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A Guide to Integrating Gender in Improvement

AUGUST 2017

This gender integration guide was prepared by WI-HER, LLC and University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and authored by Taroub Harb Faramand, Megan Ivankovich, and Julia Holtemeyer of WI-HER, LLC. The guide was produced under the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, which is made possible by the generous support of the American people through USAID and its Office of Health Systems.

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DISCLAIMER

The contents of this report are the sole responsibility of University Research Co., LLC and WI-HER, LLC and do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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In 2012, an implementation guide was released to support gender integration in improvement activities in the USAID Health Care Improvement (HCI) Project, the predecessor to the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. This current guide updates and expands on the previous guide; while it reflects the same concepts and principles, it incorporates learning and guidance that have been identified and developed during the implementation of ASSIST activities over the lifetime of the project. The authors would like to acknowledge the contributions of the following colleagues: Emily Treleaven of University Research Co., LLC (URC) and Laura Baringer, Elizabeth Romanoff Silva, Shanna Todd, and Katie Krueger of WI-HER, LLC. We would also like to thank the following ASSIST teams for their work that provides examples throughout this guide: Burundi, Kenya, Malawi, Mali, Nicaragua, South Africa, Swaziland, and Uganda.

The aim of the USAID ASSIST Project is to improve the quality and outcomes of health care and other services by enabling host country providers and managers to apply the science of improvement. The project seeks to build the capacity of host country service delivery organizations in USAID-assisted countries to improve the effectiveness, efficiency, client-centeredness, safety, accessibility, and equity of the health and family services they provide. ASSIST also seeks to institutionalize the capacity to improve through competency development at the pre- and in-service levels as well as engaging with host country governments at the policy level.

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Acronyms

ADS	Automated Directives System (USAID operational policy)
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
GBV	Gender-based violence
GenDev	USAID Office of Gender Equality & Women's Empowerment
HCI	USAID Health Care Improvement Project
HIV	Human immunodeficiency virus
IGWG	Inter-agency Gender Working Group
M&E	Monitoring and evaluation
MCH	Maternal and child health
MOH	Ministry of Health
NACS	Nutrition assessment, counseling, and support
OVC	Orphans and vulnerable children
PDSA	Plan-Do-Study-Act cycle
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
QI	Quality improvement
STI	Sexually transmitted infection
TB	Tuberculosis
URC	University Research Co., LLC
USAID	United States Agency for International Development
VMMC	Voluntary medical male circumcision
WHO	World Health Organization

INTRODUCTION

Achieving gender equality and female empowerment are now universally recognized as core development objectives, critical to closing development gaps. International conventions and articles have consistently emphasized the need for women's rights to be promoted at all levels of community and government. Yet, despite these achievements, significant gaps still remain. Many have not fully integrated gender into project assessment, design, implementation, and evaluation.

Great progress has been made over the past 25 years in increasing gender equality and working to prevent inequalities in access to primary health care, reproductive health, HIV/AIDS, and other critical services. At the same time, many gaps remain in both coverage and quality of health care. Health care improvement approaches seek to close these gaps, by applying the science of improvement to ensure that high-impact interventions reach every patient or client, every time, and improve outcomes.

Without considering gender dynamics in quality improvement (QI), improvement interventions risk failing to reach much of the population and unintentionally exploiting or harming some people. From an implementation perspective, this is an inefficient use of resources and from an improvement standpoint, this jeopardizes patient-centeredness, safety, and equity. Gender integration is key to minimizing gender-based inequalities in development and ensuring *everyone* receives equitable and quality care.

The United States Agency for International Development (USAID) has a long history of support for women and gender equality issues. In 1973, USAID established the Women in Development (WID) Office—now known as the Office of Gender Equality & Women's Empowerment (GenDev)—to maintain and increase USAID's institutional capacity to address gender-related issues and find new approaches and solutions for gender-related obstacles to development. Since 2009, USAID has made major strides in integrating gender issues into USAID strategies, projects, and procedures. Gender analysis is now one of two mandatory analysis requirements that must be integrated into strategic planning, project design and approval, procurement processes, and measurement and evaluation. Additionally, USAID established new definitions of gender issues, specifically for budget attributions in Operational Plans, and revised common indicators. To sustain and continue this progress, in 2012 USAID published the Gender Equality and Female Empowerment Policy, through which the Agency adopted a suite of new gender equality policies and strategies; reformed budgeting and reporting requirements to capture gender equality results; and created incentive funds to promote women's leadership, reduce gender-based violence, and accelerate investments in women peacebuilders, parliamentarians, agricultural producers, and owners of small and medium enterprises.

This guide outlines a unique gender integration approach—developed by WI-HER, LLC for the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project—that utilizes the science of improvement to integrate gender seamlessly into ongoing and new activities. The gender integration approach aims to build the competencies of policy makers, service providers, and community health workers to analyze and understand gender issues—including gender-based violence—that affect development activities. It allows improvement teams to identify gender gaps and issues affecting the achievement of improvement aims, examine drivers affecting these aims, design and implement activities to close gender-related gaps, and document learning.

Designed to provide conceptual knowledge and practical tools for gender integration for improvement teams around the world, this guide provides:

- An overview of key gender integration concepts.
- Concrete guidance, tools, and other resources on how to integrate gender considerations into improvement activities, using the framework of a six-step approach.

- Examples of how gender has been integrated into the work of improvement teams focused on improving health care and services.

Please note that this resource is not intended to be prescriptive. The guidance and tools presented should always be tailored to fit a particular activity’s context. A wide array of factors should be considered, including the sociocultural and political environment and the local context, and acceptance and capacity of implementing partners and stakeholders, as well as donor preferences.

About this guide

This guide is designed for quality improvement teams. It is also relevant for all staff supporting those teams, including management, technical staff, monitoring and evaluation (M&E) specialists, and research professionals. It may also be useful to anyone who aims to address gender considerations to achieve better outcomes among women and men, girls and boys, or other professionals more broadly who are seeking to address gender in their own studies or activities.

The guide is divided into three main sections to support gender integration in quality improvement activities. It walks the reader through the step-by-step process of integrating gender in improvement. Though it focuses on the process for activities that have not yet begun, the guide will also be helpful to integrate gender in activities that are already underway. Review the entire guide and determine which components are feasible for you. The Appendices provide tools and resources to support this work.

Section	What you will find
Introduction	This section provides the rationale for gender integration in improvement, describes whom this resource is for, and explains how it can be used.
Part 1: Understanding Gender & Gender Integration	This section describes what gender and gender integration are, and why they are important.
Part 2: The Six-step Approach to Integrate Gender	This section provides an overview of each step in the six-step process: <ul style="list-style-type: none"> • Step One: Conduct a gender analysis to inform program design and implementation • Step Two: Collect and analyze sex-disaggregated and gender-sensitive data • Step Three: Identify gender-related gaps and issues and develop changes to test • Step Four: Implement, monitor, and adapt gender-related changes over time to determine whether desired results are achieved • Step Five: Scale up effective interventions • Step Six: Document and share learning
Part 3: Additional Considerations	This section describes additional factors to consider when integrating gender into improvement activities, including gender-based violence, constructive male engagement, constructive female engagement, the “do no harm” principle, and aspects of people’s lives aside from gender that are important to consider.
Appendices	This section provides facilitation tools, job aids, and a list of resources.

Readers are encouraged to review all sections of the guide as they intersect with and build upon each other. Examples, tips, and case studies are provided throughout to help readers understand key concepts and facilitate use of this guide. The last appendix (**Appendix 7**) provides a list of all referenced resources.

PART 1: UNDERSTANDING GENDER & GENDER INTEGRATION

What is gender?

Gender integration requires everyone involved to work towards ensuring that policies, projects, activities, services, and delivery models are responsive to the needs of women, men, girls, and boys in all their diversity. Therefore, it is critical to first understand the difference between sex and gender.

Sex refers to the biological and physiological characteristics that identify a person as female or male. For example, males can grow facial hair and females develop breasts that can lactate. These biological and physiological characteristics do not change from culture to culture.

Gender refers to the economic, social, political, and cultural attributes and opportunities that are associated with being male or female in any society. For example, in many societies, women are considered the caretakers and responsible for the 'private sphere' of a family, while men are the breadwinners, responsible for the 'public sphere.'

Gender roles and norms

The concepts of gender vary within societies and culture; these variations are often seen through the gender roles men and women play, which are dictated by gender norms. **Gender roles** are behaviors, attitudes, and actions that society feels are appropriate or inappropriate for a girl, boy, woman, or man, according to cultural norms and traditions. For example, gender roles include the degree to which women and men attend meetings or social events, accept or seek out services, and access and use social, economic, and political resources.

Gender norms are social principles and rules that govern the behaviors, attitudes, and actions of girls, boys, women, and men in society and restrict their identity into what is considered to be an appropriate gender role at the time. Gender norms are perpetuated and reinforced throughout societies and cultures, through mechanisms such as laws that hinder equal access to economic resources (e.g., land, inheritance), the day-to-day interactions in the community and family between and amongst men and women, and media (e.g., films and advertisements that represent the stereotypes of men and women).

Gender roles and norms are learned; they can change over time, and they vary within and between cultures. Gender roles also vary in relation to other social identities such as age, social class, socio-economic status, ethnicity, sexual orientation, religion, ability, and health status; these can further influence a society's or culture's gender norms and the associated behaviors, attitudes, and actions. See **Appendix 1** for a glossary of key gender terms and definitions.

The gender roles and norms that a society assigns to males and females do not always align with every person's individual feelings. Gender identity is a person's internal, deeply felt sense of being a man or woman, or something other or in between. Sometimes this does not correspond with the sex they were assigned at birth. For example, most females think of themselves as women, and most males think of themselves as men. However, transgender people think of themselves differently from the gender assigned to the sex they were born with. This includes females who think of themselves as men (called transgender men), and males who think of themselves as women (transgender women). Some people do not think of themselves as men or women; they consider themselves gender neutral.

Gender identity is different from sexual orientation. Sexual orientation refers to the type of person that someone is sexually attracted to. When a woman is attracted to man or a man is attracted to a woman, they are called heterosexual. When a woman is attracted to another woman or a man is attracted to another man, they are called homosexual (or gay or lesbian).

What is gender integration?

Gender must be explicitly considered as an integral part of the design, implementation, and M&E of all projects, activities, and policies that aim to enhance and transform communities. **Gender integration** refers to the process of identifying and addressing gender and its impact on development outcomes as an integral part of the various project phases. Since gender, gender norms, and gender roles can greatly impact how an activity is carried out and its impact, attending to these issues on an ongoing basis is essential. Gender integration is everyone's job: if different needs, behaviors, and preferences of women, men, girls, and boys are not taken into account, then we are not working towards gender equality and improved development outcomes.

Gender refers to the economic, social, political, and cultural attributes and opportunities that are associated with being male or female in a particular society.

Gender integration refers to strategies applied in activity assessment, design, implementation, and evaluation to take gender norms into account and to compensate for gender-based inequalities.

Why gender integration?

Globally over the past 25 years, significant strides in improving gender equality have been made. Women and girls have seen remarkable advances in their rights to education, health, and employment, as well as other basic human rights, to enhance their livelihoods. International conventions and articles¹ have consistently emphasized the need for women's rights to be promoted at all levels of community and government. Yet, despite these achievements, significant gaps still remain. In developing countries, one in five girls who enroll in primary school will never finish; one in seven will marry before they are 15; and while women comprise 43% of the agriculture labor force globally, many countries limit their legal access to land and other property. Regarding access to health services, gender-based discrimination often hinders women's successful outcomes in family planning, reproductive health, and maternal health, and stigma often prevents men from seeking needed HIV, TB, and nutrition services.

Men and women must have equal opportunities to achieve their full potential. Only by addressing societal, political, and cultural gender-based inequalities can we establish a positive development cycle, which can result in improved development outcomes, as well as contribute to improved gender equity. Men, women, boys, and girls have differing health care and other social needs and face different social, economic, and cultural barriers to accessing services. If half of a population has unequal access to care or receives lower quality services, improvement efforts will make limited progress. When accessing care, men and women may face gender-specific stigma, discrimination, or other challenges that lower their quality of care. No matter the country, context, or condition, gender is a social determinant of health. To truly improve the quality of care for all patients, these differing health care needs must be explicitly recognized and addressed by providers, facilities, and health systems, especially in quality improvement activities.

How to talk about gender integration

There are a number of questions that people often ask when they first hear about gender integration. This guide has compiled a list of these frequently asked questions (FAQs) about gender and gender integration, and suggestions for how to answer them, in **Appendix 2**. These will be helpful as you make the case for gender integration to colleagues and partners. **Appendix 3** goes a step further, providing advice and suggestions for how to prepare for and facilitate discussions about gender integration in quality improvement. It includes scenarios to introduce an audience to gender issues in their work.

¹ The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979, the International Conference on Population and Development in 1994, the Beijing Platform for Action in 1995, the Millennium Development Goals established in 2000, and the Sustainable Development Goals in 2015.

Box 1. Gender integration continuum

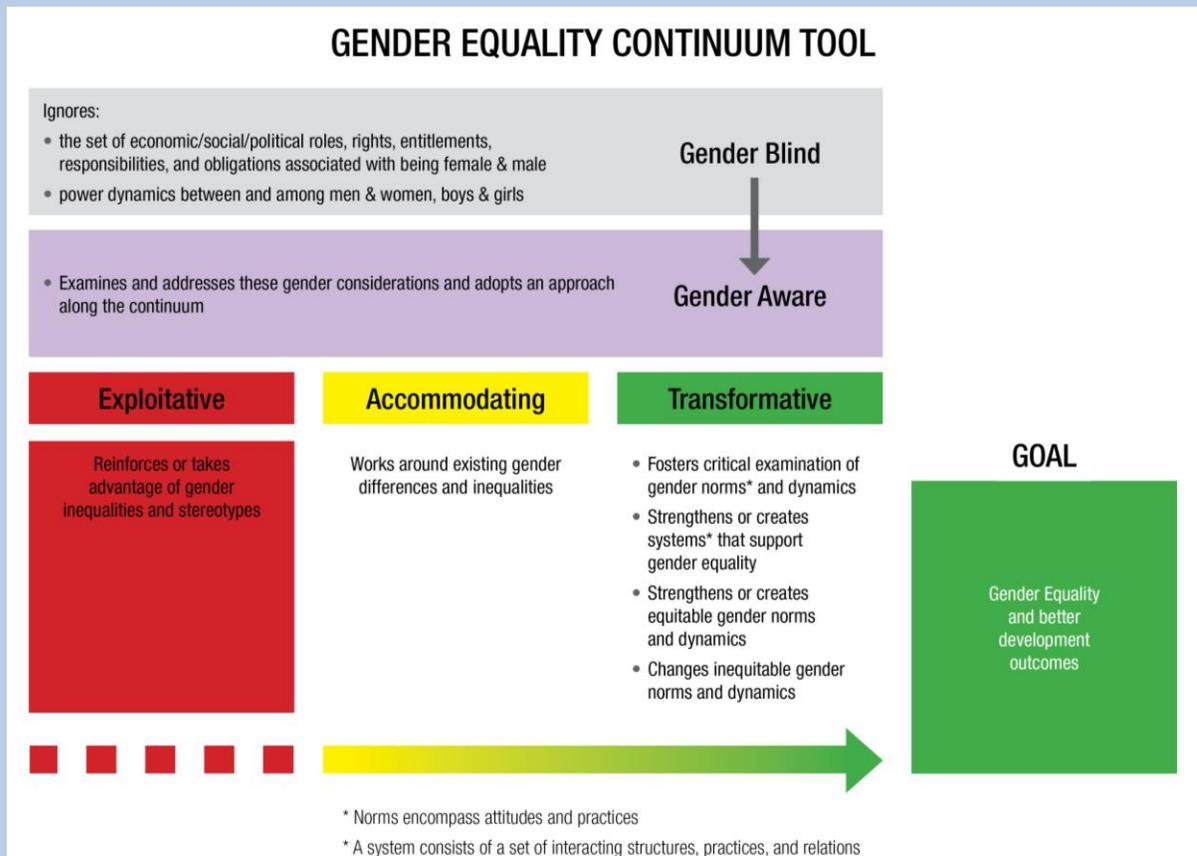
To guide a variety of projects on how to integrate gender, USAID’s Interagency Gender Working Group (IGWG) developed the [Gender Integration Continuum](#) conceptual framework (see the diagram below). This framework categorizes approaches by how they address gender inequalities in all phases of a program or policy, including planning, design, implementation, and M&E. It is important to note that different components of the same project may address gender differently.

The framework is also designed with the intended outcome that all gender-oriented projects, activities and policies ultimately use gender transformative approaches to achieve the goal of gender equality and improved development outcomes.

The framework begins by establishing that gender integrated projects, activities, and policies must be **gender aware**, not **gender blind**. **Gender aware** refers to projects that deliberately examine gender considerations and address their anticipated or potential impact on gender. If a project, activity, or policy is **gender blind**, it ignores the roles, rights, entitlements, responsibilities and obligations associated with being female and male, and the power dynamics between men, women, boys, and girls.

Gender aware activities, policies, or projects should be designed to be either **gender accommodating** or **gender transformative**. **Gender accommodating** projects, activities, and policies work around existing gender differences and inequalities, rather than working to transform them. They do not address the root causes of gender inequities and can be seen as a “missed opportunity” to begin to shift norms; however, they are often a critical first step towards gender transformation and full gender integration. **Gender transformative** projects, activities, and policies actively strive to examine, question, and change rigid gender norms and power imbalances as a means of reaching health as well as gender equity objectives.

Importantly, under no circumstances should projects, activities, or policies be **gender exploitative**. **Gender exploitative** projects take advantage of existing gender inequalities in pursuit of health outcomes and can have harmful consequences that reinforce, rather than transform, gender inequities.



PART 2: THE SIX-STEP APPROACH TO INTEGRATE GENDER

Introduction

Integrating gender in improvement activities is a critical component to achieving gender-equitable outcomes. By identifying and addressing the different needs, constraints, and opportunities of men, women, girls, and boys in quality improvement, we can improve outcomes for all and close gender-related gaps. The six-step process described in Part 2 of this guide outlines how improvement teams can integrate gender in quality improvement activities and implementation.

The six steps are:

- Step 1: Conduct a gender analysis to inform program design and implementation
- Step 2: Collect and analyze sex-disaggregated and gender-sensitive data
- Step 3: Identify gender-related gaps and issues and develop changes to test
- Step 4: Implement and monitor gender-related changes over time to determine whether desired results are achieved
- Step 5: Scale up effective changes to close gender-related gaps
- Step 6: Document and share learning

A gender-sensitive approach facilitates analyzing the social and cultural influences that determine who has access to care, who remains in care, and who receives quality care, to be able to respond appropriately. It takes the different needs, constraints, and opportunities of women, men, girls, and boys into account and responds to them strategically in activity design, implementation, and evaluation. We recognize that myriad factors at multiple levels of society affect gender norms that influence risk factors, access to care, utilization of care, and equality of treatment, and we work to respond to these norms in concert to generate shifts in thinking and behavior. It is important to address gender gaps and issues at the individual, household, and community levels when necessary, through sensitization trainings, and then consider the varied contextual factors that drive outcomes for women, men, boys, and girls in the design, implementation, and evaluation of activities. This six-step approach to gender integration allows practitioners to identify and close gender-related gaps and improve health outcomes for all.

Integrating gender in improvement activities does not mean creating improvement activities to target gender issues or with the goal of gender equality, rather it means thinking about how gender will affect and be affected by each improvement activity—no matter the desired outcome of the improvement activity. Improvement activities can target gender issues or have the explicit goal of gender equality, but gender integration goes beyond explicitly gender-focused improvement, to consider gender in all types of improvement activities.

A video explaining the six-step approach is available in English // en Español // en Français at: <https://www.usaidassist.org/resources/video-six-step-approach-help-teams-integrate-gender-improvement-activities>

Step 1: Conduct a gender analysis to inform program design and implementation

A **gender analysis** is a systematic way to identify, understand, and describe the social, economic, and political factors that shape the lives of women, men, girls, and boys and how these gender inequalities affect development outcomes.

Objectives of Step 1

- Identify how local beliefs, cultural norms, and the context in which activities are designed impact men and women, and boys and girls, differently.
- Identify and interpret gender inequalities and the relation of power between women, men, girls, and boys, and their possible consequences on achieving activity objectives and interventions.
- Determine which gender-related constraints should and can be addressed within the activity.

How it will be achieved

- Review existing gender analysis or assessment documents.
- Conduct a desk review if a gender analysis is not available.
- Conduct interviews with local community members to better understand gender issues affecting males and females in specific communities where gaps exist.

When to conduct

- Ideally before the activity begins or at the beginning, but can be done at any time during activity implementation.

What is a gender analysis?

For improvement activities to be effective, it is critical to understand the political, cultural, and social norms, beliefs, and environment in which activities operate. Gender is one aspect of this local context that must be considered to create culturally sensitive and relevant activities, and different strategies and measures may be necessary to achieve intended results and equitable outcomes for males and females. Gender analysis provides the foundation for considering gender dynamics in improvement activities. A gender analysis is a systematic way to identify, understand, and describe the social, economic, and political factors that shape the lives of women, men, girls, and boys and how these gender inequalities affect development outcomes.

Why conduct a gender analysis?

By examining the experiences of women, men, girls, and boys in different aspects of life, a gender analysis helps us to:

- Be aware of the different realities of the lives of women and men in a community or region, and with regards to a specific development outcome.
- Identify how local beliefs, cultural norms, and the context in which activities operate impact men and women, and boys and girls differently within existing social, economic, and political structures.
- Examine differences in how women, men, girls, and boys are able to decide, influence, control, enforce, and engage in individual and collective actions.
- Understand the possible consequences of those gender inequalities and power relations on achieving activity objectives and interventions.
- Understand and assess how policies, activities, and projects may impact women and men, girls and boys differently.

In sum, a gender analysis helps identify gender-related inequalities, constraints, and opportunities that may affect activity outcomes and how they should and can be addressed or leveraged within the activity design, implementation, monitoring, and evaluation. Remember that different strategies and measures may be necessary to achieve intended results and equitable outcomes for males and females. When integrated into activity design, the results of a gender analysis help determine the changes to be tested for improvement, contribute to an improved understanding of gender-related drivers in outcomes, and facilitate a better design of activities to achieve improved quality of care. Without considering gender, improvement risks failing to reach half of the population and unintentionally exploiting or harming women or men, boys or girls.

How to conduct a gender analysis

Ideally, a gender analysis will be conducted before an activity begins, in order to better understand gender issues that may affect the activity and to determine what, if any, gender constraints should be addressed. However, it is still useful if conducted during any stage of an improvement activity.

There is no specific *required* method for conducting a gender analysis. Different organizations and projects may have different methods, but at its core, a gender analysis always includes the basic elements of researching and analyzing how gender roles and norms affect the object of analysis. And it always involves collecting and analyzing sex-disaggregated data and other qualitative and quantitative information on gender issues.

There are many tools and frameworks that can provide a foundation for the analysis and be adapted based on activity needs. We have developed Gender Analysis Worksheets to help improvement teams collect, organize, and analyze information for a gender analysis, which can be found in **Appendix 4**. These can be adapted based on the activity needs, but we always encourage improvement teams to focus on answering two key questions:

- How will the different roles and status of women and men, girls and boys, affect the activity?
- How will the anticipated results of the activity affect women and men, girls and boys, differently?

Next, develop a list of illustrative questions to analyze the expected effects of activity interventions and the anticipated outcomes on gender relations, norms, and equality. The questions will vary depending on the aim of the activity, the specific context of the activity, and whether it is implemented in the facility, community, or both. See **Box 2** for an overview of sample questions, and **Appendix 5** for a more complete list; all questions should be adapted for the specific data collection needs of the activity.

Box 2. Examples of gender analysis questions

1. What are the different roles and status of women and men in the community? The household? What is the political power of men and women in the community? Who holds decision making power in the household? In the community?
 - What do men do in the community? What do women do in the community?
 - What are men's typical tasks in a household? What resources and decisions does he control?
 - What are women's typical tasks in a household? What resources and decisions does she control?
 - How and where do men and women spend their time?
 - What meetings and community decisions to men participate in? Women?
2. What knowledge, beliefs, and perceptions exist about the roles of males and females in the community?
 - *Knowledge*: What information are men and women privy to? (Who knows what?)
 - *Beliefs*: How should men and women behave? How should they conduct their daily lives?
 - *Perceptions*: How do men and women interpret aspects of their lives differently?
3. How do men and women access health care (differently)? Do boys and girls access health care equally? Why or why not?
 - Who controls health care decisions for children? Are boys and girls treated differently in the home? In the health facility? If so, how?
4. How will gender relations affect the achievement of sustainable results?
5. How will the proposed results affect the relative status of men and women? Will it exacerbate inequalities, accommodate inequalities, or transform gender relations? How? Why?

Data collection

To answer these questions, conduct a rapid desk review to understand the target population and the context in which the activity, project, or organization is operating. First review *existing* gender analyses, gender assessments, and other research on gender in the country or community where the work will take place. Look for sex-disaggregated data and quantitative and qualitative background information and gender considerations that have already been identified. While quantitative data can show you what is happening, qualitative data gives meaning to gender roles and norms, and help explain why people act in certain ways. Some examples of documents that contain relevant data on gender include:

- Census or surveillance data disaggregated by sex (e.g., health status, educational enrollment, incidence of morbidity and mortality)
 - When possible and relevant, look for data disaggregated by age, location, income, ethnicity, and education level.
- Activity or organizational documents (e.g., work plans, baseline studies, M&E plans)
- Statistics and reports from government departments and ministries (e.g., demographic and health surveys)
- Government policy documents (e.g., national policy on women's equality)
- Third-party gender studies (e.g., gender analyses, assessments, or research papers)

You will likely need additional data to better understand gender issues and gaps affecting males and females in specific communities. To get additional data, consider conducting focus group discussions, key informant interviews, participatory research, qualitative surveys, and even informal conversations with

local community members. Observing facilities, schools, households, or other venues relevant to improvement activities may provide insight into gender relations.

It is important to include different types of people in gathering data for a gender analysis and to consult with varied, local community members and leaders, health care providers, and both men and women. Diverse stakeholders on your team can provide insightful information about the localized differences between men and women in the family, social, and political spheres. This additional information allows you to gain new insights, perspectives, and ideas from gathering new data from a range of individuals; it may also help you increase data supporting the resulting recommendations and interventions.

Aspects to consider in a gender analysis

A gender analysis is organized around aspects of social and cultural relations to help understand gender relations more concretely. While there are no universal aspects to consider, we suggest using the following five domains of gender analysis listed in [USAID guidance on integrating gender equality and female empowerment into USAID's Program Cycle \(ADS Chapter 205\)](#) and outlined below.

1. **Access to and control over assets and resources:** Refers to being able to use the assets necessary to be a fully active and productive participant—socially, economically, and politically—in society.
2. **Cultural norms and beliefs:** Refers to the beliefs that shape gender identity and behavior and the perceptions that guide how men and women interpret aspects of their lives differently.
3. **Patterns of power and decision-making:** Examines the ability to freely decide, influence, control, and enforce material, human, intellectual, and financial resources, in the family, community, and country.
4. **Laws, policies, regulations, and institutional practices:** Reflects how gender affects the way people are treated and regarded by customary law, the formal legal code, and the judiciary system.
5. **Roles, responsibilities, and time used:** Examines peoples' behaviors and actions in life—what they actually do—and how this varies by gender.

TIP: The two key questions should be applied to each of the five domains and considered at both the country and activity level. Keep these key questions in mind when reviewing data, conducting research, speaking with experts, and meeting with stakeholders:

- **How will the different roles and status of women, men, girls, and boys, affect the activity?**
- **How will the anticipated results of the activity affect women, men, girls, and boys, differently?**

When examining gender across these domains, remember that gender relations change over time and across societies and locations. For example, it is different to be a woman in China now than it was in 1960. Within Uganda right now, it is different to be a woman in Kampala than to be a woman in the West Nile region. Thus, it is also important to examine the five domains of gender analysis across:

- Social relationships, including:
 - Partnerships/couples (head of household; domestic roles; decision-making power; control of resources)
 - Households and families (decision-making power for children)
 - Communities (participation in organizations and groups)
- Civil society and government institutions
- Different ethnicities, races, classes, and age
- Different geographic areas within a country

Data analysis for a gender analysis

Once all sources of information have been analyzed using the key questions and five domains, review all data and information collected holistically. This means:

1. Reviewing all data in the context of the gender roles and relationships of women, men, girls, and boys.
2. Synthesizing the gender issues identified, their interconnectedness, and how they could affect the activities and goals planned through the project.
3. Identifying how the project might respond to the issues identified through the gender analysis in order to be more effective and to promote gender equality.

See **Appendix 4** for Gender Analysis and Gender Integration Planning Worksheets that are a helpful tool to collect, organize, and analyze this information.

Develop recommendations and document the process of a gender analysis

Based on the gender analysis results and identified constraints and opportunities, develop a list of actionable recommendations to reduce gender gaps. These recommendations will serve as a basis for the driver diagram tool in Step 3. When developing recommendations, consider:

- Existing or new gender-related activities
- What resources and actions are required (e.g., staffing, funding, training)
- Supportive strategies and resources from donors and other stakeholders
- Results and associated indicators that should be incorporated
- Anticipated areas of resistance
- Unintended negative consequences (see Part 3 of this guide for an explanation of this and the “do no harm” principle)

Then develop a short write-up to describe your gender analysis process and findings. This synthesis will help you to digest and think through all you have learned. It will be useful to reference as you plan, implement, monitor, and evaluate improvement activities. It will also be useful to share with colleagues. Consider including the completed matrix and any recommendations the team developed. The write-up should be short and concise, easy-to-read, and highlight key issues.

TIP: For additional recommendations, review applicable international best practices. Consider what interventions, activities, and policies have been successful for other projects or organizations within the country, region, or globally.

TIP: If you have already begun your activity, consider how you can integrate findings into the design or how you can amend your activity. Work with gender experts to determine the most effective approach.

Findings from the gender analysis should be incorporated throughout activity design, implementation, and monitoring and evaluation. **Box 3** provides examples of gender analysis findings, and **Box 4** provides a case study of a gender analysis in Mali.

A rapid gender analysis can be done in a few days, and a more thorough gender analysis can take weeks. If a formal analysis is not possible, it is still important to informally ask questions and gather information to better understand the gender issues affecting the activity and to take those issues into account.

Remember that when integrated into activity design, the results of a gender analysis help determine the changes to be tested for improvement, contribute to an improved understanding of gender-related drivers in health outcomes, and facilitate a better design of activities to achieve improved quality of care. Without considering gender, improvement risks failing to reach half of the population and unintentionally exploiting or harming women or men, boys or girls.

Box 3. Examples of gender analysis findings

HIV/AIDS: Fear of stigma and gender-based violence lead women to be less likely to seek care and contributes to the lower rates of females enrolled into HIV care at the facility.

Malaria: Some traditional household responsibilities increase women's risk of malaria infection, including cooking the evening meal outdoors and waking up before sunrise to prepare the household for the day.

Maternal and child health (MCH): Husbands and mothers-in-law often decide whether or not a woman needs to go to the health facility, yet have little accurate knowledge about health needs of these women.

Nutritional assessment, counseling, and support (NACS): Gender norms in the community reinforce the idea that seeking care reflects weakness, contributing to higher rates of malnutrition among males in the community. However, men have better access to resources and food than women.

Orphans and vulnerable children (OVC): Factors contributing to adolescent girls dropping out of school in higher numbers than boys include families arranging for their daughters to be married so that the family can receive a dowry, and girls not feeling welcome at school once they begin menstruating.

Prevention of mother-to-child-transmission of HIV (PMTCT): Some men and women believe that male partners who accompany their partners to the antenatal care (ANC) clinic are bewitched, dominated by their spouse, or that the couple is HIV positive.

Voluntary medical male circumcision (VMMC): Men worry that their partners will fulfill their sexual desires with others during the six weeks after surgery when they must abstain from sexual intercourse.

Box 4. Gender analysis case study: Mali

USAID ASSIST Project team members conducted a gender analysis to examine the different roles and status of women and men, to identify issues that could impede or were impeding the achievement of project goals, and to analyze the impact of planned and current activities. The team reviewed current literature, including gender assessments and gender analyses about gender issues, and filled out a matrix of key gender relations and power disparities. Illustrative findings include:

Laws, policies, regulations, and institutional practices: Men cannot legally marry until age 21, but women and girls can marry at age 18, reflecting a belief that a woman should marry younger than a man. Girls under 18 can marry legally with parental consent and, furthermore, the law is not strongly enforced. Early and forced marriage puts girls at a higher likelihood of early pregnancy and complications, consequently putting both the mother and baby at elevated risks. Polygamy is legal, and creates issues relevant to maternal health, nutrition, and family planning.

Cultural norms and beliefs: It is widely believed that a woman should be under the responsibility of a man. This affects a woman's access to health care and family planning practices. Mothers-in-law tend to be primary influencers, with husbands as secondary influencers, although this can vary by community and family. Men are often granted the privilege of eating first, based on a respect for hierarchy within the family. This affects women's nutrition status, especially when pregnant or breastfeeding. Physical violence against women is something that tends to also be culturally accepted among both men and women, and affects maternal health outcomes.

Gender roles, responsibilities, and time used: At the health facility level, women are less represented in business management in the Community Health Association. Women generally represent approximately two out of 11 seats, giving them fewer responsibilities and less of a role in health-related decisions. Pregnancy and delivery are considered a woman's business, while management and leadership are considered men's business.

Access to and control over assets and resources: Women in Mali tend to have less control over assets. Women have access to social assets including social networks of women's groups, but they are underrepresented in direct village leadership. Related specifically to financial assets, resources, income, and credit at the household level, women tend to not have financial independence in Mali, as husbands are usually responsible for the management of finances within the family. This is important because men are responsible for allocating money to health care expenses and transport.

Patterns of power and decision-making: Decision-making about accessing maternal, nutritional, and family planning health services tends to rest with the husband or mother-in-law due to religious and cultural beliefs. This directly affects a woman's health outcomes and the quality of services offered. Because both legally and due to cultural norms, decision-making power about sexual intercourse rests with the man, this can create both maternal health issues and issues in promoting family planning methods. Fathers legally have parental rights over children while mothers do not.

Resources to learn more:

- Video: How to Conduct a Gender Analysis. USAID ASSIST Project (2017). <https://www.usaidassist.org/resources/how-to-conduct-gender-analysis>
- Gender analysis, assessment and audit manual & toolkit. ACIDI/VOCA (2012). <http://www.acdivoca.org/wp-content/uploads/2016/07/ACDI-VOCA-Gender-Analysis-Manual.pdf>
- Jhpiego Gender Analysis Toolkit for Health Systems. Jhpiego (2016). <http://gender.jhpiego.org/analysistoolkit/introduction/>
- A practical guide for managing and conducting gender assessments in the health sector. IGWG (2013). <https://www.igwg.org/resources/a-practical-guide-for-managing-and-conducting-gender-assessments-in-the-health-sector/>

Step 2: Collect and analyze sex-disaggregated and gender-sensitive data

Sex-disaggregated data are data that are collected and presented separately for males and females, for an intervention that is targeting both males and females. For example, data on nutrition status, education outcomes, or retention in care collected for males and females separately.

Gender-sensitive indicators measure changes in the status and role of females and males over time. They measure things like male partner involvement in antenatal care or mothers-in-law educated on maternal and child health issues.

Objectives of Step 2

- Using the insights learned from the gender analysis, determine what sex-disaggregated data should be collected, and how they will be collected and analyzed.
- Develop gender-sensitive indicators that will be examined over time.

How it will be achieved

- Collect and analyze sex-disaggregated data and gender-sensitive indicators for person-level data.
- Data should be collected continuously, and can be analyzed periodically to check for gaps; if no gaps or issues are found, decide whether to continue monitoring for gaps or switch to analyzing a new set of indicators.

When to conduct

- At the beginning of activity and then monthly

Sex-disaggregated data

In quality improvement, we aim to identify and address barriers to access and utilization of services to support improvement efforts. It is critical for improvement efforts to collect and analyze male and female access to, utilization of, and retention in services separately; this facilitates the identification of any issues one group is facing which causes them to be less likely to access or benefit from services and facilitates the development of targeted improvement activities.

Why collect and analyze sex-disaggregated data?

Collecting and analyzing sex-disaggregated data is a powerful tool to identify the quantifiable differences between women, men, girls, and boys. Disaggregating data by sex helps improvement teams to understand how each group accesses care differently and highlights when they have different development outcomes. It is critical to identify and address barriers to equal access and use of services.

Sex-disaggregated data are critical for many reasons, including the following:

- Without sex-disaggregated data, vital information is missed about the existing differences and gaps between girls, boys, women, and men, and important opportunities to adapt activities to meet their unique needs to improve outcomes can be overlooked.
- By identifying important gender-related issues before an activity starts or early on in implementation, implementers can foresee and address gender-related issues proactively.
- Sex-disaggregated data alert you to any unintended consequences of an improvement effort by showing if any aspect of the activity benefits one gender group more than another, or creates or increases negative results for one group.
- Sex-disaggregated data provide evidence to partners such as Ministries of Health and donors of gender-related barriers in health care to advocate for the value of a gender-focused approach.

Box 5 provides examples of sex-disaggregated improvement indicators and results.

TIP: Consider also collecting and analyzing *age-disaggregated data* when possible and relevant. Age-disaggregated data are data that are stratified into age groups based on developmental stages, risk factors, or different needs among different ages of beneficiaries. It is often necessary and beneficial to collect age-disaggregated data since women, men, boys, and girls of different ages can have different vulnerabilities, risks, and opportunities in different stages of their lives that can require tailored services and interventions.

Steps to collect and analyze sex-disaggregated data

Sex-disaggregated data should first be collected; then, the differences should be analyzed and monitored over time to see how indicators for males and females change.

- 1. Determine what sex-disaggregated data should be collected.** Determine which indicators should and can be disaggregated and collected based on the intervention's desired outcomes. All person-level data for an intervention that targets both males and females should be collected sex-disaggregated and analyzed with the intention of closing gaps in outcomes between women and men, and girls and boys, as well as different age groups when relevant (e.g., access services, retention in care, health outcomes). Remember that not all data disaggregated by sex informs us about improvement gaps that we need to address. For example, data collected about the number of females and males trained does not tell us about gaps in health outcomes. Another example is the number of newly born boys and girls in a certain facility. Such information is not necessary for improvement activities unless it is directly relevant to the improvement team's aim.
 - Indicators such as stock outs, the availability of equipment and medicine, and whether a health facility has a private area for counseling are not person-level data and cannot be sex-disaggregated.
 - Activities that target only males or females (for example, VMMC for males and maternal health for females) cannot sex-disaggregate data because their patients are all males or all females. However, these activities can collect gender-sensitive indicators.
 - Disaggregating data on health provider behavior by sex can reveal gender differences in how male and female providers assess and treat patients, based on their own assumptions or culturally acceptable norms of behavior.
- 2. Collect sex-disaggregated data.** The USAID ASSIST Project has developed the [multi-facility sex-disaggregated database and multi-region sex-disaggregated database Excel tools](#), designed to store and pool indicator data from facilities and create time series charts of the pooled indicator data. They automatically update the time scale of charts depending on how many months or weeks of data have been collected.
- 3. Analyze results among males and females.** Data must be analyzed to understand how men, women, boys, and girls might be impacted by an intervention or services provided. Ideally, all person-level indicators will be monitored for gender-related gaps throughout the project. However, if you find collecting and analyzing sex-disaggregated data too time consuming, start by analyzing 2-3 indicators to check for gaps: look at issues and patterns, particularly gaps between males and females, differences against national and community level data, or plateaus in improvement. If there are none, it does not mean there will never be differences, only that at this specific time those differences were not detected – but differences could appear later, as a result of improvement efforts or something else. This is why continually monitoring sex-disaggregated data is important. However, if no gaps are identified for a period of 3-6 months and you find collecting and analyzing sex-disaggregated data too time consuming, switch to analyzing a new set of indicators. However, be sure to periodically spot-check the previous indicators to make sure gaps still do not exist. If you do identify a gap, develop activities to close such gaps and monitor for improvement. See the tip box below for suggestions on how to analyze data.

- 4. Continue to collect sex-disaggregated data for long-term monitoring.** Continuing to regularly collect sex-disaggregated data is critical to your activity's monitoring and evaluation. If this does not become a regular component of data collection, then you will not be able to evaluate the impact of your gender-related change.

Box 6 provides an example of the importance of sex-disaggregated data from Uganda.

TIP: When analyzing sex-disaggregated data, ask these two key questions:

- Is there a meaningful difference in the number of [target population]?
 - Are there more female clients? Male clients? Older clients? Younger clients?
 - Is this reflective of the population (e.g., national- and community-level data)? If not, why?
- Is there a meaningful difference in the [target output]?
 - If so, why? What could be causing that difference, and how can we respond to that issue?

TIP: When we see a plateau in aggregated data, it might mean that one segment of the population has been left out of improvement efforts. If we only collect aggregated data, we are not able to identify if our change ideas are not reaching females as much as males, or vice versa. With sex-disaggregated data, we can identify these differences and then address them by testing changes specifically targeting the group that has worse outcomes. Until then, the improvement aim will not be reached. However, we must also continue improvement efforts that are working for other segments of the population. Any time you see a plateau in aggregate data, remember that sex-disaggregated data MIGHT be able to tell you why.

Box 5. Examples of sex-disaggregated improvement indicators and results

[USAID ADS 205.3.8](#) requires collecting and analyzing all population-level data by sex. An illustrative list of improvement indicators disaggregated by sex includes:

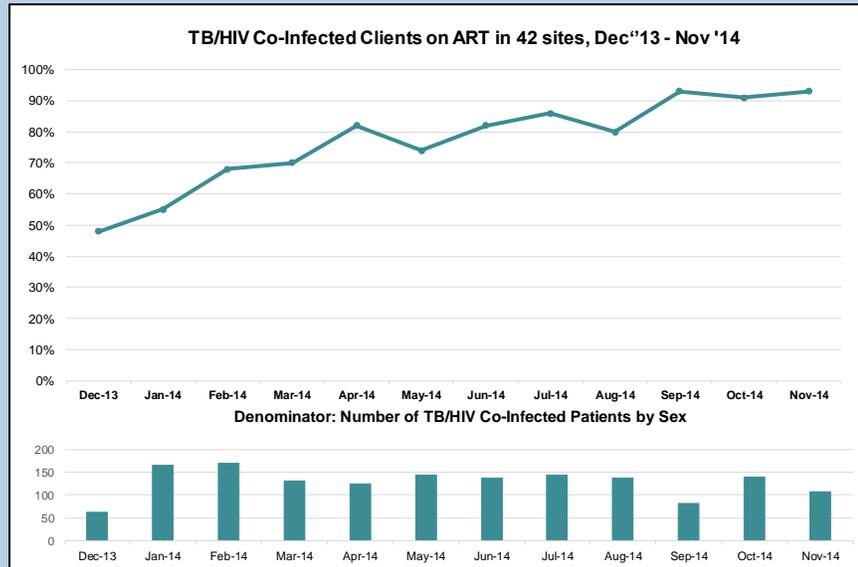
- Percentage of people living with HIV (PLHIV) (female/male) identified in the community
- Percentage of patients (female/male) newly tested positive for HIV linked and enrolled into HIV care at the facility
- Percentage of patients on antiretroviral therapy (ART) (female/male) seen in the past month who have shown clinical improvement
- Percentage of HIV patients screened for TB (female/male)
- Percentage of HIV-positive people (female/male) assessed for nutritional status
- Number and percentage of patients (female/male) assessed and categorized for malnutrition using mid-upper arm circumference and/or body mass index
- Number and percentage of patients (female/male) who recover from malnutrition
- Number of orphans and vulnerable children (female/male) accessing children's centers for psychosocial wellbeing
- Number and percentage of girls/boys enrolled in school by grade
- Number and percentage of girls/boys who pass exams by grade
- Percentage of health providers (female/male) who accurately assessed pregnant women presenting with fever
- Percentage of laboratory cultures examined for which technicians (female/male) first washed their hands

An illustrative list of gaps identified in real sex-disaggregated data includes:

- The percentage of males and females newly tested positive for HIV who were enrolled into HIV care at the facility: the rates were 72% for males and 58% for females.
- The number and percentage of female and male students enrolled in school by grade: female students were less likely to remain in school compared to their male counterparts, especially when they reached puberty. In the upper grades, there were twice as many male students enrolled compared to female students.
- The percentage of male and female clients categorized as malnourished: 87% of males were malnourished compared to 70% of females.
- Males improved their nutrition status faster than females: 1.2 months for males, and 2.3 months for females.

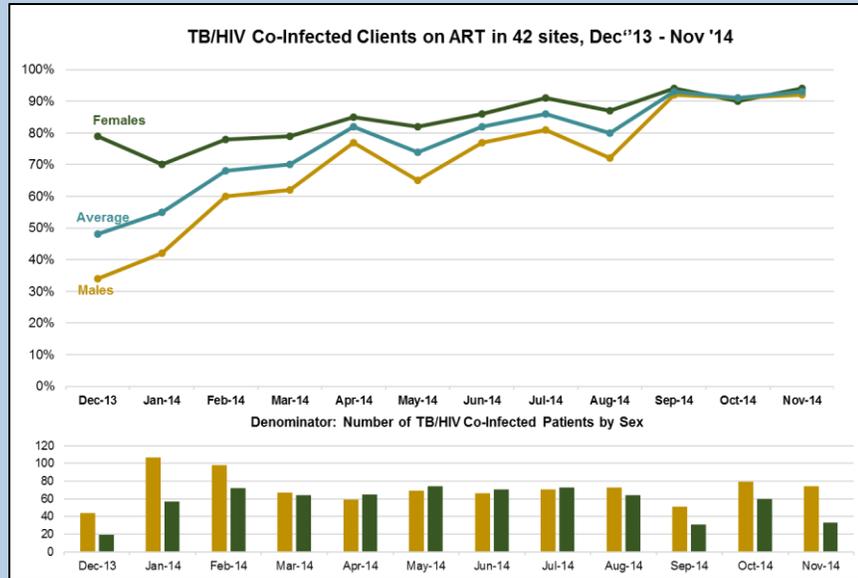
Box 6. Example of the importance of sex-disaggregated data: ART uptake among males and females in Uganda

Sex-disaggregated data enable improvement teams to analyze the differences in the results of an indicator for males and females and determine if there are any meaningful differences. In the example to the right, we see the proportion of all TB/HIV co-infected clients who are on ART in 42 facilities in Uganda that are conducting improvement activities.



However, looking at the total numbers means that we do not know whether males and females are in treatment at equal rates, thus we cannot respond to their specific needs. In the graph below, we see the same data now disaggregated by sex. This graph shows the percentage of both male and female co-infected clients who are on ART in the line graph and shows the total numbers of co-infected clients by sex below in the bar chart.

With the sex-disaggregated data, we see the rates of ART uptake are higher among females than males. If we only collected aggregated data (represented by the light blue line), we would not be able to identify these differences. With sex-disaggregated data, it became clear that males were experiencing barriers to ART uptake, so improvement teams began to develop and test changes specifically targeting men to improve their ART uptake rate.



Gender-sensitive indicators

Gender-sensitive indicators are central to the monitoring and evaluation of improvement activities. They help us know if we are on track to achieve what we have planned. They can be a measurement, number, fact, opinion, or anything that provides a signal and enables the measurement of changes in the status and role of men and women in a society over time. In health improvement activities, gender-sensitive indicators can be used to assess the impact of changes or interventions that address gender-related barriers in care. **Box 7** provides examples of gender-sensitive indicators.

Why are gender-sensitive indicators important?

Gender-sensitive indicators can show us:

- How far and in what ways activities have met their improvement objectives and achieved results related to gender equality.
- If men's and/or women's participation has increased or decreased. For example, have we increased women's and men's participation in and benefits from interventions, especially in areas where they have been historically under-represented?
 - Has gender equality been increased or decreased? For example, have we reduced gender inequality (e.g., increased access) or exacerbated gender inequalities?
- Evidence on how attention to gender contributes to more equitable and sustainable outcomes.
- Any unintended consequences of an improvement effort by showing if any aspects of the intervention benefit one gender group more than another, or create or increase negative results for one social group.

Box 7. Examples of gender-sensitive indicators

Illustrative gender-sensitive indicators include:

- Proportion of male partners who are tested for HIV at their partner's antenatal care (ANC) visit
- Proportion of male partners who test positive for HIV during their partner's ANC visit who are enrolled in HIV care
- Proportion of female partners who attend at least one education session or clinic visit with a male partner prior to undergoing voluntary medical male circumcision
- Proportion of male partners who participate in postpartum family planning counseling sessions
- Proportion of females who report that their partner accompanied them for at least one antenatal care visit during their pregnancy

Steps to collect and analyze gender-sensitive indicators

Utilizing the findings from a gender analysis or gender assessment, an activity should identify gender-related issues or constraints that may affect the activity and design indicators to track those issues over time. In developing gender-sensitive indicators, it is important to formulate measures that demonstrate removal of gender-based constraints, establish realistic separate targets for women and men, and check assumptions. Gender-sensitive indicators should capture quality and not just quantity: for example, not just measuring *attendance* but also *true participation* and decision-making, or examine the *quality of jobs*, rather than simply *numbers of women* employed.

1. **Identify the gender issues within a specific context of the activity**, using the data from your gender analysis. For example, that men tend not to be engaged in maternal or child health or that pregnant women do not have the necessary power in the family to decide they will attend ANC services or use family planning measures.

2. **Develop measures that aim to illustrate the mitigation or removal of gender-based constraints** or the change in the relationship or roles of males and females over time. Check indicators to ensure that they are working to capture quality, not just quantity. Aim to use gender-sensitive indicators to capture true participation, decision-making power, or other factors that illustrate increases in access and equality. For example, in Kenya, improvement teams decided to use male partner HIV testing as a proxy for measuring male partner involvement in maternal health because they decided HIV testing more accurately reflected constructive male engagement than attendance at a clinic visit, because partners who were truly supportive would be more likely to agree to testing for HIV.
3. **Establish baselines for each measure and realistic targets.** Separate targets for males and females and by relevant age groups. In addition, check assumptions: for example, would an intervention targeted to vulnerable children and families benefit all families equally? Instead of “Increase vulnerable children and family income by 25%,” consider “Increase child-headed households’ income by 25%.” It’s also important to track female-headed households and male-headed households separately.
4. **Analyze results.** Data must be analyzed to inform you about how men, women, boys, and girls might be impacted by an intervention or services provided. Analyze each gender-sensitive indicator to check for gaps between the desired outcome and the result that we have. In such cases, improvement teams should design specific change ideas to close the identified gap. Always remember the “*do no harm*” principle (see Part 3 for more information). It is important to also look at issues and patterns, particularly differences against national and community level data and plateaus in improvement. If there are none, it does not mean there never will be, only that at this specific time no issues, patterns, or plateaus were detected – but they could appear later, as a result of improvement efforts or something else. This is why continually monitoring data is important. However, if none are identified for a period of 3-6 months and you find collecting and analyzing data too time consuming, switch to analyzing a new set of indicators. See the tip box below for suggestions on how to analyze data. **Clarify where more information is needed, and determine how this information can be obtained.** Have you conducted a gender analysis? Interviewed both men and women?

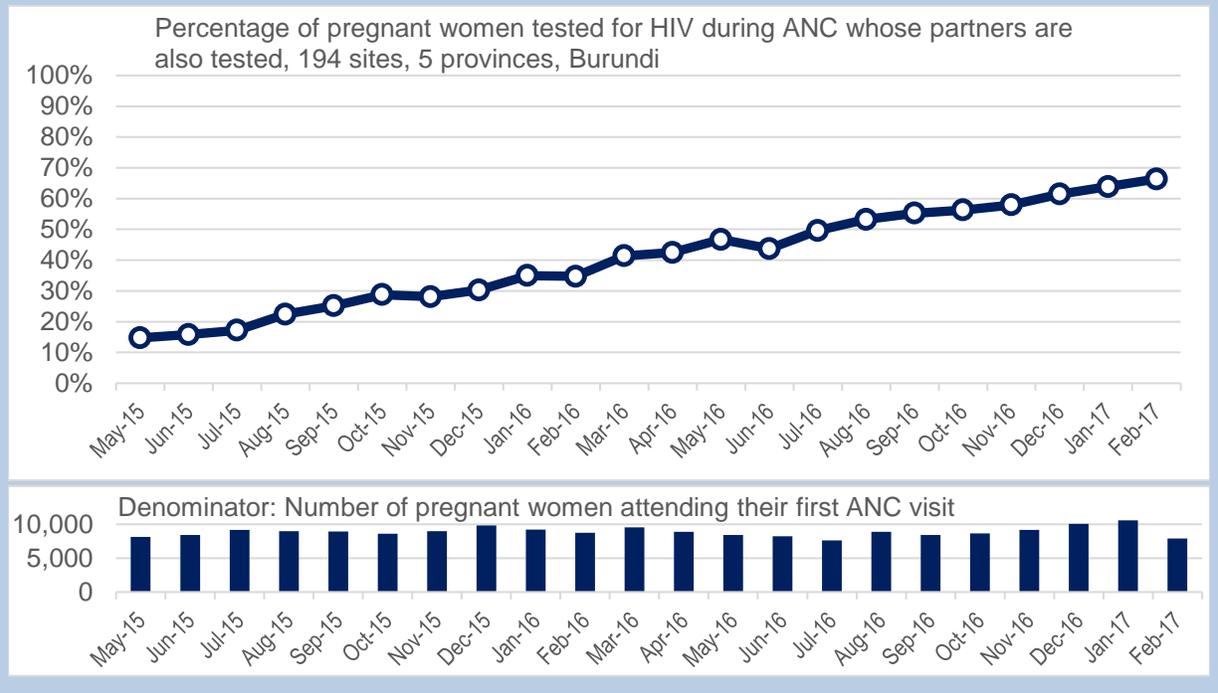
Box 8 provides an example of the importance of gender-sensitive indicators from Burundi.

TIP: Gender-sensitive indicators are most useful when they are able to measure changes in the level of inequality. You can do this through:

- Measuring proportions instead of numbers to compare proportions of males and females.
- Comparing proportions over time to the proportions expected (if available).
 - For example, in an area where the HIV prevalence is higher among women than among men, an HIV care and treatment activity should not aim for equal numbers of women and men as patients, but rather proportional to their share of the HIV burden.
- Measuring actions instead of knowledge.
 - For example, instead of the number of men who recognize the danger signs of pregnancy and birth complications, measure the percentage of men who allocate household resources for emergency transport.

Box 8. Example of the importance of gender-sensitive indicators: Male partner HIV testing in Burundi

Gender-sensitive indicators measure changes in the status and role of men and women over time. In the example below, we see the percentage of pregnant women tested for HIV whose partners are also tested for HIV, in 194 scale-up sites in 5 provinces in Burundi. This comes from the USAID ASSIST Project in Burundi, where ASSIST supported the Ministry of Health to increase male partner involvement because of its positive effect on maternal and child health outcomes. To measure male partner involvement, the improvement team decided to use male partner HIV testing as a proxy; they decided that male partner testing for HIV would more accurately reflect constructive engagement because partners who were supportive would be more likely to agree to testing. This indicator measures change in status and role of male partners by looking at their support for their pregnant partners. In addition, it provides an opportunity to link HIV positive male partners to care so they receive appropriate care and are less likely to transmit HIV, and to link negative male partners to VMMC services and to counseling on protective behaviors.



Resources to learn more:

- Compendium of gender scales. C-Change (2011). http://www.c-hubonline.org/sites/default/files/resources/main/C-Change_Gender_Scales_Compendium.pdf
- Gender and health data and statistics: An annotated resource guide. MEASURE Evaluation (2011). <http://www.cpc.unc.edu/measure/publications/ms-12-52>
- Gender-sensitive evaluation and monitoring best and promising practices in engendering evaluations. USAID (2014). http://pdf.usaid.gov/pdf_docs/pa00k43p.pdf
- M&E of gender and health programs. MEASURE Evaluation (2014). <http://www.cpc.unc.edu/measure/training/materials/m-e-of-gender-and-health-programs.html>
- Multi-facility sex-disaggregated database and multi-region sex-disaggregated database Excel tools. USAID ASSIST Project (2015). <https://www.usaidassist.org/resources/excel-databases-improvement>.
- Tool kit on gender equality results and indicators. Asian Development Bank/Australian Aid (2013). <http://www.adb.org/documents/tool-kit-gender-equality-results-and-indicators>
- USAID ADS 205.3.8. USAID (2017). <https://www.usaid.gov/sites/default/files/documents/1870/205.pdf>
- Video: Why it is important to sex-disaggregated data in quality improvement. USAID ASSIST Project (2017). <https://www.usaidassist.org/resources/why-it-is-important-to-sex-disaggregate-data-quality-improvement>

Step 3: Identify gender-related gaps and issues and develop changes to test

After determining gender-related gaps through gender analysis and analysis of sex-disaggregated data (Steps 1 and 2), the next step is to begin the **plan-do-study-act (PDSA) cycle** and **plan** by developing gender-related changes to test.

Objectives of Step 3

- Begin the first step of the PDSA cycle to develop (plan) changes to test.

How it will be achieved

- Using gaps identified in Steps 1 and 2, use the driver diagram tool to identify the first gender-related changes to test.

When to conduct

- Quarterly, or more often as needed

Basics of the plan-do-study-act cycle

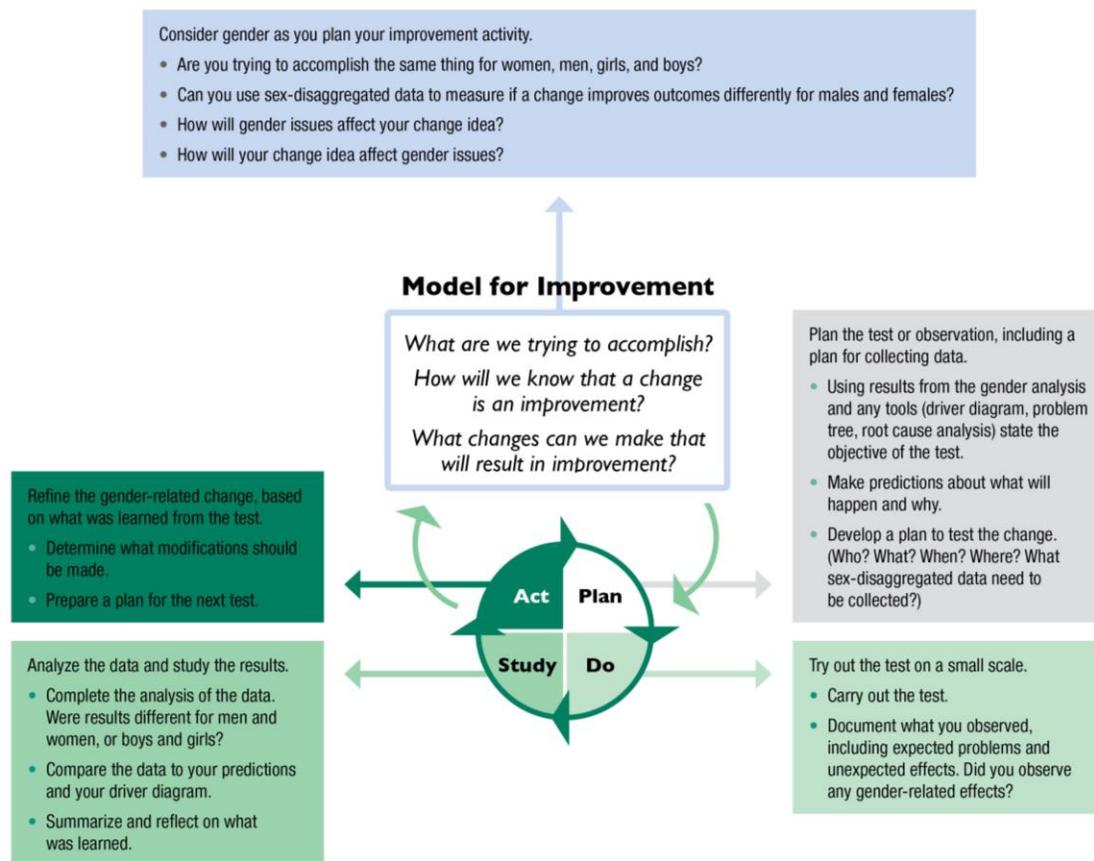
The Model for Improvement is all about testing a change. The model specifically looks at: *What are we trying to accomplish? How will we know we achieved it? What changes can we make?* The first step is to plan a [PDSA cycle](#): decide what change you would like to test (plan), then implement the change (do), analyze if the change has achieved the result you were looking for or not (study), and if it has achieved good results then you should scale up (act), or if it has not achieved the intended results, consider testing a new change and beginning the process again.

The fundamental concept of improvement is that every system is perfectly designed to achieve exactly the results it achieves. Change is at the heart of improvement. Measurement itself is not an improvement. Nothing necessarily changes when all we are doing is measuring. If we continue doing the same thing without making any changes, we will continue to get the same results. We must measure before, during, and after changes are implemented, to determine if the change leads to improvement. The key to improvement is change, but not every change is an improvement. Change ideas for addressing gender-related gaps and issues should be tested like any other change idea.

Remember, integrating gender in improvement activities does not mean creating improvement activities to target gender issues or with the goal of gender equality, rather it means thinking about how gender will affect and be affected by each improvement activity—no matter what the desired outcome of the improvement activity is. Improvement activities can target gender issues or have the explicit goal of gender equality, but gender integration goes beyond explicitly gender-focused improvement, to consider gender in all types of improvement activities. **Figure 1** below illustrates how to integrate gender at each stage of the model for improvement.

Figure 1: Integrating gender throughout the model for improvement

INTEGRATING GENDER THROUGHOUT THE MODEL FOR IMPROVEMENT



How to identify gender-related issues affecting an outcome

Once you have identified a gender-related gap, there are many different improvement tools that can help you and your team understand how gender affects a specific outcome. These include the [cause-and-effect analysis](#), [flowcharts](#), [the problem tree](#), and the driver diagram. These tools help establish the goal or aim of the improvement activity and make it clear what factors or barriers must be addressed to achieve the desired outcome. It is important to note that these tools can be used to address both gender- and non-gender-related issues. Gender issues can be present at every stage of using the cause-and-effect analysis, problem tree, and driver diagram tools. (See **Box 9** for more details about the driver diagram, and **Appendix 6** for driver diagram worksheets.)

TIP: Improvement activities should aim to model and leverage equitable practices and behaviors where possible. Emphasize and build on existing approaches, and work with champions to support gender-equitable behaviors.

Identify the key driver to address

Once you and your team have determined how gender affects a specific outcome, you should then choose one driver to focus on and design changes to test that will address that one gender-related gap or issue. As with all PDSA cycles, if you test more than one change at a time, it will be difficult to determine the effect each had separately.

Plan the other components of your change

- **Where?** Determine which sites you are going to begin to test your change in. You and your team will want to begin small, with maybe one site or two, depending on the change being tested. You may want to consider focusing on sites that have large gender gaps, as you are more likely to quickly determine the impact of your change.
- **For how long?** Determine how long will you test the change for. You may want to start with a short test cycle, and then expand as you run more PSDA cycles.
- **How will we measure?** As will be described in Step 4, a critical component of the PSDA cycle is monitoring change. Prior to implementing the change, you will need to determine how you plan on monitoring the impact. When developing your monitoring and evaluation tools, be sure to collect sex-disaggregated data, as discussed in Step 2.

Box 9. Driver diagram tool

The driver diagram (**Figure 2**) is a useful tool in planning an improvement initiative. A driver diagram helps you define the aims (or goals) of an activity or project, define the primary and secondary leverage points or 'drivers' in the system, and develop interventions based on those drivers. Generally, change ideas are developed based on the secondary drivers.

Completing a driver diagram can be a helpful exercise to think through the social determinants that affect the outcomes you want to improve. It is important to remember that there is no set number of primary or secondary drivers for an aim or outcome, and the template can be adapted. Start with your aim statement, and then fill in primary drivers that affect achieving that goal. Then choose one primary driver to focus on, and fill in secondary drivers for that one primary driver. Thus, you complete a different driver diagram for each primary driver of your aim. The diagram should be updated regularly as projects are implemented and you gain new knowledge.

Gender issues brought to light from the gender analysis conducted in Step 1 should be charted as a primary and/or a secondary driver. This will enable you and your team to identify, and then subsequently develop and test, interventions that address those issues. Likewise, gender-related gaps identified through sex-disaggregated data should also be charted as a primary and/or a secondary driver. This will enable you and your team to identify, and then subsequently develop and test, interventions that address those gaps.

Once you and your team have used a driver diagram to help identify how gender is relevant to your aim, you can target your change ideas to address or leverage the drivers .

Important driver diagram definitions include:

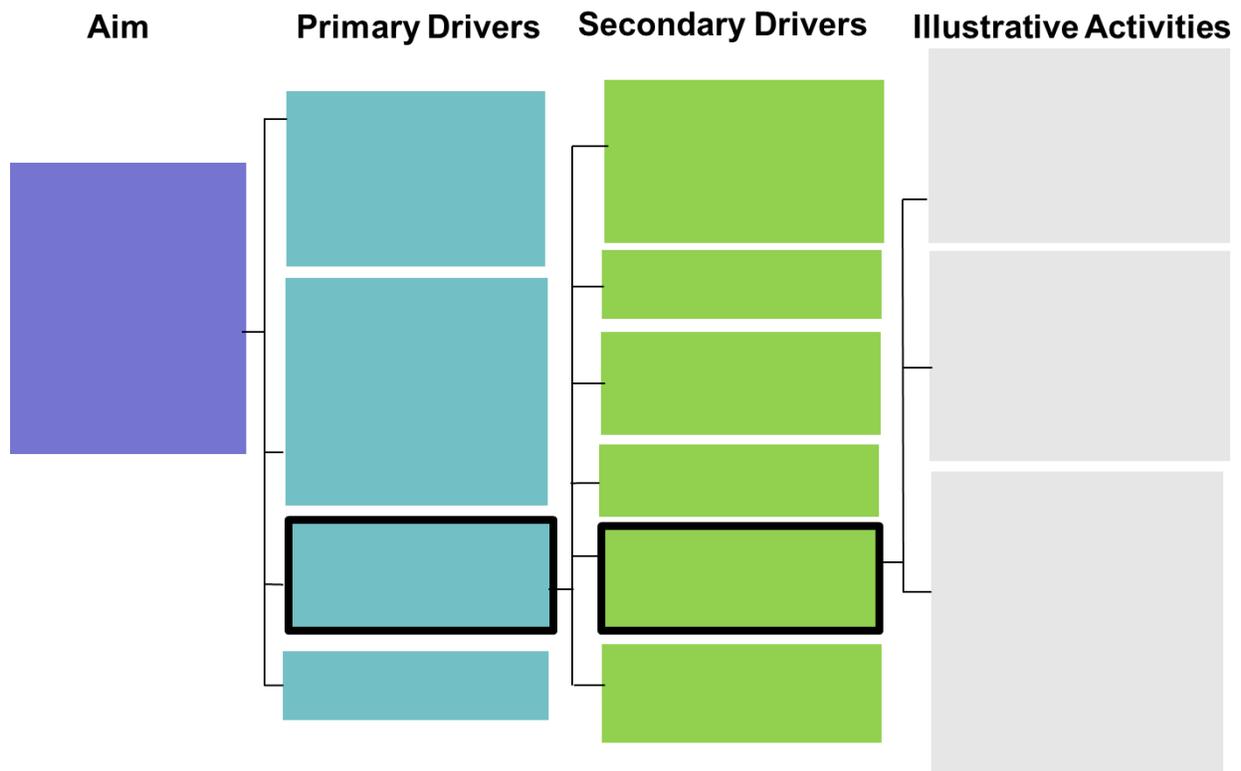
Aim: The goal or objective of the work. This could also include sub aims.

Primary drivers: A set of factors or improvement areas that must be addressed to achieve the desired outcome. They should be written as straightforward statements rather than as numeric targets.

Secondary drivers: Actions or interventions that contribute to the achievement of the primary drivers. They are used to identify the changes that should be tested to impact the primary driver.

See **Appendix 6** for worksheets on using the driver diagram.

Figure 2. Driver diagram



The driver diagram examples below (**Figure 3** and **Figure 4**) show that different people may create different drivers for the same aim or goal. In these examples, both QI teams chose to design an intervention around the lack of male participation in partners' HIV treatment to increase PMTCT service retention and ultimately impact the vertical transmission rate of HIV—but the drivers identified and illustrative activities are not the same. One of the most important parts of using a driver diagram is including potential change ideas, or illustrative activities, that could be tested. **Figure 5** shows a driver diagram for a different aim. **Box 10** provides examples of identifying gender-related gaps and issues and developing changes to test, and **Box 11** provides a case study from Nicaragua.

Figure 3. Driver diagram example 1 of decreasing vertical transmission of HIV in Malawi

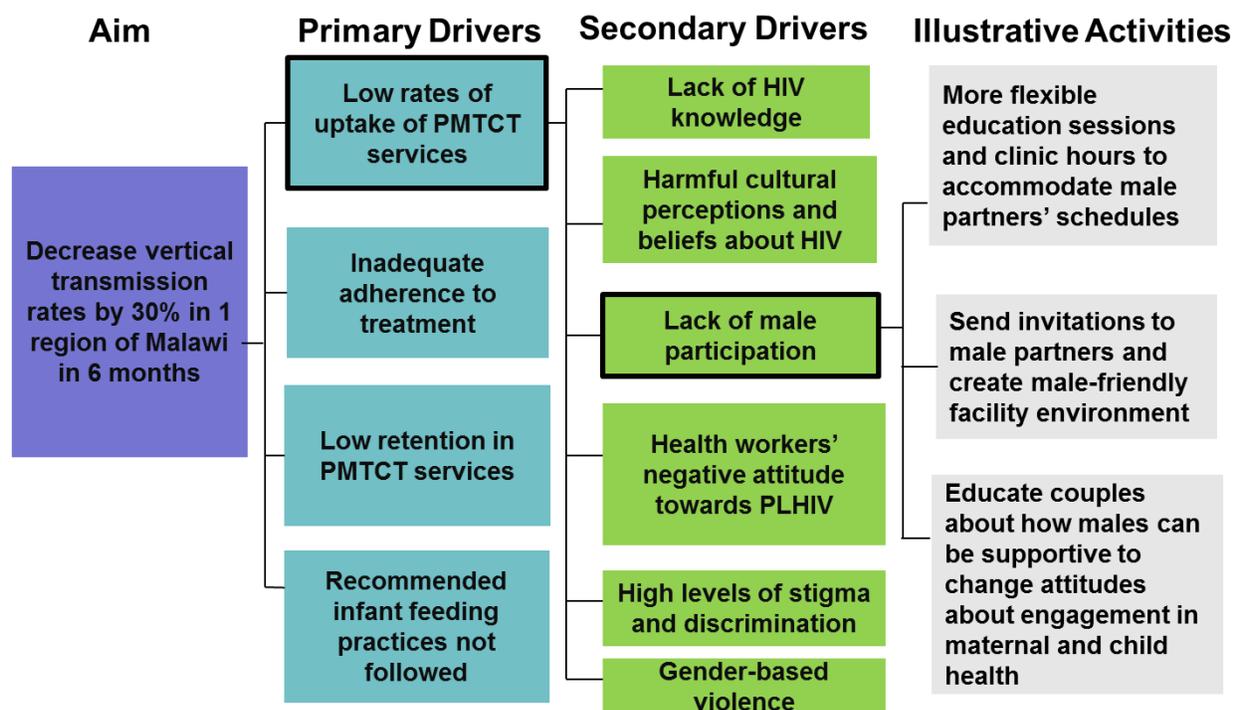


Figure 4. Driver diagram example 2 of decreasing vertical transmission of HIV in Malawi

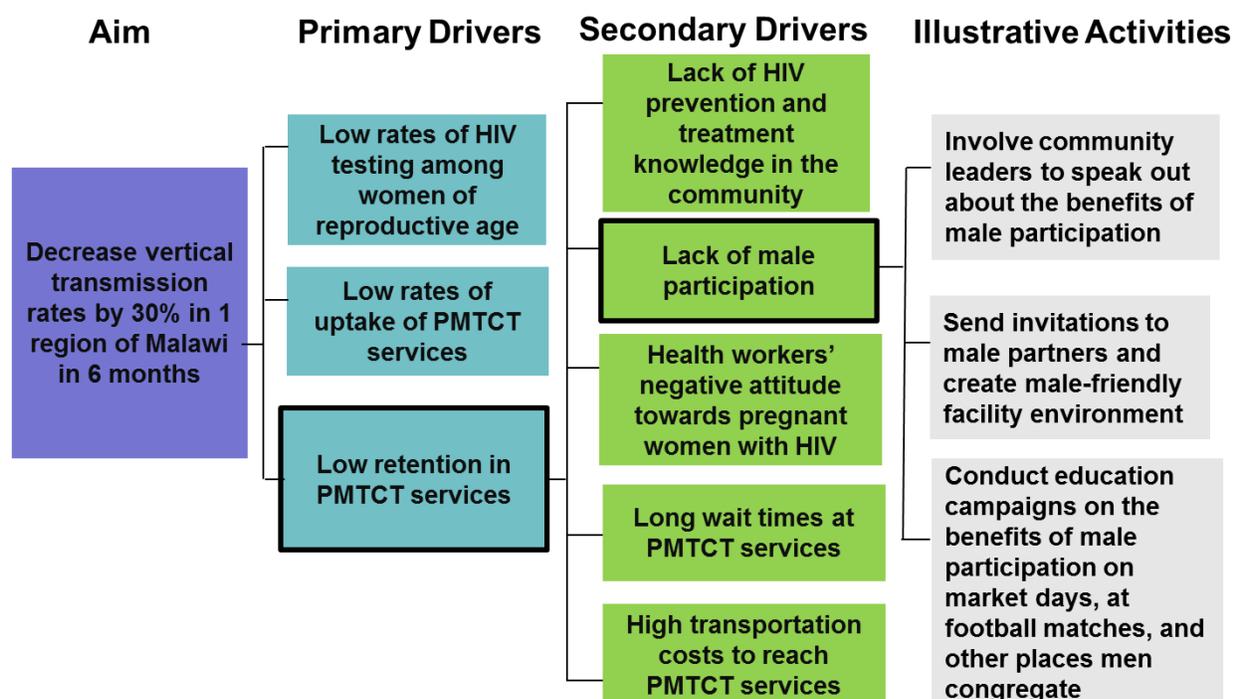
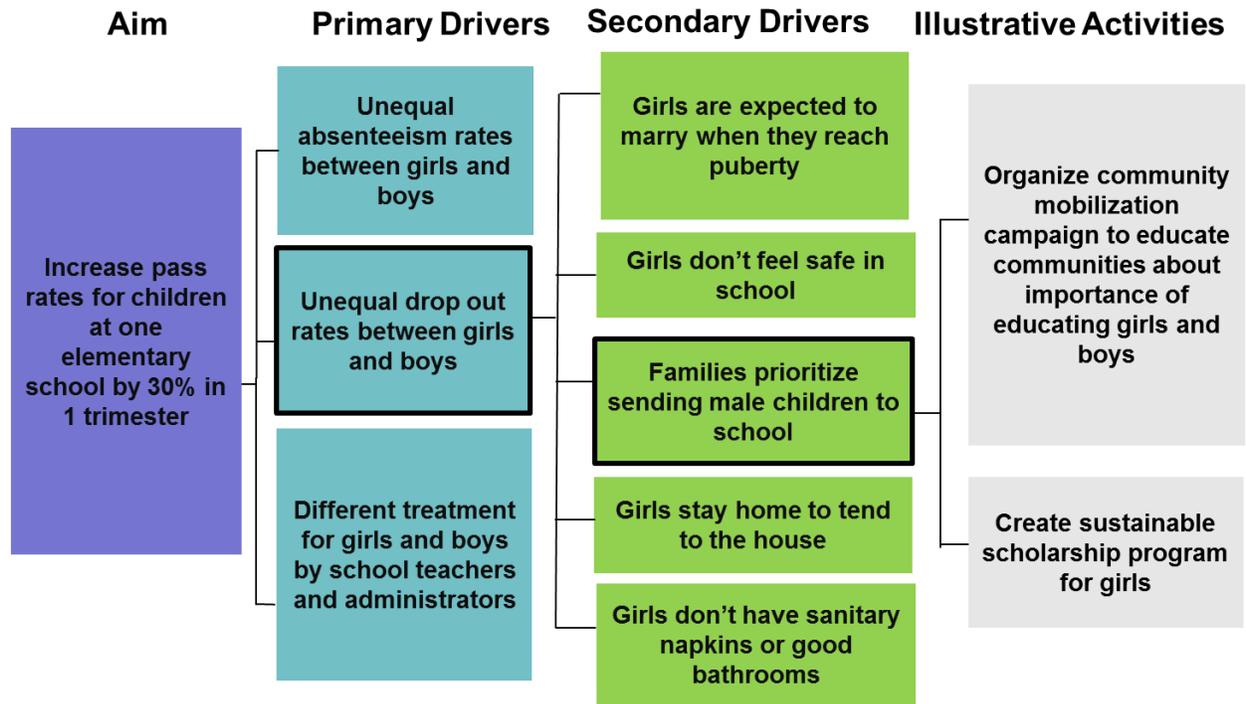


Figure 5. Driver diagram example of increasing elementary school pass rates for vulnerable children in Malawi



Box 10. Examples of identifying gender-related gaps and issues and developing changes to test

An HIV activity under the USAID Health Care Improvement Project in South Africa found that initial efforts to increase HIV testing disproportionately benefitted females. With sex-disaggregated data and without changing the overall aim of increasing testing rates, the team examined the drivers of male and female HIV testing rates separately. To increase the proportion of males getting tested for HIV, since they were being left behind, staff encouraged couples' testing and targeted male forums for male involvement in their wives' ANC services and family planning decisions, which brought more males into clinics with their wives receiving ANC, thus introducing another opportunity to test them for HIV. This integrated approach reduced the gap between males and females tested for HIV and led to an increase in male testing by 34%.

In Malawi, the USAID ASSIST Project worked with communities to increase pass rates for primary school students. By analyzing sex-disaggregated data, they found that female students passed term exams at lower rates than male students and missed more school than male students. By conducting root cause analysis to identify the underlying reasons for these gaps in educational performance, they identified that most female students who failed exams did not attend school regularly and were tasked with a heavy load of domestic chores. After identifying that harmful traditional practices and domestic chore responsibilities inhibited female students from attending school, ASSIST worked with communities to develop change ideas. These included establishing mother's groups to conduct monthly meetings with school-aged girls, where female mentors counseled them on the importance of education and the negative impact of dropping out of school. The mother's groups established two mother representatives in each village to track girls' daily school attendance and performance. Parents and teachers of girl students were encouraged to reward good school attendance and performance with learning materials or personal gifts. Other ideas included training teachers on the importance of keeping both boys and girls in school and being advocates with parents and students to stay in school, and linking with organizations that provided sanitary pads for female students during menstruation.

In Swaziland, facility improvement teams analyzed sex-disaggregated data and found that TB testing and services uptake rates among males were much lower than among females. To address this gender-related gap, they implemented advocacy and social mobilization interventions targeting males. Collaborating with the Ministry of Health and the Kick TB Campaign during Men's Health Month and the 2014 FIFA World Cup Tournament in Brazil, improvement teams offered health services and educational information at World Cup game viewing events they organized; men and their families could come and watch live and pre-recorded soccer matches in accessible locations, and also learn about TB. By organizing these viewing events, improvement teams were able to hold health promotion talks and offer TB screening to all in attendance. Community dialogues with local leaders provided education on TB, which led to their encouragement of community-wide TB awareness and treatment. A Swazi TV talk show worked to reach out to the community and bring more awareness on TB, and interviews with influential community and political leaders brought attention to the campaign. The Kick TB Campaign complemented these efforts by focusing on educating and treating TB among men and boys – particularly among the local, vulnerable population of miners.

Box 11. Case study: Integrating gender and gender-based violence prevention in medical and nursing curricula in Nicaraguan universities

In Nicaragua, the USAID ASSIST Project supported the application of continuous quality improvement to integrate HIV prevention and treatment topics in the medical and nursing training programs in nine universities. Baseline data clearly revealed strong sentiments of discrimination and stigma towards people living with HIV (PLHIV) and sexual diversity, among both students and faculty. To address this, the project worked with faculty to integrate training on HIV prevention, stigma, discrimination, sexual diversity, and gender-based violence (GBV) in epidemiology and health research classes, drawing on national laws promoting equal rights and non-discrimination. ASSIST hypothesized that by engaging medical and nursing students in discussions around human rights and respect for sexual diversity based on national legal protections, efforts to reduce stigma, discrimination, and GBV would be more effective. After receiving training and technical assistance, 96 faculty from seven universities developed capabilities to teach and promote gender equity in the university, and detect and respond appropriately to students experiencing GBV. These faculty are now addressing these gender- and HIV-related topics in classes for Nicaragua's next generation of health care providers, contributing to the national HIV response in new and sustainable ways.

To read the complete case study, please see: <https://www.usaidassist.org/resources/integrating-gender-and-gender-based-violence-medical-and-nursing-curricula-nicaraguan>.

Resources to learn more:

- Improving Health Care Quality eLearning Course. USAID ASSIST Project (2017). <https://www.usaidassist.org/resources/improving-health-care-quality-elearning-course>
- Improving Health Care Training: Facilitator Guide (<https://www.usaidassist.org/resources/improving-health-care-training-facilitator-guide>) and Participant Guide (<https://www.usaidassist.org/resources/training-participant-guide-improving-health-care>). USAID ASSIST Project (2016).
- Aims for Improvement. *Tips and Tools for Improvement*. USAID ASSIST Project (2017). https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_aimstatements_may_30_ada.pdf
- Flowcharts *Tips and Tools for Improvement*. USAID ASSIST Project (2017). https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_flowchart_may_30_ada.pdf
- Developing changes *Tips and Tools for Improvement*. USAID ASSIST Project (2017). https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_developingchanges_may_30_ada.pdf
- Plan-Do-Study-Act cycles. *Tips and Tools for Improvement*. USAID ASSIST Project (2017). https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_pdsa_may_30_revised_ada.pdf
- Problem Trees. IGWG (2017). <https://www.igwg.org/wp-content/uploads/2017/05/ProblemTrees.pdf>

Step 4: Implement, monitor, and adapt gender-related changes over time to determine whether desired results are achieved

Test (**do**) the identified gender-related changes identified in Step 3, **study** the outcomes and adapt (**act**) as necessary.

Objectives of Step 4

- Test, study, and adapt the outcomes of the change to determine whether the desired results are achieved.

How it will be achieved

- Select a few sites to test the changes selected in Step 3.
- Monitor the impact of the change over a pre-determined short period and determine which modifications need to be made.
- Implement the modifications identified.
- Continue to run the PDSA cycle with larger samples until the desired result is seen and ready to scale.

When

- As needed.

In Step 3, you and your team determined which changes to test based on your gender analysis and using QI tools like the root cause analysis, problem tree, and driver diagram. In Step 4, the goal is to run a few PDSA cycles with larger and larger samples until you are confident that the changes will work to achieve the desired gender-related aim and should be implemented more widely. Remember to document all of the change ideas and changes tested, including details of who did what, when it was implemented, how you measured it, and what you expected to happen. It is useful to keep a notebook specifically for documenting changes tested. **Box 12** provides a case study from Kenya.

Testing (Do)

Implement the change based on the plan from Step 3. Remember, your gender-sensitive change idea will probably need to analyze sex-disaggregated data and/or gender-sensitive indicators. Your change idea should take into account gender issues, but does not have to focus on gender; for example, it could be targeting mothers-in-law and husbands in different ways about the importance of ANC—targeting them because of their role as decision-makers about pregnant women’s health, and targeting them differently because of the different reasons they may have for opposing ANC and the different lifestyles they lead.

Monitor the change and document (Study)

Your team must monitor the impact of the change being tested. Through this monitoring and analysis, you will be able to determine what modifications need to be made as you continue to work through the PDSA cycle. Monitoring includes collecting and analyzing data, as well as checking if the changes are being implemented completely.

Adapt the change as necessary, prepare to re-test (Act)

Using the data collected during the monitoring of the change, adapt the change as necessary and prepare to re-test. You could scale up the number of sites or individuals who are impacted by the change.

Box 12. Case study: Addressing access to education and health services for vulnerable children in Kenya

In the Samburu Region in Kenya, a faith-based organization, the Catholic Diocese of Maralal, provides services for orphans and vulnerable children. With support from the USAID Health Care Improvement Project (HCI) and the Department of Children Services of Kenya's Ministry of Gender, Children, and Social Development, an improvement team was formed and supported to conduct a self-evaluation focusing on education services. The team found a gender gap, with fewer boys than girls accessing education and health care services.

To identify the causes of this gap, the team looked deeper into the gender roles and cultural and community practices. The Samburu people are nomadic herders of cattle, sheep, goats, and camels. Traditionally, boys care for animals, traveling from home in search of water and pasture for three or more months during the dry season and frequently missing school. Vulnerable and orphaned boys, especially those living in a child-headed household or with very old guardians, face increased demands to take care of the animals for survival. Non-related guardians and members of the community often exploit such boys by employing them as herders for personal gains while sending their own children to school. In addition to missing school, these boys face further threats to their well-being. In adolescence, many boys become *morans*, or warriors, who fight and defend the community from animal thieves while engaging in cattle rustling; these excursions and fights lead to injuries and death. The community also practices a beading system, in which *morans* are encouraged to have multiple sexual partners, increasing the risks of HIV and other sexually transmitted infections in vulnerable adolescent boys.

The community improvement team brought together stakeholders from the Department of Children Services, religious leaders, the provincial administration, police, elders, health workers, teachers, and vulnerable children themselves to come up with changes to promote boys' enrollment and retention in school. They identified the following action steps:

1. Collaborate with parents/guardians and provincial administration to monitor school enrollment and retention of school-age boys and girls.
2. Conduct community education and sensitization on the rights of children, including issues of exploitation and child labor.
3. Conduct stakeholder mapping to link food provision services with child-headed households to alleviate household burdens that keep boys from attending school.
4. Monitor attendance through school attendance rosters.
5. Lobby for waivers of school levies for vulnerable children and free or subsidized provision of other scholastic materials.

Resources to learn more:

- Gender Considerations in Monitoring and Evaluation. USAID ASSIST Project (2014). <https://www.usaidassist.org/resources/gender-considerations-monitoring-and-evaluation>
- Measures for Improvement. *Tips and Tools for Improvement*. USAID ASSIST Project (2017) https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_measureimprovement_may_30_ada.pdf
- Measurement—Time series charts. *Tips and Tools for Improvement*. USAID ASSIST Project (2017). https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_measurementtimeseries_may30_ada.pdf

Step 5: Scale up effective interventions

Once effective changes have been determined to be successful, implement them on a large scale.

Objectives of Step 5

- Scale-up successful changes tested in an effort to improve overall gender outcomes.

How it will be achieved

- After moving through Steps 3 and 4 and determining a change is successful, develop and implement a plan for scaling up successful changes.
- Identify any new gender-related issues or differences in the community in which the scale up would occur that might affect the scale up.

When

- After demonstrated improvement.

Scaling up

Once you and your team have determined that a change is successful in achieving the established aim, you should scale it up. This means implementing it across your entire health clinic or groups of clinics, or health or education system. When scaling up, be sure to remember that *not all settings are uniform*. Gender-related changes to care processes that prove to be cost efficient and improve access, quality, or retention in care should be scaled up with respect to context. Hopefully you addressed some of these potential concerns during Steps 3 and 4, but you may need to continue to adapt as gender practices and perceptions vary in different parts of a country or even among neighboring communities. Remember that gender-related changes that you tested in one setting/clinic/community and worked well might not work in another setting or geographic area. Patients and communities might perceive such activities in a negative manner. Always use the gender analysis principles and the two key questions mentioned earlier:

- How will the different roles and status of women and men, girls and boys, affect the activity?
- How will the anticipated results of the activity affect women and men, girls and boys, differently?

It is critical to always follow the “*do no harm*” principle and to observe and analyze different elements that might affect outcomes among women and men, boys and girls. (See the “*do no harm*” section of Part 3 of this guide for more information.) **Box 13** provides an example of scale-up from Burundi.

Institutionalization

Institutionalization is key to ensuring that gains made as a part of improvement activities are maintained. It entails formalizing gender-related changes, which also signals to leadership that gender integration is a central component of quality care. You can work with other QI teams, health networks, and the Ministry of Health to identify successful changes and best practices that should be scaled up. When you do identify successful changes, we encourage you to test their scale-up in new sites, and work with Ministries of Health and other partners to spread these practices.

Box 13. Example of scale-up in Burundi

In Burundi, the USAID ASSIST Project supported the Ministry of Health to increase male partner involvement in PMTCT because of its positive effect on maternal and child health outcomes. To measure male partner involvement, improvement teams decided to use male partner HIV testing as a proxy because they believed that male partner testing for HIV would more accurately reflect constructive engagement (because partners who were supportive would be more likely to agree to testing). They tested a number of change ideas and learned that the following four worked well together:

- Announcements made in churches and other venues about the advantages of male partners accompanying pregnant women to ANC visits and HIV testing for couples
- Facility health education sessions once a week focused on the advantages of HIV testing for couples
- Mobilizing men on PMTCT (importance of accompanying pregnant women to ANC visits and HIV testing for couples) by community health workers and community leaders
- Invitation letters for male partners given to unaccompanied pregnant women during their ANC visit

Then, they scaled up this package of change ideas to 194 facilities around the country. ASSIST also learned what did not work. Some facilities decided to prioritize giving ANC services to pregnant women who arrived with their male partner; however, they learned that unaccompanied women found this unfair, and some pregnant women brought men with them who were not their male partners, simply to not have to wait in line. ASSIST saw that this change idea harmed single women and women whose male partners could not come to the facility by leaving them at an unfair disadvantage and giving them a lower quality of services. This was unintentional, but still harmed patients. Thus, facilities stopped prioritizing couples for services and did not scale up that change idea.

Step 6: Document and share learning

There is much to be learned from both successful and unsuccessful changes to improve gender equality. Documenting and sharing this learning helps others learn from your experience and will help you remember lessons learned.

Objectives of Step 6

- Documenting and sharing lessons learned, both the positive and the negative.

How it will be achieved

- Document learnings and process.
- Share learning through blogs, case studies, improvement stories or videos.

When

- Ongoing, including during scheduled learning sessions.

Why document and share what has been learned?

Gender integration, like improvement, is a learning endeavor: an active process of testing changes to learn what does and does not work to make care better. Learning begins with **documentation** of what the team has tried and learned; to learn from improvement and gender integration, a team needs to be able to record information from a test or multiple tests of changes, derive insights on the effectiveness (or lack thereof) of tested changes, and plan next steps. This documentation also serves to help improvement teams communicate their results to others, including what changes yielded improvement, what changes did not, what evidence supports these conclusions, and how to implement the changes.

Sharing lessons learned is a key component of quality improvement. Sharing what you've learned with both those within your health clinic, organization, and health system, and external audiences, will help educate and provide insights to others facing similar issues. This guide emphasizes changes and learning gained from gender-related improvement activities. However, sharing is important for any improvement activity.

Documenting and sharing what you learned throughout the six-step process for gender integration is critical for many reasons. First, it enables you and your team to remember what changes were tested and why they did and did not work. Secondly, it can help create institutional memory, so that when new staff come on board, they can learn from past experiences and do not waste time and effort testing the same changes.

What should be shared?

There is much to be learned, both from what worked and what did not, from the changes that were tested and adapted. Integrating gender is a challenging process, and interventions may not always work as expected the first time. Sharing experiences can help others establish realistic expectations.

Key items to consider sharing include:

- How your team identified and developed interventions to address gender gaps.
- Specific examples of issues identified, or interventions that were very successful or ones from which you learned key lessons. For example:
 - What issues or gaps that affect the activity outcomes have you seen that are specific to women, men, girls, and/or boys?
 - What issues did you notice that affect activity outcomes regarding expected or perceived roles of women, men, girls, or boys, or interactions between males and females? What changes did your team implement or consider implementing to address these, and why?

- In implementing gender-related activities to close gaps between females and males, what tools have you used?
- Are there any specific barriers that women, men, girls, or boys tend to face in the community that puts them at greater risk for poor health? How has your team implemented changes to address these barriers?
- An overview of your team's sex-disaggregated indicators. How and why were they developed and how they are tracked?
- An overview of your team's gender-sensitive indicators. How and why were they developed and how they are tracked?
- Any adaptable learning questions and tools for tracking gender-related learning that you have developed.

TIP: Include discussions about gender gaps and how to address them in learning sessions

- Develop adaptable learning questions
 - Has your team become aware of any differences in the way women/men/girls/boys are able to access or benefit from services? Why do you think that is?
 - Are there any specific barriers that women, men, girls, or boys tend to face in the community that puts them at greater risk for poor health?
 - How was the activity implemented and how could it be modified to meet the needs of men, women, boys, or girls?
- Develop tools for tracking gender-related learning

TIP: Consider holding a knowledge cafe to discuss gender-related issues affecting your work, gender-related issues being affected by your work, ideas for making change ideas gender-sensitive, barriers to integrating gender, and ideas for gender-sensitive indicators. Knowledge cafes are small group discussions designed to explore issues and gain a deeper understanding of your own and other peoples' perspectives. The point is not for the group to come to a conclusion, but to share, listen, and discuss.

How to share lessons learned?

Documentation may take many forms, but the most basic documentation requirement is that teams have a record of what they have tried, both successfully and unsuccessfully, to test change ideas to improve care. Those who have made improvements need to convey the overall results from the tests of changes they implemented, what changes yielded improvement, what changes did not, what factors may have influenced these results, what evidence supports these conclusions, how to implement the changes, and what advice they have for others so as to best apply what they have learned.

Such communication may involve verbal, visual, and/or written means. Learning can be shared most effectively through small group conversations during meetings or workshops, or during coaching or supervision visits. Video clips, photographs, diagrams, and other visual aids can often convey key information more effectively than written documents. While written products may be the least effective method of sharing on their own, they can help to summarize key messages and points of learning. In writing, gender work can be emphasized and reported as a stand-alone activity in success stories, improvement reports, and case studies, or it can be included as an element of quarterly or annual reports or other forms of documentation. There are also websites that act as platforms for implementers to share their improvement experiences and have access to resources, stories, and tools to support improvement, which sometimes feature a section on gender. **Table 1** details many ways to share gender-related learning.

Table 1. Ways to share gender-related learning

Format	What is it?	Best use	Example of highlighting the gender component
Knowledge cafe	A small group discussion designed to explore issues and gain a deeper understanding of your own and other peoples' perspectives	The point is not for the group to come to a conclusion, but to share, listen, and discuss	Discuss gender-related issues affecting your work, gender-related issues being affected by your work, ideas for making change ideas gender-sensitive, barriers to integrating gender, or ideas for gender-sensitive indicators
Staff meetings	A presentation or guided discussion among staff	Discuss a gender-related accomplishment, opportunity, barrier, or problem	Presenting a gender-related gap identified with sex-disaggregated data and then using the Driver Diagram to brainstorm change ideas
External meetings and presentations	A presentation or guided discussion with external stakeholders, partners, etc.	Discuss a gender-related accomplishment, opportunity, barrier, or problem	Presenting how a gender-related gap was identified and addressed
Change packages	A set of specific changes that have improved care	Document and share successful change ideas	Include and explain change ideas that integrated gender, i.e. that are gender-sensitive
Video and audio clips	A short video or audio recording	Tell a story	Explain one way that you integrated gender, including why, how, what happened
Success story	A one- page overview that provides a snap shot of one successful activity component	Showcase a specific activity element, such as staff coming up with an improvement approach, influencing the national strategy, or partnering with a gender-focused organization	Explain how the initiative decided to train male partners on reproductive health issues, resulting in an improvement in women's access to services
Blog	A short, informal explanation of one component of an activity	Highlight one specific activity element as an introduction to the larger intervention	Provide a high-level summary and link to a report on how considering gender norms and involving female partners improved VMMC

Format	What is it?	Best use	Example of highlighting the gender component
Case study	A two- to four-page description of an activity or achieving a specific result	Describe how one health facility accomplished a goal or how one change idea was scaled up, with background information, details about one part of the activity, results, and lessons learned	Telling the story of how one health facility QI team identified a gender-related issue and addressed it
Written reports	A progress report, assessment, or technical report	Provide an in-depth description and analysis of an entire activity or one aspect of a project	Include sex-disaggregated results, discuss any gender-related gaps or the lack thereof, explain how they were addressed, and show results that narrow those gaps

Tips for documenting and sharing gender-related knowledge

The field of knowledge management provides many insights and techniques for sharing information which have proven invaluable for use in improvement initiatives. General principles that encourage sharing include:

- Utilize small groups of 4-8 people to allow people to exchange knowledge; use larger groups to integrate knowledge that has been created in small groups.
- Give every person a chance to say something early on (for example, within the first 30 minutes) in a meeting. This puts participants in an active mode of participating, rather than a passive mode of just listening.
- Give people a chance to get connected to each other before they try to construct new ideas together. Use introductions, social activities, information provided before the meeting, or ice-breakers that allow participants to talk informally to get a sense of each other.
- Before asking participants to discuss their thoughts on an idea or question, ask them to reflect silently for a minute to think about their answer first. Even a short time for individual reflection improves the quality of individual responses.

In thinking of written products that convey key advice to others, it is helpful to keep in mind the various intended audiences for the learning from improvement and decide on the most appropriate format and content for each audience. As a general principle for development of written materials, it is helpful to “field test” draft versions with representatives of the intended audiences to ensure that the materials clearly convey what they are intended to.

Finally, an important principle in transferring knowledge is that *we learn when we talk*. Listening provides us new ideas but as long as those ideas are just swimming around in our heads, they are neither fully formed nor implementable. It is only when a person puts an idea together in a way that allows him or her to explain the idea to others, that the idea takes shape for the person, as well as for those the person is talking with. (For more ideas on how to draw on all the knowledge in the room, see [Dr. Nancy Dixon's essay](#).) **Table 1** lists commonly used sharing formats, and for more information and examples on the sharing of learning among improvement teams, see the [USAID ASSIST Project website](#).

Resources to learn more:

- Building Capacity for Improvement Toolkit. USAID ASSIST Project (2017). <https://www.usaidassist.org/content/building-capacity-improvement>
- Documenting Learning. USAID ASSIST Project (2014). <https://www.usaidassist.org/resources/documenting-learning>
- Dr. Nancy Dixon's essay, How to Effectively Draw on the Knowledge of Everyone in the Room. Common Knowledge Associates (2012). <https://www.usaidassist.org/resources/how-effectively-draw-knowledge-everyone-room>
- Sharing Learning. USAID ASSIST Project (2014). <https://www.usaidassist.org/resources/sharing-learning>
- Webinar on knowledge management for improvement: https://www.usaidassist.org/sites/assist/files/isqua_webinar_managing_knowledge_for_improvement_w_notes.pdf
- Synthesizing Learning. USAID ASSIST Project (2014). <https://www.usaidassist.org/resources/synthesizing-learning>
<https://www.usaidassist.org/resources/synthesizing-learning>
- Tools for presenting data. USAID ASSIST Project. <https://www.usaidassist.org/content/tools-presenting-data>

PART 3: ADDITIONAL CONSIDERATIONS

Gender-based violence

In quality improvement activities, gender-based violence (GBV) is an important gender consideration that needs to be taken into serious consideration when identifying gender-related gaps. In simple terms GBV is *violence done to a person because of their gender*. This violence can be physical, sexual, emotional, or financial. Examples include:

1. A boyfriend hitting his girlfriend because she did not act the way he thinks a girlfriend should act.
2. A husband raping his wife because he thinks he has the right to sexual intercourse with her no matter what she wants.
3. Boys bullying another boy for not acting like a boy or man.
4. Women telling a childless woman that she is worthless because she has no children.
5. A husband refusing to give his wife money because he thinks she will spend it on frivolous things.

Men can inflict GBV on other men as well as women, and women can inflict GBV on other women as well as men. The violence can be from a stranger or a known person.

Globally, the World Health Organization (WHO) estimates that one in three women have experienced physical or sexual violence.² Unfortunately, we do not have estimates for men, though they are certainly victims of GBV worldwide. Social stigmas impact both women and men's ability to effectively report GBV and receive support services. Gender plays a significant role in the ways victims/survivors of GBV are perceived, the ways they seek or do not seek health treatment and/or legal support, and the ways perpetrators of violence are treated and perceived within both social and legal contexts. For example, in many cultures, men and boys who experience sexual violence face intense social stigma and shame, which reduces their willingness and ability to legally report abuse and seek medical and psychological treatment and support. Similarly, women and girls around the world are more likely to experience GBV at the hands of someone they know, which can often make it harder to report abuse or seek medical, psychological, and legal support due to familial or social restrictions on their autonomy to make personal health and legal decisions, or due to social stigma and victim blaming.

Social norms, expectations, and beliefs around GBV vary from place to place and over time, so it is important to understand your local context around GBV. It is also important to consider that norms, expectations, and beliefs around GBV may change depending on the gender, social, economic, and ethnic characteristics of the victim/survivor and the perpetrator.

During your improvement activity, if you learn that participants have experienced GBV, have a list of resources and support services prepared to provide to them. Because health workers are most often not trained in providing support services to survivors of GBV, it is important to direct patients to appropriately trained providers and support services. If you learn that participants experienced increased GBV *due to your activities*, it is vital to stop those activities immediately. To be able to detect such unintended negative consequences make sure to always investigate and ask the following questions:

- How will the different roles and status of women and men, girls and boys, affect the activity?
- How will the anticipated results of the activity affect women and men, girls and boys, differently?

Remember the “*do no harm*” principle.

² Violence against women. Factsheet updated Nov 2016. <http://www.who.int/mediacentre/factsheets/fs239/en/>

Resources to learn more:

- Addressing Gender-Based Violence Through USAID’s Health Programs: A Guide for Health Sector Program Officers (Second Edition). IGWG (2008). https://www.igwg.org/wp-content/uploads/2017/05/GBVGuide08_English.pdf
- Gender-based violence: A Primer. IGWG. https://www.k4health.org/sites/default/files/GBV%20A%20Primer_IGWG%20Facilitator%20Guide.pdf
- Guidance for Gender Based Violence (GBV) Monitoring and Mitigation within Non-GBV Focused Sectoral Programming. CARE (2014). http://www.care.org/sites/default/files/documents/CARE%20GBV%20M%26E%20Guidance_0.pdf
- How is GBV perpetuated at different levels? IGWG. <https://www.igwg.org/wp-content/uploads/2017/05/HowIsGBVPerpetuated.pdf>
 - Handout: Character statements. IGWG. <https://www.igwg.org/wp-content/uploads/2017/05/HandoutCharactrStatemts.pdf>
 - Handout: Ecological model. IGWG. <https://www.igwg.org/wp-content/uploads/2017/05/HandoutEcolModel.pdf>
- Myths and Realities of Gender-based violence. IGWG. <https://www.igwg.org/wp-content/uploads/2017/05/MythsRealitiesGBV.pdf>
- The Crucial Role of Health Services in Responding to Gender-Based Violence. IGWG (2010). <https://www.igwg.org/wp-content/uploads/2017/06/crucial-role-hlth-srvices.pdf>
- The Life Cycle of Gender-based Violence Against Women. IGWG. <https://www.igwg.org/wp-content/uploads/2017/05/TheLifeCycleGBV.pdf>
- Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators. IGWG (2008). <https://www.igwg.org/wp-content/uploads/2017/06/violenceagainstwomen.pdf>

Engagement of diverse and vulnerable populations

In any improvement activity, it is important to consider who is affected by the activity and who you are reaching—and gender is only one aspect of this consideration. Many aspects of people’s lives can affect access to and quality of care, including age, physical ability and disability, mental ability and disability, literacy, sexual orientation, and more. Though we have focused on gender here, these other aspects of people’s lives are also important to consider. For examples, rates of HIV among men who have sex with men (gay and otherwise) are often much higher than for men in general, but services targeting these men may face additional barriers. Commercial sex workers and victims of human trafficking may also face different barriers to accessing and receiving quality health care.

Depending on the local context, particularly vulnerable populations to consider may include: persons with disabilities, ethnic minorities, persons with HIV, women and girls, persons who engage in commercial sex work, victims/survivors of GBV and human trafficking, widows, persons experiencing poverty, and more. People are often vulnerable due to social stigma, marginalization, and a lack of social and political protections or rights. Each unique population will have its own set of challenges, barriers, needs, and perspectives related to the area of your improvement work, making it critical to conduct thorough gender-sensitive research and localized analysis before designing improvement activities, interventions, and initiatives. It is important that improvement activities are targeted and designed to improve outcomes for all. We should not assume that everyone has the same needs because there are many aspects and variables in life that affect outcomes, especially among the vulnerable. In addition, improvement activities designed to address the needs of one target population, may also inadvertently impact a different vulnerable group or population, making it important to adhere to a “do no harm” principle and work closely

with community and local organizations throughout all project phases to best understand the broader impact of each development or health intervention.

People of diverse gender identities

It is important to understand your local context and consider the specific needs and perspectives of people of all gender identities. Gender identity is a person's internal, deeply felt sense of being a man or woman, or something other or in between, which may or may not correspond with the sex they were assigned at birth. This includes transgender men (people born female who consider themselves men), transgender women (people born male who consider themselves women), and people who consider themselves gender neutral (people who do not consider themselves men or women). Without considering all gender identities, your improvement activity may fail to reach some groups and even unintentionally exploit or harm some groups. From a quality improvement perspective, this can cause inefficient use of resources and jeopardize patient-centeredness, safety, and equality. By considering the different needs and opportunities of women, men, girls, boys, and people of other gender identities, improvement work can strategically identify and close gaps in care and outcomes, to equitably reach those we are trying to serve.

Remember that sexual orientation is different from gender identity. Sexual orientation refers to the type of person that someone is sexually attracted to. When a woman is attracted to man or a man is attracted to a woman, they are called heterosexual. When a woman is attracted to another woman or a man is attracted to another man, they are called homosexual (or gay, or lesbian). For more information on sexuality, see the IGWG guides [Shaping Our Sexualities: Gender and Sexual Norms](#) and [What is Sexuality?](#)

Resources to learn more:

- Gender Analysis Toolkit for Key Population HIV Prevention, Care and Treatment. (FHI 360 2017). <https://www.fhi360.org/resource/gender-analysis-toolkit-key-population-hiv-prevention-care-and-treatment-programs>
- Gender and Sexual Diversity Training from the Health Policy Project: <https://www.healthpolicyproject.com/index.cfm?id=GSDTraining>
- Gender, Sexuality, and HIV Training Module. IGWG. http://www.healthpolicyinitiative.com/Publications/Documents/1408_1_IGWG_GSHIV_Module_Oct_2010_acc.pdf
- Global Health eLearning Center course on designing HIV prevention activities for key populations: <https://www.globalhealthlearning.org/course/designing-hiv-prevention-programs-key-populations>
- Global Health eLearning Center course on National Level M&E Guidelines for working with sex workers, men who have sex with men, and transgender populations: <https://www.globalhealthlearning.org/course/m-e-guidelines-sex-workers-men-who-have-sex-men-transgender>
- Global Health eLearning Center course on Service Delivery Level M&E Guidelines for working with sex workers, men who have sex with men, and transgender populations: <https://www.globalhealthlearning.org/course/m-e-guidelines-sex-workers-men-who-have-sex-men-transgender-0>
- Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. WHO (2013). http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1
- Sexual Orientation and Gender Identity Definitions and Myths. IGWG. https://www.igwg.org/wp-content/uploads/2017/05/FG_SexOrientDefsMyths.pdf
- Shaping Our Sexualities: Gender and Sexual Norms. IGWG.
 - Facilitator Guide: https://www.igwg.org/wp-content/uploads/2017/05/FG_ShapingOurSexualities.pdf
 - Presentation: Gender, Sexuality, and HIV: So What? <https://www.igwg.org/wp-content/uploads/2017/05/GendrSexualityHIVSoWhat.ppt>
- What is Sexuality? IGWG.
 - Circles of Sexuality and Definitions: <https://www.igwg.org/wp-content/uploads/2017/05/HandoutCirclesSexualityDefs.pdf>
 - Facilitator Guide: https://www.igwg.org/wp-content/uploads/2017/05/FG_WhatIsSexuality.pdf
 - Gender, Sexuality, and HIV: So What? <https://www.igwg.org/wp-content/uploads/2017/05/GendrSexualityHIV.ppt>
 - Illustrative Program Examples Related to Gender, Sexuality, HIV: https://www.igwg.org/wp-content/uploads/2017/05/FR_IllustrativProgramExamples.pdf

Human trafficking

Human trafficking is a global human rights challenge that exploits vulnerable women, men, boys, and girls; breaks down rule of law; corrupts systems of international commerce; and has the potential to cause unethical behavior and unintended exploitation. Human trafficking involves the recruitment, transportation, transfer, harboring, or receipt of persons through the use of force, fraud, or coercion for the purposes of exploitation in forced labor or commercial sexual exploitation.³ For practitioners working on development,

³ <https://www.usaid.gov/trafficking>

health, and security projects around the world, it is important to understand that human trafficking can be closely related to organized crime, ineffective legal protections, health threats, insufficient labor standards and enforcement, poor economic development, gender and ethnic discrimination, and ineffective or lacking migration policies and practices.⁴ Development and health practitioners are encouraged to address the issue of human trafficking using a gender lens to ensure that they incorporate protections against human trafficking and that protocols are established to address the issue at all levels.

With an understanding that victims/survivors of human trafficking can have differing gender-related vulnerabilities to trafficking and associated experiences of GBV, we can address the issue of human trafficking within the following areas:

- **Prevention:** By ensuring employers, social service providers, health care providers, and development practitioners are sensitized to the complex issue of trafficking, the populations vulnerable to trafficking, and the key signs to help identify abuse, the formal and informal systems and environments that allow human trafficking to flourish can be identified and eliminated.
- **Protection:** It is vital to effectively identify victims/survivors of human trafficking while simultaneously developing or strengthening national and regional referral mechanisms to ensure that victims/survivors are provided basic necessities and key health and legal assistance.
- **Prosecution:** Globally, low levels of prosecutions and convictions worldwide indicate the necessity to increase efforts to ensure justice and support for victims/survivors and to punish perpetrators.
- **Partnership:** Successful efforts to combat human trafficking require effective and efficient coordination across a broad range of stakeholders to more fully leverage a wide range of locally tailored counter-trafficking interventions.⁵

Resources to learn more:

- Counter-trafficking in Persons: Field Guide. USAID (2013).
https://www.usaid.gov/sites/default/files/documents/2496/C-TIP_Field_Guide_Final_April%205%202013.pdf

Commercial sex workers

Commercial sex workers (CSWs) are people who engage in sexual activity for their work. Globally, women, men, and transgender commercial sex workers face high levels of violence, stigma, discrimination, and other human-rights violations. These issues are often exasperated by social and legal environments that criminalize sex work and discriminate against sex workers. Improvement activities that may affect CSWs should be aware of the specific vulnerabilities and stigmas faced by commercial sex workers related to gender, health status, race, ethnic background, drug use, and other factors. Violence against sex workers is often a manifestation of gender inequality and discrimination directed at women, or at men and transgender individuals who do not conform to gender and heterosexual norms. Sex workers may be subjected to GBV related to inconsistent condom use or lack of condom use, increased risk of sexually transmitted infections (STIs) and HIV, and physical, physiological, financial, and sexual violence used as punishment for a variety of reasons. These impact sex workers' health and wellbeing, and their ability to access health care, legal protections, and social services.

When working with CSWs, remember to ensure sex workers' full range of human rights and respect their ability to make informed choices about their own lives. At all levels, practitioners should be educated on the local patterns of violence affecting CSWs and the types of vulnerabilities they face within each local

⁴ https://www.usaid.gov/sites/default/files/documents/2496/C-TIP_Field_Guide_Final_April%205%202013.pdf

⁵ https://www.usaid.gov/sites/default/files/documents/2496/C-TIP_Field_Guide_Final_April%205%202013.pdf

context. Staff capacity to understand the links between violence against sex workers and HIV or other health and development-related areas without stigmatizing or blaming sex workers is highly important to ensuring this group is effectively linked with care and services. Using participatory methods, integrated interventions, and the "do no harm" principle are all highly important to ensuring that sex workers are respected and are in decision-making positions to identify their needs and voice their own perspectives on improvement activities.⁶

Resources to learn more:

- Global Health eLearning Center course on designing HIV prevention activities for key populations: <https://www.globalhealthlearning.org/course/designing-hiv-prevention-programs-key-populations>
- Global Health eLearning Center course on National Level M&E Guidelines for working with sex workers, men who have sex with men, and transgender populations: <https://www.globalhealthlearning.org/course/m-e-guidelines-sex-workers-men-who-have-sex-men-transgender>
- Global Health eLearning Center course on Service Delivery Level M&E Guidelines for working with sex workers, men who have sex with men, and transgender populations: <https://www.globalhealthlearning.org/course/m-e-guidelines-sex-workers-men-who-have-sex-men-transgender-0>
- Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. WHO (2013). http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1

Constructive male engagement

When working on improving gender equality, it is critical to recognize that working with both women and girls, *and* men and boys is fundamental to improving gender equality and positively impacting the health of all. If gender norms in a society prevent women from accessing health services without their husband's approval, then it is important to work with both men and women to change this dynamic. In many instances, major progress on gender equality in health will only be made when both men and women participate in working to shift gender norms.

When involving men and boys, it is important to consider how they are being involved and ensure it is constructive, and not gender-blind. For example, research has shown that maternal and child health outcomes improve when male partners and fathers are involved; however, outcomes will not improve simply by clinics requiring men to accompany pregnant women and mothers to ANC visits. Supportive, constructive male engagement could include physically accompanying female partners to health clinics, but it also could include providing money for transportation to the health clinic, reminding female partners about appointments, asking how an appointment went, taking care of other children or arranging for child care during the clinic visit, and providing emotional support. Any efforts to engage male partners in health services, such as HIV testing, should also track whether they are linked to care or preventative services – both for their health and for the effect their health has on their family.

Remember that efforts to engage men in women's health should always leave the decision of whether to involve men or not up to the woman patient; if she does not want him involved, her decision must be respected. In addition, efforts should not place the burden of male engagement on women. Improvement efforts should not create extra work for women or hold women responsible for their male partner's

⁶ http://www.who.int/hiv/pub/sti/sex_worker_implementation/swit_chpt2.pdf

engagement. Women can be part of the process, but should not be solely responsible or held accountable for male involvement.

Below is an overview of the three basic male intervention approaches, enabling the development of effective male engagement activities. These approaches highlight the benefits and challenges of the various intervention approaches:⁷

- **Men as agents of change** is an approach that aims to provide services for both men and women, with the goal of providing services in a gender equitable way. It acknowledges the role that men play in supporting women's health, as well as their fundamental role in addressing the gender inequalities that harm health outcomes.
- **Men as partners** is an approach that engages and views men as allies in programming for women's health, but of which they are not a beneficiary. It acknowledges that men are open to change and many are involved in improving and impeding women's health. This approach does not address or try to change gender inequities or unbalanced power relationships that often lead to poor health outcomes.
- **Men as clients** is an approach that aims to provide men with the same kind of health services that are provided to women. This approach targets services like reproductive health services, which are often targeted to women but which men also need access to. These activities do not always address, and sometimes can reinforce, the gender norms and social roles that lead to the full realization of health.

Resources to learn more:

- Engaging Men and Boys in Health and Gender Equality: A global toolkit for action. UNFPA (2010). <http://www.unfpa.org/sites/default/files/pub-pdf/Engaging%20Men%20and%20Boys%20in%20Gender%20Equality.pdf>
- Male Engagement. IGWG. <https://www.igwg.org/priority-areas/male-engagement/>

Constructive female engagement

Just as it is important to involve male partners in women's health, it is important to involve female partners in men's health. For example, VMMC patients could be encouraged to bring their female partners, mothers, aunts, or sisters to education and counseling sessions, or on the day of the procedure. Facilities offering VMMC services could also offer health services for those females involved in VMMC. Males who test positive for HIV could be encouraged to share their status with their female partner, and attend the clinic for couples counseling.

As with male engagement, female engagement should be constructive and not gender-blind. For example, supportive and constructive female engagement could include physically accompanying male partners to health clinics, but it also could include caring for the male patient at home, cooking nutritious food for him, reminding him about appointments, asking how an appointment went, and providing emotional support. Any efforts to engage female partners in health services, such as HIV testing, should also track whether they are linked to care or preventative services – both for their health and for the effect their health has on their family.

Efforts to engage women in men's health should always leave the decision to involve women up to the patient; if he does not want any women involved, his decision must be respected. In addition, constructive

⁷ Greene M. E., Mehta M., Pulerwitz J., Wulf D., Bankole A., Singh S. Washington, DC: Millennium Project; 2006. Involving Men in Reproductive Health: Contributions to Development. Background paper to the report Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals. <https://www.faithtoactionnetwork.org/resources/pdf/Involving%20Men%20in%20Reproductive%20Health-Contributions%20to%20Development.pdf>

female engagement efforts should not place the burden of female engagement on the male patient or blame him if she is not involved.

Do no harm

In quality improvement, the “*do no harm*” principle is to never intentionally or unintentionally harm participants. To do this, it is vital to consider how a change idea will affect different groups of people—and whether it might harm one group. For example, to increase male partner involvement in ANC, a QI team decided to test prioritizing couples for services—that is, if a couple came to the facility, they would receive services before any pregnant woman who came by herself to the facility. Though this change idea did have the desired effect of increasing the number of women who brought men with them to the facility, it also harmed single women and women whose male partners could not come to the facility. It left those women at an unfair disadvantage, and gave them a lower quality of services. This harm was unintentional, but still harmed patients. If the QI team had followed a “*do no harm*” principle, it would have brainstormed how the change idea would affect different groups of people and may have realized that women without male partners present would be treated unfairly. Another effective method to do no harm is to gather participant perspectives, to hear from participants themselves what they think the effects of an activity or project are—both good and bad.

Another real-world example occurred when a QI team tested introducing income-generating activities to female-headed households to improve school enrollment among orphans and vulnerable children. While the activity reported improvements in children’s school enrollment, it overlooked the fact that some women who increased their income from the activity were subjected to GBV by their male partners due to this increase in income. Again, it is important to observe the “*do no harm*” principle at all times.

APPENDICES

Appendix 1. Glossary

Constructive Male Engagement: When men actively engage in project activities; this includes increasing men's support for health, education, and children's well-being outcomes.

Empowerment: When people are able to act freely, exercise their rights, and fulfill their potential as full and equal members of society using all of the resources (material, human, and social) available to them. While empowerment comes from within and individuals empower themselves, cultures, societies, and institutions create conditions that facilitate or undermine empowerment. It is a process and an outcome. Women's empowerment refers specifically to the ability of women and girls to act freely, exercise their rights, and fulfill their potential as full and equal members of society using all of the resources (material, human, and social) available to them.

Gender: The economic, social, political, and cultural attributes, constraints, and opportunities associated with being male or female in a particular society. It includes the roles, behaviors, activities, rights, and responsibilities that a society considers appropriate for girls, boys, women, and men. Definitions of what it means to be a woman or man vary within and between cultures and change over time.

Gender Accommodating: Describes a project, activity, or policy that acknowledges the role of gender norms and inequities and seeks to adjust to and often compensate for them. While such projects, activities, and policies do not actively seek to change gender norms and inequities, they strive work around existing gender differences and inequalities to limit any harmful impact on gender relations.

Gender Analysis: A systematic way of identifying, understanding, and describing the social, economic, and political factors that shape the lives of women, men, girls, and boys and how these gender inequalities affect development outcomes. Gender analysis involves collecting and analyzing sex-disaggregated data and other qualitative and quantitative information on gender issues.

Gender Aware: Describes a project, activity, or policy that deliberately examines and addresses local gender differences, norms, and relations and their importance to development outcomes in project design, implementation, and evaluation.

Gender-based Violence: Violence that targets individuals or groups on the basis of their gender. It can be emotional, financial, mental, physical, or sexual. Threats of such acts and coercion are also considered GBV.

Gender Blind: Describes a project, activity, or policy that ignores the roles, rights, entitlements, responsibilities and obligations associated with being female and male, and the power dynamics between men, women, boys and girls.

Gender Equality: When men and women have equal rights, freedoms, conditions, and opportunities for realizing their full potential and for contributing to and benefiting from economic, social, cultural and political development. It is the equal valuing by society of the similarities and differences of men and women and the roles they play. It is based on women and men being full partners in their home, community, and society. Equality results from equity.

Gender Equity: The process of being fair to women and men. To ensure fairness, measures must often be available to compensate for historical and social disadvantages that prevent women and men from otherwise operating on a level playing field. Equity leads to equality.

Gender Exploitative: Describes a project, activity, or policy that takes advantage of rigid gender norms and existing imbalances in power to achieve objectives. Under no circumstances should activities take advantage of existing gender inequalities in pursuit of project, activity, or policy outcomes.

Gender Integration: Refers to strategies applied in activity assessment, design, implementation, and evaluation to take gender norms into account and to compensate for gender-based inequalities. It is identifying and addressing gender inequalities during strategy and project planning, implementation, and monitoring and evaluation.

Gender Identity: Is a person's internal, deeply felt sense of being a man or woman, or something other or in between, which may or may not correspond with the sex they were assigned at birth. For example, most females think of themselves as women, and most males think of themselves as men. However, transgender people think of themselves differently from the gender assigned to the sex they were born with; transgender men are females who think of themselves as men, and transgender women are males who think of themselves as women. Some people do not think of themselves men or women, they consider themselves gender neutral.

Gender Mainstreaming: The process of incorporating a gender perspective into policies, strategies, project activities, and administrative functions, as well as into the institutional culture of an organization.

Gender Norms: Social principles and rules that govern the behavior, attitudes, and actions of girls, boys, women, and men in society and restrict their gender identity into what is considered to be an appropriate gender role at the time. They are neither static nor universal and change over time.

Gender Roles: Behaviors, attitudes, and actions society feels are appropriate or inappropriate for a girl, boy, woman, or man, according to cultural norms and traditions. Gender roles vary between cultures, over time, and in relation to other social identities such as social class, socio-economic status, ethnicity, sexual orientation, religion, ability, and health status.

Gender Transformative: Describes a project, activity, or policy that actively strives to examine, question, and change rigid gender norms and imbalance of power as a means of reaching development as well as gender equity objectives.

Gender-sensitive Indicators: Indicators designed to measure gender-related changes in society, such as changes in the status and roles of women and men in a community over time. These indicators are used to assess progress in achieving gender equality.

Sex: The biological and physiological characteristics that identify a person as female or male. Differences in sex are concerned with males' and females' anatomy and physiology, including chromosomes, genitalia, reproductive organs, and secondary characteristics. For example, males can grow facial hair and females develop breasts that can lactate. These biological and physiological characteristics do not change from culture to culture. Some people are born with a combination of female and male biological and physiological characteristics; rather than being female or male, these people are called intersex.

Sex-disaggregated Data: Data that are collected, analyzed, and presented separately for males and females in an intervention that is targeting both males and females.

Sexual Orientation: Refers to the type of person that someone is attracted to. For example, when a woman is attracted to man or a man is attracted to a woman, we say they are heterosexual. When a woman is attracted to another woman or a man is attracted to another man, we say they are homosexual (or gay or lesbian).

Appendix 2. Frequently asked questions (FAQs)

The following questions may come up frequently in your efforts to integrate gender in improvement and work with quality improvement team members and the broader community. The answers provided are not meant to be comprehensive but rather concise responses that may be useful in your work.

- **What is sex? What is gender?**

Sex is the biological characteristics that identify a person as female or male. Differences in sex are concerned with males' and females' anatomy and physiology, including chromosomes, genitalia, reproductive organs, and secondary characteristics. For example, males can grow facial hair and females develop breasts that can lactate. These biological and physiological characteristics do not change from culture to culture.

Gender is the *economic, social, political, and cultural* attributes and opportunities associated with being male or female. In a given community, men and women have different economic and social opportunities. This varies among cultures and changes over time. For example, what it means to be a man in Mexico is different than a man in Indonesia, and what it means to be a woman in Ukraine is different than what it means to be a woman in Japan. And what it meant to be a woman in Uganda in 1960 is different than what it means to be a woman in Uganda today.

- **Why address gender in quality improvement?**

Addressing the different needs, constraints, and opportunities of men, women, girls and boys is critical to any quality improvement effort. Implementing improvement interventions without considering gender dynamics risks failing to reach half of the population and unintentionally exploiting or harming one gender. From an implementation perspective, this is an inefficient use of resources. From a quality improvement standpoint, it jeopardizes patient-centeredness, safety, and equality. Through strategic integration of gender into improvement planning, implementation, and documentation, we can respond to differences between women, men, girls, and boys to achieve sustained and equitable improvement.

- **How do I start integrating gender in improvement activities?**

You can start integrating gender in improvement at any time, though we recommend you start to think about gender in the planning phase. In addition to understanding gender concepts, it is important to know and understand the local cultural, religious, and social contexts within the community you are working in—which can be different between communities in one country. Understanding various needs, constraints, and opportunities between different age groups, sexes, and social and economic statuses is critical. It is also important to understand the political context in which you are working. And last, you need to personally be in full agreement that gender integration is important and critical to improving health outcomes. Trying to convince someone that gender integration is important when you do not believe it is will not work. People will sense your reluctance and disagreements. You need to be true to yourself and to the people you serve. If you have any doubts, that is not the end of the world. This is a change process and it requires time and effort to reach the desired level—a process that leads you to feeling comfortable and confident about gender integration. Once you are familiar with the process, materials, and way to move forward, the process of gender integration will become smooth and part of your everyday activities.

- **Where do I begin to integrate gender into improvement activities?**

Everyone can contribute to the process of gender integration. While it may not always appear to be straightforward, when gender integration is approached from a perspective of improving outcomes for men, women, boys, and girls, it will be rewarding and will help teams achieve their desired improvement goals and reduce inequalities in outcomes. Introducing gender at the beginning of program planning phases is ideal. Sensitizing and training staff on gender and gender integration is critical. It will require intentional and explicit attention to addressing gender issues throughout activity planning, implementation, M&E, and documentation. Collecting and analyzing sex- and age-

disaggregated data is imperative, as is examining the gender issues that affect improvement activities. This can be done by asking the women, men, girls, and boys involved in the activities what their needs, barriers, and opportunities are related to the activity. Or it can be done through desk research. Either way, this starts the conversation of how gender affects the activities. You should also start a conversation with colleagues who have addressed gender in their projects or activities, to learn from their experience. You should also familiarize yourself with relevant gender integration resources. Once familiar with the process, materials, and the way forward, integrating gender will become a regular part of your everyday activities. This Guide provides numerous resources to support your efforts (see **Appendix 7** for a full list of resources). It is also important to reach out to colleagues and experts who have successfully addressed gender in their work for additional support and guidance.

- **Will gender integration make the activity more expensive?**

Integrating gender is a way to improve your activity, not introduce a new activity. It might increase activity costs slightly because it might involve additional training. However, gender integration content can be embedded in any QI training. This will reduce costs and enhance activity implementation in addition to contributing to institutionalization. It will require more attention from staff and potentially gender experts to ensure gender integration activities are being implemented appropriately. However, it is important to consider the potential costs of ignoring gender issues and how it can limit activity outcomes or even have unintended detrimental effects on activity beneficiaries. There are many actions practitioners can take to address gender that do not cost anything or cost very little.

- **What if we don't have gender experts on our team?**

Staff planning, implementing, and evaluating change activities do not need to be gender experts to be able to address gender issues and gaps affecting activity outcomes. Staff need to be aware that gender issues might affect activity outcomes and be sensitized to the importance of addressing gender at all levels of implementation. Staff can play different roles in addressing gender depending on their level of responsibility, but all staff should work together. Projects can use short-term expert advice on gender issues depending on activity complexity. Once gender is integrated in improvement activities, it becomes a part of daily routine activity implementation.

- **What if I face resistance to integrating gender?**

Changing people's behaviors and beliefs takes a long time, especially when it comes to addressing gender issues and gaps. In addition, people might have their own beliefs and biases about gender, especially when they come from different backgrounds and communities. Staff should be sensitive to this issue. Forcing concepts on people will not work and will not lead to sustainable change. Explaining examples (from this Guide or otherwise) about how integrating gender led to improvement will help to reduce resistance. Similarly, explaining how addressing gender might affect outcomes will help reduce resistance to gender integration among staff. Having staff participate in developing local solutions is key to their buy-in and successful implementation.

Appendix 3. How to facilitate discussions about gender and gender integration in quality improvement

Before starting to integrate gender in your improvement activities and before introducing the concept of gender integration to your colleagues, it is helpful to first introduce the idea of gender and discuss how gender impacts our daily lives. After realizing that being a woman, man, girl, or boy affects a person's life, your colleagues will be more open to discussing how gender may affect your improvement activity.

Group discussions are critical in allowing participants the opportunity to examine new ideas, challenge widely-held norms and beliefs, and open their mind to new opinions and perspectives. Discussions about gender roles and norms are not easy to start, because each person has his/her own beliefs about what is expected from women and men, girls and boys. It is helpful to frame questions about what a community's beliefs are, rather than discussions about what participants' beliefs are, because this takes the pressure off participants to explain whether they agree or disagree with the gender roles and norms.

Getting started and moving along

- Review materials and try to relate concepts to your daily life. Try and think through concepts and what they mean to you personally.
- Talk to a colleague about issues that you need more clarification on. Holding a discussion helps clarify issues and open your eyes to things you might not have thought about before.
- Talk to family and friends about certain issues that you think will help you address a gender-related challenge. This will allow productive discussions about real situations. Even if you disagree, this will help you practice addressing such controversial issues when you facilitate a discussion about gender in quality improvement.
- Understand the materials you will use in your discussion. Be prepared even if it takes more time.

Facilitating a discussion

- Do research to understand gender issues (issues affecting women and men, girls and boys) in the community and know your audience very well. To the extent possible, ask and know about their background, where they come from, their religious beliefs, social settings, cultural practices, political views if possible, and other life experiences.
- Always remember that discussions about gender will be different with each group of people. Similar ideas, themes, and beliefs may surface, but be prepared for each discussion to go differently.
- The word "gender" often has a negative connotation, so try to focus the discussion on issues affecting women and men, girls and boys without using the word gender too much. Be sure to explain this is not about empowerment of one gender only, it is about improving outcomes for all. Many people think that integrating gender is the same as focusing on women or empowering women, but this is not true (see the Glossary in **Appendix 1**).
- Take into consideration that within a group, people react to different life situations differently. This is affected by their personality and how strong their feelings are about certain issues.
- If you are put in a challenging situation addressing a gender-related issue, be patient, professional, and do not feel it is your responsibility to resolve an issue that has been affecting the status of women and men for many years.
- Your main role is to clarify concepts and address misconceptions. Being respectful of other people's beliefs and understanding of gender is very important. The minute you exhibit any reaction that might be perceived as disrespectful, you lose your audience.
- Changing people's understandings and beliefs takes a long time. Integrating gender in quality improvement can improve outcomes in less time than it takes to change beliefs.

- Never force a concept on your audience. If someone is not convinced, they might make it look like all is good, but they will never apply gender integration methodologies in their daily work.
- Bring life examples and ask your audience how they feel about certain situations.
- At times, someone might make fun of another participant's comments, or make a comment that might make you and others feel uncomfortable. Try to keep a neutral face and explain your point of view in the most respectful way. Don't take it personally and try not to be offended. It is not about you, it is about the issue at hand. At times people do this intentionally to stop the discussion. You need to be aware of this possibility and try to keep the discussion going, but always be respectful to others.
- Bring examples about gender-related issues from different countries. This shows that gender issues exist all over the world. It can also help resolve a situation or clarify a concept. People often feel much more comfortable discussing other people's issues, while relating such situations to themselves in private.
- If someone brings a matter that makes you feel uncomfortable and you have no answer to it, just say that you don't have an answer. Ask participants whether they can help address the matter.
- Gender integration in quality improvement is not about changing gender roles, this is all about integrating gender in quality improvement to have better outcomes for women and men, girls and boys. We all care about the wellbeing of our patients and beneficiaries. Always go back to this fact, mention frequently and talk about the fact that addressing gender means better outcomes for women, men, girls and boys. It is all about equality in service provision.
- Never attack any gender verbally or through body language and gestures. If participants see that you are respectful and neutral about issues, they will open up. Only then you can address different issues that might affect your activity
- Listen, listen, and listen.

Managing group dynamics

- Definitions are important. Terms such as "gender," "sex," "transgender," "gender equity," and "empowerment" mean different things to different people. To move forward, and for the sake of dialogue throughout the workshop, there must be an agreement on the generally accepted definition of each term.
- Encourage group participation from the very beginning. Sensitization exercises (see **Appendix 7**) will help you gauge the "mood" of the room, set the right climate for the discussion, and allow participants to bond with each other to allow for greater sharing of experiences in later sessions.
- Some participants feel uncomfortable discussing their views about gender-related matters openly. This is especially important to consider when addressing gender-based violence. Note people's reactions and body language to issues raised. Make sure you talk to them during breaks to better understand their thoughts and feelings. Do not single them out in front of their peers and do not talk try to argue or force beliefs. Be informative and discuss.
- Wrap-up should be handled delicately; you do not want to appear critical of or disappointed in participant results. If necessary, make additional suggestions or pose additional processing questions to help the group get to their anticipated end result.

Achieving your goal to improve quality of care

- In thinking about a service, always consider the *unique* needs of women and men, girls and boys. For example,
 - Consider the health clinic environment, including clinic hours, and how it can be improved to meet the needs of both women and men as much as possible, and be friendly to both.
 - Consider health provider and community attitudes towards women and men, and whether this affects the health services each receives.

- Consider health provider and community attitudes towards different groups of women (for example, pregnant women and HIV positive pregnant women, or married and single women) and men (for example, men with different types of jobs, or married and single men) and whether this affects the health services each receives.
- Consider health provider and community attitudes towards children, adolescents, and adults, and whether this affects the health services each receives.
- Always ask the question whether being a woman or being a man affects the health outcome of your patients in terms of access to, use of, and retention in care.
- When data is collected to monitor and evaluate progress, consider disaggregation by sex. This will give you real information about progress among women and men. Many times, such progress is different; this can help identify if one segment is not accessing services or receiving services of the same quality.
- When a difference in outcomes is identified, think about issues affecting women or men and how those issues might have affected health outcomes. Those issues might be economic, social, cultural, or political.
- Tailor your activity accordingly, as much as possible, to address those issues and continue monitoring: *design and test changes that directly address those barriers*,
- Involve the community, especially community leaders, to help address some of the issues that are beyond your control.

Scenarios for discussion

Using scenarios to discuss gender issues is an effective way to get participants thinking about relevant issues. It is important to cater each to the activity as well as the community where the work is taking place to make sure it reflects local needs and preferences. Scenarios are useful to generate discussion during learning sessions, coaching visits, or other types of training. Scenarios can be read aloud and discussed, or be a role play that participants act out. Below are some examples of scenarios and questions to facilitate discussion.

Scenario 1: A mother brings her 2-year-old son to the facility because he is very sick with a fever. She explains that at first she did not bring him because she did not think it was serious, and then when she decided to bring him, her husband would not give her the money for transportation until the following day.

- What are the gender-related issues?
 - The mother did not think her son was sick enough to take to the facility – is this because men and boys are seen as stronger, and that it is a sign of weakness for them to be sick?
 - The mother does not have the decision-making power to bring her children to the facility – the father controls the money and decides who is sick enough to go to the facility. If the child had been a girl, would he have been less likely to give the money? More?
- What are some QI activities that could prevent something like this?
 - Educating the mother on the importance of bringing children to the facility.
 - Educating the father, and the broader community, on the importance of bringing children to the facility.
- What can the facility staff do?
 - It is important to ensure clinic staff know how to provide care, but also that they will not assume men or boys are healthier and stronger than women or girls and so do not need to be helped immediately (triage), or the opposite.
 - The assumptions that staff make (and the gender roles they assume for people) can affect diagnosis, treatment, etc.
 - If we have sex-disaggregated data for children, we can learn if more boys or girls are being brought to the facility, being treated quickly and correctly, recovering quickly/slowly, etc.

Scenario 2: A 15-year-old adolescent girl visits the antenatal care clinic for the first time when she is 6 months pregnant. The staff blame her for not coming to receive care earlier and ask her not to come to the health facility without a male partner. They tell her she will be a bad mother and she is young and irresponsible.

- What are the gender-related issues?
 - The staff assumed the adolescent girl has a male partner, but that might not be true. She might not be married. She might be in a relationship with an adolescent boy her age, or maybe with an older man.
 - Whether or not she is married or in a relationship, she might also have been raped or sexually abused – by either someone who is not her male partner or by her partner.
 - Is she ashamed or proud to be pregnant? Is her family and community ashamed or proud she is pregnant?
 - Does she want the father of the child involved? If he raped her or if he is not treating her well, she may not want him involved. She may not know who the father is – but she still deserves quality care.
 - Why did the adolescent girl wait so long to visit ANC? Did she rely on someone else for transportation money and that person would not give it to her? Could she not leave the house because there was too much work to do? Was she hiding the pregnancy from her school?
 - Is the facility environment welcoming to adolescent girls? Is it easy to get to? What are the hours? Had the adolescent girl heard from her friends that the staff were mean and rude to pregnant adolescent girls?
 - Did the adolescent girl know that ANC is important and can improve the health of both pregnant women and her fetus? Where would she have learned that?
 - When and how did the adolescent girl learn she was pregnant?
 - The staff discriminated against the adolescent girl and refused her treatment because they assumed she was irresponsible.
- What are some QI activities that could prevent something like this?
 - Educating young and old, men and women, mothers and fathers, and the broader community, on the vulnerability of pregnant adolescent girls.
 - Training and reminding staff that every patient deserves respectful, quality care and treatment.
- Other thoughts?
 - The assumptions that staff make (and the gender roles they assume for people) can affect diagnosis, treatment, etc.
 - We do not need sex-disaggregated data for pregnant women because all pregnant women are females (there are no males). BUT we can disaggregate data for pregnant women by age to identify gaps in care and close them (age-disaggregated data).

Scenario 3: A pregnant woman and her male partner visit the antenatal care clinic together. They are assessed for nutrition status, and both are malnourished. Both are counseled on nutrition and food supplements. When they return for their next appointment, the male partner has started improving, but the pregnant woman has not.

- What are the gender-related issues?
 - Why did the male partner recover and the pregnant woman did not? Men often experience improved nutrition faster than women due to food allocation and power dynamics within families.
 - Women are more likely to share food supplements.

- Why did the male partner accompany his female partner to the ANC clinic? Did both know that ANC is important and can improve the health of both pregnant women and their fetus? Where would they have learned that?
- If the male partner were not present, does that mean he does not support his female partner? What about providing emotional support at home? Helping with work around the house? Taking care of other children (or ensuring that somebody does) while the pregnant woman visits the clinic? Providing transportation money?
- Does the community support male partners visiting the clinic? Do they think that is good or bad behavior for a man?
- Is the facility environment welcoming to male partners and children? Is it easy to get to? What are the hours? Had the pregnant woman and her partner heard from friends that the staff provide good care for partners and children?
- When and how did the woman learn she was pregnant?
- Does everyone receive good treatment of the same quality from the staff? Do staff prioritize couples for services, thus leaving single women and women whose partners cannot accompany them at an unfair disadvantage?
- What are some QI activities to address the issues?
 - Educating men and women, mothers and fathers, and the broader community, on the importance of nutrition and the particular nutrition needs of HIV positive pregnant women, and all HIV positive people.
 - Discuss sharing food supplements as part of nutrition assessment, counseling, and support services, and what the patient thinks s/he will do; discuss how food is allocated and shared in the family, who decides what food is bought, cooked, and who eats what.
 - Training and reminding staff that every patient deserves respectful, quality care and treatment.
- Other thoughts?
 - Globally, women are more likely than men to be malnourished, though men tend to access health services later and so their nutrition status may be worse and their HIV may have progressed further.
 - In some communities, boys tend to be malnourished more often than girls. In others, girls tend to be more malnourished. Why do you think this might happen?
 - The assumptions that staff make (and the gender roles they assume for people) can affect diagnosis, treatment, etc. The staff welcomed the male partner and assessed him for nutrition, even though it is an antenatal care clinic for pregnant women.
 - The staff did not prioritize the couple for services and let them skip the line, because this would be unfair to single women and women whose partners cannot attend.
 - We do not need sex-disaggregated data for pregnant women because all pregnant women are females (there are no males). But we can disaggregate data for pregnant women by age to identify gaps in care and close them (age-disaggregated data).

Scenario 4: A pregnant woman comes to the facility seeking antenatal care. She knows her HIV status is positive. The health facility staff demand that she brings her partner. The woman has not disclosed her HIV status to her partner.

- What could happen?
 - The woman could leave and never return to the facility. She could decide that it is more important not to disclose her HIV status to her partner, so she does not return to the facility for antenatal care.
 - The woman could disclose her HIV status to her partner, and he could abandon her, divorce her, or abuse her.

Scenario 5: A pregnant woman who is HIV positive gives birth to a 3.5kg girl. She was advised by health facility staff to visit facility regularly to avoid transmitting HIV to her daughter and also to improve her health outcomes, but she has to leave the baby with her mother-in-law and go to town for work. Her male partner does not know her HIV status and he is working in a different country.

- What could happen?
 - The woman could leave and never return to the facility. She could be too busy to visit the facility regularly, and not want to tell her mother-in-law that she is HIV positive. Then the mother-in-law will not bring the baby to the facility.
 - The woman could disclose her HIV status to her partner and mother-in-law, and they could abandon her, divorce her, or abuse her and her child.

Scenario 6: A woman gives birth in a clinic. The health care workers carefully explain the importance of family planning and healthy timing and spacing of pregnancies. They schedule for her to return for another appointment to check her health, the health of her child, and for family planning. Prior to the appointment day she tells her husband about the clinic appointment and asks him for money for transportation and service fees. Her husband thinks this is unnecessary and refuses.

- What are the gender-related issues?
 - The mother does not have the decision-making power to visit the facility – the father controls the money and decides who can visit the facility and when.
 - The father does not believe the mother that the facility visit is important for her health, their child's health, and family planning.
- What are some QI activities that could prevent something like this?
 - Encourage male partners to visit the facility during ANC visits or after delivery, and educating them on the importance of the follow-up visit to check maternal and child health, and discuss family planning.
 - Send invitation letters to male partners if the female patient wants him to be involved.
 - Send women home after delivery with a receipt of some kind for their next appointment.
 - Call women to remind them of their appointment and offer to speak with their male partner about the visit.
 - Conduct group education sessions or couples counseling on maternal and child health issues, and family planning.
 - Educate the father, and the broader community, on the importance of visiting the facility regularly for maternal and child health.
- What can the facility staff do?
 - Make male partners feel welcome at the facility and encourage them to return.
 - Discuss male partner involvement with pregnant women and mothers, and ask patients if they have a male partner they want involved.
 - Treat women respectfully and provide quality care whether or not a male partner is present.

Scenario 7: A man goes to the clinic for circumcision. His wife knows that he is going for the procedure. When he returns home, he tells her that he must abstain from sexual activity for 6 weeks to heal, prevent adverse results, and achieve the best protection from HIV. His wife does not believe him. She thinks he must be fulfilling his sexual needs elsewhere.

- What could happen?
 - The wife might convince her husband to engage in sexual activity before 6 weeks have passed, making him more vulnerable to infection and adverse events.
 - The husband might worry that his wife will go somewhere else to fulfill her sexual needs, and so engage in sexual activity before 6 weeks have passed, making him more vulnerable to infection and adverse events.

Scenario 8: A 35-year-old married man has 3 children with his wife. His wife is sick so he takes his younger child to the health clinic because she is sick, and while there the clinic staff counsel him on family planning and Zika protective measures. He says having children is his wife's job and he has nothing to do with it. He gets upset and leaves the facility thinking this must have been a trap.

- What are the gender-related issues?
 - The father thinks that family planning and having children is not something he should be involved with.
- What are some QI activities to address this?
 - Community education on family planning, Zika, and male involvement in family planning
 - Educating everyone -- young and old, men and women, mothers and fathers, and the broader community -- on the vulnerability of pregnant women to Zika and its effects
 - Educating everyone -- young and old, men and women, mothers and fathers, and the broader community -- on Zika transmission, symptoms, prevention, and effects on fetuses
- What can the facility staff do?
 - Respectful care and treatment
 - Explain that they educate all adults who come to the facility about Zika, and then provide him with Zika education and counseling, including how family planning is relevant
- Other thoughts?
 - The assumptions that staff make (and the gender roles they assume for people) and how they treat people affect whether they will return to the clinic or not

Appendix 4. Gender analysis and gender integration planning worksheets

Worksheet 1. Data capture	What are the key gender relations and power disparities in each domain?		
	Household	Community	Health facility
Laws, policies, regulations, and institutional practices			
Cultural norms and beliefs			
Gender roles, responsibility, and time used			
Access to and control over assets and resources			
Patterns of power and decision-making			

January 2017

Developed by Taroub Harb Faramand of WI-HER, LLC for the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, funded by the American people through the United States Agency for International Development (USAID) Bureau for Global Health, Office of Health Systems. The USAID ASSIST Project is managed by University Research Co., LLC (URC) under the terms of Cooperative Agreement Number AID-OAA-A-12-00101. WI-HER LLC is USAID ASSIST's lead partner for gender integration.

Worksheet 2. Data synthesis	What additional information is needed about gender relations?	What are the gender-related constraints to achieving project objectives and/or the targeted health outcome?	What are the gender-related opportunities to achieving project objectives, targeted health outcomes, and/or the targeted health outcome?
Laws, policies, regulations, and institutional practices			
Cultural norms and beliefs			
Gender roles, responsibility, and time used			
Access to and control over assets and resources			
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Worksheet 3: Planning

<p>What gender-related aims/sub-objectives can you include in your strategic planning to address gender-based opportunities or constraints?</p>	<p>What proposed changes/activities can you design to address gender-based opportunities or constraints?</p>	<p>What indicators for monitoring and evaluation will show if (1) the gender-based opportunity has been taken advantage of or (2) the gender-based constraint has been removed?</p>

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Appendix 5. Gender analysis questions and action planning

Below, find a list of illustrative questions to help you analyze the expected effects of activity interventions and the anticipated outcomes on gender relations, norms, and equality. The questions you choose for your gender analysis will vary depending on the aim of the activity, the specific context of the activity, and whether it is implemented in the facility, community, or both. Research questions be adapted for the individual data collection needs.

KEY QUESTIONS

1. How will the different roles and status of women and men affect the work to be undertaken?
2. How will the anticipated results of the work affect men and women differently? i.e., how will the activity impact:
 - Access and control over resources by different individuals and groups
 - Validation or challenges to different people's knowledge, beliefs, and practices
 - Different peoples' interests and needs
 - Participation of different individuals and groups

REMEMBER TO CONSIDER BOTH CONSTRAINTS AND OPPORTUNITIES

Sample questions by domain

I. Laws, policies, regulations, and institutional practices

- What is the status of major pieces of legislation related to gender equality in the country and what is missing?
- How do laws, policies, and regulations treat men and women differently?
- How do these laws, policies, regulations and practices impact the lives and health of men and women?
- Can women and men both inherit property equally?
- Can men and women pass on citizenship to their children?
- At what age are women and men legally allowed to marry?
- How do these answers influence the ability of males and females to access AND benefit from health services?

II. Cultural norms and beliefs

- What do men and women know? Who knows what?
- How does the community think men and women, and girls and boys should behave? How does the community think they should conduct their daily lives?
- How do men and women interpret aspects of their lives differently, depending on their gender?
- Is it culturally acceptable for men and women to seek health care?
- To what extent are women, men, girls, and boys who are HIV-positive stigmatized?
- To what extent is childrearing considered a man or woman's role?
- What are gender roles and opportunities for men and women? How do they differ between various ethnic and religious and geographical groups? How have they changed over time? How do they differ by age? How do they vary according to other differences, such as socioeconomic class, sexual orientation, and disability?
- How are health practices shaped by gender roles?
- What are the gendered cultural constraints to and supports for health? What "positive" gender relations exist here that could be strengthened to close gaps in care? To achieve gender equality?

III. Gender roles, responsibilities, and time used

- What issues or barriers related to gender could prevent participation in the activity, project, or service? Are some people excluded based on their gender (even inadvertently)?
- Are there types of gender-specific leadership roles that might provide the basis for broader participation? Are there leadership positions women already occupy?
- What type of work do women and men do? Paid and unpaid work? How many hours a day do women, men, girls, and boys engage in paid/unpaid work?
- How do men and women carry out their tasks?
- How and where do men, women, boys, and girls spend their time?
- How do these affect the activity?
- Does the gendered division of labor provide a useful framework for distributing project resources equitably and in a way that will be supportive of project objectives?
- How do women's and men's participation and leadership in health and public life differ?
- Are there spaces in which men and women interact in more equitable ways?
- Are there ways in which men already support gender equality?

IV. Access to and control over assets and resources

- Who uses project resources and services?
- Does unequal access to project resources and services prevent the project from reaching its goals?
- Are there instances of equitable access with regard to certain types of resources that might provide a model for access to other resources?
- What critical resources do women not have access to and control over (e.g., land, training, inputs, technologies, equipment, information, health care, water, loans, savings, etc.)? How does this differ for women and men?
- Are there any organizations that focus on women's empowerment? Are there any organizations that focus on engaging men in gender issues?
- What traditional practices that influence control of resources are seen in your community?
- How is income managed in households?
- Who has the decision making-power over how household resources (money, food, land, time) are allocated?
- Do women/girls and men/boys have access to basic and appropriate health services at the facility level?

V. Patterns of power and decision-making

- Who makes health care decisions within families? To what extent are women (and men) able and allowed to make decisions regarding their own health?
- Does gender-based violence keep women from obtaining health services?
- Who is able to vote and run for office at different levels of government?
- Who actually does vote and run for office at different levels of government?
- What is the representation of males and females in decision-making positions by public, private, and civil society organizations?
- Are people who are excluded from making decisions based on their gender likely to suffer adverse consequences from the decisions made by others?
- Is it possible to organize individuals who are excluded from making decisions based on their gender into groups or coalitions that may be able to negotiate for greater decision-making power?

ACTION PLANNING

- Which gender constraints and disparities must be reduced to achieve desired development outcomes? Have any key gender issues been identified that will impact the ability of the activity to achieve its goals or prevent women and men from benefitting equally?
 - If yes, then how can the activity be amended to ensure that men and women benefit equally?
 - Do the identified gender issues require the re-conceptualization and editing of over-arching objectives and the activity or project goals?
- Does the gender analysis suggest that without any proactive intervention, participation in the activity will be gender imbalanced? If not, how can the activity be designed or amended to increase participation rates for those less represented?
- Are the needs of men and women, in relation to this activity, different enough that a separate activity component focusing on women (or a sub-group of women) or men (or a sub-group of men) is necessary?
- What types of data should be collected to track the gender-related activity impacts? Develop gender-sensitive indicators to monitor participation, benefits, the effectiveness of gender equality strategies, and changes in gender relations.
- Have any potential, unintended consequences been identified? If yes, how should the project or activity counteract the unintended consequences?
- What are the opportunities for reducing gender gaps within each improvement aim/strategic priority?
- What are the opportunities for promoting the leadership of women in each improvement aim/strategic priority? Are there any entry points or opportunities for empowering especially vulnerable groups of women or men through this activity?

Be specific: Include the who, what, when, where, and how of the types of assistance that would be needed to lead to make changes in the areas identified. Be sure to consider the following:

- It might be useful to organize the recommendations into short-term, medium-term, and long-term categories to help prioritize what needs to happen next.
- Assess counterpart/partner capacity for gender sensitive planning, implementation and monitoring, and develop strategies to strengthen capacity.
- Assess the potential of the program, activity, or project to empower women, address strategic gender interests and transform gender relations.
- How should constraints and opportunities be prioritized, and what is the best way to translate these into concrete recommendations?

Appendix 6. Driver diagram worksheets

Activity Overview:

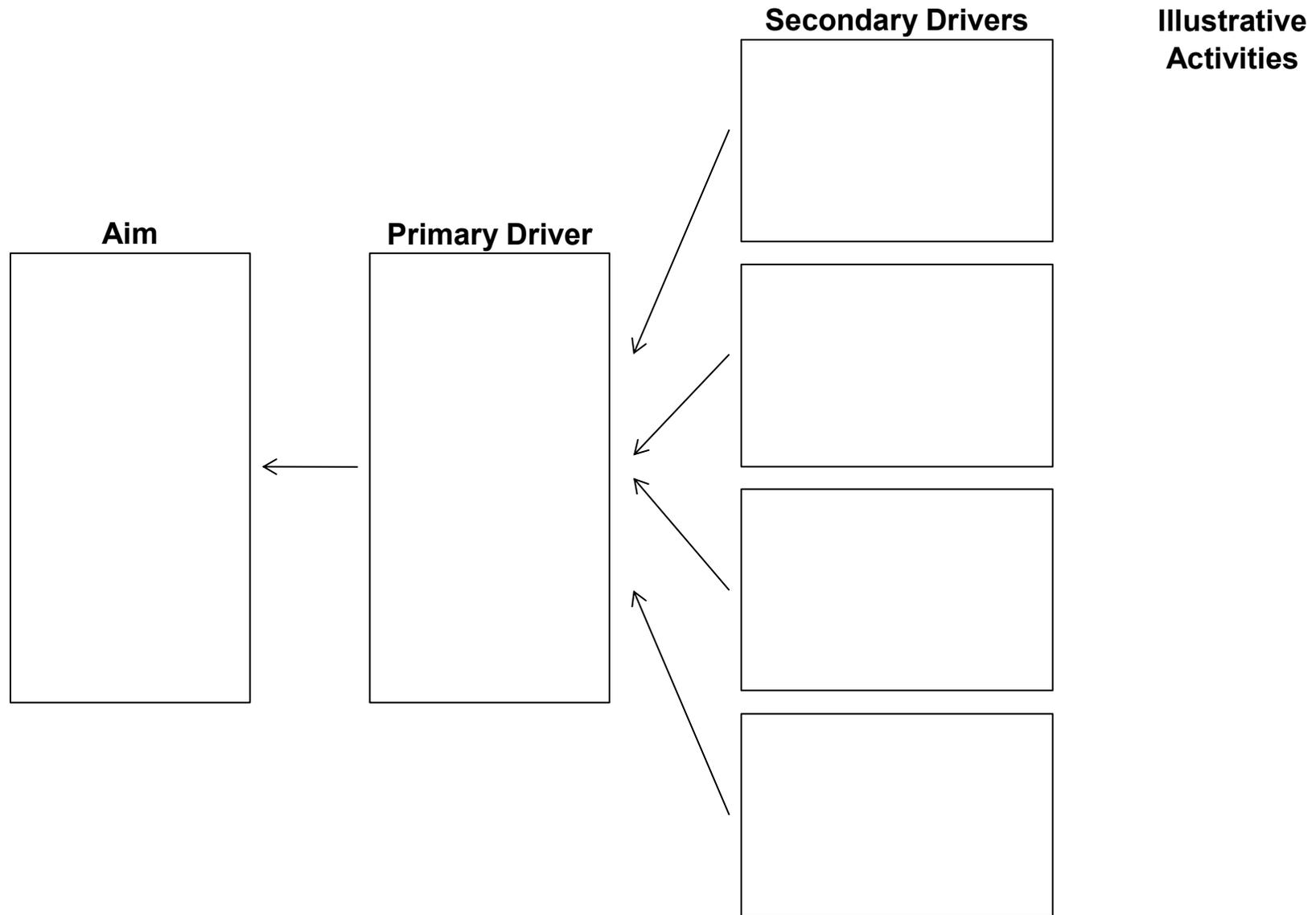
Gender considerations should be an integral component of the improvement process to make sure that activities are gender-sensitive to better achieve improved outcomes. The driver diagram is a tool to help you understand how gender affects a specific outcome and design changes to test to address gender gaps and issues in improvement activities.

Activity:

In order to address gender in improvement activities, you need to identify an improvement aim, primary and secondary drivers related to gender, develop measures for each secondary driver, and develop changes to test.

1. **The Driver Diagram** (next page). Based on the findings from the gender analysis and subsequent discussion, complete the Driver Diagram on the next page. By considering how gender affects your outcome and drivers, you can determine what gender-sensitive activities should be tested to improve outcomes.
 - a. Identify an improvement aim. This statement should be a measurable, time-sensitive description of the goal you expect to make from improvement efforts. A good improvement aim specifies the scope, has specific, achievable numerical goals, sets a time frame, and provides guidance on how the aim will be achieved.
 - b. Identify some primary and secondary drivers that lead to the aim. Be sure to include some gender-related drivers. Information from the gender analysis will help in identifying gaps that might affect desired outcomes. Refer to the Problem Tree your group developed previously to get some ideas about potential drivers.
2. **Quantifying through measurement.** On a separate sheet of paper, develop some indicators for each secondary driver to ensure changes can be measured during implementation.
3. **Designing changes to test.** Develop a list of illustrative activities that could be implemented to address the secondary drivers related to gender that you believe may yield improvement. Organize those changes according to importance and practicality.
4. **Complete the planning tool for developing a gender-related change** (page 3). Select one of the illustrative activities you developed and complete the planning tool for this change.

The Driver Diagram



Appendix 7. Resource list

Overarching guidance on gender integration

- Approche en 6 étapes pour identifier et combler les écarts liés au genre. USAID ASSIST Project (2016). https://www.usaidassist.org/sites/assist/files/6steps_gender_french_a4_ada.pdf
- El abordaje de seis pasos para identificar y cerrar las brechas relacionadas con el género. USAID ASSIST Project (2016). https://www.usaidassist.org/sites/assist/files/abordaje_de_genero_nov16.pdf
- Examples in HIV, OVC, and NACS of the Six-step Approach to Identify and Close Gender-Related Gaps Using an Improvement Approach. USAID ASSIST Project (2015). https://www.usaidassist.org/sites/assist/files/assist_strategy_to_close_gender_gaps_4_pager_0_0.pdf
- Gender and health data and statistics: An annotated resource guide. MEASURE Evaluation (2011). <http://www.cpc.unc.edu/measure/publications/ms-12-52>
- Gender Integration Continuum. Interagency Gender Working Group. https://www.igwg.org/wp-content/uploads/2017/05/FG_GendrIntegrContinuum.pdf
- Six-step Approach to Identify and Close Gender-related Gaps. USAID ASSIST Project (2016). https://www.usaidassist.org/sites/assist/files/six_step_approach_close_gender_gaps_june2016_ada.pdf
- Video: Approche en 6 étapes pour identifier et combler les écarts liés au genre. USAID ASSIST Project (2016). <https://www.usaidassist.org/resources/video-approche-en-6-%C3%A9tapes-pour-identifier-et-combler-les-%C3%A9carts-li%C3%A9s-au-genre>
- Video: El abordaje de seis pasos para identificar y cerrar las brechas relacionadas con el género. USAID ASSIST Project (2017). <https://www.usaidassist.org/resources/video-el-abordaje-de-seis-pasos-para-identificar-y-cerrar-las-brechas-de-genero>
- Video: How Addressing Gender Considerations in Improvement Work Leads to Better Outcomes. USAID ASSIST Project (2016). <https://www.usaidassist.org/resources/video-how-addressing-gender-considerations-improvement-work-leads-better-outcomes>
- Video: How to Conduct a Gender Analysis. USAID ASSIST Project (2017). <https://www.usaidassist.org/resources/how-to-conduct-gender-analysis>
- Video: Six-step approach to help teams integrate gender into improvement activities. USAID ASSIST Project (2016). <https://www.usaidassist.org/resources/video-six-step-approach-help-teams-integrate-gender-improvement-activities>
- World Development Report 2012: Gender equality and development. The World Bank (2012). <https://siteresources.worldbank.org/INTWDR2012/Resources/7778105-1299699968583/7786210-1315936222006/Complete-Report.pdf>

Integrating gender in monitoring and evaluation

- Compendium of gender scales. C-Change (2011). http://www.c-hubonline.org/sites/default/files/resources/main/C-Change_Gender_Scales_Compendium.pdf
- Gender Considerations in Monitoring and Evaluation. USAID ASSIST Project (2014). <https://www.usaidassist.org/resources/gender-considerations-monitoring-and-evaluation>
- Gender M&E. Global Health eLearning Center (2014). <https://www.globalhealthlearning.org/course/gender-m-e>
- Gender-sensitive evaluation and monitoring best and promising practices in engendering evaluations. USAID (2014). http://pdf.usaid.gov/pdf_docs/pa00k43p.pdf
- M&E of gender and health programs. MEASURE Evaluation (2014). <http://www.cpc.unc.edu/measure/training/materials/m-e-of-gender-and-health-programs.html>

- MEASURE Evaluation M&E of Gender and Health Programs Training Module (available in English, français, español). MEASURE Evaluation. <https://www.measureevaluation.org/resources/training/materials/m-e-of-gender-and-health-programs.html>
- Video: Why it is important to sex-disaggregated data in quality improvement. USAID ASSIST Project (2017). <https://www.usaidassist.org/resources/why-it-is-important-to-sex-disaggregate-data-quality-improvement>

Integrating gender in different health areas

- A Quality Improvement Approach in the Partnership for HIV-Free Survival that Responds to Gender Issues. USAID ASSIST Project (2015). <https://www.usaidassist.org/resources/quality-improvement-approach-partnership-hiv-free-survival-responds-gender-issues>
- Aborder les questions de Genre dans les Services de Planification Familiale du Post-partum. USAID ASSIST Project (2014). https://www.usaidassist.org/sites/assist/files/gendertechbrief_ppfp_french_v3.pdf
- Addressing Gender Issues in Postpartum Family Planning Services. USAID ASSIST Project (2014). https://www.usaidassist.org/sites/assist/files/assist_addressing_gender_issues_in_ppfp_services.pdf
- Addressing the Needs of Men, Women, Boys, and Girls in HIV and ART Services. USAID ASSIST Project (2013). https://www.usaidassist.org/sites/assist/files/addressing_gender_hivart_services_may2013.pdf
- Addressing the Unique Needs of Men and Women in Non-communicable Disease Services. USAID ASSIST Project (2014). https://www.usaidassist.org/sites/assist/files/addressing_gender_ncd_services_ada_may2014.pdf
- Gender and Health Systems Strengthening eLearning Course. Global Health eLearning Center (2014). <https://www.globalhealthlearning.org/course/gender-and-health-systems-strengthening>
- Gender and Sexual and Reproductive Health 101 eLearning Course. Global Health eLearning Center (2016). <https://www.globalhealthlearning.org/course/gender-and-sexual-and-reproductive-health-101>
- How a Gender-sensitive Quality Improvement Approach Supports Integrated People-centered Health Services. USAID ASSIST Project (2016). https://www.usaidassist.org/sites/assist/files/gender-sensitive_qi_and_ipchs_final_oct_2016_ada_0.pdf
- Integrating Gender in Voluntary Medical Male Circumcision Programs to Improve Outcomes. USAID ASSIST Project (2014). https://www.usaidassist.org/sites/assist/files/assist_integrating_gender_in_vmmc_techbrief_june2014.pdf
- Meeting the Different Needs of Boys and Girls in Services for Vulnerable Children. USAID ASSIST Project (2013). https://www.usaidassist.org/sites/assist/files/meeting_needs_vulnerable_boysgirls_june2013_0.pdf
- PMTCT: Addressing the Needs of Women and Their Partners to Improve Services. USAID ASSIST Project (2013). https://www.usaidassist.org/sites/assist/files/addressing_needs_womenpartners_pmtct_may2013.pdf
- Répondre aux besoins des hommes, des femmes, des garçons et des filles dans les services de VIH et ART. USAID ASSIST Project (2016). https://www.usaidassist.org/sites/assist/files/addressing_gender_hivart_services_french_july2016_ada.pdf

- Responding to Gender Issues to Improve Outcomes in Nutrition Assessment, Counseling, and Support Services. USAID ASSIST Project (2016). https://www.usaidassist.org/sites/assist/files/addressing_gender_nacs_may2016_ada.pdf
- Strengthening Community Platforms to Address Gender Norms. AIDSFree (2016). <https://aidsfree.usaid.gov/resources/strengthening-community-platforms-address-gender-norms>

Tools for gender integration

- A practical guide for managing and conducting gender assessments in the health sector. IGWG (2013). <https://www.igwg.org/resources/a-practical-guide-for-managing-and-conducting-gender-assessments-in-the-health-sector/>
- Age-disaggregated data collection and analysis tool. USAID ASSIST Project (2015). <https://www.usaidassist.org/resources/age-disaggregated-data-collection-and-analysis-tool>
- ASSIST Sex-Disaggregated District Database Template. USAID ASSIST Project (2016). https://www.usaidassist.org/sites/assist/files/sex-disagg_district_databasetemplate_june2016.xlsx
- ASSIST Sex-Disaggregated Multi-Region Database Template. USAID ASSIST Project (2014). https://www.usaidassist.org/sites/assist/files/assist_multi-region_sex-disaggregated_data_collection_tool.xlsx
- ASSIST Sex-Disaggregated Regional Database Template. USAID ASSIST Project (2016). https://www.usaidassist.org/sites/assist/files/sex-disagg_regional_database_template_june2016.xlsx
- Engendering transformational change: Save the Children gender equality program guidance & toolkit. Save the Children (2014). http://resourcecentre.savethechildren.se/sites/default/files/documents/gender_equality_program_toolkit_2014.pdf
- Gender analysis, assessment and audit manual & toolkit. ACDI/VOCA (2012). <http://www.acdivoca.org/wp-content/uploads/2016/07/ACDI-VOCA-Gender-Analysis-Manual.pdf>
- Gender Integration Checklist. USAID ASSIST Project (2012). <https://www.usaidassist.org/sites/assist/files/checklist-integratinggenderthroughouthciprojectphases.pdf>
- IGWG gender and health toolkit. IGWG (2012). A compilation of practical resources for gender integration and mainstreaming in health policies, programs, and institutions. <https://www.k4health.org/toolkits/igwg-gender>
- Jhpiego Gender Analysis Toolkit for Health Systems. Jhpiego (2016). <http://gender.jhpiego.org/analysistoolkit/introduction/>
- Módulo sobre género, violencia basada en género y trata de personas, dirigido al personal de las ONG y las instituciones formadoras de recursos humanos de la salud. USAID ASSIST Project (2014). https://www.usaidassist.org/sites/assist/files/modulo_de_genero_final.pdf
- Problem Trees. IGWG (2017). <https://www.igwg.org/wp-content/uploads/2017/05/ProblemTrees.pdf>
- Toolkit on gender equality results and indicators. Asian Development Bank/Australian Aid (2013). <http://www.adb.org/documents/tool-kit-gender-equality-results-and-indicators>

Sensitization exercises for gender integration

- Act Like a Man, Act Like a Woman. IGWG. <https://www.igwg.org/wp-content/uploads/2017/05/ActLikeAMan.pdf>
- Vote with Your Feet. IGWG. <https://www.igwg.org/training/setting-the-stage/>

Case studies in gender integration

- Améliorer la participation des partenaires masculins des femmes enceintes dans la PTME pour augmenter l'utilisation des services PTME au Burundi. USAID ASSIST Project (2017). https://www.usaidassist.org/sites/assist/files/burundi_assist_case_study_french_2may2017_ada.pdf
- Gender integration in quality improvement: Increasing access to health services for women in rural Mali. USAID ASSIST Project (2016). <https://www.usaidassist.org/resources/gender-integration-quality-improvement-increasing-access-health-services-women-rural-mali>
- Integrating Gender and Gender-based Violence in Medical and Nursing Curricula in Nicaraguan Universities. USAID ASSIST Project (2016). <https://www.usaidassist.org/resources/integrating-gender-and-gender-based-violence-medical-and-nursing-curricula-nicaraguan>
- Intégration du Genre dans l'Amélioration de la Qualité : Augmenter l'accès aux services de santé pour les femmes en milieu rural au Mali. USAID ASSIST Project (2016). <https://www.usaidassist.org/resources/int%C3%A9gration-du-genre-dans-l%E2%80%99am%C3%A9lioration-de-la-qualit%C3%A9-augmenter-l%E2%80%99acc%C3%A8s-aux-services-de>
- Strengthening integrated family planning/maternal and neonatal health postpartum services and associated health system functions in Niger. USAID ASSIST Project (2016). <https://www.usaidassist.org/resources/strengthening-integrated-family-planningmaternal-and-neonatal-health-postpartum-services>

Quality improvement

- Building Capacity for Improvement. USAID ASSIST Project (2014). <https://www.usaidassist.org/content/building-capacity-improvement>
- Cause-and-effect Analysis: A Tool for Analyzing a System or Process. USAID ASSIST Project (2014). <https://www.usaidassist.org/resources/cause-and-effect-analysis>
- Flowcharts. *Tips and Tools for Improvement*. USAID ASSIST Project (2017). https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_flowchart_may_30_ada.pdf
- Improving Health Care eLearning Course. USAID ASSIST Project (2017). <https://www.usaidassist.org/resources/improving-health-care-elearning-course>
- Improving Health Care Quality eLearning Course. Global Health eLearning Center (2015). <https://www.globalhealthlearning.org/course/improving-health-care-quality>
 - Improving Health Care training: Facilitator Guide. USAID ASSIST Project (2016). <https://www.usaidassist.org/resources/improving-health-care-training-facilitator-guide>
 - Improving Health Care training: Participant Guide. USAID ASSIST Project (2016). <https://www.usaidassist.org/resources/training-participant-guide-improving-health-care>
- Measurement – Time series charts. *Tips and Tools for Improvement*. USAID ASSIST (2017). https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_measurementtimeseries_may_30_ada.pdf
- Measures for Improvement. *Tips and Tools for Improvement*. USAID ASSIST (2017). https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_measureimprovement_may_30_ada.pdf
- Plan-Do-Study-Act cycles. *Tips and Tools for Improvement*. USAID ASSIST (2017). https://www.usaidassist.org/sites/assist/files/tipstoolsimprovement_pdsa_may_30_revised_ada.pdf
- System Modeling: A Tool for Analyzing a System or Process. USAID ASSIST Project (2014). <https://www.usaidassist.org/resources/system-modeling>

- Tools for Developing and Selecting Solutions. USAID ASSIST Project (2014). <https://www.usaidassist.org/content/tools-developing-and-selecting-solutions>
- Tools for presenting data. USAID ASSIST Project. <https://www.usaidassist.org/content/tools-presenting-data>

Knowledge management

- Documenting Learning. USAID ASSIST Project (2014). <https://www.usaidassist.org/resources/documenting-learning>
- How to Effectively Draw on the Knowledge of Everyone in the Room. Common Knowledge Associates (2012). https://www.usaidassist.org/sites/assist/files/dixon_2012_how_to_draw_on_the_knowledge_of_everyone_in_the_room.pdf
- Managing Knowledge for Improvement. USAID ASSIST Project ISQua Education Webinar (2016). https://www.usaidassist.org/sites/assist/files/isqua_webinar_managing_knowledge_for_improvement_w_notes.pdf
- Sharing Learning. USAID ASSIST Project (2014). <https://www.usaidassist.org/resources/sharing-learning>
- Synthesizing Learning. USAID ASSIST Project (2014). <https://www.usaidassist.org/resources/synthesizing-learning>

Gender-based violence

- Addressing Gender-Based Violence Through USAID's Health Programs: A Guide for Health Sector Program Officers (Second Edition). IGWG (2008). https://www.igwg.org/wp-content/uploads/2017/05/GBVGuide08_English.pdf
- Gender-based violence: A Primer. IGWG. https://www.k4health.org/sites/default/files/GBV%20A%20Primer_IGWG%20Facilitator%20Guide.pdf
- Guidance for Gender Based Violence (GBV) Monitoring and Mitigation within Non-GBV Focused Sectoral Programming. CARE (2014). http://www.care.org/sites/default/files/documents/CARE%20GBV%20M%26E%20Guidance_0.pdf
- How is GBV perpetuated at different levels? IGWG. <https://www.igwg.org/wp-content/uploads/2017/05/HowIsGBVPerpetuated.pdf>
 - Handout: Character statements. IGWG. <https://www.igwg.org/wp-content/uploads/2017/05/HandoutCharactrStatemts.pdf>
 - Handout: Ecological model. IGWG. <https://www.igwg.org/wp-content/uploads/2017/05/HandoutEcolModel.pdf>
- Myths and Realities of Gender-based violence. IGWG. <https://www.igwg.org/wp-content/uploads/2017/05/MythsRealitiesGBV.pdf>
- The Crucial Role of Health Services in Responding to Gender-Based Violence. IGWG (2010). <https://www.igwg.org/wp-content/uploads/2017/06/crucial-role-hlth-srvices.pdf>
- The Life Cycle of Gender-based Violence Against Women. IGWG. <https://www.igwg.org/wp-content/uploads/2017/05/TheLifeCycleGBV.pdf>
- Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators. IGWG (2008). <https://www.igwg.org/wp-content/uploads/2017/06/violenceagainstwomen.pdf>

People of diverse gender identities

- Gender Analysis Toolkit for Key Population HIV Prevention, Care and Treatment. (FHI 360 2017). <https://www.fhi360.org/resource/gender-analysis-toolkit-key-population-hiv-prevention-care-and-treatment-programs>
- Gender and Sexual Diversity Training from the Health Policy Project: <https://www.healthpolicyproject.com/index.cfm?id=GSDTraining>
- Gender, Sexuality, and HIV Training Module. IGWG. http://www.healthpolicyinitiative.com/Publications/Documents/1408_1_IGWG_GSHIV_Module_Oct_2010_acc.pdf
- Global Health eLearning Center course on designing HIV prevention activities for key populations: <https://www.globalhealthlearning.org/course/designing-hiv-prevention-programs-key-populations>
- Global Health eLearning Center course on National Level M&E Guidelines for working with sex workers, men who have sex with men, and transgender populations: <https://www.globalhealthlearning.org/course/m-e-guidelines-sex-workers-men-who-have-sex-men-transgender>
- Global Health eLearning Center course on Service Delivery Level M&E Guidelines for working with sex workers, men who have sex with men, and transgender populations: <https://www.globalhealthlearning.org/course/m-e-guidelines-sex-workers-men-who-have-sex-men-transgender-0>
- Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. WHO (2013). http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1
- Sexual Orientation and Gender Identity Definitions and Myths. IGWG. https://www.igwg.org/wp-content/uploads/2017/05/FG_SexOrientDefsMyths.pdf
- Shaping Our Sexualities: Gender and Sexual Norms. IGWG.
 - Facilitator Guide: https://www.igwg.org/wp-content/uploads/2017/05/FG_ShapingOurSexualities.pdf
 - Presentation: Gender, Sexuality, and HIV: So What? <https://www.igwg.org/wp-content/uploads/2017/05/GendrSexualityHIVSoWhat.ppt>
- What is Sexuality? IGWG.
 - Circles of Sexuality and Definitions: <https://www.igwg.org/wp-content/uploads/2017/05/HandoutCirclesSexualityDefs.pdf>
 - Facilitator Guide: https://www.igwg.org/wp-content/uploads/2017/05/FG_WhatIsSexuality.pdf
 - Gender, Sexuality, and HIV: So What? <https://www.igwg.org/wp-content/uploads/2017/05/GendrSexualityHIV.ppt>
 - Illustrative Program Examples Related to Gender, Sexuality, HIV: https://www.igwg.org/wp-content/uploads/2017/05/FR_IllustrativProgramExamples.pdf

Commercial sex workers

- Global Health eLearning Center course on designing HIV prevention activities for key populations: <https://www.globalhealthlearning.org/course/designing-hiv-prevention-programs-key-populations>
- Global Health eLearning Center course on National Level M&E Guidelines for working with sex workers, men who have sex with men, and transgender populations: <https://www.globalhealthlearning.org/course/m-e-guidelines-sex-workers-men-who-have-sex-men-transgender>

- Global Health eLearning Center course on Service Delivery Level M&E Guidelines for working with sex workers, men who have sex with men, and transgender populations: <https://www.globalhealthlearning.org/course/m-e-guidelines-sex-workers-men-who-have-sex-men-transgender-0>
- Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. WHO (2013). http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1

Additional resources

- Counter-trafficking in Persons: Field Guide. USAID (2013). https://www.usaid.gov/sites/default/files/documents/2496/C-TIP_Field_Guide_Final_April%205%202013.pdf
- Engaging Men and Boys in Health and Gender Equality: A global toolkit for action. UNFPA (2010). <http://www.unfpa.org/sites/default/files/pub-pdf/Engaging%20Men%20and%20Boys%20in%20Gender%20Equality.pdf>
- Gender 101: Gender Equality at USAID eLearning Course. USAID Learning Lab (2013). <https://usaidlearninglab.org/library/gender-101-gender-equality-usaid>
- Involving Men in Reproductive Health: Contributions to Development. Background paper to the report Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals. Millennium Project: Greene M. E., Mehta M., Pulerwitz J., Wulf D., Bankole A., Singh S. (2006). <https://www.faihtoactionnetwork.org/resources/pdf/Involving%20Men%20in%20Reproductive%20Health-Contributions%20to%20Development.pdf>
- Male Engagement. IGWG. <https://www.igwg.org/priority-areas/male-engagement/>
- USAID ADS Chapter 205: Integrating gender equality and female empowerment in USAID's program cycle. USAID (2017). <https://www.usaid.gov/sites/default/files/documents/1870/205.pdf>.
- USAID gender equality and female empowerment policy. USAID (2012). http://www.usaid.gov/sites/default/files/documents/1865/GenderEqualityPolicy_0.pdf

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