GUIDELINE FOR GENDER MAINSTREAMING IN HEALTH POLICIES

Ministry of Health and Mass Media, Sri Lanka

2025

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Foreword

Sri Lanka's health sector has made remarkable strides over the years, achieving strong health outcomes that surpass expectations for its income level. The country has successfully eliminated diseases like malaria, filariasis, polio, and neonatal tetanus. Life expectancy has steadily increased, reflecting improvements in healthcare access and quality. Most healthcare services, including 95% of inpatient care and 50% of outpatient care, are provided by the public sector free of charge.

However, Sri Lanka’s journey towards achieving the targets of Sustainable Development Goals by 2030 requires overcoming barriers to health services. Gender is one such barrier which is considered as a major persistent obstacle impeding equitable access and outcomes for women, men, girls and boys. As such, lowering this barrier is crucial for expanding access to health services.

In addressing the multifaceted challenges of public health, it is imperative to recognize the profound influence of gender on health outcomes, access to care, and health equity. Gender mainstreaming in health policies is not merely an aspirational goal; it is an essential approach to designing inclusive, responsive, and equitable healthcare systems that meet the diverse needs of all individuals.

This guideline serves as a resource for policymakers, providing strategic insights and actionable frameworks to integrate gender considerations into health policy formulation, implementation, and evaluation. By emphasizing evidence-based practices and intersectional approaches, it underscores the necessity of dismantling systemic barriers and promoting gender equity as a cornerstone of public health.

We stand at a pivotal moment where transformative change in healthcare is within reach. It is our hope that this guideline will empower policymakers to advance gender-responsive health policies, ensuring that no individual is left behind in the pursuit of health and well-being for all.

Dr. Asela Gunawardena

Director General of Health Services

Acknowledgements

This Guideline for Gender Mainstreaming Policies of the Ministry of Health represents a collaborative effort by the Director General of Health Services with Planning Division and Family Health Bureau of the Ministry of Health in Sri Lanka, and numerous national and sub-national stakeholders.

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Finally, our gratitude is extended to the local Data Impact Team of Vital Strategies for the enormous contribution in coordination of this procedure.

Acronyms & Abbreviations

CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
DHS	Demographic and Health Survey
FGD	Focus Group Discussions
GAM	Gender Analysis Matrix
GAQ	Gender Analysis Questions
GAT	Gender Assessment Scale
GGI	Gender Gap Index
GII	Gender Inequality Index
GRAS	Gender Responsive Assessment Scale
ICPD	International Conference on Population Development
IHD	Ischemic Heart Disease
IMMR	Indoor Morbidity and Mortality Return
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer and other sexual orientations and gender identities
KII	Key Informant Interviews
MIS	Management Information System
OECD	Organization for Economic Co-operation and Development
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization

Terms used[1]

Gender

Gender is a concept that defines the social, cultural, and behavioral differences associated with being male, female, or outside the traditional binary classifications, beyond just biological sex. It influences nearly every aspect of life, including identity, roles, relationships, and societal expectations.

Transgender

Transgender individuals are people whose gender identity differs from the sex they were assigned at birth. This identity is deeply personal and can encompass a wide spectrum, including binary (male or female) and gender diverse identities. Being transgender is not about physical appearance or medical procedures - it's about how someone identifies and experiences their gender.

Gender Mainstreaming

Gender mainstreaming is the process of integrating gender perspectives and considerations into policies, programs, and decision-making to ensure equality and address disparities. It seeks to transform systems and structures that perpetuate gender biases, fostering equitable outcomes for all.

Gender Analysis

Gender analysis is a systematic approach to understanding the differences in roles, needs, and impacts of policies or programs on individuals based on their gender. It helps identify inequalities and ensures that interventions are inclusive and equitable.

Gender Neutral

Gender neutral programs and policies ignore gender customs, responsibilities, and relations, while often supporting traditional gender-based roles that favour one sex. Gender-neutral policies treat everyone the same in the spirit of fairness, ignoring the differences in opportunities and resource allocation based on gender.

[1] WHO. Gender. Published 2010. https://www.who.int/health

Gender Sensitive

Gender sensitive programs and policies consider different gender norms, roles, and relations, but do not consider the consequences of the existing inequalities between genders. These programs and policies acknowledge that there is a problem without providing solutions.

Gender Responsiveness

Gender responsiveness refers to the practice of actively addressing and responding to the specific needs, experiences, and challenges of all genders within policies, programs, and interventions. It goes beyond acknowledging gender differences to ensuring that actions actively promote gender equality and empower marginalized groups.

Gender Specific

Gender specific programs and policies purposely target and benefit a group of women or men, or in countries where it is legal, people who are non-binary, based on their needs, gender norms, roles and relations.

Gender Transformative

Very few programs or policies are gender transformative. Gender transformative policies consider and address the differences in gender roles and norms, identifying the root causes, while simultaneously looking for ways to change them based on the specific needs of each gender.

Table of Contents

Annexures

1. Introduction to the Guideline

1.1. Background

Sri Lanka has a robust, well-structured, and long-standing system to deliver healthcare, with good health outcomes. The country has been able to achieve this on a modest budget, while being a low-income/lower-middle-income country. The state health-care provision is free of charge and the health care system is acknowledged as being efficient and equitable in many dimensions[2].

Sri Lanka has made significant strides in its health policy response, which is evident from the multitude of national health policies and action plans developed and implemented with the aim of improving the quality and safety of healthcare services across the country. Overall, Sri Lanka's health policy response demonstrates a strong commitment to improving healthcare outcomes and addressing public health challenges, but whether they address gender inequities needs inquiry.

The Constitution of the country ensures non-discrimination and guarantees formal gender equality. Female literacy rate of women (92.3%) is on par with that of men (94.3%) in year 2021 and life expectancy at birth of women (80.23 years), is more than that of men at 72.85 years[3] showing equity in these two domains. However, some gender disparities still do exist in certain areas. The Global Gender Gap Index ranks 122 (2024), seven positions behind from 2023[4]. Gender Inequality Index (GII) is a composite measure of gender inequality using three dimensions: reproductive health, empowerment, and the labour market. Sri Lanka ranks 92nd out of 191 countries on the Gender Inequality Index (2021) and 122nd out of 146 countries on Global Gender Gap Index. (2022)[5]. Although the health indicators are foremost amongst the neighboring countries, gender disparities do exist in Sri Lanka.

[2] Rajapaksa L, De Silva P, Abeykoon A, Somatunga L, Sathasivam S, Perera S et al. Sri Lanka health system review. New Delhi: World Health Organization Regional Office for South-East Asia; 2021.https://iris.who.int/bitstream/handle/10665/342323/9789290228530-eng.pdf?sequence=1

[3] Sri Lanka - Life expectancy at birth 2022 | countryeconomy.com

[4] Global Gender Gap Report 2024

[5] A Gender Equity Report Sri Lanka 2023 https://genderhealthdata.org/wp-content/uploads/2024/04/Sri-Lanka-Gender-Report-website.pdf

Lack of sex disaggregated data in some health data sources, lack of awareness of gender as a key health determinant leads to apathy with which many health disparities, remain un-noticed and disregarded in most of the health policies.

To develop effective policies, future health policies must be gender responsive.

1.2. International and National Policies

These are some of the key policies and conventions ratified by Sri Lanka relevant to gender mainstreaming:

International

i. International Conference on Population and Development (ICPD) Programme of Action (1994)[6]
ii. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW): Adopted in 1979[7].
iii. Beijing Declaration and Platform for Action (1995)[8]
iv. World Health Organization (WHO) Gender Mainstreaming Strategy 2001[9]

National

i. National Policy on Gender Equality and Gender Empowerment 2023[10]
ii. Multi-sectoral National Action Plan to address Sexual and Gender-based Violence in Sri Lanka 2024[11] (Health Sector is one of the key sectors)
iii. Women's Empowerment Act of 2024[12]

[6] https://partners-popdev.org/icpd/ICPD_POA_summary.pdf

[7] https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against women#:~:text=On%2018%20December%201979%2C%20the%20Convention%20on%20the,1981%20after%20the% 20twentieth%20country%20had%20ratified%20it.

[8] Beijing Declaration and Platform for Action
https://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf

[9] https://iris.who.int/bitstream/handle/10665/348338/WHO-EURO-2002-3968-43727-61515 eng.pdf?sequence=1&isAllowed=y

[10] https://srilanka.unfpa.org/en/publications/national-policy-gender-equality-and-womens-empowerment

[11] https://www.childwomenmin.gov.lk/uploads/common/sgbv-nap-2024-2028.pdf

[12] https://parliament.lk/uploads/bills/gbills/gazette/english/6348.pdf

1.3. Purpose of the Guideline

Gender mainstreaming is an internationally accepted strategy that aims to institutionalize gender equality across policies, programmes and projects. Given the powerful impact that gender has on the health of women and men and its intersectionality with other discriminatory factors, it is imperative that health managers and policymakers be equipped with knowledge and skills to address health inequities based on gender and integrate gender dimensions in all health policies.

At the moment, there is no institutionalized framework or guidelines providing guidance on gender mainstreaming in health policies or a formal requirement when developing health policies. This guideline and checklist are expected to fill this gap.

The purpose of this guideline is to assist health policy developers/policymakers in Sri Lanka, to strengthen the policy development process, by gender mainstreaming health policies to ensure that the health policies are gender responsive or gender transformative.

1.4. Scope

This guideline attempts to provide a simple outline of steps to be taken to ensure that the Policy being developed is gender mainstreamed using the tools developed by WHO for gender mainstreaming. Brief description of topics such as gender, gender and health and gender mainstreaming are included to ensure conceptual clarity and for policymakers to be on the same page on the topic of gender mainstreaming.

Objectives of the Guideline

General Objective:

To facilitate mainstreaming Gender in health policies of Sri Lanka

Specific Objectives:

1. To provide an understanding of the process of gender mainstreaming and the significance of gender disaggregated data in this process
2. To give guidance in doing a gender analysis prior to the development of any policy
3. To offer explicit direction on the procedures for incorporating gender considerations into new policies that will be developed in the future
4. To provide guidance to conduct a gender analysis of existing policies and ensure that they are gender mainstreamed whenever revised

2. Methodology

Development of this guideline followed the following steps:

- An inception paper with detailed methodology was developed and shared with all relevant stakeholders and thereafter presented at a multistakeholder consultation and consensus reached.

- Desk review of available global resources relevant to integrating gender in health policy was done and the following were shortlisted:
    - Gender Mainstreaming for Health Managers: a practical approach: Facilitator guide. WHO 2022[13]
    - Tools for assessing gender in health policies and programs (Health Policy Project USAID) 2014[14]
    - Gender mainstreaming a global strategy for achieving gender equality & the empowerment of women and girls: gender mainstreaming[15] (UN Women)
    - Gender analysis in health A review of selected tools Department of Gender and Women's Health[16]
    - Handbook on Gender Mainstreaming for Gender Equality Results[17]
    - Toolkit for Mainstreaming and Implementing Gender Equality 2023 (OCED)[18]

- Of these documents, Gender Mainstreaming for Health Managers: a practical approach: Facilitator Guide developed by WHO was selected and contextualized for use in Sri Lanka.

[13] WHO updates its widely-used gender mainstreaming manual 2022 WHO updates its widely-used gender mainstreaming manual

[14] Health Policy Project. 2014. Tools for Assessing Gender in Health Policies and Programs. Washington, DC: Futures Group, Health Policy Project ISBN: 978-1-59560-098-1 Gender Health Assessment Tools for Policies & Programs - Gender & Health Hub

[15] Gender mainstreaming: a global strategy for achieving gender equality & the empowerment of women and girls UNWOMEN https://unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/Gender-mainstreaming-Strategy-for-achieving-gender-equality-and-empowerment-of-women-girls-en.pdf

[16] Gender analysis in health A R E V I E W of S E L E C T E D T O O L S Department of Gender and Women's Health World Health Organization https://iris.who.int/bitstream/handle/10665/42600/9241590408.pdf?sequence=1&isAllowed=y

[17] Handbook on Gender Mainstreaming for Gender Equality Results/UN Women/2022

[18] Toolkit for Mainstreaming and Implementing Gender Equality 2023 Organisation for Economic Co-operation and Development(OCED) https://www.oecd.org/en/publications/toolkit-for-mainstreaming-and-implementing-gender-equality-2023_3ddef555-en.html

- Using the selected tools three policies out of 25 policies (>10%) available in the Health Ministry website were analyzed and assessment completed. This experience was used in the development of this guideline.

- A series of stakeholder meetings were held as the next step, as stakeholder meetings are essential before developing and implementing gender mainstreaming policies to gather information and for situational analysis. Six Key Informant Interviews (KII) and three Focus Group Discussions (FGD) were held for this purpose. KIIs were conducted with the relevant stakeholders including policymakers and Health and Programme Managers. FGDs were conducted with key stake holders, engaged in the process of health policy development, engaged with gender issues, and with multi stake holders including gender stakeholders, officials of the Ministry of Health, other government Ministries and departments, professional colleges, academia, UN agencies and activists of gender rights.

- Incorporating the findings of the desk review and the stakeholder meetings, this guideline with the checklist that should be used in developing health policies in the future was formulated.

3. Introduction to gender mainstreaming

Gender mainstreaming is a strategy or process aimed at integrating a gender perspective into all stages of policymaking, planning, implementation, and evaluation. The goal is to ensure that the concerns and experiences of all genders are considered and addressed, promoting equality and preventing discrimination.

3.1. Gender

Sex and gender are integrally related and influence health in different ways. Sex refers to 'the different biological and physiological characteristics of females, male persons, such as chromosomes, hormones and reproductive organs', whilst gender refers to 'the socially constructed characteristics of women, men, girls and boys and other gender identities'[19]. This includes norms, roles and behaviors associated with being a woman, man, girl or boy, or transgender as well how social relationships with each other are conducted[20]. It is not solely defined by biological differences but is heavily influenced by cultural, social, norms that existed in the respective society at the time. These gender norms and roles are codified in traditions, practices and even in some laws influencing everything from career choices to interpersonal relationships.

The impact of gender on individuals and society is profound. Gender stereotypes and discriminatory practices affect the choice of education, employment, healthcare, and fulfilling expectations of the individuals. Addressing gender-based disparities requires comprehensive strategies that promote equity, equality and inclusion.

Gender is often confused with biological sex, which only refers to the anatomical and physiological characteristics that distinguish male and female bodies. The distinction between sex and gender is crucial for recognizing gender issues related to health matters using and based on sex disaggregated data.

As it is a social construct, gender varies from society to society and can change in the same society over time.

In summary, gender influences societal roles, access to resources, decision-making, and overall opportunities, shaping the experiences of individuals and communities. For

[19] Gender and health (WHO); https://www.who.int/health-topics/gender#tab=tab_1

[20] Gender and health (WHO); https://www.who.int/health-topics/gender#tab=tab_1

policymakers, understanding gender is essential to addressing structural inequalities, reducing biases, and fostering inclusive policies. By integrating gender perspectives into decision-making processes, policies can better reflect the diverse realities of populations, promote equity, and contribute to more effective and just outcomes across men women, boys and girls and all gender identities and sexual orientations.

3.2. Gender and Health

The intersection of gender and health recognizes that gender, along with other social determinants, shapes health outcomes through differential exposure to factors like material resources, psychosocial stress, and behaviors, leading to health inequalities and disparities.

Gender significantly shapes health outcomes by influencing societal roles, responsibilities, choices and access to resources. It affects how individuals interact with healthcare systems and experience health interventions.

Gender influences exposure to health risks, and responsiveness of health systems. For example, women may face barriers to reproductive health services such as buying condoms or access to safe abortion, while men might experience stigma around seeking mental health support or using screening programmes for prostatic or bowel malignancies.

Gender diverse individuals often face discrimination in healthcare, discouraging them from seeking care for mental health issues, suicidal thoughts, or STIs, which are common in the LGBTQ+ community[21].

For health policymakers, understanding gender is crucial to address these disparities, reducing inequities, and fostering inclusive healthcare strategies and activities. By integrating gender perspectives into policies, policymakers can ensure equitable access to health services, improve health outcomes for diverse populations, and create systems that promote fairness and empowerment across all men, women, girls, boys and other gender identities and sexual orientations.

Research highlights how societal expectations around masculinity and femininity (gender norms) shape health behaviors. For instance, men may engage in riskier

[21] Front. Sociol., 23 August 2024,Sec. Medical Sociology,Volume 9 - 2024

behaviors due to societal pressures, while women might face barriers to accessing healthcare due to their domestic caregiving responsibilities[22].

Thus, gender needs to be considered in developing health policies as a social variable that has far-reaching impacts on health, but objective analysis is needed to understand the different effects of gender from the effects of biological sex and other biological variables[23].

Addressing this difference is vital for developing equitable health policies and programs that cater to the diverse needs of all gender groups, ensuring improved health outcomes and access for everyone.

3.3. Intersectionality

Gender must not be seen in isolation from other factors of social stratification. Gender cuts across other social factors that lead to health inequities such as socioeconomic status, ethnicity, age or place of residence. Gender norms, roles and relations should always be understood as interacting with these other factors. This concept is called intersectionality[24]. Therefore, rather than treating gender as a single, isolated factor, intersectionality reveals the complexities of how gender operate alongside other social categories in influencing one's life.

For instance, the experiences of a woman may differ significantly based on her ethnicity, economic background, or sexual orientation. This framework challenges one-size-fits-all approaches to social justice related to health outcomes by emphasizing that people face complex and multifaceted challenges. In practice, intersectionality underscores the importance of inclusive approaches to addressing gender inequality. Policies focusing solely on "women" as a homogenous group risk overlook the distinct barriers faced by marginalized subgroups, such as women of various ethnicities, LGBTQ+ women, or women with disabilities. Intersectional policies, therefore, insist on nuanced strategies that address the multifaceted nature of gendered experiences.

[22] Bottorff, J.L., Oliffe, J.L., Robinson, C.A. et al. Gender relations and health research: a review of current practices. Int J Equity Health 10, 60 (2011). https://doi.org/10.1186/1475-9276-10-60

[23] Elizabeth Barr, Ronna Popkin, Erik Roodzant, Beth Jaworski, Sarah M Temkin, Gender as a social and structural variable: research perspectives from the National Institutes of Health (NIH), Translational Behavioral Medicine, Volume 14, Issue 1, January 2024, Pages 13–22, https://doi.org/10.1093/tbm/ibad014

[24] NAM, Health Inequities, Social Determinants, and Intersectionality,Social Determinants of Health, Discussion paper,December 2016

By adopting an intersectional perspective, we gain a deeper understanding of social inequalities and develop policies where equity is truly achieved.

3.4. Sex disaggregated data and gender analysis

Biological sex and gender are fundamental aspects of health and wellbeing. Yet, many policies fail to consider biological sex or gender differences, and even when they do, this is often limited to merely including statistical information in the policy.

Gender analysis is a systematic methodology for examining the differences in roles and norms for women and men, girls and boys; the different levels of power they hold; their differing needs, constraints, and opportunities; and the impact of these differences in their health and wellbeing (in this context)

Sex and age disaggregated data and gender analysis of such data serve as the backbone for understanding and addressing the disparities and inequalities that exist between genders across various sectors, particularly health. By systematically analyzing differences in health experiences and outcomes between men, women, and other gender groups based on gender, policymakers can develop strategies to foster a fair and inclusive society delivering universal access to health care.

Sex and age disaggregated data helps to reach an understanding of how different genders experience issues such as access to resources, healthcare, and education which lead to health disparities and inequitable health care delivery deliberately or often unknowingly unintentionally.

3.5. Gender analysis and gender mainstreaming.

Gender analysis and gender mainstreaming are interconnected concepts that play a crucial role in shaping health policies to ensure equity and equality.

As defined by the United Nations, gender mainstreaming is:

"… the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally, and inequality is not perpetuated[25]."

Gender mainstreaming is not only a question of social justice but is necessary for ensuring equitable and sustainable human development by the most effective and efficient means.

Gender mainstreaming is the process of integrating gender perspectives into all stages of policymaking, planning, and implementation with the objective of ensuring that all health policies address the needs of all genders: men women and other gender identities.

The gender analysis provides insights needed to inform the policymakers of the specific challenges and needs of different genders and through gender mainstreaming, health policies can be designed to promote equality and improve health outcomes for men, women and other gender identities.

[25] The Report of the Economic and Social Council for 1997. United Nations, 1997.

4. Gender Mainstreaming the Proposed Policy: Based on the WHO tools

Gender mainstreaming ensures that the concerns and experiences of all genders are considered and addressed, in all stages of policymaking, planning, implementation, and evaluation. This prevents discrimination and promotes equity and equality of the intended health outcomes of the policy.

Conduct gender analysis of the health condition relevant to the policy

4.1. Conduct a Situational Analysis

A situational analysis should be conducted before initiating gender analysis of the relevant health condition. Information including sex disaggregated data relevant to the health condition being analyzed should be collated before the application of WHO tools for gender mainstreaming. Accurate information from a range of sources can contribute to gain insight into the health condition/issue being analysed.

These sources include:

- Data from secondary and published sources;
- Rapid appraisals using both quantitative and qualitative methods such as gathering health service–based data (MIS) or interviewing major stakeholders;
- Condition-specific expertise on its epidemiology and ways of transmitting, preventing and diagnosing and treating it;
- Studies of knowledge, attitudes and behaviours;
- Consultations with local women, men and health care providers;
- Reports from nongovernmental organizations;
- Data from regions or countries with similar demographic, cultural, political and economic contexts.

Methodology of Situation Analysis:

I. Conduct a Desk Review to:

   Review National and International conventions related to gender equality and non-discrimination, where the Sri Lankan government has ratified and is committed to. Some of these documents are listed in the earlier section.

   Collection of information relevant to the topic using the above sources. Collation of sex disaggregated data would be a challenging task due to the lack of published national level sex disaggregated data, but most of the raw data available in the MISs of different directorates and programmes may contain some of these. Sources such as IMMR, Annual Health Bulletin, Annual Reports of programmes, Sri Lanka Census Data, Women's Wellbeing Survey data, DHS, often have sex disaggregated data. If not, policymakers need to rely on published research data on the topic.

II. Conduct Stakeholder meetings to gather information from the above-mentioned sources.

III. The formulating and consultative methodologies need to include gender experts and other stakeholders working in the area of gender equality.

4.2. Application of WHO tools for Gender Analysis of the Health Condition

Usually formulated as questions, gender analysis tools guide one through a systematic process of examining the influence of gender-based differences and inequality on health. The reasons behind gender-based differences in health are often difficult to uncover by using traditional health analysis methods. Conducting gender analysis is, in many ways, like tending a garden. What appears on the surface neither adequately reflects the complexity of the intertwining roots beneath nor reflects the stronghold these roots may have in the soil. Gender analysis is a similar process. Things must be examined in a bottom-up manner, understanding the realities of local populations before moving up to national and international levels to understand the root causes of how and why power, rights and access to important health-related resources are distributed unequally among sub populations.

This guideline attempts to introduce application of WHO tools for gender analysis. The gender analysis process using WHO tools has five main steps which must be completed using four WHO Gender Mainstreaming tools.

Step 1

4.2.1. Application of Gender Analysis Questions (GAQ) – Tool No. 1

This Tool designed by WHO is a very user friendly and simple tool and recommended to be used as the first step. Gender Analysis Questions (GAQ) is annexed in this guideline (Annexure 1).

The tool uses 8 key questions with many supplementary questions covering key dimensions of the topic which will help to identify different gender perspectives of the topic. These questions are widely open but, in this exercise, policymakers need to answer them from a gender perspective looking through a gender lens. The policymaker should understand how the experiences differ among men, women, boys, girls and other gender identities, and recognize their implications to proceed with the development process.

The key questions are:

I. What is the illness, disease or health condition of interest?
II. When does this condition occur?
III. Where does this condition occur?
IV. Who gets ill?
V. What are the people affected by the condition doing about it?
VI. How do access to and control over resources affect the provision of care?
VII. How do health services meet the needs of the men and women and other gender identities affected by this condition?
VIII. What are the predominant health and social outcomes of this condition?

Three sample applications of the WHO "Gender Analysis Questions" (GAQ) for 3 health topics (Case Studies) are annexed with this guideline (Annexures 5,6, and 7). These sample applications would be able to provide guidance to the policymakers/policy developers on gender analysis using this tool.

Step 2

4.2.2. Completion of Gender Analysis Matrix (GAM) using the findings of the GAQ – Tool No. 2

The GAM (Annexure 2) is a simple way of presenting the findings of the analysis to cluster the factors that influence the condition/issue under three headings: Biological factors, Socio-cultural factors and Access to and Control over Resources. Biological factors will identify those which are mostly related to biology and are addressed in the traditional manner. Then again, in any society the last two are clearly related and often defined by the gender norms, roles and relations. These factors are considered at six dimensions to recognise the gender dimensions that need to be addressed in the policy.

These dimensions are:

1. Risk factors and vulnerability
2. Access and use of health services
3. Health seeking behaviour
4. Treatment options,
5. Experiences in Health Care Settings
6. Health and Social Outcomes and Consequences

Attention should be focused on the findings of the analysis and utilised in the development of the policy.

The GAM provides a clustered format for the answers to the GAQ and can also point out where further work is needed to fully understand what is happening with a particular health condition.

Overlap or duplication between questions –

The questions dealing with sociocultural factors and access to and control over resources sometimes overlap or are duplicated. This is acceptable if the information is reflected somewhere in the Matrix, so that it can form part of the policies which would be developed based on this information.

All the boxes do not have to be filled in -

All the boxes in the Matrix do not have to be filled in to make the analysis complete. The column on biological differences, for example, often has only a few boxes filled in. When this happens, it could mean the following:

- Sociocultural factors have more explanatory power than biological factors for that particular health condition;
- No evidence is available to answer the question at the time;
- More consultations needed with other experts or stakeholders;
- More research and evidence may be needed.

Two sample applications of the WHO "Gender Analysis Matrix" (GAM) for two health topics are included in the annexes for this guideline (Annexures 8,9). These sample applications would be able to provide guidance to the Policymakers/Developers on the utilization of this tool.

Step 3

4.2.3. Development of the Policy responding to the findings of GAM

The policy can be developed in the usual manner with the findings summarized in the GAM taken into account by the policy developers. The whole process of gender mainstreaming will be easy and effective by having a gender expert included in the team developing the policy. If there are limitations in accessing a gender expert, consultation and seeking assistance from the Gender and Women's Health Unit of the Family Health Bureau is recommended.

Step 4

4.2.4. Introduction of WHO Gender Responsive Assessment Scale (GRAS) – Tool No. 3

For a policy or programme to be gender-responsive, it must fulfill two basic criteria:

- Gender norms, roles and relations are considered; and
- Measures are taken to actively reduce the harmful effects of gender norms, roles and relations – including gender inequality.

The ***Gender Responsive Assessment Scale (GRAS)***, includes five levels, two of which hinder the achievement of gender equality and health equity (Annexure 3). The third level, gender sensitivity, is the turning-point - when policies or programmes recognize the important health effects of gender norms, roles and relations. Only when a policy or programme is gender-sensitive can it be either gender-specific (level 4) or gender-transformative (level 5) – where the real action begins.

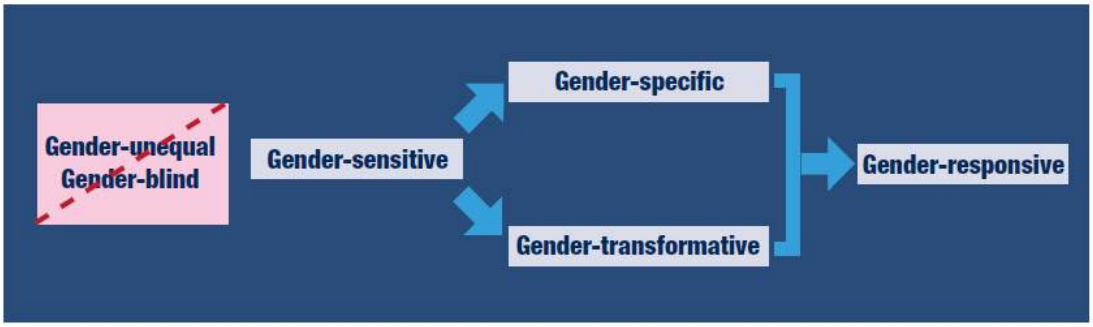

Figure 1: Gender Responsive Assessment Scale (GRAS)

The five levels of Gender Responsive Assessment Scale[26] (GRAS) –

Level 1: Gender-unequal

- Perpetuates gender inequality by reinforcing unbalanced norms, roles and relations privileges men over women (or vice versa). Often leads to one sex enjoying more rights or opportunities than the other.

[26] Gender Mainstreaming for Health Managers – A Practical Approach, WHO, 2011

This level is not recommended as it perpetuates gender inequalities.

Level 2: Gender-blind

- Ignores gender norms, roles and relations. Very often reinforces gender-based discrimination. Ignores differences in opportunities and resource allocation for women and men. Often constructed based on the principle of being "fair" by treating everyone the same

This level ignores gender dimensions and is not recommended.

Level 3: Gender-sensitive

- Considers gender norms, roles and relations. Does not address inequality generated by unequal norms, roles or relations. Indicates gender awareness, although often no remedial action is developed.

This level is the turning point, but although it considers gender norms, roles and relations, no remedial action is taken.

Gender Responsiveness:

The next 2 levels come under Gender Responsiveness. Gender Responsiveness considers gender norms, roles and relations and addresses them in the policy. This is what a policy should be. There are two levels within gender responsiveness.

Level 4: Gender-specific

- Considers gender norms, roles and relations for women and men and how they affect access to and control over resources. Considers women's and men's specific needs. Intentionally targets and benefits a specific group of women or men to achieve certain policy or programme goals or meet certain needs. Makes it easier for women and men to fulfill duties that are ascribed to them based on their gender roles.

This level is recommended.

Level 5: Gender-transformative

- Considers gender norms, roles and relations for women and men and that these affect access to and control over resources. Considers women's and men's specific needs. Addresses the causes of gender-based health inequities. Includes ways to transform harmful gender norms, roles and relations. The objective is often to promote gender equality. Includes strategies to foster progressive changes in power relationships between women and men.

This is the most desired level

4.2.5. Application of WHO Gender Assessment Tool (GAT) – Tool No. 4

After the development of the policy responding to the findings of GAM, this tool could be applied to evaluate the success of gender mainstreaming efforts. This tool comprises of 23 questions with a simple scoring system can now be applied to the developed policy (Annexure 4). This tool can also be applied to an existing policy at the time of reviewing or revising the policy in order to gender mainstream an existing policy.

The tool as given in the Annexure 4 is simple, self-explanatory and categorizes the policy from a gender angle as Gender – unequal, blind, sensitive, specific or transformative.

The GAT is a rapid assessment tool to determine which GRAS level the Policy is within. The GAT supports the user to easily indicate where things may be on track or where it is not. In particular, if the answer to the majority of questions 1 – 18 is 'yes', it reflects that the policy is gender-responsive and therefore either gender-sensitive, gender-specific or gender-transformative. Further analysis will be required to determine which GRAS level applies to the policy – in particular to distinguish between gender-sensitive (not action oriented) and gender-specific or transformative – where true gender planning and actions occur. If the answer to the majority of questions 19 – 23 is 'yes', the policy may be either gender-blind or gender unequal – and is therefore not gender-responsive.

The GAT can be utilised to gauge whether a policy is at least gender sensitive – and then refer to the gender checklist as a guide for some suggested corrective actions.

Step 5

4.2.6. Making necessary changes and finalizing the Policy

Based on this analysis the proposed/developed policy could be revisited to upscale the policy to be gender responsive (gender specific or gender transformative).

5. Check List for Ensuring Gender Mainstreaming in Health Policies

		Yes	No	Not Relevant/ Uncertain
01.	Was sex and age disaggregated data collected from multiple sources?			
02.	Was data disaggregated by sex and age collected on mortality, morbidity, survival rates and, disability from the health-related topic concerned?			
03.	Was data collected on the concerned topic by health determinants such as ethnicity, rural/urban, poverty level etc.			
04.	Were the International and National policies related to Gender such as “National Policy on Gender Equality and Women's Empowerment" taken into consideration in developing this policy?			
05.	Was the National “Guideline for Gender Mainstreaming in Health Policies” referred to and used in the policy development process?			
06.	Was a gender analysis (on the health topic to be addressed by the policy) done, using sex and age-disaggregated data, utilizing the four tools mentioned in the guideline?			
07.	Does the team developing the policy have both male and female team members?			
08.	Has existing knowledge on gender norms, roles and relations used in gender analysis?			
09.	Was a Gender Expert/s involved in the policy development process?			
10.	Does the language describe the Scope, Vision and Target Audience in the policy articulate inclusivity and equality of men, women, boys, girls and gender diverse identities?			

		Yes	No	Not Relevant/ Uncertain
11	Was attention focused on diversity among men, women, boys, girls and other gender identities and sexual orientation when determining goals, objectives, strategies and activities?			
12.	Does at least one goal, objective or strategy explicitly address gender equality or gender as a determinant of health? (as identified in the gender analysis)			
13.	Were needs of men, women, girls and boys and diverse gender identities and sexual orientation considered when targeting activities towards the particular needs of the group that may have a higher burden of the disease or whose health may be more vulnerable?			
14.	Does this process involve women and men in design phases, as beneficiaries and as programme staff members in implementation?			
15.	Have process and outcome indicators included in monitoring and evaluation frameworks and activities ensure that they are disaggregated by sex and age? (as a minimum and where appropriate).			

Annexures

Annexure 1

WHO Gender Analysis Questions (GAQ) – Tool No. 1

1. What is the illness, disease or health condition of interest?

- Is it an acute or chronic condition?
- Is it a communicable or a non-communicable condition?
- What are the risk factors for this condition?
- Are they different for women and men, boys and girls?

2. When does this condition occur?

- Does it occur at any specific time in the life course?
    - Can biological factors explain increased vulnerability of the affected individual and/or group during this period? Which ones?
    - Can sociocultural factors explain increased vulnerability of the affected individual and/or group during this period? Which ones?
    - Which gender norms, roles and relations during this period may explain increased vulnerability?
- Is vulnerability increased at any specific time of the year?
    - Around or during a particular season (that is, related to climate)? Around crop time?
    - Are there any particular activities that men or women carry out at this time that may increase their vulnerability?

3. Where does this condition occur?

- Is it in rural or urban contexts?
    - Does this have different implications for groups of women or men, boys or girls?
- Is it linked to any particular factor in the social or physical environment?
    - Does it occur in the workplace, school settings, in the field or at home?
    - Do cases occur in places where either women or men tend to go or may be more numerous?
    - Do these women or men belong to a particular sociocultural group (economic, political or otherwise)?

4. <u>Who gets ill?</u>

- Can biological factors explain why women, men, girls or boys are affected differently by this condition?
    - Does the sex of the individual increase the risk for or vulnerability to this condition? How?
    - Do age or other physiological factors, such as hormone levels, matter? How?
- What are the specific gender norms, roles or relations of the community in question that may increase the risk for or vulnerability to this condition?
    - Do these norms affect men and women similarly or differently?
    - Does the affected group belong to a particular socioeconomic, ethnic or marginalized group?
    - Do the daily activities of women or men affect the risk for and vulnerability to this condition? If so, what kind of activities (paid or unpaid) increase risk, and who is responsible for carrying these out?
    - Do access to and control over resources affect the risk of and vulnerability to this condition?
    - Does the level of individual or community empowerment influence the risk for and vulnerability to this condition?
- Is this different for women, men, boys and girls?
    - Do educational opportunities influence the risk for and vulnerability to this condition?
    - Is this different for boys and girls in the target population? How?
    - Do paid employment opportunities influence the risk for and vulnerability to this condition?
    - Is this different for women and men in the target population? How?
    - Do women's and men's household, community and workplace responsibilities influence the risk for and vulnerability to this condition?

5. What are the people affected by the condition doing about it?

- Are both women and men seeking services appropriately for this condition?
    - Who is attending health services for treatment? Women? Men? Certain age groups? Certain Socio-economic groups?
    - Who is consulting traditional healers or seeking alternative therapies for this condition?
    - Women? Men? Certain age groups? Certain socioeconomic groups?
- Do biological factors affect health-seeking behaviour related to this condition? How?

- Are these factors different for men and women? How?
- Do sociocultural factors affect health-seeking behaviour related to this condition? How?
  - Are these factors different for women and men? How?
- Do gender norms, roles or relations affect women's or men's willingness or ability to recognize that they are ill and/or to seek treatment? How?
  - How do women's and men's access to and control over resources affect their willingness or ability to recognize that they are ill and/or to seek treatment?
  - Do women have the ability to decide to seek treatment on their own?

6. How do access to and control over resources affect the provision of care?

- Is health services facility-based or provided in the community? Or both?
  - Does the site of service delivery exclude any particular group? Which one? For what reasons?
- Does access to and control over resources affect the type of health services received for this condition? How?
- Do women and men have the resources necessary to seek and use available health services for this condition?
- Do they have access to these resources to seek health services? Is access different for women and men?
  - Can they make or influence decisions about the use of these resources to seek health services?
  - Is decision-making different for men and women?
  - If women and men have different access to and control over resources, how does this affect their experiences with health services? Does such a difference affect the quality of care received?
  - Does access to and control over resources affect treatment options? How? Is this different for women and men?
- Do women or men in the affected group have specific types of financial or social vulnerability that may affect their ability to access and use health services?
  - Is this vulnerability worsened by age, ethnic or religious affiliation, sexual orientation or other factors?
- If the affected population does not have the resources necessary, what networks or facilities are available to them for support?
  - Do these differ for women and men?
- Are user fees affordable for this condition?
  - Do they differ for men and women of different groups? How?

- Are there any individual, indirect costs related to accessing health services, such as transport or child care, that may affect women and men differently?
- Do health insurance schemes have different eligibility criteria for women and men?
    - Do health insurance schemes include the services necessary to address this condition? Are there differences according to employment, marital or other status? If so, how does this affect women and men?
    - Do health insurance schemes include coverage for medicines and access to additional services, such as mammography or voluntary HIV counselling and testing? Are there essential services for this condition that health insurance does not cover?
    - If health insurance schemes do not exist and health services are not offered free of charge, how are low-income women and men accessing health services?
    - What individual or community strategies are used?
    - Are these different if the patient is male or female? How?
- What are the opportunity costs (such as lost opportunities for income generation) for seeking and accessing care?
    - Are these different for women and men?

7. <u>How do health services meet the needs of the men and women affected by this condition?</u>

- Do biological factors influence treatment options, uptake and adherence?
    - Do these differ for women and men of different groups (including age)? How?
- Do sociocultural factors influence treatment options, uptake and adherence?
- Are these different for women and men of different groups (including age)? How?
    - Are women's and men's different roles considered in treatment options for this condition?
- Are gender norms and relations considered? How?
    - What consequences may be incurred in treating this condition if gender norms, roles and relations are not considered?
- Are health workers generally aware of the different ways men and women of different ages can express their symptoms when suffering from this condition?
- Do women and men have different experiences with health services for this condition? What kinds? For what reasons?
    - Do experiences in health care settings differ by age, marital status, sexual orientation, ethnic or religious affiliation, socioeconomic status or other factors? How and for which groups?

8. <u>What are the predominant health and social outcomes of this condition?</u>

- As a result of this condition, are there differences (between women, men, girls and boys), in recovery, disability or mortality?
  - Are these outcomes influenced by sex or age?
  - Are these outcomes influenced by gender norms, roles or relations? Are the influences different for women and men?
  - What are the broader social effects of these outcomes?

Health and social outcomes and consequences

- Who (other than the immediate patient) is also affected? Children? Partners? Families? Communities? In what ways?
  - How do these effects vary if the affected person is a woman or man?
- Do the sociocultural characteristics and consequences of the condition differ for women and men, such as the division of responsibilities in the household, employability, stigma or divorce?
- Who else provides care (outside the health care system) for this condition?
  - What are the opportunity costs for this caretaking work?
- Do these differ for men and women?
  - How are men and women coping with the effects of this condition?
- How does sex, or other biological factors, affect the coping strategies for this condition?
- How do gender norms, roles and relations affect the coping strategies for this condition?
  - Do access to and control over resources matter when coping with this condition?
  - Do these differ for men and women? How?

Annexure 2

WHO Gender Analysis Matrix (GAM) – Tool No. 2

Factors that influence health outcomes: *Health related considerations*	Factors that influence health outcomes: *Gender-related considerations*		
	Biological factors	Socio cultural factors	Access to and control over resources
1. Risk factors and vulnerability			
2. Access and use of health services			
3. Health seeking behaviour			
4. Treatment options			
5. Experiences in health care settings			
6. Health and social outcomes and consequences			

Annexure 3

WHO Gender Responsive Assessment Scale (GRAS) –Tool No. 3

GRAS Classification Table

Level	Assessment	Comments
Gender Unequal		
Gender Blind		
Gender Sensitive		
Gender Specific		
Gender Transformative		

Annexure 4

WHO Gender Assessment Tool (GAT) – Tool No. 4

Objective: ***To determine the gender-responsiveness of a Policy***

Scoring hints:

In particular, if you answered yes to the majority of questions 1 – 18, you can consider your programme gender-responsive and therefore either gender-sensitive, gender-specific or gender-transformative. Further analysis will be required to determine which GRAS level applies to your programme or policy - in particular to distinguish between gender-sensitive (not action oriented) and gender-specific or transformative - where true gender planning and actions occur.

If you answered yes to the majority of questions 19 – 23, your programme may be either gender-blind or gender unequal – and is therefore not gender-responsive.

No may indicate gender-blindness.

Yes, may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

	Yes	**No**
1. Do the vision, goals or principles have an explicit commitment to promoting or achieving gender equality? **Scoring hints:** No may indicate gender-blindness. Yes may indicate that the programme is gender sensitive, gender specific or gender transformative.		
2. Does the policy or programme include sex as a selection criterion for the target population? **Scoring hints:** No may indicate gender-blindness. Yes may indicate that the programme is gender sensitive, gender specific or gender transformative.		
3. Does the policy or programme clearly understand the difference between sex and gender? **Scoring hints:** No may indicate gender-blindness. Yes may indicate that the programme is gender sensitive, gender specific or gender transformative.		
4. Does the target population purposely include both women and men? **Scoring hints:** No may indicate gender-blindness. No may also indicate the programme is gender-specific if either sex is addressed in the context of broader gender norms, roles and relations. Yes may indicate that the programme is gender-sensitive or gender-transformative.		

	Yes	No
5. Have women and men participated in the following stages? • Design • Implementation. • Monitoring and evaluation **Scoring hints:** No may indicate that the programme or the specific stage of programming is gender-blind or gender-unequal. Yes may indicate that the programme or the specific stage of programming is gender-sensitive, gender-specific or gender transformative.		
6. Have steps been taken to ensure equal participation of women and men? **Scoring hints:** No may indicate that the programme is gender-blind or gender-unequal. No could also indicate gender-specificity if one sex is targeted in the context of broader gender norms, roles and relations. Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		
7. Do both male and female team members have an equal role in decision-making? **Scoring hints:** No may indicate that the programme is gender-unequal or gender-blind. Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative		
8. Does the policy or programme consider life conditions and opportunities of women and men? **Scoring hints:** No may indicate that the programme is gender-blind. Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		
9. Does the policy or programme consider and include women's practical and strategic needs? **Scoring hints:** No may indicate that the programme is gender-blind or gender-unequal. Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		
10. Have the methods or tools been piloted with both sexes? No information **Scoring hints:** No may indicate that the programme is gender-blind, gender-unequal or gender-specific. Yes may indicate that the programme is gender-sensitive or gender-transformative..		
11. Does the policy or programme consider family or household dynamics, including different effects and opportunities for individual members, such as the allocation of resources or decision-making power within the household? **Scoring hints:** No may indicate that the programme is gender-blind or gender-unequal. Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		

	Yes	No
12. Does the policy or programme include a range of stakeholders with gender expertise as partners, such as government affiliated bodies, national or international non-governmental organizations or community organizations? **Scoring hints:** No may indicate that the programme is gender-blind. Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		
13. Does the policy or programme collect and report evidence by sex? **Scoring hints:** No may indicate that the programme is gender-blind or gender-unequal. Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		
14. Is the evidence generated by or informing the policy or programme based on gender analysis? **Scoring hints:** No may indicate that the programme is gender-blind or gender-unequal. Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		
15. Does the policy or programme consider different health needs for women and men? **Scoring hints:** No may indicate that the programme is gender-blind, gender-unequal or gender-specific (if one sex is targeted). Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		
16. Does the policy or programme include quantitative and qualitative indicators to monitor women's and men's participation? **Scoring hints:** No may indicate that the programme is gender-blind or gender-unequal. Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		
17. Does the policy or programme consider gender-based divisions of labour (paid versus unpaid and productive versus reproductive)? **Scoring hints:** No may indicate that the programme is gender-blind or gender-unequal. Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		
18. Does the policy or programme address gender norms, roles and relations? **Scoring hints:** No may indicate that the programme is gender-blind or gender-unequal. Yes may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.		

	Yes	No
19. Does the policy or programme exclude (intentionally or not) one sex but assume that the conclusions apply to both sexes? **Scoring hints:** No may indicate that the programme is gender-sensitive, gender-specific or gender-transformative. Yes may indicate that the programme is gender-blind or gender-unequal.		
20. Does the policy or programme exclude one sex in areas that are traditionally thought of as relevant only for the other sexes as maternal health or occupational health? **Scoring hints:** No may indicate that the programme is gender-sensitive, gender-specific or gender-transformative. Yes may indicate that the programme is gender-blind or gender-unequal.		
21. Does the policy or programme treat women and men as homogeneous groups when there are foreseeable, different outcomes for subgroups, such as low-income versus high-income women or employed versus unemployed men **Scoring hints:** No may indicate that the programme is gender-sensitive, gender-specific or gender-transformative. Yes may indicate that the programme is gender-blind or gender-unequal.		
22. Do materials or publications portray men and women based on gender-based stereotypes? **Scoring hints:** No may indicate that the programme is gender-sensitive, gender-specific or gender-transformative. Yes may indicate that the programme is gender-blind or gender-unequal.		
23. Does the language exclude or privilege one sex? **Scoring hints:** No may indicate that the programme is gender-sensitive, gender-specific or gender-transformative. Yes may indicate that the programme is gender-blind or gender-unequal.		

Annexure 5

Case Study 1 -

Use of GAQ to conduct a gender analysis of "Patient Safety"

Introduction:

Patient safety is a global concern for all healthcare providers, as well as to the public. Sri Lanka is no exception, and attention has been drawn to this subject, often sporadically, following an adverse incident[27]. In 2016, the Directorate of Healthcare Quality and Safety (DHQS) introduced guidelines on adverse event reporting, with the objective of facilitating the development of a formal reporting system to be used to improve patient safety.

The DHQS iterates its responsibility as "Research for quality improvement and patient safety" as one of its key functions[28]. The circular letter issued in 2013[29] initiated the programme of monitoring identified indicators of health care quality and safety under 20 broad topics (areas/activities). The circular on clinical indicators of health quality and safety was issued in 2017[30], to report on them which covered four main specialties - Surgery, Medicine, Obstetrics & Gynecology and Pediatrics.

Situation Analysis on Health care and Patients Safety

Global literature

Significance of Patient Safety issues is well recognized at a global level.

Patient Safety issues: Impacts at global level (WHO 2023)[31]
Around 1 in every 10 patients is harmed in health care from unsafe care
More than 3 million deaths occur annually. Globally 4 in 100 people die in low-to-middle income countries
Above 50% of harm (1 in every 20 patients) is preventable; half of this harm is attributed to medications
Patient harm potentially reduces global economic growth by 0.7% a year.
The indirect cost of harm amounts to trillions of US dollars each year

[27] S. Sridharan Patient Safety In The Health Care System Sri Lanka https://rdhsofficegampaha.org/files/2019/07/Clinical-Indicators.pdf

[28] Directorate of Healthcare Quality and Safety https://quality.health.gov.lk/index.php?option=com_content&view=article&id=10:overview&catid=10:about-us&lang=en&Itemid=110

[29] Circular from Secy Health HQSA/MoH/06/2012 dated 30/07/2013

[30] IMPLEMENTATION OF CLINICAL INDICATORS IN ALL FOUR MAJOR SPECIALTIES 2017 Quality Secretariat Ministry of Health https://www.quality.health.gov.lk/images/news/2020/12-SD-9-Implementation-of-clinical-indicators-in-all-four-major-specialties-.pdf

[31] Patient Safety 2023 https://www.who.int/news-room/fact-sheets/detail/patient-safety

Some sex disaggregated data is available at global level to understand that different genders experience and report adverse events differently.

A cohort study[32] of healthcare workers (HCWs) in USA found that females were more likely to report local Accident & Emergency after either influenza (OR = 2.28, p = 0.001) or COVID-19 (OR = 2.57, p = 0.008) vaccination compared to males. Women reported more interruptions in their daily routine following COVID-19 vaccination than men. While more women than men scheduled their COVID-19 vaccination before their days off in anticipation of symptoms.

A detailed retrospective analysis[33] of cases reported for compensation revealed that older male patients experienced a higher rate of medical errors. On the other hand, the older females experienced a higher rate of improper handling of general nursing (Females 3.14% vs Males 0.47%), informal writing or modification of medical records rate (Females 5.03% vs Males 2.80). and post operation complications (5.69% Females vs 2.80% Males)

A population based, retrospective matched cohort study from 2007 to 2015 from Canada using records from 104,630 patients, treated by 3,314 surgeons, (774 female and 2,540 male) after accounting for patient, surgeon, and hospital characteristics, found that patients treated by female surgeons had a small but statistically significant decrease in 30-day mortality, and similar surgical outcomes (length of stay, complications, and readmission), compared with those treated by male surgeons[34].

Sri Lankan literature

Although some data are available related to patient safety in Sri Lanka sex disaggregation is hardly conducted most of sources.

A study looked at a total of 556 articles published in Sri Lanka out of which 66 were selected for the review. Out of 66 studies, 18 (27%) were in medication safety and only 8% was on safety culture. The authors commented on the dearth of studies on the subject, and it is time to promote more research that will contribute to improvement of patient safety in Sri Lanka[35]. There was no reference to sex disaggregated data or analysis in any of the areas of study.

A retrospective review was performed on withheld and recalled medicines available at National Medicines Regulatory Authority (NMRA) official website in Sri Lanka, between June 2018 and August 2021. A total of 163 defects were identified in 143 defective medicines. The most

[32] Yin, A., Wang, N., Shea, P.J. et al. Sex and gender differences in adverse events following influenza and COVID-19 vaccination. Biol Sex Differ 15, 50 (2024). https://doi.org/10.1186/s13293-024-00625-z

[33] P.Liu,Y Yang, J,Cheng Gender differences in medical errors among older patients and inequalities in medical compensation compared with younger adults Original Article Public Health, 20 September 2022
Sec. Aging and Public Health Volume 10 - 2022 | https://doi.org/10.3389/fpubh.2022.883822

[34] Wallis C J, Ravi B, Coburn N, Nam R K, Detsky A S, Satkunasivam R et al. Comparison of postoperative outcomes among patients treated by male and female surgeons: a population based matched cohort study BMJ 2017; 359 :j4366 doi:10.1136/bmj.j4366

[35] "A Review of Research on Patient Safety in Sri Lanka":Ranasinghe GSP, Panapitiya PWC, Ranga Sabhapathige, Dilrukshi Deerasinghe, Samarage SM, International Journal of Scientific Research and Engineering Development-– Volume 4 Issue 5, Sep- Oct 2021 https://www.researchgate.net/publication/354527530_A_Review_of_Research_on_Patient_Safety_in_Sri_Lanka

common types of defects were contamination (n = 59, 36.2%), stability defects (n = 41, 25.2%), packaging and labelling defects (n = 27, 16.6%) and active pharmaceutical ingredient defects (n = 26, 15.9%). Gender analysis by way of details of the drugs and their use for males and females was not included in the study[36].

Another study, a cross-sectional descriptive study was carried out to assess the current patient safety culture in a tertiary care hospital in Sri Lanka, using a self-administered questionnaire with eleven dimensions of patient safety culture, with 389 respondents including Administrators, Consultants, and Postgraduate trainees, Medical Officers, House officers and Nursing Officers showed there is a positive response towards patient safety culture within the organization. However, sex disaggregation of the participants of the study was not provided which may have given an insight to the gender biases prevalent among them[37].

Table 1: Summary of data on selected indicators obtained by the Directorate of Healthcare Quality and Safety - 2019-2021

	2019	2020	2021
Falls/Safety issues	3982	2565	2014
Treatment/ Diagnosis issues	671	626*	217*
Drug/ IV/ Blood issues	2373	1640	1415
Surgery/ Anesthesia issues	128	37*	2*
Laboratory issues	1415	1700*	211*
Labour/ Delivery issues	44	242*	351*
Miscellaneous/ Other	2568	1784	1148
Caesarean Section Rate	40.67%*	39.81%	43.30%
Proper use of Partogram	87.97%*	87.58%*	87.10%
MRSA Bacteraemia Rate per 10,000 patient days	2.66	3.39	1.99
Post Caesarean Surgical Site Infection Rate (percentage)	0.86%	0.58%	0.66%

* Response rate was below 50%

Source: Directorate of Healthcare Quality and Safety, Ministry of Health, Sri Lanka: Healthcare Quality and Safety Bulletin 2019, 2020, 2021.Available from https://drive.google.com/file/d/1LgA5LHGMBIgIu-xBhUu8V8wExpnhJ-pV/view?usp=sharing

An analysis of adverse events taking place was conducted in 2019 but sex disaggregated data is not available[38]. As shown in Table 1 although the adverse event reporting as a quality indicator is institutionalized by the Directorate of Healthcare Quality and Safety, there is no sex disaggregation of the data done at the moment.

[36] Jegath Janani Tharmalinga Sharma , Madumai Ketharam , Kaumada Binoli Herath , Senathiraja Sherley Shobia : Quality of medicines in Sri Lanka: a retrospective review of safety alerts BMC Health Serv Res . 2023 Sep 12;23(1):980. doi: 10.1186/s12913-023-09995- https://pubmed.ncbi.nlm.nih.gov/37700302/

[37] M Amarapathy, S Sridharan, R Perera, Y Handa Factors Affecting Patient Safety Culture In A Tertiary Care Hospital In Sri Lanka INTERNATIONAL JOURNAL OF SCIENTIFIC & TECHNOLOGY RESEARCH VOLUME 2, ISSUE 3, MARCH 2013 https://www.ijstr.org/final-print/mar2013/Factors-Affecting-Patient-Safety-Culture-In-A-Tertiary-Care-Hospital-In-Sri-Lanka.pdf

[38] S. Sridharan Patient Safety In The Health Care System Sri Lanka https://cdn.who.int/media/docs/default-source/patient-safety/psirls/maldives/2.4-patient-safety-sri-lanka-final.pdf?sfvrsn=c2e22b8f_7

National policies related to patient safety:

National Policy on Healthcare Quality & Safety[39] which was launched in the year 2015 addresses seven key areas of healthcare quality and safety. However, Sex disaggregation of relevant data is not mentioned here.

National Policy on Healthcare Quality and Safety of Ministry of Health 2015 covers seven key areas, with the key result area 7: addressing research for quality improvement and patient safety. While this policy provides detailed guidance on the directions and domains for research the need of sex disaggregated data is not mentioned.

Healthcare Quality and Safety Strategic Plan (2021-2025): The Ministry of Health has developed a strategic plan to enhance healthcare quality and safety. The plan includes initiatives to improve infrastructure, introduce performance reviews, and develop guidelines for better patient care.

Guidelines on reporting data on adverse events[40]. However, the information collected is not sex disaggregated.

Gender-related safety concerns for patients receiving care:

Gender is a major determinant of health for women and men in globally and Sri Lanka is no exception. Gender norms, roles and relations interact with biological factors, influencing people's exposure to disease and risks for ill health. Therefore, it is important for health policymakers to consider the different needs of all men and women and other gender identities and sexual orientations related to their gender. Tailoring health policies and programmes to take into account these differences in needs can improve their impact, reduce health inequities and advance the right to health for all.

Health of an individual is significantly determined by social, economic, and environmental factors that lie beyond the health care delivery, such as poverty, education, employment and physical security. Gender inequality is an important determinant of health, and still remains a challenge in Sri Lanka, as elsewhere.

[39] https://www.quality.health.gov.lk/images/pdf/resources/policy/national_policy_quality_and_safety.pdf
[40] https://www.quality.health.gov.lk/images/pdf/resources/guidelines/guidelines_for_adverse_event_reporting.pdf

Women lag behind men in many indicators of social well-being, share in agricultural holdings and wages. Women's lower labour force participation rate and their higher average hours per day spent in unpaid care work also reflect gender inequality. Only one in every six adolescent girls in Sri Lanka has comprehensive knowledge about HIV/AIDS. On a more positive note, women have better life expectancy and healthy life expectancy at birth than men in Sri Lanka. Current gendered health disparities such as: cirrhosis of the liver and road traffic injuries are in the 10 leading causes of death among men) but not among women. Alzheimer's disease and circulatory diseases are in the 10 leading causes of death among women but not among men[41].

The female suicide rate in Sri Lanka is one of the highest in the world, and there are high rates of self-harm in young women living in rural, disadvantaged groups. These acts are mostly impulsive, following perceived wrongful treatment, often related to family disputes or conflicts with intimate partners. However, when considering data from the past decade, male deaths by suicide are significantly higher than female deaths by suicide[42].

Gender disparities in the health care workforce too exist. Women comprise about six in every 10 doctors and over nine in every 10 nurses. (WHO). Despite this, gender disparities still exist in terms of access to healthcare and the quality of care received.

Sri Lanka ranks 92nd out of 191 countries on the United Nations Development Programmes 2021 Gender Inequality Index[40] and 110th out of 146 countries on the World Economic Forum's 2022 Global Gender Gap Index[41]. The Global Gender Gap Index 2024 Sri Lanka ranks 122 out of 146 countries with a GGI of 0.653[43] [44].

Gender identities are recognized in Sri Lanka, and a Gender Recognition Certificate, issued by the Ministry of Health allows for a change of gender in the birth certificate. However, discrimination of LGBTQ individuals within the health care delivery system exists

[41] Sri Lanka: gender and health WHO Regional office for South East Asia
https://iris.who.int/bitstream/handle/10665/344695/GER-Sri%20Lanka-eng.pdf?sequence=1

[42] SRI LANKA A Gender Equity Report April 2023 https://genderhealthdata.org/wp-content/uploads/2024/04/Sri-Lanka-Gender-Report-website.pdf

[44] Global Gender Gap Report 2024 https://www3.weforum.org/docs/WEF_GGGR_2024.pdf

Application of the WHO Tool: Gender Analysis Questions (GAQ)

Gender Analysis of Healthcare Quality and Safety

1. **What is the condition**? "Quality of health care & safety"

Quality of health care is defined as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"[45]. The World Health Organization describes patient safety as: *"The cultures, processes, procedures, behaviours, technologies, and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce its impact when it does occur"*[46]. Common adverse events that may result in avoidable patient harm are medication errors, unsafe surgical procedures, health care-associated infections, diagnostic errors, patient falls, pressure ulcers, patient misidentification, unsafe blood transfusion and venous thromboembolism[47].

- **Is it acute or chronic condition?**

  This is a multifactorial health system issue affecting individual's health due to multidimensional gaps and lapses related to care providers as individuals and the health system as a whole.

- **Is it a communicable or a noncommunicable condition?**

  This does not apply here

- **What are the risk factors for this condition?**

The factors associated with patient safety are non-functional equipment, lack of trained maintenance staff, systemic failures, poor budgetary allocations, lack of access to necessary drugs, patient poverty, delays, and other procurement processes.

Patient safety issues are commonly described surrounding the following: lack of basic nursing care, in particular in relation to feeding, hydration and pressure area care; misdiagnosis, often

[45] https://www.jointcommissioninternational.org/-/media/jcr/jcr-documents/our-priorities/board-education/definitions-of-quality-and-patient-safety-final.pdf

[46] https://www.who.int/teams/integrated-health-services/patient-safety/policy/global-patient-safety-action-plan

[47] WHO Patient Safety (2023) https://www.who.int/news-room/fact-sheets/detail/patient-safety

due to diagnostic overshadowing and communication difficulties; delayed investigations and treatment; non-treatment decisions etc.

- **Are they different for women and men, boys and girls?**

Biological Differences: Women and men have different physiological responses to medications and treatments, which can affect patient safety.

Design of Medical Equipment: Medical equipment and devices such as Personal Protective Equipment (PPE) are often designed with male bodies in mind, (developed for larger hands and can often be less easy to hold and operate for female staff). Differences in thumb size or grip strength can make the user-experience extremely variable, and many female staff need to sustain greater levels of force to use the equipment.

Serious patient safety concerns are associated with a range of medical devices predominantly used for women, such as pelvic mesh.

The importance of sex disaggregated data has been highlighted by the trials of the cardiac resynchronization therapy device (CRT-D), which were previously deemed to be beneficial for anyone whose heart takes 150 milliseconds or longer to complete a full electrical wave. The trials only included 20% of female participants, but when data from several trials was combined and analyzed it became clear that women reacted differently to the device. Female participants, who had the pacemaker fitted, were found to have a 76% reduction in heart failure or death.

Gender biases in healthcare can lead to disparities in the quality of care received by women and men. Women's symptoms are sometimes dismissed or not taken as seriously as men's, which can delay diagnosis and treatment.

Labelled anxious, depressed or irrational[48]: Studies and testimonials indicate that women are more likely to have their physical symptoms attributed to psychological issues by clinicians, with many feeling that clinicians had dismissed them as hysterical. This can manifest itself in various ways such as -

Unheard and undervalued: Several patient safety issues were identified concerning pelvic mesh implants the scale and severity of avoidable harm that resulted from these interventions over a period of several decades is shocking and could have been reduced if the women involved were listened to sooner and critically, if they had been appropriately informed in the first place.

[48] Dangerous exclusions: The risk to patient safety of sex and gender bias
https://www.patientsafetylearning.org/blog/dangerous-exclusions-the-risk-to-patient-safety-of-sex-and-gender-bias

The review found that the women involved had been dismissed and sidelined for years as they fought hard to raise awareness of the issues and prevent others from suffering as they had. The defensive and unresponsive attitudes the women were met with highlighted a shameful disregard for the value of their voices in improving patient safety.

In contrast, men tend to ask fewer questions, suggesting a potential gender gap in patient communication with healthcare professionals.[49]

Intersectionality: There is evidence that systemic and individual biases in healthcare negatively impact on the safety and care of, but not exclusive to, the following groups: transgender patients, healthcare workers, patients from different ethnic backgrounds, patients living with a disability.

2. When does this condition occur?

It can happen at all ages

3. Where does this condition occur?

Cross cutting in all health settings

Medication Errors: These can happen at various stages, including prescribing/documenting, dispensing, and administering medication. Common causes include miscommunication, incorrect dosages, and failure to account for patient-specific factors such as allergies or drug interaction.

Patient Falls: Falls are prevalent, especially among the elderly, those with mobility issues, or patients undergoing treatment that affects balance. This is the highest incidence among adverse events reported.

Surgical Errors: These can occur during preoperative, intraoperative, and postoperative phases. Surgical errors can occur during heavy work burden, exhaustion of providers and inadequate equipment and support services.

[49] Clara Monaca, Matthias Weigl, Holger Pfaff Patient involvement in patient safety measures: the impact of demographic and socioeconomic factors – a scoping review 2024, Journal of Public Health
https://doi.org/10.1007/s10389-024-02340-w

Patient misidentification: A report of the Joint Commission published in 2018 identified 409 sentinel events of patient misidentification out of 3326 incidents (12.3%) between 2014 and 2017.

Unsafe transfusion practices: Data on adverse transfusion reactions from a group of 62 countries show an average incidence of 12.2 serious reactions per 100,000 distributed blood components.

4. Who gets ill?

Gender norms affect men and women differently. As discussed earlier.

Some procedures that are more common with women, such as breast implants, mesh use in stress incontinence, repair of ventral hernias, caesarean delivery have higher risk of adverse event possibility.

- **Do access to and control over resources affect the risk of and vulnerability to this condition?**

  Paid care may influence decision making on the need and the type of procedure e.g. Caesarean delivery, Interventions for IHDs.

- **Does the level of individual or community empowerment influence the risk for and vulnerability to this condition?**

  Public awareness and social mobilization on patent safety issues will influence this as women's surgical (therapeutic) and optional procedures.

- **Is this different for women, men, boys and girls?**

  Women are more likely to undergo "non-essential "procedures from a medical viewpoint.

- **Do educational opportunities influence the risk for and vulnerability to this condition?**

  Yes

- **Is this different for boys and girls in the target population? How?**

  Access to information through health care personnel and via digital information sources is different to rural women, illiterate women, poor women etc.

- **Do paid employment opportunities influence the risk for and vulnerability to this condition?**

  Availability of health insurance may lead to a biased decision by the provider and a negative bias if the patient is poor.

- **Is this different for women and men in the target population? How?**

  Men are working in most families and may have funds and insurance and to a lesser extent for women.

5. What are the people affected by the condition doing about it?

- **Are both women and men seeking services appropriately for this condition?**

  Yes, details are given earlier, but no disaggregated data are available to get the number of claims etc.

- **Do sociocultural factors affect health-seeking behaviour related to this condition?**

  Yes, details given earlier.

6. How do access to and control over resources affect the provision of care?

Seeking redress after an adverse event is difficult for women and other marginalized groups: Intersectionality with other domains.

There is no formal discrimination, but LGBTQ community will find difficult to challenge the existing system.

Women have less resources than men to ask for redress or campaign for change in this regard.

- **If the affected population does not have the resources necessary, what networks or facilities are available to them for support?**

  The formal systems such as reporting to authorities Hospital/Police or courts are available, but some constraints are there both financial and structural. However, few NGOs and CSOs are available to seek help.

- **Do health insurance schemes have different eligibility criteria for women and men?**

No, discrimination directly but indirectly by identifying the conditions are linked to the premiums.

- **Do health insurance schemes include the services necessary to address this condition?**

  There is no medical insurance against medical negligence, but the health professionals (Only doctors) have their own cover for medical errors which makes it possible to negotiate a solution.

- **Are there differences according to employment, marital or other status? If so, how does this affect women and men?**

  Employment but not for being men and women.

7. How do health services meet the needs of the men and women affected by this condition?

- **Do women and men have different experiences with health services for this condition? What kinds? For what reasons?**

  Response to adverse events from the health care providers is usually a positive one and unlikely to related to the sex of the affected person.

8. What are the predominant health and social outcomes of this condition?

It depends on the injury or damage caused.

- **How are men and women coping with the effects of this condition?**

  The women are affected badly as disability and outcome of the injury affect them more.

Annexure 6

Case study - 2

Use of GAQ to conduct a Gender Analysis of "Mental Disorders"

1. What is the condition?

Mental disorders are chronic conditions. Non communicable diseases.

Risk factors: There are biological, psychological and socio –cultural risk factors and trauma. These risk factors differ for women, men, boys and girls.

- **Biological:** Hormonal Differences: Hormonal fluctuations, particularly in women, can influence the prevalence of certain mental disorders, such as depression and anxiety.
- **Genetic Predisposition**: Some mental disorders may have a genetic component that varies between sex.
- **Sociocultural Factors**: Gender Roles and Expectations: Societal expectations and gender roles can impact mental health. For example, women may face more stress due to income inequality, low social ranking, discrimination and unrelenting domestic and childcare responsibilities.
- **Stress from Gendered Environment:** Women are more likely to report symptoms of mental disorders following stressful life events due to the higher stress burden they experience in a gendered environment.
- **Psychological Factors:** Coping Strategies: Men and women often employ different coping strategies for stress, which can affect their mental health outcomes. These different coping strategies are being influenced with their gender roles and norms.
- **Trauma Exposure:** Women are more likely to experience sexual and intimate violence, childhood trauma, and repeated trauma exposures, which can lead to higher rates of PTSD and mood disorders.

2. When does this condition occur?

Can occur at any time of the life cycle, but some mental disorders are more prominent in certain periods of life cycle such as in reproductive age, and for individuals in relationships. Also, gender norms increase vulnerability.

3. Where does this condition occur?

Sector: Mental disorders are present as cross cutting conditions in all urban, rural and estate areas, but higher in the estate sector, and gender norms increase vulnerability.

- **Environment:** It occurs in all environments, but mainly observed in domestic settings where gender norms, roles and attitudes and restricted environment has a significant influence. Mental stress in work environments which is influenced by gender norms, roles and attitudes may affect mental health of an individual. Mostly women are affected compared to men.
- **Specific groups:** As regards social or cultural groups affected by the condition - LGBTQ+ community is affected due to gender discrimination, which negatively affect their mental health, which may even lead to suicide.

4. Who gets ill?

- **Biological factors:** Such as pregnancy (postpartum blues, puperal psychosis), and menopause (depression, loss of libido) affect the mental health of women. This is complicated by gender norms, roles and attitudes (caring and household responsibilities).
- **Sociological factors**: These norms affect men and women differently – household chores for women and role of bread winner for men (incapacity to work, work loss, harvest loss in drought for farmers.)
- **Intersectionality:** This effect is more added up with poverty, disability, less education… etc. Women are more likely to experience multiple social disadvantages, such as lower socioeconomic status, which can exacerbate mental health issues.

5. What are people affected by the condition doing about it?

There are notable differences in how men and women seek mental health care.

- **Men:** Men are generally less likely to seek professional mental health care compared to women. This can be due to societal norms that discourage men from expressing vulnerability or seeking help.

  Stigma: Men often face greater stigma around mental health issues, which can deter the from seeking care.

Informal Help Seeking: Men are more likely to seek informal help, such as talking to friends or family, rather than professional help.

- **Women:** Women are more likely to seek professional mental health care and are generally more open about their mental health struggles. Women are diagnosed with mental health conditions at higher rates, partly because they are more likely to seek help and report their symptoms. Women often have stronger support networks and are more likely to use these networks to seek help.

Factors Influencing Help-Seeking Behaviour

- **Mental Health Literacy:** Higher mental health literacy is associated with a greater likelihood of seeking help. Men with low mental health literacy are particularly at risk of not perceiving a need for mental health care.
- **Cultural and Societal Norms:** Gender roles and societal expectations play a significant role in shaping help-seeking behaviours.

6. How do access to and control over resources affect the provision of care?

Certain factors contribute to disparities in the provision of mental health care between men and women.

- **Men** - Men with lower incomes may find it more challenging to afford mental health services, leading to delays in seeking help or foregoing care altogether. Men in unstable or insecure job situations may be less likely to take time off for mental health appointments due to fear of job loss or financial instability. Men often face greater stigma around mental health issues, which can deter them from seeking help. This stigma can be exacerbated by societal norms that equate seeking help with weakness. Men may have fewer social support networks compared to women, making it harder for them to find encouragement and assistance in seeking mental health care. Limited resources and long waiting times for mental health services can discourage men from seeking help, especially if they perceive the process as cumbersome or unhelpful. Men are generally less likely to seek professional mental health due to a lack of mental health literacy, reluctance to admit vulnerability, and preference for informal help-seeking methods.

- **Women -** Women often face greater economic barriers to accessing mental health care due to income inequality and lower social ranking. Women are more likely to utilize healthcare services,

including mental health services, compared to men. Women may have less control over financial resources and decision-making power within households, which can impact their ability to seek and receive mental health care. Women often have stronger social support networks, which can influence their ability to access and utilize mental health resources. Women may face more stigmas when seeking mental health care.

Opportunity Costs: Opportunity costs can affect men and women differently when it comes to accessing or seeking mental health care;

Income Disparity: Women often have lower incomes compared to men, which can limit their ability to afford mental health care services. This results in higher opportunity costs for women, as they may need to choose between mental health care and other essential expenses.

- **Employment Status:** Men and women may have different employment statuses and job security, which can impact their ability to take time off work for mental health appointments or therapy sessions.
- **Social and Cultural Factors:** Caregiving responsibilities can limit the time of women and resources for seeking mental health care.
- **Stigma:** Men may face greater stigma around seeking mental health care, which can lead to higher opportunity costs in terms of social acceptance and perceived masculinity.
- **Support Networks:** Women often have stronger social support networks, which can help mitigate some of the opportunity costs associated with seeking mental health care

7. How do health services meet the needs of the men and women affected by this condition?

Health services should meet the needs of men and women affected by mental disorders through various approaches, tailored to address the unique challenges faced by each gender.

- **For Men:** Targeted Outreach: Programs should be specifically designed to engage men in mental health care, addressing stigma and encouraging help-seeking behaviour. There should be services that focus on substance use disorders, which are more prevalent among men. Initiatives should be aimed at reducing the higher rates of suicide among men, including crisis intervention and support services.
- **For Women:** Programmes should focus on services that recognize and address the impact of trauma, which is more common among women, especially those who have experienced sexual assault or domestic violence. Mental health services should be integrated with reproductive

health care, addressing issues such as postpartum depression and anxiety. Facilitating support groups and community-based programs that provide a safe space for women to share their experiences and receive support should be established.

Both biological and socio-cultural factors play a significant role in influencing treatment options, uptake, and adherence for men and women with mental disorders.

- **Biological Factors:** Genetic predispositions can affect how individuals respond to certain treatments. Some people may metabolize medications differently, impacting the effectiveness and side effects of treatment. Hormonal fluctuations, particularly in women, can influence the course of mental disorders and the effectiveness of treatments. For instance, hormonal changes during menstrual cycles, pregnancy, or menopause can affect mood and anxiety levels.

- **Socio-Cultural Factors:** Cultural stigma around mental health can deter individuals from seeking treatment. Men, in particular, may face greater stigma and be less likely to seek help due to societal norms around masculinity. Some cultures may view mental health issues as a sign of weakness or a spiritual problem, leading to reluctance in seeking professional help, especially among men. The availability of social support networks can impact treatment adherence. Women often have stronger social support networks, which can encourage them to seek and adhere to treatment. Differences in health literacy can affect how individuals understand and manage their mental health conditions. Women tend to have better health literacy as they have more contacts with health staff.

- **Intersectionality:** Gender roles and expectations can influence treatment options and adherence, and women are more affected. Economic disparities can affect access to treatment and adherence. Women, in particular, may face economic barriers that limit their ability to seek and continue treatment.

8. What are the predominant health and social outcomes for men and women of this condition?

- **Health Outcomes**

  Men: Men are more likely to suffer from substance use disorders, ADHD, and antisocial personality disorder, and have higher rates of suicide compared to women.

Women: Women are more likely to experience depression, anxiety, and somatic complaints, and have higher rates of Generalized Anxiety Disorder (GAD) and PTSD due to experiences with sexual assault and abuse.

- **Social Outcomes**

  Men: Men often face greater stigma around mental health issues, which can deter them from seeking help, which leads to poorer social outcomes, including isolation and difficulties in maintaining relationships.

  Women: Women may experience more stress due to income inequality, low social ranking, and unrelenting childcare responsibilities. However, they are more likely to seek help and utilize social support networks, which can lead to better social outcomes.

- ***Shared Outcomes***

  General Health: Both men and women can experience overall health issues such as obesity, malnutrition, and chronic diseases due to poor dietary habits.

  Social Support: Access to social support networks and community resources can play a crucial role in improving nutritional outcomes for both genders.

  Addressing these differences requires a gender specific approach to nutrition programs and policies, ensuring that both men and women receive the support they need to achieve optimal health and well-being.

Annexure 7

Case Study -3

Use of GAQ for Gender Analysis of "Nutrition"

1. What is the condition?

Nutrition is the science of how the body takes in and uses food. It's all about understanding the nutrients the body needs to function properly and how different foods contribute to overall health of a person. Good nutrition involves eating a balanced diet with the right amount of each nutrient to maintain health, support growth, and reduce the risk of chronic diseases.

Risk Factors – There are several differences in nutrition risk factors between men and women due to biological lifestyle and socio- cultural factors.

Biological:

- **Nutrient Requirements**:
  Iron: Women generally need more iron than men due to menstrual blood loss.

  Calcium: Women, especially post-menopausal women, need more calcium to reduce the risk of osteoporosis.

  Vitamins: Women often need higher amounts of certain vitamins like folate and vitamin D, while men might need more of others like vitamin B5 (pantothenic acid).

- **Caloric Needs:**
  Calories: Men typically require more calories than women due to higher muscle mass and larger body size.

- **Health Risks**:
  Osteoporosis: Women are at a higher risk of developing osteoporosis, especially after menopause, due to lower bone density.

  Heart Disease: Men are generally at a higher risk of heart disease at a younger age compared to women[1].

  Iron Deficiency: Women are more likely to suffer from iron deficiency due to menstrual blood loss. This is compounded in areas where dietary iron intake is low.

Obesity: Men and women might face different risks for obesity based on their physical activity levels and dietary habits. Men might consume more calories due to larger portion sizes, while women might be more prone to restrictive dieting, impacting their overall nutritional status.

Vitamin Deficiencies: Both men and women can suffer from various vitamin deficiencies, but the types of deficiencies might differ based on dietary patterns and lifestyle choices.

Lifestyle Factors:

Physical Activity: Men often engage in more intense physical activities, which can influence their nutritional needs and risk factors.

Dietary Habits: Men and women may have different dietary habits and preferences, which can affect their nutritional intake and health outcomes.

Socio – cultural differences regarding nutrition between Men and Women:

- **Gender Roles and Expectations:**

  Women: In some cultures, women may be expected to eat after the men and children, often leading to inadequate food intake and nutritional deficiencies.

  Men: Traditional gender roles may pressure men to prioritize work over their own health, leading to poor dietary choices and nutritional neglect.

- **Education and Awareness**:

  Women: Lower levels of education among women in certain regions can limit their knowledge of nutrition, leading to poor dietary practices and increased vulnerability to malnutrition.

  Men: Lack of awareness about the importance of balanced nutrition and healthy eating habits can also affect men, especially in cultures where discussing health and nutrition is not common.

- **Economic Status:**

  Women: Economic constraints can limit access to nutritious food, and women, especially those in low-income households, may be more affected due to their caregiving roles and responsibilities. Women, particularly in low-income households, may prioritize feeding their families over their own nutritional needs.

  Men: Economic pressures to provide for the family can lead men to prioritize cheaper, less nutritious food options, affecting their nutritional status.

- **Social Norms and Practices:**

  Women: Social norms that favour men over women in food distribution and healthcare access can lead to higher rates of malnutrition among women.

  Men: Social practices such as communal drinking and unhealthy eating habits can increase the risk of nutritional problems among men.

2. When does this condition occur?

Nutritional problems can occur at various stages of the lifecycle, and there are some differences between men and women.

Stages of Malnutrition in the Lifecycle:

- **Pregnancy and Early Childhood**: This is a critical period where malnutrition can have long-lasting effects. Malnourished pregnant women are more likely to experience complications, and their infants may be born underweight or prematurely.
- **Childhood and Adolescence**: Malnutrition during these stages can lead to stunting, wasting, and underweight issues.
- **Adulthood**: Malnutrition in adults can result from poor dietary habits, chronic diseases, or socioeconomic factors. It can lead to deficiencies in essential nutrients and increase the risk of chronic diseases like heart disease and diabetes.
- **Older Age**: Older adults are at risk of malnutrition due to factors like reduced appetite, difficulty chewing or swallowing, and chronic illnesses. Malnutrition in older adults can lead to weakened immune systems and increased frailty.

Differences in nutrition between Men and Women:

- **Pregnancy and Lactation:** Women have increased nutritional needs during pregnancy and breastfeeding to support foetal growth and milk production. Malnutrition during this period can have severe consequences for both the mother and the child.
- **Childhood:** Boys are more likely to be undernourished than girls, especially in certain regions. This can be due to biological factors and social practices that favour boys over girls.
- **Adulthood:** Men and women have different nutritional requirements due to differences in body composition and hormonal factors. For example, women generally need more iron due to menstrual blood loss, while men may need more calories due to higher muscle mass.

- **Older Age:** Women may be at higher risk of osteoporosis due to hormonal changes after menopause, which increases the need for calcium and vitamin D.

3. Where does this condition occur?

Sector:

Nutritional problems are present as cross cutting conditions in all urban, rural and estate areas, and can have different implications for men and women in rural, urban, and estate contexts due to varying socio-economic, cultural, and environmental factors.

- **Rural Areas**:

Men: Men in rural areas often engage in physically demanding agricultural work, which can lead to higher caloric needs. However, limited access to diverse and nutritious food can result in deficiencies.

Women: Women in rural areas may face additional challenges due to their dual roles in household and agricultural work. They might have less time to prepare nutritious meals and may prioritize feeding their families over their own nutritional needs.

- **Urban Areas:**

Men: Urban men might have better access to a variety of foods, but they may also be more prone to consuming processed and unhealthy foods due to busy lifestyles and the availability of fast food.

Women: Urban women may have better access to healthcare and nutrition education, but they can also face challenges such as balancing work and family responsibilities, which can impact their dietary habits.

- **Estate (Plantation) Areas**:

Men: Men working in plantations may have physically demanding jobs, like rural areas, and their limited access to diverse and nutritious food can result in deficiencies.

Women: Women in estate areas may have limited access to diverse foods and may rely heavily on their staple food leading to potential nutritional deficiencies.

Cultural Practices: Cultural norms and practices can influence dietary habits differently in rural, urban, and estate areas, affecting the nutritional status of men and women.

Understanding these differences is crucial for developing targeted nutritional interventions that address the specific needs of men and women in different contexts.

Nutritional problems can indeed vary for men and women due to differences in their physical and social environments.

Environment:

- **Physical Environment:**

Occupational Demands: Men and women often have different occupational roles, which can affect their nutritional needs. Men might have jobs that require higher physical exertion, leading to higher calorie and protein needs. Women, especially those in caregiving roles, may have different energy requirements and may be more prone to certain nutrient deficiencies.

Understanding these differences is crucial for developing effective nutritional strategies tailored to the specific needs of men and women in their respective environments.

4. Who gets ill?

Biological factors: women, men, boys, girls

Biological factors play a significant role in women, girls, men, and boys to have different nutritional problems and conditions.

- **Hormonal Differences:**

Women and Girls: Hormonal fluctuations due to menstruation, pregnancy, and menopause can affect nutritional needs. For example, women require more iron during menstruation to compensate for blood loss. Pregnancy increases the need for nutrients like folate, iron, and calcium to support foetal development.

Men and Boys: Boys experience growth spurts during puberty, which increases their caloric and protein needs. Men typically have higher muscle mass, leading to increased protein and caloric requirements compared to women.

- **Body Composition**:

Women and Girls: Women generally have a higher percentage of body fat and lower muscle mass compared to men. This can influence their metabolic rate and nutritional needs. Women are also more prone to conditions like osteoporosis due to lower bone density.

Men and Boys: Men have higher muscle mass and larger body size, leading to higher caloric and protein requirements. They are also more susceptible to certain conditions like heart disease, influenced by their metabolic rate and body composition.

- **Productive and Reproductive Roles:**

  Women: Nutritional needs change significantly during pregnancy and breastfeeding. Adequate intake of nutrients like folate, iron, and calcium is crucial for the health of both the mother and the baby.

  Men: While men do not experience the same reproductive health-related nutritional changes, factors like testosterone levels can influence their muscle mass and overall nutritional needs for their productive role.

- **Growth and Development:**

  Children and Adolescents: Both boys and girls have unique nutritional needs during growth spurts. Boys may require more calories and protein to support muscle growth, while girls need adequate nutrients to support menstruation and overall development.

- **Genetic Factors:**

  Genetic Predispositions: Certain genetic conditions can affect nutrient absorption and metabolism differently in men and women. For example, hemochromatosis (iron overload) is more common in men, while coeliac disease (gluten intolerance) may be more prevalent in women.

  Men's and women's responsibilities in the household, community, and workplace can significantly influence their risk for and vulnerability to nutritional conditions.

  Responsibilities:

- **Household Responsibilities:**

  Men: In some cultures, men may be expected to focus on work outside the home, which can lead to irregular eating patterns and reliance on convenience foods, increasing the risk of poor nutrition.

  Women: Women often bear the primary responsibility for food preparation and caregiving. This can lead to women prioritizing their families' nutritional needs over their own, sometimes resulting in inadequate nutrient intake for themselves. Additionally, time constraints due to household responsibilities can limit opportunities for women to engage in physical activity.

- **Community Involvement:**

  Men: Men's community roles, such as participating in local leadership or social events, can influence their dietary habits. Social gatherings often involve consuming large quantities of food and alcohol, which can contribute to poor nutrition and health problems.

  Women: Women involved in community activities may have better access to nutritional education and resources, but they may also face cultural and social pressures that limit their food choices. For instance, in some communities, women may not have the same access to nutritious foods as men.

- **Workplace Responsibilities:**

  Men: Men often work in physically demanding jobs that require higher caloric and protein intake. However, long working hours and job-related stress can lead to unhealthy eating habits, such as skipping meals or consuming fast food.

  Women: Women in the workplace may face different challenges, such as balancing work and family responsibilities. This can lead to time constraints that affect their ability to prepare healthy meals. Additionally, workplace environments that do not support breastfeeding can impact the nutritional health of both the mother and her infant.

5. What are people affected by the condition doing about it?

- **Men:**

  Social Norms: Men might be less likely to seek medical care due to societal expectations that they should be stoic and self-reliant. This can lead to underreporting of nutritional issues and delays in seeking help.

  Awareness: Men may have lower awareness of nutritional problems and their long-term impact on health, which can contribute to a lower likelihood of seeking medical advice.

  Access and Utilization: Men might prioritize work and other responsibilities over health check-ups, leading to less frequent use of healthcare services.

- **Women:**

  Social Norms: Women are often more health-conscious and proactive in seeking medical care for themselves and their families. This can lead to earlier identification and management of nutritional problems.

Awareness: Women, especially those involved in caregiving roles, may have better knowledge of nutrition and the importance of maintaining a balanced diet, increasing the likelihood of seeking help when needed.

Access and Utilization: Women may face barriers to accessing healthcare due to economic constraints or cultural factors, but they are generally more likely to utilize available healthcare services compared to men.

- **Influencing Factors / Intersectionality:**

Education: Higher levels of education can lead to better awareness of nutritional issues and a greater likelihood of seeking medical care.

Economic Status: Economic constraints can affect the ability to access healthcare services, impacting both men and women differently.

Cultural Factors: Cultural beliefs and practices can influence attitudes towards seeking medical care for nutritional problems. In some cultures, there might be stigma associated with seeking help, affecting both men and women.

Overall, women are generally more likely to seek medical care for nutritional problems compared to men, but various factors, including social norms, awareness, access, and economic status, play a significant role in this behaviour.

6. How do health services meet the needs of the men and women affected by this condition?

Health services often face challenges in meeting the nutritional needs of men and women due to various **social, cultural, and biological factors**. Here are some key differences:

- **Women:**

Access to Services: Women may face barriers to accessing health services due to cultural norms, caregiving responsibilities, and limited mobility.

Nutritional Programs: Programs often target women, especially pregnant and lactating women, with interventions like iron and folic acid supplementation.

Education and Support: Women may receive more nutritional education and support, particularly in maternal and child health programs.

- **Men:**

Under-Representation: Men are often under-represented in nutritional programs, which can lead to unmet nutritional needs.

Cultural Norms: Men may face cultural barriers that discourage them from seeking help for nutritional issues.

Focus on Workforce: Nutritional programs for men may focus only on improving productivity and physical health for the workforce.

- **Shared Challenges:**

Gender Sensitivity: Both men and women may benefit from gender-sensitive approaches that consider their unique needs and circumstances. Improving overall access to healthcare services can help address nutritional problems for both sexes.

- **Intersectionality:**

Gender roles and expectations can influence treatment options and adherence, and women are more affected. Economic disparities can affect access to treatment and adherence. Women, in particular, may face economic barriers that limit their ability to seek and continue treatment.

7. What are the predominant health and social outcomes for men and women of this condition?

The health and social outcomes of nutrition can vary significantly between men and women due to biological, social, and cultural factors.

Health Outcomes:

Women:

Reproductive Health: Poor nutrition can lead to complications during pregnancy and childbirth, affecting both the mother and the baby.

Bone Health: Women are at higher risk of osteoporosis, especially post-menopause, due to lower calcium intake and hormonal changes.

Anaemia: Women are more prone to iron-deficiency anaemia, which can lead to fatigue, weakness, and other health issues.

Men:

Cardiovascular Health: Poor nutrition can increase the risk of heart disease, hypertension, and stroke in men.

Muscle Mass: Men may experience muscle loss and decreased strength due to inadequate protein intake.

Metabolic Health: Men are at higher risk of developing metabolic syndrome and type 2 diabetes due to poor dietary habits.

- **Social Outcomes:**

Women:

Economic Impact: Poor nutrition can affect women's productivity and economic participation, especially in low-income settings.

Social Stigma: Women may face social stigma and discrimination related to body image and eating disorders.

Caregiving: Women often bear the primary responsibility for caregiving, which can impact their own nutritional status and health.

Men:

Workforce Participation: Poor nutrition can affect men's ability to work and perform physically demanding tasks.

Mental Health: Men may experience mental health issues related to body image and eating disorders, although these are often underreported.

Social Norms: Men may face societal pressure to conform to certain body standards, leading to unhealthy dietary practices.

- **Shared Outcomes:**

General Health: Both men and women can experience overall health issues such as obesity, malnutrition, and chronic diseases due to poor dietary habits.

Social Support: Access to social support networks and community resources can play a crucial role in improving nutritional outcomes for both genders.

Addressing these differences requires a gender specific approach to nutrition programs and policies, ensuring that both men and women receive the support they need to achieve optimal health and well-being.

Annexure 8

Case Study – 4

Gender Analysis of Nutrition using the Gender Analysis Matrix (GAM)

Factors that influence health outcomes: ***Health related considerations***	**Factors that influence health outcomes:** ***Gender-related considerations***		
	Biological factors	**Socio cultural factors**	**Access to and control over resources**
1. Risk factors and vulnerability	Nutrient Requirements: Women generally need more iron than men due to menstrual blood loss. Post-menopausal women, need more calcium to reduce the risk of osteoporosis. Women often need higher amounts of certain vitamins like folate and vitamin D, while men might need more of others like vitamin B5 (pantothenic acid). Caloric Needs: Men typically require more calories than women due to higher muscle mass and larger body size. Health Risks: Women are at a higher risk of developing osteoporosis, especially after menopause, due to lower bone density. Men are generally at a higher risk of heart disease at a younger age compared to women[1]. Women	Physical Activity: Men often engage in more intense physical activities, which can influence their nutritional needs and risk factors. Women often bear the primary responsibility for food preparation and caregiving. This can lead to women prioritizing their families' nutritional needs over their own, sometimes resulting in inadequate nutrient intake for themselves. Additionally, time constraints due to household responsibilities can limit opportunities for women to engage in physical activity. Dietary Habits: Men and women may have different dietary habits and preferences, which can affect their nutritional intake and health outcomes.	Men's community roles, such as participating in local leadership or social events, can influence their dietary habits. Social gatherings often involve consuming large quantities of food and alcohol, which can contribute to poor nutrition and health problems. Women involved in community activities may have better access to nutritional education and resources, but they may also face cultural and social pressures that limit their food

Factors that influence health outcomes: ***Health related considerations***	**Factors that influence health outcomes:** ***Gender-related considerations***		
	Biological factors	**Socio cultural factors**	**Access to and control over resources**
	are more likely to suffer from iron deficiency due to menstrual blood loss. This is compounded in areas where dietary iron intake is low. Obesity: Men and women might face different risks for obesity based on their physical activity levels and dietary habits. Men might consume more calories due to larger portion sizes, while women might be more prone to restrictive dieting, impacting their overall nutritional status.		choices. For instance, in some communities, women may not have the same access to nutritious foods as men.
2. Access and use of health services		Women may face barriers to accessing health services due to cultural norms, caregiving responsibilities, and limited mobility. Programs often target women, especially pregnant and lactating women, with interventions like iron and folic acid supplementation. Women may receive more nutritional education and support, particularly in maternal and child health programs. Men are often under-represented in nutritional programs, which can lead to unmet nutritional needs. Men may face cultural barriers that discourage them from seeking help for nutritional issues. Nutritional	Women may face barriers to accessing healthcare due to economic constraints or cultural factors, but they are generally more likely to utilize available healthcare services compared to men.

Factors that influence health outcomes: ***Health related considerations***	**Factors that influence health outcomes:** ***Gender-related considerations***		
	Biological factors	**Socio cultural factors**	**Access to and control over resources**
		programs for men may focus only on improving productivity and physical health for the workforce.	
3. Health seeking behaviour		Women are often more health-conscious and proactive in seeking medical care for themselves and their families. This can lead to earlier identification and management of nutritional problems. Women, especially those involved in caregiving roles, may have better knowledge of nutrition and the importance of maintaining a balanced diet, increasing the likelihood of seeking help when needed. Men might be less likely to seek medical care due to societal expectations that they should be stoic and self-reliant. This can lead to underreporting of nutritional issues and delays in seeking help. Men may have lower awareness of nutritional problems and their long-term impact on health, which can contribute to a lower likelihood of seeking medical advice. Men might prioritize work and other responsibilities over health check-ups, leading to less frequent use of healthcare services.	

Factors that influence health outcomes: ***Health related considerations***	**Factors that influence health outcomes:** ***Gender-related considerations***		
	Biological factors	**Socio cultural factors**	**Access to and control over resources**
4. Treatment options		Gender Sensitivity: Both men and women may benefit from gender-sensitive approaches that consider their unique needs and circumstances. Improving overall access to healthcare services can help address nutritional problems for both sexes. Intersectionality: Gender roles and expectations can influence treatment options and adherence, and women are more affected. Economic disparities can affect access to treatment and adherence. Women, in particular, may face economic barriers that limit their ability to seek and continue treatment	
5. Experiences in health care settings		Cultural stigma may deter individuals seeking care, negative effects of masculinity, strong social support system for women, improved nutritional health literacy in women	Women do not have autonomy outside home, less control over financial resources, strong social support systems Men – financial instability, less social support, preference for informal help seeking

Factors that influence health outcomes: ***Health related considerations***	**Factors that influence health outcomes:** ***Gender-related considerations***		
	Biological factors	**Socio cultural factors**	**Access to and control over resources**
6. Health and social outcomes and consequences	Women are at a higher risk of developing osteoporosis, especially after menopause, due to lower bone density. Men are generally at a higher risk of heart disease at a younger age compared to women[1]. Women are more likely to suffer from iron deficiency due to menstrual blood loss. This is co Reproductive Health: Poor nutrition can lead to complications during pregnancy and childbirth, affecting both the mother and the baby in areas where dietary iron intake is low. Obesity: Men and women might face different risks for obesity based on their physical activity levels and dietary habits. Men might consume more calories due to larger portion sizes, while women might be more prone to restrictive dieting, impacting their overall nutritional status. Cardiovascular Health: Poor nutrition can increase the risk of heart disease, hypertension, and stroke in men. Men may experience muscle loss and decreased strength due to inadequate	Bone Health: Women are at higher risk of osteoporosis, especially post-menopause, due to lower calcium intake and hormonal changes. Anaemia: Women are more prone to iron-deficiency anaemia, which can lead to fatigue, weakness, and other health issues. Economic Impact: Poor nutrition can affect women's productivity and economic participation, especially in low-income settings. Social Stigma: Women may face social stigma and discrimination related to body image and eating disorders. Caregiving: Women often bear the primary responsibility for caregiving, which can impact their own nutritional status and health.	Social Support: Access to social support networks and community resources can play a crucial role in improving nutritional outcomes for both genders.

Factors that influence health outcomes: ***Health related considerations***	**Factors that influence health outcomes:** ***Gender-related considerations***		
	Biological factors	**Socio cultural factors**	**Access to and control over resources**
	protein intake. Men are at higher risk of developing metabolic syndrome and type 2 diabetes due to poor dietary habits. Workforce Participation: Poor nutrition can affect men's ability to work and perform physically demanding tasks. Mental Health: Men may experience mental health issues related to body image and eating disorders, although these are often underreported.		

Annexure 9

Case Study - 5

Gender Analysis of Mental Disorders using Gender Analysis Matrix (GAM)

Factors that influence health outcomes: ***Health related considerations***	**Factors that influence health outcomes:** ***Gender-related considerations***		
	Biological factors	**Socio cultural factors**	**Access to and control over resources**
1. Risk factors and vulnerability	Hormonal Differences, Genetic Predisposition, Coping Strategies	Gender Roles and Expectations, Stress from Gendered Environment, coping strategies being influenced with gender roles and norms., sexual and intimate violence, childhood trauma, and repeated trauma exposures	
2. Access and use of health services		Men – less likely to seek care due to financial instability, stigma, societal norms, few social support, lack of mental health literacy, reluctance to admit vulnerability, preference for informal help-seeking Women- Economic barriers, lower social ranking, more utilization, less decision-making power within households, strong support networks	Financial instability, social support networks, lack of mental health literacy, reluctance to admit vulnerability, lower social ranking, less control over financial resources, stigma

Factors that influence health outcomes: ***Health related considerations***	**Factors that influence health outcomes:** ***Gender-related considerations***		
	Biological factors	**Socio cultural factors**	**Access to and control over resources**
3. Health seeking behaviour		Men – less likely to seek care due to financial instability, stigma, societal norms, few social support, lack of mental health literacy, reluctance to admit vulnerability, preference for informal help-seeking Women- Economic barriers, lower social ranking, more utilization, less decision-making power within households, strong support networks	financial instability, social support networks, lack of mental health literacy, reluctance to admit vulnerability, lower social ranking, less control over financial resources, stigma
4. Treatment options	Genetic predispositions, hormonal fluctuations, can affect treatment	Men – targeted outreach programs, to address stigma, encourage help-seeking behaviour, services on substance abuse disorders, programs to address suicides Women – programs to address impact of trauma, mental health services to be integrated with reproductive health care, facilitate support groups, safe spaces for survivors of violence	

Factors that influence health outcomes: ***Health related considerations***	**Factors that influence health outcomes:** ***Gender-related considerations***		
	Biological factors	**Socio cultural factors**	**Access to and control over resources**
5. Experiences in health care settings		Cultural stigma may deter individuals seeking care, negative effects of masculinity, strong social support system for women, improved mental health literacy in women	Women do not have autonomy outside home, less control over financial resources, strong social support systems Men – financial instability, less social support, preference for informal help seeking
6. Health and social outcomes and consequences	Men are more likely to suffer from substance use disorders, ADHD, and antisocial personality disorder, and have higher rates of suicide. Women are more likely to experience depression, anxiety, and somatic complaints, and have higher rates of Generalized Anxiety Disorder (GAD) and PTSD due to experiences with sexual assault and abuse.	Men often face greater stigma around mental health issues, which can deter them from seeking help, which leads to poorer social outcomes, including isolation and difficulties in maintaining relationships. Women may experience more stress due to income inequality, low social ranking, and unrelenting childcare responsibilities. However, they are more likely to seek help and utilize social support networks, which can lead to better social outcomes.	

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