Japan International Cooperation Agency

REFERENCE MATERIAL FOR GENDER MAINSTREAMING IN THE HEALTH SECTOR

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Governance and Peacebuilding Department
Japan International Cooperation Agency (JICA)
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Reference Material for Gender Mainstreaming in the Health Sector

The Japan International Cooperation Agency (JICA) aims to achieve gender equality and women's empowerment through gender mainstreaming in its development projects. Gender mainstreaming in development projects refers to the incorporation of a perspective that promotes gender equality and women's empowerment in all stages of a project (i.e., planning, implementation, and monitoring and evaluation). Gender mainstreaming enhances the effectiveness of the JICA's projects by addressing different issues and needs of the people of any gender and hence contributes to the realization of an inclusive society, where everyone can fulfill their potential. Through gender mainstreaming in the health Sector, people of all genders are expected to be able to access and enjoy the benefits of health care services which will lead them to improvement in health for all.

Gender is a term that refers to socially and culturally constructed attributes associated with being female or male. Many societies not only categorize humans as "female" or "male" based on biological features but also give specific values to each and prescribed their respective roles and behaviors. Thus, gender not only refers to "sex" in a biological sense but also associates sex with specific roles and behaviors expected to women and men by society.

A perspective of gender (or gender perspective) is a perspective that focuses on gender issues, needs, and impacts arising from the different social roles and power relations of women and men in all spheres of the society, including policies, programs, institutions, and organizations. In development projects, this perspective is indispensable to deliver equitable benefits to women, girls and all other beneficiaries regardless of their gender.

Purpose of Reference Material

The Reference Material serves as a guide for all stakeholders of JICA's projects to understand gender issues, the importance of gender mainstreaming in the health sector, and sample methods of how to incorporate a gender perspective into each stage of a project cycle.[i] The Material especially focuses on the following three sub-sectors selected in accordance with JICA's project strategies and priority issues.

(1) Promoting Maternal and Child Health and Sexual and Reproductive Health

Examples of Initiatives: improvement of maternal and child health services, promoting continuum of care for maternal and childcare, and dissemination of maternal and child health handbooks.

(2) Strengthening Measures Against Infectious Diseases

Examples of Initiatives: strengthening diagnose, surveillance, and research for infectious disease prevention, building and strengthening the system of diagnosis and treatment,

[i] It must be noted that involvement of men is important for addressing gender issues, and also gender issues faced by men must be addressed in the efforts for transforming patriarchy. Capturing and addressing gender issues faced by other genders (other than 'women' and 'men') are also important in gender mainstreaming.

strengthening prevention and awareness raising for infectious diseases, improvement of health service delivery, and COVID-19 responses.

(3) Promoting Universal Health Coverage (UHC)

Examples of Initiatives: Improvement of accessibility to basic health care services, medical and health insurance systems, non-communicable diseases (NCD), countermeasures for aging, etc.

How to use Reference Material

Chapter 1. Major gender issues and their causes in the health sector

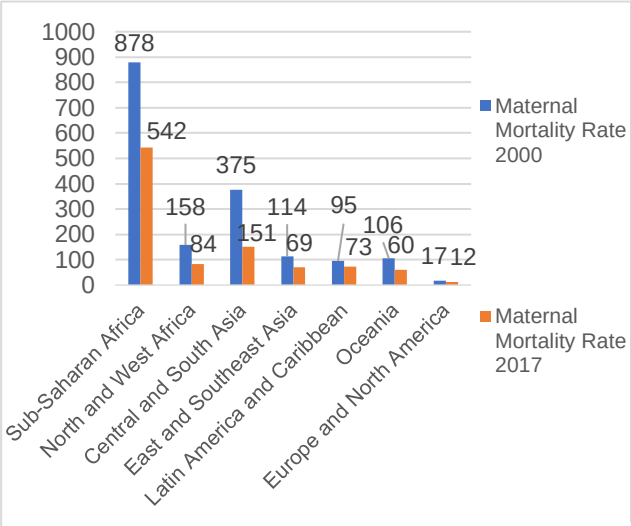
This chapter outlines three major gender issues and their causes that must be understood for gender mainstreaming in the health sector.

(1) Maternal mortality is still high in some countries and areas.
(2) Women face higher risks of infectious diseases than men.
(3) Women are hindered from receiving adequate health service when needed.

(1) [Mother and child health]: Maternal mortality is still high in some countries and areas

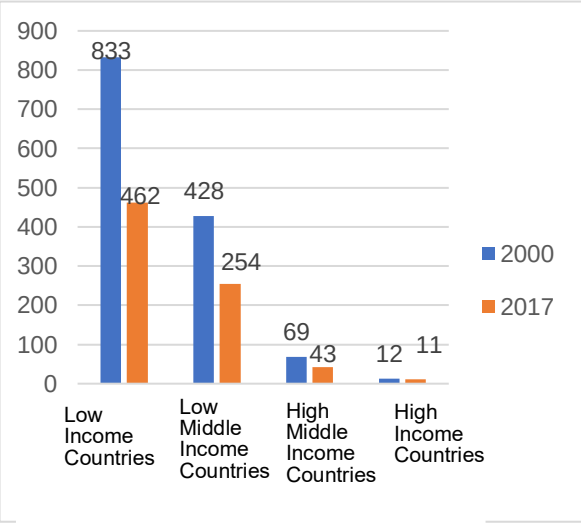
Gender issues in maternal and child health include restrictions of access to health care services including continuum of maternal and child health care and sexual and reproductive health care. These issues are caused by unequal social norms of gender and religious restrictions, which could result in difficulty such as malnutrition in pregnant women and maternal mortality.

The maternal mortality rate is high in countries where access to quality health services is difficult.[1] The number of maternal mortalities in the world, which was 451,000 per year in 2000, has been improving worldwide, with decreasing to 295,000 in 2017. However, it is still significantly high in Sub-Saharan Africa, and 95% of them are in low- and middle-income countries, of which 65% are in African countries[2] (see Figures 1 and 2).



Source: WHO World Health Statistics 2021

Figure 1: Changes in maternal mortality rate by region



Source: WHO World Health Statistics 2021

Figure 2: Changes in maternal mortality rate by income group

(1)-1 Distractions from prevention, early diagnose and treatment, and continuum of care

Complications during and after pregnancy are the main causes of maternal mortality. However, most complications are preventable and treatable by accessing appropriate healthcare services. It is essential for pregnant women to receive antenatal check-ups at the right time for prevention. However, owing to gender-based physical, economic, and sociocultural restrictions, women may not be able to access to maternal and child health services during pregnancy, which hinder the continuum of maternal and childcare after childbirth. For example, health facilities may not be

located within a safe distance for pregnant women. Also, when health services are not for free, women need to obtain permission from men for the cost of maternal and child healthcare services if men **predominately make decision** in the household. If men are reluctant to pay, women may not be able to receive health services such as antenatal checkups at the right timing.

Sociocultural restrictions also prevent women from receiving healthcare services. For example, when women are restricted from traveling outside of the house alone or limited to contact with others (especially men), including doctors, they tend not to be able to access to maternal and child health services. In addition, women spend more time on unpaid housework and care work than men due to the **stereotyped gender division of labor.** A lack of time hinders women from accessing to the required maternal and child health services. Thus, women face difficulties in visiting health facilities and obtaining accurate information related to healthcare services. Consequently, the **opportunity to receive the continuum of care from antenatal to postnatal** may be restricted.

(1)-2 Malnutrition of pregnant women due to unequal distribution of food

Unequal distribution of food for women in households affects maternal mortality. In a male-dominated society, disproportional food distribution within the household particularly affects the health of women and girls. For example, when men are considered important as breadwinners at home and food is preferentially distributed to men, women may not be able to receive sufficient nutrition and may suffer from chronic malnutrition. This trend is particularly pronounced during seasonal food shortages, amines, and disasters.[3] **Undernutrition in women increases the risk of illness**, and for pregnant women it increases the risk of maternal mortality.[4] Also insufficiency in energy and nutrient intake, such as iron, from pre-pregnancy and during pregnancy may affect fetal development. Insufficient fetal development increases the risk of obesity and lifestyle diseases of children such as cardiovascular disease and diabetes in adulthood.[5]

(1)-3 Impact of limitation of sexual and reproductive health and rights to maternal mortality

Limitation of sexual and reproductive health and rights is one of the factors that disrupts maternal health. Having too many pregnancies and short birth intervals are particularly related to high maternal mortality. Therefore, improvement of status and awareness on sexual and reproductive health and rights, including sexual relations and contraception, is an important countermeasure. According to a survey conducted in 57 countries around world, among 15–49-year-old women with partners, only 55% acquired decision-making rights over sexual and reproductive health in terms of receiving health services, usage of contraceptives, and sexual consent (including refusal of sexual intercourse).[6] It is important that women and men learn correct knowledge about pregnancy and childbirth and be able to receive appropriate measures and plan family planning according to their health conditions.

TIPS: Sexual and Reproductive Health and Rights (SRHR)

Sexual and reproductive health and rights are term defined in the Action Plan confirmed in International Conference on Population and Development in Cairo, Egypt in 1994. It stipulates that all human beings have the right to freely decide their own sexual and reproductive health throughout their lifetimes so that people may have a safe and satisfying sexual well-being. This includes deciding whether to give birth or not, and selecting

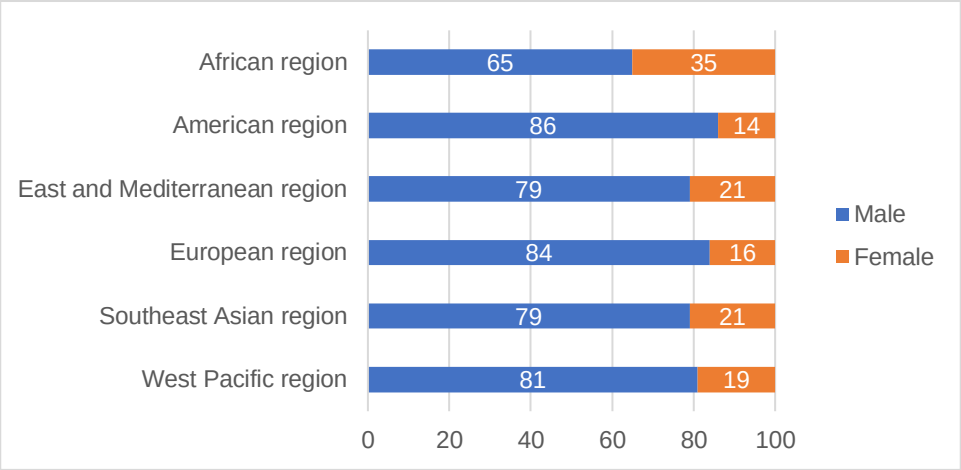
when and how many children to have in their lifetimes. It is necessary to change the perceptions and empower women when the right for decision-making is only given to men.

Teen pregnancy caused by **child marriage and unintended pregnancy by sexual violence** are also factors that increase maternal mortality. Not a few developing countries socially tolerate child marriage, with more than one-third of women married under the age of 18, of whom 35% are girls under the age of 15. As a result, 7.3 million girls under the age of 18 give birth annually, including 2 million are under the age of 15, and 70,000 girls die annually from complications of pregnancy and childbirth.[7]

Teen pregnancy has a high maternal risk due to the underdevelopment of mental and physical conditions, as well as newborn health risks caused by low birth weight due to premature birth. Low-birth-weight infants often require special medical intervention after birth because of their immature body function.[8] Also, women who experience teen pregnancies tend to have a higher number of children in their lifetime. As a result, they are more exposed to the health risks associated with pregnancy and childbirth. Especially in countries where child marriage is banned but child marriage is still performed as a custom, child pregnancy often faces social stigma and criticism from health workers. To avoid such stigmas, adolescent pregnant women tend to avoid hospitalized delivery and depend more on illegal abortions, which increases health risks.[9] In addition, unsafe abortions, such as unlicensed abortions, may increase the risk of infectious diseases due to the lack of a hygienic environment. Women who have undergone **female genital mutilation (FGM)** also have an increased risk of infection during pregnancy and childbirth. More than two 200 million women and girls have experienced FGM in more than 30 countries in Africa, Middle East and Asia[10] If the situation would not be improved, it is predicted that 4.6 million girls will experience FGM by 2030[11]. Women and girls who have undergone FGM are also at a substantial risk of infectious diseases and bleeding as they experience pain during excretion, sexual intercourse, and child delivery. In addition to their physical effects, they also tend to suffer from mental illnesses, such as middle and long-term trauma, anxiety, and depression.[12]

(2) [Measures against infectious diseases]: Women face higher risks of infectious diseases than men

Women are at a higher risk of infection than men for three reasons. First, women are more likely to be at a substantial risk of infection. In many countries, women are responsible for the care work of children and the elderly at home because of the **stereotyped gender roles.** In addition, 70% of workers working at the frontline of medical practice, such as nurses, midwives, and community health workers, are women. Also, 83% of the care workers at care facilities for the persons with disabilities and the elderly are women[13] (see Figure 3). Consequently, women and girls involved in such care work have **more risks to be exposed to infectious diseases**.



Source: NHWA for 61 countries for nursing data

Figure 3: Female-male ratio of nurses in each region of the world (2019)

The second reason is malnutrition. When women's status is low in society and at home, they tend to suffer from chronic malnutrition due to **uneven distribution of food,** and the risk of infection increases.[14]

Third, women are more likely to be economically and socially vulnerable to infectious diseases compared to men. Women are more likely to engage in informal-sector and non-regular employment than are men; thus, many women are excluded from social welfare.[15] This is because economic stagnation due to the pandemic of infectious diseases such as COVID-19 affects women's livelihoods and employment. During the COVID-19 pandemic, declining and unstable income and employment make it difficult for livelihood, which led to the avoidance of medical expenditures and access to health services. This has led to the spread of infection, deterioration of physical condition, and an increased risk of infectious diseases. In addition, preliminary treatment in health facilities for boys tends to be prioritized over girls as boys are expected to be the breadwinner to the family.[16] Consequently, it creates difference between genders on **early diagnosis of infectious diseases and contact tracking of the infection**.

TIPS: Cholera Outbreaks and Gender

While it is considered that there is no gender difference in infection rates for infectious diseases transmitted through water and meals such as cholera, women face a higher risk of infection at any age group older than school children having more opportunities for exposure to the transmission route. Especially in society with strict gender norms, they are responsible for house chores and care work, which have more contact with sources of infection such as water, food, excrement as through water fetching, housework and cooking, care of children and sick members in the family due to gender division of labor. Also, when women got infected, they face the possibility of severe illness caused by fatigue due to heavy workloads, Therefore, it is important to provide social mobilization about infection prevention to women. Understanding the importance of boiling water and the appropriate handling of food and excrement not only enables women to prevent transmission of infection but also to prevent the spread of infection among the family. At the same time, to reduce the risk of women, it is necessary to conduct activities for men to change the perception regarding power relation at home and reduce the burden of house work by gender division of labor. By doing so it would reduce the frequency of women's contact to infectious source and prevent severe symptom during illness for women.

(Oxfam. 2012. Gender and Vulnerability to Cholera in Sierra Leone: Gender analysis of the 2012 cholera outbreak and an assessment of Oxfam's response)

Infectious diseases are **also a significant issue from the point of view of maternal and child health**. For example, malaria infection is a significant risk of both maternal and infant mortality for pregnant women, as infection causes symptoms such as severe anemia and obstruction of blood flow from the mother to the fetus.[17] Early diagnosis and treatment are important for the response to malaria infection. However, when women are unable to receive immediate health care services owing to **male-centered decision-making** or the burden of the **gender division of labor** and the diagnosis or treatment is delayed**, i**t may prolong treatment or even cause death. Early diagnosis and preliminary treatment as well as the tracking of infected persons are important n for other infectious diseases such as tuberculosis.

In addition, women and girls are at a higher **risk of infection for sexually transmitted infections (STIs) such as** HIV/AIDS.[18] The risk of transmission of HIV to women is also increased by domestic violence (DV) and sexual violence by husbands and partners. In particular, girls in child marriages face a higher risk of infection as they face difficulty in negotiating for safe sexual intercourse owing to unequal power relations with their partners and lack of sexual and reproductive knowledge.[19] Under the circumstances of restrictions and lockdown due to the COVID-19 pandemic, it has been confirmed that sexual violence and domestic violence are exacerbated, and SGBV is more severe under pandemic situations.[20]

(3) [Promoting universal health coverage]: Women are not able to receive adequate health service when needed

Universal health coverage (UHC) aims "to ensure that all people receive appropriate health services such as prevention, treatment, and rehabilitation at affordable costs." The UHC index, which indicates the prevalence of UHC, improved from 45.8% in 1990 to 60.3% in 2019 globally. However, regional disparities are still large, and some countries have an important level of over 95% coverage, while countries in Sub-Saharan Africa have a low level of less than 25%; thus, urgent improvement is required.[21]

Under such circumstances, according to the survey by UHC2030, women and girls as the group which is denied the access to health service by the social structure and having most difficulty[22].

Low achievement of UHC is affected by several factors. Physical factors include lack of nearby health facilities with a hygienic environment and lack of means of transportation to health facilities. Economic factors include lack of health expenses due to poverty. At the same, resource shortage on the health provider side such as lack of human resources or skills for healthcare service of the providers affect a degree of achieving UHC. In addition to such factors, **socio-cultural norms that aggravate gender discrimination** have a significant impact. Specifically, the following two points can be mentioned:

First, access to health services is suppressed because of biased social norms that restrict women's behavior. For example, women are hindered from accessing health services owing to **biased decision making at home or social norms,** such as restrictions on women going out without male permission or male accompaniment. Sometimes, women must obtain male permission to go to a health facility. Women are also sometimes only allowed to be seen by female

doctors or restricted from physical contact of different gender for **religious reasons**. When women are not able to get vaccinated with tetanus vaccinations during delivery, as male health workers are not allowed to vaccinate them, it increases the risk of infectious diseases during delivery. In particular, when there is a **shortage or absence of female health workers in the area**, this will hinder women's access to health services.

Second, on the service provider side, a gender perspective is required for facility development aimed at promoting the use of health services. Although a new health facility is established in the community considering convenience of time capacity and transportation for women, if there are no curtains or partitions in the examination room or in-house patients' room to secure the privacy of women, women may avoid going to the health facility, which may prevent improvements of women's health condition. In addition, if female health workers, such as female doctors, are absent, some women are still prevented from receiving health services as they are not able to receive medical treatment from men because of gender norms or religious reasons.

Therefore, to achieve UHC, it is necessary to consider the responses to gender-based factors that underlie the challenges of eliminating gender-based inequality in access to health.

Also, it must be noted that women are not the only ones who face gender issues. Strong stereotypes of "masculinity" could have a negative impact on men. For example, men often take risk behaviors that are harmful to their health, such as smoking and drinking, as a symbol of "masculinity" within the community. In addition, men tend to not visit health facilities when they are ill or under-report their symptoms.[23] Such behaviors are influenced by views of **toxic masculinity** that stereotype illness and visiting health facilities as "weak" or "not masculine."

As described above, when conducting analysis, it is important to incorporate a gender perspective into the analysis and determine the issues that women, men, and the people in different situations face, followed by improving access to healthcare services that meet their needs.

TIPS: Sexual and Gender-Based Violence (SGBV)

SGBV is a violence based on gender inequalities in power relations and gender norms, including physical, mental, and sexual violence and denial of access to resources and services. The definition of violence includes threats and forced actions. It is a severe violation of human rights not only among women and girls but also among men and boys. It includes customs harmful to the health such as FGM against girls and domestic violence (DV) between partners and spouses. There have been measures aimed at eradicating SGBV globally, and some countries have banned SGBV in domestic laws; however, it remains as a great challenge to eradicate it. The healthcare sector plays a role in the protection of victim/survivors, especially in cases of DV and sexual violence. Health facilities treat the victim/survivors, collect evidences, and provide psychological care in cooperation with the police. Therefore, it is important to conduct training for gender mainstreaming and victim/survivor-centered SGBV response, as well as awareness raisings in order to prevent stigma and victim/survivor-blaming at health facilities, and to promote appropriate responses for victims/survivors. (UNHCR Emergency Handbook. 2022. Sexual and Gender Based Violence (SGBV) prevention and response)

Chapter 2. Importance of gender mainstreaming in the health sector

Following the gender issues and their causes presented in the previous chapter, this chapter explains the importance of a gender perspective in development projects from two aspects: realization of gender equality and women's empowerment, and increase of development effectiveness. It also outlines international frameworks for achieving gender equality in the health sector.

2-1 Why is gender mainstreaming important in health sector?

(1) Physical and Mental Health as a Right Guaranteed to All Human Beings

Living a healthy life is one of the most important developmental issues that the international community should tackle as it is a right guaranteed to all human beings and which women should thus naturally enjoy. However, as mentioned in the previous chapter, various unequal socio-cultural gender norms and gender-based unequal power relations affect restriction of women's and girls' access to health services due to physical, economic, and socio-cultural factors, and sexual and reproductive health and rights, which affect health condition of women and girls. Thus, this issue deeply concerns women's health. To provide health care services that meet the needs of women without gender inequality, it is necessary to understand the circumstances and factors that women and girls face and consider the contents of the service and means of provision including time and space. In so doing, women and girls have access to health services and thus promotes the achievement of UHC, which refers to "the status to ensure that all people receive appropriate health services such as prevention, treatment, and rehabilitation at affordable costs." In addition, sexual and reproductive health/rights are expected to be an active initiative; this is an important aspect of empowerment for women and girls because it aims for them to gain ownership of their own bodies.

(2) Maximizing the Impact of Development

When implementing a development project in health sector, the final beneficiaries of the project always include the women and girls residing in the area, including female health workers as the direct beneficiaries. As shown in the previous chapter, there is an increased health risk to women due to physical, economic, and sociocultural factors preventing or making it difficult for women to access health services. Activities with gendered perspective respond to such gender issues, thus enhances the developmental impact as a whole. For example, when providing technical training to health workers in a country where women can only receive health service from female health workers, prioritizing training opportunities for female healthcare workers enable to provide appropriate and improved health service to the women in unequal situation.

Also, a lack of a gendered perspective may limit the developmental impact. For example, when constructing a new health facility without properly conducting survey the needs and issues women are facing, it may select the construction place to where women are physically, socially inaccessible or unreachable by safety reason. Thus it may occur difference in usage by gender.

Furthermore, women's needs and issues may be considered less important due to absence of women at policy making. For example, women's nutrition program may not receive enough budget during overall budget allocation, which disrupts improvement of nutrition for women whom key player in the area, thus leading to delay of the improvement of the nutrition in the entire area.

2-2 International frameworks to achieve gender equality in health sector

(1) The 2030 Agenda for Sustainable Development and Sustainable Development Goals (SDGs) (2015)

Gender equality and women's empowerment are considered a prerequisite for achieving the Sustainable Development Goals (SDGs) of the 2030 Agenda for Sustainable Development. In other words, gender equality and women's empowerment are the means to realize all 17 goals and 169 targets, and actions for achieving gender equality and women's empowerment are required.

Among the 17 goals, Goal 5, which addresses gender equality and women's empowerment, aims to empower women and eliminate gender-based discrimination and build a society in which all people equally enjoy their rights and opportunities, and share responsibilities. The following is a list of targets of Goal 5, which is related to the health sector. Relevant points are highlighted in orange.

- 5.1 End all forms of discrimination against all women and girls everywhere.
- 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres.
- 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.
- 5.4 Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies (…).
- 5.5 Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life.
- 5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.
- 5.c Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.

The table below shows other Goals, Targets and Global indicators relevant to both the health sector and gender equality and women's empowerment, except for Goal 5.

Goal	Target	Global indicator
3: Ensure healthy lives and promote well-being for all at all ages.	3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.	3.1.1 Maternal mortality ratio 3.1.2 Proportion of births attended by skilled health personnel
	3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.	3.2.1 Under-five mortality rate 3.2.2 Neonatal mortality rate
	3.7 By 2030, ensure universal access to sexual and reproductive health-care	3.7.1 Proportion of women of reproductive age (aged 15-49 years)

	services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.	who have their need for family planning satisfied with modern methods 3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group
	3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all.	3.8.1 Proportion of the target population covered by essential health services 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income
	3.c Substantially increase health financing and the recruitment, development, training, and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.	3.c.1 Health worker density and distribution

*: Highlights in orange indicate relevance to achieving gender equality and women's empowerment.
Reference: Prepared based on the information
https://www.mofa.go.jp/mofaj/gaiko/oda/sdgs/statistics/index.html (Accessed April 20, 2022)

(2) Formulation of Global Strategy to Achieve SDG Goals by the UN

At the United Nations MDG Summit held in 2010, the activities and international strategies of "Every Women Every Child" were advocated, and the Global Strategy for Women's and Children's Health was formulated at the behest of the Secretary-General of the United Nations. In 2015, this was updated as the "Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)" as the global strategy to achieve the SDGs. This strategy aims to ensure that all women, children, and adolescents enjoy physical and mental health and well-being without hindrance by social and economic barriers in order to achieve a sustainable society by 2030.[24] In addition, the UN Women set Violence Against Women (VAW) as a priority sector in the "Strategic Plan 2018–2021", and urged the improvement of access to health service, judicial system, police, and social services for women who experience sexual and physical violence. It also advocates at the national level and conducts social mobilization about HIV/AIDS countermeasures, of which sexual violence increase the risk of infection, as a policy-level coordinating institution.[25]

(3) Establishment of the Global Fund to Fight AIDS, Tuberculosis, and Malaria

In 2002, the Global Fund to Fight AIDS, Tuberculosis, and Malaria raised funds for the response of the world's three major infectious diseases (HIV/AIDS, tuberculosis, and malaria) through a private initiative. It is the world's largest international fund and partnership organization.[26]

(4) Gender Mainstreaming in WHO's Plan and Strategy

1) Promoting Gender Mainstreaming: Formulation of the "Thirteenth General Programme of Work, 2019-2023"

WHO's 71st General Assembly, held in 2018, positioned gender mainstreaming as the core task to achieve universal health coverage and the SDGs, and the Strategy for Integrating Gender Analysis and Actions into the Work of WHO strengthens such activities.

2) Strategy Regarding Reducing Maternal Mortality

The following action plans were formulated as roadmaps to reduce neonatal and maternal mortality ratios.

- ENAP (Every Newborn Action Plan: 2014)[27]

  As an action plan for reducing preventable neonatal death and stillbirth by 2030, it stipulates that all pregnant women undergo at least four prenatal checkups, all deliveries are assisted by professional healthcare workers, and all women and newborns receive postnatal care within 2 days after delivery.

- EPMM (Ending Preventable Maternal Mortality: 2015)[28]

  As the goals and strategies for eradicating preventable maternal mortality, this aims to eliminate domestic and nation-based inequality in access to maternal and child healthcare services and quality of care and inequality caused by the results of care. It also continues to improve care, including sexual and reproductive health and family planning.

(5) Formulation of UNFPA Strategic Plan 2022-2025

The United Nations Population Fund (UNFPA), established in 1969 under the initiative of the United Nations General Assembly, is the largest organization that provides population-related support to developing countries with international funds. It provides support to each country to improve sexual and reproductive health and family planning services based on individual choices. UNFPA's "Strategic Plan 2022–2025" aims to improve women's livelihoods and achieve gender equality by providing universal access to sexual and reproductive health and rights and reducing maternal mortality.

Chapter 3. Mainstreaming gender perspective in project cycle

Gender mainstreaming in a project means integrating a gender perspective in all the stages of the project: planning, implementation, monitoring, and evaluation. This Reference Material presents the following five practical steps to mainstream a gender perspective in a project.

- **Step 1 "Social and gender analysis":** Conduct a social and gender analysis. Specifically, identify gender issues through analyzing related policies, structures, organizations, and different experiences, challenges and needs of women and men in the region, in view of promoting gender equality and women's empowerment.
- **Step 2 "Formulation of an activity plan":** Formulate a plan of activities to address the gender issues identified at Step 1.
- **Step 3 "Setting gender indicators":** Set quantitative and qualitative indicators to objectively measure the effects of the activities.
- **Step 4 "Implementation and monitoring with a gender perspective":** Establish a gender-responsive implementation structure. With a gender perspective, implement activities, and monitor the progress, results, and impacts (unexpected positive and negative effects of project implementation).
- **Step 5 "Evaluation with a gender perspective":** Evaluate implemented activities that had incorporated a gender perspective, and their results and impacts.

The table below shows the five steps for gender mainstreaming applied in three project phases: project formulation phase, project implementation phase, and after project completion. Step 1 to 3 fit into the project formulation phase, Step 4 is the project implementation phase, and Step 5 is the phase after project completion. Although a gender perspective must be incorporated throughout all phases, it is particularly important to mainstream a gender perspective in the project formulation phase (Step 1 "Social and gender analysis" to Step 3 "Setting gender indicators").

Project formulation phase			Project implementation phase	After project completion
Step 1 Social and gender analysis	Step 2 Formulation of an activity plan	Step 3 Setting gender indicators	Step 4 Implementation and monitoring with a gender perspective	Step 5 Evaluation with a gender perspective

The following table indicates where to refer in the Reference Material according to the project cycles of technical cooperation, Official Development Assistance (ODA) loan and ODA grant.

Scheme	Project cycle	Where to refer in the Reference Material
Technical Cooperation	At the time of preparing the Terms of Reference (TOR) for the data collection survey, detailed design study and basic design study	Step 1 (Analysis)
	At the time of drafting Main Point Discussed in the Record of Discussion (R/D) (activities related to gender), PDM, and Ex-Ante Evaluation document	Step 2 (Activity planning), Step 3 (Indicators)
	At the time of preparing the TOR of the project, implementing the project, and reviewing a monitoring sheet	Step 4 (Implementation and monitoring)

ODA loan	At the time of preparing the TOR for the data collection survey and Preparatory Survey, and drafting Project Planning Documents (1)	Step 1 (Analysis)
	At the time of preparing Minutes of Discussion (M/D), Project Planning Document (2)/(3), Records of hearings, and drafting Ex-Ante Evaluation document	Step 2 (Activity planning), Step 3 (Indicators)
	At the time of supervising the project and reviewing Project Status Report	Step 4 (Implementation and monitoring)
ODA grant	At the time of preparing the TOR for the data collection survey and Preparatory Survey, and drafting Project Planning Record (1)	Step 1 (Analysis)
	At the time of preparing Minutes of Discussion (M/D), Project Planning Document (2)/(3), and Ex-Ante Evaluation Document	Step 2 (Activity planning), Step 3 (Indicators)
	At the time of supervising the project and reviewing Project Monitoring Report	Step 4 (Implementation and monitoring)

Details of Steps 1 to 5 are explained in the following sections.

Step 1. Social and gender analysis

The first thing to perform in gender mainstreaming of a project is to identify gender issues through social and gender analysis. Specifically, a survey is to be conducted to collect and analyze gender-disaggregated data and related information in the target countries and areas to understand the current situation and issues of each gender. It is especially important to understand 1) behaviors and actions of people of different genders and their beliefs and values, 2) social and cultural norms and practices affecting those people, and 3) issues that they face based on their gender.

The table below is a "List of Survey Items and Contents for Social and Gender Analysis" to be referred to when preparing a survey. It shows exemplary survey items with respective survey questions. When a survey content is related only to a specific sub-sector, the name of the sub-sector is shown in a square bracket, "[sub-sector]". The list also includes 'Basic information' that helps better understand the current situation and issues related to gender in the sector and the sub-sectors. Furthermore, since every project is expected to contribute to Goal 5 of the SDGs, including the elimination of sexual and gender-based violence (SGBV), it is desirable to collect and analyze a wide range of data; thus, the survey items include those related to Goal 5. It should be noted that these survey items and contents are examples. Thus, in accordance with the purpose and scope of the project, survey items and contents should be modified or added.

List of survey items and contents

Survey items	Survey contents
Policies and systems	
Health/gender-related policies/plans: incorporation of related legal provisions and contents	☐ Activities on gender issues and gender relations in law, policies, strategies, and national level action plans in health sector ☐ Situation of women's legal status (legal status of women's right to self-determine divorce, property ownership, child rearing, reproductive health, etc.)
Laws and regulations on maternal and child health	☐ Is using contraceptives legal? ☐ Is abortion legal?
Laws and regulations on SGBV	☐ Situation of laws, policies, and national level action plans to protect women who suffered SGBV ☐ Does the scope of the laws include mental, social and economic violence?
Organizational structure	
Degree of women's participation in decision-making system and situation of allocation	☐ Number and ratio of healthcare workers (doctors/nurses/ midwives) (by gender, by qualification, by job title) ☐ Are there any gender differences in employment criteria?
Capacity of healthcare professionals	☐ Do heath workers have basic knowledge of gender? Have they received training on gender? ☐ Are there any gender differences in the number of health workers who have received training?
Institutional structure regarding maternal and child health	☐ Are there deliveries assisted by traditional midwifes? ☐ What is the rate of child delivery in institutional delivery at health facilities?
Health worker allocation situation for infectious diseases	☐ Proportion by gender of health workers who examine, treat and care for patients with infectious diseases
Health worker allocation situation for relating to	☐ Are women actively involved in the formulation and management of health service programs?

achievement of UHC	☐ Are women medical professionals with nationally-certified qualifications (doctors, nurses, midwives) assigned to health facilities according to administrative guidelines? ☐ Do female health workers exist in the community? ☐ What are the restrictions for female health workers in receiving training? ☐ Is traditional health care common in the target area?
Institutional structure regarding SGBV	☐ Situation of the system for counseling, support, and monitoring for women who suffered SGBV ☐ Is there a one-stop support center within health facilities to protect SGBV victims/survivors? ☐ Is there a cooperation or referral system with hospitals, hotlines, consultation desks, and police for women who suffered SGBV (such as introduction/referral to other hospitals or higher-level organizations)? ☐ How many cases of violence against women are reported, and how much intervention by government is done in the target area? ☐ Situation of health care service provision to victim/survivors of SGBV ☐ Number of obstetrician-gynecologists, midwives, emergency physicians and nurses who received the training on response for SGBV
Diverse stakeholders (collaboration)	
Cooperation with gender-related institutions Cooperation with donors	☐ Is there cooperation with the Ministry of Women or any organizations promoting gender equality? ☐ Situation of activities with a perspective of women's empowerment and gender equality by other donors and international organizations in the health care sector
Condition and issues on access in target area (access to health care services)	
Health facility situation means of access	☐ Proportion of delivery assisted by healthcare workers (such as midwives) with appropriate knowledge and skills ☐ Is there any gender gap in accessibility to regional health facilities? ☐ What are the factors that make it difficult for women to access health facilities (e.g., time constraints, lack of means of transportation, behavioral restrictions, and lack of decision-making rights for movement and expenditure on transportation)? Has any gender-based difference in health needs been identified? ☐ Are there any social norms that prevent women from receiving health services from male health workers? ☐ Is health education or sex education provided by government or health workers in the area? ☐ Do the resident women targeted by the project have access to the necessary knowledge and information on health? ☐ Is any women's group working on health in the community?
Gender perspective in the design, installation, and operation of health facilities	☐ Are waiting rooms, examination rooms, patient rooms, toilets, and lighting in health facilities designed to ensure the privacy and safety of women? ☐ Are women's opinions taken into account in the planning and operation of local health facilities? Are women proactively involved in the process?
Situation of access to maternal and child health	☐ Number of pregnant women who received antenatal and postpartum care, or continuous care ☐ Is there any information-provision service or education program on family planning? ☐ Is there any gender-based difference in the degree of understanding on contraceptives? ☐ Is it possible to obtain contraceptives? Is it possible to use them? ☐ Is it possible to insert contraceptives such as intrauterine device or implanting contraceptive device at health facilities?
Situation of access to infectious disease response	☐ Is there any opportunity to be diagnosed and receive treatment for STIs?

Situation of access for achieving UHC	☐ Are travel distance, means of transportation, budget, and travel restrictions in public for women considered while selecting the location of a planned health facility? ☐ Is there any means of transportation that allows women to travel safely to the existing health facilities? ☐ Is it possible for women to travel to health facilities by themselves?
Health Status of the residents	
Health conditions of residents	☐ Gender-specific health indicators, and usage of health services ☐ What is the most serious disease in the target area? Is there any gender-based difference in the disease's incidence? What are the most common health issues among women, or diseases specific to women? ☐ Is there any gender gap in nutrition conditions in the area? ☐ Are any customs that have negative impacts on women's health in the area such as child marriage, female genital mutilation?
Situation of maternal and child health	☐ Maternal mortality rate; what are the high-risk age groups for maternal mortality? ☐ What are the main medical, environmental, and socio-economic factors that raise risks for maternal mortality? ☐ What is the proportion of pregnant women with anemia in the target population? Is there any difference in the incidence of anemia by gender? ☐ Is there any difference between occurrence of infant mortality, neonatal mortality, destruction of growth, and low birthweight by gender? ☐ How different is the target area's gender ratio at birth from the world average?
Situation on infectious diseases	☐ Infection rate and treatment rate by gender
Gender division of labor	
Division of labor on caring	☐ What is the gender-based ratio of the responsibility for caring and nursing for family members in the household?
Participation in decision-making	
Decision-making on medical care	☐ Do women have the decision-making right on receiving healthcare services? ☐ Do women have the decision-making right on medical expenses? ☐ Do women have the decision-making right on means of collecting health-related information such as mobile phone and access to the Internet?
Social norms on maternal and child health	☐ Are there any socio-cultural restrictions on breastfeeding such as non-medical custom on breastfeeding period, wasting colostrum or avoiding baby bottles? ☐ What are the cultural and social attitudes toward unmarried mothers and illegitimate children?
Decision-making on maternal and child health	☐ Who makes decisions on family planning in the household? Do the women targeted by the project have the decision-making right on pregnancy, delivery, and child rearing? ☐ Do women and men have necessary knowledge to make decisions on sexual and reproductive health?
Decision-making on infectious diseases	☐ Who makes decisions on the use of infection-preventing drugs and equipment such as mosquito net? ☐ Is there any stereotype that sexually transmitted infections (STIs) are caused by women? ☐ Is there any social and cultural restriction on the methods of preventing STIs such as using contraceptives?
Decision-making on UHC	☐ Who makes decisions on medical checkups? ☐ Do women have financial means to receive health services?
Construction sites (for construction component only)	
Employment and working environment of construction workers	☐ What is a percentage of construction workers by gender? ☐ What are the reasons if female workers are fewer than male? e.g., gender norms, including fixed gender division of labor, specification of eligibility for men only in recruitment and/or any requirements that look neutral but exclude women

	indirectly in the local contexts, and risks of SGBV for engaging in construction. ☐ Do female construction workers face challenges? What are they? e.g., restrooms/toilets and/or changing rooms set up only for men use, gender harassment to the women by their co-workers and/or residents near the sites, and lack of a reporting system for those issues. ☐ Is there any culture or custom for paying less to women even if they engage in same work as men? (wage discrimination)
SGBV risks	☐ Have female construction workers and/or local women near the construction sites experienced SGBV? (Where are the high-risk areas, such as truck stops and markets, where interaction with local communities occurs? Is there enough lighting in construction workers' latrines and living space?)

[Tips on survey methodology]

Social and gender research methods include literature review, interviews (including Key Informant Interviews and Focus Group Discussions), field observations, and inspections. It is also useful to use "gender analysis tools" (referred to the attached list of reference materials at the end of the document) specifically developed to gain more accurate understanding of gender relations, such as gender division of roles and labor, and access and control over resources. Other points to be considered in conducting surveys are as follows.

* Interview both women and men to see if there are differences in their perceptions.
* When forming groups for interviews or discussions, carefully assess if target groups should be gender-mixed or single-gender. It depends on the cultural practices and social norms of the target country/area as well as the content and purpose of the information to be gathered. If women have difficulties expressing their opinions in front of men, it is desirable to interview women and men separately. On the other hand, mixed group discussions may provide the participants with an opportunity to deepen their discussions while understanding each other's perceptions.
* Girls and boys may also have different needs and perspectives, thus make an effort to collect their voices.
* For sensitive contents such as SGBV, it is preferable that staff of local NGOs with experience and expertise conduct individual interviews rather than group interviews. Carefully protect anonymity and confidentiality of the respondents.

In order to identify gender issues based on the collected data and information, the following points should be taken into account during the analysis.

- Division of labor: Are there any stereotyped gender division of labor?
- Access: Are there any gender disparities in the access to resources, services and the benefits derived?
- Control: Who manages and owns resources and services? Who controls benefits (are there any gender-based biases)?
- Decision making: Are there any gender-based biases in participation in decision-making?
- Organizational capacity: Do relevant institutions have policies, experience, and capacity to promote gender equality and women's empowerment?
- Sexual and Gender-Based Violence (SGBV): Are there any SGBV within the scope of the health sector?
  (Example: Female genital mutilation, adolescent pregnancy due to child marriage)

In addition, to ensure the project help the promotion of gender equality and women's empowerment, consider the following points:

- Will the benefits from the planned project be equally enjoyed by all beneficiaries regardless of gender? If there are any possibilities that they may not be equally beneficial to all, what are the reasons? What should be done to make them equally beneficial?
- What are the entry points for eliminating inequalities, such as gender-based prejudices, and social, cultural, and institutional constraints, and further promoting gender equality in a society?

Against the gender issues identified in Step 1, Step 2 and the subsequent Steps propose effective activities and present some points to keep in mind during implementation: Step 2 lists up gender-responsive activities for helping develop Activities section of a Project Design Matrix (PDM) (see "List of Effective Activities for Solving Gender Issues" in Step 2), and Step 4 introduces tips for the implementation of the activities set in Step 2.

Step 2. Planning gender-responsive activities

In order to address gender issues identified in the previous Step, an activity plan needs to be developed and reflected in the PDM. In planning activities, it is important to take into account all three of the following aspects.

(1) Actions to strengthen agency of women and girls (Agency)

Actions to empower women and girls to overcome their relatively disadvantaged positions through strengthening their capabilities and increasing their opportunities.

(Examples: Gaining knowledge on maternal and child health, participation in social mobilization activities and training for behavioral change, and improvement of health by women themselves based on knowledge on nutrition)

(2) Actions to change people's mindset, attitudes and behaviors (Relations)

Actions to transform gender power relations by addressing patriarchal social norms, people's attitudes and behaviors.

(Examples: improvement of health awareness by engaging men, boys, and religious and community leaders, participation in programs to promote understanding on sexual and reproductive health and rights, social mobilization to promote understanding of participation of women, and human resource development of health workers)

(3) Actions to transform policies and institutional mechanisms (Structure and systems)

Actions to review and develop relevant policies and institutional mechanisms to promote gender equality and women's empowerment.

(Examples: strengthening health administration and systems, reforming medical and health insurance systems, development of comprehensive approach including mother and child with surrounding people for health system and policy, and establishing health facilities)

These three aspects are interrelated, and it is necessary to work on all these three when promoting gender mainstreaming activities to address the identified gender issues. For example, gaining knowledge on maternal and child health is an activity to strengthen women's agency itself as shown in above (1). However it is necessary to raise awareness on women's and newborn's health of community leaders and men in the area, as shown as example in (2). This is because when men do not understand the importance of maternal and child health service, it is difficult for women to access maternal and child health service as men often decide on household finance to spend on health care. Although women gain the access, it is difficult to sustain her access without the understanding of the community and male members of the family. Also, when it is difficult for women to access health service socio-culturally, it is important to provide countermeasure in policy and system by the administration side, such as establishing women's medical center or counseling office targeting women.

Below are the examples of effective activities to tackle gender issues. In addition, sample activities for sub-sectors are shown in boxes.

2)-0 List of useful measures to tackle gender issues (common for the health sector)

Identified gender issues	Useful strategies and measures (example)
Policies and systems	
Measures against gender issues are not incorporated in health policies.	☐ Promote an increase in female administrative officers at the policy-making level and introduce a quota system to promote women in management positions ☐ Conduct gender training for government officials. The contents include impacts of gender bias on institutional operation and system, significance of gender mainstreaming (healthy institutional operation, broader project outcome, improvement in sustainability), and action planning to promote gender mainstreaming ☐ Conduct workshops to identify gender issues and creating action plans with a gender perspective
Capacity for gender-disaggregated data collection and analysis of the gender-disaggregated data is low.	☐ Conduct gender training to officers of relevant organizations. (impacts of gender bias on institutional operation and system, significance of gender mainstreaming, and gender statistics.) ☐ Conduct research by gender analysis methods involving health workers and residents in the target area
Institutional structure of the government and implanting agencies	
There are few women health workers, and it is difficult for women to receive health services.	☐ Prepare an environment and systems to promote employment of female health workers such as women's dormitories, employment incentives, securing safe means of commuting, easy-to-access workplaces, and flexible working hours. ☐ Introduce a quota system on the number of female health workers. ☐ Establish scholarships and dormitory to encourage women to enter medical schools and women's medical vocational schools. ☐ Allocate female health workers in the community, or incorporate community health workers into public health administration in collaboration with health facilities, by providing training, presenting promising career paths, and establish a system of payment for services . ☐ Support technical training on maternal and child health and preventing and treating diseases with high risks of morbidity for women.
risks of infection among women are increasing due to Mmany personnel of health facilities and care workers such as health volunteers are women, and the risks of infection among women are increasing.	☐ Conduct training to acquire appropriate knowledge on infectious diseases and infection prevention and responses.
Few health workers understand the healthcare needs of women and the restrictions that women face in receiving health services.	☐ Conduct gender training to health workers. ☐ Prepare a guideline on gender mainstreaming for health service provision. ☐ Create an opportunity or forum to have health workers and women residents exchange opinions so that women's needs are made clear and the restrictions facing women are understood.
There is no health facility or support system to address sex crime and SGBV victims.	☐ At the designing stage of a health facility, ensure that a one-stop support center of SGBV is set in the facility. ☐ Conduct training to health workers on response to SGBV victims/survivors. ☐ Include response for SGBV victim/survivor in the contents of operational procedures and guideline of examination at health facilities. ☐ Build a referral system among the relating institutions such as Ministry of Health, the police, the judiciary, and the municipality.

Issues on access in target area (access to health care services)	
Health facilities are not designed to ensure the privacy and safety of women, making it difficult for women to use them.	☐ Design the examination room, patients' room, toilets, and surrounding lightings in such a way that they ensure the privacy and safety of women. ☐ Conduct a needs survey to women and women's groups in the target area at the planning stage of facility construction and reflect the needs to the plan.
It is difficult for women to access health facilities owing to distance and lack of means of transportation. In addition, the number of health facilities accessible to women are limited.	☐ Establish health facilities near the community so that women do not need to travel far to access to them. ☐ Select the construction site in consideration of the accessibility of women from where they live. ☐ Provide telemedicine using digital devices. In addition, establish the conducive service usage environment, facilities, and systems for women to access digital devices. ☐ Provide outreach medical examination and check-up services. Also strengthen the capacity for health workers for outreach. (Such services include visiting homes and providing health information and services by community health workers. At the same time, distribute contraceptives while educating women on sexual and reproductive health and how to use contraceptives.) ☐ Provide transportation to health facilities.
Women's access to health information and knowledge is limited.	☐ Hold awareness raising sessions on health and medical information for women. ☐ Conduct social mobilization activities for men on women's access to health information and knowledge. ☐ Conduct social mobilization activities to provide health information to women and raise their health awareness through available media and methods appropriate for women.
The method of social mobilization is not friendly to low-literate women.	☐ Develop teaching materials and social mobilization methods tailored to the target audience, such as using visual teaching materials.
Men tend not to visit health facilities owing to the gender norm that use of health services is not masculine.	☐ Conduct social mobilization activities involving local leaders to change the biased gender norm about receiving health service.
Gender division of labor	
Women spend so much time performing unpaid care and domestic work that they have no time to receive health services.	☐ Conduct participatory workshops on gender division of roles (Activity Profile, Daily Activity Calendar, etc.) to encourage women and men to modify their understanding on gender division of roles. ☐ Conduct social mobilization activities to promote men's participation in housework and childcare with the cooperation of influential people such as community leaders and religious leaders. ☐ Develop a strategy to provide integrated services (e.g., child vaccination and family planning, prenatal and postnatal health checkup services) in one place to improve convenience.
Participation in decision-making	
Women do not have the right to make decisions on their household finance and receiving healthcare. Thus, they cannot receive the paid healthcare services that they desire.	☐ Conduct social mobilization activities in the community to reach a consensus on the importance for women to receive health services and pay for such services at their own discretion. ☐ Establish a health insurance system and conduct social mobilization to educate community members about the system. ☐ Conduct social mobilization activities on maternal and child health and a sense of body ownership for the entire family.
Men's awareness of women's health remains low.	☐ Conduct training for men to raise their awareness and promote their understanding of the importance of women's health services.

Construction of infrastructure	
- Employers tend to hire men over women for construction work of infrastructure. - Women face challenges in the working environment.	☐ Promote women's employment as construction workers through, for example, setting a percentage of women among all employees (a quota system). ☐ Promote/arrange a female-friendly working environment, such as ➢ equal pay for equal work regardless of their gender, ➢ ensure privacy and safety for women through different ways, including providing transportation to construction site, setting up separate toilets for women and men (and possibly all-user toilets), separated break space for women and men, and lighting for nighttime work; and write down above in an agreement with a contractor.
Risks of SGBV increase among female construction workers and local women around the site during a period of construction.	☐ Take safety measures at the sites, including education of gender equality and women's empowerment as well as human rights to construction workers. ☐ Conduct training on Gender-Based Violence (GBV) and Sexual Exploitation, Abuse, and Harassment (SEAH) for construction workers. Raise awareness on GBV and SEAH in the affected communities. ☐ Write down prevention and responding to SEAH in an agreement with a contractor.

2)-1 List of useful measures to tackle gender issues (1: Maternal and child health)

Identified gender issues	Useful strategies and measures (example)
Conditions and issues on access in target area (access to healthcare services)	
Entire community is hesitant to use health service such as maternal and child health services. Men tend not to understand that it is important for women to receive prenatal and postnatal check-ups.	☐ Upon conducting training for community leaders and gaining their understanding, conduct social mobilization activities involving related counterparts and community. ☐ In the contents of social mobilization, include prenatal and postpartum care, assistance and institutional delivery by midwifery specialists, the importance of vaccination, and the importance of the health and nutritional status of pre-pregnant, pregnant, and breastfeeding women.
Many men think that the maternal and child health handbook is nothing to do with them.	☐ Conduct awareness-raising activities for men about the maternal and child health handbook. ☐ Develop teaching materials that include not only mothers and children but also fathers in contents and illustrations.
The burden of pregnant women for household work is not reduced. Men do not participate in childcare.	☐ Conduct awareness raising activities (such as father classes) on maternal and child health for men. The activities should cover experiences as a pregnant woman, interaction with infants, changing diapers, and bathing of infants. ☐ Organize a "male group" and "father group" in cooperation with community health workers to raise awareness on men's involvement in maternal and child health services and gender equality.
Unintended pregnancies are repeated because women are unable to participate in family planning.	☐ Conduct social mobilization activities to encourage participation in family planning among partners. ☐ Conduct social mobilization activities on a sense of body ownership for women. ☐ Conduct awareness raising activities on SGBV to the residents and conducting sex education by health workers. ☐ Conduct training on inserting intrauterine device or implanting contraceptives to obstetrician-gynecologist and midwives.
There are societies where boys are preferred over girls.	☐ Promote the appropriate use of ultrasonic reflectscope and reduce the risk for it to be used for fetal selection by considering the socio-cultural norms of the region when introducing the tool.

	☐ Conduct social mobilization to families to encourage girls to receive health services as well as boys.

2)-2 List of useful measures to tackle gender issues (2: Infectious diseases response)

Identified gender issues	Useful strategies and measures (example)
Conditions and issues on access in target area (access to healthcare services)	
Women's access to infectious disease prevention and treatment may be limited. Women's access to hospitals may be delayed owing to the social stigma of infectious diseases and the low financial status of women, thus the completion of the treatment for infectious diseases may be longer than that of men.	☐ Design a free or low-cost system for treatment and prevention targeting pregnant women and infants, and people with special needs such as HIV-positive individuals, orphans, and single mothers. ☐ Conduct social mobilization activities for relevant groups such as mothers, pregnant women, men, fathers, adolescents, and schoolchildren to promote not only early diagnosis of infection, but also prevention of infection and more gender equal participation in decision-making and care at home. ☐ Work with residential organizations or organize a women's group for health services to arrange equal distribution of equipment and medicine for preventing infectious diseases such as mosquito nets and preventive medications. ☐ Actively employ female doctors in a core medical facility for infectious disease diagnosis or establish a women's medical center.
Pregnant women are at high risk of malaria infection, which not only increases risks to their own health but also the risks of miscarriage, intrauterine fetal death, premature births, and fetal growth restriction.	☐ Implement measures such as distribution of free or low-cost pesticides, mosquito nets with pesticide, and intermittent preventive treatment (IPT) by health facility providing maternal and child health service or community health workers in malaria-affected areas. ☐ Formulated a plan to prioritize the distribution of rapid diagnostic kits to pregnant women by medical institution.
Women have higher risks of infection than men as they play a central role in caring for patients in the family.	☐ Conduct Community Home Based Care (CHBC)[ii] approach training targeting men. ☐ Conduct social mobilization activities to residents on infection prevention, immunization, and early treatment. ☐ Conduct social mobilization activities on improving the nutrition status of women and family members to the residents.
Surveillance and tracing of infected patients are difficult as many women have no access to hospitals.	☐ Design treatment system to provide free or low-cost treatment and means of prevention targeting pregnant women and infants, people with special needs such as HIV-positive individuals, orphans, and single mothers. ☐ Conduct social mobilization activities in communities to encourage families to reach a consensus on the importance of health services for women and necessary expenses to access the health service. ☐ Establish a referral system with regional medical institutions by allocating health promoters who manage the health status of residents and provide preventive health education.
Participation in decision-making	
Incorrect treatment notions such as men should have sexual intercourse with multiple partners or the virgin cleansing myth [iii] result in spreading infectious diseases.	☐ Conduct social mobilization on HIV prevention, peer education, and training on sex education with a gender perspective. ☐ Provide contraceptives and conduct social mobilization on STIs to the residents so that people refrain from behaviors that increase risks of such infections.

[ii] Community Home Based Care (CHBC) is all types of physical, mental, comforting, and religious medication to patients done at home (WHO, 2007).

[iii] The virgin cleansing myth is a misconception that having sexual intercourse with virgin girls cures HIV/AIDS infection.

There is a common notion that mother-to-child infection of HIV is women's fault.	☐ Provide training on preventing mother-to-child infection to both women and men in the community.

2)-3 List of useful measures to tackle gender issues (3: Promoting universal health coverage)

Identified gender issues	Useful strategies and measures (example)
Institutional structure of the government and implanting agencies	
Good practices for gender mainstreaming are limited to a small number of areas.	☐ Build a system for the central government and local governments to share information and good practices and report results. ☐ Hire or assign gender officers in local health administrative organizations at levels ranging from province to commune. ☐ Conduct workshop to develop effective strategies to disseminate gender and health guidelines and programs to regions. ☐ Establish a budget allocation system that allows local health budgets to be allocated to activities on gender equality in the health sector based on national policies.
Conditions and issues on access in target area (access to healthcare services)	
Women and men do not have equally access to health services.	☐ Support designing and introducing a health insurance system that covers every person regardless of gender. ☐ Plan strategy to promote women's and girls' health and gender equality and promote in cooperation with other donors. ☐ Establish health facilities which provide cost-free or low-cost health services to where women can safely access.
Women's opinions are not reflected in health services or community activities.	☐ Conduct community meetings with health workers and residents or allocate community promoter to allows all people, including women, girls, men, and boys, to report their opinions and problems regarding health services and community health activities. ☐ Work with civil society organizations and human rights groups that promote gender equality in social mobilization activities and monitoring of the government to ensure that women, girls, and marginalized people are treated equally in the health system.
Behaviors such as smoking and drinking are encouraged as masculine behavior. Going to health facilities are considered as not masculine behavior.	☐ Conduct social mobilization activities for men on the risks of smoking and drinking. ☐ Conduct social mobilization activities involving local leaders to change biased gender norm towards receiving health service.

Good practices in gender mainstreaming

The following shows good practices in gender mainstreaming relating to two or three of the above aspects.

Example of JICA's activities 1: Ghana "Project for Improving Continuum of Care for Mothers and Children through the introduction of combined MCH Record Book", 2017-2022, Technical Assistance Project

Project Outline: This project aims to provide quality maternal and child health services and continuous care by nationwide distribution of a maternal and child health handbook and training on utilization and integration of maternal and child health services by institutionalizing the handbook and developing the capacity of health workers.

Activities with a Gender Perspective

- Improvement of health awareness of pregnant women and families through a maternal and child health handbook

  The dissemination of the maternal and child health handbook developed by the project aimed to encourage mothers and children to actively make decision in health checkups through the health status written in the handbook. In fact, pregnant women and mothers stated that they decided to visit health facilities after seeing the illustrations in and symptoms listed in the handbook. In addition, by reading the maternal and child health handbook with male family members, the women used the handbook to learn about maternal and child nutrition and protection of maternal health, and encourage men to raise their awareness on maternal and child health. There is positive change in the behavior.

- Strengthening the capacity of health workers to promote beneficial behaviors by patients

  The project conducts “respectful care” training to health workers. The training aims to have such workers discuss behavioral changes in patients through role-playing, and have the workers learn to conduct hearings from mothers and decide the care with the mothers. Thus the nutrition issues can be solved in a way that is acceptable to the mothers. The training also aims to encourage mothers to make decisions on their health in a proactive fashion.

Example of JICA's activities 2: Pakistan “Project for Strengthening Routine Immunization System in Primary Health Care Settings”, 2019-2022, Technical Assistance Project

Project Outline: This project aims to increase the immunization rate of infants and the tetanus vaccination coverage of child-bearing-aged women by developing the capacity of health workers, The goals are to be achieved by improving the quality of services at healthcare facilities through supervision and conducting social mobilization activities in communities for eradicating polio.

Activities with a Gender Perspective

- Increasing the immunization rate of women by vaccination-related technical assistance to Lady Health Workers

  The project provides training on vaccination to Lady Health Workers (LHWs) who are the community health service promoters for pregnant women, especially in areas with strict religious norms, traditional values, and strong patriarchy that limit women’s activities. The training has helped improve women’s tetanus vaccination rate in such areas as women are restricted from showing their bare arm to male vaccinators. In addition, as mothers have started obtaining correct information on immunization and infectious diseases from LHWs, they have started getting vaccinated actively. The improvement in LHWs’ capacity plays a major role in the expansion of COVID-19 vaccination in women as LHWs reached out to women by visiting them at home.

- Promoting awareness change by social mobilization involving leaders in the region

  Targeting the areas with low immunization coverage, the project conducts social mobilization sessions on immunization and women’s health involving religious leaders and male residents. Such sessions have aimed to raise residents’ awareness so that women can make their own decisions on using health facilities. As the literacy rate of the women in the target area is low, copies of a handbook called Family Health Book, which uses illustrations to describe nutrition issues of infants and pregnant women, the symptoms of infectious diseases, and immunization schedules, are provided to the residents. The handbook has raised the residents’ awareness by allowing each family to learn about the health issues

of pregnant women and infants from the start of pregnancy, during delivery, and in the postnatal period. After the sessions, the immunization rate of the residents increased.

Step 3. Setting gender indicators

After considering activities with a gender perspective, indicators (gender indicators) will be set to measure expected results (changes) of such activities. When setting indicators, set quantitative indicators as much as possible to objectively assess the status of the changes. If it is difficult to set quantitative indicators, qualitative indicators can be set to measure the progress of change. Examples of gender indicators are indicated below.

List of gender indicators (common)

Policies and systems
• Number of policies, plans, and guidelines developed with a gender perspective
Institutional structure of the government and implanting agencies
• Number and proportion of female health workers and managers • Number of women among all the participants of the health sector training in Japan and/or a third country • Number and proportion of gender-related training participants in the target area
Conditions and issues on access in target area (access to healthcare services)
• Status of reflection of women's needs regarding designing health facilities and equipment to health services (e.g., the number and proportion of facilities equipped with waiting rooms by gender, women-only examination rooms/hospital rooms/toilets, lighting) • The number and proportion of women who have benefited from the development of health facilities and equipment (e.g., the number and percentage of female examinees at newly established medical facilities) • Frequency of facility visits or duration of commuting to health facilities for women • The number and proportion of households, whose household budgets include use of health services for women
Gender division of labor
• The number and proportion of men participating in domestic work or the number and proportion of women who feel that the burden of domestic work has been reduced
Participation in decision-making
• The number of female leaders and proportion of female members of community health committees • The number of monitoring by the administration on DV and conflict cases in household • The proportion of residents with perception affirming SGBV[iv]
Construction of infrastructure
• Percentage of women among construction workers • Satisfactory levels of construction workers on working environment (by gender) • Number of trainings on gender equality and women's empowerment and human rights, targeting to construction workers • Number of participants of the trainings (by gender) • Changes in understanding of gender equality and women's empowerment (comparison of answers to questionnaires before and after the trainings) • Incorporation of an article on prevention and responding to SEAH into an agreement with a contractor • Equal pay for equal work regardless of any gender (only for cases where gender-based wage discrimination have been observed)

List of gender indicators (1: Maternal and child health)

Institutional structure of the government and implanting agencies
• Maternal mortality rate and infant mortality rate

[iv] Many surveys adapt questioning methods for the indicator, such as whether a husband can hit his wife if she did not take the role of child-rearing.

• Proportion of incidence of pregnancy complications • The rate of development of maternal and child health handbooks by local governments (national penetration rate) • The distribution rate of maternal and child health handbooks • The proportion of women with anemia • The number of users, categories, and services of maternal and child health • The proportion of children vaccinated • The proportion of delivery assistance by skilled professional health workers
Conditions and issues on access in target area (access to healthcare services)
• The proportion of hospital deliveries • The number and proportion of antenatal and postnatal checkups, the number of each checkup • The completion rate of continuum maternal and childcare • The proportion of users of maternal and child health booklets • Percentage of women and families, including men, who understand the risks of pregnancy and how to address emergencies
Gender division of labor
• The number of male participants in awareness-raising sessions regarding maternal and child health, such as fathers' classes • The number of male partners accompanying women for prenatal and postnatal checkups • The number of men in households, who participate in childcare; and the number of households, where a male family member participates in childcare
Participation in decision-making
• The number and proportion of women who discuss sexual and reproductive health and rights, such as how many children they want to have and sexual intercourse, with their partners • Percentage of using contraceptives based on family planning (modern methods (contraceptives, pills), traditional methods (extra-vaginal ejaculation, Ogino method)

List of gender indicators (2: Response for infectious diseases)

Institutional structure of the government and implanting agencies
• Decrease of infection cases by gender (infection rate) • Decrease of severe cases and death by infectious diseases by gender (mortality rate) • The percentage of women visiting health facilities for infectious diseases • The proportion of infants receiving required vaccinations • The proportion of possession of infection control products by women • The percentage of women receiving infectious disease preventive medicine • The rate of completion of preliminary treatment of infectious disease for women (early start and continuation for those who are not completely cured)

List of gender indicators (3: Universal health coverage)

Institutional structure of the government and implanting agencies
• The number of facilities providing basic obstetrics and newborn care • The number of deliveries and operations at the target health facilities • The number of patients for in-house and outpatient treatment at the target health facilities • The number of examinations for women by advanced medical equipment at the target health facilities • Percentage of health facilities that women are more likely to use
Conditions and issues on access in target area (access to healthcare services)
• Number and proportion of health insurance covered populations by gender • The number of women users and proportion of usage of health facilities

Step 4. Gender responsive project implementation and monitoring

A project should also include actions to respond to situations of the stakeholders of different gender, including their gender issues and needs identified in Step 1. For example, forming a gender-balanced implementation body and providing gender training for the team members of implementing parties are important aspects. Examples include creating an environment that enables women to join, responding to low literacy rate beneficiaries, and involving community leaders to promote women's participation.

In monitoring, gender-disaggregated data and gender indicators set in Step 3 help understand the implementation status of the activities, including the participation rates of women and men, and assess if the expected results are being achieved.

If unexpected gender issues have been identified during the monitoring, effective solutions should be formulated, assessed on the compatibility with the project scope and progress, and added in the project as new activities. Where the situation allows, it is desirable to revise project plans, such as Project Design Matrix (PDM) and Plan of Operation (PO) accordingly.

The table below illustrates points to keep in mind during project implementation and monitoring.

Points to remember for gender-responsive project implementation and monitoring

Category	Points to remember
Implementation structure	● Verify the gender balance of your counterpart unless certain inconvenient circumstances exist. If it is not balanced, think carefully about what measures could be taken. ● When female promoters are lacking, consider the method to increase female promoters. ● Allocate a gender specialist in C/P and the project officers. ● Conduct gender training for counterparts, project staff, and Japanese experts before and after the commencement of the project. If it is evident that participants have a lack of understanding and perception of gender, think carefully about what measures could be taken to continuously raise gender awareness. ● Regarding the employment of project staff, ask them to sign the written approval after explaining to the target group of people the prohibition clauses about sexual harassment and exploitation. ● Japanese experts should consider the culture and practices of target countries and areas and heighten their awareness regarding sexual exploitation, abuse, and harassment on the project sites. They should always be discreet toward each other and should not speak and unconsciously behave unfairly toward anyone. ● Establish a consulting service window (available for all stakeholders) that provides measures against SGBV and harassment. ● Designate international and local gender specialists, as necessary. ● Involve a gender-based auditing system.
Implementation of activities	● Understand the time schedule of the target women and set the time and place for each action at a desirable time space. Consider participation in project activities to avoid increasing the burden of certain people and groups. ● When women's literacy rate is low, choose appropriate communication method for skill and information transmission through training and technical assistance (such as using illustration and photos instead of letters for explanation, and learning in a group), and confirm the attendance situation continuously to see people who need information and skill are attending the training. ● Make sure women always involve in decision making process, consider member structure, meeting facilitation to create the environment that women are easy to

	participate and share opinion to reflect the voices of women. ● Depends on the age, social class, ethnicity, disabled, education level, and family structure, women face different situation thus their issues, needs, and impacts from the development are different. Consider the diversity within women. ● Encourage involvement and promote understanding of men, boys, and residents in the area. (For example, encourage male family's accompany to antenatal and neonatal checkup) ● Conduct a pre-activity survey to select the right target to make sure the techniques are communicated to people in need. ● Review the contents of the educational materials and documents to not strengthen the stereotype and gender division of roles. (For example, using male care worker image (photos and illustrations) to avoid stereotype that care is for women's work) ● Make sure to encourage community and religious leaders who have an enormous influence in communities to understand gender issues and participate in project activities if inadequate gender norms and gender-related discrimination exist in project sites. ● If there are issues of SGBV in the target area, provide knowledge of impact of SGBV and how to prevent it in gender training and social mobilization.
Monitoring	● If the participation in project activities and the benefits derived from them are advantageous to either men or women without a legitimate reason, identify the cause and examine what measures can be taken to deal with it (e.g., participation in activities, provision of medical equipment, and increase in income occur with only one gender; women are more likely to be denied a loan or receive a smaller loan amount than men even when both women and men can afford the loan) ● Confirm the time schedule of the target women and set the time and place for each action at a desirable time space. Additionally, verify whether participation in those activities increases the burden on a certain person or group of people. ● Continuously confirm whether the teaching style of the techniques meets the style of women's learning experiences and styles and whether people who need such techniques are attending the training. ● If there is a difference in the practice and settlement of introduced techniques between women and men, identify the factors causing the issue and respond to them. ● Make sure to encourage community and religious leaders who have an enormous influence in communities to understand gender issues and participate in project activities if inadequate gender norms and gender-related discrimination exist in project sites.

Step 5. Gender mainstreaming evaluation

In the evaluation phase, project achievements, implementation process, outcomes, and impacts should be assessed with a gender perspective, while evaluating the project in accordance with a prescribed project evaluation framework (ex-post evaluation) and evaluation methodology (DAC six evaluation criteria). When identifying the outcomes and impacts, attention needs to be paid to signs of emerging outcomes and impacts as well as already achieved outcomes and impacts. If there is difference in benefits received by women and men, details of the difference and its causes should be analyzed.

It should be noted that during the evaluation, whether be it quantitative or qualitative, gender-disaggregated data and information should be collected, whenever possible, and analyzed. When conducting interviews, attention should be given to gender balance and attributes of the survey participants. Group formation (either single-gender or mixed-gender) will be decided depending on the content of the interview. Gender composition of an evaluation team should also be decided after thorough consideration.

The following shows gender-responsive evaluation questions listed in accordance with the DAC six evaluation criteria.

Check points for gender-responsive evaluation

OECD DAC 6 evaluation criteria	Check points
Relevance	Development policy, development needs of the counterpart country - Do the activities with a gender perspective match the policies that promote gender equality or the priority issues and contents set forth in the health sectoral policy? Inclusion of diverse people - Are the beneficiaries biased to particular gender group? - Was information also collected from girls' and women's groups when selecting beneficiaries? Appropriateness of the plan and approach - Has a method taken not excluded specific gender group? - Had a method taken the way various beneficiaries participate in the project activities and benefit from the project? - Has a method taken increased the labor burden of a particular gender group? - Have the activities been changed or revised according to the monitoring?
Coherence	Coherence between global goals and initiatives such as SDGs and global norms and standards - Did project activities with a gender perspective align with global initiatives including SDGs? - Did project activities with a gender perspective contribute to the achievement of international goals such as SDGs?
Efficiency	- Were the knowledge and experiences of women and girls and women's groups effectively utilized in the implementation of project activities? (e.g., Did the project adopt methods such as communicating important information to protect women's health, including the importance of antenatal and postnatal care, through women's groups? Did it help to derive the output as planned?) - What is the gender balance of the participants of the training in Japan or Third Country training?

Effectiveness	- Did project activities with a gender perspective make an initial achievement? - Did project activities with a gender perspective contribute to achieving a project goal and project outputs? - What kind of beneficiaries benefit from the project? (e.g., Is there any difference of attributes in beneficiaries who received technical training or those who have improved health condition?)
Impact	- Did the implementation of project activities with a gender perspective show indirect positive effects? (e.g., improvement of nutrition and education for children, development of women leader outside the health sector, reduction of DV and SGBV, system reform based on approach to administration) - Is there any negative impacts caused by absence of activities with a gender perspective or lack of gender analysis? (e.g., women's workload has increased as a result of supporting nutrition education, conflicts in households have increased regarding the usage of the increased income) - Was there any change in the status and perception of women's participation in economy, society, and politics?
Sustainability	- Can girls and women continue the activity without any burden? - Can women participate continuously in the activities in health sector (including training and community health group or resident group such as health promoters) and contribute to the sustainability of the project output? - Has the perspective and behavioral change caused by the project in the community and household remained consistent? (e.g., Has the understanding toward the importance of women's and girls' health and capacity risen?) - Will the concerned government continue considering the voice of women and incorporate it in health policies and systems? - Will the concerned government adopt actions with a gender perspective in health policies and systems? - Will the concerned government allocate budget to actions with a gender perspective?

Regarding effectiveness (outcomes), impact, and sustainability, identify how gender-responsive activities have contributed to the promotion of gender equality and women's empowerment, taking into account the three aspects of agency, relations, and structure and systems (see Step 2). Specifically, "agency" refers to what women have become able to do as a result of the implementation of the activities (including not only their own abilities but also changes in the external environment surrounding the women). “Relations” refers to how the activities have helped transform the gender relations among stakeholders and in societies. As for “structure and systems,” the scope of evaluation includes how the activities have been integrated into policies and systems, as well as operational policies and plans of the implementing agencies, and how gender equality has been promoted in the organization. If a negative impact is identified, lessons learned should be extracted as much as possible for reflecting in future projects.

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