



Research in Gender and Ethics (RinGs): Building stronger health systems



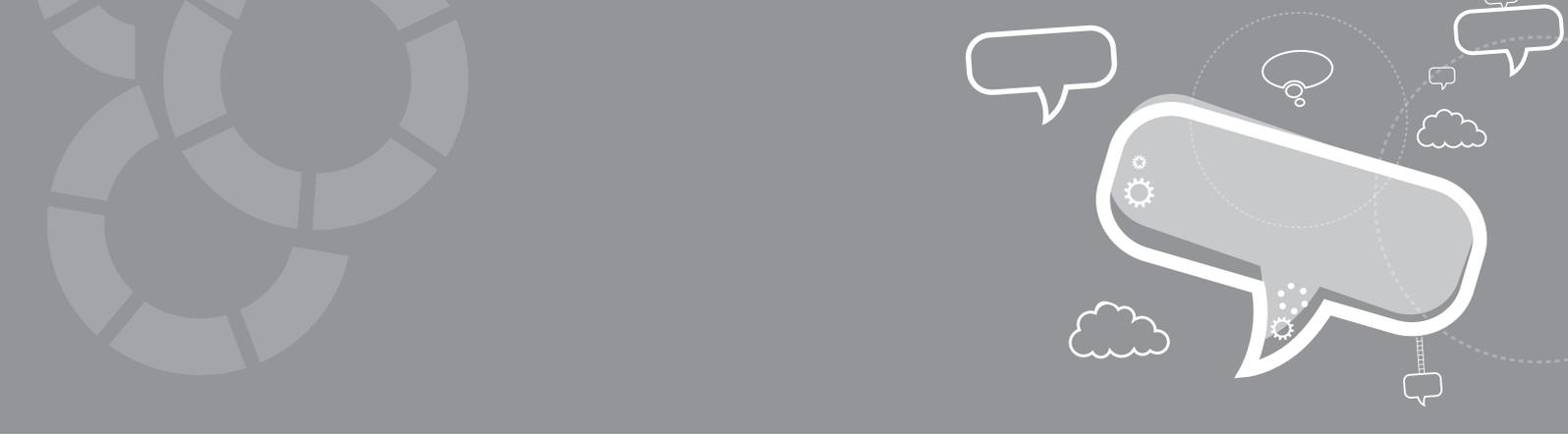
Gender and health systems Reader: Key findings from nine research projects



January 2018

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1. Introduction

“Gender is always a neglected field in the design of health systems in many countries. Having gender analysis research could open the eyes of policy makers to be more gender sensitive and perhaps encourage them to put gender in the core of policy formulation in the future” (RinGs Small Grant Researcher).

Health systems are not gender neutral. Incorporating gender analysis into health systems research is vital if our research is to accurately reflect the power relations that exist within health systems, and to understand how these create inequalities in needs, experiences, and outcomes among women, men, and people of other genders.

In Research in Gender and Ethics (RinGs): Building Stronger Health Systems, we are trying to encourage greater incorporation of gender analysis into health systems research. We have published guides on how to do gendered research (Morgan et al. 2016; RinGs 2016) and to illuminate what an intersectional analysis can bring to the work (Larson et al. 2016). However, we are aware that some researchers struggle to apply this type of approach, wondering what issues they could focus on and how to use appropriate concepts, methods and analytical approaches to conduct quality research on gender and health. Others remain unconvinced that this approach will add value to their work and would like further evidence of the utility of a focus on gender equity.

In 2015, RinGs held a competitive call among our three Research Project Consortia – Future Health Systems,

ReBUILD, and RESYST – to submit proposals for small research grants on gender, ethics and health systems issues relevant to low- and middle-income countries (LMICs). The small grants were part of a larger initiative and learning platform which aimed to galvanise gender and ethics analysis within, and improve the knowledge base on gender aware approaches to, health systems research. This Reader brings together case studies from the small grants programme.

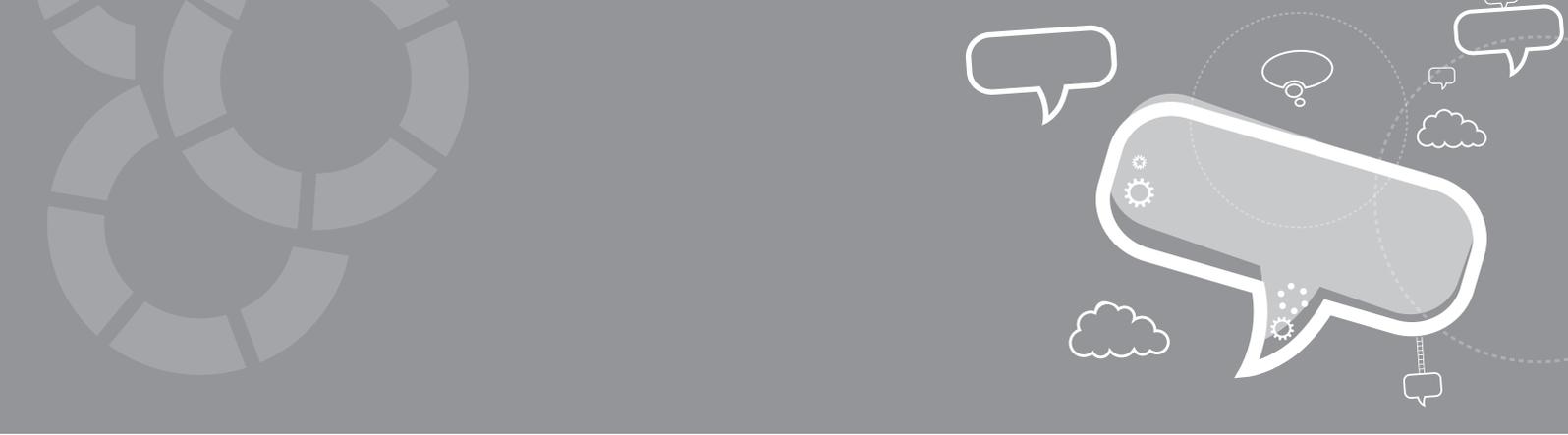
These studies explore some of the core spheres of health systems research: care-seeking; financing and contracting; governance; human resources; and service delivery. Their purpose was to deepen gender analysis by pursuing one or more of the following:

- Embedded approaches (making sure analysis is relevant and owned by local partners);
- Cross-cutting work (exploring how gender intersects with other axes of inequality, such as age, poverty, geography, disability and sexuality);
- Ethics in addressing power relations and social exclusion in health systems research.

The small grant researchers considered gender during the development of research aims, objectives, and/or questions; within the development of study designs and data collection tools; during the process of data collection; and in the interpretation and dissemination of results. They used a mix of qualitative and quantitative methods and worked in a wide variety of settings in low- and middle-income countries. Their work is showcased here in a series of case studies.

Each case study demonstrates the importance of using a gender analysis in health systems research. This analysis enabled the researchers to explore new ways of looking at the world around them, it built new skills, and it led to some unexpected findings. It also demonstrates how such an approach can be applied in practice.

We hope that this Reader will be of interest to established health systems researchers who are interested in how they can integrate gender into their work. It could also be a tool used in capacity development interventions or in university teaching courses to prompt learners to consider the usefulness of a gendered approach or to think through how to apply theoretical concepts of gender, intersectionality and ethics in practice.



2. Gender and human resources for health

Human resources for health are one of the key pillars of the health system – from homes, to communities, to health care centres, to hospitals, to Ministries of Health – those people whose labour drives the health sector are vital to access, uptake, and quality of services. Yet, as Newman (2014) has pointed out, gender inequity is rife within the systems which organize and manage human resources for health and greater attention needs to be paid to collecting data which drives decision-making in this area. Three case studies – from Cambodia, Zimbabwe and Uganda – explore the relationship between human resources for health and gender equity in more detail.

The first case study in this section explores the enablers and barriers to women’s leadership in the health sector in Cambodia. Using an innovative life history approach enables the authors to track health care workers’ perceptions of

their working lives over time and explore how gender roles and relations have affected their trajectories. The second case study looks at issues of training and deployment in Zimbabwe to uncover the gendered biases that prevent men’s and women’s equal treatment. It employs a life history approach alongside other more conventional methods. The inclusion of the views of human resource managers offers a sense of how social norms become informal policy regardless of written policy. In the third case study, from Uganda, the lens shifts to community health workers, a cadre of worker which is often simultaneously lauded as a crucial force in expanding health service access whilst being notoriously underpaid and under-supported by the health system. The authors use a photovoice methodology to enable Community Health Volunteers to develop and describe their own analysis of the gendered norms which shape what roles are considered feasible and acceptable within the community and hence within the health system.

Questions to consider:

1. All three case studies include the views of men and women. Are there differences and discrepancies in the ways that they view the same phenomena?
2. How do women’s domestic responsibilities shape their ability to perform their health system roles? What impact do domestic responsibilities have on women’s opportunities for progression and leadership?
3. What other gendered social norms shape the field of human resource management in these case studies?
4. What are the advantages of analyzing gender within human resource policy and practice? How could these findings be used to advocate for change?
5. Why do you think the authors used the methods that they did? What are the benefits and challenges of using these methods over more conventional ones?

2.1 Women and leadership within the Cambodia health sector

Sreytouch Vong and Bandeth Ros, ReBUILD Research Consortium

Globally, there are more than 59 million health workers. Although women make up the vast majority of the health workforce men occupy the majority of leadership positions (Dhatt et al 2017).



ABOVE: Midwife is providing service for pregnant women at a local health center in rural Cambodia



Health sector reform started in Cambodia in 1996. After almost twenty years of health system strengthening and human resource development the health sector employed 19,172 health workers (MoH 2012). Women comprised the majority of employees in the formal health system, but were less likely to hold senior professional, managerial and policy-making roles and had fewer opportunities to retrain for new positions (WHO 2010a; Doyal 2003). As a result, women were, and continue to be, under-represented in the management structure of the Ministry of Health (MoH), and only 20% of leadership roles were occupied by women (Men et al. 2011).

This situation raises several challenges:

- Because there are few women in managerial, policy and decision-making roles, there are insufficient opportunities for women’s voices to be included in health policies, including human resources for health (HRH) approaches, strategies and management systems.
- Career progression for women to advance through the health sector in both clinical and managerial pathways is difficult. This is often the result of life experiences, such as child-rearing, looking after the home and family (which are often the responsibility of women), and that women are not considered in the development of human resource (HR) policies, including the creation of career pathways.
- The majority of the population is female, and many have unique health care needs related to their reproductive role.

Given the social and cultural context in Cambodia, women prefer to be cared for by female health care workers. While this need can often be met at the primary health care level, when care is required at secondary and tertiary levels women do not access care as there are sometimes few female doctors and specialists (WHM, 2009).

The aim of this study was to explore the career pathways in the health workforce in Cambodia. Key constraining and enabling factors affecting women’s career advancement are discussed below.

Methods

Qualitative, in-depth interviews with health managers in Battambang province, Cambodia were conducted. Fieldwork was carried out in February 2016 in two operational districts (Battambang and Moug Russei), in Battambang Province, Cambodia. Twenty participants (14 women and six men) were purposively recruited from the two operational districts. Selected participants were aged 40 or above and started their career during the 1980s or 1990s. A life history approach was used to capture gendered experiences related to career trajectories, facilitators and barriers to the decisions of male and female managers to enter, progress and advance their technical skills and career within the health sector through time, and the implications of this for leadership today. Data was analyzed using an inductive thematic approach. This study received ethical approval from the National Ethics Committee for Health Research in Cambodia.

Key findings

Constraining factors

Domestic chores: Juggling work and family life was a major challenge for woman managers. In particular, they found it difficult to combine caregiving, such as breastfeeding and taking care the elderly in the family, with their managerial role. Coping mechanisms included leaving their job early or bringing children to work. In some cases, they needed to take a break from their job for a period of time.

Some male managers validated the view that women were responsible for household chores. They emphasized that roles between men and women within the family were defined and that women are supposed to work inside household, while men were in charge of business outside the household. They felt life would be very difficult if this became unclear.

“...I carried my child with me as no one took care my child. Here [health facility] people can help me took after my child...”
(Married woman)

“It’s the roles of women to take care [of our] homes, it must be like that! In fact, we need to divide the tasks, household chores and work outside... if we mix it up, we can’t do many things!” (Married man)

At the same time, some women felt that while household responsibilities were a burden, they did not prevent them from holding leadership positions.



“A man will have a meal without worrying about cooking after work. However, after work, women have to cook and clean dishes because their husband could not do that...but I don’t think this is the obstacle for women, it just makes her a bit tired.”
(Married woman)

Social norms influencing female leadership:

Another constraint for women in leadership positions was that men were valued more than women in leadership positions. For example, female managers felt that their voice was less respected; being younger and having a lower level of technical skill was also seen to influence respect received.

“[In the meeting] mostly they accept men’s ideas because they believe that men have a long-sighted vision. Moreover, men are more well-educated than me; most of them are doctors and I am just a medical associate. Therefore, my skill and knowledge are lower than them...”
(Married woman)

“Some people are disappointed [with me] as he is older [than me] and I became his chief.” (Single woman)

Other managers described the ways in which society is biased against women, even if they have the relevant capacity and qualifications. Additionally, some woman managers emphasized that men often dominated conversations, turning to other men in the group for input.

“It’s a cultural barrier. Some men still think women are not capable yet and are still weaker than men.” (Married woman)

“When there are many men at the leadership position, their decision-making is often biased to their men. I think if the number of political decision makers are somewhat equal between men and women, the decision-making will not be too biased.” (Married man)

Due to these social norms, some woman leaders felt the need to work extra hard to improve their outputs, so that respect and trust could be gained.

Enabling Factors

Support from spouses and relatives:

Female facility managers emphasized the need for support from relatives and spouses. Some female managers illustrated that sometimes their spouses needed to postpone their work in order to help looking after children and giving time to their partners to work.

“My husband is often the one who cooks the rice...Once we finish eating, I do dishes and return to work... it does go against the gender norms, but my husband understands my condition.”
(Married woman)

Institutional support from male leaders:

All female facility managers acknowledged strong support from the (male) head of the local institution in providing advice, particularly in the early stage of their career and leadership roles. Additionally, having support from junior colleagues was seen as important for female managers.

“...I never expected a man, being a leader, to value women like this because generally a man is likely to get promoted. However,

my chief was different from other [men]; he promoted women.” (Married woman)

Self-motivation: Female managers perceived that self-motivation was important to their leadership positions. Some mentioned working hard as a major factor for the success, while others mentioned the importance of being willing to enter into a leadership position in the first place. Another woman manager emphasized the importance of “thinking like men” and considered that women can adopt men’s characteristics and behaviors as a way to motivate themselves to take up a leadership position.

“First, it is about my hard work. Second, I have a determination that if I decide to do something, I have to do it well. I think hard work is important to help me succeed.”
(Married woman)

“Though I was nervous, I had to do and must achieve it. At that time, I told myself I had to try it!” (Married woman)

Capacity/qualifications of women:

Other female facility managers identified capacity and qualifications as an important factor in helping women obtain leadership positions. Similarly, male managers also emphasized that capacity is crucial and could lead to greater respect for female managers.

“Men won’t listen to women because those women do not yet have enough capacity. If they have enough capacity, they won’t feel so. It is probably because those women do not receive enough education that is hindered by society and previous cultural norms.” (Married man)



“For leadership, if the women are smart and having high knowledge they can lead! But if some women are not smart, [and have] no capacity, how can she be a leader?” (Single woman)

Conclusion

Strategies promoting equity in leadership within the health workforce need to be implemented at different levels.

- At the individual level, self-motivation, support from family or spouses, and appropriate capacity and qualifications of female providers all empower women to break through the glass ceiling.

- At the community level, gender roles and norms within the family and community need to be challenged and changed. Giving more opportunity to girls to obtain general education could be a starting point.

- At the institutional level, having support from male managers and colleagues who are willing to promote women in leadership helps to advance women’s position within the workforce.

- At the health systems level, policies are needed which support women’s advancement within the health workforce.

Promoting gender equity in the health workforce requires a long vision and commitment. If we do not have more women in the workforce and leadership positions, the workforce may not be resilient and responsive to the needs of the entire population, particularly women. If more women are not able to enter into leadership roles, the goal of having equitable health systems will remain an unattainable objective.

2.2 How gender roles and relations affect health workers’ training opportunities and career progression in rural Zimbabwe: Implications for equitable health systems

By Stephen Buzuzi, Biomedical Research and Training Institute, Zimbabwe; ReBUILD Research Consortium

Introduction

Although there is increasing attention to the role of gender in health systems, there is limited empirical evidence on how human resources for health are influenced by gender. Gender in human resources policy and planning is neglected in many contexts (Gupta and Alfano 2011), especially in developing countries, and many approaches that are used lack systematic attention to gender issues. Gender affects occupational



ABOVE: Clinic in a remote rural area. This clinic was very busy on the day the team visited and it was staffed by one nurse and a nurse aid. The other nurse was on leave at the time of the visit

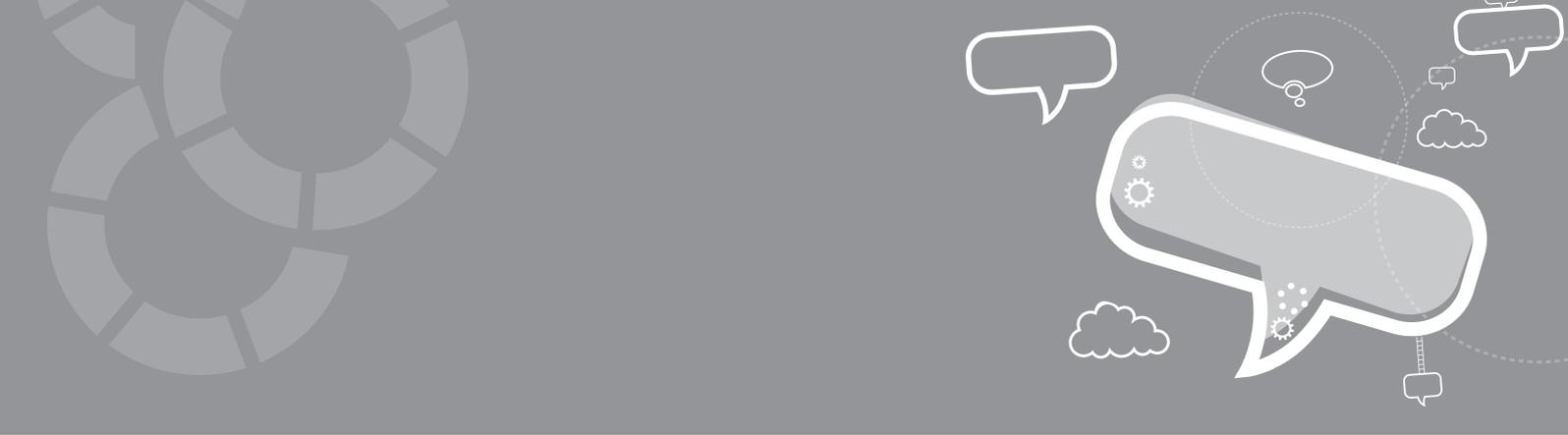
choices, career patterns and working practices (Standing 2000).

While attention has been placed on employment patterns and pay, gender imbalances in posting and deployment, particularly the structural and geographic location of men and women, have received little attention. This mixed methods study sought to assess how gender roles and relations shape the

posting, deployment, access to training and career progressions of health workers in rural Zimbabwe.

Methods

The study was carried out in the Midlands Province in four districts: Gokwe North, Gokwe South, Chirumanzu and Kwekwe. A cross-sectional mixed-methods design was used and this included policy and document review,



in-depth interviews using life/career posting histories to explore personal experiences, opportunities and challenges with nurses, midwives and environmental health technicians N=19 (8M, 11F) and key informant interviews N=11 (6M, 5F) with human resource managers at different levels. A total of 140 (57M vs 83F) health workers who were in the system from the year 2000 responded to the questionnaire, which consisted of 59 Primary Care Nurses and State Certified Nurses, 21 Registered General Nurses, 32 Midwives and 28 Environmental Health Technicians. The respondents were drawn from the Government, Rural District Council and Faith-based/Mission sectors. Permissions to carry out the study were obtained from the National, Provincial and District offices of the Ministry of Health and Child Care (MoHCC) and ethical approval from the Medical Research Council of Zimbabwe. Informed consent was obtained from the participants before they were interviewed. Quantitative data was analysed using summary statistics and qualitative data was analysed thematically using the framework approach.

Key Findings

Gender, training and career pathways

Types of employment: Participants reported that the health sector is largely feminised, with women accounting for the majority of health care workers, and with gender imbalances within the different professions in Zimbabwe.

Health workers felt that the imbalance stems from the careers men and women tended to pursue and the recruitment processes for training (discussed further below) which affect this.

For example, men and women tended to pursue different career paths after joining the health sector. Participants noted that women generally opted for careers in midwifery and theatre nursing, while men opted for environmental health and psychiatric nursing. A career in midwifery was preferred for women because of opportunities for promotion associated with the profession, such as Sister-in-Charge, or Matron for Maternal and Child Health departments. The results also show that women were opting for anesthesia because of opportunities for locum with private doctors, hence more income earning opportunities.

According to respondents, female health workers tended to shun psychiatric nursing because it required them to have the strength to restrain patients, and they avoided environmental health because it involved riding motor bikes in rough terrains. Interestingly, some HR managers noted that there was an increase in men entering into midwifery motivated by donor funding of incentives for Maternal and Child Health programmes (Health Transition Fund, Results Based Financing).

Training and promotion opportunities:

According to Zimbabwean health system regulations, access to training is based on both

seniority and years in service. Both health workers and HR managers were of the belief that the system afforded equal opportunities for men and women. However, barriers to training access and career development were found to be shaped by gender roles and norms at the household and institutional level. Men, for example, tended to be 'impatient' with the system and opted for self-funded training courses. In contrast, most women waited their turn to take up training opportunities, and when these opportunities arose, they were sometimes unable to take them up due to gendered family responsibilities. Regarding pregnancy and training, a Senior Nursing Officer stated:

"If one is almost due then they may not be able to go for training, but after they give birth they can come back and continue with their training." (IDI 02 – Environmental Health Technician, Male)

A nurse/midwife who deferred post basic training said:

"When I delivered my baby boy on the 28th of October I was supposed to write my exams, they then deferred me... so I was delayed a bit." (IDI 01 – State Certified Midwife, Female)

Impact of postings on men and women:

In terms of relocation for career development or new opportunities, a clear pattern emerged of wives following husbands who may be working in different sectors, such as education. This meant that 67% of males who were transferred stayed close to their families.



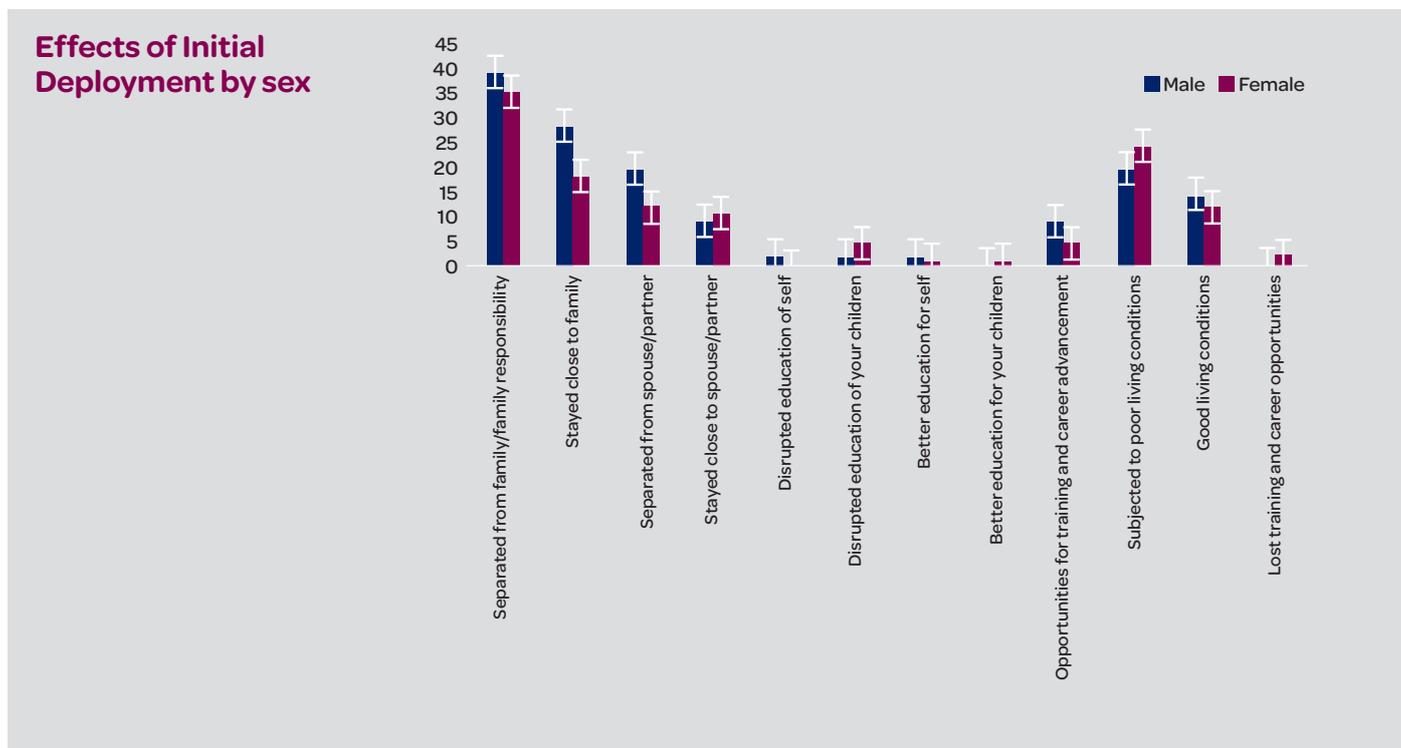
In contrast, some female health workers reported that, when their husbands changed jobs and relocated, they often had to resign from their jobs to seek new ones, sometimes in a different sector, therefore sacrificing the accruing of years of service required to access training and the opportunities for promotion. This affected their career levels; not least because many reported later re-joining the health sector in junior/lower posts, therefore experiencing loss of pay/accepting lower pay, delaying their time for

promotion and upgrading and/or upskilling etc. A nurse/midwife who resigned to follow her husband stated:

"It affected me because when I went for upgrading, other upgradings were already done and I was told that my name was once listed at my previous posting location and it was said that "No this one resigned from this hospital so she will find other things where she is", secondly most of my juniors are now Sisters- in-Charge, they always laugh at me that they have been promoted before me, so it affected me so much.

I think if I was still there I was going to be one of the seniors there." (IDI 01 – State Certified Midwife, Female)

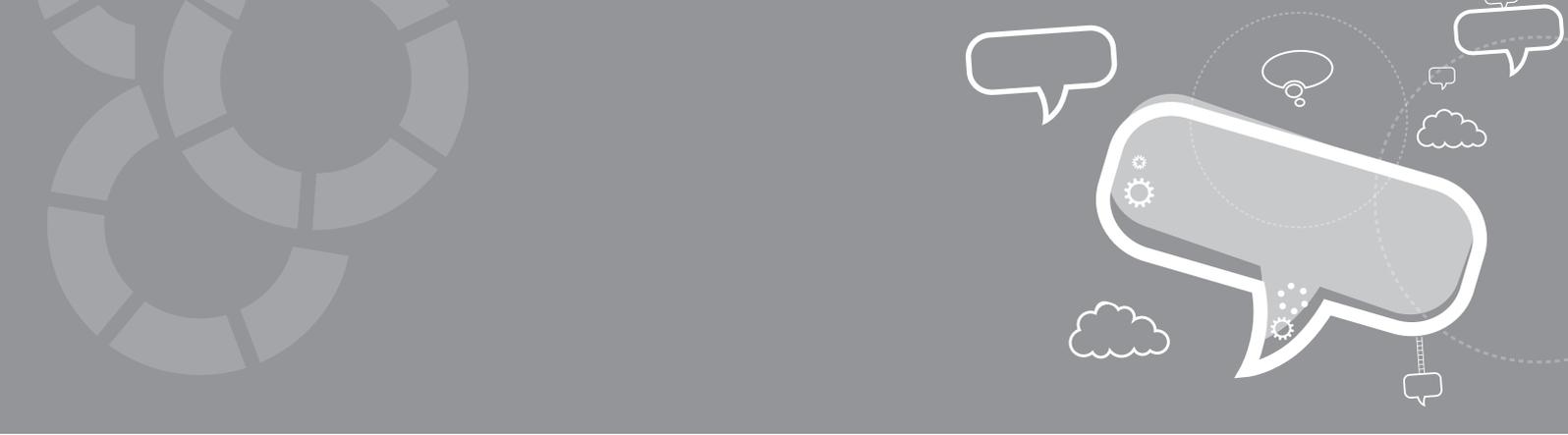
The effects of separation from families were multi-faceted and included: an increase in household expenditures particularly transport; maintaining two homes; and separation of siblings, such as when younger children stayed with the mother and older children with the father. The effects of deployment on men and women are outlined in the figure below.



In addition to the above, there was a preference of HR managers to deploy men in the most remote rural areas (because it was felt that they would stay longer in the posting location than women), which

presents conditions of inequity as the men attain needed experience and were able to advance their careers much faster than women. This is because the men deployed in the most remote rural areas obtained lots

of exposure on the job, which they would not obtain if they were working at central hospitals because some of the tasks that they perform at those locations would be carried out by more senior health workers.



Conclusion

Although the health sector is largely female-dominated, posting and deployment policies and practices at different levels of the health system and across health professions, create conditions for gender inequities associated with delayed access to training and promotion opportunities. The findings depict how men and women are affected

differently by the existing posting and deployment policies and practices in terms of their access to training, promotion and career development opportunities in Zimbabwe.

Men faced fewer barriers compared to women; however, the systems were not responsive to these inequities. These

findings present an opportunity for policy reform in the implementation of equal employment policies, by drawing on a gender perspective to show how inequities arise. This study concludes that women's career progression is shaped by both the posting and deployment systems and by their family roles and responsibilities.

2.3 Exploring gendered experiences of community health workers using photovoice in rural Wakiso District, Uganda

David Musoke, Charles Ssemugabo, Rawlance Ndejjo, Elizabeth Ekirapa-Kiracho, School of Public Health, Makerere University College of Health Sciences, Kampala, Uganda; Future Health Systems Research Consortium

Introduction

Community health workers (CHWs) play an important role in strengthening health systems, and increasing the availability of community-level primary health care services. In many countries they are considered frontline staff who support their professional counterparts (Singh and Sachs 2013).

In Uganda, they are the first contact of the population with the health system, this is particularly important in rural areas. The Ministry of Health introduced CHWs, locally referred to as Village Health Teams (VHTs), to mobilize individuals and households for better health (Ministry of Health 2000; Ministry of Health 2005).

Most CHWs in Uganda are women who are volunteers chosen by community leaders. They are literate and receive some training so that they can provide health information and refer patients to health care facilities. Their responsibilities include community mobilization, education, the promotion of good hygiene and sanitation, and child health (MOH 2010).

Gender – the social roles, activities, characteristics and behaviors that society prescribes for men and women – is an important dimension in human resources for health that has not been given due attention, especially in low- and middle-income countries (George 2008; Newman 2014). According to different studies, female CHWs are often: not recognised as skilled workers (Mumtaz et al. 2003), deployed to services closely related to gendered roles and beliefs, such as child rearing (Utomo et al. 2006), affected by personal security concerns, and lacking in household support (Mohan et al. 2003). On the other hand, male CHWs often: receive greater recognition for their work, have household support, and are more respected.

While recognition of the gendered experiences of CHWs is emerging, very little is known about CHWs perspectives of such experiences. Understanding the gendered roles of CHWs is important in establishing how these roles influence performance and relationships in communities, and highlighting any gender inequities. This study explored the differential roles of male and female CHWs in rural Wakiso district, Uganda.

Methods

The study used photovoice, an innovative community-based participatory research approach. Through the photovoice process, participants take photographs throughout their community related to key themes and then participate in group discussions about the photographs taken. Ten CHWs (five men and five women) participated in this study. The CHWs took photographs for five months about their gender-related roles within the community which were discussed in monthly meetings. The discussions from the meetings were recorded, transcribed, translated to English, and emerging data analyzed using content analysis in Atlas ti version 6.0.15.



The study had approval from Makerere University School of Public Health Higher Degrees, Research and Ethics committee, and was registered at the Uganda National Council for Science and Technology.

“Men easily explain their private sexuality issues to us... and we advise them accordingly...”

Key Findings

A total of 432 photographs were taken during the study yielding an average of eight per participant per month. The results are presented under six main themes as follows: addressing men on their terms; women’s health issues and treatment of children; response to emergencies; geographic coverage during community mobilization; involvement in manual work; and availability to offer services in community.

Addressing men on their terms

From the photos and resulting discussions, it was noted that male CHWs were consulted more by men for their own health concerns, particularly with regard to sexual and reproductive health and to a lesser degree issues like alcoholism. Men’s preference for male CHWs is captured in the quotation below.

“Men easily explain their private sexuality issues to us [male CHWs] for example when they contract sexually transmitted infections, they can come and describe to us the symptoms they are experiencing and we advise them accordingly. In addition, they also find it easier to request for condoms from male CHWs which is sometimes harder for them to do among female CHWs.”
(Photographer 2, man, age 53)

Male CHWs were sometimes called upon by women to mediate with their male partners when there were conflicts in the family related to health issues, such as failure to accompany women in hospital or a refusal to use contraception.

Women’s health and treatment of children

CHW discussions spurred by the photographs also highlighted that women prefer to speak to other women when it comes to their reproductive health and that they believed that female CHWs knew more about the topic of maternal health. In part, this was because they were women and possibly mothers themselves and so could draw on direct personal experience in performing their role.

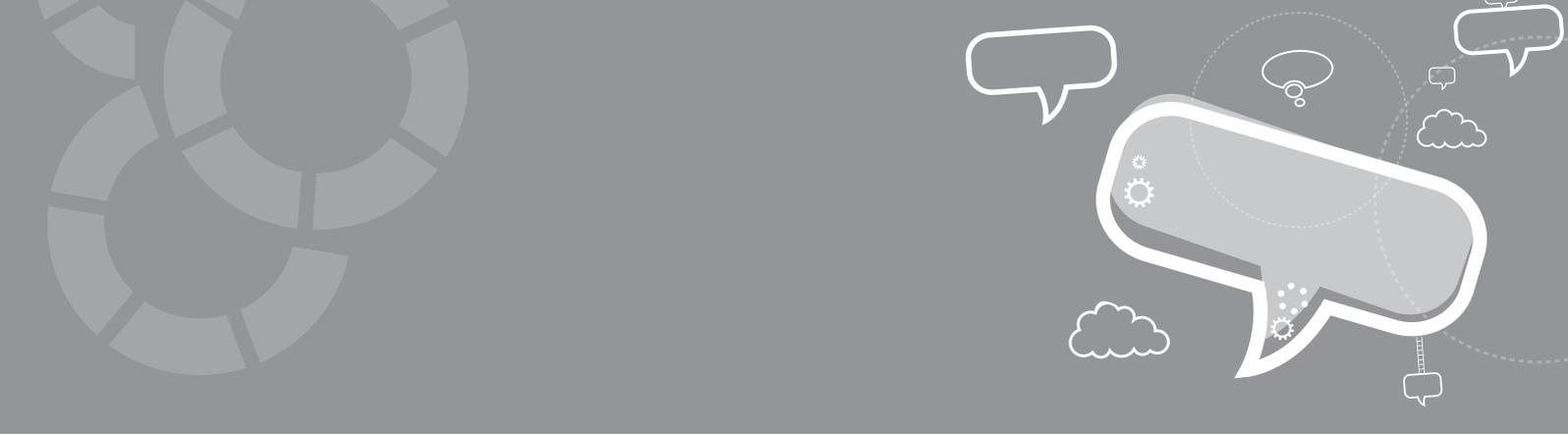
These female CHWs were an informal source of counselling for young people, couples, and women facing pregnancy-related problems. Although both male and female CHWs treat childhood illnesses, women were considered to be more involved in this activity, and other related roles such as immunization.

Response to emergencies

It was revealed from the photos and discussions that male CHWs are faster in responding to health emergencies in terms of taking the sick, especially children and pregnant women, to health facilities than their female counterparts. This is because men have more access to transport such as bicycles and motorcycles. This is not only in terms of



ABOVE: A female CHW (centre) visiting a couple that had a baby



possession but also the social norms that constrain women’s ability to use bikes and motorbikes.

“As a male CHW, I can use any means of transport available like a bicycle or motorcycle or car to transport a patient to a health facility in case of any problem in the community. For a female CHW, it might be hard to use certain means of transport like bicycles to transport a patient to the hospital.”

(Photographer 10, man, age 31)



ABOVE: A male CHW prepares to take a sick child to the health facility on his motorcycle.

Geographic coverage during community mobilization

Regarding mobilizing communities for public health campaigns, such as immunization or monitoring field activities across villages, CHWs agreed that male CHWs cover larger areas compared to women. The greater ability of male CHWs to use transport also enabled them to take up supervisory roles among CHWs which included data collection and synthesis.

“When we are doing our roles in the community like visiting homes, men travel longer distances since we are more energetic than women. A man can move to a larger area and visit many homes if the day is for conducting home visits compared to a woman. Even though we may also get tired at the end of the day, we still have more energy than the women to do a lot of work in the same period.”

(Photographer 10, man, age 31)

such as maintaining latrines and cleaning and desilting wells, and constructing barriers to protect water sources from animals. This was because of the gendered division of labour in communities, in addition to social norms that restrict women from engaging in physical interventions such as cleaning wells.



ABOVE: A male CHW (left) with a colleague digging a drainage channel for a community water source.

Involvement in manual work

Male CHWs were more likely to be involved in manual labour as part of their role -

Availability to offer services in community

From the study discussions, it was established that female CHWs spend more time in the communities due to the gendered division of remunerated labour. Women spend most of their time at home doing unpaid domestic and care work, like cooking, house cleaning, washing clothes, and looking after children. The few female CHWs who carried out income generating activities were either involved in agriculture in their home gardens or small scale retail businesses within their homes. As a result, they tended to be more available to attend to problems in the community than their male counterparts who often work outside the community.

“I was treating a patient very early in the morning. It is sometimes hard to find a male community health worker at home at such a time. Many times, they would have already gone for work but me, I was still around.”

(Photographer 8, woman, age 28)



Conclusion

This photovoice study provides insights into various aspects of the gendered experience of CHWs in rural communities in Uganda, reflecting strategic positioning, gendered access to resources, division of labour and social norms. Although responsibilities were the same for both male and female CHWs, they reported that in practice CHWs were involved in different types of work depending on their gender. The gendered division of labour in communities reinforced female caregiving roles related to child care and also made women more available in communities

to address local problems. Due to their privileged ownership and access to motor vehicles, male CHWs were noted to be able to assist patients with referrals to facilities during health emergencies more quickly, cover larger geographic distances during community mobilization activities, and take up supervisory responsibilities. Due to the gendered division of labour in communities, male CHWs were also observed to be more involved in manual work, such as supporting renovation of latrines and cleaning wells.

As a participatory methodology, photovoice lends itself to revealing gendered community values and can be a starting point for addressing gendered inequalities in communities. These gendered experiences should be considered while designing and implementing CHWs programmes. This is to ensure that CHWs are not only effective in their roles as health agents and equality advocates, but that health systems more broadly serve to address gender inequalities and advance health outcomes equitably.

3. Gender, care seeking and service delivery

Gender impacts upon the type of services that people need, their ability to access these services and the treatment that they receive by the health system. The first case study in this section explores the experiences of non-indigenous populations and their ability to access maternal health care in Masindi, Uganda. Through focus group discussions, the authors gathered data on barriers to access, social beliefs, the attitudes of health care workers, and male involvement. The second case study is on eye health in the Indian Sunderbans and takes a mixed methods approach to an intersectional analysis, uncovering some interesting findings about the ways that gender and poverty interact. The third

case study takes us to China and the issue of unpaid care of the elderly – an often-overlooked element of care giving with enormous implications given that many countries have an ageing population. The authors analyze whether the gender of the person receiving care effects the levels of attention that they receive. Finally, the fourth case study takes on the issue of male involvement in the prevention of mother-to-child transmission of HIV in Enugu, Nigeria. A common critique of gendered approaches to research is that it fails to consider men as gendered people. These case studies address the issue of male access to health care and to its financing, and offer starting points for considering this type of analysis.

Questions to consider:

1. The first case study takes an intersectional approach where other social stratifiers were considered alongside gender. What does this add to the analysis?
2. Looking across all of the case studies, how do harmful social and cultural norms effect access to care?
3. Why do you think unpaid family care continues to be an overlooked element of health systems research?
4. Many researchers of health systems consider equity only in as much as they consider levels of poverty. These case studies provide some examples of how this might be an inadequate approach. What are they?
5. Men often find it difficult to access health services. Can you think of other examples of this apart from in relation to the prevention of mother-to-child transmission of HIV?

3.1 Why are maternal health outcomes worse for migrant women in Masindi, Uganda?

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Introduction

Globally, 298,000 women die due to pregnancy-related causes each year and half of these occur in Africa (WHO ICM 2014). In Uganda, maternal mortality has marginally reduced from 526/100,000 to 435/100,000 livebirths between 2001 and 2011 (UDHS and ICF 2012). The presence of a skilled attendant during the entire continuum of care for maternal and new born health has great potential to reduce maternal and new born morbidities and mortality (WHO 2010b).

In 2013, an intervention to mobilize communities in Masindi, Uganda for maternal and new born health was introduced and the results showed marked improvement in utilization of maternal health services such as antenatal care and health facility delivery. However, non-indigenous populations were found to use maternal health services less than the indigenous populations. The non-indigenous population are mainly migrants from the West Nile region of Arua and Nebbi, who provide a cheap source of labour for the sugar plantation and sugar factory in Kinyala.



ABOVE: Author with midwives in the health centre maternity ward

Poverty, educational level, distance from health facility, and costs of transport to and from health facilities are recognized as barriers to access (Nabukera et al. 2006). Cultural and traditional practices have also been recognized as factors shaping high maternal and neonatal mortality. Most data come from general populations, without disaggregating barriers in access for different groups.

The aim of this study was to gain a deeper understanding of internal migrants' low access and utilisation of maternal and new born care services in Masindi, Uganda.

Methods

This qualitative study was conducted in Nyantonzi Parish, Masindi district, western Uganda. Five focus group discussions (FGDs) were conducted. Two FGDs were conducted with women who had recently delivered and one was conducted with pregnant women. In addition, two FGDs were conducted with men: one group whose spouses

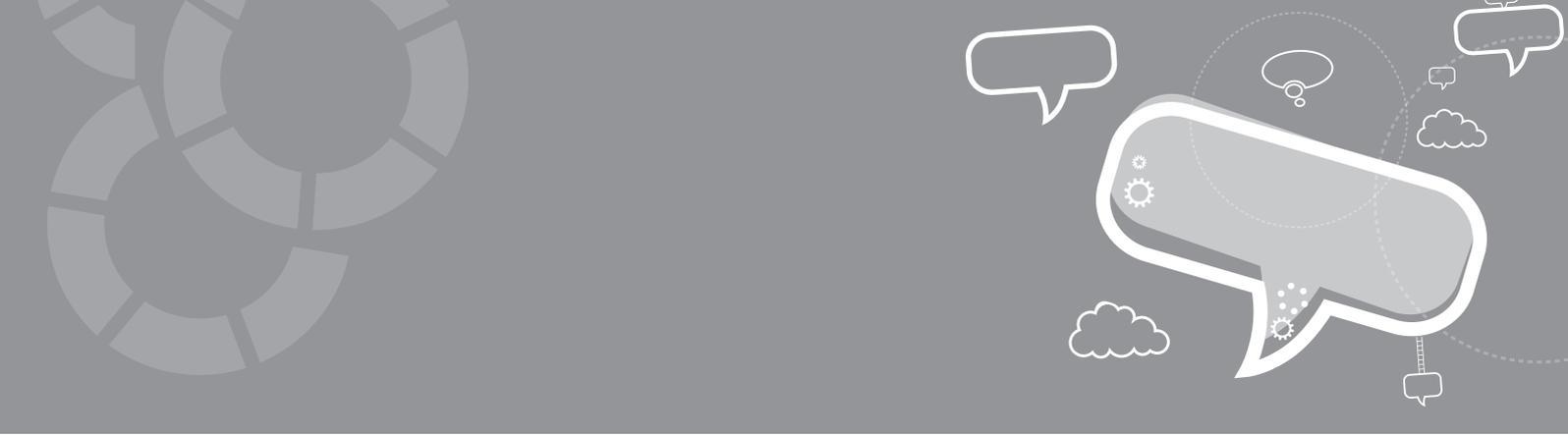
were pregnant and another group whose spouses had recently delivered. All groups were selected on the basis of being migrant populations (migrant population was defined as people who were of the Lugbara ethnic group). Data was analyzed using a thematic approach. This study was approved by the Higher Degrees Research and Ethics Committee of the School of Public Health, Makerere University, Uganda.

Key Findings

Barriers to access maternal and new born services

Lack of financial resources:

Low-income levels for men and women and high delivery costs were a common reason for low utilisation of delivery services. Women said they relied on crops in the garden and when it is planting, weeding, or harvest times they do not have enough money to procure essential requirements for delivery.



“Our major problem has been money, you may start experiencing labour and you fail to transport yourself to the hospital, even our husbands don’t have proper jobs. This alone has made women to sit back and deliver at home, if there is money every woman will want to deliver in health centre.” (Respondent 1, FGD 2).

The cost of delivery care is expensive and requires buying essential items required for delivery. The cost of 20,000 shillings required for a ‘mama kit’ for delivery is considered high and the expense is sometimes considered unnecessary by the women since they can use old material for receiving the baby.

these things you can give birth..., on an old ‘kitenge’ (piece of cloth women wear) you can deliver, in the health centre nurses will just chase you.” (Respondent 5, FGD 2)

Social beliefs: Community members perceive it to be cowardly for a woman to rush for care at the health facility during childbirth. Endurance of labour pains is considered a sign of a strong woman and delivering without the help of a second party is a heroic action.

“Here the moment you move on to seek care from the health unit the community members insult you by calling you a coward and saying that you are only married because of the bed service but for other issues you are not a woman.” (Respondent 5, FGD 4)

Neglect by health workers: Neglect by health workers was a common complaint by respondents. Some of the male respondents explained that their partners are treated in a manner that they felt was degrading.

“Nurses on many occasions abuse the women [saying] that they are stupid and do not know anything to do with deliveries. Coupled with that is lack of attention. For example, recently a woman was to deliver; she came to the health unit with a helper, on reaching the health unit no one gave her attention, not until the helper decided to take her home. But she ended up delivering on their way back, this made a bad record for the health centre.” (Respondent 7, man FGD)

Respondents were strongly convinced that the main reason for neglect, discrimination, and mistreatment by health workers was related to their ethnic differences. The women explained that when they reach the health facility, health workers first identify the patients’ ethnic identity by looking at their names or their ability to speak the local dialect. Sometimes a simple greeting in the local dialect is used as a ‘screening tool’ to separate indigenous from migrant population:

“For example I am a Lugbara, another mother is an Alur and then a Munyoro mother. If a nurse came and asked us in Runyoro only one mother will reply, those who do not answer back in the language will be abandoned, the Munyoro mother will be attended to first. At that moment,

“Our major problem has been money... if there is money every woman will want to deliver in [a] health centre...”

“When you go to the health centre to deliver they tell you to prepare with delivery items like mama kit and new things like clothes, basin. As said earlier, delivery comes with a lot of demands, what demands? They tell you to buy mama kit, cotton wool, gloves, yet to raise money as transport is a problem for our husbands yet that small transport to take you to the health facility cannot be raised, many of us are used to giving birth at home now, someone will say let me save this money for other things, even I use it as transport many other things are not bought, at home even without

In order to fulfil the community norm of being a resilient woman, some women do not inform their husbands when they first go into labour. Instead women keep quiet until their labour pains intensify. It is only when they are about to reach the second stage of labour that they communicate to their husbands, usually when they are about to deliver within the next thirty minutes. One respondent said, for example, that she went on normally with her house chores and garden activities for the entire day until the labour pains were strong and she soon delivered.



you will automatically know that she was picked because of tribe, you become timid, they will even start barking at you because you cannot explain your problems, even when nurses talk, you don't understand.” (Respondent 1, FGD 1 women group)

Neglect by health workers is perceived to be an indirect means of demanding informal payments from the women. Informal payments influence the health workers to adjust their reception from being rude to being very caring:

“The nurses asked me for money... they said if I don't have money they will not help me, they asked for 20,000 which I said I did not have, one of them said I should give 15,000... they started working on me very fast as soon as my husband paid the money.”
(Respondent 5, FGD 1 women group)

The problem of informal payments is so critical that women who do not provide the money demanded are denied access to care. One woman, for example, witnessed a migrant woman get off the delivery bed because she could not afford the “fee”.

Education: Level of education was also seen to influence the type of treatment women received at health facilities. Some women believed that having a higher education reduced the risk of discrimination by health workers. However, some respondents argued that indigenous women with lower education levels are treated better compared to immigrants of the same low education level, meaning that education levels alone could not adequately explain their mistreatment:

“It is not education but I think it is because we are from far, because even uneducated Banyoro are attended to very well.” (Respondent 1, FGD 1 women group).

Lack of male involvement: The responsibility of care during pregnancy, labour and childcare has been relegated to the women to the extent that women are held responsible if something goes wrong with the pregnancy. Women are expected to purchase all the requirements needed for delivery. Mens’ responsibility in relation to pregnancy is to buy items for the new born baby, and to remind their spouses

about antenatal care. A minority of the men and women agreed that few men fully support women throughout pregnancy, labour and childcare. Some men are reported to be concerned about their pregnant spouse and even arrange for transport and escort them to the health centre. Others purchase all the requirements needed for delivery and provide special food for their spouses.

Conclusion

There are a number of barriers to access to maternity care among migrant women in Masindi, Uganda. These barriers can be addressed at two levels. At the household level, there should be deliberate efforts to engage with men to support their partners during pregnancy and childbirth for example, by saving money and preparing for transport to the health facility in case of antenatal care and delivery. At the district level, there is need for district local managers together with district health managers to create a dialogue platform in which communication barriers and the mistreatment of migrant women can be addressed in the health sector.

3.2 Are the women of Indian Sundarbans living in the dark? An intersectional analysis of eye health care seeking among the elderly

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Introduction

Worldwide, approximately 670 million people are visually impaired, among whom 269 million suffer from low vision and 45 million are blind. Nearly 90% of these people live in low- and middle-income countries (WHO 2014). With increases in life expectancy and population, the share of age-related non-communicable visual impairments within these regions continues to rise (WHO 2010a). India alone has almost 22% of the world's visually-impaired population, while the country is home to 12.9 % of the world's aged population (UN 2015). Estimates show 82% of blind people and 65% of moderate and severe blind people in India are older than 50 years of age (WHO 2010a).

Women make up approximately 64% of all blind people, partly because women live longer and partly due to their poor access to health care services (Courtright & Lewallen 2007). In the backdrop of decreasing economic means and erosion of family networks for women in particular and for elderly in general, aged women emerge as the 'doubly disadvantaged' group within the society (Mackintosh and Tibndebage 2004). In countries like India women often delay seeking treatment



ABOVE: Optometrists doing eye examinations of elderly women in Sundarbans, India

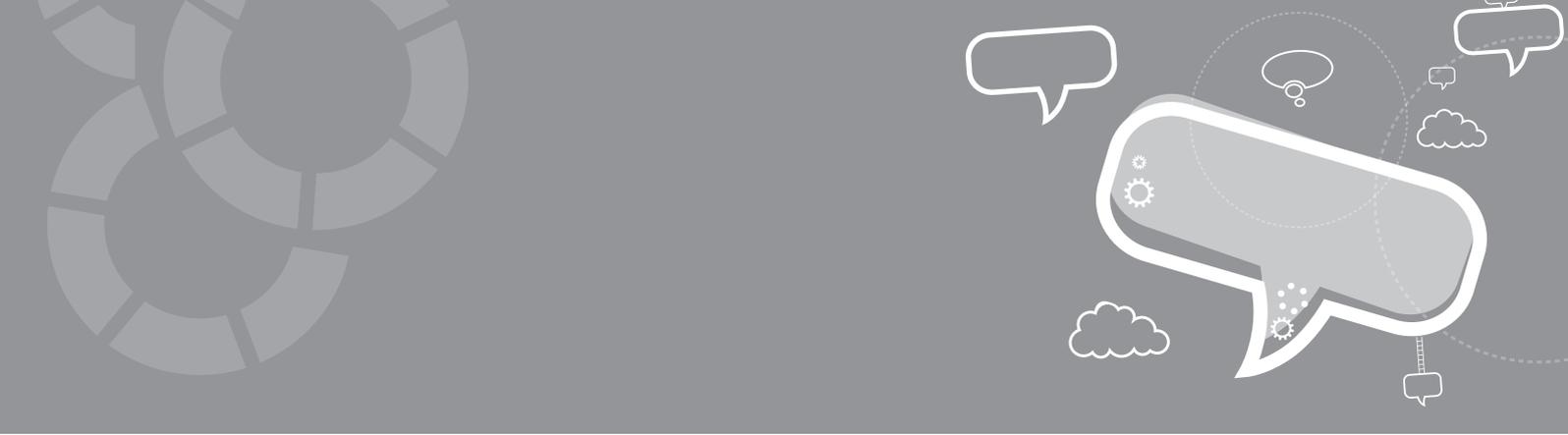
because they have limited access to resources and time, less mobility, they do not value their health as much as that of others, and they need to be accompanied to the health facility (Lewallen & Courtright 2002, Mackintosh & Tibndebage 2004, WHO 2010a). Gender dynamics, such as control over resources and decision-making, play an important role in influencing health seeking behaviour and access to preventive and curative health care.

This study examined the intersection of gender with age, socioeconomic status, and education to better understand visual impairment among the elderly in the Indian Sundarbans. It found that women were the most disadvantaged, that gender intersects with other social stratifiers in complex ways, and that improving economic status may not automatically result in women's improved eye health status.

Methods

The research was undertaken in the Indian Sundarbans, situated in the southern part of the eastern Indian state of West Bengal. A quantitative survey was undertaken, starting first with eye screening of the elderly by optometrists, followed by multi-stage random sampling to select visually-impaired individuals across 12 villages. Out of those screened, 442 (174M/268F) individuals with eye problems in either of their eyes were surveyed using structured questionnaires. Demographic information related to age, economic status, and education were also collected. Following the quantitative study, 24 (12M/12F) in-depth interviews were conducted with visually-impaired elderly men and women from surveyed individuals. Quantitative data was analysed in STATA 11 and qualitative interviews were analysed thematically and coded using NVIVO 10.

The study acquired Ethical Review Board clearance from the IIHMR University Institutional Committee for Ethics and Review of Research and Department of Health and Family Welfare, Government of West Bengal, India.



Key Findings

Association of gender and age with

visual impairments: The results from this study show that age is an important determinant for developing visual impairments, and more so in case of blindness. In terms of the intersection of gender and age, the lower the age the less likely the elderly were found to develop blindness, for both men and women.

However, older women were found to be more likely to develop visual impairments compared to all other categories.

Association of gender and poverty

with visual impairments: Compared to poor women, the results showed that both poor men and non-poor men are less likely to develop any kind of eye problems. Strikingly, non-poor women were more likely to develop a visual impairment than poor men.

Most respondents who participated in the qualitative interactions asserted that women are more likely to have eye problems, however, when asked about financial conditions of those vulnerable to eye problems and whether visual impairments have anything to do with the financial status, the answers were varied. While some of respondents strictly linked poverty to visual impairments, many of them believed that it can affect both rich and poor people.

Association of gender and education

with visual impairments: The intersection between gender and education showed that level of education has an association with the level of visual impairments among men only;



ABOVE: Investigators interviewing the elderly post eye examination

while educated women do not appear to have better eye health compared to uneducated women both in case of low vision and blindness. Compared to illiterate women, illiterate men were less likely to develop visual impairments, however, the result is significant only in case of blindness. In comparison to illiterate women, both literate men and women were less likely to develop low-vision or blindness, however, the result is significant only in case of literate men. This indicates that education is more of a preventative factor among men compared to women.

Conclusion

The study showed the role of gender in relation to visual impairments among the elderly of the Indian Sundarbans. It explored how gender cross cuts with other social stratifiers, such as age, education, and poverty to determine eye health status. Given the rising share of the elderly population and epidemiological transition of disease patterns more towards non-communicable diseases, this study put forward evidence on predictors of visual impairments for policymakers, especially for those who work on eye diseases.



When gender is considered alongside age, we can see how the two intersect to influence the level of visual impairments among men and women, with older women being more at risk. When gender is considered alongside education, we can see that education is preventative among men only. And when gender cross cuts with poverty, poor men are in a better position compared to non-poor women in terms of level of developing visual impairments. That means improving economic status does not necessarily ensure better eye health status for women.

Without applying an intersectionality lens to the analysis, these distinctions would be lost. This has implications for health research, as research which only considers a single stratifier will miss different degrees of vulnerability across the groups. In terms of policy, this analysis shows that policymakers need to be more cautious when developing a blanket approach to address social issues like ageing, or health problems like visual impairments, especially if they seek to target those who are most vulnerable.

3.3 Gender analysis of family care for elderly: evidence from Beijing, China

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Introduction

Care giving within households is the foundation of health systems, especially for the elderly population in China where 98% of the elderly rely on daily care provided by family members, and only 2% rely on care from professionals and social welfare organisations. Because of the lack of well-functioning long-term care programmes, as well as the historical filial piety tradition (the belief that adult children have the responsibility to support their parents), Chinese elderly prefer to rely on family members in their last years of life (Kadoya and Yin 2014).

Caregivers and care receivers are the two major components of the Chinese family care system. Caregivers include: spouses, sons, daughters, sons-in-law, and daughters-in-law. There are many papers discussing the gendered differences in who cares for the elderly in China. Kadoya and Yin (2014) found that sons (and their wives) were more likely to be primary caregivers for parents compared to daughters, which is consistent with historical tradition. Other studies have shown that daughters played a more important role in caring for parents (Zhan and Rhonda 2003; Chesley and Poppie 2009). There are few studies, however, which analyze the gendered differences in the care received by the elderly.



ABOVE: One of the interviewers conducting the interview in rural areas

Methods

This study aimed to explore differences in receiving family care among the elderly, and to examine the factors affecting care received. The study was divided into two parts: the first part was a quantitative analysis of survey data, which aimed to explore gendered differences in receiving family care among the elderly, and to examine the risk factors affecting care received. The second part consisted of qualitative semi-structured interviews with several households, which aimed to explore the opinions of elders and their children regarding family informal care within households. The findings help to provide a picture of the elderly family care situation and contribute to improving policy and public attention on gender equity within households in taking care of the elderly.

For the quantitative component, data was extracted from the Health and Social Support of the Elderly Project, which was conducted in three districts in Beijing in 2013. A group of 924 elders (458M, 466F) were included in the study. The

data gathered were stored and analyzed using SPSS 19. A Mann-Whitney U test was conducted comparing mean hours of care received by elderly by sex. Descriptive analysis was also conducted for sub-groups who did not receive any care in the last week. Binary logistic regression was used to examine the relationship between care received by elderly and different variables, including sex.

For the qualitative component, 18 households (including elders and one of their children) were interviewed regarding family informal care. Among the 18 elders, nine were female and nine were male. Among the 18 children, ten were daughters and nine were sons. Nine households were from urban areas (Haidian District) and nine were from rural areas (Miyun district). Only households with elderly parents who were more than 60 years old were included. A customized semi-structured interview guide for elderly parents and their adult children was developed. Data was analyzed using a thematic approach.

Key Findings

Care received by the elderly:

The results showed that elders received an average of 16.5 hours of care in the preceding week; men received an average of 15.6 hours, while women received an average of 17.4 hours. The care included: helping the elderly with feeding, cooking, bathing, dressing, toileting, grooming, physical ambulation, making calls, managing money, taking medicine, shopping, taking the bus, and walking. On average women received two more hours of care from children compared to men. 27% of the elderly did not receive any care from their children in the last week. There was no significant difference in the hours of care elderly received between men and women ($p>0.1$). The logistic regression showed that gender was not a significant determinant of the proportion of elders who received six hours or more of care in the preceding week; however, age, monthly income, and health status significantly affected the care received by the elderly (see below).

The qualitative research showed that a traditional support system was still mainstream in rural areas, however, there was a transition underway in urban areas. All of the nine rural elders interviewed were cohabiting with their children while only one of the nine urban elders was cohabiting with children. In rural areas, the traditional norm of “bring up sons to support parents in their old age” was still well accepted; sons and daughters-in-law were still the core force in supporting

parents. On the contrary, in urban areas, eight out of nine elders thought that daughters were more reliable than sons, and daughters provided more hours of care compared to sons and daughters-in-law.

Factors affecting care received:

Factors affecting the family care received by the elderly included: age, income, number of children and health status.

- Age played a role in whether care was received or not. People aged 70–79 years received the most care. Those who were younger (60–69 years) often did not receive any care from their children in the preceding week.
- Among the elderly who received care, men had 4000 Yuan or more monthly income, while women had less than 1999 Yuan monthly income. Overall, elderly people with a monthly income of more than 4000 Yuan were less likely to receive care from their children. This may be due to the fact that richer elderly parents have more freedom in choosing care from outside the family, rather than relying on the help and assistance of their children.
- Elderly men who received care had a higher percentage of secondary and tertiary education, while most of the women who received care were illiterate and had only primary education.

- Health status was significantly associated with the care received by the elderly. Compared with healthy elders, those living with chronic disease were more likely to get more than six hours of care from their children in the preceding week. Those who were healthier were less likely to receive care.
- Elderly people who only had one child received the most care in the preceding week, while those with two or more children were less likely to receive care.
- Despite the fact that elderly women had more care-related needs and fewer resources, there was no significant difference between men and women in the care received.

Conclusion

Overall, the study concluded that unpaid elderly care is an important part of the health system and better understanding who provides and receives care is important in terms of identifying weaknesses and gaps in provision and responding with social policy. Due to the transition away from a traditional filial piety system, social welfare systems, such as long-term care insurance and professional care institutions in China need to be strengthened if elderly are to receive the care they need.

¹ China's one-child policy was introduced as part of the family planning policy in 1979. The policy allowed exceptions for many groups, including ethnic minorities, couples living in rural areas, couples whose first child had a disability, and etc. As of January 1st, 2016, China's one-child policy ended and all Chinese couples were allowed to have two children.

3.4 Strengthening male involvement in prevention of mother-to-child transmission of HIV in Enugu State, Nigeria

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Introduction

Nigeria has the second highest HIV prevalence in Sub-Saharan Africa and the risk of mother-to-child transmission of HIV in children below the age of 15 is between 25-40% (Federal Ministry of Health Nigeria 2010). In 2010, the Nigerian government committed to achieving a 50% reduction in mother-to-child transmission of HIV and 50% improvement in HIV counselling and testing.

Prevention of mother-to-child transmission (PMTCT) services in Nigeria include: ante-natal care, basic information about HIV transmission and prevention; HIV counselling and testing; prevention of unintended pregnancy; and antiretroviral treatment. Efforts to improve uptake of PMTCT have been hindered by the lopsided focus on medical interventions and neglect of the social factors that contribute to mother-to-child transmission (Theuring et al 2009). In particular, lack of male involvement is considered a key challenge to the uptake of PMTCT services (Morfaw et al. 2013).



ABOVE: A beneficiary of PMTCT services in Facility C.

Our research explored the extent of male involvement in PMTCT in Enugu state, Nigeria and its effects on married women's access to and use of PMTCT services. The findings showed that only a few men accompanied their wives to antenatal care. Men's attendance with their partners to educational sessions on prevention of unintended pregnancies and HIV counselling and testing was also reported to be low. Women were said to come for their antiretroviral treatments alone and on some occasions, would also collect medicine for their partners.

Methods

The study was undertaken in Enugu State, southeast Nigeria. The study focused on two types of health facilities offering comprehensive PMTCT services: one tertiary (University of Nigeria Teaching Hospital (UNTH) Ituku Ozalla), and two secondary facilities (Mother of Christ Hospital, and Bishop Shanahan Hospital Nsukka). Document review was used to describe the nature and extent of male participation in PMTCT in Enugu state.

In-depth interviews (IDIs) and Focus Group Discussions (FGDs) were held with three different categories of respondents selected from the identified health facilities as detailed below.

For category one, three married women of reproductive age who were HIV positive, available in the health facilities on the days they were scheduled for treatment and their partners were selected for IDIs per health facility (total nine women and nine male partners). For category two, 12 health workers comprising four males and eight females were interviewed. Their selection was based on availability. In facility A, a male medical doctor working in the ART clinic and three female nursing sisters were interviewed; two from the ANC clinic and one in the HIV counselling and testing (HCT) clinic. At facility B, a male pharmacist in the ART programme was interviewed. The other three were female nursing sisters; one was in charge of the PMTCT programme, another provided services in the HCT clinic, while the third provided services in the ANC clinic. At facility C, a male pharmacist in charge of the ART programme and a male doctor also providing ART services were interviewed. The other two were female nursing sisters, one in charge of ANC clinic and the other working in the HCT clinic. In the third category, FGDs were held with two male and two female support groups, between six to eight persons per group, in Enugu East and Enugu North Senatorial zones.

Data was analyzed using content thematic analysis. Themes were coded using NVivo 11. Queries were run to facilitate the analysis and tables/ summaries of the findings were

generated according to the categories of participants. Ethical clearance was obtained from the ethics committee of the University of Nigeria Teaching Hospital, Ituku Ozalla.

Key Findings

Factors affecting men's participation in PMTCT

Factors which contributed to the limited participation of men in PMTCT included individual and relationship factors, gendered community norms and expectations, and health system factors.

Individual and relationship factors:

Individual and relationship factors included: time constraints, poor spousal communication, and non-disclosure of status to one's partner.

"The reason why it is difficult for men to participate in PMTCT services is just because of time. Because the work men do, keep them busy, like if a man is a driver, he will not be at home at the time his wife may want to go and access the PMTCT services. So, time is the main problem we have" (P8 FGD Male Support Group Nsukka).

"Most of them will confide in you, "my husband is negative, he doesn't know I'm going to this place; please, I don't want him to know". That is what they will tell you. And others will tell you, I am positive, I don't know about my husband" (Health worker 2, at Facility A).

"...Because maybe, he has no clear knowledge of what the woman is passing

through, the issue of PMTCT, the need to assist her during that period. If he has clear knowledge of the situation, definitely he will make time to accompany her" (P1 FGD Male support group Enugu).

"What happens to men all the time is that they feel that family planning is always for the women..."

"Well, I have never asked him to accompany me" (Female HIV client 3 at Facility B).

Gendered community norms:

Gendered community norms and expectations included: pregnancy being perceived as a woman's responsibility, male dominance in household decision-making, and ridiculing of men who accompany women to ante-natal care visits.

"...What happens to men all the time is that they feel that family planning is always for the women... that it is the women that need such services...that is why I don't follow my wife to go for it" (P6, FGD male support group, Nsukka).

"They see it as a woman's work to go for her PMTCT service especially this ANC" (Health worker 3 at Facility B).

"For the man, it will look as if the woman now rules him" (P3, FGD Female support group Nsukka).

Health system factors: Health system factors included: ante-natal care services that were only woman-centred, unwelcoming attitudes of health workers

to men who accompany their partners, and the fact that appointments for anti-retroviral treatment for partners were scheduled separately (meaning separate visits to the health care centre).

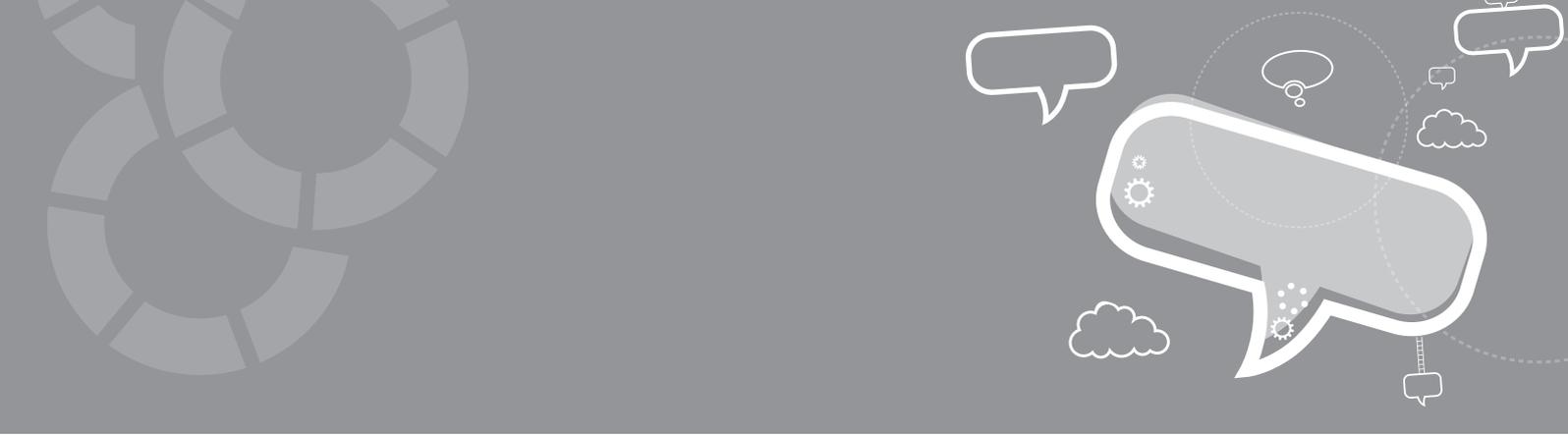
"The attitude of the nurses at times contributes a lot to why some don't like to follow their wives for antenatal" (P2, FGD Male support group Enugu).

"We designed it (ante-natal care, PMTCT, post-natal care) in such a way that men are excluded here" (Health worker 4 at Facility A).

"The date of appointment differs. Because my wife will be coming next week and my own falls today. So, there is no way we can come together" (P3, FGD, male support group, Nsukka).

Effects of male involvement (or lack of) on access and use of PMTCT by women

The perceived benefits of male partner participation in PMTCT included: male partners understanding and accepting the programme, women being freer to access the programme, reduction of the effects of male dominance on access to and uptake of PMTCT, male partners being better positioned to support their female partners emotionally and financially, couples being more able to work together towards preventing unintended pregnancies, and the promotion of adherence to treatment.



“So what I think that men do, which is cultural for us, is to ensure that the woman has the means of transportation to the clinic. And that is precisely the same thing that those whose wives are HIV infected do. The key male involvement in PMTCT is trying to understand that this woman needs to take her drugs everyday whether they are concordant positive, or discordant” (Health worker 4 at facility A).

“But, if they clear the ground from day one, it will make everything to be smooth... So, a woman will only encounter problems maybe when the man is not properly informed or counseled about it; but if the man has already been brought into the picture from day one, he is very likely to cooperate. So, everything depends on the initial counseling before the commencement of the drugs” (Health worker 4 at Facility C).

community norms and expectations, and health system factors. The challenges related to individual and relationship factors are poor spousal communication, and non-disclosure of HIV status to one’s partner. The main constraint arising from gendered community norms and expectations include the notion that going to ANC is a woman’s responsibility, resulting in ridiculing of men who accompany women to ANC. A change in the understanding of men and women about what male involvement in PMTCT entails, as well as a change in their attitude to male involvement in PMTCT is essential to overcome these challenges. Consequently, there is need for effective public enlightenment programmes focusing on HIV/AIDS and its modes of transmission and prevention methods, in particular the essence of male participation in prevention of mother-to-child transmission of HIV/AIDS. The advantages of spousal communication and disclosure of HIV status to one’s partner as an essential strategy in encouraging and ensuring adherence to ART treatment for affected spouses needs to be emphasized. Such public sensitization should be tailored to also discourage community norms that pregnancy and going to ANC are women’s responsibility, as well as discrimination against people living with HIV/AIDS. The suggested public enlightenment programmes could be undertaken through electronic and print media, churches, markets, community dialogue, and sensitization in men’s and women’s organizations and at support group meetings. Health workers and government agencies, such as National Action

“... if the man has already been brought into the picture from day one, he is very likely to cooperate...”

“... I receive my ART drugs in the same facility with my wife. And I normally make sure every morning, at 8 o’clock, I take the drug, my wife takes hers too, and in the night we take our drugs at the same time” (P5 FGD Male support group Enugu).

Other challenges men experience which constrain their involvement in PMTCT as identified by some health workers include difficulty accepting that they are HIV positive and limited knowledge about PMTCT. A serious consequence of male partners having limited knowledge about PMTCT is the inability of some to provide psycho-social support for their female partners.

Lack of men’s involvement in PMTCT was found to contribute to: difficulty in breastfeeding properly or as recommended for a HIV positive woman, difficulty with keeping to scheduled ante-natal care appointments, inability to discuss outcome of counselling visits, inability to discuss prevention of unwanted pregnancies, and poor adherence to antiretroviral treatment. At the same time a major challenge in involving men in PMTCT – limited spousal communication – results from lack of understanding between couples and inadequate HCT counselling by HCT workers.

“For sure, if a man is aware that his wife is HIV positive and has known from day one that she has to be on drugs, he can as well be reminding her, asking her questions like have you taken your drugs, have you done this and that, etc.” (Health worker 4 at Facility C).

Conclusion

The findings show that challenges hindering men’s effective involvement in PMTCT services emanate from individual and relationship factors, gendered



Committee on HIV/AIDS (NACA), State Action Committee on HIV/AIDS (SACA), and Local Action Committee on HIV/AIDS (LACA), in collaboration with religious and traditional/ community leaders, and male and female peer educators, among others, should carry out the recommended public enlightenment programmes.

To address challenges emanating from health system factors, such as time constraints for some men to attend PMTCT

services due to work schedules, and long waiting time, ANC services being women-centered, unwelcoming attitudes of health workers at ANC to men, and scheduling of separate appointments for ART treatment for partners, recommended measures are that health workers should run two shifts for PMTCT services in order to accommodate schedules of clients who may not be able to come in the mornings, inclusion of male targeted programmes in PMTCT to make the services male friendly,

attitudinal changes by health workers through training and retraining to make PMTCT facility environment male friendly, and joint appointments for ART treatment for HIV positive couples to encourage couples coming at the same time. In addition, policy measures need to be put in place to deal with the identified challenges if effective uptake of PMTCT services is to be achieved.

4. Gender and health system financing

The inclusion of targets for universal health coverage in the Sustainable Development Goals has led to a great deal of analysis of how countries should fund the health services required by their citizens. However, all too often this thinking and subsequent decision-making is done without adequate attention to gender. A recent paper by Witter et al (2017) describes the folly of this approach

suggesting that insufficient attention has been paid to the interaction of gender and health financing and calling for better collaboration to fill this gap. The case study in this section provides an example of health systems research that does just this. The authors used social science methods to review how men were involved in efforts to expand access to maternal health services through a pre-paid card.

Questions to consider

1. Why do you think health economists have paid less attention to the ways in which gender might affect access to financing for health services?
2. Why is it important to include men in maternal and child health services?
3. Do you think different health financing methods might have different outcomes depending on the gender of the person using them?
4. What other methods could be used to assess the gendered aspects of health financing interventions in different countries?

4.1 Male involvement in the National Health Insurance Fund (NHIF/KfW) prepaid insurance card for pregnant women in Pangani District, Tanzania

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Introduction

In Tanzania, estimates from 2010 show a maternal mortality ratio (MMR) of 454 maternal deaths per 100,000 live births (TDHS 2010). For every 1,000 live births in Tanzania, four or five women died of pregnancy-related causes. Reasons for low usage of maternal care are complex, including shortage of resources, long distances to services, high costs, and low capacity to provide services. Gender analyses suggests that maternal mortality is linked to a wide range of factors in women's lives, including the value placed by women and by their families and communities on women's health, women's economic position, their access to education and information, and their capacity to make autonomous decisions (Yargawa and Leonardi-Bee 2015). 'Gender exclusion', in this case the exclusion of men in planning or implementing interventions, can be a major barrier to achieving improved maternal and child health (Comrie-Thomson et al. 2015).



ABOVE: An expected mother attending one of antenatal care services

Health insurance, maternal health and gender

In 2010, the National Health Insurance Fund (NHIF) of Tanzania piloted a programme aimed at improving maternal and child health through the provision of insurance coverage to poor families (Kuwawenaruwa et al. 2015). The pilot programme used the NHIF platform to support and strengthen the expansion of social health insurance coverage to include informal sectors through providing free maternal and child health insurance cards, named the "NHIF/KfW prepaid insurance card", to poor pregnant women and their newborns in selected regions of Tanga and Mbeya.

Our study sought to understand male involvement in the implementation of a National Health Insurance Fund (NHIF/KfW) for pregnant women in Pangani District, Tanzania. It examined the factors associated with male involvement or lack of involvement in the programme and identified strategies that can be used to increase male involvement.

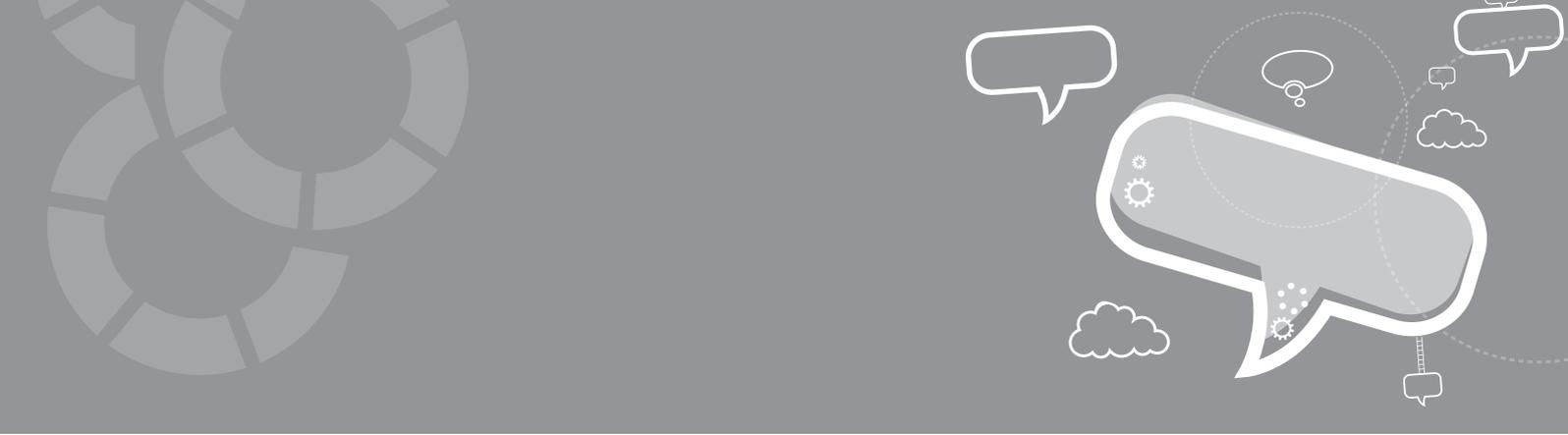
Methods

In-depth interviews (IDI), focus group discussions (FGDs) and group discussions were conducted in Pangani district, Tanzania. Five group interviews were conducted with health care providers at two health facilities, four with female nurses only and one with female nurses and one male nurse. The managerial group discussions were conducted with the district health management team (CHMT) and comprised of three females and four males, the regional health management team (RHMT) (two females and one male), and the NHIF zone manager at regional level that had two females. Lastly, three focus group discussions and six in-depth interviews were conducted with partners who re-enrolled/did not re-enroll post the initial 12 month of the NHIF/KfW prepaid insurance card, and two group interviews were conducted with community health workers (4 male and 7 female). The study employed a thematic analysis approach. Ethical approval was received from the Institutional Review Board of the Ifakara Health Institute, Tanzania.

Key Findings

Male involvement in the implementation of NHIF/KfW prepaid insurance card

Men were involved in the implementation of NHIF/KfW prepaid insurance card scheme in various ways: during its design; inauguration; registration; and in community sensitization sessions at the village level and health facilities.



Health System Factors: At the health care facilities, women were encouraged to attend with their partners during antenatal visits. This was to ensure they were all tested together for HIV, as well as educated on how to take care of the pregnancy and prepare for delivery. Participants often stated that while men increasingly go with their wives for first ANC and test for a number of diseases together, they were not always told about the insurance programme while at the facility:

“Things have changed because few years back when you are pregnant you can come alone for health checkups and start ANC services, but nowadays to have a test or even to be registered, you have to come with your husband...”
(FGD – women at Pangani Hospital).

“We were told whenever we come to clinic each one has to come with the partner to be tested, I came with him...we were examined but we were not told about the NHIF/KfW insurance programme...”
(FGD – women at Mwera Health Centre).

“... you are lucky if you are accompanied by your partner to hospital... in reality I haven't ...”

Economic Factors: Maternal and child health care services should be free of charge as per the health care policy. However, in many cases families and partners incur costs related to transport and the purchase of supplies. During the implementation of the project, the costs related to the service provision

for the women and the family were borne by the programme. This encouraged male involvement because they could be confident that they would not have to pay for extras at the point of provision:

“Nowadays he has changed, when you fall sick he asks you to go to the facility as he knows it's free...he cannot say I don't have to go because we do not have money...if I wouldn't have gone with him the first day he could not know...” (FGD – women at Pangani Hospital).

Social Norms: Women had different views with respect to levels of men's involvement in the provision of reproductive and child health care services. It is not a usual thing to see a man accompanying the partner as well as carrying a baby to the hospital:

“But just seeing a man carrying the baby with happiness...how many are they...you are lucky if you are accompanied by your partner to hospital...in reality I haven't...”
(FGD – women at Mwera HC).

In addition, a number of women claimed that they did not involve men directly when they went for ANC services and registered for the programme because men were at work. This reflects the perception that the role of men in the community is to work and that women should care for the family.

Strategies to increase male involvement

Participants identified strategies to improve male involvement in the implementation of NHIF/KfW prepaid insurance card in Pangani District. These are as follows:

Communication between partners:

Communication between partners was one of the ways to increase men's involvement. Some of the men who have been involved in the programme are now responsible to take their children to the health facility for growth monitoring and when they are sick:

“When you tell a man that I am sick, he will ask you to go to the health facility, you will go and get services ...when the child falls sick he will take him to the doctor and when prescribed he will go to find the drugs if they are not available at facilities...” (FGD – women at Mwera HC).

Use of village meetings: In the villages, there are routine meetings every three months. During the meeting, participants discuss various topics and make decisions together for the betterment of the whole community. Health care providers and Community Health Fund (CHF) coordinators can use such meetings to educate/sensitize the community. At times doctors/health workers are given time to talk at the end of the meetings specifically during the any other business session:

“We suggest that during the village meetings doctors should be given priority to speak as they emphasize on health

issues men will get to learn, as we usually come with the kids every day to the facility....” (FGD – women at Mwera HC).

Education: Men pointed out that one of the strategies to increase their participation was through education, as they will gain more knowledge about health care services and whatever has been happening in the facilities:

“Your wife goes to clinic while you just go to the farm.... it’s wrong.....most of the time we are supposed to accompany our partners

and get to know whatever is happening..... there is low awareness.....it’s good whenever people are being sensitized, or as the village chairman calls for a meeting and inform the community whatever is happening...” (FGD – men at Mwera Village).

Conclusion

Programme implementation together with other factors such as health system factors, economic factors and social norms act as facilitators and barriers of male partner involvement in the implementation of the NHIF/KfW insurance

programme. These factors played out in complex and interrelated ways. Improvement in the health care provision and community sensitization of the importance of male partner involvement in the implementation of maternal and child health care programmes needs to be prioritised in order to improve their participation and mitigate the effect of socio-economic and cultural factors that differentiate the roles of women and men, affect men’s engagement in maternal and child health, and influence health outcomes.

5. Gender and health system governance

Health system governance refers to the guidelines and tools which shape the health system, as well as the processes and institutions to check that these are being adhered to and ensure accountability for progress towards health goals. There is ample evidence to show that health systems policy development does not always pay adequate attention to gender and that even when these policies include gender, good intentions can ‘evaporate’ when it comes to measurable indicators

and actual implementation. This case study analyses policies for the prevention of mother-to-child transmission of HIV in Tanzania. Using a gender framework, it assesses whether the policies are gender unequal, gender blind, gender sensitive, gender specific or gender transformative. Despite the considerable attention that has been given to the ways in which gender can affect vulnerability to HIV and access to services these policies fall short of the ideal.

Questions to consider

1. What are the benefits of applying this gradient of gender specificity to health sector policies? Can you think of other areas of policy where this tool could be applied?
2. Why should policies on HIV and sexual and reproductive health pay attention to gender?
3. How does gender analysis in health systems governance link to the area of human resources for health and the case studies in the earlier section?
4. How could policies on the prevention of mother-to-child transmission respond better to the issues of male involvement which were the focus of case study four in the care seeking and service delivery section of the Reader?

5.1 Mainstreaming gender into guidelines for the prevention of mother to child transmission of HIV in Tanzania

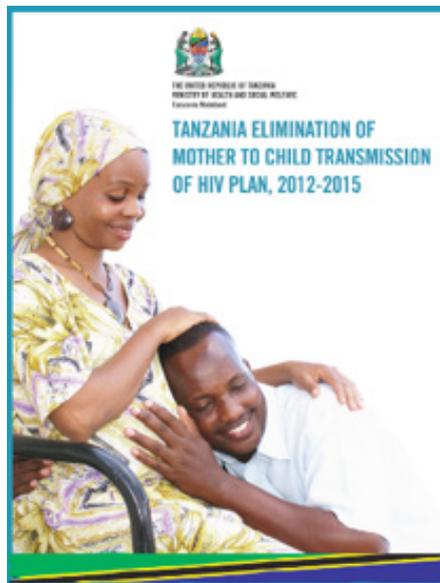
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Introduction

In Tanzania, the prevention of mother to child transmission of HIV (PMTCT) is a health sector priority, but there is very little information on how well gender is mainstreamed in national PMTCT guidelines and processes. Mainstreaming gender into PMTCT programming is expected to lead to increased coverage, efficiency, and effectiveness of services, contributing towards a reduction of child and maternal illness and death (Ravindran and Kelkar-Khambete 2008).

Addressing gender concerns includes consideration of gender-related barriers to accessing PMTCT services and understanding the challenges patients experience in adhering to the professional advice given in those services. Gendered challenges include:

- Unequal ownership of resources between men and women (women not going or going late to PMTCT clinics due to lack of money for travel; or women being unable to make appropriate decisions due to financial constraints);



ABOVE: Affectionate male involvement in PMTCT is promoted in the policy document

- Unequal decision-making power in sexual relationships, contraceptive use, and in choosing infant feeding options.

This research assessed the gender content of key policy documents in order to better understand how this area could be strengthened (Nyamhanga et al. 2017).

Methods

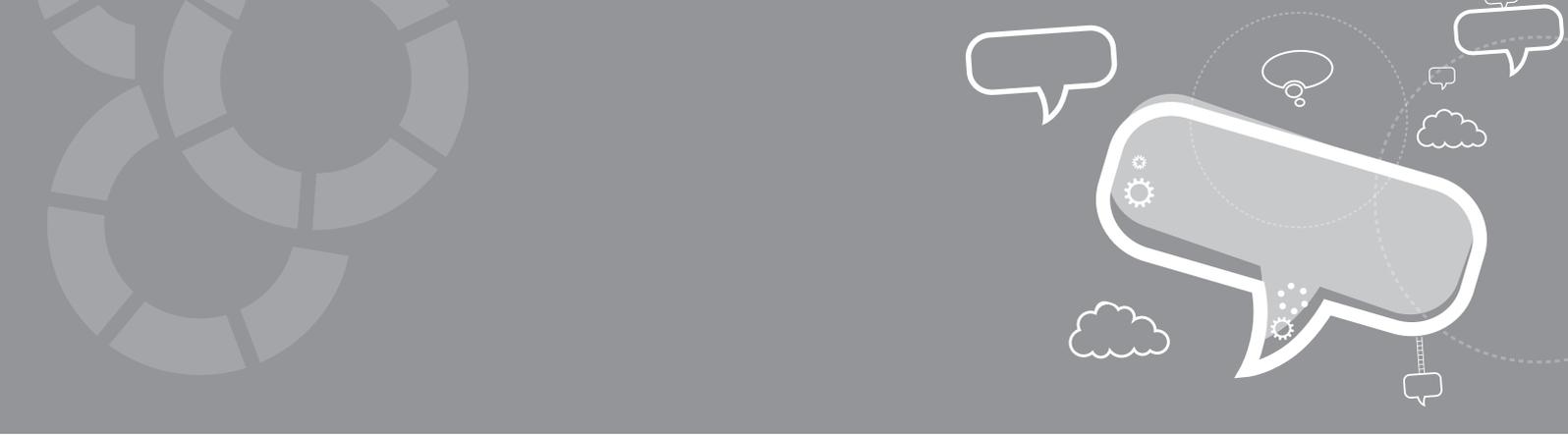
Data collection occurred in three public health facilities in Mwanza City, Tanzania: Sekou Toure Regional Hospital, Nyamagana District Hospital, and Buzuruga Health Centre, which serves in lieu of a district hospital for Ilmela. Data were collected by reviewing PMTCT policy/strategy documents. A total of five PMTCT policy/strategy documents were reviewed and analyzed. The documents were obtained in hard/soft forms from the Ministry of Health and Social Welfare, and consisted

of all PMTCT policy documents that could be obtained from the Ministry. Documents were organized according to their respective categories – that is, guidelines, frameworks, and strategic plans – and reviewed for gender responsiveness using thematic content analysis. Ethical approval for this study was obtained from the Institutional Review Board (IRB) of Muhimbili University of Health and Allied Sciences.

From unequal to transformative - the Gender Responsive Assessment Scale

In order to analyse the gender content of PMTCT policy and practice in Tanzania five PMTCT guidelines were assessed to identify and extract any content on gender and assessed according to their compatibility with the WHO Gender Responsive Assessment Scale (GRAS) (WHO 2011). The GRAS divides gender responsiveness into five levels:

- **Level 1** – gender unequal – contains content which perpetuates gender inequality by reinforcing unbalanced norms, roles and relations.
- **Level 2** – gender blind – contains content which ignores gender norms, roles and relations. The content of such documents, for example, ignores differences in opportunities and resource allocation for women and men.
- **Level 3** – gender sensitive – contains content which indicates awareness of the impact of gender norms, roles, and relations, but no remedial actions are developed.



- **Level 4** – gender specific – contains content which goes beyond indicating how gender may hinder PMTCT to highlighting remedial measures, such as the promotion of couple counselling and testing for HIV.
- **Level 5** – gender transformative – contains content which includes ways to transform harmful gender norms, roles and relations. Such documents contain strategies to foster progressive changes in power relationships between women and men.

Key Findings

Gender is mentioned: Gender-related issues are mentioned in all of the guidelines, indicating some degree of gender responsiveness. The level of gender responsiveness of PMTCT policy documents, however, varies, with some graded at GRAS level 3 (gender sensitive), and others at GRAS level 4 (gender specific). None of the reviewed policy documents could be graded as gender transformative. Gender sensitive policies included the National Scale up Plan for The Prevention of Mother to Child Transmission of HIV and Paediatric HIV Care and Treatment, 2009-2013, The National Guidelines for Comprehensive Care Services for Prevention of Mother to Child Transmission of HIV and Keeping Mothers Alive (2013), and the National Communication Strategy for the Elimination of Mother to Child Transmission of HIV (2014 – 2017). These documents have sections acknowledging the influence of gender

on PMTCT, but lack sections on remedial measures. And when statements do consider gender, they are often too general to offer effective guidance. Policies rated at GRAS level 4 went beyond indicating gender awareness to also state measures for addressing specific concerns of women and men and addressing gender inequity. This was the case only for the National Training Refresher Package: Services for Comprehensive Care and Prevention of Mother-to-Child Transmission, Participant Manual, 2013.

But policies do not set out to transform gender relations:

While the policy documents indicate recognition of gender inequality in decision-making and access to resources as a barrier to accessing PMTCT services by women, no attempt is made to transform harmful gender norms, roles, or relations. For example, the policy documents do not include actions to transform norms around masculinity that discourage men from seeking care, taking an HIV test, or accompanying their partners to PMTCT clinics.

And they haven't mainstreamed

gender: Overall, gender was not mainstreamed into any of the documents in the sense that gender was not considered in all key sections. For example, gender was not integrated into the documents' goals and objectives or the strategies. As a result, while the documents were responsive to gender at different degrees, gender was not effectively mainstreamed throughout any of the policy documents.

Conclusion

Gender analysis of PMTCT policy documents revealed gender related gaps which partly explain limited success of the program. Although gender is often one of the guiding principles of the introductory chapters of key PMTCT guidelines in Tanzania, gender is not mainstreamed and document goals, objectives, and strategies do not incorporate gender considerations. Most policy documents are gender sensitive, that is, they indicate gender awareness without stating remedial measures. This might be explained by the fact that in the design stage of a policy or strategy, gender is handled as an "add on" in order to fulfil certain requirements, rather than being made an integral part of the entire policy.

Overall, this study revealed limited integration of gender concerns (less or lack of attention on the disadvantageous position of women in terms of inequality in ownership of resources, power imbalance in decision-making, asymmetrical division of roles, and masculine norms that distance men from maternal and child care) in PMTCT guidelines. Revision of guidelines to mainstream gender is greatly needed if PMTCT services are to effectively contribute towards a reduction of child and maternal morbidity and mortality in Tanzania.

6 Reflecting across the case studies

The case studies in this Reader showcase the importance of gender analysis within health systems research. In fact, a focus on gender and other axes of power and inequality is part of ethical research practice. On a practical level, these case studies also demonstrate how gender analysis can be applied to health systems research. In this section we have included the questions for consideration included above, along with the key findings from case studies.

6.1 Key messages about how gender plays out in health systems

6.1.1 Human resources for health

Questions to consider:

1. All three case studies included the views of men and women. Were there differences and discrepancies in the ways that they view the same phenomena?
2. How do women's domestic responsibilities shape their ability to perform their health system roles? What impact do domestic responsibilities have on women's opportunities for progression and leadership?
3. What other gendered social norms shape the field of human resource management in these case studies?

4. What are the advantages of analyzing gender within human resource policy and practice? How could these findings be used to advocate for change?
5. Why do you think the authors used the methods that they did? What are the benefits and challenges of using these methods over more conventional ones?

Key findings from studies included in reader:

- The social roles, activities, characteristics and behaviors that society prescribes for men and women are an important dimension in human resources for health that has not been given due attention, especially in low- and middle-income countries.
- The health workforce is not a meritocracy, it is influenced and biased by sexist societal norms which privilege men over women.
- In Cambodia, women reported that domestic chores and unpaid care responsibilities interacted with harmful societal norms and were a barrier to their progression and leadership in the health sector.
- Cambodian women's leadership in the health workforce was enabled through support from spouses and relatives, backing from male leaders within their institutions, self-motivation, and increased capacity and skills.
- In Zimbabwe access to training and career development were shaped by gender roles and norms at the household and institutional level. Gendered family responsibilities meant that women were not always able to take up training and career opportunities when they arose.
- Women in Zimbabwe are expected to follow their husbands when they were transferred to other areas of the country for work. Women reported re-joining the health sector in junior/lower posts, therefore experiencing loss of pay/ accepting lower pay, delaying their time for promotion, and upgrading and or upskilling.
- HR managers in Zimbabwe preferred to deploy men in the most remote rural areas, which presented conditions of inequity as the men gained exposure and experience through these postings which then advanced their careers much faster than the careers of women.
- In Uganda, Community Health Workers' roles and responsibilities were structured according to gendered norms. Women were often confined to the home performing domestic work and unpaid care and, as a result, they tended to concentrate on maternal and child health. At the same time, men had access to transport and their use of it was acceptable to the community so they performed more emergency care work. Men were also considered more suitable for physical labour such as digging ditches.

6.1.2 Care seeking and service delivery

Questions to consider:

1. The first case study took an intersectional approach where other social stratifiers were considered alongside gender. What does this add to the analysis?
2. Looking across all of the case studies, how do harmful social and cultural norms effect access to care?
3. Why do you think unpaid family care continues to be an overlooked element of health systems research?
4. Many researchers of health systems consider equity only in as much as they consider levels of poverty. These case studies provide some examples of how this might be an inadequate approach. What are they?
5. Men often find it difficult to access health services. Can you think of other examples of this apart from in relation to the prevention of mother-to-child transmission of HIV?

Key findings from studies included in reader:

- Gender relations and roles need to be considered when designing and implementing programmes within the health system to ensure that health systems serve to address gender inequalities and advance health outcomes equitably.

- An intersectional analysis can provide profound insights into reasons for a lack of service utilization and can help us to improve quality of care.
- In India, when gender was considered alongside age, older women were more vulnerable to visual impairment. When gender was considered alongside education, education was found to be a preventative factor only among men. And when gender cross cut with poverty, poor men were found to be less vulnerable compared to non-poor women in terms of developing visual impairments. Without applying an intersectionality lens to the analysis, these distinctions would be lost. This has implications for health research, as research which only considers a single stratifier will miss different degrees of vulnerability across the groups.
- In China, despite the fact that elderly women had more care-related needs and fewer resources, there was no significant difference between men and women in terms of the care received. Factors affecting the family care received by the elderly included: age, income, number of children and health status.

- In Uganda, low access and use of maternal and newborn services by non-indigenous, internal migrants was, in part, due to neglectful, discriminatory attitudes and demands for informal payment and behaviours among health care workers which were related to ethnic differences.
- In Nigeria, there were key gender-related constraints to male involvement in

PMTCT at the individual, community, and health system level, which had a negative effect on PMTCT outcomes. These constraints include: difficulty in breastfeeding properly or as recommended for HIV-positive women, difficulty with keeping scheduled ante-natal care appointments, inability to discuss outcome of counselling visits, inability to discuss prevention of unwanted pregnancies, and poor adherence to antiretroviral treatment.

6.1.3 Financing

Questions to consider

1. Why do you think health economists have paid less attention to the ways in which gender might affect access to financing for health services?
2. Why is it important to include men in maternal and child health services?
3. Do you think different health financing methods might have different outcomes depending on the gender of the person using them?
4. What other methods could be used to assess the gendered aspects of health financing interventions in different countries?

Key findings from studies included in reader:

- While health financing is often treated as if it is gender neutral and will affect men, women and people of other genders equally, the way in which these schemes are organized and implemented has



implications for men's and women's access to and use of health services.

- In Tanzania men were involved in the design, inauguration, and registration for the NHIF/KfW prepaid insurance card for maternal health. Interventions like community sensitization meant that men were better educated about care for women and children and more aware of issues like the cost of travel to the health care centre. However, social and cultural barriers were still a hindrance to male involvement.

6.1.4 Governance

Questions to consider

1. What were the benefits of applying this gradient of gender specificity to health sector policies? Can you think of other areas of policy where this tool could be applied?
2. Why should policies on HIV and sexual and reproductive health pay attention to gender?
3. How does gender analysis in health systems governance link to the area of human resources for health and the case studies in the earlier section?
4. How could policies on the prevention of mother-to-child transmission respond better to the issues of male involvement which were the focus of case study four in the care seeking and service delivery section of the Reader?

Key findings from studies included in reader:

- Despite an acknowledgement that gender inequity effects pre-disposition to ill health and measures to stay well, gendered analysis has yet to be mainstreamed into health systems governance and throughout the institutions for oversight and accountability within the health sector.
- In Tanzania, a review of policy documents related to the prevention of mother-to-child transmission of HIV found that most policy documents are gender sensitive, that is, they indicate gender awareness without stating remedial measures. Despite an understanding that gender inequity influences the effectiveness of such programmes, little attention was paid to the disadvantageous position of women in terms of inequality in ownership of resources, power imbalance in decision-making, asymmetrical division of roles, and masculine norms that distance men from maternal and child care.

6.2 Learning across the studies

From these case studies we have learned that in-depth gender analysis is critical if we are to transform inequitable systems and structures within the health system.

"I have been able to do an analysis of our data using the gender analysis frameworks i.e. to answer pertinent issues relating to gender inequities observed in the data and also relating the data to existing literature."
(RinGs Small Grant Researcher)

Gender intersects with other social stratifiers, such as age, socio-economic status, ethnicity, and education to influence how vulnerability is experienced within the health system. Because of this, researchers should disaggregate data by sex and other social stratifiers.

"Gender analysis provides further insight to answer the question "how?" and dissects the different layers of power and vulnerabilities as opposed to other methodologies." (RinGs Small Grant Researcher)

"Gender analysis takes one beyond sex differentiation and extends a lens to examine the power dynamics within and across the households in deciding health care utilization." (RinGs Small Grant Researcher)

This type of disaggregation can be a first step to more intersectional analysis of health systems. Beyond data disaggregation, using gender frameworks can help researchers to effectively incorporate gender into their data collection and analysis.

You don't have to be a gender expert to begin this type of analysis as strong research skills and the desire to work differently count for a lot. Working together with others who are grappling with issues related to gender and health systems can help you move forward. Once you have applied a gender lens to one study you are more equipped to consider gender in other areas of your research.



“The RinGs study has opened up my mind on how I can further research in gender and ethics. I will use future opportunities to build up on it and take it forward.”
(RinGs Small Grant Researcher)

While gender analysis should ideally be incorporated into all stages of the research process, not all research needs to have a direct focus on gender. At a minimum, health systems research should incorporate gender into the development of study designs and data collection tools

as well as the process of data collection. The resources included below will help researchers to think about how gender analysis can be effectively incorporated into health systems research content, implementation, and outcomes.

7. Further Resources

Future Health Systems (2016). Galvanising Gender Analysis and Practice in Health Systems. *Future Health Systems (2016). Key Message Brief*, No. 4. Available at: <http://resyst.lshtm.ac.uk/resources/galvanising-gender-analysis-and-practice-health-systems-reflections-research-gender-and>

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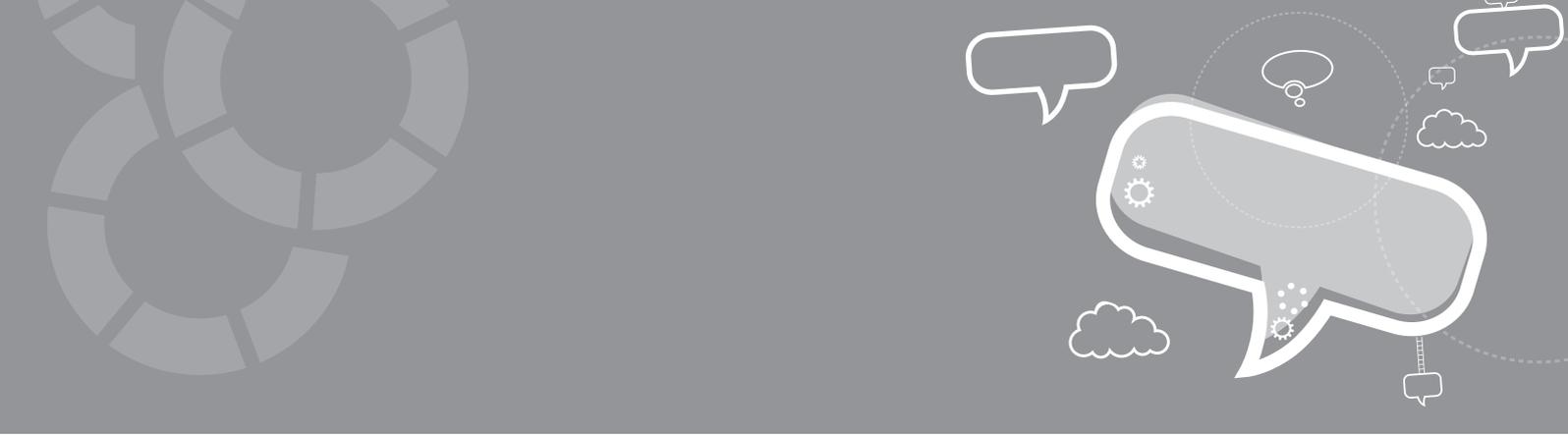
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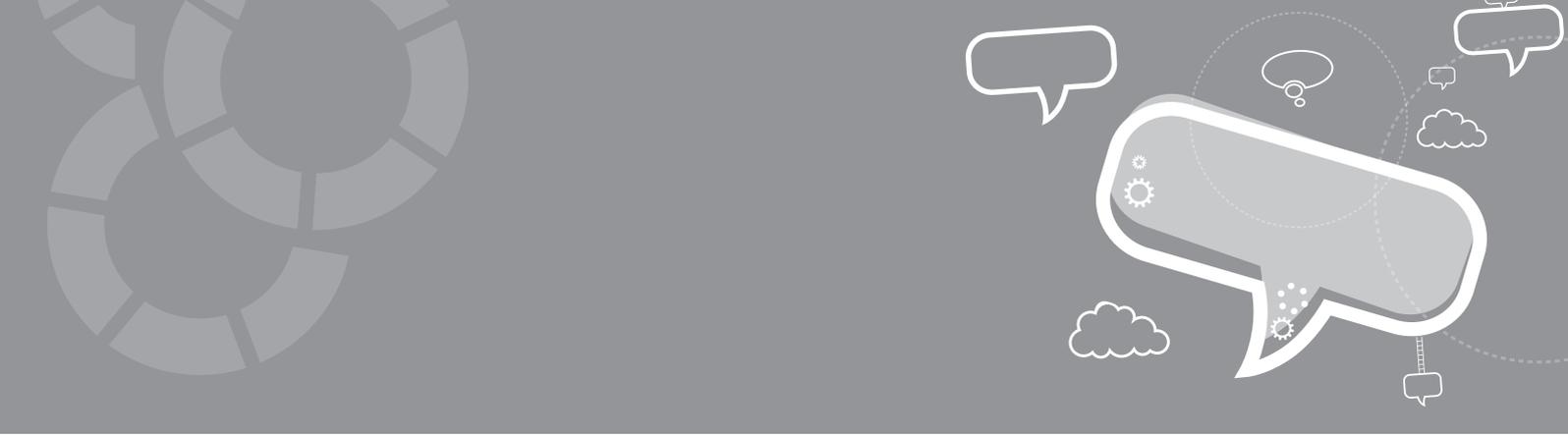
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Acknowledgements:

This reader was prepared by Rosemary Morgan, Johns Hopkins Bloomberg School of Public Health, and Kate Hawkins, Pamoja Communications Ltd, with input from the Research in Gender and Ethics (RinGs): Building Stronger Health Systems' team and the research leads.

RinGs is funded by the UK Department for International Development (DFID) for the benefit of low- and middle-income countries. The views expressed are not necessarily those of DFID.

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