Archives of Women's Mental Health (2019) 22:759–770
https://doi.org/10.1007/s00737-019-01001-2

ORIGINAL ARTICLE

The current status of gender-sensitive mental health services for women—findings from a global survey of experts

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Received: 19 June 2019 / Accepted: 29 August 2019 / Published online: 16 September 2019

Abstract

Integrating gender in all aspects of health services is important and mental health is no exception. Despite several recommendations regarding the need for gender-sensitive mental health services, the actual availability of these is not clear, both in high and low-income countries. We sought to understand what aspects of gender-sensitive mental health care were considered a priority by global experts in women's mental health and how satisfied they were with the current availability of these services in their own place of work. A survey with 43 items under 7 domains of gender-sensitive mental health care for women was sent to 150 experts in women's mental health across the world, of whom 73 responded. Rating on each item was from 0 to 5. While majority of the experts rated most of the items as being very important (median score of 4 and above), some areas that were considered most important included training of mental health professionals in gender sensitivity, having private spaces for examination, using a life course approach to service planning and delivery, and assisting women who find it difficult to navigate the system and mother-baby units. However, satisfaction rates with available services were quite low overall and much lower among experts in low-income countries compared with those from high-income countries. Even in high-income countries, only 6 of the top 20 items were scored as satisfactory by at least 50% of experts. This expert survey method to arrive at consensus on top priorities for improving delivery of gender-sensitive mental health care indicates that at least 72% of the items provided in the survey were considered extremely important. Poor satisfaction of experts in both high- and low-income countries with availability of gender-sensitive services indicates the need for local and global strategic action and multilevel stakeholder engagement.

Keywords Gender sensitive · Women · Sex · Mental health · Services · Psychiatry

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Introduction

The discussion about gender-sensitive services for women with mental health problems arose for several reasons. These included the interface between reproductive health and psychiatric problems (Fisher et al. 2009; Abel and Rees 2010), the experience of gender-based violence including sexual abuse which is much more common among women (Watts and Zimmerman 2002), high rates of gender-based violence among women with mental illness (prevalence of lifetime partner violence among women with depressive disorders as high as 45%) (Trevillion et al. 2016; Morrow and Columbia 2002), the role of social determinants of health in help-seeking (Stewart 2007), and prevalence of certain disorders such as depression (World Health Organization 2007), in many cultures, the experience of patriarchy and lack of a voice manifesting as somatization (Nichter 1981; Kirmayer and Young 1998), women's poor access to mental health care due to lack of transport or childcare responsibilities (World Health

Organization 2013), women's need for social support especially peer support (Ramsay et al. 2001), and the role of life stage in the manifestation of psychiatric problems (Women's Centre for Health Matters 2009). In addition, women have higher 12-month and lifetime prevalence rates for mood (period 7.3%, 6.5–8.1%; lifetime 14.0%, 12.4–15.9%) and anxiety disorders (period 8.7%, 7.6–9.8%; lifetime 18.2%, 16.2–20.4%) compared with men (Steel et al. 2014). Moreover, pregnancy and postpartum period also contribute to increased vulnerability and risk of developing new illness and relapse of pre-existing mental illness in women. The pooled prevalence of common mental disorders in postpartum is ~20% in low- and middle-income countries (Fisher et al. 2012) and the risk of postpartum relapse in women with pre-existing bipolar disorder is nearly 37% (Wesseloo et al. 2016).

Gender also influences the progression of substance use disorders and pathways to treatment seeking (Green 2006). Substance use problems among women are less likely to be identified in health-care settings (Brienza and Stein 2002). Women are also more likely to report concerns about child-related issues on treatment entry (Wechsberg et al. 1998), experience economic and other barriers while seeking help (Brady and Ashley 2005), and are more likely to report shame and embarrassment while in substance abuse treatment (Thom 1987). This highlights the need for gender sensitivity in treatment programs for substance use as well as other psychiatric disorders for women, especially in view of the fact that they have children in their care and report impact on functioning in more life domains than men due to substance use disorders (Fillmore et al. 1997).

Historically, while the concept of gender-sensitive mental health care has been talked about by many, policy level initiatives were only available in the early 2000s in a few countries. Feminist activism and advocacy by several researchers may have had a role to play. Two documents from the UK stand as a landmark. The first was titled "*Into the Mainstream: an evidence-based guide for service development and practice*" (Department of Health 2002) which called for a reappraisal of women's mental health presentations in the context of their complex and often traumatic lives. The second titled "*Supporting Women Into The Mainstream: commissioning women-only day care services*" (Newbigging and Abel 2006) tried to streamline special services for women with mental health problems in the community.

Specific recommendations for gender-sensitive mental health services in these two documents included the formation of women-only and women-sensitive day care services, the need for supporting women to make choices about the nature of care and treatment provided to them, including who should provide it, have staff who give women the space and time to talk, attention to the physical environment and provide women-only spaces which make women feel safe, ensure respect and confidentiality, use a life-stage approach to understand women's distress and pay attention to their social and living situation; provide trauma-informed care for abuse and violence, focus on body image and reproductive concerns, use a strengths-based approach, encourage peer support with other women, and enable women in being an active participant in their own care.

In addition, the report also created a Good Practice Checklist which included details of access, information, staffing, and range of service provisions. The reports emphasized the need for mental health professionals to be trained and be sensitive about reproductive health, body image, domestic violence, and sexual health including abuse, become informed about the role of gender and complexity in mental health presentations and response to treatment, develop and provide trauma-informed care, and develop collaborative approaches and shared decision-making with women for both medical and social prescribing.

Abel and Newbigging (2018) discuss in a document produced by the British Medical Association entitled "*Unmet needs in women's mental health*" how these pathbreaking initiatives were not sustained beyond a point and currently have been largely ignored in service planning except in the area of perinatal metal health. They call for a reappraisal and examination of these recommendations and emphasize the need for more gender-sensitive mental health care.

Judd et al. (2009) highlight the impact of gender differences on mental health and on course and experience of mental illness. They explain the need for adopting a women-centered mental healthcare model which contextualizes service delivery in relation to socio-cultural and economic factors, while ensuring good outcomes and minimizing re-traumatization.

In Lancet's seminal series on women's mental health, Howard and colleagues (Howard et al. 2017) call for a gendered perspective in mental health research, by analysing results by gender and including gendered risk factors such as intimate partner violence as covariates (Howard et al. 2017). "*Gender disparities in mental health*" by the World Health Organization (WHO) highlights the issues of gender-based violence, the influence of gender in patterns of health seeking, gender stereotyping in diagnosis, gendered nature of comorbidity, gender bias in research, to name a few, and also recommend gender-sensitive services to deal with these issues (World Health Organization 2007).

While there have been several papers recommending the need to enhance gender-sensitive and gender-friendly mental health care for women with mental health problems (Kimerling et al. 2015; Kissin et al. 2015; World Health Organization 2002), there are very few studies that have assessed availability or satisfaction with such services globally. There is however some literature on mental health professionals' training needs and their comfort in handling women who present to mental health services and report family

violence (Sweeney et al. 2018; Ruijne et al. 2019; Trevillion et al. 2016). It is therefore important to obtain practice-based evidence on provider and user satisfaction and uptake of gender-sensitive service delivery (Barkham and Mellor-Clark 2003).

This survey was conducted among mental health professionals who were identified as experts and who were practitioners or researchers in women's mental health across the world. The aim of the survey was to understand the current priorities in gender-sensitive mental health services globally and the satisfaction among experts about existing availability of each of the components of a gender-sensitive service in their place of work.

Materials and methods

An online survey using the platform Google Survey was used. An invitation was sent to 150 professionals (psychiatrists, clinical psychologists, social workers, nurses, non-governmental organizations) who were identified as experts in the area of women's mental health. The list of experts was based on persons known as clinical experts or leaders in the field and was determined by the first author's knowledge of the leaders and members of organizations working in the field of women's mental health. We also asked for nominations from known experts. It was ensured that not more than one person from a single service or institution was invited to prevent any duplication and no more than three experts were invited from each country. The survey was sent out to 60 experts from low- and middle-income countries (LAMIC) and 90 from high-income countries (HIC) and covered all continents. The higher numbers of experts from HIC was due to the fact that there were more active researchers and professionals in women's mental health from high-income countries. However, due to the fact that we did not have any identifying details, we do not have the exact countries from which these responses came.

The survey was anonymous and no identifying data was asked for. The details asked included their profession (psychiatrist, psychologist, social worker, nurse), the nature of service where they worked (general hospital, academic institution, psychiatric hospital, outpatient clinic), and whether they were from a LAMIC or HIC. The name of the country or city was not asked. Online consent was sought and it was specifically mentioned that no identifying details will be asked for, that they were free to not respond to any item and to withdraw their participation at any point. No incentive was provided and the survey was in English. The study was approved by the institutional ethics committee of National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, India.

Based on existing literature (Women's Centre for Health Matters 2009; Victorian Women and Mental Health Network 2009; Oertelt-Prigione et al. 2017; deKleijn et al. 2015; The Women's Health Council 2007; Elliott et al. 2005), key domains were shortlisted and items representing each domain were generated. Agreement between the first and second author (PSC and GS) on key domains was established and any disagreements between first and second authors were then discussed with the author VS. These were then sent to three experts for content validity.

The survey included 43 questions under 7 domains of gender-sensitive mental health care. The domains were as follows: creating an atmosphere of safety and respect, gender-friendly structural arrangements, involving women in planning of services, meaningful access to care for self and children, availability of women-specific information, gender-specific training, and gendered data analysis.

Respondents were asked to rate the importance of each area of a gender-sensitive service on a Likert scale of 0 to 5 (Least Important to Most Important) and also rate their satisfaction with the availability of these services in their own place of work on a scale of 0–5 (Not at all Satisfied with current availability to Extremely Satisfied). An additional option of "Not-Applicable" was also provided in the survey.

Analysis Statistical Package for Social Sciences version-22 was used for analysis.

We calculated univariate statistics for the expert ratings for each item and rank ordered their importance under each domain using the median score. We compared the satisfaction (score of 4 or 5) about current availability of the top twenty most important items rated by experts between HI and LAMIC using the chi-square test.

Results

The survey was sent to 150 professionals, of whom 73(49%) responded. The respondents included psychiatrists (81%), psychologists (8.2%), social workers (5.4%), and nurses (5.4%). Their places of work included university hospitals (41%), general hospitals (18%), public (17%) and private (10%) psychiatric hospitals, and community clinics and outpatient clinics(14%). Of the 73 respondents, 43 (58%) were from low-income countries and 30 (42%) were from high-income countries.

Ratings by domain

Table 1 contains the rank-ordered final expert panel ratings within each of the domain of gender-sensitive mental health care based on importance:

Domain I—Gender-friendly structures: 10 of 15 items were ranked high and mainly included structural

Table 1 Rank-ordered final expert panel ratings within each domain of gender-sensitive care and satisfaction with current availability based on the median rank score

Serial no.	Item	Importance			Satisfaction with current availability		
		N	Median (IQR)	Mean (SD)	*N*	Median (IQR)	Mean (SD)
1. Gender-friendly structural arrangements							
1	Ensuring private spaces for physical examination	72	5 (5,5)	4.47 (1.1)	72	3.5 (2,5)	3.32 (1.564)
2	Provision of mother-baby units to allow for and encourage bonding with babies in the postpartum period	72	5 (5,5)	4.42 (1.135)	71	1 (0,3)	1.58 (1.499)
3	Adequate provisions for availability of menstrual hygiene facilities (sanitary napkins, etc.) in inpatient and outpatient settings	72	5 (4,5)	4.39 (1.12)	71	2 (1,4)	2.15 (1.746)
4	Child-friendly environments (affordable childcare and/or supervision)	72	5 (4,5)	4.2 (1.154)	71	1 (0,2)	1.07 (1.269)
5	Dedicated breastfeeding areas in outpatient clinics	72	5 (3,5)	4.15 (1.274)	72	1 (0,2)	1.11 (1.39)
6	Availability of economical and safe public transport to and from the hospitals	72	5 (4,5)	4.15 (1.21)	73	2 (0,3)	2.01 (1.687)
7	Facilities more conducive to visiting children such as separate family visiting areas	72	5 (3.25,5)	4.14 (1.19)	71	1 (0,2)	1.35 (1.445)
8	Services located near public transport routes	72	5 (4,5)	4.12 (1.201)	73	2 (1,4)	2.32 (1.723)
9	Separate toilets for men and women	72	5 (3.25,5)	4.06 (1.342)	72	4 (2,5)	3.49 (1.592)
10	Having separate wards in hospitals for women	72	5 (4,5)	4.04 (1.272)	71	2 (1,4)	2.28 (1.814)
11	Lockable bedroom and bathroom doors	72	4 (3,5)	3.85 (1.411)	71	2 (1,3)	2.15 (1.653)
12	Having "women-only" areas for sitting and recreation in psychiatry wards, floors, and units	72	4 (3,5)	3.79 (1.31)	71	1 (1,2)	1.62 (1.428)
13	Gender segregation in emergency psychiatry settings	72	4 (2.25,5)	3.5 (1.538)	69	0 (0,2)	1.01 (1.377)
14	Separate waiting rooms in outpatients	72	2 (1,3)	2.19 (1.58)	71	0 (0,1)	0.49 (0.984)
15	Separate queues for men and women for registration and collecting medications	72	2 (0,3.25)	1.94 (1.801)	68	0 (0,1)	0.66 (1.241)
2. Creating an atmosphere of safety and respect							

Table 1 (continued)

Serial no.	Item	Importance			Satisfaction with current availability		
		N	Median (IQR)	Mean (SD)	*N*	Median (IQR)	Mean (SD)
1	Safety mechanisms in place for preventing violence or abuse in inpatient settings such as nurse call buttons/loud alarms	72	5 (5,5)	4.42 (1.123)	70	2 (0,4)	2.26 (1.924)
2	Private, non-discriminatory, respectful, and sensitive provider-women interaction	72	5 (4,5)	4.35 (1.177)	71	2 (1,3)	2.31 (1.479)
3	Patient education regarding the risks of forming intimate relationships with fellow patients/staff while in a vulnerable state	72	5 (4,5)	4.33 (1.175)	70	1 (1,3)	1.79 (1.55)
4	Protecting women who may be sexually vulnerable due to the illness (such as disinhibition during mania or being homeless)	72	5 (4,5)	4.31 (1.171)	70	2 (1,3)	2.06 (1.676)
5	Use of trained, sensitive, and compassionate female security personnel in situations that compromise dignity, e.g., in restraining an agitated female patient	72	5 (4,5)	4.25 (1.184)	70	1.5 (1,2.25)	1.74 (1.451)
3. Having choices and meaningful access to care							
1	Choice of being assessed and examined by women doctors/ nurses in women reporting sexual assault and women with history of intimate partner violence	72	5 (4,5)	4.39 (1.115)	68	2 (1,3.75)	2.28 (1.563)
2	Quick assessments and special provisions to bypass routine hospital queues and lengthy procedures in case of sexual assault	72	5 (4,5)	4.37 (1.137)	67	2 (0,3)	1.93 (1.636)
3	Trauma-informed mental health care, i.e., staff sensitivity towards previous experiences of trauma the patient may have undergone	72	5 (4,5)	4.33 (1.179)	72	2 (0,3)	1.9 (1.62)
4	Assistance for women who find it difficult to understand and navigate the mental health care system	72	5 (4,5)	4.29 (1.124)	72	1 (0,3)	1.64 (1.541)

Table 1 (continued)

Serial no.	Item	Importance			Satisfaction with current availability		
		N	Median (IQR)	Mean (SD)	*N*	Median (IQR)	Mean (SD)
5	Short waiting times for women with young children	72	5 (4,5)	4.26 (1.131)	72	1 (0,2)	1.51 (1.463)
6	Gender-specific group programs	72	4 (3,5)	3.97 (1.178)	72	1 (1,3)	1.76 (1.468)
7	Ensuring a gender-sensitive approach to bed allocation and the allocation of staff to individual patients	72	4 (3,5)	3.96 (1.25)	70	2 (1,3)	1.89 (1.528)
8	Short waiting times for older women	72	4 (3,5)	3.95 (1.332)	72	1 (0,2)	1.53 (1.444)
9	Offering women choices about the type of support they receive, and who provides it to them (i.e., a choice between a male or female doctor)	72	4 (3,5)	3.75 (1.242)	71	2 (1,3)	1.79 (1.453)
4. Life-stage issues and participation in care							
1	A more interpretive rather than paternalistic style of provider-patient relationship, characterized by shared decision-making in terms of treatment options and making informed choices about their treatment	72	5 (4,5)	4.33 (1.143)	72	2 (1,3)	2.08 (1.651)
2	Using a life course approach in service planning and delivery, i.e., how life events and stages in a woman's life cycle affect mental health	72	5 (4,5)	4.29 (1.136)	73	2 (1,3)	2.01 (1.448)
3	Taking into account the "social determinants' of health, i.e., acknowledging how a woman's personal and social circumstances determine her mental health and help-seeking	72	5 (4,5)	4.22 (1.109)	72	1 (0,3)	1.71 (1.515)
4	Using specific feedback from women patients while making policy and administrative decisions	72	5 (4,5)	4.12 (1.166)	72	1 (0,2)	1.31 (1.328)
5	Advanced directives which enable women to be actively involved in their treatment and plan future course of options	72	5 (3.5,5)	4.11 (1.173)	72	1 (0,3)	1.61 (1.683)
6		72	4 (3,5)	4 (1.21)	70	2 (1,3)	2.09 (1.549)

Table 1 (continued)

Serial no.	Item	Importance			Satisfaction with current availability		
		N	Median (IQR)	Mean (SD)	*N*	Median (IQR)	Mean (SD)
	Use of female community healthcare workers in basic mental health services						
5. Gender-specific training of mental health professionals							
1	Training mental health professionals to treat and respond to gender-sensitive health areas such as domestic violence, unwanted pregnancies, child neglect, and intimate partner violence	72	5 (5,5)	4.47 (1.094)	72	2 (1,3)	1.86 (1.377)
2	Incorporating gender-sensitive healthcare practices in undergraduate and postgraduate teaching curricula	72	5 (4,5)	4.22 (1.129)	71	1 (0,3)	1.55 (1.35)
3	Staff and practitioners with specialized training and experience in women's health	72	5 (4,5)	4.22 (1.17)	73	2 (1,3)	1.85 (1.488)
4	Undertaking staff training activities to ensure current knowledge of gender-sensitive care is incorporated into routine practice	72	5 (4,5)	4.14 (1.134)	72	1 (0,2.75)	1.51 (1.482)
6. Information							
1	Efficient grievance redressal process including provision of legal aid	72	5 (4,5)	4.18 (1.125)	69	1 (0,3)	1.64 (1.455)
2	Complaint desks manned by female personnel	72	4 (3,5)	3.73 (1.284)	69	1 (0,2)	1.46 (1.399)
7. Gendered data analysis							
1	Monitoring gender sensitivity in the healthcare system through frequent audits and analyzing sex-disaggregated data	72	5 (3.5,5)	4.1 (1.169)	71	1 (0,2)	1.17 (1.531)
2	Incorporating gender sensitivity into performance appraisals to ensure that gender sensitivity is taken seriously and becomes an integral part of daily service delivery	72	4 (3,5)	3.96 (1.144)	71	1 (0,2)	1.11 (1.41)

arrangements such as privacy, access, and security. In addition, the need for mother-baby units and childcare and child-friendly services were considered very important.

Domain II—Creating an atmosphere of safety and respect had five items and all of these were ranked very high.

Domain III—Having choices and meaningful access to care: This domain focused on trauma-informed care, services that are sensitive to women who have reported sexual assault, and also choices related to the provider. The need for all forms of trauma-informed services ranked high

Domain IV—Life-stage issues and participation in care: All items were ranked high by majority of the experts. The highest-ranking item was the need for a more interpretive rather than paternalistic style of provider-patient relationship and the need for shared decision-making in terms of treatment options.

Domains V, VI, and VII—the emphasis was on training of all mental health professionals including the need for

Table 2 Comparison of satisfaction of availability of the top 20 items of gender-sensitive mental health care between expert ratings from high-income and low-income countries

Serial no.	Highest rated items (importance)	Importance (Overall; $N = 73$) Most important *n* (%)	Current availability (HIC; $N = 30$) Satisfied in HIC *n* (%)	Current availability (LMIC; $N = 43$) Satisfied in LMIC *n* (%)	*p* value
1	Training mental health professionals to treat and respond to gender-sensitive health areas such as domestic violence, unwanted pregnancies, child neglect and intimate partner violence	61 (83.56)	6 (20.69)	3 (6.98)	0.144
2	Ensuring private spaces for physical examination	60 (83.33)	23 (79.31)	13 (30.23)	< 0.001
3	Using a life course approach in service planning and delivery, i.e., how life events and stages in a woman's life cycle affect mental health	60 (82.19)	5 (17.24)	2 (4.65)	0.11
4	Assistance for women who find it difficult to understand and navigate the mental health care system	60 (82.19)	9 (31.03)	1 (2.33)	0.001
5	Provision of mother-baby units to allow for and encourage bonding with babies in the postpartum period	59 (81.94)	8 (27.59)	1 (2.38)	0.003
6	Choice of being assessed and examined by women doctors/nurses in women reporting sexual assault and women with history of intimate partner violence	58 (81.69)	12 (44.44)	5 (12.2)	0.003
7	Quick assessments and special provisions to bypass routine hospital queues and lengthy procedures in case of sexual assault	58 (81.69)	11 (42.31)	3 (7.32)	0.001
8	Short waiting times for women with young children	59 (80.82)	4 (13.79)	3 (6.98)	0.429
9	A more interpretive rather than paternalistic style of provider-patient relationship, characterized by shared decision-making in terms of treatment options and making informed choices about their treatment	59 (80.82)	15 (51.72)	1 (2.33)	< 0.001
10	Taking into account the "social determinants" of health, i.e., acknowledging how a woman's personal and social circumstances determine her mental health and help-seeking	59 (80.82)	9 (30)	2 (4.65)	0.006
11	Private, non-discriminatory, respectful, and sensitive provider-women interaction	58 (80.56)	15 (51.72)	2 (4.76)	< 0.001
12	Safety mechanisms in place for preventing violence or abuse in inpatient settings such as nurse call buttons/loud alarms	58 (80.56)	19 (67.86)	4 (9.52)	< 0.001
13	Patient education regarding what risks of forming intimate relationships with fellow patients/staff while in a vulnerable state	58 (80.56)	12 (42.86)	0 (0)	< 0.001
14	Protecting women who may be sexually vulnerable due to the illness (such as disinhibition during mania or being homeless)	58 (80.56)	12 (42.86)	4 (9.52)	0.001
15	Adequate provisions for availability of menstrual hygiene facilities (sanitary napkins, etc.) in inpatient and outpatient settings	58 (80.56)	16 (57.14)	3 (6.98)	< 0.001
16	Child-friendly environments (i.e., affordable childcare and/or supervision)	57 (80.28)	3 (10.71)	1 (2.33)	0.293
17	Services located near public transport routes	58 (79.45)	17 (56.67)	4 (9.3)	< 0.001
18	Staff and practitioners with specialized training and experience in women's health	58 (79.45)	6 (20)	5 (11.63)	0.342
19	Trauma-informed mental health care, i.e., staff sensitivity towards previous experiences of trauma the patient may have undergone	58 (79.45)	12 (41.38)	5 (11.63)	0.004
20	Using specific feedback from women patients while making policy and administrative decisions	58 (79.45)	6 (20.69)	1 (2.33)	0.015

ongoing training and updates on areas such as pregnancy and partner violence and ensuring adequate availability of such staff at all times in any system. The need to provide information to women about their rights and legal literacy ranked high as also did the need for gender-aggregated data during clinical audits.

Table 2 compares expert ratings on satisfaction with availability between HI and LAMIC countries of the top twenty items ranked as important. A score of 4 or 5 was considered adequate satisfaction. It is quite clear that the frequencies of satisfaction ratings were much lower in low-income than high-income countries. However, even in high-income countries, only 6 items out of the top 20 actually received satisfaction rating by at least 50% of experts. Less than 50% of experts rated satisfaction with 14 of the top twenty important items. Of the 6 items which received more than a 50% satisfied rating, four were related to structural aspects of care including private spaces for physical examination (79.3% in HIC and 30.2% in LAMIC); safety mechanisms such as alarms (68% and 9.5%); menstrual hygiene facilities (57.1% and 7%); and services near public transport routes (56.6% and 9.3%).

Two were related to shared decision-making and a non-paternalistic method of care (51.7% in HIC and 2.3% in LAMIC); non-discriminatory and respectful provider patient interaction (57.7% and 4.8%). Among experts from LAMIC, of the 43 items, only one (ensuring private spaces for physical examination) item received more than 25% satisfaction.

Discussion and conclusions

The major findings of this survey include a ranked listing of the most important aspects of gender-sensitive care for women with mental health problems from a worldwide expert panel. The survey also highlights the satisfaction which experts have with these aspects in their respective places of work.

Experts rated most items highly (mean score > 4) in terms of their importance (Table 1). The main areas rated highly by majority of the experts included provision of mother-baby units and childcare, accessibility to services, separate wards in hospitals for women and safety mechanisms for preventing violence or abuse in inpatient settings, respectful and sensitive provider-women interaction, patient education regarding risks and safety, having trained, sensitive and compassionate staff including female security personnel, choices of provider gender especially in situations of sexual assault, trauma-informed mental health care, a life course approach in service planning and delivery, focus on social determinants, using feedback from women providers for service planning, access to information, grievance redressal and legal aid, availability of gender-aggregated data, and most importantly, training of mental health professionals in gender-sensitive care.

However, what is a matter for concern is the fact that even in HI countries, experts were far from satisfied with majority of these items (Table 2). The only areas of satisfaction that were rated as high (by 50% or above) were related to the more structural aspects of care such as separate toilets, privacy for examinations, and safety mechanisms such as alarms. Apart from these, the only two areas where 50% of experts from high-income countries reported satisfaction were related to the provider-patient relationship.

Several reports have highlighted the need for services to be sensitive to the diversity of women's needs and backgrounds including race, sexuality, and disability (The Women's Health Council 2007), enable women to make choices about their care and treatment (Abel and Newbigging 2018)(Women's Centre for Health Matters 2009), the need to provide safe and women-only spaces, especially in inpatient care (Victorian Women and Mental Health Network 2009), enable women to develop skills for addressing their difficulties by handling issues of self-management (Newbigging and Abel 2006), promoting self-advocacy and advocacy for women who need support to voice their views (Department of Health 2002), and value women's inner resources and strengths in their road to recovery (Barnes et al. 2002). Our study highlights the same issues.

In addition to services, the importance of gender sensitivity and gender-based training for mental health professionals that can be applied to services worldwide appears to be an urgent need. An evidence-based curriculum for gender (women)-sensitive care, similar to that developed by the World Psychiatric Association on handling intimate partner and sexual violence would be extremely helpful for organizations and services to adapt (Stewart and Chandra 2017). This may also serve as an important advocacy tool when requesting for funds and staffing.

What is of immense concern is the dismal situation in the LMICs. In most items, the satisfaction with availability was very low. While this may reflect an overall lower quality of mental health care in many countries, the lack of some basic aspects of women-friendly services cannot be accepted. Although, greater representation of men in the workforce as administrators and clinicians, and low priority given to gender-sensitive care may be some obstacles, it is interesting to note that many of the items ranked as important do not necessarily need a lot of funds. They, therefore, reflect a way of thinking by clinicians and administrators which requires training, sensitization, and constant revaluation. These include creating adequate representation of all genders in important administrative decision-making bodies and as clinicians/providers, training in gender-sensitive care, using feedback from women service users to enhance services and having more respectful and equal provider patient interactions.

It is also important that metrics in services for licensing or revalidation are viewed through a gender lens and sex and gender-disaggregated data is available for all quality measures. This would mean including specific details in electronic medical records wherever they exist.

The challenges to implementing a gender-sensitive approach to mental health services could be the lack of training on this aspect in the postgraduate curriculum, not having enough representation of women in hospital administration and decision-making bodies, and not using gender sensitivity as a quality metric for services.

It might help us to look around at services in other health systems and derive encouragement. We should use the VA system as an example in which program managers conduct "environmental rounds' to ensure that the culture of gender sensitivity ("not every GI is a Joe") is incorporated in every aspect of care (deKleijn et al. 2015). There is also data from the HIV/AIDS field regarding aspects of gender-sensitive care such as facilitating communication with peers, meeting women "where they are", acknowledging their agency, and providing self-determination opportunities, facilitating access to women-specific and culturally sensitive information, and providing tailored programs for women, which we could incorporate (Carter et al. 2013).

This study has important limitations. The items of the survey were based on literature review and domains identified were based on expert validation. While this might be enough for a preliminary survey, for this to be used as a tool in the future, the items need to be factor analysed in order to establish domains. We received responses from only 73 of the 150 experts to whom we had sent the survey and therefore, it cannot be said to be entirely representative, though 49% response rate in online surveys can be considered satisfactory based on response rates in other studies among physicians that have used web-based surveys (Cobanoglu et al. 2001; Cunningham et al. 2015). In a meta-analysis of web-based surveys among physicians, the mean response rate for the 68 surveys reported in 49 studies was 39.6% (Cook et al. 2000). The survey was in English, which could have prevented non-English speaking experts from responding. However, non-responders could have differed from responders introducing a possible response bias in the survey. We also do not have identifying data of the countries from which we received this information or even continents to ensure that we got an entirely worldwide distribution. While these are important variables, the aim was not to identify specific countries as having problems, especially when these were reports about the expert's place of work and not representative of the whole country. Another limitation is the absence of age and gender of the survey respondents. Results are also sensitive to the expert group compilation and the fact that we had an over representation of psychiatrists compared with other mental health professionals. There are some areas that were not addressed in the survey such as the need for services that are sensitive to sexuality, race and disability needs, or the need for physical and reproductive health services to be integrated into mental health care. Finally, the availability measured the satisfaction rather than the actual availability of services.

Despite these limitations, the article offers a model for policy makers, clinicians, and administrators to think with a gender lens. Receiving information from 73 experts on women's mental health from around the world on this important topic, we believe is a first step to opening the discussion on this important topic. The scope was wide and did not limit itself only to clinical care. The 43 items ranged from an approach to care, safety issues, social determinants, and the culture of care. The fact that we got responses from both high-income and low-income countries (almost equal) and hence were able to compare the availability of services (albeit using a proxy measure) is also an important strength.

Integrating gender in all aspects of quality improvement is necessary and any planning of mental health services or structures must include "women-friendly" aspects at the drawing board rather than as an afterthought. An important step would be open dialogues between different stake holders about what constitutes a gender-sensitive mental health service for that city or region, as cultural issues and social realities may be different in each context. The components of the service may also differ based on the nature of care, with different items of each domain being more relevant for different care settings such as inpatient care, outpatient clinics, community based services, or rehabilitation facilities. User involvement is of paramount importance as it is often they who have an inner and ringside view of the needs for themselves and their peers. The paper also opens the door to other follow-up work that might involve the patients' views and actual data on male to female assault on inpatient psychiatry units.

Finally, it might be useful to develop a checklist for assessing how gender sensitive a psychiatric service in order to conduct audits and improve services. The Department of Health, UK, reports and recommendations of 2002 and 2006 (Newbigging and Abel 2006; Barnes et al. 2002) have laid out several areas under which a service should be evaluated such as needs assessment and service and resource mapping, including a comprehensive range of services, monitoring and reviewing provision, information, access, and staffing, to name a few and include many of the domains that have been assessed in our survey. These and additional items may be used by any service that wants to do a gender audit that is rated both by professionals and women users.

Compliance with ethical standards

Ethical approval All procedures performed were in accordance with the ethical standards of the institutional and/or national research committee (Institutional Ethics Committee, National Institute of Mental Health and Neuro Sciences, Bangalore, India, Ref no.: NIMHANS/EC/BEH SC/13/2018) and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent Informed consent was obtained from all individual participants included in the study.

Conflict of interest The authors declare that they have no conflict of interest.

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