increase in young men's use of condoms?

9. Elson and Evers: A National Policy Framework for the Health Sector (3)

This report was written, and the framework presented, in order to suggest 'ways in which health sector programme support can be made more gender aware' (p. 4). It is intended to 'provide a basis for the design of more gender aware and as a consequence, more sustainable and equitable sector programmes' (p. 4).

The first three chapters lay the foundation for the framework that is presented in Chapter 4. Chapter one explains the nature of health sector reform both in its intentions and assumptions as well as in its implementation. It shows how, despite the broad spectrum of areas in which reform is implemented, from service re-organization, new management, personnel, financing and information systems, to stakeholder involvement and accountability, the success of health sector reform is measured in financial terms rather than in health outcomes. 'In practice, the monitoring and evaluation process tends to emphasize financial indicators with less emphasis on qualitative indicators… outcomes … or process indicators …' (p. 9). 'There is an unstated assumption that a better managed and more efficient ministry will deliver more effective services – in terms of addressing health needs, especially those of women and the poor' (p. 11).

The second chapter presents typical approaches to gender analysis in health sector reform, particularly a focus on 'women as targets'. It shows the limitations of this approach, notably in its tendency to focus only on the needs of mothers, or on women-specific components of the health system such as on the sex of health workers (p. 13). This approach does not address the impact of gender relations on men and women's health, 'gender bias in health service design and delivery' and 'the key issue of households, and especially women within them, as providers of health care' (p. 14).

The chapter then provides a list of what would be required to improve gender analysis in health sector programmes by 'recognizing the sector as a gendered structure, in which gender is always present, even if women are absent'. The requirements presented are:

- redefining the scope of the sector by looking at how men and women within households both provide and consume services;
- analysing the interaction of the paid (productive) and unpaid (reproductive) economy recognizing institutional biases and gendered institutional norms which result in gender inequalities in access to health services as consumers, and as providers disaggregating health information systems by gender;
- recognizing that the same health programme will deliver different benefits to men and women; and
- recognizing that gender bias in health sector institutions damages the effectiveness and sustainability of sector programmes (p. 14).

Chapter three gives content to these requirements, analysing why the health sector is a 'gendered structure'.

Chapter four then moves into the framework. Its aim is improving the gender-awareness of sectoral programme support (that is programme aid coordinated by donors). It includes a checklist (p. 24) on the process of institutionalizing attention to gender equity which would be useful for those developing a gender policy, for example, for a department of health or a university or, indeed, the WHO. The contents are a mix of internal institutional matters and programming matters.

It summarizes its approach to ensuring a gender-sensitive national sector framework in a checklist as shown in Box 6.

A second checklist (Box 7) explores whether

health sector institutions are gender sensitive in relation to: whether and how men and women's service needs are considered; access; women's voice in decision-making in service delivery; enforcement of gender aware policies in service delivery; ensuring gender aware policies in employment; and determining ways of financing the sector (p. 24).

The chapter then considers the relationship between inputs, outputs and impacts, and provides a list of issues to consider regarding how gender-aware indicators at each of these levels might be developed. These relate to financial information systems which incorporate recommendations arising from gender analysis, for example ensuring that priorities from this analysis can be identified in the financial information system and are included in the annual review of the sector programme. This would create an opportunity for the budget process to be more gender-aware (p. 25).

Components identified are: identifying and costing gender priorities in health care delivery and monitoring expenditure through the management information system; ensuring stakeholders know of these priorities in order to strengthen monitoring; monitoring and evaluating the gender balance in use of services, tracking information on gender balance in indicators of health status of non-users (thus requiring both facility-based and household information); and evaluation of cost recovery (pp. 26–28).

The framework goes on to present requirements for strengthening capacity for gender analysis, covering: management of gender awareness in health

Box 6

Checklist for a gender-sensitive national sector framework (3)

Macro

Include households as producers and consumers as part of the sector. The gender (and age) divisions within households must also be brought into the picture.

Make the logical framework more gender-sensitive, by appropriate gender-disaggregation of goals, purpose, outputs, activities, and indicators.

Make Assumptions in Log Frame gender-sensitive by specifying assumptions about:

- the role of the unpaid reproductive economy, especially as providers of health care;
- the degree and forms of gender inequality;
- the nature of intra-household cooperation and conflicts and how this affects demand for and access to health services and the quality of care provided in the household;
- gender divisions of work and income and how this affects decision making and the quality of care provided in the household;

What is the gender balance in key financial and strategic policy making bodies such as:

- the Ministry of Finance;
- coordinating committees of donors and governments which oversee the progress at each stage of sector programmes.

Institutional capacity assessment should include:

- a profile of the gender-balance in decision making at all levels of the sector;
- evaluations of gender focal points in key organizations (Ministries of Finance, Planning, etc);
- assessment of the roles of the Women's Ministry, and women in the Parliamentary Finance Committee (or a similar organization).

Meso considerations

Assessment of the health ministry should note gender balance in employment within in the Health Ministry noting, gender balance at different levels of the ministerial hierarchy.

- Identify missing stakeholders: When community organizations are consulted, are both men's and women's voices heard? Do institutional stakeholders represent the interests of individual men and women users and producers of services? Are household providers of health care given a voice?
- Assess gender differences in access to public service and resources. Do men and women have the same access to employment, credit, public transport, and schools and public information?

Micro considerations

- Assess imbalances within the household: men and women's decision making roles; access to resources (income, food, land, transport, clean water, and sanitation) in the household.
- Does the household operate in an equitable and cooperative manner or are there gender (and age) hierarchies which affect individual's ability to gain access to public and private services?

sector programmes, for example, training the planning unit in gender at the start or having a gender focal point in the unit; identifying gender priorities in training providers and in primary health education services; and improving the demand-side of the health information picture through needs assessments at household level and of service providers at community level. The authors note that this is especially important for identifying intersectoral priorities, for example for understanding the relationship between female education and infant mortality rates, maternal morbidity and mortality, or women's participation in sanitation programmes and child mortality (p. 29).

In the current context of health sector reform, an analysis that alerts the reader to the gender-related dynamics of both the process of decision-making around reforms and the actual health systems is very helpful.

Every health-sector reform process is different, as are the country-contexts. Thus while this paper presumes a greater use of public services by men, for example, this may be specific to countries where religious principles keep women in the home. More importantly, most countries which are engaged in some aspects of health sector reform are not doing so through sector programmes (i.e. donor coordinated initiatives) so the imperatives of the process may differ, yet many of the issues described in the report still apply. While this is not a comprehensive checklist that simply requires ticking off, it is a valuable resource that needs to be adapted to suit specific settings.

Box 7

Checklist on gender sensitivity of health sector institutions (3)

- ☐ Are health sector institutions – hospitals, clinics, stakeholder organizations, ministry of health – international health organizations – gender sensitive in assessing the needs of service users?
- ☐ Do they consider how men and women's health needs differ and at all stages of life?
- ☐ Do they consider how those different needs might be addressed directly? In assessing the ability of users to gain access to services?
- ☐ Do they consider gender differences in ability to pay the costs (transport, official and unofficial fees) of using health services?
- ☐ Do they consider gender differences in relation to work schedules? In ensuring women's voice in decision making in service delivery?
- ☐ What is the gender balance of employment at national, district, regional, local levels of health service?
- ☐ Do women represent at least 30 per cent of decision-makers at all levels?
- ☐ Is there gender stereotyping in employment?
- ☐ Are there support networks for women and men employees?
- ☐ Does the organization of work take account of women's reproductive responsibilities? (post natal care, childcare, pregnancy, family food preparation, for example)
- ☐ What is the gender balance in community health committees?
- ☐ Are there links between community health committees and community groups (men's and women's) in enforcing gender aware policies in service delivery?
- ☐ Is there gender balance among field staff?
- ☐ Is there gender bias in the orientation of services?
- ☐ Do field workers speak directly to women and men in households?
- ☐ Are there links between community health centres and local women's groups?
- ☐ In ensuring gender aware policies in employment?
- ☐ Have health reforms had the same impact on male and female employment levels?
- ☐ Have health reforms affected male and female occupations differently?
- ☐ In determining ways of financing the sector?
- ☐ Is consideration given to gender-specific implications of different forms of cost recovery such as user charges and insurance?

10. Liverpool School of Tropical Medicine: Guidelines for the Analysis of Gender and Health (6)

The guidelines open with background information on the meaning of gender and of health and the differences between a gender analysis as compared to a women's health focus. It outlines the changing approaches from the 'women in development' to the 'gender and development' paradigms, which may be useful for people schooled in this field, but are probably less so for health managers and practitioners.

This is followed by guidelines for Gender Analysis and Action using three steps: analysis, planning and strategies. Step 1 is a Gender Analysis Framework, comprising three parts. The first identifies patterns of ill health: who gets ill, when and where. The second and third are matrices to facilitate analysis. (See Figures 13 and 14 below).

These bring together the central foci of gender analysis (power relations, access to and control over resources etc.) with some degree of institutional analysis. It however presumes substantial analytical capacity on the part of the user. For example, it asks the user to identify differences in men's and women's access to and control over resources and how these might affect their decisions regarding where they seek health care, cost of services and location of services (33). This type of analysis presumes the user is aware of power dynamics regarding access to and control over resources that may not be self-evident. As another example, in exploring the category of 'activities' it asks whether there are health risks associated with particular activities. The user may not be able to conceptualize health risks – for example the mental health impact of an old woman alone caring for her grandchildren in a rural area. Regarding 'gender norms', the user is asked to consider how local perceptions and norms regarding illness and treatment affect women and men's willingness/ability to admit to being ill, and to seek treatment (33). This is again information which people trained in a bio-medical approach are likely to be unfamiliar with.

Alternatively it presumes a vast quantity of research providing this information, which is rarely available. The book does alert the reader to the problem of absence of adequate information, potential sources of information and biases in information (22–25). This makes it useful for the researcher, particularly in identifying research topics, but harder for the practitioner to use.

Step 2 of the guidelines concerns Gender Sensitive Planning. These outline the broad questions one should ask in relation to health systems and to research, integrating many of the issues raised in other tools. Under 'Health Policy' it covers the policy environment, policy content and health care management and decision making. Under 'Health Care Resources' it covers financing health care and staffing health care services. 'Service Provision' con-

Figure 13 Matrix: Why do different groups of men and women suffer from ill health? (6)

Vertical categories:	Household	Communities	Influence of States/markets international relations

Figure 14 Matrix: How are men and women's response to ill health influenced by gender? (6)

Vertical categories:	Household	Communities	Available health services
Horizontal categories in both matrices:			
How do the activities of men and women influence responses to illness?			
How does the relative bargaining position of men and women influence responses to illness?			
How does access to and control over resources influence how men and women respond to ill health?			
How do gender norms affect responses to illness?			

siders quality of care particularly in relation to attitudes and stereotypes and accessibility focusing on location, opening times, costs, information and confidentiality. The final section is on 'Information Systems'. As with all such checklists, it does not help the user with methodologies on how to do these assessments let alone how to act upon them, but it is useful to have this series of questions in an integrated format (34–39).

This step ends with a checklist for design and implementation of clinical research trials, both in terms of their ethical sensitivity and scientific rigour (40), presented below. (See Box 8.)

Step 3 provides such examples of strategies to address gender inequities. In relation to the health sector, to 'mainstream' gender awareness in policy, this document proposes development of a gender policy within health institutions (and provides some examples and issues to consider) and the need to change organizational structures and practices. It offers an illustration of the 'key elements which contribute to the institutionalization of a gender

Box 8

Checklist for ensuring gender issues are addressed in clinical trials (6)

Ethical Issues

Whose needs/interests do the research questions aim to address? Why is the research addressing these particular needs? Where is the impetus to address these needs coming from?

How do the research questions fit into broader research and policy agendas? Do they accept or challenge gender stereotypes and power relations both in health research and practice?

Issues for Study Design

Does the research question address the potential differential impact of a disease / intervention upon women and men?

Does the study assume women and men face the same or different risks of exposure, infection or disease in relation to the disease under study?

Does it assume that women and men respond similarly or differently to the treatment/intervention under study?

What data/previous research supports or challenges these assumptions?

What are the implications, in terms of both the research process and the research findings, of assuming gender has or does not have an impact on disease/intervention outcomes? For example: How would these issues affect study design in terms of hypotheses, findings and conclusions, stratification and study samples?

Hypotheses and study groups

Do study hypothesis groups include women and men? Why, or why not? Are these reasons tenable?

Sampling

Are study groups stratified and of sufficient size that gender differences in response can be analysed?

Implementation

Was gender considered in the study design? Is there a difference in the numbers of women and men recruited by the study? Are differences anticipated as a result of the pilot? If so, why? You will need to consider the reason people join the study – inducements and barriers: whether the decision to join the study is made by an individual and whether it is influenced by gender considerations. E.g. a woman's decision making power, issues of how consent is obtained and from whom.

Does gender influence continuation and dropout rates? Do more women or men drop out? Why? How can research implementation address this?

Are there differences in the potential costs and benefits to men and women of participating in a trial? How does this influence implementation, such as recruitment and consent procedures?

Analysis

Does analysis ensure that findings can be differentiated by gender?

How can the findings be presented in a way that the gender differences or similarities are clarified?

How can the gender implications be made clear to policy makers and planners? For example: the applicability of findings to each sex, gender differences in responses to the intervention, possibilities of differential access to the treatment or intervention tested by the research.

perspective', using the 'web of institutionalization' concept (49). It then proposes training and awareness raising; making changes to service provision to improve access and quality and improving information systems. It raises broad issues and provides examples for each.

While alerting the user to key process issues and elements which contribute towards the institutionalization of a gender perspective, the Liverpool School of Tropical Medicine guidelines do not provide the actual tools for effecting institutional change for implementing gender mainstreaming. Nor do they elaborate on the debates and options regarding a separate policy and/or policy group on gender equality as opposed to or in addition to gender mainstreaming.

The document has a section on developing indicators for mainstreaming gender in planning and describes the differing roles of process, output and impact or outcome indicators. It provides examples of gender sensitive indicators (and how to gather such information) in a project plan format (goals, objectives and activities, and possible indicators at each level) which do go beyond disaggregated data to measure changes in attitudes and awareness, an area often avoided (59). It goes on to address why working in other sectors is important for addressing the underlying determinants of health and gives examples.

The last major section offers case studies to elucidate the content of the guidelines with real examples. It argues that 'gender analysis has the potential to enhance the scientific rigour and ethical sensitivity of a piece of biomedical research', but in the case study in which it raises this issue, the research was done as an academic exercise. To actually have it done within the health systems' programming would have required a great deal of institutional change. The final case study further illustrates this problem. The 'Lessons to be learnt' provided at the end of this case study note that 'Despite the best intentions to keep gender on the agenda, competing priorities, including getting the overall task completed, may interfere'. This is the main weakness of the guidelines.

To summarize, while the guidelines provide tools for analysis, they do not address, in concrete terms, how one might actually institutionalize the use of such tools. They do not address the fact that decision-makers are faced with a wide range of concerns, gender equality being only one of these (when it is on the agenda at all). This has implications for whether a tool that addresses only gender is likely to be useful to decision-makers at various levels. The section on changing institutions opens up discussion this area, but does not provide detailed suggestions and methodologies.

11. OXFAM – A Tool Kit: Concepts and Frameworks for Gender Analysis and Planning (5)

This book compares a wide range of frameworks for gender analysis. Its intention is not to take a position on which works best, but to give the reader an understanding of different frameworks. It is, however, clearly supportive of the Social Relations Approach.

It points out that different frameworks have different assumptions, objectives, strengths and weaknesses. It opens by pointing out a number of factors that provide context and strengthen a gender analysis and identifying which of the different framework address these factors. For example, it distinguishes between frameworks that focus on gender relations and those which focus on gender roles. It points out that by looking only at roles, the context in which actors live may be ignored, which can undermine projects by failing to take account of the whole picture (p. iv).

The factors considered in examining gender analysis frameworks are: incorporation of other social relations such as class, race, ethnicity or disability; dynamism i.e. the ability to recognize that gender relations change over time and to be able to examine change; analysis of gender roles or gender relationships; the value accorded to intangible resources such as political or social resources (networks, rights, skills, confidence and credibility, time); whether the framework is built on the goal of women's empowerment, as opposed, for example to the efficiency approach which may give priority to efficiency over issues of justice or women's empowerment; the role of the planner – top-down or as facilitator only? (pp. ii–vi).

Its section on 'key concepts' is easy to follow, and covers most of the commonly used concepts in gender analysis so that it offers a helpful guide (pp. ix–xii).

It then presents six different frameworks (in each case following the same format for presentation) covering:
– a description of the framework;
– a case-study; and,
– a critique which explores the main uses of the framework, why it appeals and its potential limitations.

This section also offers possible adaptations of the framework to address the criticisms presented.

11.1. The Harvard Analytical Framework and People Oriented Planning[3]

11.1a The Harvard analytical framework[3]

This is a grid/matrix for collecting data at the micro level to help planners design more efficient projects and improve overall productivity by mapping the work of men and women in a community and highlighting key differences. This approach is similar to that taken in the USAID framework presented in this report. It has four main components. An 'activity profile' identifies all relevant productive and reproductive tasks and asks who does what, by age, time allocation and place of work. An 'access and control profile' lists the resources used to carry out the work and the benefits realized from it, and who has access to and control over the benefits (pp. 3–6).

'Influencing factors' charts the factors which affect the gender differentiation in activities or resources as identified in the profile (p. 6). This helps to identify external constraints and opportunities.

A 'Project Cycle Analysis' examines project proposals or areas of intervention in the light of gender-disaggregated data and social change in four stages of the project cycle: project identification, design, implementation and evaluation. A set of questions at each stage guides the planner. They look, amongst other things, at women's needs and access to or control over resources and benefits, at the awareness of project personnel of women's needs and the involvement of women in implementation and evaluation. The questions under implementation explore personnel, organizational structures, operations and logistics, finances and flexibility (pp. 7–8).

11.1b The People-Oriented Planning Framework

This was developed as an application of the Harvard Framework to the situation of refugees. It attempts to address more appropriate targeting and more efficient use of donors' resources, as well as reducing disparities between the sexes. It begins with a 'Refugee Population Profile and Context Analysis' – who are the refugees and what were the diverse factors which shaped gender relations before flight and during asylum (pp. 13–14). The activity analysis differs from the Harvard Framework in that it looks

Figure 15 The Harvard analytical framework activity profile (5)

Activity profile		
Activities	**Women/girls**	**Men/boys**
Production activities (agriculture, income generating, employment, . . .)		
Reproductive activities (water, fuel, food preparation, childcare, health, cleaning & repair, market related . . .)		
Access and control profile		
Resources (land, equipment, labour, cash, education/ training . . .)		
Benefits (outside income, asset ownership, basic needs, education, political power/ prestige . . .)		

3. The author's source is Overholt, Anderson, Cloud and Austin, *Gender Roles in Development Projects*, Kumarian Press Inc, Connecticut, 1985.

at the period before flight and after. It also adds the concept of 'protection' (legal, social and personal) in order to identify 'protection gaps'; such as whether there are mechanisms for protecting orphaned children (pp. 14–15). The analysis of use and control of resources identifies different resources men and women may have lost as well as current resources they control and use as refugees (p. 15).

The positive aspects of these frameworks, as described in the OXFAM Tool Kit (5) are that they are easy to use, give a clear picture and are non-threatening because they are gender-neutral, relying on 'facts' only. This is at the same time the predominant critique, since they were developed from an 'efficiency' perspective without considering how one might change existing inequalities. Another critique is that by focusing separately on women and men, the areas of connection, bargaining and negotiation between them as individuals and groups are not explored and therefore interventions may be too simplistic or miss opportunities for change. This is linked to the process for using these frameworks, since they are top-down approaches which may 'miss the complexities of the community's reality and can miss key opportunities for change'.

11.2. The Moser Framework[4]

This was developed to set up gender planning as a type of planning in its own right. The framework's first tool 'Gender roles identification/triple role' is to map the gender division of labour. It identifies women's triple role as productive, reproductive and community activities and aims to make women's work visible and to ensure equal valuing of tasks. Community work is divided into 'community managing' work undertaken primarily by women such as ensuring provision of resources like water and 'community politics' which are activities undertaken primarily by men and linked to formal politics (pp. 25–26).

The second tool 'Gender needs assessment' identifies women's practical and strategic needs, recognizing that these needs arise not only because of women's triple role, but also because of their subordinate position to men.

The third tool is on 'Disaggregated data at the intra-household level'; looking at who controls what within the household and who has what power of decision making (p. 27).

The fourth tool 'WID/GAD policy matrix' is an evaluation tool for examining projects to determine which policy approach they take. The policy approaches presented in this framework are welfare, equity, anti-poverty, efficiency and empowerment. (See Box 4 of this review for an illustration of how each of these policy approaches deals with gender, and their link to the 'practical' and 'strategic' gender approaches as mentioned above).

Tool 5 on 'Linked Planning for balancing the triple role', assesses whether a project increases work in one of women's roles to the detriment of another (p. 28). Tool 6, 'Incorporation of women, gender-aware organizations and planners into planning' argues for women's participation in order to ensure that real practical and strategic gender needs are addressed.

There is a case study which builds on the one used to present the Harvard Framework, thus illustrating diverse issues which would have been more adequately addressed had some of Moser's tools been used. These relate specifically to empowerment and recognition of the interrelationship of women's productive roles with the other roles they play.

The positive aspects of the Moser Framework that the OXFAM Tool Kit identifies are that it moves beyond a technical approach to planning and challenges inequality. Further, the concepts of practical and strategic gender needs are powerful tools for thinking about how to address women's needs and work towards a more balanced relationship between women and men. The tool also makes all work visible. It recognizes that there will be institutional/political resistance to gender analysis; and by categorizing policy approaches it helps to consider the main policy assumptions driving any project (p. 31).

The critique is that by looking at roles rather than relationships it can ignore questions of power and the dynamics of the interaction of relationships. It ignores other dimensions of inequality, and also the fact that not all women have a double or triple role. Further, it fails to make a distinction between the 'community' dimension of the triple role, which is about location of activity and the other two – pro-

4. Adapted by March from Moser, C., *Gender Planning and Development: Theory, practice and training*, Routledge, London, 1993.

ductive and reproductive, which are about what is produced.

The OXFAM Tool Kit raises some questions about the division between 'practical' and 'strategic' noting that some argue that this is rather a continuum, where a concept such as 'transformatory potential' might be a helpful addition. The 'practical' and 'strategic' gender needs framework also ignores men's interests, and considers only women's strategic and practical gender needs. Other critiques are that it does not examine changes over time and that it does not recognize that policy approach may be complementary or intertwined. Finally, it has 'emancipation of women from their subordination' as its goal. The OXFAM Tool Kit points out that if development workers do not accept this as legitimate, there will be strong resistance.

11.3. Capacities and vulnerabilities framework (CVA)

This is a tool for external agencies planning emergency relief interventions to meet immediate needs, and to build on people's strengths to support their efforts at long-term social and economic development. The approach identifies people's capacities or strengths; and their vulnerability – physical or material, social or organizational and motivation and attitudes. It also considers these for both men and women, and disaggregates across other differences such as class, political and language differences. The Capacities and Vulnerabilities Analysis can be applied over time to assess change, including change in gender relations (pp. 35–37).

The OXFAM Tool Kit notes that this framework is useful in that it maps complexity can be used at a macro level as well as a micro level can be used over time and incorporates social interactions and the psychological realm. It challenges the status quo by noting vulnerabilities existing in the social structure, thus preventing people from arguing for a return to 'things as normal' (pp. 42–43). She identifies its limitations in that the gender analysis can be inadequate – vulnerabilities and capacities must be disaggregated by sex or the framework will not provide these insights. She suggests also that the categories of capacities and vulnerabilities should be expanded to include those that relate to the body, to control over it and to sexuality.

11.4. Gender Analysis Matrix (GAM)

This framework aims to determine the different impacts of development interventions on women and men by providing a community-based technique for the identification and analysis of gender differences and initiating a process that identifies and challenges assumptions about gender roles within the community (See Figure 12, Part 1, page 31 of this review).

Other dimensions of differences such as age, class or race can be added to this matrix. The GAM is used with groups of community members, with men and women in equal numbers, who assess the impact of the project on each category on a monthly basis for the first three months and thereafter every three months. Once the matrix is completed, participants consider if each of the potential or actual changes is consistent with project goals or not.

The OXFAM Tool Kit notes the positive dimensions of this methodology include that it is participatory; it allows analysis of both the separate experiences of men and women and the connections between them (in household and community); it includes intangible resources; it helps anticipate resistance; and it monitors change over time. The limitations include the requirement of a good facilitator. Further, it presumes that women are able to articulate their views. On the contrary, it may require considerable investment in time and effort to build women's confidence to voice their experience before they will be able to participate as equals in completing the matrix. Its ability to monitor change over time does require continuity, and challenging gender role stereotypes.

11.5. Women's Empowerment Framework

This framework aims to identify the extent to which an intervention supports women's empowerment and equality. It has different levels of equality as presented in the Women's Empowerment Framework (see Figure 16 on the following page).

In addition to levels of equality, it considers to what extent projects consider issues concerning the relationship between women and men, rather than only women's roles. It offers three 'Levels of Recognition' of women's issues in a project: negative (the project leaves women worse off in relation to men), neutral and positive (pp. 55–57).

The OXFAM Tool Kit notes that a positive aspect of

the framework is that it explains the role of empowerment as intrinsic to the process of development. It extrapolates the practical/strategic gender needs/interests concept into a progression. The hierarchy of levels of equality has been questioned however. Also it looks only at equality in the relationship between women and men, and not at other aspects such as rights, claims and responsibilities. Where both women and men are denied of their rights, and are passive beneficiaries of an intervention to the same extent, the above framework would indicate 'equality'. The framework does not look at other sources of inequality – by class, race, and place of residence and so on, treating women as a homogenous group.

11.6. Social Relations Approach

This approach has five key concepts: the goal of development as human well being, the concept of social relations, institutional analysis, gender policies, and immediate, underlying and structural causes.

It assesses development not only in terms of technical efficiency but also in terms of human well being defined as survival, security and autonomy. The concept of production is taken to include market production but subsistence production, reproductive activities and activities related to caring for the environment (p. 63).

Social relations are used as the entry point for identifying structured inequalities between different groups of people in society. The approach recognizes that social relations construct individuals' sense of who they are; that these relations change; and that social relations provide resources for people, such as networks people can rely on for survival. It argues that development needs to support those relationships that build on solidarity and reciprocity and which build autonomy rather than reduce it (pp. 63–64).

The approach uses an institutional analysis asking who does what, who gains, who loses, which men and which women, in order to identify how institutions create and reproduce inequalities, focusing on four sites: the state, the market, the community and family/kinship. The international community can be added. Within each institution, it considers five dimensions: rules (what is done, how, by whom and who will benefit); resources (what is used, what is produced including human resources, material resources and intangible resources such as information or political influence); people (who is in, who is out, who does what); activities (what is done, by whom, who gets what and who can claim what); and power (who decides; whose interests are served) (pp. 64–67).

The approach describes policies by their different levels of gender-awareness. It defines gender-blind policies as policies that recognize no distinction between the sexes, thus incorporating existing gender inequalities. It has three different categories of 'gender-aware' policies, all of which recognize that both men and women are involved in activities, often on the basis of inequality as a result of which projects may impact differentially on them. The three categories are 'gender neutral policies' which attempt to target and benefit both men and women effectively, working within existing gender divisions of resources and responsibilities. 'Gender specific policies' respond to the practical gender needs of a specific sex, again working within existing gender divisions of resources and responsibilities. 'Gender redistributive policies' intend to transform existing distributions to create a more balanced relationship between men and women (p. 67).

The approach requires an analysis of causes (immediate, intermediate and structural, at all institutional sites) and effect (immediate, intermediate and long-term) (p. 68).

One positive dimension of this approach as identified by the OXFAM Tool Kit is that it is 'an attempt to develop a whole new framework for development thinking: one where gender is central to the analysis. It is not an attempt to develop an add-on for

Figure 16 Women's empowerment framework (5)

Levels of equality	Were they tackled in this project?
Control	
Participation	
Conscientization	
Access	
Welfare	

gender or a separate way of thinking' (p. 74). The focus on institutions is a very concrete entry point for identifying social relations and it incorporates both micro- and macro- levels and the interrelationships between them. The OXFAM Tool Kit notes its limitations include that it requires a very complex analysis (matching the reality of the complexity of society) and it requires information (p. 75).

The tool kit is of course limited in that it summarizes frameworks. To do any of the frameworks justice would require going back to the originals. None of the frameworks were developed specifically for health. Most of the frameworks require substantial insight into gender relations and substantial information in order to be used.

The Gender Analysis Matrix is 'do-able' without these constraints because it draws on the knowledge base of participants. The process of doing it would also help to conscientize the WHO officials or consultants as to the perceptions of participants. However, here too, it requires specific skills in order to work – notably facilitation skills and the time to build the confidence of women to identify and articulate their perspective and the community's acceptance of the equal participation of men and women in project design and monitoring.

12. PAHO: Workshop on Gender, Health and Development: Facilitator's Guide (8)

This manual was developed to build the capacity of those running the Pan American Health Organization's (PAHO's) technical programmes – nutrition, mental health, occupational health etc. It aims to clarify the concept of gender and its relevance for health and to build skills and methodologies to operationalize a 'gender approach' through using the manual in a 14 hour (2 day) workshop.

The first two modules present standard tools for gender training, but use only health examples, thus offering a 'translation' of gender concepts directly into the health context. They define characteristics of gender, gender roles and access to and control over resources, showing how each of these has a health impact. The third module provides a framework for distinguishing between biological and social influences on health (p. 57). (See Figure 5.)

The manual gives examples of each of these dimensions, making it easy for a health practitioner to grasp the concepts. Module four then applies these concepts to programme development by providing a series of case studies of health issues and considering what sorts of interventions would take account of the gender dimension in the health problem. It applies the gender analysis concepts of 'practical and strategic' to identify steps that might recognize and address the gender dimensions of women and men's health needs (p. 73). It provides Ronald Labonte's concept of an 'Empowerment Continuum' to interrogate the transformative process, not only for individual men and women, but also processes aiming to shift from the health system having power over the population towards partnerships. The continuum describes four empowerment mechanisms:

- interpersonal encounters: facilitate self-validation through dialogue;
- support groups: facilitate opportunities to overcome isolation ("not only sufferer");
- community organization: facilitate organization around common problems that go beyond personal interests; and
- political action coalitions: facilitate social movements that go beyond limitations of community organization to achieve political/social change. (pp. 75–79).

Using the examples of promoting breast-feeding; detection and control of tuberculosis; design of a community based intervention for promotion of mental health; the health of the elderly; and a campaign to stop tobacco addiction, it illustrates how interventions need to be aware of how differences in gender characteristics (such as in access to and control over resources) lead to health differences. It then explores how interventions can deal with the health problem in isolation (practical gender approach) or can attempt to alter the causes of the problems thus challenging gender norms (strategic gender approach) (pp. 80–92). The use of examples makes the analysis easy to follow.

Modules five and six move from determinants of health to health interventions, providing questions regarding project objectives, implementation and

Figure 17 Steps for conducting a gender diagnosis (8)

impact to guide a gender analysis. The key questions can be summarized as (p. 104):

Project objectives

- What gender roles did the project target in its objectives and to what purpose?
- What particular health needs of women and men did the project target in its objectives?
- What development approach predominated in its objectives: welfare, anti-poverty, efficiency, equality or empowerment? What other approaches can be identified?
- Did it use a practical or strategic gender approach?

Implementation and impact of project

- What particular health needs of women and men were affected and how?
- What development approach actually predominated?
- Did a practical or strategic gender approach predominate in the implementation?
- What changes occurred during the process of the project's implementation in terms of access to and control over one or more resources (material /economic, political, information/ education, time, internal)?
- What elements of Labonte's Continuum of Empowerment could have been incorporated, either in the project design or during its implementation, to respond more equitably and efficiently to the particular health needs of women and men?

The brief notes describing possible analyses of different case studies using these questions provide

practical insight to the reader about using a gender analysis for health programming. Most of the insights would, however, come out of the workshop process, with the information providing only a guide to the facilitator.

Module 7 is forward looking, offering steps for conducting a gender diagnosis, which draws together the previous modules (see Figure 17 of this review, page opposite). In using this framework, the idea is to first diagnose the situation, followed by identifying further information needed to carry out an in-depth diagnosis and then, based on this further information, to reformulate project objectives and indicators so that they reflect a gender approach. Having done this, the next step is to develop a strategy to put into operation the reformulated objectives, identifying opportunities and/or obstacles in achieving these objectives (p. 120).

The material in this manual has been tested with WHO officials, amongst others, thus responding directly to the needs of WHO. From this perspective, WHO would do well to build on work already done. It is very simple to use, carries diverse case studies to address concerns of different departments of WHO and is not time-consuming to apply. For training purposes in WHO, it provides ample material to help officials understand the concept of 'gender', how it impacts on health and health services and what sorts of questions need to be asked when developing policy, programmes or research questions.

Its limitation is that it is a manual for facilitators rather than for people who need to conduct a gender analysis themselves. Much of the insights it generates would surface during group discussions, based on the experiences of participants. Also, by using the traditional gender training discourse, for example of 'development approaches', 'practical and strategic approaches' and the like, it may seem to have too much jargon which does not resonate with its intended users. The manual does not give substantial input on actual strategies, bar its suggestions of diverse approaches to empowerment and its many examples of what could be done in particular cases. Readers could extrapolate from these to their own research, policy or programming situation. The workshop is clearly meant only for orientation. Readers would have to look elsewhere for tools on implementation.

13. Royal Tropical Institute: Gender and Organizational Change – Bridging the Gap between Policy and Practice (4)

This book was developed out of a Gender Working Group workshop for donor NGOs in the network Eurostep, hosted by the Dutch development organizations HIVOS and NOVIB. The workshop was held in recognition of the fact that while donor agencies usually focused on promoting gender equality in counterpart organizations, they themselves needed to analyse gender inequality in their own internal structures, systems and cultures, as well as in their work with counterpart organizations.

The book aims to contribute to the debate on this topic and to provide some tools to support readers in 'their quest to make a difference in the gendered outcomes of their agencies' (p. 8).

It is written as a series of chapters and is not a guideline or tool per se. It does, however, provide much summary input on issues to consider in analysing organizations and in making interventions. This review will note only some of these by way of example.

Chapter 1, on organizational development and gender identifies four components of any organization that determine its organizational behaviour: strategy, structure, systems and culture. Additional factors identified are the organization's history and vision; the relationship between its internal structures, systems and culture; the external environment which impacts on it; and the dynamics between senior management and lower levels of the organization (pp. 19–20). It develops the concept of a 'learning organization' and presents different levels of institutional learning: single-loop (changing rules – the 'how'); double-loop (changing the 'why'); triple-loop (changing the underlying principles) (p. 22). It outlines features required for organizational change to be organic and democratic and notes that the first requirement is organizational analysis as to why

gender relations are unequal and to what degree; what gender relationships influence the organization's values, objectives and policies and how they are embodied in its practice.

Chapter 1 also offers a list of characteristics through which an organization's commitment to addressing diversity can be recognized, and describes requisites to ensure or safeguard diversity in an organization, which include gender but also other factors such as ethnicity, class, sexuality, ability or age. It offers a list of ways in which an organization can be 'gendered' which covers: organizational ideologies and overall goals; value systems; structures; management styles; job descriptions; practical arrangements, space and time; expression of power; images and symbols (pp. 27–28).

Chapter 2: 'Gender dynamics within the donor organizations' describes the findings of interviews with people in five NGO donor organizations and characterizes different types of organizations (gender-blind, gender-aware, gender-redistributive) in relation to how management, other employees, and change agents respond to these environments and possible strategies in each (p. 52).

Chapter 3: 'Gender intervention-experiences with counterpart organizations' uses case studies of donor-counterpart interactions in order to interrogate the issues that arise from the unequal power relations embedded within these interactions. The conclusion identifies why it is that donor organizations need to practice what they preach – including that they frequently have higher expectations of their counterpart organizations than they do of themselves! It provides a critique of tools as the basis for change, identifying the need for attitudinal change in order for substantial organizational transformation to take place (pp. 69–71).

Chapter 4: 'Two sides of the same coin', continues on this theme. It provides an analysis of constraints to making organizations more gender aware (pp. 76–78). It ends with an outline of some of the factors essential to the process of organizational assessment and change 'to create scope for gender sensitive organizational development':

– commitment to gender equality and the promotion of gender sensitivity, understanding and analysis;
– listening and sensitivity;
– legitimizing the debate on gender;
– those with power being aware of their power in the organization;
– dialogue, not confrontation, as the motor of change;
– transparency in communication;
– achieving attitudinal change;
– change agents being both modest and ambitious;
– building a culture of mutual respect;
– building strategic alliances;
– availability of resources for supporting the change process;
– patience, realism and flexibility;
– learning and creativity;
– the agreement by all parties on indicators for quantitative and qualitative changes from the outset (pp. 81–84).

Chapter 5: 'Imagining a gender-sensitive organization' goes into greater details about how organizational shape, gender parity and organizational culture or style impact on the degree of gender sensitivity of an organization. It ends with a description of features of a gender-sensitive organisation (pp. 91–92).

Chapter 6: 'A roadmap of gender and organizational change' provides iterative processes through which an organization would take on a process of organizational change (see Figure 18 below). It stresses that this is not a linear process. This is essentially the 'framework' provided by this book. This chapter goes into each 'step', providing guidelines about action at each stage. The section on evaluation, for example, suggests that in addition to outcomes, one should look at the impacts of the process of organizational change around gender in such areas as knowledge and skills of staff, organizational quality, programme quality. Specific components of each are presented (p. 106).

Chapter 7: 'Organizational culture, the change agent and gender' considers the characteristics required of a change agent and provides a range of strategies for change agents to use.

Chapter 8: 'Strategies for developing more gender-sensitive practice' provides guidelines for a gender assessment of an organization – certainly a requirement if an organization is to take on a change process. It offers a questionnaire which organizations can use as a starting point. The questions are grouped in the following categories:

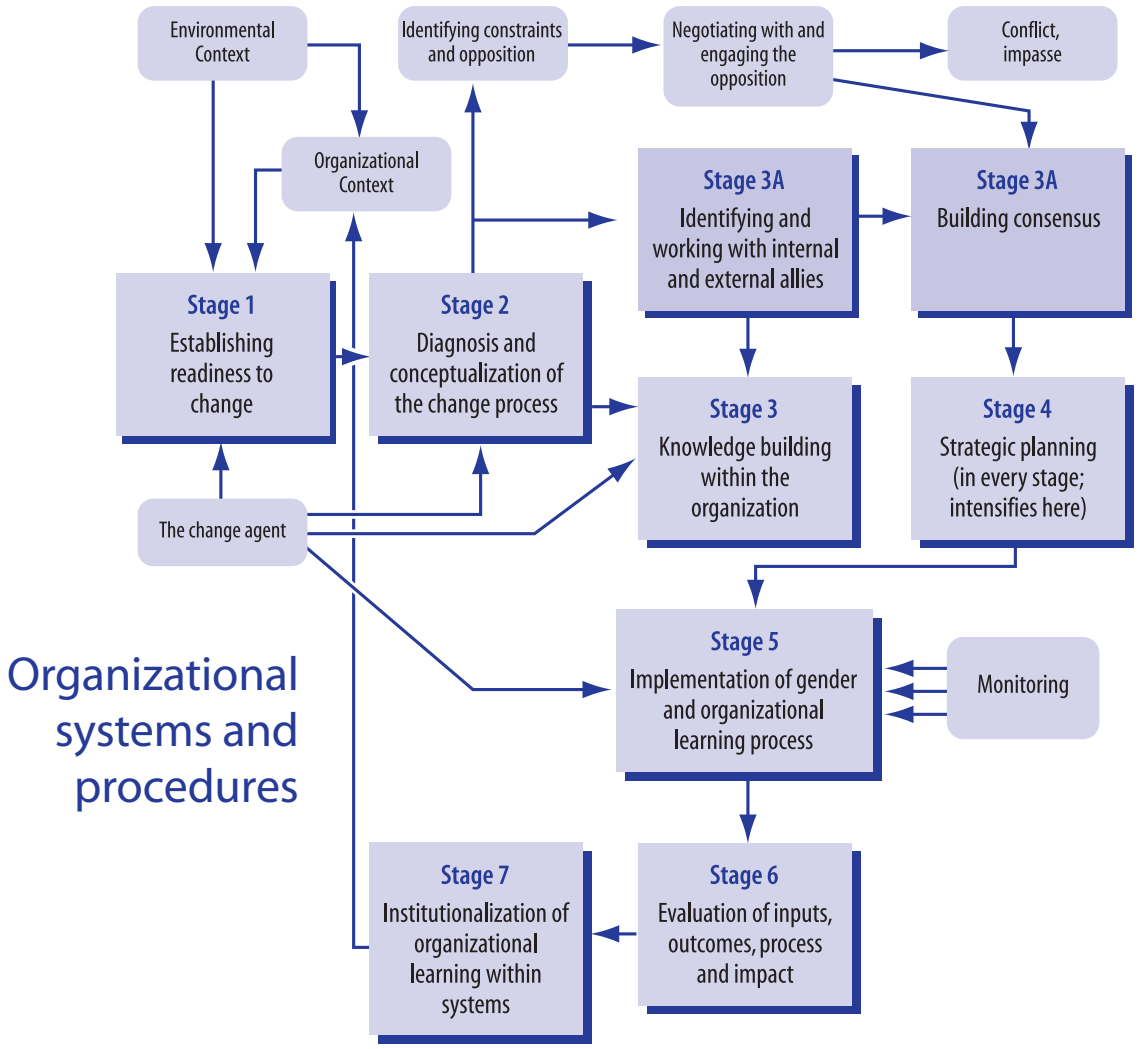
- Core business of the organization': mission, goal, objective, intervention strategy, products;
- Structure, systems and resources: structure, systems, operations/implementation, decision-making, planning, monitoring and evaluation, communication/information, personnel and resources;
- Organizational culture; and
- External context (pp. 136–144).

It describes this as an adapted version of Sara Longwe's Women Empowerment Framework.

Those responsible for institutional transformation of WHO will find the insights as well as the 'tools' offered very helpful in giving structure to the process and in providing insights about where and why things can go wrong. It is probably most important for WHO in its recognition that an organization cannot foster commitment to gender equality or gender awareness in its external programming, when its internal functions contradict these values. WHO may find it useful to see how these organizations went about assessing their own approach to gender equality (Chapter 2) in order to gain insights about the process of transforming WHO into a gender-aware organization.

The book does not consider the specific constraints faced by a multilateral organization in terms of the distance and diversity of accountability structures, but this does not detract from its primary purpose, which is the internal functioning of the organization.

Figure 18 Gender and organizational change: a roadmap (4)



14. Sida: Handbook for Mainstreaming a Gender Perspective in the Health Sector

The handbook was developed 'to further the development of awareness and capacity for working with gender perspective in the health sector' within Sida (2).

It has a clear explanation of what is meant by gender, gender equality and mainstreaming as a strategy for gender equality (Chapter 1) and a good overview of how gender equality is of relevance in relation to health and health systems (Chapter 2). The handbook focuses on bilateral development cooperation processes and therefore indicates what questions to ask and how to ensure that gender equality concerns are addressed in the processes of sector analysis; project formulation/appraisal; annual review; and evaluation. As such, it is helpful in identifying questions that need to be asked in order to understand the overall project context and in order to identify objectives and indicators relevant to project goals. It justifies the questions it poses, so that the reader can understand why a particular question may provide information that helps to promote gender equality in the project. Any actions it proposes are likewise predominantly at the bilateral level, since this is the level at which donor cooperation is negotiated.

The handbook is also useful for gender equality advocates in the field, including within WHO, to get an understanding of the donors' process of analysis of programme and project design. This will help them identify the moments at which the advocates could lobby or otherwise engage to influence donor agreements with government or other implementing agencies or to monitor implementation.

It does not provide substantial guidance on the kinds of actions that might be included in projects to actually address the gender gaps that are identified through the sector analysis and project formulation processes. In other words, while it achieves its objectives as a gender tool at the level of donor interactions with national governments, it is not a practitioner's tool for interventions to improve health or health care.

15. UNFPA: Support for Mainstreaming Gender Issues in Policies and Procedures (16)

This is an internal policy document to guide UNFPA programme officials. It begins by laying out UNFPA's principles in relation to gender equality, using as starting points the documents of the International Conference on Population and Development (ICPD) and Fourth World Conference on Women (FWCW).

The guidelines are based on the premise that operationalization of the principles of gender equality, equity and empowerment of women is essential for securing and guaranteeing both women's and men's reproductive and sexual health and rights. They go on to describe the specific activities that UNFPA could support in this field, ranging from advocacy to implementation programmes. The three broad areas covered are reproductive and sexual health; population and development; and institution building.

Anyone working in these three broad areas may find this useful since it draws out key areas for intervention in a few pages. These are based on international mandates, through the decade conferences and are thus contemporary.

16. USAID: Gender Analysis Tool Kit (9)

This is a set of ten analytical tools, in separate booklets, which are intended to be user-friendly methods for policymakers, programme and project managers for integrating gender considerations into development efforts. It could be adapted to the operations of other bilateral and multilateral donors, NGOs and governmental organizations.

The tool uses the concept of 'Gender Considerations in Development' (GCID) rather than 'gender mainstreaming'. Its intention is to ensure that USAID

or other users of the Tool Kit examine the extent to which they consider 'gender', described as 'the different rights, roles, and responsibilities of men and women', since this is a critical variable for sustainable socioeconomic development.

16.1. GCID Framework: A tool for assessing institutionalization of gender concerns in development organizations (9.1)

This booklet describes the logic of the ten tools, which take development programme managers through the various steps required to use gender analysis in their daily work. It is useful from an organizational perspective, because it offers seven steps of skill and capacity required for institutionalizing gender concerns. These steps are:

- awareness of the importance of gender issues for development outcomes;
- commitment to addressing gender issues in the institution's activities;
- capacity for formulation of gender-focused questions;
- capacity for carrying out gender and social analysis;
- capacity for applying the findings of gender and social analysis to the institution's portfolio;
- capacity for systematic monitoring and evaluation of gender-specific programme impact; and
- systematic reporting of gender-relevant lessons learned, and subsequent programme adaptation (p. 6).

It then provides a table showing the kinds of actions an institution will have taken at each of the above steps in order to address gender issues in its institutional structures and procedures (p. 11). This would be a useful quick guide to help people who are trying to decide what processes are needed to address gender inequality within an organization. The book then shows which of the ten tools will be helpful in implementing each step.

The next three booklets are all classified as 'Quantitative Tools' which would be useful in the first three steps of the GCID framework as described above.

16.2. Quantifying gender issues: A tool for using quantitative data in gender analysis (9.2a)

This tool aims to demonstrate how quantitative data can be used as a starting point for carrying out gender analysis. It is a slide presentation explaining the justification for doing so. This booklet outlines the tool kit's approach to the relationship between gender relations and development goals, arguing that gender relations can be in contradiction to one or more development goals and act as a constraint to the accomplishment of these goals. On the other hand, gender relations can act as a catalyst that, if appropriately incorporated into development strategies, improves goal accomplishment (p. 9).

The booklet notes that quantitative data provides information, but its usefulness depends on how it is interpreted. It uses examples, such as life expectancy, to show how differentials between men and women alter between countries, thereby alerting the analyst to the need to explore social and economic factors (p. 19, p. 24). It concludes that quantitative data enables one to identify relevant gender issues and to formulate the right questions for gender analysis (p. 38). It argues that gender analysis helps development practitioners to target resources, benefits and activities effectively and efficiently, taking into account economic, political and cultural realities. Gender analysis also helps predict the impacts that interventions are likely to have (p. 39).

This comes as a series of slides, which are useful for a basic introduction to the role of data in identifying the impact of gender relations on development. Many examples concern health issues, making it a useful tool for WHO and other organisations working in the area of health, in orienting staff on why gender disaggregated data is essential and in winning their recognition of the value of gender analysis for achieving the health goals of their respective programmes.

This booklet should however not be used without reference to other tools that are necessary to gain more insight into the nature of gender analysis.

16.3. Country Gender Profiles: A tool for summarizing policy implications from sex-disaggregated data (9.2b)

This tool offers practical guidelines on how to construct country-specific gender profiles which identify and describe gender issues pertaining to a country's overall development status or of a specific sector. It suggests the broad categories that should be covered and the importance of linking findings on gender differences to relevant devel-

opment goals or strategies. It then spells out how to chart quantitative data, including a discussion of software options and the role of different sorts of charts (pie, bar, stack etc.). It is thus of use to a person actually responsible for gathering and analysing quantitative data.

16.4. Gender and Household Dynamics: A tool for analysing income and employment data from surveys (9.2c)

This tool is a model for gathering and presenting descriptive sex-disaggregated information on income and employment in rural areas (women's and men's participation in local, regional and national economies) to help formulate gender-informed questions for sectoral policy analysis. It uses an actual rural household survey, presents the findings, followed by a copy of the survey questionnaire form. There is some discussion of the strengths and weaknesses of this particular survey in terms of identifying gender differentials.

The next two booklets are classified as 'Diagnostic Tools' which would be useful in the third and fourth steps of the GCID framework as described in booklet 1 above: formulation of relevant questions and gender analysis.

16.5. Gender and Policy Implementation: A tool for assessment of the impact of policies on women and men (9.3a)

This is a rapid appraisal tool, called 'the gender policy inventory', for mapping the policy and institutional environment and for developing hypotheses about how policy (laws, procedures etc.) impacts differentially on diverse populations, especially on women and men. This tool was developed because of the recognition that policy can have unintended impacts. It was therefore important to analyse the sequence of events – from the formulation of policies to their ultimate consequences – for both women and men 'at the firm and household level'. It points out that this information is needed in order to understand the factors which produce differential impacts, so that corrective actions may be identified and implemented. (The tool is presented in Figure 10 of this review).

The booklet then presents the principles guiding implementation of the Gender Policy Inventory, which are bottom-up, integrated (into preparation of overall country strategy), and focus on gender. It notes that the inventory is most powerful as a diagnostic and analytical tool at the micro-level. It explains the value of the inventory in moving beyond a single discipline or ministry. It provides concrete examples to make the process easier for the user to understand.

The last section of this tool notes that a team undertaking such an inventory requires extensive knowledge of the country, skills in economic and social analysis, interviewing experience, familiarity with sectoral development and expertise in gender analysis.

16.6. Sex and Gender – What's the difference? A tool for examining the sociocultural context of sex differences (9.3b)

This is a tool for combining quantitative and qualitative information for gender analysis 'to inform policy formulation and to ensure that men and women have an equal likelihood of benefiting from and contributing to sustainable development' (p. 1).

It focuses on identifying sex imbalances and on formulating questions on the different roles and responsibilities of men and women in society, why these roles persist and how policies could be formulated to take these differences into account (p. 1). The 'Basic Model' comprises four steps. Step 1 is the 'examination of sex-disaggregated quantitative data to identify phenomena that are potentially indicative of gender issues in development'. Step 2 is 'identification of the principal practices that are producing the phenomenon'. Step 3 is 'analysis of the economic, political and cultural contexts in which the phenomena occur in order to understand the major underlying forces that motivate and sustain the practices in question'. Step 4 is 'provision of general guidelines on how the knowledge gained from this process can be applied to development strategies' (p. 6). It uses a number of case studies to illustrate the method.

The case study allows the reader to see how an inductive method of gender analysis works. It would appeal to those trained in qualitative analysis because it moves from qualitative data, shows its value and then helps the reader recognize why information requires interpretation and what paths to follow in building the analysis.

Figure 19 Technical and Economic Analysis: Planning to Meet the Necessary Conditions (9.4a)

	Step 5: Resources needed	**Step 6:** Resources available	**Step 7:** Actions & resources needed
1. Message / programme			
2. Funds			
3. Personnel			
4. Technology			
5. Collection / distribution points			
6. Transportation			
7. Others			
Step 8: Refined project objectives and sub-objectives			

Figure 20 Gender and Social Analysis: Planning to Maximize Accessibility of Resources (9.4a)

Step 9: List most essential project resources (from Figure 19, above)				
	Step 10: Access factors	**Step 11:** Constraints	**Step 11** cont.: Knowledge gaps	**Step 12:** Potential solutions
A. Language				
B. Training / education				
C. Residence				
D. Communication				
E. Finances				
F. Time				
G. Legal rights				
H. Social rank				
I. Others				
Step 12 continued: Devise project strategy and implementation plan				

16.7. Necessary and sufficient conditions for sustainable development: A tool for gender-informed project planning (9.4a)

This guideline was developed for use by development planners and practitioners in order to be able 'to anticipate constraints to access of resources, and to increase the likelihood that the necessary resources will be sufficient to achieve the desired outcome' (p. 1). 'It serves to make development projects more viable and realistic by including social and gender considerations' (p. 3). The tool is primarily for planning but can be used as a diagnostic tool or for evaluation. There is a 'Basic model for identifying necessary and sufficient conditions for gender-informed development projects' comprising 12 steps which fit into three phases, each of which has a worksheet for the user to fill in, building up the picture step by step. Worksheet 1 was presented in Figure 8 of this review. Worksheets 2 and 3 are presented above as Figures 19 and 20.

The worksheets offer a method for undertaking a basic situation analysis – a prerequisite to good project planning. They do not go into the kind of detail required to ensure that the necessary information about gender relations will be identified to put into the worksheets. They presume someone with some gender analysis skills will be involved in the process. In relation to 'legal rights', for example, it asks 'will differentials be a factor for beneficiaries?' but the user may not be aware of the rights which pertain to the project.

16.8. Gender in monitoring and evaluation: A tool for monitoring and evaluation of development projects (9.4b)

This tool aims to ensure that the project design

allows for tracking and assessing the effects of project activities on participant populations, distinguished by socio-economic and cultural factors such as gender, ethnicity, class and age. Using the tool would allow people to have evidence of the impact of projects on people.

It uses standard monitoring and evaluation methodology, emphasizing the use of indicators to measure people's involvement and decision making. It is based on the logical framework used by many donors. It focuses attention on the gender dimensions of how projects affect people's abilities to improve their living standards. The focus on people addresses equity of benefits, equality of participation by different social groups and individuals and sustainability of development effort (p. 2).

The tool sets up a hierarchy of objectives and actions that link project activities, outputs, purpose and goal. There is an assumed cause-and-effect relationship between these elements. For each level, a matrix is established to identify objectives, indicators, targets, baseline, data source, timing, responsibility, cost and comments (assumptions, special circumstances, etc.) (p. 7). The tool defines each of these, thus providing a step by step guide to building a monitoring and evaluation plan.

Information is collected separately for women and men or other relevant social categories: 'seeing the differences may be the first step in addressing them'. In addition to collecting sex-disaggregated data on the indicators, gender-specific analysis of the indicators is required and the tool notes the importance of planning for this in advance. 'Disaggregated information does not automatically lead to understanding of what it means or how to correct apparent inequalities. Technical assistance may be needed from specialists in the project's sector and in social (and gender) analysis to devise the analysis plan' (p. 30).

Many governments supporting WHO require the use of logical frameworks for project proposals. This guideline unravels what appears to be a very complex format, to make it accessible, and its logic clear.

This methodology ensures that the planner thinks through the process from beginning to end, and unravels assumptions or risks that may undermine a project. It is very helpful both for those involved in a project and for those funding or managing a project at a distance (such as a multi-country intervention) because it provides a methodology for discussing everything from project goals to what will be done by when with participants. This makes the management process easier.

Considering indicators as integral to project design means that the purpose of any project will be thought through well in advance. Thus careful consideration of the nature and content of indicators, and within this, of the achievements with respect to gender concerns at different stages of the process, can become part of the process of integrating gender concerns into project planning and implementation.

If the methodology is not applied in a participatory manner it will not facilitate a sense of ownership. The methodology can appear very fixed and non-negotiable, which can be a problem since factors beyond the control of WHO staff or project participants can affect deadlines or even project design. If used for ongoing monitoring, however, such problems would be detected along the way and the plan would be altered accordingly.

16.9. Documenting development program impact: A tool for reporting differential effects on men and women (9.4c)

This tool is primarily for USAID program officers. The first section covers basic definitions and concepts regarding gender and development. The tool serves as a reminder to them that if gender has been identified as an integral factor in an activity, then outcomes or results of the activity must be examined in relation to impacts and benefits related to gender (p. 11). It argues that this should be done within standard, required, reporting formats and discusses different types of such formats.

16.10. Gender research guide for the agriculture, environment, and natural resource sectors: A tool for selecting methods (9.4d)

This is a reference book, covering checklists, gender analysis, planning and training, guidelines, monitoring and evaluation, participatory research, time allocation and farming systems research. While most of it is only relevant to agriculture, environment and natural resources, it does include brief descriptions of many of the key gender analysis materials.

The value of the USAID Tool Kit

The overall approach of the books in the tool kit is that 'gender imbalances' can be relevant to development goals either because they contradict one or more of those goals or because they act as constraints or catalysts to goal accomplishment. The position underlying these tools is that 'the effectiveness and efficiency of interventions depend on an understanding of the economic, political and cultural realities' (9.3b, p. 16). The need for gender analysis is motivated by this concern.

The tools provide processes and procedures to obtain information that would allow an analyst to identify the impact of gender relations on society, in relation to a specific problem or intervention. Many tools require gathering of data to answer their questions, however, and many require informed analysis of data, which presumes prior training in how to undertake a gender analysis.

In addition, the tools do not challenge gender inequality in its own right. As a result, they will not help the user to identify how to take advantage of a particular intervention to promote gender equality and human rights generally, or to improve women's condition, unless this is required in order to ensure the effectiveness and efficiency of the intervention.

Another limitation of the usefulness of this tool kit is that this was published in 1994 and so more recent materials are not included.

17. WHO: Gender and Health – Technical Paper (18)

WHO's 'Gender and health' technical paper aims to 'make accessible a review of the literature on gender and health that would introduce WHO staff, health policy-makers and planners to the concept of gender and to illustrate the role of gender in health and health policy and programme development' (p. 4). It is intended to be a first step within a broader process within WHO that will include the development of technical documents in relation to specific disease and policy and programme issues, as well as a practical guide to making health-related programmes gender sensitive.

The paper provides a simply written, conceptually clear outline of key issues in gender and health. It begins with basic concepts and then covers issues of risk; the impact of gender roles on women's lives; gender inequalities in health care; reconfiguring research and broad conclusions.

The lack of jargon and clarity of presentation makes this an invaluable document for use in orientation of WHO staff. All new programme staff could be required, as part of their orientation, to read the paper and then to write a short briefing on gender in relation to their own field, for example. They could be asked to consider specific dimensions, drawn from the paper. Some examples include gender differences in women and men's perceptions of a health problem or condition, and gender factors influencing the social determinants of the problem and obstacles to addressing it. They may also be asked to consider how gender issues impact on health service organization and through this, influence differential access to services. This could ensure that WHO staff has had time to identify and reflect on the impact of gender inequality on their area of concern, before starting any work for WHO. Staff already at WHO might be asked to undertake similar activities if they have never been exposed to the issues. In the same activity they could consider the impact of other inequalities, to ensure an overall social justice approach and that diverse barriers to health and health care are surfaced, rather than only gender inequality.

The paper considers only gender inequality and, while it notes this limitation, it does not give pointers in each section as to the extent to which the issues described are also framed by class, ethnic, age or other social factors. It would be important for WHO to ensure that its staff undertake synthesized analyses, so that addressing gender is not an 'add on' but part of an overall commitment to health and effort to take account of hidden factors which may limit the impact of health research or interventions.

The paper does not give substantial attention to the gendered nature of health institutions. It examines the impact of gender relations on health worker/client relationships and the differential gen-

der impact of some aspects of health sector reform, such as fees for services. However, it does not go into questions of management style, or on how decisions are made on resource allocation and setting priorities and other institutionalized dimensions of gender inequality. This is unfortunate, considering that it is often institutionalized dimensions of gender inequality which undermine the capacity of the health system to meet women's and men's health needs adequately.

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    - 9.1. Gender Concerns in Development (GCID) Framework Van den Oever P. *GCID Framework: A Tool for Assessing Institutionalization of Gender Concerns in Development Organizations.*

9.2. Quantitative Tools

9.2.a. Jerome J. *Quantifying Gender Issues: A tool for Using Quantitative Data in Gender Analysis.*

9.2.b. Jerome J. *Country Gender Profiles: A Tool for Summarizing Policy Implications from Sex-Disaggregated Data.*

9.2.c. Caro D, Riordan J, Cable M. *Gender and Household Dynamics: A Tool for Analyzing Income and Employment Data from Surveys.*

9.3. Diagnostic Tools

9.3.a. Weidemann W. *Gender and Policy Implementation: A Tool for Assessment of Policy-Derived Impacts on Women and Men.*

9.3.b. Jerome J, van den Oever P. *Sex and Gender – What's the Difference?: A Tool for Examining the Sociocultural Context of Sex Differences.*

9.4. Planning and M&E Tools

9.4.a. Van den Oever P. *Necessary and Sufficient Conditions for Sustainable Development: A Tool for Gender-Informed Project Planning.*

9.4.b. Caro D, Lambert V. *Gender in Monitoring and Evaluation: A Tool for Developing Project M&E Plans.*

9.4.c. Martin P. *Documenting Development Program Impact: A Tool for Reporting Differential Effects on Men and Women.*

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annex 1

FRAMEWORK USED FOR ANALYSIS OF TOOLS

Book details (title, author, publisher, etc.)

General questions

Intended purpose of book?

Intended target audience of book?

Who could use it?

Does this book focus on a particular sector?

Does it address social justice issues generally, or only gender inequality?

Any comments on format?

Missing links and gaps?

Specific questions

Social determinants of health and illness

Does the document provide information about or ask questions to:

- Identify the social, cultural, economic and political factors which make women sick; which make men sick? (e.g. that women are responsible for fetching water which is done in the morning when mosquitoes are around hence making them vulnerable to malaria?; that men are more likely to work in mines and be vulnerable to related lung disease);
- Identify actions which the reader could take to address these;
- Identify the relationship between these determinants (e.g. the interaction of gender inequality and poverty which makes more women poor, and leads women therefore into 'transactional sex' which makes them vulnerable to STIs; that men are often migrant labourers and hence have sex outside of long-term relationships and are vulnerable to STIs);
- Identify actions which the reader could take to address these.

Biology/sex as a determinant of vulnerability to illness

- Identify the ways in which biological factors contribute to the health problem under consideration, and the way in which social construction of gender does.

Health seeking behaviour

Does the document provide information about or ask questions to:

- Identify factors which impact on men and women's ability to access health services;
- Identify actions which the reader could take to address these;
- Assess factors which make men and women's experience of health services positive or negative;
- Identify actions which the reader could take to address these;
- Explore the nature of power relations between men and women as they pertain to either of their health seeking behaviour;
- Identify actions which the reader could take to address these;
- Explore how gender roles may influence the ability of men or women to participate in health promoting activities, community activities, etc.

Quality of care of health services

Does the document provide information about or ask questions to:

- Identify whether curricula are gender-sensitive;
- Assess accessibility of services to different categories of clients;
- Assess affordability of services;
- Assess adequacy of services (are they good enough);
- Assess appropriateness of services (- range of services; technology; in terms of the extent of the problem);
- Assess acceptability of services (culturally; human rights values);
- Identify gender inequality in provider-client relationships;

Format of table used to answer specific questions:

	Has this issue been covered?	Explanation and Examples	Reference (page, chapter and section)
Specific questions, as listed below: e.g. *1. Social determinants of health and illness* Does the document provide information about or ask questions to:			
Identify the social, cultural, economic and political factors which make women sick; which make men sick? (e.g. That women are responsible for fetching water which is done in the morning when mosquitoes are around hence making them vulnerable to malaria?; that men are more likely to work in mines and be vulnerable to related lung disease) *1.2. Identify actions which the reader could take to address these*			

- Identify actions which the reader could take to address these;
- Identify social, economic or cultural prerequisites for technical interventions to be effective;
- Identify actions which the reader could take to address these.

Health promotion

Does the document provide information about or ask questions to:

- Identify the underlying causes of the specific behaviours;
- Identify actions which the reader could take to address these;
- Identify the underlying causes of the specific behaviours targeted in Information, Education and Communication (IEC) messages;
- Identify actions which the reader could take to address these;
- Elicit cultural meanings associated with this specific problem and whether these match or contradict the approach and explanations provided by western medicine;
- Identify actions which the reader could take to address these;
- Identify all the sectors whose activities impact on the problem (and which need to be addressed in any intervention).

Impact of health financing

Does the document provide information about or ask questions to:

- Identify impact of financing system (e.g. 'cost-sharing'; 'fees for services') on women;
- Identify whether resources target women to overcome existing inequalities;
- Identify costs of time and other inputs contributed by women and men;
- Identify means of covering these costs so that the intervention does not in fact become a burden to intended beneficiaries (assume it can make increased demands on women's unpaid labour).

Policy

Does the document provide information about or ask questions to:

- Identify which international human rights treaties or agreements pertain to this problem;
- Identify the policy dimensions pertaining to gender equality for this problem;
- Identify if there are policies or regulations which hinder or promote this intervention;
- Identify whether interventions build skills at all levels for participation in policy making and evaluation.

Research and monitoring

Does the document provide information about or ask questions to identify:
- If there is research data on any of the issues;
- If existing research explored the
  a) views and meanings in relation to the issue;
  b) needs of: women and men; young and old; leadership and ordinary citizens; and those responsible for service delivery;
- If data is disaggregated by sex;
- If findings might be affected by local perceptions of the legitimacy of researchers;
- If the methodology ensured that beneficiaries were questioned.

What are the means of monitoring the effectiveness of implementation?
- Input from management?
- Input from practitioners?
- Input from beneficiaries? (Women? Men? Old and young? Leaders and ordinary citizens? Marginalised groups?)

What are the actions which the reader could take to ensure targeted beneficiaries are heard?

Are tools provided for developing and assessing indicators to identify gender inequality?

Is information provided on how to monitor movement towards gender equality?

Consultation and participation of target group in design, implementation and monitoring

Does the document provide information about or ask questions to identify:
- If all the relevant actors have been consulted about the need for an intervention;
- If they have been involved in designing this intervention; which interventions;
- The costs of participation for individuals and groups so that they can be remunerated.

What are the means of monitoring the effectiveness of implementation?
- Input from management?
- Input from service providers?
- Input from beneficiaries? (Men? Women? Old and young? Leaders and ordinary citizens? Marginalised groups?)

What are the actions which the reader could take to ensure targeted beneficiaries are heard?

Are institutions and mechanisms for accountability on progress towards gender equality mentioned?

How would such institutions be involved?

Institutional management

Does the document provide information about or ask questions to identify:

- gender inequality in access to education and training;
- actions which the reader could take to address these;
- the nature of gender inequality in institutional relationships;
- representation of women in decision-making structures;
- processes of decision-making (top-down; participatory);
- actions which the reader could take to address the above and build institutional support for promoting equality both within the institution and in its external actions.