AFRICAN DEVELOPMENT BANK GROUP

GENDER MAINSTREAMING CHECKLIST FOR THE HEALTH SECTOR

January 2009

TABLE OF CONTENTS

ANNEXES

ACRONYMS AND ABBREVIATIONS

ADB	:	African Development Bank
AIDS	:	Acquired Immune Deficiency Syndrome
CBOs	:	Community-based Organizations
CEDAW	:	Convention on the Elimination of all forms of Discrimination Against Women
CSP	:	Country strategy paper
DFID	:	Department for International Development
ESIA	:	Environmental and Social Impact Assessment
ESAP	:	Environmental and Social Assessment Procedures
GAD	:	Gender and Development
CGP	:	Country Gender Profile
FGM	:	Female Genital Mutilation
HIV/AIDS	:	Human Immunodeficiency Syndrome
IFAD	:	International fund for Agriculture Development
MDG3	:	Millennium Development Goal 3 (focusing on gender)
M&E .	:	Monitoring and Evaluation
GPOA	:	Gender Plan of Action
NGOs	:	Non-governmental Organizations
NEPAD	:	New Partnership for Africa's Development
ODI	:	Overseas Development Institute
PCN	:	Project Concept Note
PCR	:	Project Completion Report
PPF	:	Pre-Project Facilitation
PRSPs	:	Poverty Reduction Strategy Papers
RFIs	:	Regional Financial Institutions
PMU	:	Project Management Unit
RBCSP	:	Result based Country Strategy Paper
RMC	:	Regional Member Countries
SIDA	:	Swedish International Development Agency
SSA	:	Sub-Saharan Africa
STDs	:	Sexually Transmitted Diseases
TB	:	Tuberculosis'
TOR	:	Terms of Reference
UA	:	Unit of Account
WHO	:	World Health Organization
WID	:	Women in Development'

1. INTRODUCTION

1.1 Background and Rationale

1.1.1 Gender differences and inequalities are a major cause of inequity in health care systems because of the different roles women and men play in society. For example, in addition to the different gender specific diseases, women often have less direct access to resources and are often less able than men to take measures to protect themselves against certain diseases. Men and women's different roles also impact who takes care of the sick and the elderly at home or in health facilities. Available evidence shows that women wait longer than men to seek medical care partly due to their unwillingness to disrupt household functioning until they become incapacitated. Therefore, gender disparities in health status, access and use of health services and in health outcomes persist, signifying a need to address gender inequality in health sector interventions.

1.2 Strategic Context

1.2.1 Within the Bank's focus on infrastructure development for reduced maternal mortality and improved health service delivery, the checklist will propose gender mainstreaming strategies and selected indicators to effectively address gender issues in the health sector. This will further contribute to addressing the areas related to MDGs on gender equality as outlined in the Bank's Medium Term Strategy (2008 – 2012).

1.3. Purpose of the Checklist

1.3.1 The purpose of the Checklist is to provide Bank staff as well as consultants with a tool to facilitate effective analysis and identification of the gender issues in the health sector, to design appropriate gender sensitive strategies/components, allocations of resources and definition of monitoring indicators through all stages of the project/program cycle. For effective gender analysis and mainstreaming in projects, the Checklists should be used together with the Bank's Operations Manual and the Environmental and Social Procedures (ESAP). On the use of the ESAP, the preparation of gender-sensitive terms of reference for Environmental and Social Assessment studies should be a key consideration to demonstrate good practices in mainstreaming gender in any Bank funded sector intervention, including health sector projects.

2. ENTRY POINTS FOR GENDER MAINSTREAMING

2.1 Identification

2.1.1 The project identification begins with the preparation of a Project Concept Note (PCN). The PCN is prepared based on information provided by the regional member country as part of the background to their project request submitted to the Bank. **In category 1 and 2 projects this can be specifically addressed** when preparing the terms of reference of the ESIA.

2.2 Preparation

2.2.1 The project preparation stage involves a field visit or a Bank mission to verify and gather additional information in order to build a preliminary consensus on the project design as follows:

- ***Consultations for in-depth gender analysis should*** involve all the key stakeholders particularly the potential project beneficiaries including women's groups, development partners and private sector health providers through field visits to the project areas and conducting focus group discussions with separate groups of men, women and mixed gender groups.
- ***Complete the gender information gaps*** identified during the identification stage is completed through collection of secondary data from the ministry or department of health and other related ministries such as gender/women's ministry, research institutions and other development partners.
- ***Project objective*** should clearly articulate gender constraints and the dimensions addressed by the planned Bank health sector project.
- ***Project activities such as*** the construction of a health infrastructure, training of health service providers and staff, sensitization of health service users should clearly spell out how they lead to the achievement of identified gender equality objectives in the proposed health sector projects. .
- ***Project indicators*** should reflect a realistic estimation of the realization of planned and measurable activities towards achievement of the project gender quality objectives. This stage of the project design should also verify that the project has been categorized based on the guidelines in the Environmental and Social Assessment Procedures (ESAP) as to whether it will positively and negatively impact gender equality in the project area in the context of the health sector.

2.3. Appraisal

2.3.1 The appraisal phase is primarily aimed at refining the project design in terms of the gender issues to be mainstreamed, such that they are all incorporated throughout all possible entry points to the project components of the proposed Bank health sector project objectives and component activities as follows:

- ***Defining project gender objectives should*** clearly articulate and address identified gender gaps in the sub-sector informed by both quantitative sex disaggregated data and the qualitative information gathered from the participatory consultative process.
- ***Identifying project gender activities*** is critical for ascribing project benefits in a health sector project.
- ***Verification of project gender indicators for*** gender monitoring have to be set consistent with the project gender equality objectives using data from the baseline survey and/or any other available reliable data.
- ***Developing gender-monitoring tools should be linked to*** clear monitoring report tools such as progress reports, stakeholder meetings, field visits and mid-term reviews.
- ***Defining project inputs by gender,*** such as gender consultants, equipment and resources for capacity building and advocacy.
- ***Defining planned project outputs by gender*** should be clearly linked to the gender inputs in project activities.
- ***Defining project impacts by gender*** should be clearly linked to the tracking of gender result-based impacts in regular monitoring and evaluation, supervision and progress reports, during the mid-term review and post completion of impact assessments of the proposed health project
- ***Results-based logical framework should*** indicate that the gender indicators are explicit, realistic and consistent with those of the gender equality indicators in the national health sector strategy and the PRSP.

Table I: Gender Checklist for Appraisal Report

CHAPTER 1: STRATEGIC THRUST	***1.1 Project Linkages with Country Strategy and Objectives:*** Outline the main gender dimensions of the current country development and sector strategies and the Bank Country Assistance Strategy (e.g. the gender dimensions defined in the country PRSP, Health Sector Strategy and Bank CSP) that are part of the strategic thrust and rationale for the planned health project. 1***.2 Rationale and Bank's Involvement:*** Review whether the gender dimensions are part of the underlying hypothesis of why the proposed health project is needed and why it is needed at that time. ***1.3 Donors Coordination:*** Assess whether the gender actions under the proposed Bank health project are aligned to the other donor gender equality interventions for the health sector in the PRSP and MDGs Country Strategies.
CHAPTER II-PROJECT DESCRIPTION	***2.1 Project Components:*** Assess whether the options of activities to address the gender issues in the sector identified are viable omprehensive gender analysis in the initial stages of the proposed Bank health sector project. ***2.2 Technical Solutions Retained and Other Alternatives Explored:*** Determine what, if any, is the value added to promoting gender equality and the empowerment of women in the proposed Bank health project. ***2.3 Project Type:*** Determine whether gender issues relating to the proposed Bank health project would be effectively addresed by either targeted intervention or activities mainstreamed in the project component activities. ***2.4 Project Costs and Financing Arrangements:*** Determine the cost estimates to implement the activities on gender issues in the proposed health project. This is mainly to ensure adequate resources and allocation for the implemenation of gender mainstreaming actions in the project budget/cost estimates. ***2.5 Project's Target Area and Population:*** Determine the project population by a socio-economic assessment identifying and disaggregating by subpopulation key indicators, such as health service rates for both women and men. ***2.6 Participatory Process for Project Identification, Design and Implementation:*** Define gender responsive participatory approaches for the consultative process for enhancing stakeholderder ownership and comittment to the proposed health project objectives. ***2.7 Bank Group Experience and Lessons Reflected in Project Design:*** Review whether lessons learnt from gender mainstreaming activities in previous Bank health interventions have been applied in the design of the proposed project. ***2.8 Project's Performance Indicators:*** Verify whether the identified gender indicators for monitoring key actions to address gender issues and expected gender equality results in the proposed health project are and consistent with those of the gender equality indicators in the national health sector strategy and PRSP.

CHAPTER III: PROJECT FEASIBILITY	***3.1 Economic and Financial Performance:*** Review the potential impact in terms of costs and economic benefits of the project for women and men of the proposed Bank health project potential target population. ***3.2 Environment:*** Verify that an ESIA plan outlining the possible impacts of the proposed health project and measures to mitigate the negative effects thoughout the project cycle is prepared. ***3.3 Climate Change:*** Determine whether there is any potential climate risk impact on the attainment of the gender equality benefits of the planned Bank health project. ***3.4 Social:*** Verify whether all the quantifiable and non quantifiable gender and socially related direct and indirect benefits have been defined and are realistic. ***3.5 Involuntary Resettlement:*** Assess whether the proposed Bank health project have relocation site selection in the design and if this has taken into account both women and men's concerns such as safety of the relocations' site and the proximity of viable sources of livehoods and access to basic social services.
IV: IMPLEMENTATION	***4.1. Implementation Arrangements:*** Define the specific institutions within the organizational structure of the project executing Agency and implemementing partners which will be responsible for executing, monitoring and evalution of the activities of the project components. ***4.2: Monitoring/Supervision***: Assess whther the monitoring systems to be established under the proposed health project including the activities, indicators and composition of staff will facilitate generation of gender dissaggregated data and themeasurememt of progresson the implemtation of the project gender mainstreaming strategy. ***4.3. Governance:*** Assess whether there are any Governance risks, e.g. corruption that may affect the level of participation and adversely benefit any of the potential targets groups particularly the girls in the Bank proposed health project activities and whether any measures are required to mitigate against the envisaged risks. ***4.4. Sustainability:*** Assess the extent of the RMC's continued commitment to mainstreaming gender dimensions in its health service delivery that are critical to ensuring success of the proposed project project**.** ***4.5 Risk Management:*** Identify any of the potential risks in the context of the RMC's PRSP/National Development Plan and Health Strategy that may affect the implementation and sustainbility of the gender strategy in the proposed Bank health project design.
V. LEGAL INSTRUMENT	***5.1 Legal Instrument****:* Assess whether the RMC's national and local legal instruments and regulatory frameworks support the creation of an enabling environment for the mainstreaming of gender interventions for the development of the health sector ***5.2 Main Conditions of the Bank Funded Health Intervention*****:** Assess whether there are any of the key features of the gender mainstreaming strategy in the proposed health project that need to be listed as condtions to loan or/and grant entry effectiveness. ***5.3 Compliance with Bank Policies:*** Review whether the gender mainstreaming strategy in the health project being designed is in line with the priority areas on health in the Bank's Gender, Health Sector Policies and the CSP.

2.5. Gender issues in health delivery systems

Key questions

- How effective are health services for women and men in the client population? At the primary level? Secondary level? Tertiary level? Are primary levels being bypassed for higher levels of care?

- What socioeconomic or cultural constraints do people face in accessing health services at each level? Are there differences in access between women and men?
- What access to associated health services (water supply and sanitation improvement, other disease control measures) do women and men in the client population have? To what extent do women and men actively participate in planning and managing such programs?
- Are changes being proposed in the provision of health services that will change gender relations? How will the changes affect women? Will the changes be acceptable to women/men?
- What formal health delivery systems are available to the client population, both clinical and non-clinical? To what extent do women use them? What is the ratio of female users to male users?
- Are there women health workers in the community? What are their roles?
- Is recourse to traditional medicine and traditional healers common in the project area? Are traditional practitioners mainly male or female? Are there female traditional birth attendants?
- What traditional health measures are practiced locally? Do health delivery systems make use of traditional knowledge? Would an inventory of traditional notions and practices assist the program?
- What are the constraints preventing more women from being trained or being appointed as health providers?
- What factors reduce women's access to health services? Consider factors such as timing of services, lack of time for women, distance, and lack of money for transportation, restrictions on women's movement in public, lack of female staff in clinics, lack of privacy for examination, complicated or intimidating procedures, and poor facilities.

Key strategies to address gender issues in health service delivery

- Collect sex-disaggregated data on the use of formal and informal/traditional health services and access to medicine.
- If the intention is to strengthen basic health services, then focus on supporting primary health care units.
- Locate health centers where they are conveniently accessible to women. Ensure that hours of service delivery fit in with women's work schedule.
- Improve the knowledge of the client population on health matters, to enable them to participate in improving health and associated services.
- NGOs or community-based organizations may be involved in such initiatives.
- Establish an emergency transport system in communities by supporting the most feasible methods of emergency transport and community commitment to transport women to hospitals.
- Ensure that the executing agency places sufficient emphasis and devotes adequate resources to training women as health providers at all levels of the health delivery system.

- Consider assisting the executing agency in recognizing the need and taking action to increase the number of female health service providers by recruiting women for all areas of health delivery, as community health workers, health educators, doctors, health administrators and managers, nurses, midwives and paramedics.

BOX 1: MATERNAL MORTALITY RISK FACTORS AND HEALTH SERVICE DELIVERY[1]

Key questions

- What is the incidence of maternal deaths? What are the main maternal risk factors? What are the major clinical, environmental, and socioeconomic causes? Which age groups are the most at risk? What percentages of births do medically trained midwives assist?
- What are the childbearing years for women? What health problems among the client population predominantly affect women or are female specific?
- Is violence against women prevalent in the project area? What community or health services are offered to abused women?
- Are there women-to-women services in maternal and child health programs (including reproductive health and family planning)? Does lack of women-to-women maternal and child health services constrain women from using health services?
- Distribute relevant information on food and nutrition to improve the diet of women, children and men in the client population.
- If violence against women is prevalent in the area, initiate measures to prevent violence against women.
- Are sexually transmitted diseases (STDs) a problem in the targeted community, for men? For women? Are there societal attitudes that constrain the population from recognizing or reporting such occurrences? Are there cultural constraints on measures to protect against the spread of STDs?
- If HIV/AIDS is a serious health problem, who cares for AIDS sufferers?

3. PROJECT IMPLEMENTATION AND SUPERVISION

3.1 Implementation

3.1.1 This should examine established institutional arrangements of the human resource capacity institutions within the organizational structure of the designated Executing Agency and other implementing partners responsible for the execution of the activities to mainstream the gender dimensions defined in the proposed project components. This stage of the project design should also assess the capacity building needs for the Executing Agency and Project Management (PMU) staff to create required competencies for effective implementation of the defined gender mainstreaming activities in health project components. A number of actions need to be taken during project start-up\launch and during the project to ensure effective gender mainstreaming including:

- Use of the project launch workshop as an opportunity to clarify and emphasize project objectives which have been designed to promote gender equality.
- Ensure a gender balance in project staff, for instance by briefing the Executing Agency on the Bank's gender policy.

[1] (Adapted from Asian Development Bank).

- Include gender sensitivity and/or gender expertise in the terms of reference for all project posts.
- Check that staff training covers gender and health issues relevant to this project.
- Make sure that male and female project staff have equal access to training opportunities related to the project.
- Ensure criteria for gender equality issues are taken into account in the local procurement of goods and services.

3.2 Monitoring and Supervision

3.2.1 The monitoring and supervision of the project focuses on tracking progress with regard to achieving gender targets and objectives as set out in the project and also facilitates the collection of gender-disaggregated data on the project's impact on gender equality in health. An important part of the monitoring and supervision of the project is the Mid-term Review that assesses whether the project gender objectives are on course and defines actions to address problems affecting the implementation of the gender project strategy.

3.3 Project Completion and Evaluation

3.3.1 During this stage of evaluation the focus should be on assessing the extent to which the systems put in place by way of the project design have contributed to the realization of the proposed health project gender objectives by **assessing the extent to which gender project objectives are being met**. When reviewing the gender disaggregated data and other gender dimensions of the project and **comparing baseline data and end of project gender indicators** this shows the extent to which the project has contributed to increased access to health services for both men and women in the project target area. To learn from experiences and establish best practices it is **necessary to identify key areas that influence project success or failure** and document factors that contribute to the success or failure of the project.

Annex 1: Common Gender Dimensions in the Health Sector

Locations and timings selected for health centers and posts: do not always take into consideration the problems of users, sometimes planners look more at trying to cover clusters of villages geographically and less at practical issues of access.

Health personal: Often men are chosen as health workers, because requirements for training include basic literacy, if not a few years of basic education and relatively few women in more isolated rural areas are eligible under such conditions. It is rare that training for outreach health workers is adapted for illiterate people. Male workers cannot always provide health care to women in the community, particularly in relation to childbearing, but also in societies where segregation is practiced.

Health education: efforts in the centers are not necessarily communicated accurately to household members, either, since messages have been designed for women more than for men. Women are, however, seldom well placed in the community to be able to transmit hygiene and health-related messages with authority. As a result, there can be gender differences in awareness of health risks, and gender-based barriers to implementing adequate preventive health measures.

Biological aspects of women's health: Differences between men and women in personal autonomy and bargaining power within relations put women at risk of physical and sexual abuse and limits their ability to negotiate sexual practices that protect against STDs including HIV/AIDS.

Cultural practices: Cultural practices observed in some areas such as female genital mutilation and child marriage seriously affect women's sexual and reproductive health e.g. increase risk of pregnancy related complications, as well as limiting socio-economic opportunities for girls.

Son preference: In some societies, this often leads to a tendency to invest more family resources in the prevention and treatment of illness for sons rather than daughters. This may, for example, result in preferential allocation of food to boys and lead to nutritional deficiencies and poor physical development for girls in childhood and a higher risk of complications during childbirth.

Work allocation; Women's heavy workloads and multiple responsibilities for productive and household/childcare activities mean that the opportunity costs for seeking care may be high, particularly where distances, transport or health centre hours are problematic

Annex 2: Key Elements in Gender Analysis

Gender analysis is the essential first step towards designing and implementing health policy, health projects and health research in a gender sensitive manner. Gender analysis aims to identify significant gender differences and inequities in who gets ill, when and why and in how women and men respond to illness. The gender analysis helps to identify:

1) Who suffers from ill health (patterns of ill-health)?
2) Why particular groups suffer from ill-health (factors affecting who suffers from ill-health)?
3) How men and women's responses to ill-health are influenced by gender (factors affecting responses to illness)?

Stakeholder Identification and Analysis

This should also take into account that different groups of women may have different needs related to variations in factors such as geographical location and cultural, religious and socio-economic background. The following are some of the key factors to be considered:

1) The major groups inside and outside the community who have an interest in the project?
2) The main areas of interest/concern for each group?
3) The issues with regard to education on which there is reasonable degree of consensus?
4) The issues and the priority areas of concern that are specific to each of the stakeholder groups and in particular the women.

Institutional Analysis

The capacity of a programme or project to deliver on commitments to gender parity and equality in health is determined by the individuals and the organizations in which it is implemented and the institutional structure in which they are implemented. However, finding institutional structures that can effectively be used for gender mainstreaming for any development intervention including a health sector project is often a challenge.

Participatory Approach

Experience in variety of contexts health sector project suggest that unless specific steps are taken to ensure the equal participation of men and women, women are often excluded. As a result, projects fail to benefit from women's contributions and fail to meet the particular needs and interests of women. Therefore, for effective consultation with stakeholders, care is needed to ensure that both female and male representatives are included among the usual group of stakeholders consulted during such missions, and that the question concerning probable influence of and impact upon gender relations are raised during discussions. A number of techniques are often used in gender sensitive participatory approaches including the following:

- **Conversational Interviews: This promotes** the free expression on the existing gender dimensions in the health sector identified by the stakeholders, particularly women and the poor on a one to one basis or in groups on a number of themes or topics directly related to a planned education intervention.

- **Focus Group Discussions are important for** facilitating the collection of data from a large sample of the stakeholders in groups at one time.
- **Direct Observation: Notes and takes into account the** behaviour traits and patterns and other notable events in relation to the identified stakeholders in the context of the proposed education intervention.
- **Participant Observation:** Facilitates the understanding of people's motivations, perceptions and attitudes towards the planned health project in order to determine their preferences as well as their constraints and incentives in participating in the proposed health intervention.
- **Needs Assessment:** Extracts information about people's needs, raises participants' awareness of pertinent health issues and provides a framework for prioritizing needs including the different needs of women and men and these may change seasonally and at different life stages.
- **Mapping:** Generates baseline data using visual aids and through participatory discussions to define priorities and aspirations for a planned health intervention by the various defined key stakeholder.
- **Socio-economic Surveys:** Collect both quantitative and qualitative socio-economic data the potential target population including demographic characteristics, forms of livelihood and access to social services.

Annex 3: Strategies for Gender Mainstreaming in Health

Recognition of gender inequality in access to health care and health system: The initial considerations for a strategy to mainstream gender equality in a health sector intervention are to start with an appropriate understanding of gender inequality. The different ways in which the socioeconomic and cultural aspects of being male or female affect the health risks of individuals and their access to health services are generally better able to promote and mainstream gender issues.

Recognition of socioeconomic and cultural factors prevents access to services. e.g., women's heavier workload, their lack of independent income, the unwillingness of families to invest in women's health and cultural attitudes. In addition, the responses of the health system can be improved not just through more facilities, drugs and staff but also through a health system that has been reorganized and reoriented to promote access and client focus. Planners should recognize women's role as providers and promoters of preventive, as well as curative health care in the household and the community. Women must be seen as agents of change, and not only as beneficiaries of development interventions.

Consultation with all stakeholders is critical because it leads to a better understanding of issues and therefore a better identification of needs. Consultation and dialogue makes the processes transparent, valid and credible thus help build consensus. The process itself can raise awareness about health and about the need to address aspects of gender inequality that affect women's health. All categories of stakeholders need to be identified and women's representation must be ensured. Women's organizations can play an important role in this respect.

Capacity strengthening is needed in different places (e.g. government, NGOs and women's organizations) and at different levels (local, regional and national). Capacity needs to be developed for different kinds of activities: from policy development by the national government and sector programs to management and administration, human resource planning, service delivery, management information system, and support for authentic consultation with civil society. The capacity to refocus services to client needs and manage change at all levels is critical. There is a need to expose decision-makers at the highest level to gender-equality objectives and dialogue with stakeholders.

Another challenge is that the determinants of health go far beyond the confines of the health sector and any attempt to tackle the problems of gender must therefore grapple with a variety of cross-sectoral issues at a number of different levels. Obtaining political commitments at the highest levels of Government is just as important as securing cooperation between different ministries and between the ministries, health professionals and other stakeholders. If health care systems are to respond adequately to problems caused by gender inequality, it is not enough simply to "add in" a gender component late in a given project's development. Interventions on health system reforms, health education, health outreach and health policies and programs must consider gender from the beginning. In addition, gender equality in health must be a basic consideration, not only in programme design and implementation (such as nutrition, health education, hygiene, Tuberculosis etc), but in all aspects of the health sector. Further, facilitating a wider understanding that there are technical, practical and operational reasons for considering gender in national programme design is not merely a donor interest or conditionality.

Annex 4: Gender Issues in Health Sub-Sectors

Gender issues in primary health care

- Unavailability of women-to-women services in maternal and child health programs (including reproductive health and family planning).
- Lack of decision-making power especially when it comes to sexual and reproductive health issues.
- Religious or cultural restrictions that prevent women from leaving their homes and from receiving health care from male providers.
- Frequent existence of unfriendly environments that do not respond to the sexual and reproductive health rights and special needs of women, further impeding their access to health care.
- Lack of a voice on the distribution of family resources inhibits women from meeting the cost for health care.
- Negative attitudes of health providers to clients seeking reproductive health services, inadequate knowledge on sexual and reproductive issues management and counselling, unfavorable facilities for provision of quality SRH services, unfriendly client provider relationships, and lack of adequate supplies and of participatory gender sensitive approaches in planning.
- Lack of self-esteem and knowledge resulting in women denying the existence of a health problem and/or hesitating to complain of ill-health. Inability to obtain health care through constraints in reaching a place of service delivery due to a series of other obstacles, such as distance from the health centre, lack of time and money, no-one to look after her children, the hours of operation of the health centre and the long queues, may mean losing a day's work and wages.
- Inappropriate health care including the health centre not being in operation, no female health staff in attendance and services of the health facility may be limited to a narrow spectrum, with only MCH care aimed specifically at women. Reproductive health problems are many and varied and women may not find either the facilities for screening, or personnel with appropriate skills.
- High opportunity costs of follow-up health services, which prevent women from continuing with and completing the treatment.

Gender issues in reproductive health

- Cultural socio-economic factors may result in high incidences of maternal deaths.
- Low percentages of births are assisted by medically trained midwives.
- Unavailability of health services treating illnesses related to violence against women or abused women.
- Societal attitudes that constrain the population from recognizing or reporting such occurrences of STDs.
- Female poverty and lack of access to resources contributing to the low level of access to reproductive health services, e.g. high cost of contraceptives may restrict access to women and men.
- Lack of decision-making power for women among couples or extended families.
- Sex-based differences in knowledge and attitudes regarding fertility decisions.
- Insufficient legal instruments to promote women have access to contraceptives regardless of age, marital status, and number of children, e.g. women may require the permission of males to obtain contraceptives or an abortion.
- Lack of culturally appropriate information/education programs on family planning that is adapted for low literacy populations and programs which target women or men, or both sexes.

Gender issues in health delivery systems

- Ineffective health services for women and men at primary, secondary, and tertiary education.
- Socioeconomic or cultural constraints affect women and men in accessing health services at each level.
- Lack of associated health services (water supply and sanitation improvements and other disease control measures) that women and men in the client population may find inaccessible.
- Inadequate participation by women and men in the planning and managing of health services' programs.
- Lack of recognition by the formal health delivery systems of traditional health knowledge, notions and practices.
- Insufficient appreciation of other factors that affect women's access to health services including timing of services, lack of time for women, distance, lack of money for transportation, restrictions on women's movement in public, lack of female staff in clinics, lack of privacy for examination, complicated or intimidating procedures, and poor facilities.