
The importance of gender analysis in research for health systems strengthening

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Abstract

This editorial discusses a collection of papers examining gender across a range of health policy and systems contexts, from access to services, governance, health financing, and human resources for health. The papers interrogate differing health issues and core health systems functions using a gender lens. Together they produce new knowledge on the multiple impacts of gender on health experiences and demonstrate the importance of gender analyses and gender sensitive interventions for promoting well-being and health systems strengthening. The findings from these papers collectively show how gender intersects with other axes of inequity within specific contexts to shape experiences of health and health seeking within households, communities and health systems; illustrate how gender power relations affect access to important resources; and demonstrate that gender norms, poverty and patriarchy interplay to limit women's choices and chances both within household interactions and within the health sector. Health systems researchers have a responsibility to promote the incorporation of gender analyses into their studies in order to inform more strategic, effective and equitable health systems interventions, programmes, and policies. Responding to gender inequitable systems, institutions, and services in this sector requires an 'all hands-on deck' approach. We cannot claim to take a 'people-centred approach' to health systems if the status quo continues.

Keywords: Gender, health systems, health systems research, human resources, health financing, health services, governance, equity, health inequalities

Introduction

In this special supplement, we bring together a rich collection of papers examining gender across a range of health policy and systems contexts. The papers interrogate differing health issues and core health systems functions using a gender lens. Together they produce new knowledge on the multiple impacts of gender on health experiences and demonstrate the importance of gender analyses and

gender sensitive interventions for promoting well-being and health systems strengthening.

The role of gender within health systems

Gender is defined as the 'socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for men and women' and people of other genders (WHO 2016).

Key Messages

- Gender inequities shape health experiences across a range of issues and across the life cycle, and affect the ability of health systems to respond.
- Evidence shows that health systems policy development does not always pay adequate attention to gender and that even when policies include gender, good intentions can ‘evaporate’ when it comes to measurable indicators and actual implementation.
- Health systems researchers have a responsibility to promote the incorporation of gender analyses into their studies in order to inform more strategic, effective and equitable health systems interventions, programmes and policies.
- Policy and interventions which consider and address gendered power relationships are needed if we are to transform inequitable systems and structures within the health system.

Gender analysis within health systems research seeks to understand how gender power relations create inequities in access to resources, the distribution of labour and roles, social norms and values, and decision-making (Morgan *et al.* 2016). Gender power relations 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. There is ample evidence that health systems policy development does not always pay adequate attention to gender and that even when these policies do include gender, good intentions can ‘evaporate’ when it comes to measurable indicators and actual implementation (Morgan *et al.* 2016).

What do the papers focus on?

The papers cover a range of health issues and health systems areas, from access to services, governance, health financing, and human resources for health. Papers on health services focus on malnutrition in Kenya (Muraya *et al.* 2017), maternal health in Uganda (Morgan *et al.* 2017), Prevention of Mother to Child Transmission (PMTCT) in Tanzania (Nyamhanga *et al.* 2017) and adolescent mental health in Gaza, Liberia and Sri Lanka (Samuels and Jones 2017). These papers provide a critical lens on how gender roles and relations shape experiences across the life cycle and affect access to services. Papers on health financing (Witter *et al.* 2017a, multiple contexts) and human resources for health in fragile/post conflict contexts (Witter *et al.* 2017b, Cambodia, Zimbabwe, Sierra Leone and northern Uganda) discuss why and how gender shapes core health functions/health systems building blocks in complex and often unanticipated directions. Two papers emphasise the importance of health system governance and gender responsive leadership (Nyamhanga *et al.* 2017; Witter *et al.* 2017b). The papers use a range of methods to show how gender analysis can be used in different ways and at different time points. Many draw on embedded approaches, where researchers work in close partnerships with policy makers and practitioners in ways which support the sharing of tacit knowledge and the gendered experiences of different people within both health systems and communities.

How do the papers demonstrate the value of gender analysis?

The papers show how ‘gender intersects with other axes of inequity’ within specific contexts to shape experiences of health and health seeking within households, communities and health systems, demonstrating the importance of taking forward an intersectional approach. For example, Muraya *et al.* (2017) show how gender, generation, and

marital status intersect to shape decision-making processes around accessing malnutrition programmes in one area of Kenya. In a context of polygamous marriages where many husbands live away from home in search of income, junior wives often defer to senior wives or elder women (grandmothers) in deciding which children should access services and when. Witter *et al.* (2017a) explore the Rashtriya Swasthya Bima Yojana scheme in India, a nationwide social protection mechanism for poor households which allows five household members to be enrolled to cover hospitalisation costs. They report that in larger households age and gender interplay to influence enrolment: girls and older women are less likely to be registered and are therefore least likely to benefit from the package.

The papers also illustrate ‘how gender power relations affect access to important resources’. In Uganda, Morgan *et al.* (2017) show how mothers reported a lack of control over financial resources and how they are used, as well as lack of male support when purchasing items for delivery or hiring transportation to the health facility. In Gaza, Samuels and Jones (2017) demonstrate how access to counselling following violence or trauma is mediated by gendered cultural norms. Witter *et al.* (2017b) demonstrate how across four different fragile contexts access to training—and especially in-service training and upgrading—was particularly difficult for women, especially when it involved travel and time away from households and gendered caring responsibilities.

The ways in which gender roles and relations link to poverty and other equity stratifiers is complex and context specific, yet all the papers ‘demonstrate that gender norms, poverty and patriarchy interplay to limit women’s choices and chances both within household interactions and within the health sector’. Although not an explicit focus of any of the papers; gendered violence emerges as a clear theme. Adolescent girls experience sexualised violence in Liberia where hyper-masculinity has become the norm following years of conflict (Samuels and Jones 2017); in Tanzania PMTCT processes can put women at risk of violence if they are seen as having brought HIV into the marriage (Nyamhanga *et al.* 2017); and in Uganda pregnant women experience violence from their husbands and from health workers during delivery (Morgan *et al.* 2017). Health workers themselves are also at risk of violence, particularly in times of conflict where they can be a deliberately targeted; with female health workers at increased risk of sexual violence (Witter *et al.* 2017b). For women, the disproportionate exposure to and experience of inter-personal violence is one outcome of ‘structural violence’, where underlying social structures systematically harm or otherwise disadvantage certain individuals or populations.

Concluding thoughts

The series provides some key lessons on the role of gender within health systems. As health systems researchers we have a

responsibility to promote the incorporation of gender analyses into our studies in order to inform more strategic, effective and equitable health systems interventions, programmes and policies. Policy and interventions which consider and address gendered power relations are particularly needed if we are to transform inequitable systems and structures within the health system. We have shared examples of the kinds of questions that might be asked and potential analyses elsewhere (Morgan *et al.* 2016).

We also have a responsibility to ensure that we carefully consider and share how the research we conduct—from data collection through analysis and write up—is imbued with complex power relations, and has the potential to reinforce, leave untouched, or positively transform inequities in the short or longer term. Our outputs need to go beyond the realm of peer reviewed publications to actively inform policy and practice debates. In addition, we have a responsibility to document and develop platforms to encourage methodological rigour and share the ethical dimensions and dilemmas encountered in our work (e.g. MacGregor and Bloom 2016; Molyneux *et al.* 2016, Global Health Social Science Website¹). Last, we need to form partnerships for change. Gender inequities shape people's experience of health across a range of issues and across the life cycle. Gender also influences the ability of health systems to respond effectively to the people that they serve. Given that much of the evidence that we use to help us overcome health systems' weaknesses are 'gender blind' there is a need for a change in researcher mindset and greater investment in capacity development interventions, e.g. with feminist scholars and human rights researchers. Gender transformative interventions and research need to take an intersectional approach (Larson *et al.* 2016) and concentrate on both the software and hardware of health systems; this can be complementary to understanding and building the everyday resilience of health systems across diverse contexts (Barasa *et al.* in press; Gilson *et al.* 2017). Incorporating an intersectional approach into health systems research should not be seen as the responsibility of a small sub-set of often under-supported scholars. Rather, responding to the profoundly gender inequitable systems, institutions, and services in this sector requires an 'all hands-on deck' approach. We cannot claim to take a 'people centred approach' to health systems if the status quo continues.

Note

1. <https://globalhealthsocialscience.tghn.org>.

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