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Chapter 11: Gender-sensitive, respectful service delivery

Gendor 101 training materials

Jhpiego is a nonprofit global leader in the creation and delivery of transformative health care solutions that save lives.

In partnership with national governments, health experts and local communities, we build health providers' skills, and we develop systems that save lives now and guarantee healthier futures for women and their families. Our aim is revolutionizing health care for the planet's most disadvantaged people.

Jhpiego is a Johns Hopkins University affiliate.

Published by:
Jhpiego Corporation
Brown's Wharf
1615 Thames Street
Baltimore, Maryland 21231-3492, USA
www.jhpiego.org

Chapter 11: Gender-sensitive, respectful service delivery

Learning objectives

By the end of this session, participants will be able to:

- Describe quality of care through a gendered lens
- Describe standards of respectful care provision
- Identify ways in which their personal perceptions of clients may influence their interactions with them

Time needed

2 hours 5 minutes (minimum)

Materials needed

- Two blank Jamboards
- Facilitator Resource: Role Play Scenarios
- Participant Handout: WHO Quality of Care Framework
- Participant Handout: Jhpiego Gender Service Delivery Standards Facilitation Guide

  (https://jhpiego.sharepoint.com/:b:/s/JhpiegoResources/ER4XijepcZBJj4EM-hbxMXEB8zZIbdeOz0kSU3cBEnFhhQ)
- Participant Handout: Jhpiego Gender Service Delivery Standards

  (https://jhpiego.sharepoint.com/:b:/s/JhpiegoResources/EYOUkWezleNJisDoAi7s2hUB2ydh9OuTA2wDgnyCV982mw)
- Facilitator Resource: PowerPoint on Jhpiego's Global Gender Service Delivery Standards

Advance preparation

1. Email copies of each participant handout to participants.
2. Save a copy of the PowerPoint on Jhpiego's Global Gender Service Delivery Standards to your laptop, and practice presenting.
3. Review the 3 options for reinforcing the standards after the presentation. Select which option you will implement.
4. [If you will be implementing **Option 1: Discussion** or **Option 3: Revised Role Play** below] No advanced preparation.
5. [If you will be implementing **Option 2: Slido/Mentimeter Polls** below] Log into your Mentimeter or Slido account. (Note that it is recommended that facilitators who **do not have a paid account with either Mentimeter or Slido use Slido**; the remaining instructions will assume that facilitators are using a free Slido account. Zoom Polling will not work in this situation as there are 20 standards and Zoom only allows hosts to input up to 10 answer options). Create a new event. Add the three following multiple-choice questions.
   - Question 1: Which standard do you think would be most challenging for health facilities to adopt?

- Answer Choices:
  - [Provide each standard]
- Question 2: Which standard do you believe is most relevant to your program?
- Answer Choices:
  - [Provide each standard]
- Question 3: Which standard do you believe is least relevant to your program?
- Answer Choices:
  - [Provide each standard]

Facilitator Note: It is highly recommended that facilitators recruit an additional individual to support them with the technological logistics of this session, particularly during the role play.

Steps

Introduction (1 minute)

Explain the increasing focus globally and by the World Health Organization (WHO) on the importance of quality and experience of care as central to reproductive, maternal, newborn, and child health. State that the WHO has indicated experience of care as an important domain of its quality of care framework. Likewise, leading agencies have indicated the importance of gender inequality as an issue for accessing quality care.

Introducing the issue of quality of care from a gender lens (8 minutes)

1. **Technology Action:** At any point after participants have joined the meeting, begin creating breakout rooms for the "Role Play" activity.
   - Up to 5 groups (randomly distributed participants)
   - Check "Breakout rooms automatically close after"
     - 15 minutes
   - Check "Notify me when time is up"
   - Countdown after closing breakout room: 30 seconds
2. Lead a quick 3-minute brainstorm with participants around the question: What do you consider to be the key aspects of quality of care?
3. **Technology Action:** Share a link in the chat to a blank Jamboard.
4. Call participants' attention to the link in the chat. Invite participants to add sticky notes to the board in response to the question, "What do you consider to be the key aspects of quality of care?"
5. **Technology Action:** Screen share the Jamboard and demo how to add sticky notes (described below).
   - Click on the sticky note icon within the toolbar to the left of the board, write a word/phrase, click save, and then click anywhere on the Jamboard to go back to the main Jamboard and move your sticky note around or resize it.
6. Invite a few participants to unmute and share verbally what they consider to be a key aspect of quality of care and why. As participants add ideas to the Jamboard, you may also ask who posted a

particularly interesting/pertinent sticky note (because sticky notes are added anonymously, you will need to confirm first who added a particular sticky), and then ask that individual to share more about the idea verbally.

Facilitator Note: As participants record/share their ideas, make sure to probe for elements of the WHO quality of care framework.

Optional Adaptation

Instead of using a Jambaord to collect responses to the question about quality of care, facilitators may use an open ended/open text question from polling software such as Slido or Mentimeter to collect responses from participants. Note that this will require advance preparation on the part of the facilitator. Log into your Slido or Mentimeter account prior to the session and add an open ended/open text question which asks, "What do you consider to be the key aspects of quality of care?" During the session, present the poll and invite participants to contribute their ideas using the numeric code or QR code.

7. **Technology Action:** Screen share the Participant Handout: WHO Quality of Care Framework.
8. Remind participants that they can access this handout from their email. After giving a general overview of the framework, draw participants' attention to the "experience of care" component. Explain that client experience of care is a core aspect of quality of care. It means providing client-centered care. Experience of care encompasses the variety of interactions clients have with the multiple components of the health delivery process (e.g., client ability to communicate needs to providers and health workers, provision of respectful care, etc.)
9. State that, through its programming, Jhpiego seeks to improve quality of care by promoting improved experience of care in addition to improving quality of provision of care. Given our focus on reproductive and maternal health, we need to consider experience of care from a gender perspective. There are various approaches and methods to improving experience of care. A first, important step is to engage health workers in a participatory way to understand the problem and define solutions. Understanding quality of care issues driven by gender inequality is not always so obvious because gender inequality is embedded in sociocultural practices and behaviors. A gender lens is needed to analyze why, and how, women are denied their rights to quality, respectful, and equally accessible care. State that you will begin the analysis using role plays. (Spend no more than 5 minutes on steps 6 to 8).

Role plays (1 hour 10 minutes)

1. Explain that participants will be divided into five groups. Each group will be given a scenario. A facilitator will enter their room soon after opening breakout rooms and will share in the chat the group's scenario.
2. Next, explain that each group will have 15 minutes to read through the scenario they are given, assign each group member one of the characters in the scenario, and prepare to act out their scenario. Tell participants that their role plays must emphasize the gendered aspects of their group's scenario (e.g., gender discrimination, gender stereotypes, gender-discriminatory laws or policies that result in exclusionary or disrespectful behaviors and/or outcomes). Tell participants that they will have up to 5 minutes to perform their role-play in front of the larger group.
3. Explain that, since we're virtual, participants won't be able to act out all aspects of the role play; for example, participants won't be able to move around the room. Consequently, these role plays may be informal and do not need to be perfect; the goal is to convey information about the gendered

aspects of the group's scenario. However, participants should consider how they can make use of Zoom features during their role play; for example, participants may:

- Turn their camera off to imitate leaving a room.
- Mute themselves to have a pretend side-conversation, or to indicate being farther away from other participants who are talking.
- Use any props that they have near-by.
- Change their Zoom background to something representative of the scene.

4. Ask if anyone has any questions. Suggest that participants spend some time introducing themselves to anyone they may not know as they wait for the facilitator to come and share their group's scenario. However, a facilitator will arrive within about the first minute. (Spend no more than 5 minutes on steps 1 to 4).

Facilitator note: If some groups have more participants than the number of characters in the case study they were assigned, they may wish to create additional characters or have the extra group members serve as role play directors as the group practices.

Facilitator note: Some male participants may feel uncomfortable representing a female character. The facilitator should be sensitive to reactions of discomfort expressed by male participants and, when appropriate, remind them of any previous discussions about gender roles. The facilitator should also encourage the men to reflect on their reactions. If absolutely necessary, male participants who are uncomfortable representing a female character may be given a male character description.

Facilitator note: Some participants may feel uncomfortable representing characters who do not conform to dominant gender and/or sexuality norms (e.g., a gay character). It is important to emphasize that this is only an exercise, and explain that the activity is intended to explore precisely the types of feelings people may have about non-normative sexual and gender identities.

5. **Technology Action:** Open the breakout rooms.
6. **Technology Action:** Join each breakout room, one by one. Copy and paste each group's scenario in the chat after you've entered their breakout room.
7. **Technology Action:** Close the breakout rooms after approximately 15 minutes. Make sure that your screen is not being shared as people return to the main room, so that all participants can be seen in gallery view.
8. Explain that each group will present their role plays now, starting with group 1. Explain that each group will be spotlighted so that the rest of the participants will be able to focus on those individuals participating in the role play.
9. **Technology Action:** Begin spotlighting the first group. Hover over the video that you would like to spotlight. Then, click the three blue dots in the top right-hand corner of their video, and select "Spotlight for Everyone". To add a spotlight, hover over an individual's video and click "Add Spotlight".

Technology Note: Consider asking the participants of each group to raise their hand immediately before you begin spotlighting them, or when it is their turn to present. By raising their hand, their videos will all be moved to the top left of your Zoom screen.

10. Instruct the participants in the audience to take note of the following elements during the role-play performance:

- Gender-insensitive, discriminatory and/or disrespectful attitudes and behaviors observed in the role-play.
- Underlying gender norms that may contribute to the gender-discriminatory attitudes observed.

11. Remind the first group that they will have 5 minutes.
12. **Technology Action:** After the first group has performed its role-play, remove the spotlight from each participant (click the three blue dots in the top right-hand corner of their video and select "Remove Spotlight"). Note that participants' view will return to Speaker View.
13. Ask the workshop participants in the audience to share what they observed in terms of gender-discriminatory attitudes and behaviors and the gender norms that might have contributed to these attitudes and behaviors.
14. **Technical Activity:** As participants share their ideas, write them on a second blank Jamboard. Do not share your screen at this time. (You will share the Jamboard notes with participants later in the session).

Facilitator Note: It's recommended that someone other than the lead facilitator take notes on the Jamboard, so that the lead facilitator can focus on the role plays and debrief. A co-facilitator or admin support should play the role of note-taker.

15. After participants from the audience have commented, ask the role players to briefly describe what they had intended to express through their role-play. (Spend no more than 3 minutes on steps 15 to 17).
16. Repeat steps 11 to 17 for the remaining groups.

Facilitator note: During the role play debriefs, participants may point out actions related to general poor communication or lack of support, but make sure to probe for the gender norms and discrimination that lead to such behavior, for example:

- Scenario 1: Acceptance of women's suffering, gender-based violence (GBV)
- Scenario 2: Inability of midwives to challenge senior, male doctors
- Scenario 3: Homophobia and related stigma, men being able to decide on condom use with wife but not male sexual partner
- Scenario 4: Beliefs about masculinity and fertility
- Scenario 5: Gender stereotypes about girls needing to be chaste, judging the girl for being "loose"

17. **Technology Action:** Screen share the Jamboard on which you have been taking notes.
18. Once all five groups have performed their role plays, review all of the gender-discriminatory attitudes/behaviors (and corresponding gender norms) that you listed on the Jamboard. Ask participants if they think there is anything missing and add to the list as needed. (Spend no more than 2 minutes on this step).
19. Before moving to the next section, facilitate a 5 to 10 minute group discussion using the following questions:
    - Were the scenarios realistic?
    - Which forms of gender discrimination occur most often during health service delivery?

- How do your programs currently address some of the forms of gender discrimination illustrated in the role plays?

Presentation on Jhpiego's global standards for gender-sensitive services (45+ minutes)

1. Next, tell the group that Jhpiego's gender unit has developed global standards for gender-sensitive services. Jhpiego programs are expected to work with health facilities to integrate these standards into their quality improvement processes.
2. **Technology Action:** Screen share the PowerPoint on Jhpiego's global standards for gender-sensitive services.
3. Use the discussion points under each slide to discuss the standards. (Spend no more than 30 minutes on this step).
4. After you have presented, allow participants 5 minutes to ask questions and/or make comments.
5. Remind participants that they can access Participant Handout: Jhpiego Gender Service Delivery Standards Facilitation Guide, and Participant Handout: Jhpiego Gender Service Delivery Standards from their email.

Facilitator Note: After the presentation, select between **one of the following** options to reinforce the delivery standards. Consider with which option you are most comfortable, as well as which option will most effectively engage your specific participants. You should also consider how much time you have available.

Option 1: Discussion (10 minutes)

Consider this option if your participants are comfortable participating in full-group discussions over Zoom and you have limited time to reinforce the standards. Note that the exact timing for the discussion may be adjusted based on your needs and the needs of participants.

1. Facilitate a 10-minute group discussion using the following questions:
   - Are there any standards that would be challenging for health facilities to adopt? Which ones? Why?
   - Are some standards less or more relevant to your program? Which ones? Why?
   - What support would you require to advance these standards in your program?

Option 2: Slido/Mentimeter Poll Questions (15 minutes)

Consider this option if your participants find full-group discussions challenging and you would prefer an option that provides some additional prompting to support a more focused discussion.

1. Explain that participants will now have an opportunity to further reflect on each of the standards and how they might be applied to their work.
2. Explain that you will show a series of 3 questions, one at a time. Participants will have a chance to respond, and then you will discuss the question and responses with the group. (Spend no more than 1 minute introing the activity).
3. **Technology Action:** Share your screen showing the first Slido poll question ("Which standard do you think would be most challenging for health facilities to adopt?")
4. Invite participants to either scan the QR code to submit their response, or to go to Slido.com and use the numeric code to respond to the poll.

5. Invite 1 to 2 participants to share how they voted and why. (Spend no more than 5 minutes on each poll).
6. Repeat steps 3 to 5 for the remaining 2 questions.

Option 3: Revised Role Play (60 minutes)

Consider this option if you have a smaller number of participants and want to provide participants with an opportunity to reflect more deeply on how the standards might be integrated and applied to specific health scenarios. Note that this option takes significantly more time than the other options. This activity may be completed in addition to one of the activities above as time allows.

1. Explain that groups will now have an opportunity to revisit their role plays from earlier in the session and begin to consider how they might apply the standards discussed in the presentation to those scenarios.
2. Explain that participants are going to do one more role play. They will have the same scenario that they had previously. However, this time around, instead of acting out the scenario as shared in the original description, each small group will re-imagine the scenario as it might have gone had the health providers adhered to Jhpiego's standards for gender-sensitive services.
3. Note that these can again be highly informal presentations. Additionally, participants are welcome to switch up who plays which character. The most important aspect of this second role play is that the group intentionally incorporates Jhpiego's standards.
4. Explain that participants will again have 15 minutes in their small group to prepare, and then up to 5 minutes to present when they return.
5. Ask if anyone has any questions. (Spend no more than 5 minutes on steps 1 to 5).
6. **Technology Action:** Open the breakout rooms.

> **Technology Note:** As long as you facilitate this activity on the same day as the first role play, there will be no need to re-create breakout rooms, as the settings from the previous breakout room will have been saved and will not need to be updated for this second breakout room activity.
>
> If this activity will be facilitated on a different day (or if you will be required to end and then re-start the Zoom meeting for any reason), you will need to re-create the breakout rooms. In this case, we recommend screenshotting the breakout rooms prior to closing the Zoom meeting so that you have a record of who should be in each room.

7. **Technology Action:** Send a broadcast message when groups have 5 minutes, and then 1 minute left.
8. **Technology Action:** Close the breakout rooms.
9. Explain that each group will present their role plays now, starting with group 1. Explain that each group will be spotlighted so that the rest of the participants will be able to focus on those individuals participating in the role play.
10. **Technology Action:** Begin spotlighting the first group. Hover over the video that you would like to spotlight. Then, click the three blue dots in the top right-hand corner of their video, and select "Spotlight for Everyone". To add a spotlight, hover over an individual's video and click "Add Spotlight".

Technology Note: Consider asking the participants of each group to raise their hand immediately before you begin spotlighting them, or when it is their turn to present. By raising their hand, their videos will all be moved to the top left of your Zoom screen.

11. Ask participants to consider which standards are being intentionally integrated into the new scene as they watch the role play.
12. Remind the first group that they will have 5 minutes.
13. **Technology Action:** After the first group has performed its role-play, remove the spotlight from each participant (click the three blue dots in the top right-hand corner of their video and select "Remove Spotlight"). Note that participants' view will return to Speaker View.
14. Ask the workshop participants in the audience to share which of Jhpiego's standards for gender-sensitive services they observed. Use the following questions to facilitate a brief discussion:
    - What standards did they notice or recognize?
    - How did adhering to these standards affect the scenario?
    - What longer-term outcomes do you suspect these standards might have on the character's (or characters') health and well-being?
15. After participants from the audience have commented, ask the role players to briefly describe what they had intended to express through their role-play. (Spend no more than 3 minutes on steps 14 to 15).
16. Repeat steps 10 to 15 for the remaining groups.

Closing (1 minute)

End the activity by stating that all individuals, regardless of gender, sexual orientation, age, economic status, ethnicity, or other social identifier, have the right to quality, respectful, and accessible care. Delivery of quality care requires health systems to take into account and address gender disparities and other social inequalities.

Sources

- Interagency Gender Working Group (IGWG). n.d. *Introduction to Gender Analysis and Integration*. https://www.igwg.org/training/gender-analysis-and-integration/. Accessed December 21, 2016.
- Population Reference Bureau. 2009. *A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action*, 2nd ed. Washington, DC: Population Reference Bureau.

Facilitator handout: Role Play Scenarios

Scenario 1

You are a new midwife who arrives on duty in the hospital where you work. As you take over duty from the previous midwife, Mary, you are told that one of the women in labor, Siah, is 17 years old, gravida 1 para 0 (G1P0), full term, has reportedly been in labor for 8 hours, and was admitted to the hospital 4 hours ago. You are told that she is uncooperative and difficult to examine because she holds her legs together and cries. You observe the 17-year-old lying on a bed in the labor area with only a sheet covering her. The labor area does not have curtains between beds and you know Mary usually takes the sheet off when examining clients and has been known to force women's legs apart when she doing an exam. She usually communicates little with women in labor except to tell them to "be quiet" or "shut up."

You have asked Mary why she treats the patients so rudely. Mary looks at you with a frown and says, "This is how we are all treated, isn't it? Our husbands hit us all the time. We are all abused. It's our duty as women to suffer, especially while giving birth!"

Mary leaves and you take over the care of Siah. Fortunately, you see that you have only two women in labor at this time.

Scenario 2

You are a midwife who was recently employed in the labor and delivery ward in the county hospital. You have become concerned because you hear from community members that they do not want to go to the hospital in labor because they are treated so poorly. You also observe that:

- On arrival, women are given a bed number and are referred to by that number rather than their name.
- The other midwives make fun of the women, especially those from lower socioeconomic groups.
- The women are given no privacy. There are no curtains separating beds. There are drapes on the ward but there is no attempt to drape women during examinations.
- Women are forced to stay in bed and lie on their backs during labor and birth.
- Women are frequently pushed and shoved if they attempt to sit up or turn over during the birth.
- Women are left alone when their midwife goes out for tea or lunch.

You are quite concerned about the abusive and disrespectful treatment the women receive. You try to raise the issue with your supervisor in charge, a male ob-gyn. He asks why you are worried about such trivial things when women are dying due to hemorrhage and pre-eclampsia.

Scenario 3

John is 30, single, and lives with his parents. He started having sex with men when he was a teenager. He knew that being gay was natural for him, but he was worried his family would find out and make his life miserable. Other gay friends of his had been "discovered" by their parents and their lives had become hell. To avoid this, John got married.

For 1 year, John stayed with his wife without seeing other men. After 1 year, he felt he could no longer wait, so he started having sex with one of his former lovers. Even when he was with his wife, he was thinking about having sex with this man. In the marriage, he insisted on the use of condoms, but in his

sexual relations with his male lover, he found it more difficult to negotiate safer sex. After 2 years of married life, John learned that one of his previous male partners had tested positive for HIV, so he started to worry about his own status. What would people think if he was HIV-positive? Would they find out that he was gay? How would he be treated?

For a while, he avoided getting tested because he was afraid he would be exposed as gay. But he was confused and worried that he might have HIV. Eventually he went to get tested, but the voluntary counseling and testing (VCT) counselor made him feel uncomfortable. She asked a lot of questions about John's sex life, and when John mentioned having had sex with men, she said, "No, you are not one of those! You seem different!" John left the VCT without taking the test and told himself he would never go back.

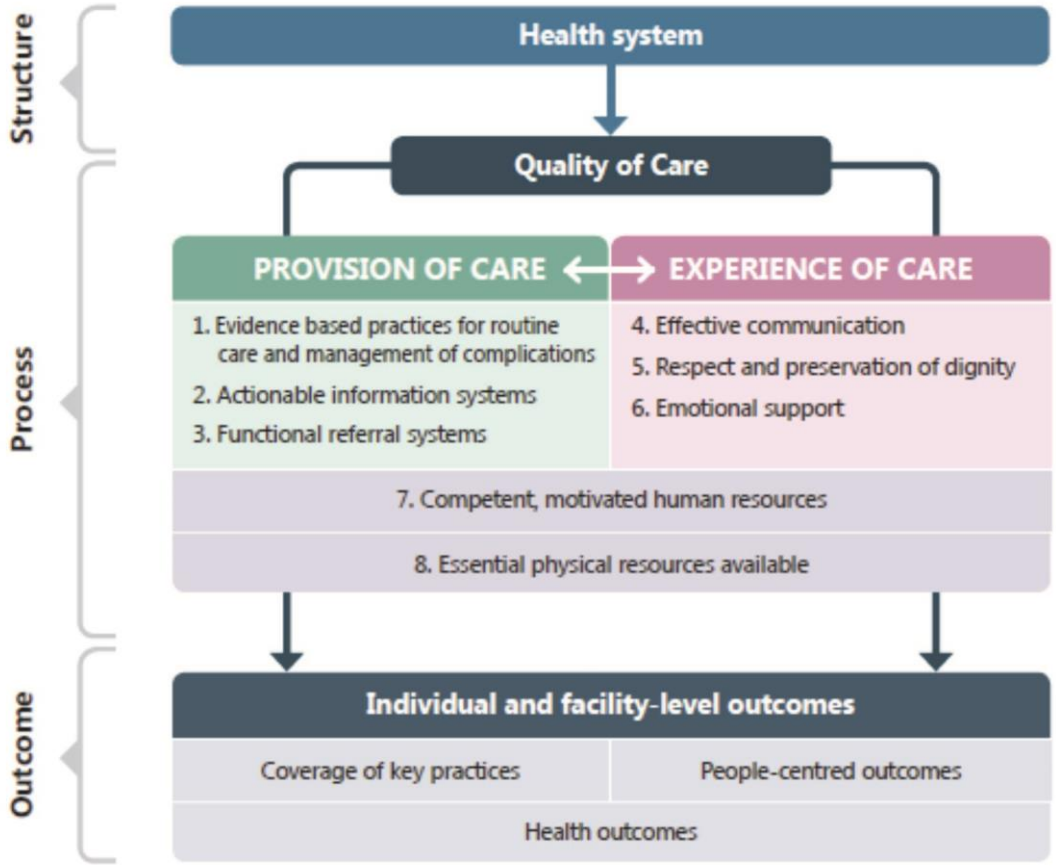
Scenario 4

You are a nurse advising a couple on postpartum family planning. The couple, Michael and Jaughna, have just had their first child, and you are advising them on long-acting reversible contraceptives. Michael and Jaughna have indicated that they prefer not to have any more children. Their parents each had five children, and they do not want to shoulder the same economic or caregiving burden. Michael has heard from a friend that a vasectomy could more permanently prevent pregnancy. But you are shocked when he suggests this. After all, they just have one child. In your society, children are considered God's gift! Fathering many children is an important sign of manhood. You know that vasectomy is a contraceptive method available in some clinics, but it is not a common practice, nor do you think it should be. You continue to explain other long-acting methods even as Michael tries to ask more about vasectomy.

Scenario 5

You are a nurse working in the local dispensary. Layla is a 14-year-old girl who comes to the dispensary with many questions about how to prevent pregnancy. You are surprised and not sure what to say. You tell her that she is too young to be asking such questions. She persists, albeit shyly, and eventually asks about some pills she heard that can prevent pregnancy after having sex. You realize she is talking about emergency contraception and suspect that she may have already had sex. You wonder where her mother is and what kind of mother has let her child become loose like this?!

Participant handout: WHO Quality of Care Framework



Source

Tunçalp Ö, Were WM, MacLennan C, et al. 2015. Quality of care for pregnant women and newborns—the WHO vision. BJOG 122:1045–1049.
http://www.who.int/maternal_child_adolescent/topics/qualityof-care/who-vision-quality-care-for-pregnant-women-and-newborns.pdf?ua=1.

Participant handout: Jhpiego gender service delivery standards facilitation guide

JHPIEGO GENDER SERVICE DELIVERY STANDARDS: **FACILITATION GUIDE**

Introduction

Purpose of This Tool

This tool assesses the quality of facility's provision of gender-sensitive, respectful care. It is designed for health providers, facility managers and central, provincial/regional or district health managers who want to improve the services for which they are directly responsible. It is intended to engage providers in a participatory approach to understand their vision of high quality care, and to apply applicable standards to their country context and facility's context.

These gender standards provide an opportunity for facilities to:

1) Understand and apply the key components of respectful, gender-sensitive care,
2) Measure facilities' progress in a way that allows for comparison across facilities, districts and countries,
3) Identify performance gaps that need to be reduced or eliminated in service delivery, and
4) Create action plans for quality improvement.

The tool:

- Lists key performance standards.
    - Each performance standard has verification criteria with "YES", "NO", and "N/A" (not applicable) answer options.
    - Each verification criteria has a recommended means of verification, as described in the next section.
- Objectively establishes the desired level of performance.
- Measures actual level of performance when applied to a facility.
- Helps identify performance gaps and facility challenges.
- Provides an opportunity to recognize and reward high performing facilities to improve motivation and commitment.

Unlike the traditional format of facility guidelines or assessments, the tool uses a format that allows providers to quickly understand and assess the key elements of gender-sensitive, respectful service delivery, and to identify gaps and challenges. Facility managers and providers can then implement appropriate interventions to address any lack of knowledge and skills, an inadequate enabling environment (including infrastructure, resources and policies), and/or lack of motivation to close these gaps.

The results of the implementation of this tool can provide a baseline assessment and measurement of progress over time. Findings can be used as a mechanism to guide the quality improvement process, inform managerial decisions, and reinforce momentum for change. Measurement also makes it possible to present managers and providers with quantitative targets. Achieving and making sustained progress on these targets has an important motivating effect for those involved in the improvement process.

The tool can be used for several purposes:

- **Self-assessments**: these are conducted by a provider on his or her own work. The provider uses the performance assessment tool as a job aid to verify if s/he is following the recommended standardized steps during the provision of care. These assessments can be performed as frequently as desired or needed.
- **Internal assessments**: are implemented internally by facility staff. These can be in the form of **peer assessments** when facility staff use the assessment tool to mutually assess the work among colleagues, or **internal monitoring assessments** when managers and/or providers use the tool more comprehensively to periodically assess the services being improved every three to four months.
- **External assessments**: are implemented by persons external to the facility. These are usually conducted by central/regional/district level of ministries of health, donors, or implementing partners. They can take the form of **facilitative supervision** when the purpose of the visit is to provide support for identification of performance gaps and interventions, or **verification assessments** when the purpose of the visit is to confirm compliance with recommended standards of care, and to recognize achievements. In case of verification assessments, representatives of the clients and communities being served should be involved in the process in an appropriate way. For instance, there could be a community member on the team conducting the assessment of the facility, or the facility scores or quality improvement plans could be shared with them on a regular basis to increase accountability.
- **Integration into other standards**: The tool can be used as a stand-alone method of assessing a facility's provision of gender-sensitive, respectful care. Alternatively, relevant standards can be integrated into other standards documents and quality assurance processes.

Background on Tool Development

Over the last two decades, Jhpiego has been implementing a practical approach for performance and quality improvement, called Standards-Based Management and Recognition (SBM-R). Working with partner organizations, we have obtained very encouraging results in the achievement of standardized, high-quality health care through the use of a streamlined, step-by-step methodology, the creative management of the process of change, and the joint and active involvement of providers, clients and communities in the improvement process.

Jhpiego has developed a range of SBM-R Standards focusing on health areas including, but not limited to, family planning, antenatal care, and immediate postpartum and post-abortion family planning. In developing these standards for gender-sensitive, respectful care, Jhpiego's existing standards were reviewed, as well as gender standards for health services quality assurance developed by the Futures Group and Jhpiego under the USAID funded Afghanistan Health Services Support Project. We also conducted a literature review of international and national

guidance (listed in the Works Cited section below) on integrating and measuring gender-sensitive health service delivery through a quality of care framework. The standards were informally pilot tested in Nigeria, Rwanda, Tanzania, Ethiopia and Mozambique, and were reviewed by experts and practitioners in maternal and child health, neonatal health, gender, male engagement and family planning. This helped determine the estimated length of time to apply the tool, best means of verification, and edits to improve language, reduce repetition, and revise order and flow of the standards and criteria. They are being implemented in Mozambique, Nigeria and Tanzania.

Example of Implementation of the Standards in Tanzania

Jhpiego Tanzania has adapted and integrated the Gender Service Delivery Standards in assessments and quality improvement processes for their reproductive, maternal, newborn, child, and adolescent health (RMNCAH) and HIV key populations projects.

- The USAID Boresha Afya project led by Jhpiego integrated the standards into a formative health facility assessment to understand the gender-related facility barriers and opportunities to achieving quality RMNCAH services in five project-supported regions in the Lake and Western Zones. The verification for clients were adapted into questions to be used in an assessment with clients in the community.
- The USAID Maternal and Child Survival Program (MCSP), the USAID Boresha Afya project and the Global Affairs Canada-funded Uzazi Salama Rukwa project, integrated the Gender Service Delivery Standards across existing Continuous Quality Improvement standards for various health services (e.g., maternal health, newborn health, family planning) of the Ministry of Health, Community Development, Gender, Elderly and Children. Local teams made adaptations according to their context. For example, the criteria of 30 percent women in leadership in health facilities, was revised to at least 50 percent. The standards are implemented quarterly as part of the quality improvement processes of maternal and newborn care in hospitals, health centers, and dispensaries.
- Under the USAID-funded Sauti Project, the standards were adapted to assess the gender-sensitivity of HIV combination prevention services within the quality improvement/quality assurance (QA/QI) processes for mobile Community-Based HIV Testing and Counselling Plus

(CBHTC+) services on a quarterly basis. The standards were adapted with a focus on key populations including men who have sex with men and female sex workers. The full set of standards are assessed quarterly by Gender Program Officers under the supervision of a Gender Advisor. Four standards were adapted to be indicators for quarterly quality assurance (QA) assessments, which a clinical QA Advisor tracks. These standards were prioritized for their proximate relation to project indicators, including:

- Percent of biomedical providers trained on gender equality and rights using Sauti gender, gender-based violence (GBV) and sexuality training manual
- Percent of beneficiaries and providers interviewed who reported having ever observed or experienced an abuse at the site by anyone
- Percent of clients that receive information about all available contraceptive methods and provide informed consent for method implemented
- Percent of HIV infected beneficiaries offered partner counseling/assisted disclosure and partner HIV testing services (HTS).

Description of the Tool

The tool includes 20 standards, organized in 5 sections as follows:

Section	# Standards	# Verification Criteria	Page #
1. Availability & Accessibility of Services	9	36	1-4
2. Male Engagement and Family Inclusiveness	2	9	5
3. Provider-Client Interaction	4	17	6-7
4. Key Aspects of Cordial and Respectful Relationship (information box - not scored)			7-8
5. Health Care Policies and Facility Management	5	15	8-9
TOTAL	**20**	**77**	

Means of Verification

In each section, we list means of verification that should be used to assess whether or not each verification criterion has been achieved.

There are five means of verification which are indicated a letter C, D, I, R or S. They are defined as follows:

- **C:** Client interviews. These should be conducted in private where the provider or facility manager cannot hear the client. The client should be informed about the purpose of the questions, and assured of the confidentiality of her or his responses;
- **D:** Direct structured observation of physical facilities, administrative or clinic processes. This can include reviewing inventories of material resources (e.g., infrastructure, supplies, medications, written materials);
- **I:** Inquiry through key informant interviews with providers or facility managers. The provider and the team should ask questions and probe when necessary to determine if procedure is performed or the item exists as described in the tool. For particularly sensitive questions, the assessor can pose the question as a hypothetical. For example, for standard 9.2, (No client is asked by providers for fees outside of the approved policy, gifts, favors, bribes or sexual acts in exchange for care) the assessor could ask a question such as ""Have you ever heard of a client having to pay a bribe or exchange a sexual favor in exchange for care in this facility or district?" This allows the provider to state whether or not this practice occurs without laying blame on a particular provider, or implicating her or himself.
- **R:** Review of clinical and administrative records that pertain to the provision health services, such as: registers, job aids, guidelines, protocols and policy documents. A small selection of client charts will be reviewed for completeness of reporting and to observe what types of information are being collected on the forms (e.g., gender and age of perpetrator, type of assault, was emergency contraception provided, was post-exposure prophylaxis provided, etc.) Although personal identifiers may be visible to the assessment team when reviewing charts or GBV registers, personal identifiers or any individual client information should not be collected. This is to protect the safety and confidentiality of all clients.
- **S:** Simulation. For standards that are difficult to assess with the means of verification above, ask the provider what s/he would do in a particular situation. To assess provider-client communication, the assessor can ask the provider about what s/he would do in a hypothetical scenario, or, do a short role-play in which the assessor is a client seeking family planning, and the provider should demonstrate his or her counseling approaches.

Please note that multiple means of verification may be needed to assess some criteria. Where the assessor can choose which of the means of verification should be used to verify whether a criterion is met, there is a comma (,) between each mean listed. If multiple means of verification need to be used together, there is a plus sign (+) between each mean of verification.

For example, for verification criterion 1.5 ("There are a referral system and an up-to-date referral directory in place for clients of any gender or age"), we recommend the means of verification "I + R." This means that the assessor should interview the provider to ask if such a directory exists (using the means of verification **I** for interview) and should ALSO ask to see it (using **R** for records review).

Alternatively, to assess the criterion 2.3 (Each inpatient client has her/his own bed and is not

required to share a bed with another person or use the floor), the assessor can EITHER interview the client (**C**) or directly observe (**D**).

Prompts

Some verification criteria are difficult to ask about. For these, we have included *prompts in italic text* with suggested language to use in the tool. For phrasing the questions to ask about other verification criteria, the assessor should use his or her judgment and appropriate local language. If a response is unclear, the assessor should rephrase the question, repeat back what s/he has understood, and/or probe for further information.

Assessment Process

This tool is not meant to be used as a traditional external assessment, but rather an opportunity for providers and facility managers to learn about and establish their own vision for what high-quality care looks like in their facilities, and to set benchmarks against which to continually measure their progress on quality improvement. Towards that end, we suggest the following process:

1. Identify the Facilities and Stakeholders That Will Participate

The assessor should work with the relevant ministries, donors, communities and/or facility managers to introduce and gain shared ownership over the use of the standards, and to select facilities for use of the tool. The tool can be used for any type of facility (e.g. district hospital, health center or rural outpost), but keep in mind that facilities with fewer resources may have greater challenges in meeting all the standards.

2. Organize a Team

A key task of the assessor is to organize teams for the implementation of the improvement process. Most service delivery processes do not depend on the action of single providers, they are the result of team efforts, therefore, it is important to expand the group of committed people beyond champions. Ask the facility manager to identify a quality assurance team or an individual at the facility who will be responsible for applying the tool, filling out the Scoring Sheet, developing and implementing quality improvement action plans based on the results of the tool, conducting on-going supervision and mentorship to improve quality of services, and reporting scores to relevant stakeholders. It is desirable to work with networks of services rather than isolated services. Working in networks of similar services or facilities, which can exchange experiences and provide mutual support usually favors the achievement of positive changes.

The process emphasizes bottom-up action and client and community involvement. A key purpose of the SBM-R process is to provide local health workers and the clients and communities they serve with practical tools that empower them and increase their control on the health delivery process. Clients and communities are not seen as passive recipients of health activities but as

essential partners in the health care process. To the maximum extent possible, client and community representatives should be part of the improvement teams, plans and activities.

3. Prepare the Team

a) Orient the facility teams on the standards through a one-day or half-day workshop, going through each standard to ensure the teams understand the language, context and means of verification. We suggest beginning the workshop with a participatory, open facilitation exercise in which team members or small groups brainstorm 5-8 key elements of gender-sensitive, respectful care. It is helpful to first present or discuss specific scenarios of the treatment of patients in facilities. These can each be written on a sticky note and presented to the group. Through group discussion, the facilitator or volunteer from the audience can organize the sticky notes with key elements of gender-sensitive care into common categories on a flip chart paper.

   Participants can also conduct a role play of a client-provider interaction or counseling session that displays both positive and negative behaviors in relation to gender-sensitive, respectful care, and then allowing facility teams to discuss on what might be important key elements of gender-sensitive respectful care based on the role play. This may allow for deeper reflection of real life scenarios.

   Suggested agenda:

   - SBM-R approach overview and introduction of standards
   - Setting standards for desired performance- group exercise
   - How to conduct the assessment and the scoring process
   - Role play group exercise
   - Developing and implementing action plans, recognizing progress
   - Timeline

b) Through group discussion, the team should come to agreement on standards they would like to apply in their own facilities. They can add new standards to the tool, or use language from relevant standards in the tool to refine their own standards. The intention of this participatory exercise and inclusion of the team's standards is to promote reflection and inspire ownership around the tool and QI process.
c) Present the checklist tool to participants, explaining the rationale for each, and ask them to choose the standards that are relevant and useful for their country and facility's context. If any of the key elements brainstormed by the group earlier is missing, ask the group to write it into the format of a new standard. Participants are also welcome to revise the language of standards if necessary to better align with local terminology and policies while still keeping the principle of the standard. For example, in Tanzania, the pilot team working on the Maternal and Child Survival Project revised language to cite specific laws and policies for Tanzania in relation to age of consent and gender-based violence guidelines for the health sector.

d) Explain the Scoring Sheet and process (details below) to participants, establish a timetable for conducting the assessment, timeline for reporting facility scores to Jhpiego, and recognition/reward system for facilities that achieve measurable progress over time.

4. Adapt the Tool

Based on workshop feedback, update the tool to reflect these changes, review the tool against relevant national guidelines to ensure it is in compliance (e.g., look up the age at which a child or adolescent is legally permitted to give consent without a parent or guardian), and ensure that all participants are using the same tool to allow comparison across facilities if possible. This can be done through a workshop to orient the QA team on the tool, including providers familiar with RMNCAH service delivery, to review the tool and identify areas that need to be adapted to the local context, policies and procedures.

5. Apply the Tool

The first use of the tool should be conducted by providers *in conjunction with* Jhpiego staff (ideally the Gender Advisor, Gender Focal Point, and/or other technical staff who have been trained on gender, including the quality improvement team at Jhpiego and at the facility). This will ensure that providers understand what each the meaning and purpose of each standard, how to ask about it, and how the means of verification can be used. When conducting the visit,

a) Introduce yourself and explain the objectives of the tool, particularly that it is meant to provide assistance to the providers and not to critique their performance
b) Thank the staff for their participation, allow time for cordial introductions and for staff to tell you about their facility (e.g. when it was established, how many GBV cases they receive each month, and anything else they may like to tell you)
c) Explain that the assessment will last approximately 3 hours and includes time to conduct a tour of the facility, the interviews and records review
d) Identify the staff that typically carries out the activities or procedures for interviewing
e) The assessment tool must be used to guide the observation and interviews
f) Be objective and respectful during the assessment
g) Ask clarifying questions to individuals responsible for these areas if needed
h) Probe to get the precise information, do not assume responses
i) Feedback should not be provided during the assessment and should only be shared afterwards
j) Identify correct sources of information (e.g., administrative forms, statistical records, service records)
k) Ask the person to show documents, equipment, or materials as appropriate

After the first use of the tool, conduct a debriefing meeting with the QA team within the next day to clarify any standards that posed difficulty.

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a) Introduce yourself and explain the objectives of the tool, particularly that it is meant to provide assistance to the providers and not to critique their performance
b) Thank the staff for their participation, allow time for cordial introductions and for staff to tell you about their facility (e.g. when it was established, how many GBV cases they receive each month, and anything else they may like to tell you)
c) Explain that the assessment will last approximately 3 hours and includes time to conduct a tour of the facility, the interviews and records review
d) Identify the staff that typically carries out the activities or procedures for interviewing
e) The assessment tool must be used to guide the observation and interviews
f) Be objective and respectful during the assessment
g) Ask clarifying questions to individuals responsible for these areas if needed
h) Probe to get the precise information, do not assume responses
i) Feedback should not be provided during the assessment and should only be shared afterwards
j) Identify correct sources of information (e.g., administrative forms, statistical records, service records)
k) Ask the person to show documents, equipment, or materials as appropriate

After the first use of the tool, conduct a debriefing meeting with the QA team within the next day to clarify any standards that posed difficulty.

6. Score the Tool

Facilities will receive a score of either zero, 1 or N/A (not applicable) for each standard, and an overall facility score (out of a highest possible score of 20) for the level of gender-sensitive service delivery. Scores for each standard should be recorded on the tool, noting any comments or missing items. This will be used to identify the facility's gaps and challenges, set goals and create a quarterly or biannual action plan for quality improvement. Once enough facilities are using the tool, the scores can be used to introduce an element of healthy competition between facilities or districts to increase respectful care.

a) Immediately record the information collected to ensure no data are lost.

b) Mark each verification criteria individually as "YES", "NO" or "N/A" (not applicable). Mark "YES" if the procedure is performed or the item exists as it is described. Mark "NO" if the procedure is not performed, if it is performed incorrectly or if a required item does not exist. Mark "N/A" if this verification criterion is not relevant or cannot feasibly be measured.

c) Provide concise justification for any criteria marked "NO" and "N/A" by recording any gaps, issues, or missing items/elements of care in the comments column.

d) Do not leave any verification criteria blank.

e) In the comments column, write down all pertinent comments, in a concise form, highlighting relevant issues and potential causes or challenges in meeting the criteria.

f) Only if all verification criteria are met should a standard receive a score of 1. Do not give a partial score if only some of the verification criteria are met.[1] Instead, be sure to mark in the Comments section what was missing.

g) If any verification criteria are missed, a standard should receive a score of zero.

h) If a verification score is N/A, and all other verification criteria in this standard are met, this standard should still receive a score of 1 **and not zero**.

i) Add the scores for all the standards and record that number on the Scoring Form in the row "TOTAL." Also record any comments, overall strengths and challenges on the Scoring Form.

Example 1:

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	Y	N	N/A	COMMENTS
1. The facility maintains conditions that ensure		3.1 Separate, private rooms are available for confidential client counseling with auditory and visual privacy (cannot be heard or seen	D	☒	☐	☐	

[1] No partial scores are used in order to keep the scoring process as straightforward and easy to calculate as possible.

and safeguard clients' privacy and confidentiality		from outside)					
		3.2 Women in labor and patients undergoing physical examinations have some visual privacy (curtains, screen or wall)	D, I, C	☐	☒	☐	
		3.3 The registration book is not accessible to anyone other than the providers/ facility managers	D + I	☒	☐	☐	
		3.4 Client records are kept confidential and can only be accessed by the client and her/his providers	D + I	☒	☐	☐	
		3.5 Clients of all gender identities and sexual orientations are treated equally with regard to confidentiality (nondisclosure) of health information	C, D	☒	☐	☐	

In the example above, the assessment team notes that all women in labor deliver together in one large room with no privacy, but all of the other criteria are met. **This standard would then be scored zero**.

Example 2:

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	Y	N	N/A	COMMENTS
10. The facility provides a welcoming, male-friendly environment		10.1 Providers encourage and allow women to bring a companion of any gender with them to FP and ANC visits, labor & delivery, and HCT	D	☒	☐	☐	
		10.2 Providers encourage and allow fathers to accompany their children to clinic visits (for immunization, routine examinations, malaria treatment, etc.)	D, I, C	☒	☐	☐	
		10.3 The facility offers services to men, including vasectomy and male condoms	D + I	☒	☐	☐	
		10.4 The facility has conducted demand creation to increase male utilization of services (e.g.	D + I	☐	☐	☒	

		advertising services and conducting outreach in traditionally male-dominated physical spaces such as taxi ranks, bars, sports facilities, etc.)					

In the example above, the assessment team notes that it partners with a community-based organization that conducts demand creation in traditionally male-dominated physical spaces, and so this verification criterion is marked "N/A" for not applicable. Since all the other criteria are met, **this standard is scored with a 1**.

On the Scoring Sheet, the assessor should record the score for each standard, sum these scores, and provide a total overall score for the facility. The assessor should also copy any notes on missing items or important information onto the score sheet.

Development of Action Plans

After every assessment, the facility staff should develop operational plans in order to implement the improvement process. These plans are relatively simple tools that outline what are the gaps and the causes that need to be eliminated, the specific intervention to be conducted, the person(s) in charge, the deadline for the task, and any potential support that may be needed. The identification of the responsible person(s) and the setting of the deadline are extremely important because they allow better follow up of the activities included in the plan. Operational plans should be developed upon analysis of the results of the baseline or follow-up monitoring assessments by teams of facility providers/managers working in the different areas of service provision being improved. The plans should be shared with relevant stakeholders, partners and donors to document progress.

It is important to understand that the process is usually initiated by a small group of committed persons because it is very infrequent to find widespread support for a new improvement initiative. It is, therefore, key to identify committed champions for the initiative and incorporate them in the initial improvement efforts. Providers are encouraged to focus on action and begin with simple interventions (the "low hanging fruit") in order to achieve early results, create momentum for change, and gradually acquire change management skills to address more complex gaps.

Sample Template for Action Plan

Gap/Challenge	Intervention/Action	Person Responsible	Support	Deadline

How Often To Use the Tool

After the first visit with the Jhpiego assessor's assistance, subsequent quarterly or biannual uses should be conducted by a provider(s) or facility manager(s) responsible for quality improvement. Ideally, it will be the same person each time, and s/he will also be responsible for documenting and sharing facility scores with Jhpiego and relevant ministries/donors. This person should compile and analyze facility scores to present to relevant ministries, partners, communities or donors to show which facilities are succeeding, which need greater support, and any trends in key areas of quality improvement across districts or regions. For example, the facility may score low on provider-client communication, indicating that further training is needed in this area.

The Jhpiego assessor should conduct one assessment in partnership with the facility team each subsequent year to ensure consistency in applying the tool and scoring process described above.

How to Track Performance

The scores and action plans should be shared with relevant stakeholders such as district, state and national ministries of health, facility managers, and providers. Key results from implementation of the action plans, gaps and challenges addressed, etc. can also be summarized and shared with clients and communities.

How to Recognize and Reward High Performance

Facilities showing the greatest improvement should be recognized for their achievements by Jhpiego, the MOH or other stakeholders. This could include simple steps such as sharing feedback and praise via email or a phone call. For significant successes, recognition could include a formal letter, presenting providers with a certificate of recognition, a visit to the facility with a key government or MOH official, and/or a brief article in local news media.

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Glossary of Terms

- **First-line support** is the immediate care a GBV survivor should receive upon first contact with the health or criminal justice system. The WHO defines "first-line support" using the acronym **"LIVES"**: **L**istening, **I**nquiring, **V**alidating, **E**nsuring safety, and **S**upport through referrals.
- **Gender** refers to the economic, social, political, and cultural attributes and opportunities associated with being women and men. The social definitions of what it means to be a woman or a man vary among cultures and change over time. Gender is a sociocultural expression of particular characteristics and roles that are associated with certain groups of people with reference to their sex and sexuality.
- **Gender-based violence (GBV)** is any form of violence against an individual based on that person's biological sex, gender identity or expression, or perceived adherence to socially-defined expectations of what it means to be a man or woman, boy or girl. The most common forms are sexual assault, intimate partner violence and child abuse, but GBV also includes physical and psychological abuse, threats, coercion, arbitrary deprivation of liberty, and economic deprivation, whether occurring in public or private life. GBV is rooted in gender-related power differences, including social, economic and political inequalities. It is characterized by the use and abuse of physical, emotional, or financial power and control. GBV takes on many forms and can occur across childhood, adolescence, reproductive years, and old age.
- **Gender Identity** refers to a person's internal, deeply felt sense of being a man or woman, or something other or in between, which may or may not correspond with the sex assigned at birth. Because gender identity is internal and personally defined, it is not visible to others.
- **Provider** refers in this tool to health care workers in general, and can include any type or level (physician, nurse, social worker, police officer, midwife, psychologist, et al.) This is because the number and type of providers who deliver services will differ across countries and even across facilities.
- **Sex** refers to the biological differences between males and females. Sex differences are concerned with males' and females' physiology.
- **Transgender** refers collectively to people who challenge strict gender norms by behaving as effeminate men or masculine women, adapting "third gender" roles, or embarking on hormonal and surgical treatment to adjust their bodies to the form of the desired sex. Transgender persons often find that the sex assigned to them at birth does not correspond with the innate sense of gender identity they experience in life. Transgender may include **transsexuals** (people whose physical sex conflicts with their gender identity as a man or a woman); **transvestites** (people who cross-dress for sexual gratification but do not wish to be a person of the other sex); and **intersex persons** (people whose sexual anatomy is neither exclusively male nor exclusively female).

Participant handout: Jhpiego gender service delivery standards

JHPIEGO GENDER SERVICE DELIVERY STANDARDS

Name of Facility _____

Name of Person Completing This Tool _____

Title of Person Completing This Tool _____

Date _____

Please read the Facilitation Guide for instructions on how to use this tool, available at www.jhpiego.org/gender

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION[1]	YES	NO	N/A[2]	COMMENTS
Availability & Accessibility of Services							
1. Services are equally accessible to women, men, adolescent girls and adolescent boys, and other gender identities[3]		1.1. Facility offers emergency services 24 hours a day, including services for obstetric complications, physical trauma, and essential post-GBV care (emergency contraceptives, HIV post-exposure prophylaxis, and first-line support[4]) *Prompt: During what hours are emergency services available? Are the following services available during these hours: post-GBV care including EC, PEP, and GBV first-line support?*	C + I	☐	☐	☐	
		1.2 Facilities offer some evening/weekend hours for routine services for clients (e.g. working mothers/fathers) who cannot attend during typical business hours	C + I	☐	☐	☐	
		1.3 Providers give all clients the full range of information and services they need, regardless of age, marital status, gender identity or socioeconomic status *Prompt: For example, would a married adult woman seeking family planning services receive the same information and services as an unmarried adolescent?*	C, D, S	☐	☐	☐	

[1] Means of Verification are coded in the following format: **C:** interviews with clients; **D:** Direct observation of clinical procedures and physical facilities; **I:** interviews with providers and facility managers; **R:** review of clinical and administrative records, policies and protocols; and **S:** Simulation or role play to demonstrate the interaction or communication. **Choose as appropriate.**

[2] N/A=Not Applicable. If N/A is checked, this verification criterion does not factor into the overall score for the standard. (e.g. if the facility gets an N/A for one verification criteria but meets all the others, this standard should still receive an overall score of 1)

[3] Other gender identities can include: transgender people (people's whose personal gender identity does not correspond with their biological sex), intersex people (people born with both male and female genitalia), agender people (those who do not identify with any gender), et al.

[4] First-line support for GBV includes basic empathetic counseling, documenting violence, conducting safety planning and providing referrals. For more information, please see Jhpiego's GBV Quality Assurance Standards, available at www.jhpiego.org/gender

		1.4 Facility ensures all patients have equal access to care, regardless of sex, gender identity, sexual orientation, marital status, age, disability, race, religion, ethnicity, etc. *Prompt: Have you ever heard of any patient being turned away from the facility due to the ethnic group they were from, because they were unmarried, because they were gay, or for any other reason?*	C, D + I	☐	☐	☐
		1.5 Facility has a referral system and an up-to-date referral directory in place for clients of any gender or age	I + R	☐	☐	☐
2. Facilities' infrastructure accommodates needs of all clients		2.1 Location of health services is accessible to clients of any gender and age *Prompt: How long does it take for clients to travel to the health facility? What means of transportation are available and affordable?*	C	☐	☐	☐
		2.2 Facility has clean restrooms available for clients of any gender with a functioning toilet, water, soap, towels, and privacy	D	☐	☐	☐
		2.3 Facilities offer each inpatient client her/his own bed and no client is required to share a bed with another person or use the floor	C, D	☐	☐	☐
3. The facility maintains conditions that ensure and safeguard clients' privacy and confidentiality		3.1 Facility has separate, private rooms available for confidential client counseling with auditory and visual privacy (cannot be heard or seen from outside)	D	☐	☐	☐
		3.2 Facility offers some privacy (curtains, screen or wall) to women in labor and patients undergoing physical examinations	D, I, C	☐	☐	☐
		3.3 Facility ensures the registration book is not accessible to anyone other than the providers/ facility managers *Prompt: Who has access to this registration book?*	D + I	☐	☐	☐

		3.4 Facility keeps client records confidential and can they only be accessed by the client and her/his providers	D + I	☐	☐	☐	
		3.5 Providers treat clients of all gender identities and sexual orientations equally with regard to confidentiality (nondisclosure) of health information	C, D	☐	☐	☐	
4. Clients' agency, autonomy and well-being are respected regardless of gender		4.1 Except for clients who are dependents or minors,[5] providers do not require a client's spouse, partner or family member to give consent for any services *Prompt: Are there any services that a client needs her spouse's consent to receive?*	C, D, I + S	☐	☐	☐	
		4.2 Providers give female clients about their health directly (e.g. provider does not give information to male spouse, partner or guardian *instead* of to the woman herself) *Prompt: Have you ever seen a provider who gives information about a woman's health to her male partner instead of to her directly?*	C, D, I + S	☐	☐	☐	
		4.3 Facility providers care to all individuals according to the facility's triage system or on a first-come, first-serve basis, regardless of whether the client is accompanied by a spouse, partner or family member *Prompt: How does this facility decide whom to see first? Should a woman who is accompanied by her spouse allowed to skip the line?*	C, D + I	☐	☐	☐	
		4.4 Facility prioritizes patients for care based on urgency of the medical condition, regardless of gender *Prompt: Have you ever heard of a man being seen first, even if a woman is waiting with an equally serious need for care?*	C, D + I	☐	☐	☐	

[5] Each country defines "minor", "child" and "dependent" differently. **Provider should follow national law**, or if none exists, minors can be considered children under the age of 12. "Dependents" refers to children or persons who are under the care of a legal guardian who is legally authorized to give consent on the client's behalf (e.g. a mentally or physically-impaired client who cannot voice consent, or a child who is too young to understand a procedure or its implications).

5. Clients have access to— and receive information about— all available contraceptive methods		5.1 Provider explains the different contraceptive methods available, checks that the client has understood, asks if s/he has a method in mind, and lets the client's needs guide the consultation	C, D, S	☐	☐	☐	
		5.2 Providers are knowledgeable and communicate clearly about services and contraceptive methods available at the facility	C, D, S	☐	☐	☐	
		5.3 Providers allow clients of any gender and age to voluntarily choose any available and appropriate family planning method, including permanent methods such as sterilization, regardless of the number of times a woman has been pregnant or given birth, or client's marital status *Prompt: If a woman requests permanent sterilization, would her marital status or the number of children she already has affect whether or not you fulfil her request?*	C, D, S	☐	☐	☐	
		5.4 Providers respect client's choice of method if available. (If **NOT** available, provider offers an alternate, medically appropriate method, or a referral to a facility that offers client's preferred method)	C, D, S	☐	☐	☐	
		5.5 If a client declines to use a method, provider respects her/his choice and further care is not denied *Prompt: What would you do if a client refuses the method you suggest?*	C, D, S	☐	☐	☐	
		5.6 Unless required by national law, providers do not require any client (except minors or dependents) to seek their spouse, partner or family member's consent to undergo voluntary sterilization[6] *Prompt: Can a woman undergo voluntary sterilization without her spouse's consent?*	C, D, I + S	☐	☐	☐	

[6] Unless required by national law. If the facility is in a country where national law requires spousal consent, check the "N/A" box for "not applicable."

		5.7 Providers never sterilize any client without her or his informed consent	C, D + I	☐	☐	☐	
		5.8 Facility ensures contraceptive commodities, supplies and equipment covering a range of methods, including long acting and emergency contraception, are integrated within the essential medicine supply chain to increase continuous availability	D + R	☐	☐	☐	
6. Clients have access to emergency contraception (EC) regardless of their circumstance, gender or age		6.1 When medically indicated, provider offers any client (or their guardian in the cases of minors and dependents) EC regardless of age, marital status, **AND** without another person's consent *Prompt: if a woman has been sexually assaulted, does she need anyone's consent to obtain emergency contraceptives?*	C, D + I	☐	☐	☐	
		6.2 If client requests EC and it is medically indicated, provider identifies whether the client has been exposed to unprotected sexual intercourse within the last 5 days (120 hours), and if yes, provider offers EC	I + S	☐	☐	☐	
		6.3 Provider asks questions and records responses related to sexual behavior and need for EC in a professional and non-judgmental manner *Prompt: How would you ask the client about why she needs EC and what happened? What would you say if she told you she was drinking and out alone at night?*	C, D, I, S	☐	☐	☐	
7. Clients can choose the gender of their provider		7.1 Facility ensures female and male providers are available at the health facility for clients who prefer a particular gender	C, D + I	☐	☐	☐	
		7.2 Providers inform clients that they can choose the gender of their provider if available	C, D	☐	☐	☐	
		7.3 Facility honors client's preference on the gender of their provider	C, D + I	☐	☐	☐	

8. There are information, education & communication (IEC) materials accessible to clients of all genders		8.1 Facility ensures materials (e.g. posters) are available in high-traffic locations in the facility such as waiting rooms, in the local language(s), and accessible to a low-literacy audience so that clients of any gender can see and understand them	D	☐	☐	☐	
9. No client is denied care because s/he cannot pay fees		9.1 Providers never detain any client due to inability to pay fees	C, D + I	☐	☐	☐	
		9.2 Providers never ask any clients for fees outside of the approved policy, gifts, favors, bribes or sexual acts in exchange for care *Prompt: Have you ever heard of a client being asked to pay a bribe or exchange a sexual favour to receive care, or better quality care?*	C + I	☐	☐	☐	

PERFORMANCE STANDARD	SCORE	VERIFICATIONCRITERIA	MEANS OF VERIFICATION	YES	NO	N/A	COMMENTS
Male Engagement & Family Inclusiveness							
10. The facility provides a welcoming, male and family-friendly		10.1 Providers encourage and allow women to bring a companion of any gender with them to FP, ANC, labor & delivery, HCT	C, D + I	☐	☐	☐	
		10.2 Providers encourage and allow fathers to accompany their children to clinic visits (for immunization, routine examinations, malaria treatment, etc.)	C, D + I	☐	☐	☐	

environment and services		10.3 Facility offers services to men, including vasectomy and male condoms	D + I	☐	☐	☐	
		10.4 Facility conducts demand creation to increase male utilization of services (e.g. advertising services through outreach in traditionally male-dominated physical spaces such as taxi ranks, bars, sports facilities, etc.)	I	☐	☐	☐	
11. Provider offers couples/partner counselling on communication and joint-decision making		11.1 Providers have been specially trained to counsel couples on ANC, Family Planning, PMTCT and HCT, couples communication, joint decision-making on FP and birth planning	I	☐	☐	☐	
		11.2 Facility offers sexual and reproductive health counseling to couples/partners, including skills building on couples'/partners' communication and negotiation	C, D + I	☐	☐	☐	
		11.3 Provider asks client if s/he would like to have a companion present **AND** only invites a companion to be present if the client gives permission	C, D, I, S	☐	☐	☐	
		11.4 Providers educate and engage male partners who may influence health-decision making in the relationship and family, on the importance of supporting female partners to seek care, and seeking care for children	C, D, I, S	☐	☐	☐	
		11.5 Provider emphasizes the importance of *shared* decision-making and emphasizes s/he is not asking men to take control	C, D, I, S	☐	☐	☐	

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	N/A	COMMENTS
Provider-Client Interaction							
12. The provider establishes a cordial and respectful relationship with the client and their companion (if present) **(DETAILS IN THE BOX BELOW)**		12.1 Provider treats the client and her/his companion (if present) respectfully **(DETAILS IN THE BOX BELOW)** *Prompt: Can you name a few key approaches you use to treat a client respectfully, how you communicate with him or her, and ensure how you ensure privacy?*	C, D, S	☐	☐	☐	
		12.2 Provider uses empathetic interpersonal communication skills during the entire visit	C, D, S	☐	☐	☐	
		12.3 Provider assures client of confidentiality	C, D, S	☐	☐	☐	
		12.4 Provider ensures necessary privacy during the visit	C, D, S	☐	☐	☐	
		12.5 Provider explains to the client and companion what s/he is going to do and encourages her/him to ask questions	C, D, S	☐	☐	☐	
		12.6 Provider displays non-stigmatizing, non-judgmental attitude to all clients, including unmarried clients/ adolescents seeking reproductive health services *Prompt: What would you say to an unmarried 15 year-old girl seeking condoms?*	C, D, S	☐	☐	☐	
		12.7 Provider does not leave a client unattended or alone when s/he needs care *Prompt: Have you ever seen or heard of a client in need of care who was left unattended?*	C, D, S	☐	☐	☐	

		12.8 Providers never physically, sexually, verbally or emotionally abuses any client *Prompt: Have you ever heard of a client who was physically, sexually, verbally or emotionally abused by a provider at this facility?*	C, D, S	☐	☐	☐	
13. Provider gives appropriate emotional support for post-abortion care, and post-abortion family planning		13.1 Provider shows compassion and addresses any feelings of denial, guilt, shame, anxiety, fear, depression and loss *Prompt: How would you counsel a woman who has come in for post-abortion care?*	C, D, S	☐	☐	☐	
		13.2 Provider treats post-abortion client in a non-judgmental, respectful and professional manner	C, D, S	☐	☐	☐	
		13.3 If/when client is ready, provider gives information on post-abortion contraceptive options, including long-acting methods and emergency contraception	C, D, S	☐	☐	☐	
14. Providers take into account gender barriers that impact health-seeking and utilization of services		14.1 During ANC, provider asks female clients if they can make the decision about whether to deliver in a facility, and if not, encourages her to bring the decision-maker to her next appointment for counseling *Prompt: Do you ask female clients if they can decide on their own where they will deliver? If they say they cannot, do you encourage them to bring the decision-maker, for example their spouse, for counseling?*	C, D, S	☐	☐	☐	
		14.2 During contraceptive counseling, provider asks female clients if they are able to decide for themselves whether or not to use FP, and if not, encourages her to bring her partner to her next appointment for counseling	C, D, S	☐	☐	☐	

		14.3 Provider asks if she would be at risk of GBV if her partner participates in FP. [If **YES**, the provider offers GBV counseling and care according to national guidelines or Jhpiego GBV Quality Assurance Standards.[7] If **NO,** trained provider is available, a referral is made to nearby GBV services.]	C, D, S	☐	☐	☐	
		14.4 During antiretroviral therapy counseling, provider asks if there are any reasons that would prevent the client from taking HIV medication on schedule or for returning for follow up, including influence from spouse, family or others	C, D, S	☐	☐	☐	
15. Providers address myths or beliefs that impact health-seeking and utilization of services		15.1 During ANC or FP counseling, providers ask clients and their companions if they hold any beliefs that would prevent them from using FP, attending ANC, using a male or female condom, breastfeeding, delivering in a facility, seeking an HIV test, or STI treatment	C, D, S	☐	☐	☐	
		15.2 Providers dispel false beliefs or myths held by clients or companions around the provision of care using scientific facts. (For example, some clients falsely believe contraception and abortion affect the ability to conceive in the future)	C, D, S	☐	☐	☐	

[7] The Jhpiego GBV Quality Assurance Standards are a comprehensive checklist that outlines essential components of high quality post-GBV care. Available at www.Jhpiego.org/gender

Key aspects of a respectful relationship (DETAILS OF STANDARD 15- THIS SECTION IS NOT SCORED)		
Treating the client respectfully • Greet the client cordially (and companion if present) • Introduce him/herself • Call client by his/her name or appropriate title • Show concern and respect client's culture, beliefs and ideas • Displays a non-judgmental attitude and avoids judgmental terms, instead using specific, appropriate clinical and counselling terms	**Interpersonal communication skills** • Encourages client to ask questions and answers them • Listens to client • Maintains eye contact • Uses language and terminology that client understands • Speaks in the language of the client, or offers a translator • Uses open and friendly non-verbal communication expressions (smiling, facing client directly, etc.) • Uses visual-aids during counseling • Allows client to repeat the information to verify comprehension • Checks if the client has understood • Summarizes salient (important) points when necessary • Explains to the client what to expect during the clinic visit • Gives information on return visits and invites client to come back any time for any reason • Facility shows concern for clients who have missed appointments and attempts to follow up, as possible • Providers speak up against disrespectful conduct among other providers such as insults, verbal abuse or scolding of clients; • The facility has in place a policy that encourages positive communication and does not allow harsh or abusive language	**Ensuring privacy during the visits** • Keeps the door and curtains closed • Only people/staff authorized by the client can come into the consultation/examination room or area • The client can undress/dress privately • The client remains covered during examination • If possible, the examination is witnessed by a matron authorized by the client • Provider pays special attention to privacy and confidentiality of clients seeking care for GBV or STIs • Facility and providers accommodate companions for women in labor and other clients, to the extent possible and when requested by client

PERFORMANCE STANDARD	SCORE	VERIFICATION CRITERIA	MEANS OF VERIFICA-TION	YES	NO	N/A	COMMENTS
Health Care Policies & Facility Management							
16. Clients and providers can enjoy an environment free of sexual or other abuse		16.1 Facility has a written zero-tolerance policy or client service charter that expressly prohibits sexual, physical or other abuse of clients and providers	I, R	☐	☐	☐	
		16.2 Providers have received training and are knowledgeable about what constitutes sexual harassment or abuse	I	☐	☐	☐	
		16.3 Facility documents and acts upon any instances of abuse according to facility's policy	C + I	☐	☐	☐	
17. Policies support equal opportunities for providers of all genders for advancement and compensation for comparable work		16.1 Providers, regardless of gender, receive equal pay and benefits for equal work	I, R	☐	☐	☐	
		16.2 Facility has a written non-discrimination policy	R	☐	☐	☐	
		16.3 Facility ensures at least 30% of the facility's leadership team is female or of a non-traditional gender identity	D, I	☐	☐	☐	
		16.4 Providers of any gender have an opportunity to be involved in the facility's planning and policy formulation	I	☐	☐	☐	
		16.5 Regardless of gender, facility ensures that providers of equal seniority and training have equal decision-making and influence *Prompt: Amongst this facility's leadership, do you feel that the most senior men and women have equal decision-making power and influence?*	I	☐	☐	☐	
		16.6 Facility gives providers of any gender equal opportunity to work the same number of hours and shifts, regardless of whether or not they have children	I	☐	☐	☐	
		16.7 Facility ensures providers of any gender have the same opportunities for training, professional development and promotion	I	☐	☐	☐	

18. Providers are trained on gender equality and human rights		18.1 Facility ensures all providers have received training on gender equality and human rights within the past two years	I	☐	☐	☐	
19. A feedback mechanism exists for clients to report their level of satisfaction, or to file complaints		19.1 Facility ensures there is a hotline, suggestion box, exit feedback form, or ombudsperson (an impartial representative) that clients can use to give anonymous and confidential feedback on their experience at the facility	D, R	☐	☐	☐	
		19.2 Provider informs client of the existence of the feedback mechanism(s)	C, D	☐	☐	☐	
20. Health information systems data are regularly used for gender analyses and evaluation to improve gender-equitable service delivery		20.1 Facility disaggregates all relevant data by sex and age	R	☐	☐	☐	
		20.2 Facility analyzes and uses sex and age-disaggregated data to improve and tailor services offered, approaches used, and commodities stocked	I, R	☐	☐	☐	

TOTAL STANDARDS:	20
TOTAL STANDARDS OBSERVED:	
TOTAL STANDARDS ACHIEVED:	