Gender Service Delivery Standards

FACILITATION GUIDE

jhpiego

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.

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.

Works Cited

1. Engenderhealth, Government of Tanzania, USAID CHAMPION Project, Unpublished. Performance Standards for Male-Friendly Health Services.
2. Engenderhealth, 2003. COPE Handbook: A Process for Improving Quality in Health Services.
3. Government of Afghanistan, 2009. Quality Assurance Standards: Gender.
4. IMCI. Desired Performance Standards for Integrated Maternal and Child Health Observation for Quality Child Health Services in Basic Health Centers.
5. Health Policy Initiative & USAID, 2010. Gender Integration Index.
6. Health Policy Project, 2014. Tools for Assessing Gender in Health Policies and Programs.
7. International Gender Working Group, 2009. A Manual for Integrating Gender Into Reproductive Health and HIV Programs: From Commitment to Action (2nd edition).
8. International Gender Working Group, 2013. A Practical Guide for Managing and Conducting Gender Assessments in the Health Sector.
9. IPPF WHR, 2000. Manual to Evaluate Quality of Care from a Gender Perspective
10. IPPF WHR, 2002. How Gender Sensitive Are your HIV and Family Planning Services? HIV/Gender Continuum.
11. Jhpiego, 2005. Standards Based Management and Recognition: A Field Guide.
12. MEASURE Evaluation PRH. Menu of Indicators: Gender sensitivity in the service delivery environment
13. MSH, 2010. Managing Health Service Delivery. In Health Systems in Action.
14. Population Council, 2009. Lessons from PROCOSI. Reference Guides For Health Care Organizations Seeking Accreditation for High-Quality, Gender-Sensitive Reproductive Health Services
15. WHO, 2014. Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations.
16. WHO, 2001. Equity, Equal Opportunities, Gender and Organizational Performance.
17. WHO, 2011. Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence.

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).