1. Purpose and Usage of These Guidelines

(1) Purpose

These Guidelines are created to promote gender mainstreaming in JICA’s projects in the field of health. By referring to JICA’s Operation in Health Sector—Present and Future—(Position Paper), produced in 2013, these Guidelines aim to help JICA officials understand gender perspectives in the field of health and incorporate gender-responsive activities in each stage of project formulation, implementation, monitoring, and evaluation. Gender-responsive activity examples contained in these Guidelines include activities that have been implemented in many projects.

Based on the priorities in the Position Paper, these Guidelines focus on three sub-sectors of (1) health system (strengthening administrative capacity for health, improving health services, addressing the shortage of health workers), (2) maternal and child health, and (3) infectious disease control (e.g., HIV/AIDS, malaria, tuberculosis).

(2) What Is Gender Mainstreaming?

Gender mainstreaming is a process to identify development issues, needs and impacts from gender perspectives at every stage of planning, implementation, monitoring and evaluation of development policies, programs, and projects. This process is recognized as an indispensable means to achieve gender equality.

Gender equality does not mean that men and women become the same, but aims to realize a society where equal opportunities and life chances are provided to both men and women, so that everyone can achieve self-fulfillment regardless of gender. A gender (equality) perspective refers to “being aware that apparently rigid division of labor or power relations existing between men and women are something socially constructed.” In the contexts of JICA projects, it includes an approach to review the projects from different angles; for example, whether or not the activities currently being planned or implemented in the projects can help resolve issues or meet needs resulting from different social roles men and women are expected to play or power relations based on gender; whether or not the activities cause another gender disparity; or whether women’s participation in the decision-making process is facilitated in the activities of the projects.¹

¹These Guidelines for Promoting Gender Mainstreaming in JICA Projects focus on development activities from gender perspectives which seem applicable at the stage of planning and implementation of projects, on the premise that they are used by JICA officials and other related parties who do not always have specialized knowledge on gender equality and women’s empowerment.
(3) How to Use These Guidelines

When using these Guidelines, you may start from 2. The Necessity of Promoting Gender Mainstreaming in the Field of Health to understand gender perspectives in health, and then proceed to 3. Perspectives for Gender Mainstreaming and Incorporation into Projects. After looking through common items under 3.1, check in the tables under 2.3 through 3.4 to note gender perspectives and issues in each sub-sector and how to incorporate gender perspectives into projects. In doing so, you may refer to the table below to find the items applicable to each project in each sub-sector and project cycle stage. For more detailed information, you may refer to 4. Main References.

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</table>

You may also refer to below for important points to be aware of when using these Guidelines.

[Important points to be aware of when using these Guidelines]

(i) There is no need to apply concrete examples given in these Guidelines to all projects uniformly since those examples may not be applicable to target communities/areas due to differences in culture and society or for reasons relevant to the project in question. At the same time, it may be necessary to select or add sections to refer to as appropriate because these Guidelines do not cover all approaches to be taken from gender perspectives.

(ii) In all projects, it is important to incorporate the perspectives of the socially vulnerable people (e.g., the poor, people with disabilities, LGBT², elderly people) into the mainstream, in addition to gender perspectives. These Guidelines are expected to help all users better understand about diversity in the field of health, eventually contributing to mainstreaming other socially vulnerable people.

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² LGBT stands for lesbian, gay, bisexual and transgender. The term comprehensively refers to people who choose to live a life that does not correspond to, or that is free from, legal, biological or social gender by birth, and generally include people with gender identity disorder.
2. The Necessity of Promoting Gender Mainstreaming in the Field of Health

(1) Current Situation of Health from the Gender Perspective

Social norms and gender power relations have significant impact on the health and well-being of men and boys, as well as those of women and girls.

- Women cannot travel a long distance because they have significant time constraints due to the roles they should play in their households, including cooking for their family. In some societies, women cannot receive necessary health services because, for example, community norms do not allow a woman to go by herself to a clinic far away from home.
- Women, who often have less cash from men and no decision-making power over household budgets, often need approval from their husbands and/or in-laws for financing the cost to receive necessary services. In the cases where the status of women and girls is low in the family, financing the cost may not be approved so that women and girls cannot receive necessary health services.
- Pubescent boys tend to avoid receiving health services even when they contract a sexually transmitted disease because they don’t want to be seen as a coward by their friends.
- Women sometimes contract HIV from their partners because their partners have sexual relationship with someone else due to social norms that favor sexually active men or because men have the decision-making power on condom use.
- Particularly with regard to services related to reproductive health and domestic violence, few women or girls want to receive services from male community health workers in some societies.
- Personnel at the policymaking level and in management positions are mostly men in the health field where female workers are predominant at the end-level.

As shown above, social norms and gender power relations have negative impacts on men and women as to their health and reception of health services. In light of these backgrounds, health projects need gender-responsive activities.

Meanwhile, many survey and research initiatives have clarified the correlation between women’s (girls’) education and health indicators. For instance, it is known that, regardless of place of residence (cities or rural areas) or socio-economic situation, educated women receive more health services, including perinatal checkups and assistance for delivery, than uneducated women or women who have shorter years of education. Additionally, many data have been reported to show that women’s education leads to reduction in the mortality and malnutrition of children. Empirical data to support correlation between female employment and use of maternal and child health services and the maternal mortality rate have been accumulated. With these backgrounds, facilitating cooperation with other sectors is also crucial to improve health indicators.

(2) Effects of Gender Mainstreaming on Health Projects

Many maternal and child health programs and projects have targeted women to respond to needs related to health of women and children. Since the importance of men’s involvement in the field of reproductive health was pointed

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3 Malhotra et al. (2003), “Impact of Investments in Female Education On Gender Equality”

4 Abu-Ghaida et al. (2004), “The Economic and Human Development Costs of Missing the Millennium Development Goal on Gender Equity”,

5 Paruzzolo et al. (2010), “Targeting Poverty and Gender Inequality To Improve Maternal Health”,
out at the International Conference on Population and Development (ICPD) in 1994, empirical research has been conducted, albeit gradually, on projects targeting both men and women and effects of such projects in the field of maternal and child health.

For instance, a research initiative that reviewed 78 study and research outcomes on men’s involvement and/or participation in the field of maternal and child health concluded that men’s involvement and/or participation in maternal and child health has effects on: understanding of family planning, use of contraceptives, reduction of women’s labor burden during their pregnancy with the help of men, preparation for delivery and response to delivery emergencies, participation in postpartum checkups, better communication between partners on family planning, and emotional support for women during their pregnancy.6

Similarly, another research that reviewed 14 study and research outcomes about men’s involvement in health of expectant and nursing mothers verified five indicators: complications, length of hospital stay after delivery, perinatal depression, use of health services for expectant and nursing mothers, and maternal death. As a result, men’s involvement in health of expectant and nursing mothers has a strong correlation with reduction in the probability of women’s postpartum depression and with the use of health services for expectant and nursing mothers (rates of receiving deliveries with professional birth attendants and postpartum care). (No results on study or research covering maternal death were available.) The effects on the use of health services for expectant and nursing mothers were attributed to men’s involvement in health of expectant and nursing mothers that helped men become aware of health services and support women’s use of such services.7

Meanwhile, issues have been pointed out as to men’s involvement and/or participation in maternal and child health; women have difficulty talking about sensitive topics in front of their male partners and women who cannot participate together with men are unfavorably treated. To maximize the effects of men’s involvement and/or participation, it is required to allow women to choose whether they receive services as individuals or as couples.

Additionally, effects of gender mainstreaming in health projects include not only effects on projects but also gender-responsive effects. For example, training female healthcare personnel is important not only because an increase in their number makes it easier for women to take health services but also because that would increase women’s employment opportunities, which facilitates women’s economic independence and participation in socio-economic activities.

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7 Yargawa et al. (2015), “Male involvement and maternal health outcomes: systematic review and meta-analysis http://jech.bmj.com/content/early/2015/02/19/jech-2014-204784.full.pdf+html
8 Davis et al. (2013) (mentioned above)
3. Perspectives for Gender Mainstreaming and Incorporation into Projects

3.1 Items Common to All Projects
Items that must be considered in all projects covered in these Guidelines include the following.

(1) Incorporation of Gender Perspectives into Project Formulation

(i) Include the following gender information in information/data collected for project formulation.
- Current situation and issues of women in the target country (social and economic overview)
- Gender issues in the field of health
- Gender-related policies/institutions and organizations in the field of health
- Other information and data that seem necessary

Helpful reference: JICA’s Country Gender Profile, other donors’ gender reports by country, etc.

(ii) Analyze the information and data collected in (i) above, and reflect gender perspectives on Project Survey Sheets and Terms of Reference as much as possible (e.g. collection of data by gender).

(2) Incorporation of Gender Perspectives into Surveys at the Preparatory Stage
To incorporate gender perspectives into surveys (research at the preparatory stage, detailed planning survey, research for prior evaluation), examine measures, including those provided below, in light of the details of the project, characteristics of the target area, and time, physical and budget constraints of the survey.

(i) Allocation of gender mainstreaming specialists to the study team
Allocate gender mainstreaming specialists to the study team to be dispatched when conducting surveys at the preparatory stage. Proposed items to be handled by gender mainstreaming specialists, which should be provided in TOR of the surveys, include the following.

- Collect information about the current situation and issues in the field of “health” (to be replaced with an applicable name of sector, such as health system, maternal and child health, and infectious disease control; hereinafter the same should apply), and organize and analyze the results.
- Analyze the status of gender mainstreaming in projects that have been, or are being, conducted by JICA or other aid organizations in the field of “health” in the target country, and identify lessons learned.
- Based on survey results, put together gender perspectives that should be incorporated into projects.
- Provide advice to promote incorporation of the gender perspectives put together into project plans and draft PDM.

For reference, an example of announcement for public procurement of gender mainstreaming team members on a project-work contract basis (for individual contractor) is attached as an appendix to these Guidelines (Public Notice Sample of Work Execution Contract with Project Members Responsible for Gender Mainstreaming [Individual Contract]).

(ii) When gender mainstreaming specialists are not allocated
When gender mainstreaming specialists are not allocated but specialists in charge of other items will also cover gender mainstreaming, the specialists should conduct surveys from gender perspectives by
Guidelines for Promoting Gender Mainstreaming

referring to these Guidelines and/or ADB (2006) Gender Check List: Health\(^9\) depending on the applicable sectors, and reflect the surveys on items of gender equality promotion at the time of evaluation prior to project [technical cooperation]/social development promotion (gender perspectives) [ODA Loan, Grant Aid] and on cooperation framework (targets, results, activities). When gender personnel, including national staff, is available at the local JICA office, allowing the personnel to participate in the team may be considered. Furthermore, gaining cooperation of the nation’s Ministry of Women’s Affairs or local NGO that fully understand gender situations in the country and subcontracting surveys to local consultants are likely to help plan gender-responsive activities that are more suitable for the local situations.

When conducting interviews or hearings, provide opportunities for men and for women, separately, or set time accessible for each gender. Pay consideration to the gender of the facilitator and interpreter.

(3) Incorporation of Gender Perspectives into Project Implementation

Preparatory surveys for technical cooperation projects based on business implementation contracts and Grant Aid, state in the Terms of Reference (specifications) 5. Implementation Policy and Important Points that “business should be implemented with attention to paying consideration to gender in all activities by referring to the Guidelines for Promoting Gender Mainstreaming in JICA Projects [Health].”

When implementing gender-responsive projects, gender training will become more suitable for the local situation with cooperation from organizations such as Ministry of Women’s Affairs and local NGOs that understand the gender situation in the country.

(4) Incorporation of Gender Perspectives into Monitoring and Evaluation

Set indicators for gender-responsive monitoring and/or evaluation.

Examples:

- Health indicators by gender
- Number of female/male healthcare personnel and the level of training
- Use/benefits of health services by gender

When conducting interviews or hearings, provide opportunities for men and for women, separately, or set time accessible for each gender. Pay consideration to the gender of the facilitator and interpreter.

\(^9\) Japanese translation by the Human Development Department is available.
3.2 Health System Strengthening

The World Health Organization (WHO) defines that a health system is composed of six “building blocks”: service delivery, health information system, health workforce, access to essential medical products, vaccine and technologies, health financing, and leadership and governance. JICA’s *Operation in Health Sector—Present and Future*—(Position Paper), produced in 2013, defines that health system strengthening is building systems to advance universal health coverage (UHC) and strengthening their management.

Examples of gender-responsive activities for the three points stated in the Position Paper, e.g., administrative capacity for health (leadership and governance), service delivery, and health workforce, from among health systems, are listed below. In the examples of gender-responsive activities, activities are indicated with a square mark while considerations are indicated with a diamond mark.

### Administrative Capacity for Health

<table>
<thead>
<tr>
<th>Administrative capacity perspective</th>
<th>Example of gender-responsive activity</th>
<th>Expected effect/impact</th>
</tr>
</thead>
</table>
| Responsibility for management      | □ Formulate practical policy that addresses gender inequality/unfairness (e.g. national health insurance program that both men and women can join).  
✧ Cooperate with other aid organizations so that Health Ministry’s national strategy will promote health of women and girls and gender equality.  
✧ Promote cooperation with programs outside of the health sector (e.g., girls’ education, safe schools, literacy education/economic opportunities for women, safe place to live, fair and safe employment, safety net and legal services). | ➢ Improved fairness between men and women with regard to access to health service.  
➢ Improved quality and efficiency of health systems  
➢ Improved responsiveness to health needs of men and that of women |
| Accountability                     | □ Build system that allow anyone, including women, girls, men and boys, to report their opinions on health services and community health activities as well as problems.  
✧ Support citizens’ organizations that promote awareness raising, government monitoring and gender equality, marginalized people, and human rights organizations so that women, girls and marginalized people are treated equally in health systems.  
✧ Collect information and data as to how successful organizations have provided services and management systems with integrated support for women, girls and marginalized people. |                                                                                                                                 |
| Decentralization                   | □ Build communication systems that enable the central government and local governments to share information and successful practices and report results.  
▷ Allocate gender personnel to local (from the province level to the end level) administrative organizations for health.  
✧ Support policymakers at the central level to build effective strategies for gender and health guidelines and programs.  
✧ Allocate local health budgets to activities for gender equality in the field of health in line with national policies. |                                                                                                                                 |
<table>
<thead>
<tr>
<th>Administrative capacity perspective</th>
<th>Example of gender-responsive activity</th>
<th>Expected effect/impact</th>
</tr>
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</table>
| Leadership                          | □ Strengthen leadership and ability of women and girls to help them assert their health needs.  
  □ Increase opportunities for women to be in a management position in the field of healthcare.  
  ✶ Involve public organizations, private-sector organizations, and citizens’ organizations, including women’s organizations and human rights organizations, in program design, implementation and monitoring and evaluation.  
  ✶ Find religious leaders, community leaders, prominent persons who can publicly oppose to gender inequality and state support for gender equality, human rights, and improvement of women’s and girls’ well-being to bring changes.  
  ✶ Support lawmakers, local leaders, or other policymakers who promote gender equality and spare no efforts to protect health of women and girls. | |
### Service Delivery

<table>
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<th>Example of gender-responsive activity</th>
<th>Expected effect/impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improved access</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Social and cultural norms restrict women’s freedom to move.</td>
<td>☐ Community health workers visit households and distribute contraceptives to each household. ☐ Provide means of transportation to health facilities. ☐ Provide traveling medical care service.</td>
<td>Women’s improved access to health services</td>
</tr>
<tr>
<td>➢ Women are in charge of health management of the family, including children, in many societies and cultures.</td>
<td>☐ Provide integrated services (immunization for children, family planning, perinatal checkup services) at one place to make the services more convenient and accessible for women. It is particularly effective in countries where the immunization rate of children is high while the rates of family planning and receiving perinatal checkups are low.</td>
<td>Women’s improved access to health services</td>
</tr>
<tr>
<td>➢ Women must perform domestic labor and child-raising, including childcare, in many societies and cultures.</td>
<td>✓ Provide day care services for children at health facilities. ✓ Provide services at times appropriate for women (e.g., avoid time for preparing meals or working in the field).</td>
<td>Women’s improved access to health services</td>
</tr>
<tr>
<td>➢ Men’s use of health facilities is limited due to their work hours and place of work in many societies and cultures.</td>
<td>☐ Provide extension services by community health workers at places of work.</td>
<td>Men’s improved access to health services</td>
</tr>
<tr>
<td>➢ Reasons for restricted access to health services vary between men and women.</td>
<td>☐ Provide boys and girls with life-skill education on gender power relations, risk taking behavior, and health, which includes critical understanding of existing gender norms, at schools. ☐ Raise men’s and women’s awareness of women’s decision-making on the number of children, the use of condom, etc.</td>
<td>Changing gender norms and removing the restriction of access to health services</td>
</tr>
<tr>
<td><strong>Improved use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Contact with opposite gender outside of the family is not preferred in some societies and cultures.</td>
<td>✓ Provide waiting space by gender, if possible, when it is desirable in the society or culture. ✓ Provide services by a service provider of the same gender as target participants, if possible.</td>
<td>Improved use of health services by women and men</td>
</tr>
<tr>
<td>➢ According to gender norms in some societies and cultures, it is not manly to use health services.</td>
<td>☐ Raise awareness to overturn the negative idea that receiving health services is feminine and weak.</td>
<td>Improved use of health services by men</td>
</tr>
<tr>
<td>➢ Women’s right to make a decision is restricted in some societies and cultures. ➢ When women’s status is low, a disease may lead to abandonment, divorce, DV, etc.</td>
<td>✓ Understand that women’s being sick or using birth control may lead to abandonment, divorce, DV, etc. particularly when their husband oppose to it, and maintain confidentiality.</td>
<td>Improved use of health services by women</td>
</tr>
</tbody>
</table>
## Health Workforce

<table>
<thead>
<tr>
<th>Gender perspective/issue</th>
<th>Example of gender-responsive activity</th>
<th>Expected effect/impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ When priority is placed on boys’ education, the educational environment for women is often inferior to that for men.</td>
<td>◇ Allow men and women to fairly receive pre-service training for human resource development through occupational counseling, scholarship, etc.</td>
<td>Increase in the number of women working as professionals with qualifications</td>
</tr>
<tr>
<td>➢ Social or cultural norms or safety reasons may prevent women from attending a school or working by themselves.</td>
<td>□ Establish women’ dormitories at vocational schools, hospitals, etc. to increase opportunities for women to learn and work. ◇ Pay consideration to enabling women to work as health workers in rural areas (e.g., subsidy for door keys or other safety measures at clinics and residents, support from residents).</td>
<td>Increase in the number of women working as professionals with qualifications; Increase in the number of female health workers in rural areas</td>
</tr>
<tr>
<td>➢ Gender discrimination exists in some workplaces.</td>
<td>◇ Protect female workers from gender discrimination in education, continued professional education, and employment systems. Gender discrimination includes discrimination in wages, employment requirements, promotion, training or other professional development and workplace guidance.</td>
<td>Decreased gender discrimination in workplaces</td>
</tr>
<tr>
<td>➢ Marriage, pregnancy and childcare have greater impact on women than on men.</td>
<td>◇ Uphold non-discriminatory gender-equal policy on education, employment, salary and support for health workers who are pregnant or the heads of households based on local labor laws.</td>
<td>Increase in the number of women who continue to work/study even after marriage, during pregnancy, or while raising their children</td>
</tr>
<tr>
<td>➢ Personnel at the policymaking level and in management positions are mostly men in the health field where female workers are predominant.</td>
<td>◇ Secure equal opportunities for professional training. ◇ Review education materials and references to ensure that they use pictures, illustration or other images that connect women with the decision-making level and management positions. ◇ Introduce affirmative action goals and take actions to secure equal opportunities for women to be in positions to lead health personnel.</td>
<td>Increase in the number of women in management/leadership positions</td>
</tr>
<tr>
<td>➢ Care providers, including end staff and health volunteers, are mostly women.</td>
<td>□ Disseminate messages that men can be care providers, including nurse and community health worker, against the gender role stereotypes of female care providers. □ Establish men’s dormitories so that men find it easier to enter nursing schools. □ Develop national policy about community health workers, and integrate community health workers into public health systems through cooperation with health facilities, training, support, presentation of career path, payment for services, etc. ◇ Review education materials and references to ensure that they use pictures, illustration or other images that connect men with care providers.</td>
<td>Increase in the number of men as care providers, including end staff and health volunteers Improved position and treatment of end staff and health volunteers</td>
</tr>
</tbody>
</table>
Case study (i): Mexico

The following case of the health sector reforms in Mexico shows that continued use of monitoring for strengthening complex and dynamic relationships between all elements of health systems helps improve results.

**Health personnel and services:** The government recognized that women were important care providers in households and that female community workers and midwives were the last hope for those who had difficulty accessing health services as they lived in remote areas or could not afford the cost. Women were often the most active members of village health committees and the like.

**Use of information to improve leadership and governance:** The Health Ministry had clearly promoted women’s rights and introduced innovative initiatives for reproductive health. The most relevant and controversial reform was revision of the family planning policy with the addition of three new contraceptives (implants for subdermal use, condom for women, emergency contraceptive) to the essential medicine list.

**Governance for gender equality:** The reforms in Mexico considered gender as the center of health system issues. The Health Ministry established a center for gender equality and reproductive health, which proposed national policies on reproductive health, and conducted monitoring and evaluation of public services related to the policies. The center also promoted cross-sectorial introduction of gender perspectives, including gender-responsive budgeting, collection of gender-segregated health indicators and monitoring of gender inequality in terms of access to health services and quality of health services.

A comparison between 2000 when the health sector reforms started and 2006 when the reforms ended revealed that the effective coverage of antenatal care and delivery with birth attendants improved from 90% to 93%. The effective coverage of cervical cytology also increased from 36% to 41%.

The experience in Mexico proves that it is possible to carry out a combination of wide-ranging reforms to implement a specific strategy. In the case of Mexico, the specific strategy was to improve reproductive rights of women and girls. The reforms provided opportunities for building comprehensive challenges beyond traditional approaches to women’s health.

Source: USAID (2014) *Gender and Health Systems Strengthening, Global Health Learning Center*[ see 4. Main References]

Case study (ii): Nepal

As part of its decentralization strategy, the Health and Population Ministry in Nepal started the procedure for transferring the management of local health facilities to the Health Facility Operation and Management Committees (HFOMCs), with the goal of allowing HFOMCs to reach marginalized communities to provide more comprehensive health services. HFOMCs use participatory approaches and participatory tools to find groups that have not used health services, analyze possible reasons for that, and, based on the results, formulate plans to enable excluded groups to use health services.

**Responsibility for management:** Role of HFOMCs in health administration

HFOMCs, responsible for operational management and supervision of health facilities, manage health facility staff, ensure proper supply of medicine and equipment, plan and implement health programs, and engage in coordination with other related health system organizations. Additionally, HFOMCs play a role to bridge gaps between communities and health staff.

**Accountability:** Quality, obstacles to access, etc.

In the decentralized health system in Nepal, HFOMCs are responsible for providing all people with high-quality health services. In that respect, following issues exist:

- Remote communities that are geographically remote or that have limited means of transportation
- Obstacles such as improper infrastructure, high treatment cost, and staff with insufficient skills
- Diversity due to ethnicity, religion, and social stratum (caste)
- Low status of and discrimination against women and girls

Currently, it seems that HFOMCs have not identified, and do not have the ability to identify, needs of disadvantaged groups and taken proactive measures to address the needs. Under these circumstances, the government promotes gender mainstreaming and includes gender equality in health-related national policies and national plans to allow all people to equally access high-quality health services.

Source: USAID (2014) *Gender and Health Systems Strengthening, Global Health Learning Center*[ see 4. Main References]
3.3 Maternal and Child Health

Examples of gender-responsive activities are put together below based on the six elements supporting the implementation of maternal and child health services [(1) strengthening central administrative capacity, (2) strengthening local administrative capacity, (3) strengthening functions of healthcare facilities, (4) health personnel capacity building, (5) raising communities’ awareness and strengthening community functions, and (6) strengthening cooperation between parties related to service implementation (including use of the Mother and Child Health Handbook)], which are listed in the Thematic Guidelines on Maternal and Child Health produced in fiscal 2011. See Administrative Capacity for Health under 3.2 Health System Strengthening for (1) and (2), and see Health Workforce under 3.2 Health System Strengthening for (4). In the examples of gender-responsive activities, activities are indicated with a square mark while considerations are indicated with a diamond mark.

### Strengthening Functions of Healthcare Facilities

<table>
<thead>
<tr>
<th>Gender perspective/issues</th>
<th>Example of gender-responsive activity</th>
<th>Expected effect/impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Social and cultural norms restrict women’s freedom to move.</td>
<td>□ Community health workers visit households and distribute contraceptives to each household. □ Provide means of transportation to health facilities. □ Provide traveling medical care service. □ Establish health centers at locations convenient for women.</td>
<td>Women’s improved access to health services</td>
</tr>
<tr>
<td>➢ Women are in charge of health management of the family, including children, in many societies and cultures.</td>
<td>□ Provide integrated services (immunization for children, family planning, perinatal checkup services) at one place to make the services more convenient and accessible for women. It is particularly effective in countries where the immunization rate of children is high while the rates of family planning and receiving perinatal checkups are low.</td>
<td>Women’s improved access to health services</td>
</tr>
<tr>
<td>➢ Women must perform domestic labor and child-raising, including childcare, in many societies and cultures.</td>
<td>△ Provide day care services for children at health facilities. △ Provide services at times appropriate for women (e.g., avoid time for preparing meals or working in the field).</td>
<td>Women’s improved access to health services</td>
</tr>
<tr>
<td>➢ Reasons for restricted access to health services vary between men and women.</td>
<td>□ Provide boys and girls with life-skill education on gender power relations, risk taking behavior, and health, which includes critical understanding of existing gender norms, at schools. □ Raise men’s and women’s awareness of women’s decision-making on the number of children, the use of condom, etc.</td>
<td>Changing gender norms and removing the restriction of access to health services</td>
</tr>
<tr>
<td>➢ Contact with opposite gender outside of the family is not preferred in some societies and cultures.</td>
<td>△ Provide waiting space by gender, if possible, when it is desirable in the society or culture. △ Provide services by a service provider of the same gender as target participants, if possible. □ Allocate female health personnel to rural areas.</td>
<td>Improved use of health services by women and men</td>
</tr>
<tr>
<td>➢ Women’s right to make a decision is restricted in some societies and cultures. ➢ When women’s status is low, a disease may lead to abandonment, divorce, DV, etc.</td>
<td>△ Understand that women’s being sick or using birth control may lead to abandonment, divorce, DV, etc. particularly when their husband oppose to it, and maintain confidentiality.</td>
<td>Improved use of health services by women</td>
</tr>
<tr>
<td>➢ Men find it difficult to use health centers mainly used by women.</td>
<td>□ Make healthcare facilities more accessible for men (to promote the use for family planning, etc.) · Set hours for men, separately from those for women. · Provide gender-segregated doors.</td>
<td>Improved use by men</td>
</tr>
<tr>
<td>Gender perspective/issues</td>
<td>Example of gender-responsive activity</td>
<td>Expected effect/impact</td>
</tr>
<tr>
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</tr>
<tr>
<td>Some societies prefer boys.</td>
<td>Note social and cultural norms of the target country/region when introducing ultrasonic inspection systems for prenatal diagnosis.</td>
<td>Reducing the risk of fetus selection</td>
</tr>
</tbody>
</table>
Raising Communities’ Awareness and Strengthening Community Systems

<table>
<thead>
<tr>
<th>Gender perspective/issue</th>
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</table>
| ➢ Decisions in a household are made mostly by men (The impact is significant particularly when cost is involved). | ☐ Formulate communication strategy by gender.  
• Media to be used (TV, radio, newspaper, puppet play, play, PR vehicle, leaflet, etc.)  
• Use of female organizations, female groups, schools, unions, community associations, etc. to widely reach women  
• Whether or not to use text  
• Implementation of pre-test  
☐ Create massages that can be accepted by men and by women, respectively.  
• Implementation of pre-test  
❖ Make efforts to change men’s awareness and behavior through workshops, group education (study sessions, participatory sessions, etc.) and leader development. In doing so, it is said to be more effective to include participatory sessions, such as role playing or asking “what will you do if XXX…”  
☐ Provide classes for fathers where fathers simulate pregnant women, play with infants, change diapers or experience how to give baby a bath. | Promoting men’s participation and understanding |

| ➢ In-laws sometimes play a big role in decision-making on maternal and child health in households. | ☐ Raise awareness among extended families, including in-laws.  
❖ The content of awareness-raising activity should include perinatal care, deliveries with birth attendants, and importance of health and nutritional status of women before or during pregnancy (e.g. possibility of iron-deficiency anemia if priority in allocating food, particularly protein, is placed on men in a household). | Promoting extended families’ participation and understanding |

| ➢ Some communities are not active in terms of the use of maternal and child health services. | ❖ First involve religious leaders, school teachers, and other persons who are influential in the community.  
❖ Involve persons who are engaged in traditional medicine, including providing training for traditional midwives.  
❖ The content should include not only perinatal care and deliveries with birth attendants but also importance of health and nutritional status of women before or during pregnancy. | Promoting understanding in the community |

Strengthening Cooperation Between Parties Related to Service Implementation (Including Use of the Mother and Child Health Handbook)

<table>
<thead>
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</table>
| ➢ Many men consider the Mother and Child Health Handbook has nothing to do with them. | ❖ Include a father in the illustrations and pictures used on the front cover or the content of the Mother and Child Health Handbook.  
☐ Describe the role of the Mother and Child Health Handbook in the abovementioned classes for fathers. | Promoting men’s participation and understanding |

Case study (iii): Laos (UNICEF)
The Caring Dads communication campaign, which was launched to complement efforts to improve maternal and newborn health, encouraged fathers to support pregnant women and mothers in caring for themselves and their babies. The Ministry of Health, in collaboration with UNICEF and Lao Trade Union, developed comprehensive methods to advocate for greater involvement by men in family care. These campaigns were aimed primarily at wage-earning fathers, who have been identified as the group most likely to engage in commercial sex, the source of the growing HIV prevalence within the country. Posters and booklets on themes such as the Daring Dad in Pregnancy had been reprinted because of unexpectedly high demand.

**Case study (iv):** Bangladesh Maternal and Child Health/Health System Strengthening Program (JICA) [The Safe Motherhood Promotion Project (SMPP) I & II (Technical Cooperation), Maternal, Neonatal and Child Health Improvement Project I (ODA Loan)]

In the project, residents group played a significant role to establish community-based system to support expectant and nursing mothers. During SMPP phase I, community residents groups were mobilized for strengthening preparation for delivery and emergency cases in the community as a part of community activities. The main activities of community residents groups are: a) identification and tracking of all pregnant women in a community, b) establishment of a community fund to provide necessary support for deliveries and emergencies, c) advocacy campaign for safe delivery, and d) promotion of understanding among women’s families. Group members are comprised of men and women about equally. While religious leaders as well as the mothers-in-law had created obstacles at the inception of the community activities, the groups gradually earned the trust of the people in the community through support activities such as providing transport services to the hospital for women when the complications of labor and other emergency situations occur. Finally, the groups gained support from local governments and community leaders. With the combination of support for the communities and the activities for improvement of quality services in hospitals, as a result of 5-years activities of SMPP, antenatal care and deliveries at public hospitals in Narsingdi District in 2011 had increased 8.5 times and nearly 3 times respectively from those in 2006.

The government of Bangladesh promotes nationwide dissemination of Community Support Groups, based on the experiences of community residents groups of the Narsingdi Model. Involving the overall community in the activities enabled pregnant women to receive proper health and medical care with greater understanding by their families. This is the way to protect the health of women and children by the whole community.

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**Case Study (v):** Palestine Project for Improving Reproductive Health with a Special Focus on Maternal and Child Health, Project for Improving Maternal and Child Health and Reproductive Health II (Technical Cooperation) (JICA)

People’s movement and access are controlled by the separation wall and many checkpoints within the West Bank of Palestine, and in some cases women cannot continue to go to the same hospitals or clinics because of new separation walls or checkpoints. Many women go to various medical facilities for prenatal checkups, delivery and immunizations of their children because of the restriction of movement and economic reasons. Medical facilities are operated by various organizations such as the Ministry of Health (MOH), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), NGOs, and the private sector. As their maternal and child health services were provided in different ways and the means of recording varied, it was difficult for mother and child to receive a continuum of care. To improve access to the medical facilities for mothers and children as well as continuous maternal and child health care, the Project started development of the first Arabic Mother and Child Health Handbook (MCHHB) in 2005. During Phase II of the Project, development of utilization system of the MCHHB, utilization and dissemination of the MCHHB across Palestine, and technical trainings to maternal and child health service providers were supported. The MCHHB has also been used in the West Bank since 2008 and in Gaza since 2009.

The impacts of the MCHHB from the gender perspective include:

1. **Women’s participation in decision-making**
   Pregnant women/mothers can use the MCHHB as a self-learning tool to improve their knowledge of perinatal care and childcare thus empowering them to participate in making decisions related to their own health and the health of their children. There were few chances for women to discuss family planning, with traditional values of preference for many children. The MCHHB provides women an opportunity to discuss the timing of their next child and/or family planning methods with their husband.

2. **Male participation**
   Illustrations of a father together with a mother and child are drawn on the front cover as well as in the contents of the Palestinian MCHHB. Since the MCHHB was introduced, more fathers now take their children to immunizations and/or health checkups. In one case a husband bought nutritious food for his pregnant wife after reading the MCHHB.
Case study (vi): Afghanistan (USAID)

It was revealed that, in Afghanistan, there were obstacles to access to family planning services and the use of the services by women after delivery. The obstacles included weak cooperation between the obstetrics department and department that provided family planning services in the same hospital, and gender norms that women should not make any decisions on family planning without their husbands.

To address these obstacles, places for counseling on family planning were established next to maternity clinics to facilitate access between the two departments. Other gender-responsive activities include:

- Providing husbands and in-laws with counseling on family planning.
- Sending short text messages via mobile phones to men who don’t come to the clinics.

Consequently, at five hospitals in Kabul, expectant mothers who visited the hospitals after deciding which contraceptive they desired to use increased from 12% at the baseline stage to 36% after the start of group counseling and to 48% after the start of individual counseling (including involving husbands through short text messages), and to 55% after the start of counseling for in-laws.

Source: USAID (2012) Applying Improvement Methods to Increase Coverage and Quality of Family Planning Services

http://www.globalhealthlearning.org/sites/default/files/page-files/Increasing_coverage%26quality_FP_services_Nov12_1.pdf
3.4 Infectious Disease Control

While the Position Paper does not limit the targets of support to specific infectious diseases, the Guidelines focus on the three major infectious diseases of HIV/AIDS, malaria, and tuberculosis for reference because gender-responsive activities differ between infectious diseases. In the examples of gender-responsive activities, activities are indicated with a square mark while considerations are indicated with a diamond mark.

**HIV/AIDS:** Biologically and anatomically, women are more likely to be transmitted with HIV than men. The transmission rate is high among men who have sex with men and those who are engaged in sex business.

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<tbody>
<tr>
<td>➢ Gender is deeply related to young people’s risky sexual activity.</td>
<td>☐ Provide HIV prevention education, peer education and sex education programs, covering gender equality issues, for pubescent people.</td>
<td>Encouraging young people to think about how to develop responsible male-female relationships</td>
</tr>
<tr>
<td>➢ It is inclined to suppose that women are responsible for mother-to-child transmission of HIV.</td>
<td>☐ Provide men and women with programs to prevent mother-to-child infection.</td>
<td>Men’s improved awareness of and responsibility for mother-to-child infection</td>
</tr>
<tr>
<td>➢ Home care for HIV-infected patients are mostly supported by women.</td>
<td>☐ Promote men’s participation in the Community Home Based Care (CHBC) approach.</td>
<td>Provision of home care for HIV-infected patients supported by both men and women</td>
</tr>
</tbody>
</table>

**Malaria:** Malaria infection during pregnancy increase risks of anemia of expectant mothers, stillbirth, spontaneous abortion, low-birth-weight babies, etc.

<table>
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</thead>
<tbody>
<tr>
<td>➢ Women’s access to malaria prevention/treatment is limited in some regions.</td>
<td>☐ Implement activities that aim to eliminate reasons that limit women’s access (see 3.2). ☐ Include people who need special support (HIV-infected patients, infants, widows) in the targets of free or low-cost prevention/treatment in addition to expectant mothers and infants. ☐ Raise awareness among mothers, expectant mothers, men, fathers, pubescent people, and school-age children, respectively, which helps not only detect malaria infection early but also include messages that lead to prevention and more equal decision-making and/or sharing of nursing care in households.</td>
<td>Women becoming able to receive malaria prevention/treatment</td>
</tr>
<tr>
<td>➢ Pregnant women are at high risk of malaria infection, which increase the risks of rise in severity of their conditions, stillbirth, intrauterine mortality, premature birth, developmental disabilities, etc.</td>
<td>☐ In malaria epidemic areas, use maternal and child health services to distribute free or low-cost insecticide-treated mosquito nets and provide intermittent preventive treatment (IPT) or other effective treatment.</td>
<td>Decline in the risk of expectant mothers’ malaria infection</td>
</tr>
</tbody>
</table>
**Tuberculosis**: Gender differences often exist as to tuberculosis treatment.

<table>
<thead>
<tr>
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</table>
| ➢ Delay in being detected to be infected with tuberculosis is often occurs among men or among women.  
➢ It is said that men tend not to complete treatment.  
➢ It is said that the period between seeking treatment and being diagnosed with tuberculosis or completing treatment is longer among women than among men due to women’s difficult access to hospitals. | ☐ Grasp causes of delay in detecting tuberculosis infection for the implementation of activities according to social and cultural situations.  
☐ When women’s access is restricted, implement activities that aim to eliminate the causes (see 3.2).  
☐ One of the reasons why for men’s delay in detecting tuberculosis infection or not completing treatment is that they cannot go to health centers as they work during daytime hours. Such a case can be covered with outreach by community health workers to places of work.  
☐ Causes of women’s delay in detecting tuberculosis infection include that they cannot be seen by male health staff and that they fear tuberculosis infection (which can lead to divorce and abandonment in some societies). Possible activities in such cases include increasing the number of female health staff and raising awareness of tuberculosis. | Early detection of tuberculosis  
Increase in the number of patients who complete tuberculosis treatment early |
4. Major References

[Examples of data collected, examples of consultant TOR, examples of successful practices, references, etc.]
http://www.adb.org/publications/gender-checklist-water-supply-and-sanitation

USAID (2014) Gender and Health Systems Strengthening, Global Health Learning Center
[E-learning course for USAID field staff: terminology, reference, examples of successful practices, etc.]
http://www.globalhealthlearning.org/course/gender-and-health-systems-strengthening

WHO (2002) Gender and Tuberculosis
[Gender and tuberculosis: gender differences, etc.]
http://www.who.int/gender/documents/en/TB_factsheet.pdf?ua=1

[Gender and HIV/AIDS: gender differences, etc.]
http://www.who.int/gender/documents/en/HIV_AIDS.pdf?ua=1

WHO (2007) Gender, Health and Malaria
[Gender and malaria: gender differences, etc.]
http://www.who.int/gender/documents/gender_health_malaria.pdf?ua=1
7. Content of work
To help the promotion of gender mainstreaming in 【project title】，the party engaged in this project work shall fully understand the current situation of gender mainstreaming surrounding this project and participate in a research team as a member responsible for gender mainstreaming (or participate by individually traveling for the project as needed) to confer with and coordinate views with JICA officials, etc. and conduct surveys necessary for promoting gender mainstreaming, as stated below. It is also required to appropriately provide advice on gender mainstreaming to JICA officials, etc. in charge through study meetings, etc. Specific duties are as follows:

(1) Preparation period in Japan (MMM – MMM 20XX)
   (i) Understand the details (collect and analyze necessary materials and information – including written request and relevant reports) of the project to be implemented in 【sector issue】，and consider how to integrate gender perspectives into a specific project, referring to references, etc. for gender mainstreaming.
   (ii) Consult with 【the department in charge】 about information to be collected through field surveys, and prepare a questionnaire (proposal) in English.
   (iii) Consider measures to be taken for gender mainstreaming, based on project-related materials (PDM (Project Design Matrix) proposal, PO (Plan of Operation) proposal, etc.).
   (iv) Participate in meetings to discuss future policies and measures, study meetings, etc.

(2) On-site work period (early/mid-/late MMM 20XX)
   (i) Participate in meetings with the local JICA office, etc.
   (ii) Participate in consultations/negotiations with the target country’s government agencies and field surveys
   (iii) Collect information and data related to the area in charge to understand the current status:
   A) Analyze the current status of gender mainstreaming in relevant organizations.
      (a) Examine relevant literature/documents to collect information;
      (b) Conduct questionnaire surveys with relevant organization and departments/divisions (including the distribution and collection of questionnaires); and
      (c) Analyze the current state of gender mainstreaming and future possibilities, based on the literature/documents collected and questionnaire survey results.
   B) Understand earlier projects and (for a project currently underway) specific efforts toward gender mainstreaming.
   C) Understand the status of implementation efforts in relevant projects conducted by other donors.
   D) Conduct a hearing survey of the National Machinery (the target country’s government agency for the empowerment of women), including the Ministry of Women, for women’s empowerment.
   (iv) Organize gender perspectives needed in the project and measures to take (proposal):
      A) Consult with JICA survey team members, the Office for Gender Equality and Poverty Reduction, etc. about gender perspectives and measures to take in the project, and prepare a gender mainstreaming plan that suits the system and capabilities of implementation organizations and responds to the current situation.
      B) Prepare implementation system plans (related organizations, capabilities required and the number of people) necessary for expected activities
      (v) Cooperate in areas relevant to gender mainstreaming of project-related documents (PDM proposal, PO proposal, ex-ante evaluation sheet, etc.).
      (vi) Report field survey results to the JICA office, etc.

(3) Work period in Japan (MMM – MMM 20XX)
   (i) Cooperate in preparation of reports, relevant materials (PDM proposal, PO proposal, R/D (Record of Discussions) proposal and M/M (Minutes of Meetings)) concerning gender mainstreaming-related areas of the project concerned.
   (ii) Attend a post-homecoming debriefing meeting and other domestic meetings to report survey results.

(4) Organization period (early/mid-/late MMM 20XX)
   (i) Based on results of literature and field surveys, organize and sort out survey items for gender mainstreaming in 【sector issue】，develop measures on how to incorporate gender perspectives into the project, and prepare a mission completion report.
   (ii) After consultation with 【the department in charge】，hold a seminar (about 1.5 hour) for JICA officials to report
survey results.

8. Work products, etc.
Work product(s) generated under this Contract are (is) as follows:
(1) Mission completion report (in Japanese)
Prepare a mission completion report including field survey results, and submit it in the form of electronic data. It is also required to include concrete measures to promote gender mainstreaming in the sector concerned, beyond the scope of the target project.