How to do gender analysis in health systems research: A guide
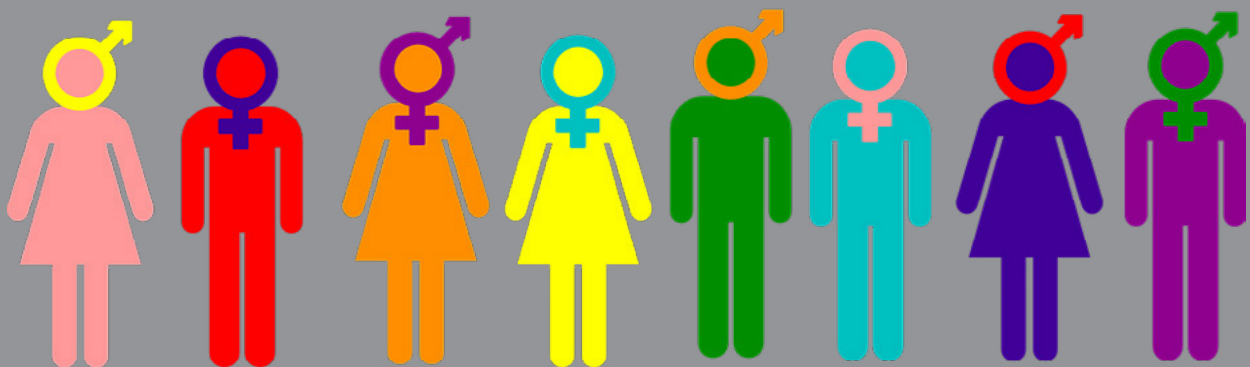
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Introduction

Many donors now require that health systems research takes account of gender. However, all too often the inclusion of gender in health systems research is regarded as a 'tick-box' exercise, or it is considered an 'add-on', an extra task that is sometimes considered irrelevant.

Social justice advocates take a different approach to gender - demanding that research does not just seek to describe the world around us but instead aims to transform institutions, structures, systems, and norms that are discriminatory.

Within RinGs we believe that analysis of gender (and other intersecting axes of inequality) is vital to ensuring quality health systems research and that gender analysis done well can deliver insights which have the potential to revolutionise policy and practice. In our publications and tools we aim to: provide practical advice on how to overcome the barriers and impediments to gender analysis; suggest tools and techniques that health systems researchers can take up in their work and learn together about what works under what circumstances.

The majority of the information included in this brief is taken from the paper: "How to do (or not to do...) gender analysis in health systems research", published in Health Policy and Planning (Morgan et al. 2016). The paper includes a more detailed discussion of many of the topics presented below.

Who is this resource for?

If you are just starting out in your research career, or if you have been conducting research for some time but have not given the issue of gender much thought until now, this guide is for you. It will help you to go beyond just a focus on women or disaggregating your data by sex to assist you in thinking through some of the gendered power relations in health systems and the inequities that follow from them. It leads you through a series of steps and critical questions that you can ask as you undertake your research.

We hope that as a result you will see gender analysis as not just another – last minute – chore to be performed, but as something that can significantly enhance the relevance, robustness and rigour of your work.

Contribute to the resource and discussions

Help us to strengthen this guide by sharing your own resources, papers, experiences, and thinking. Join a growing community of practice that is interested in gender in health policy and systems research! Contact us at **RinGs.RPC@gmail.com**, visit our website at **http://resyst.lshtm.ac.uk/rings**, or join the discussion on our LinkedIn page at **https://www.linkedin.com/groups/8293050**.

Overview of gender and health systems research

Health systems are gendered because we live in a gendered world. The World Health Organization (2016) defines gender as:

"Socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women."

What gender means varies over time and across contexts; in contrast to sex, which refers to the chromosomal characteristics that distinguish men, women and intersex people (Sen et al. 2007).

Gender can affect how vulnerable people are to particular health conditions, whether they have power over how household resources are spent on health care, amounts of access to services, the design and use of medical technologies and medicines, how the health workforce is structured, and how health policies are developed and implemented.

In recent years health systems thinking has evolved to have more of a focus on: 1) complexity and the interconnected nature of the different components that make up the system; and 2) 'people-centredness', how the values and interests of people in the health system and the power relations between them profoundly affect the ways that health systems operate. Socially constructed power relations between and among men, women and people of other genders can lead to different health system needs, experiences, and outcomes. Gender is also shaped by other hierarchies related to sexuality, class, race, ethnicity, education, age, and (dis)ability (Bottorff et al. 2011 Larsen et al. 2016; Hankivsky 2012).

Understanding these differences can help us to build more effective and equitable health systems, or at the very least take care not to increase inequities. Unintended consequences of health systems research could include: increased domestic violence, abuse, or partner control, or the reinforcement of harmful stereotypes. There is an ethical imperative that health systems researchers 'do no harm' to the people that they seek to serve through their work. Gender analysis can help with this.

Gender sensitive research: The basics

❶ Breaking down data by sex

To begin a gender analysis of health systems data you first need to disaggregate it by sex. When you gather information you need to distinguish between men, women, and people of other genders. Aggregated datasets can mask differences between the sexes, leading to assumptions that all people share the same experiences – this bias can affect the validity and reliability of research in negative ways. For example, when you are looking at the health workforce if you don't take account of sex you may miss important information such as whether the staffing hierarchy is gendered (Nowatzki & Grant 2011; Johnson et al. 2009).

In addition to sex, data should also be disaggregated by other social markers, such as sexuality, class, race, ethnicity, education, age, and (dis)ability. This disaggregation should be a 'trigger' that encourages deeper investigation and where appropriate, action.

❷ Organising your thinking using gender frameworks

There is no single framework that will perfectly meet the needs of all health systems researchers. Frameworks are a useful research tool as they help researchers to further organize thinking, research questions, data collection, and analysis. Examples of four frameworks which can be used within health systems research can be found in the column to the right.

What most of these frameworks do is lead you through a process where you are encouraged to answer questions related to key domains that constitute gender power relations. The framework below organises these domains into four categories: who has what (access to resources); who does what (the division of labour and everyday practices); how values are defined (social norms, ideologies, beliefs, and perceptions) and who decides (rules and decision-making).

Four gender frameworks that address health systems

❶ **Guide for analysis and monitoring of gender equity in health policies** http://bit.ly/22UarEp

❷ **Addressing Gender and Women's Empowerment in mHealth for MNCH: An analytical Framework** http://bit.ly/1U8zIaA

❸ **Guidelines for the Analysis of Gender and Health** http://bit.ly/1UhLi4u

❹ **Gender Analysis Toolkit for Health Systems** http://bit.ly/1YfNxXM
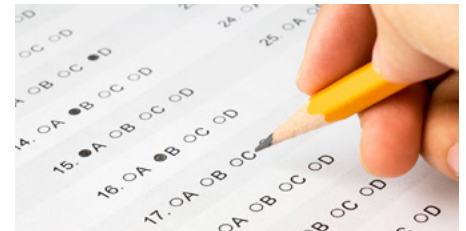
Gender Analysis Framework: Gender as a power relation and driver of inequality

What constitutes gendered power relations	
Who has what?	Access to resources (education, information, skills, income, employment, services, benefits, time, space, social capital etc.)
Who does what?	Division of labour within and beyond the household and everyday practices
How values are defined?	Social norms, ideologies, beliefs and perceptions
Who decides?	Rules and decision-making (both formal and informal)
How power is negotiated and changed	
Individuals/ People	Critical consciousness, acknowledgement/ lack of acknowledgement, agency/apathy, interests, historical and lived experiences, resistance or violence
Structural/ Environment	Legal and policy status, institutionalisation within planning and programs, funding, accountability mechanisms

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❸ Using gender analysis questions

Gender analysis questions help researchers move beyond describing the differences between women, men and people of other genders, to examine why and how power relations cause inequities between people in health systems interactions. In the table below you can see how gender analysis questions might relate to the six WHO building blocks: service delivery; human resources; health financing; leadership and governance; information and research; and medical products and technologies. These questions are organized in relation to the four domains for understanding gender as a power relation outlined in the framework above.

Service delivery

Access to resources	To what extent do health facilities provide services with appropriate conditions (with functioning toilets, bathing areas for inpatient facilities, shelter from sun/rain in the waiting area) and with appropriate staff for all populations? Do sexual and reproductive health services provide services to both men and women? Are they available to those who are unmarried or widows/ widowed? To what extent are marginalized populations (transgender people, ethnic minorities, migrants, inhabitants of informal settlements, people employed in illegal occupations, etc.) able to access relevant information and care? What are the barriers that affect their access? How does gender interact with these other forms of marginalisation among these communities to affect access to health care? Are there services for gender-based violence such as domestic violence?
Division of labour and everyday practices	To what extent are maternal and child health outreach visits or clinics organised considering women's agricultural, economic, or caretaking activities in their communities? How do women's social roles, such as childcare and infant feeding, affect their access to and utilization of health facilities?
Social norms	Do services encourage the participation of men in women's and children's health? If yes, how, and on what terms? To what extent are certain health conditions normalised (e.g. reproductive tract infections)? Do providers normalise irrational use of certain procedures (e.g. oxytocin to induce labour, caesarean sections that are not medically indicated)?
Rules and decision-making	Who decides whether and how much to allocate household resources to pay for health care services? Do women require the permission of a male partner or relative to access a healthcare facility? To what extent are there policies in place guiding health services to be more gender-responsive? Do they have review procedures to ensure follow up?

Human resources

Access to resources	To what extent do women and men have the same access to educational and training opportunities? To what extent do family support and roles help or limit opportunities for training by gender, marital status or parity? Are there sex differences in relation to remuneration, promotion, job security, working hours and benefits across and within all types of health workers? How does this interact with marital status, parity or sexual orientation?
Division of labour and everyday practices	To what extent are women more or less likely to work in frontline service delivery in poorly compensated (including volunteer) or less supported positions than men? To what extent are women more or less likely to work in management positions than men?
Social norms	Are female and male health providers recognised differently? To what extent are female providers expected to provide more emotional support than male providers? To what extent are female providers less likely to ask for promotions and less likely to complain about poor working conditions than male providers due to less assertive social norms?
Rules and decision-making	Are there female members and workers from across the health workforce hierarchy on committees that adjudicate over sexual harassment in the health workforce? Has gender been mainstreamed into human resource policy, and if so how, with what impact? Are there policies in place – and implemented - to effectively address sexual harassment against health workers? To what extent are there adequate maternity, paternity and family leave policies for both female and male health workers at all levels?

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Health financing

Access to resources	Are girls, women, boys or men more or less likely to know about user fees exemptions, cash transfer entitlements and health insurance benefits? To what extent are services that are needed by only some populations included in performance-based incentive programs or health insurance plans? Do insurance packages include services exclusively used by women, such as maternal health? Do they include services for men's sexual and reproductive health? To what extent do user fees or the removal of user fees have more impact on women from marginalised groups, because they have less access to cash? Have sex-disaggregated information on out-of-pocket expenditures on health been obtained? What services incur the greatest out-of-pocket expenditures for men and women? And what is the impact on individuals and households?
Division of labour and everyday practices	To what extent are services provided by female vs. male health workers more likely to be included in performance-based incentive programs? To what extent are girls, women, boys or men more or less likely to work in jobs that offer health insurance? To what extent is insurance coverage available to people who work in the informal sector, in paid domestic service, in seasonal or part-time work, or unpaid home-based carers? Are women from marginalised groups more likely to be found in these types of work?
Social norms	To what extent are marginalised groups less likely to follow up on financial claims because of less assertive social norms, or a history of government discrimination? Are health workers in public facilities more likely to respond to certain groups of clients based on perceived ability to pay, gender etc.
Rules and decision-making	Who designs insurance policies? Are women involved or people from marginalised groups? Who designs exemptions or waivers from payment? Is it mostly male managers? To what extent are health budgets publically debated by political parties? Are these political parties skewed by gender or other social determinants? Do insurance policies require levels of paperwork and verification that are not possible for marginalised groups? To what extent is health spending made public at different health system levels and who has the right to access such data?

Leadership and governance

Access to resources	Who is more likely to have information about health entitlements? Who is more likely to have higher literacy levels and access to social capital enabling them to participate more effectively in health committees and other forms of health planning? Who is more likely to have access to transport to travel to headquarter locations to participate in health planning processes? To what extent have those in leadership positions received training in gender sensitivity or gender mainstreaming?
Division of labour and everyday practices	What is the representation of women and men in boards, panels, working groups and other decision-making bodies, or in supervisory and management positions? To what extent are there differences by sex and other social markers in participation, decision-making and planning of interventions? Who is more likely to vote and how does this influence political priorities for health? Who engages with policy makers at the local and national level? Does having more female legislators ensure more support for women's health services, like safe abortion? If yes, how?
Social norms	To what extent are men or women more or less likely to register complaints or participate in accountability initiatives due to social norms around assertiveness? To what extent are stigmatised populations less able to advocate for their health needs?
Rules and decision-making	To what extent do policies exist to ensure that females are represented on decision-making bodies? To what extent do structures at the community level (including community health workers) have the opportunity to feed into decisions and priority setting in the health sector?

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Information and research

Access to resources	Who has access to the skills, devices and technology that transmits and processes health information? How do they use this information? Who gets to do health systems research and can access research scholarships?
Division of labour and everyday practices	Who bears the burden of routine data collection in health systems, and do these frontline workers have the capacity, time and support to do so effectively? To what extent are there gender differences? Who supervises data collection and are they given gender training?
Social norms	What kind of social norms permeate medical text books and are they discriminatory? To what extent are people from stigmatised groups less likely to respond to data collection efforts? Does conservative gender bias make reporting on rape, violence against women, or maternal deaths less likely? If yes, in what way? To what extent do information systems have mechanisms for detecting and treating domestic violence?
Rules and decision-making	Who decides what data is collected and how health system performance measured? Do indicators include issues that may differ by men and women? How accessible is routine health information and are there policy measures that ensure their transparency? To what extent are there confidentiality measures in place to protect the rights of marginalised or stigmatised groups?

Medical products and technologies

Access to resources	To what extent do women have sufficient literacy, autonomy, and ICT-access to effectively use mHealth interventions or other medical projects? To what extent is protective health equipment and gear made to fit bodies that are not the male standard? How is the financing for commodities required specifically by women different than those needed specifically by men or the general population?
Division of labour and everyday practices	How do men's and women's roles & responsibilities affect use of products (e.g. bed nets, vaccinations)? What are the challenges different groups of women and men face in adhering to long term treatment (e.g. for tuberculosis of HIV)? Are they appropriately supported within health systems and community based structures?
Social norms	How do women and men within households and communities prioritise individuals' access to medical technologies, e.g. are boys or girls more likely be prioritised for oral rehydration therapy (ORT)? To what extent are female providers less or more likely to be risk averse and therefore more likely to use protective equipment than male providers? Does this differ across and within cadres?
Rules and decision-making	Which cadres are authorised to prescribe and distribute certain drugs or commodities and is there a gender difference? Why? To what extent does regulation stand in the way of making certain commodities more widely accessible for key populations, e.g. medical abortion, blood? What is the effectiveness of regulatory mechanisms to ensure that medical products for key populations are not misused, e.g. oxytocin to augment labour?

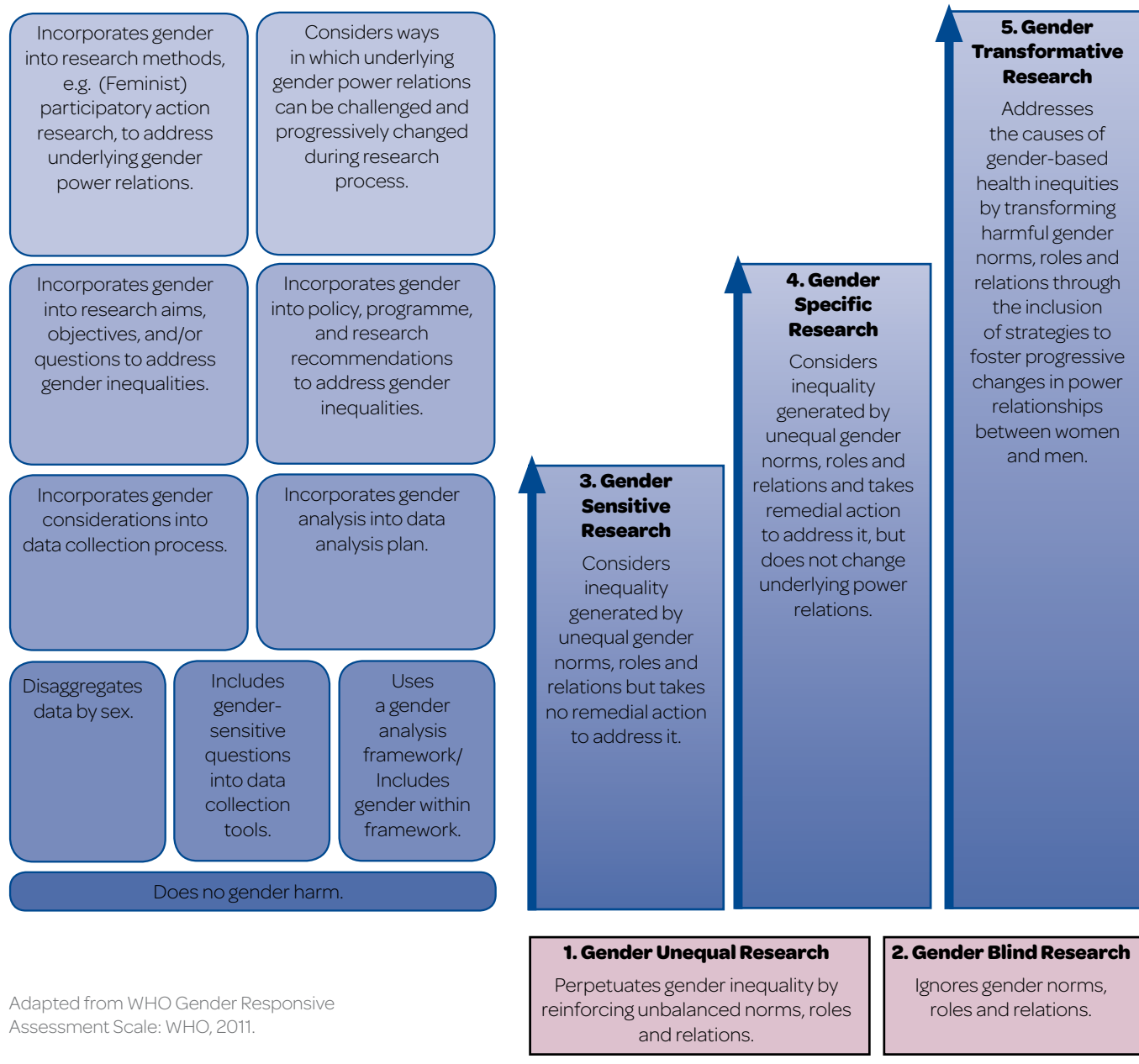• **resyst.lshtm.ac.uk/rings** • **twitter.com/RinGsRPC**

Integrating gender analysis into the research process

The research process is a cycle and gender can be integrated into the process at any point. There are different degrees in which gender can be incorporated into health systems research. The WHO's gender responsive assessment scale can be used to assess the degree to which gender is incorporated into research (WHO 2011). The scale includes five levels: gender unequal, gender blind, gender specific, gender sensitive, and gender transformative, which are represented in the figure below. Each level includes a range of activities that researchers can undertake to ensure that gender is incorporated into their work.

Incorporating gender analysis into health systems research: from gender unequal to gender transformative research

5. Gender Transformative Research
Addresses the causes of gender-based health inequities by transforming harmful gender norms, roles and relations through the inclusion of strategies to foster progressive changes in power relationships between women and men.

Incorporates gender into research methods, e.g. (Feminist) participatory action research, to address underlying gender power relations.

Considers ways in which underlying gender power relations can be challenged and progressively changed during research process.

4. Gender Specific Research
Considers inequality generated by unequal gender norms, roles and relations and takes remedial action to address it, but does not change underlying power relations.

Incorporates gender into research aims, objectives, and/or questions to address gender inequalities.

Incorporates gender into policy, programme, and research recommendations to address gender inequalities.

3. Gender Sensitive Research
Considers inequality generated by unequal gender norms, roles and relations but takes no remedial action to address it.

Incorporates gender considerations into data collection process.

Incorporates gender analysis into data analysis plan.

Disaggregates data by sex.

Includes gender-sensitive questions into data collection tools.

Uses a gender analysis framework/ Includes gender within framework.

Does no gender harm.

1. Gender Unequal Research
Perpetuates gender inequality by reinforcing unbalanced norms, roles and relations.

2. Gender Blind Research
Ignores gender norms, roles and relations.

Adapted from WHO Gender Responsive Assessment Scale: WHO, 2011.

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Defining aims, objectives, or questions

Incorporating gender into research aims, objectives, or questions is a high degree of gender incorporation. It involves research which is specifically developed to consider and address inequality generated by unequal gender norms, roles and relations. Such research includes an aim, objective, and/or question that explicitly addresses gender and gender relations. Subsequent research activities will then be developed in relation to the overarching aims, objectives and questions. While not all research needs to have a specific aim, objective or question that considers gender, in order to ensure that your work addresses this important dimension of health systems research, it is important that gender is considered in relation to the research activities discussed below.

Development of study designs and data collection tools

There are many different study designs which can be used within health systems research. The study design chosen will reflect the overall research aims, objectives, and questions. Research that aims to be gender sensitive, gender specific, or gender transformative are likely to adapt different study designs, with the latter approach incorporating a design which specifically aims to challenge gender relations.

Participatory Action Research (PAR) is one approach that researchers can use to transform gender relations. PAR is based on the understanding that people in 'people centred health systems' are not passive and that they are best placed to understand and alter their context by reflecting on the challenges that they are facing (Loewenson et al. 2014). PAR also challenges researchers outside the communities under consideration to reflect on their own power

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in relation to how knowledge is generated. Feminist PAR takes into account the way gendered power relations shape societies and how this effects discrimination against women (Corbett et al. 2007).

Data collection

Incorporating gender analysis into the data collection process includes understanding how the research process itself can be imbued with power relations and biases. There are certain considerations that researchers need to make to ensure that

these power relations and bias do not negatively affect the data that is collected.

When collecting data consider how the gender of the person collecting data could impact upon the quality and the accuracy of the information received. In some cultures people may not be comfortable, or may feel it is inappropriate, to share information with someone of another sex. Just as gender can impact the quality of the data, so too can age, class, ethnicity, and occupation, and it is important to consider how the characteristics

Examples of PAR that takes a gendered approach

South Sudan Health Action and Research Project (SHARP): South Sudan has the highest maternal mortality rate in the world at 2054 women per 100,000 live births. The newly established state has suffered years of war, leaving an already rudimentary healthcare system severely depleted. In addition, the country faces multiple other sexual and reproductive health challenges such as teenage pregnancy. SHARP developed a curriculum for the training of community facilitators to support dialogue and reflection on norms and values shaping maternal mortality and health service access and use.

Training of facilitators focussed on dialogue between older and younger women and men, comparing social and gender norms and practices between present and past, sharing knowledge on maternal health and discussing what needs to be changed for maternal health to improve. Groups used drawings, statements and proverbs to explore the relationships between communities in relation to gender and generation. For some women, this was their first experience of holding a pen or pencil. The 'but why' technique was used to probe and understand the rationale behind different cultural norms, their meanings and whether they were seen as fair. Through the facilitated discussions between genders and generations, statements for change were negotiated and agreed. This is an inspiring example of how community engagement can shift gender and societal norms and lead to more nuanced action by the health sector.

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All text adapted from authors' own. See hyperlinks for fuller explanation

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of data collectors may bias responses. Training people to collect data from their own communities is one way to increase the overall accuracy of the findings and reduce bias (Hunt 2004; Nieuwenhoven & Klinge 2010). However, data collectors who understand local context may still be unable to recognise their own biases when collecting data. All data collectors must therefore receive adequate training and supervision. Processes that support reflection on data collection, such as joint reviews of transcripts and debriefing meetings among team members, are critical to identify potential bias and check assumptions regarding how gender and power relationships may shape interactions and data.

During data collection, think about how a participant's involvement may affect their relationship with their partner, co-workers, or community members in adverse ways. For example, in certain contexts, by not addressing gender power relations, increased domestic violence, abuse, or partner control was an unintended consequence of mHealth interventions because they improved women's access to information and resources, without taking into consideration men's control over these elements (Deshmukh & Mechael 2013; Jennings & Gagliardi 2013).

Consider who is present during the data collection process. For example, if both men and women are present during interviews, focus group discussions, or surveys, this may change the quality and accuracy of the data collected, as each may be reluctant to share information about their lives and work, or their views about gender relations (Hunt 2004). Alternatively, in healthcare settings, healthcare workers may be reluctant to speak up if a female/male superior is present, or a patient may be unwilling to provide sensitive information if a healthcare worker of the same or opposite sex is present.

Lastly, think about how the timing and location of data collection can affect people's involvement. Women and men have different responsibilities in relation to work and family life, and as a result, may be available at different times of the day. For example, women often have a double-burden in relation to work and home life which may affect their ability to participate within a study. It is important to choose a convenient time and place in which to engage in data collection so that people are not excluded (Hunt 2004).

Analysis and interpretation of results

Researchers' own underlying gender biases and assumptions can affect data analysis and the results reported. Appropriate training and seeking opportunities to engage different perspectives, including from research participants on their view of emerging themes, are ways to ensure the research reflects the ground realities examined. During data analysis, did you consider how researchers' own underlying gender biases and assumptions may affect how the data is analysed or how the results are reported? If yes, how did you consider this and what steps did you take to minimize any negative effects?

Research communication

In reaching conclusions from your research and communicating your findings, it is important to consider who is empowered and disempowered as a result of the research outcomes, including the extent to which your research progressively transforms gendered power relations in health systems, or at least does not further exacerbate them. As you write up your study you may want to consider how men, women and people of other genders are portrayed in order to ensure that harmful gendered stereotypes are not replicated.

When designing research communication activities remember that this is an additional opportunity to 'truth check' your analysis by designing products and fora which encourage two-way communication with the decision makers, institutions, or communities that you are studying. Make the most of critics and critical friends to test the gender analysis in your work. Consider how best to frame your research in terms of the levels of literacy of the people who you have conducted your enquiry with and their access to the Internet and tailor your outputs accordingly. When designing research events don't fall down at the last hurdle – avoid at all costs the dreaded 'all male panel'! See: **http://allmalepanels. tumblr.com/** for more details.

Conclusion

Gender analysis is important for health systems research. All too often the inclusion of gender is regarded as a 'tick-box' exercise, or it is considered an 'add-on', an extra task that is sometimes considered irrelevant or not worthwhile. When gender is included, it often fails to go beyond the sex disaggregation, with little consideration given to how gender power relations replicate or transform inequities within health systems. Incorporating gender analysis into health systems research can help researchers and policymakers understand how gendered power relations create inequalities in health system needs, experiences, and outcomes. Stronger health systems research leads to better recommendations, more strategic interventions and programs, and more effective policies; the inclusion of gender analysis into health systems research is a core part of that endeavour.

If you are interested in pursuing gender-orientated research and would like further materials or discussion, please visit **http:// resyst.lshtm.ac.uk/rings** or contact **RinGs.RPC@gmail.com.**

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