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GENDER SENSITIVITY AND PATIENT CARE AMONG HEALTHCARE WORKERS: A SYSTEMATIC REVIEW

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ABSTRACT
Gender sensitivity of health workers may affect the quality of patient care, but data linking gender and development (GAD) training, gender sensitivity, and patient care remains fragmented. Through PRISMA, PubMed, ScienceDirect, Google Scholar, HERDIN, Philippine E-Journals were used to search for studies from 2016 to 2026, and gray literature for relevant local mandates. Out of 1,573 records, eight reports were identified from six studies. Four (4) are empirical research studies, one (1) local case study, and one (1) national policy circular. Gender sensitivity was moderate to high and was not correlated with perceived application of gender sensitive care. No research has reported the full pathway from training to patient care. The evidence that is available is essentially all cross-sectional and very limited in scope, with little at the local level. There is a clear need for quantitative research at the worker level to examine the relationship between gender sensitivity and patient care in Philippine hospitals.

Keywords:
Gender sensitivity; gender and development; healthcare workers; patient care

INTRODUCTION

There has been a continuing effort to improve the quality of healthcare in public hospitals. Despite this, patients may still be subjected to bias, stereotyping and unequal treatment. Gender sensitivity (the capacity to recognise gender disparities and to bring that awareness into one's own behaviour and decision making (PCW, 2011)) can have a significant impact on both the way in which providers deliver care and the way in which patients experience care (World Health Assembly, 2007). When gender is not taken into account, clinical judgement can be compromised. For example, women's chronic pain has on occasions been dismissed as being 'psychological' rather than 'physical' (Samulowitz et al., 2018). Healthcare workers themselves vary in their level of gender sensitivity with training and clinical experience being known to be factors (Than et al., 2020).

In the Philippines, Republic Act No. 9710 (the Magna Carta of Women) and the Gender and Development (GAD) framework of the PCW require all government agencies, including public hospitals, to mainstream gender equality in their policies, programmes and services (PCW, 2011; Republic Act No. 9710, 2009). The existence of such mandates does not necessarily mean that the requirements will be implemented in practice. Gaps in the implementation of the GAD guidelines have been documented in Philippine higher education institutions (Gil, 2021).

Research in local public hospitals has shown that although patients are generally satisfied with the quality of medical care they receive, they rate the interpersonal aspects of care (e.g. communication and compassion) less favourably than they do the technical aspects of care (Gerzon & Salugsugan, 2020; Rosales, 2024). Research into gender sensitivity in healthcare has typically focused on the patient experience or on the short term effects of gender sensitivity training. There is very little research that has looked at the full pathway from training to patient care (Lindsay et al., 2019).

The perspectives of healthcare workers are also rarely examined and only a small number of studies have used a quantitative approach to assess the relationship between the gender sensitivity of healthcare workers and patient care, particularly in the context of Philippine public hospitals. Understanding this relationship could be of great value in enabling hospital leaders to design training and institutional support that reflects how healthcare workers themselves understand and apply gender sensitivity and whether this in fact leads to improved patient experience.

This study seeks to synthesise the current evidence on gender sensitivity, GAD training and patient care among healthcare workers. It will identify the methodological and contextual gaps in the literature and provide a foundation for future primary research, including research in Philippine public hospitals. Specifically it aims to: (1) describe how gender sensitivity is defined and measured and how it is supported through policy and training; (2) examine the relationship between gender sensitivity training, the gender sensitivity of healthcare workers and

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patient care as found in the existing literature; and (3) identify the gaps in the literature, particularly those relating to healthcare workers, quantitative research and Philippine hospitals.

METHODS

This study used a systematic review approach in accordance with the PRISMA 2020 guidelines (Page et al., 2021). This is in contrast to an ad hoc literature review which would not allow for the identification of the evidence on gender sensitivity, GAD training and patient care among hospital workers in a systematic and transparent way.

Eligibility Criteria. Eligibility criteria were established prior to the searches and are presented in Table 1. Studies were included if they were published in English between 2016 and 2026 and either examined gender sensitivity or gender awareness among hospital workers or GAD training or gender mainstreaming in a health care or public sector context. Policy and institutional documents were used to describe the policy environment and were not used to assess the impact of policy or training. Where multiple reports described the same study they were grouped and treated as a single study.

Selection Process and Data Collection. The searches were carried out on the databases PubMed, ScienceDirect, Google Scholar, and two Philippine databases (HERDIN and Philippine E-Journals) during November 8, 2026. We searched the PCW website and the United Nations library catalog in Geneva using the phrase "gender sensitivity" for gray literature sources. We used four topic areas: (1) gender sensitivity or awareness in healthcare; (2) GAD or gender mainstreaming in institutions; (3) gender-sensitivity training; and (4) gender sensitivity and patient care. We tailored the search terms to each source and applied a 2016–2026 date filter when available.

Before screening, duplicates were removed. Titles and abstracts were then reviewed and full texts were assessed against the eligibility criteria. Each reason for full-text exclusion were also documented. A structured spreadsheet created with Claude by Anthropic was used to track screening decisions and record extracted data.

Table 1. Eligibility Criteria

Domain	Inclusion	Exclusion
Topic	Gender sensitivity or awareness among healthcare workers, or GAD training or gender mainstreaming in a health or public-sector setting.	Gender topics unrelated to healthcare; patients' clinical outcomes without a link to provider gender sensitivity.
Population	Healthcare workers, health facility staff, or health-sector organizations	Patients or the general population only; students only
Publication type	Peer-reviewed primary empirical studies; theses; official or institutional reports and policy documents	Review articles, editorials, commentaries, opinion pieces, conference abstracts, study protocols, conceptual chapters, undated web pages
Design	Quantitative, qualitative, or mixed methods; policy and institutional documents for the policy context only	Studies with no findings (e.g., protocols)
Date and language	Published 2016 to November 2026; English	Published before 2016; other languages
Other	Multiple reports of one study were linked and counted once	Superseded policy documents; no full text available

Quality Appraisal. We assessed the four empirical studies using the 2018 version of the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018). First, we checked whether each study clearly stated its research questions and whether the data collected could answer them. Studies that met both screening checks were then evaluated against design-specific criteria, each rated "yes," "no," or "can't tell." Following MMAT guidance, we assessed mixed-methods studies against the qualitative, quantitative descriptive, and mixed-methods criteria. Because the MMAT advises against calculating an overall score, we report results for each criterion. The number of "yes" ratings were only included as a descriptive summary. We did not assess the institutional case study report or policy circular because these document types are outside the MMAT's scope. No study was excluded on quality grounds.

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Synthesis. The studies differed in design, setting, and measures, so meta-analysis was not employed. Instead, we used a narrative synthesis (Campbell et al., 2020) to organize the findings around the three objectives. We summarized study characteristics and appraisal results in tables and present findings as reported in the sources. We did not formally assess bias due to missing results or the certainty of the evidence.

RESULTS

The search identified 1,573 records: 1,570 from databases and repositories and 3 from other sources. After removing 178 duplicates, we screened the titles and abstracts of 1,395 records and excluded 1,372. We sought the full texts of the remaining 23 reports. Six were unavailable or behind paywalls, leaving 17 for eligibility assessment. We excluded 9 reports: 4 review articles, 2 with an ineligible design, 2 of an ineligible publication type, and 1 involving the wrong population. In total, 8 reports representing 6 studies or documents were included (Figure 1).

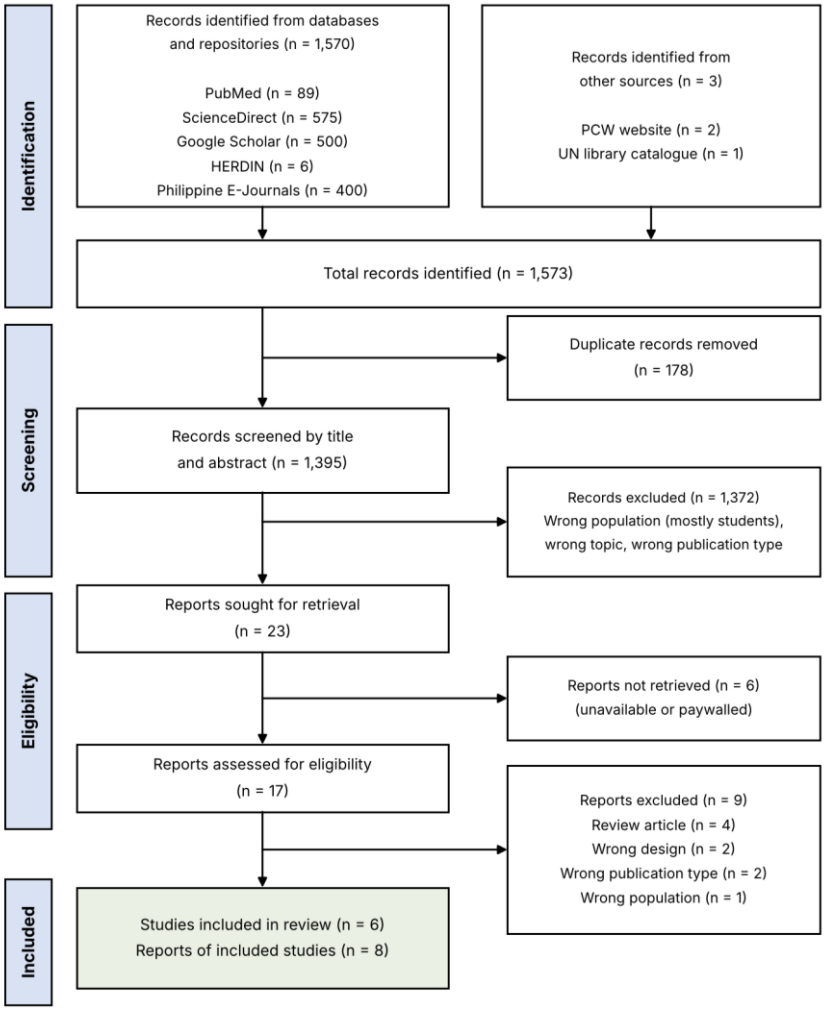


Figure 1. PRISMA 2020 Flow Diagram of Study Selection

The eight reports, published between 2020 and 2026, covered six studies or documents (Table 2): four empirical studies from Germany, Canada, the United States, and Israel; a case study at a tertiary hospital in the Philippines; and a Philippine national policy circular. Two studies each had two reports: the German HeartGap project (Mollenhauer et al., 2026; Sgraja et al., 2026) and interviews conducted in Canadian pediatric rehabilitation (Lindsay & Kolne, 2020; Lindsay et al., 2022). Both HeartGap reports draw on the same nurse survey (n = 111), and the two Canadian reports describe the same set of interviews.), while Sgraja et al. (2026) also present the physician (n = 155) and patient (n = 390) surveys. Thus, within the included reports, these latter data are reported only by Sgraja et al. (2026). The physician survey appeared in a separate publication, but that report was not found

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in the searches. Participants included physicians, nurses, allied health clinicians, and clinic staff. Patients participated only in the HeartGap study. The settings ranged from cardiology wards and pediatric rehabilitation to Veterans Affairs primary care and mixed-specialty services.

MMAT results are summarized in Table 3, with ratings for individual criteria provided in Appendix D. The designs were appropriate to the questions each study addressed. All studies used established or documented measures, except the Israeli survey, which used an instrument developed by the investigators. The main limitations involved sampling and response rates: survey participants were recruited voluntarily through non-probability methods. The U.S. study had a 39% response rate. Because HeartGap responses were anonymous, its response rate could not be tracked, and the Israeli study did not report a response rate. The qualitative study was conducted at one site and included a predominantly female sample. Several studies also relied on self-reported outcomes.

Table 2. Characteristics of the Included Studies and Documents

Study (reports)	Setting and design	Participants	Findings relevant to this review
HeartGap Mollenhauer et al. (2026); Sgraja et al. (2026)	Germany. Cardiology and internal medicine wards with a cardiology department. Nationwide online survey, May 2024–February 2025, within a mixed-methods project (focus groups, interviews, scoping review). Two reports.	Nurses (n = 111); physicians (n = 155); inpatients (n = 390)	Gender sensitivity (N-GAMS, 1–5): nurses M = 3.46, physicians M = 3.95. Perceived implementation of gender-sensitive care (1–4): physicians 2.45, nurses 2.91, patients 3.04. Higher sensitivity did not go with higher perceived implementation (nurses r = −.36). Barriers were mainly structural and organizational.
Pediatric rehabilitation interviews Lindsay & Kolne (2020); Lindsay et al. (2022)	Canada. One pediatric rehabilitation hospital. Qualitative interviews (August–November 2019), thematic analysis. Two reports of the same study.	23 providers (19 women, 3 men, 1 transgender man) from several disciplines	Training needs: little knowledge or training; wanted content on gender differences, communication, and practice; varied delivery formats. Challenges: lack of training, stereotypes, binary documentation and misgendering, complexity of gender identity, clinician gender.
VA workforce survey Than et al. (2020)	United States. 12 Veterans Affairs medical centers. Cross-sectional survey; weighted multivariable regression.	256 of 649 invited (39%); 91 primary care providers and 151 staff answered the gender sensitivity items	Gender sensitivity (10-item scale adapted from GAI-VA, 1–5): M = 4.04 overall (providers 4.10, staff 4.00). Providers: women's health training and positive clinic communication associated with higher sensitivity. Staff: experience with women patients, women's health team, rural site associated with higher; longer VA service with lower.
Israeli physicians survey Khamisy-Farah et al. (2024)	Israel. Cross-sectional mixed-methods survey distributed through medical associations and professional networks.	189 physicians (104 attending, 85 residents; 57.1% women)	Low-to-moderate exposure to gender and sexuality content (M = 2.03, 1–5) and preparedness (1.99 medical school; 2.18 specialty training); perceived lack of training M = 3.26; 67% saw training as contributing to professional capabilities to a great or very great extent.
Baguio hospital case study Josef et al. (2023)	Philippines. Baguio General Hospital and Medical Center (tertiary). Institutional case study based on interviews and document review.	Hospital GAD focal point system (42 members)	Focal points in all departments since 2016; about 19–20% of 2022 budget to GAD (mandated minimum 5%); gender-responsive services, staff equity measures, GAD training; started as legal compliance; focal staff overburdened.

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Study (reports)	Setting and design	Participants	Findings relevant to this review
National policy circular Philippine Commission on Women (2025)	Philippines. Memorandum Circular No. 2025-07 (26 August 2025), applying to all government agencies.	Policy document	Reaffirms gender mainstreaming as the mandated strategy under RA 9710 and GAD as its guiding approach; directs agencies to design, fund, implement, monitor, and report initiatives through GAD plans and budgets and accomplishment reports.

Note. GAD = Gender and Development; N-GAMS = Nijmegen Gender Awareness in Medicine Scale; GAI-VA = Gender Awareness Inventory–VA; VA = Veterans Affairs; RA = Republic Act. Scale ranges are shown in parentheses; scales differ between studies and are not directly comparable.

Definition and measurement. Across the empirical studies, gender sensitivity generally meant healthcare workers' knowledge and attitudes, as well as their ability to recognize sex- and gender-related differences and take them into account in patient care (Lindsay & Kolne, 2020; Mollenhauer et al., 2026; Than et al., 2020). The studies, however, measured this concept in different ways. The HeartGap surveys used the Nijmegen Gender Awareness in Medicine Scale (N-GAMS), adapted for nurses (13 items on a 5-point scale), as well as researcher-developed questions about implementation. Than et al. (2020) used a 10-item measure adapted from the Gender Awareness Inventory–VA.

Khamisy-Farah et al. (2024) created a survey about clinicians' experience, preparedness, and consideration of sex and gender in treatment. The Canadian study, on the other hand, explored these issues through interviews rather than a formal scale. The Philippine sources focused on how gender initiatives are put into practice within institutions. The PCW circular names gender mainstreaming as the required strategy and GAD as the framework for changing institutional structures and processes (PCW, 2025). The hospital case study, meanwhile, looked at the reach of its GAD focal-point system and how it allocated funding (Josef et al., 2023). None of the included studies used a validated gender-sensitivity scale in the Philippine context.

Table 3. Summary of Quality Appraisal (MMAT 2018)

Study	MMAT category	Criteria rated yes	Main concerns
Pediatric rehabilitation interviews (Lindsay & Kolne, 2020; Lindsay et al., 2022)	Qualitative	5/5	Single site; mostly women participants
HeartGap, nurse survey (Mollenhauer et al., 2026)	Quantitative descriptive	3/5	Voluntary, non-probability sample; response not trackable; modified scale; small samples for regressions
HeartGap, integrated report (Sgraja et al., 2026)	Mixed methods	4/5	Survey samples below planned sizes; response not trackable
VA workforce survey (Than et al., 2020)	Quantitative descriptive	3/5	39% response; cross-sectional; one health system
Israeli physicians survey (Khamisy-Farah et al., 2024)	Quantitative descriptive (open-ended items analyzed thematically)	2/5	Sampling frame and response rate not reported; investigator-developed instrument; no limitations section

In studies that measured gender sensitivity, scores generally fell in the moderate-to-high range. In HeartGap, mean scores on a 5-point scale were 3.46 (SD = 0.75) for nurses and 3.95 (SD = 0.73) for physicians. In the VA study, the overall mean among primary care providers and staff was 4.04 (SD = 0.6), with scores of 4.10 for providers and 4.00 for staff. Because the studies used different scales, these results should not be compared directly.

Institutional and policy support. The case of Baguio General Hospital and Medical Center illustrates how a public hospital can put the Philippine mandate into practice (Josef et al., 2023). The hospital has had a 42-member GAD focal-point system since 2016, with representatives in every department. In 2022, it allocated approximately 19–20% of its budget to GAD, exceeding the mandated minimum of 5%. The report notes that few government

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institutions reach that threshold. Its activities included gender-responsive services, such as support for survivors of abuse, workplace gender-equity measures, and GAD training, which the report says helped deepen staff understanding. The initiative began to comply with the law, but the report also describes the workload placed on already stretched focal staff and the need to select focal points more carefully and provide incentives.

The studies also show that the workplace can influence how gender-sensitive care is delivered. These practices were less common in university hospitals and hospitals (Mollenhauer et al., 2026). VA staff on women's health teams had higher gender-sensitivity scores (Than et al., 2020). In Canada, clinicians said that binary documentation systems made gender-sensitive care more difficult and called for stronger support from their institutions (Lindsay et al., 2022).

Training and gender sensitivity. Three empirical studies and one hospital case report discussed training. In a VA survey, primary care providers who had received women's health training and reported positive communication within their clinics also tended to show higher gender sensitivity (Than et al., 2020). Because the study was cross-sectional, however, the authors caution that this association does not establish cause and effect. Israeli physicians reported low-to-moderate exposure to gender and sexuality topics during training (M = 2.03, SD = 0.98) and similarly low preparedness (M = 1.99 for medical school and 2.18 for specialty training). They also felt they needed more training (M = 3.26, SD = 1.16). At the same time, 67% (127 of 189) said that training could greatly or very greatly strengthen their professional skills (Khamisy-Farah et al., 2024). Canadian pediatric rehabilitation clinicians described receiving little or no training and identified topics and formats they wanted, including gender differences, communication, and applied practice (Lindsay & Kolne, 2020). German nurses showed a moderate gender sensitivity, even though they had not received specific training. Mollenhauer et al. (2026) suggest that their person-centered nursing education may have helped. A report from a Philippine hospital also says GAD training strengthened staff commitment, although it does not provide data to measure this effect (Josef et al., 2023). However, none of the studies tested training by comparing outcomes before and after a program or with a control group.

Gender sensitivity and patient care. HeartGap was the only study to examine the relationship between gender sensitivity and care-related measures, and none of the included studies assessed patient care directly. Higher gender sensitivity did not appear to translate into higher perceived implementation of gender-sensitive care. Among physicians, gender sensitivity was not significantly associated with guideline knowledge (M = 0.63 on a 0–1 index) or perceived implementation (M = 2.45, SD = 0.59, on a 4-point scale). Among nurses, higher sensitivity was associated with lower perceived implementation on the ward (r = −.36, n = 109; Mollenhauer et al., 2026; Sgraja et al., 2026). The authors propose that nurses with greater sensitivity may assess current practice more critically. They point primarily to structural and organizational barriers, rather than negative attitudes, to explain the gap. Patients, for their part, rated gender-sensitive care positively (M = 3.04, SD = 0.65, on a 4-point scale) and reported relatively few additional needs (Sgraja et al., 2026)., SD = 0.65, on a 4-point scale) and reported relatively few additional needs (Sgraja et al., 2026).

Physicians reported a moderate degree of consideration of patients' sex and gender when selecting medication (M = 2.84, SD = 1.20). They also moderately agreed that they had observed differences in how symptoms present across sex and gender (M = 2.97, SD = 1.12; Khamisy-Farah et al., 2024). The Philippine hospital report notes favorable patient-satisfaction ratings, although it does not provide supporting data (Josef et al., 2023).

None of the included studies examined the complete pathway from training, through gender sensitivity, to patient care. Instead, the evidence addresses only parts of this relationship: one study linked training with gender sensitivity, one project examined sensitivity alongside perceived implementation and found no association or an inverse association, and no study associated these factors to patient care.

Healthcare-worker perspective. All four empirical studies included healthcare workers using surveys or interviews, although each focused on a relatively specific group: cardiology nurses and physicians, pediatric rehabilitation clinicians, VA primary care teams, or physicians in Israel. Patients' perspectives appeared only in the HeartGap study.

Quantitative methods. Three studies, the HeartGap study, the VA survey, and the Israeli survey, used quantitative measures with healthcare workers. All three took a cross-sectional approach and relied on volunteers. Response rates were either low or not reported. None followed participants over time or tested an intervention, and none linked healthcare workers' measures with patient outcomes.

Philippine and local-government hospital settings. The review included only two Philippine sources: a case study of a tertiary hospital and a national policy circular. Neither assessed individual healthcare workers' gender sensitivity or patient care. The hospital in the case study was a large tertiary referral center, and smaller provincial and district hospitals were not represented in the included research.

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Outcomes and settings. The care-related outcomes were based on participants' perceptions or self-reports, such as implementation ratings and descriptions of practice. No study linked healthcare workers' gender sensitivity to clinical outcomes or patient-reported outcomes. Most research took place in high-income countries and focused on particular clinical settings, so its findings may not readily apply to Philippine public hospitals.

DISCUSSION

This review consolidated six studies or documents, reported in eight publications, on gender sensitivity, GAD training, and patient care among hospital workers. Where it was measured, gender sensitivity was generally moderate to high. At the same time, exposure to training was often limited, and participants commonly felt that more was needed. Higher gender sensitivity did not consistently correspond to stronger perceived implementation of gender-sensitive care. No study followed the full pathway from training to patient care, and the Philippine evidence focused on institutions rather than individual healthcare workers.

In the HeartGap study, greater gender sensitivity was not linked to stronger perceived implementation. This suggests that awareness matters, but may not be enough by itself. The authors point to organizational and structural barriers as part of the picture. This aligns with Canadian clinicians' calls for wider institutional support and with the VA finding that team structures were linked to healthcare workers' sensitivity. Similarly, the Philippine hospital case was backed by required planning and budgeting and a designated focal-point system. In general, the findings suggest that training may have limited impact on its own. It may be more effective when supported by clear documentation systems, enough staff, and accountability. Because this conclusion is based on only a few cross-sectional studies using self-reported data, more research is needed to confirm it.

Evidence on training remains limited and relies largely on self-reports and associations. One U.S. study found that women's health training was associated with higher gender sensitivity. Physicians in Israel and clinicians in Canada also described gaps in their preparation and called for more training. However, none of the studies directly assessed whether training improved outcomes. This is consistent with an earlier systematic review, which found too little evidence to establish the effectiveness of gender-sensitivity training and called for research on its longer-term effects (Lindsay et al., 2019).

In the Philippines, the review identified a strong policy mandate under Republic Act No. 9710 and the 2025 PCW circular, along with one detailed example of institutional practice. However, the available evidence does not measure individual healthcare workers' knowledge, attitudes, or practices, nor does it connect these factors to patient care. The Baguio case was presented as an encouraging example, but its methods are described only briefly, making it difficult to know how representative the findings are. The report also notes that few government institutions meet the minimum 5% GAD budget allocation. In addition, the review found no studies from provincial or other local-government hospitals, which may differ considerably from large tertiary centers.

Implications. Hospitals can make training more effective by improving documentation, staffing, and monitoring. Future research in Philippine public hospitals should: (a) assess healthcare workers' gender sensitivity with validated tools suited to the local context; (b) record training details, such as who attended, when it happened, and what topics were covered; (c) link staff-level measures to patient-reported or clinical outcomes; and (d) use study designs like before-and-after studies to show changes over time.

Limitations. The literature review is small and varied. Most studies used cross-sectional designs, relied on self-reported information, and recruited volunteers. Response rates were low or not reported. Two studies each appeared in two reports, and one project accounted for much of the evidence on gender sensitivity and perceived implementation. As a result, the number of reports may overstate the independence of the findings. Most studies were also conducted in high-income countries and focused on specific clinical areas.

The review process also has limitations. A single author screened the records, extracted the data, and assessed study quality. The review included only English-language reports, and six reports could not be retrieved. Some searches also produced very large result sets that were screened in relevance order only up to a set limit, so relevant studies may have been overlooked.

CONCLUSION

Research on gender sensitivity, GAD training, and patient care among hospital workers remains limited, relies largely on cross-sectional studies, and comes mostly from outside the Philippines. The data suggest that greater gender sensitivity alone may not lead to more gender-sensitive care, and no study has yet examined the full link between training and patient care. Further quantitative research in Philippine public hospitals should assess healthcare workers' perspectives alongside patient care

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