ISSUE BRIEF ON GENDER INTEGRATION

BASED ON THE SUMMATIVE EVALUATION OF THE INNOVATING FOR MATERNAL AND CHILD HEALTH IN AFRICA INITIATIVE

KEY CONCEPTS

Gender: *'socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.'* [1]

Sex: '*biological attributes that distinguish male from female'* [2]

Implementation Research: *'the scientific inquiry into questions concerning implementation—the act of carrying an intention into effect, which in health research can be policies, programmes, or individual practices (collectively called interventions). The intent is to understand what, why, and how interventions work in "real world" settings and to test approaches to improve them.'* [3]

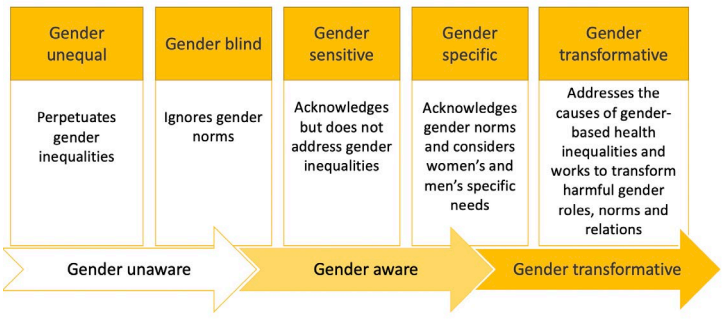
CONTEXT

The issue brief on gender integration was prepared as part of the summative evaluation of the Innovating for Maternal and Child Health in Africa (IMCHA) initiative to improve maternal, newborn and child health outcomes by strengthening health systems, using primary health care as an entry point. IMCHA was launched in March 2014 by the International Development Research Centre (IDRC), the Canadian Institutes of Health Research (CIHR) and Global Affairs Canada (GAC) and is scheduled to end in July 2021.

IMCHA supports 28 research projects in 11 African countries that were awarded to 19 research teams in a first round, followed by 9 synergy grants expanding the scope and depth of selected projects. All teams are led by a Principal Investigator (PI) of an African research institution and have, in addition, a Co-Principal Investigator (Co-PI) affiliated with a Canadian research institution and a Co-PI in a decision-making position, generally in local, regional or national government. Two additional grants were awarded to Health Policy and Research Organisations (HPRO) in West and East Africa that are tasked with supporting capacity-strengthening of the research teams, facilitating mutual learning among them, supporting knowledge translation and raising the profile of the research in order to facilitate the adoption of results at scale in national and regional health policies.

The summative evaluation was implemented between November 2019 and September 2020. Data were collected between December 2019 and May 2020, including an online survey of IMCHA researchers and key informant interviews with researchers, decisionmakers and other stakeholders in Canada and in programme countries. The issue brief provides a summary and a deeper analysis of how gender was integrated in the IMCHA initiative.

GENDER AND IMPLEMENTATION RESEARCH



Adapted from Greaves et al. [5]

Gender analysis explores differences between and among men, women, and people of diverse genders. It examines gender in relation to social stratifiers and assesses how relations of power play out at multiple levels and through diverse pathways. [4] Gender analysis in implementation research examines how gendered power relations influence the implementation of an

intervention, as well as the extent to which the research process itself progressively transforms gendered power relations, or at least does not exacerbate inequalities.

Strategies for incorporating gender in research include (i) disaggregating data by sex and other social stratifiers, (ii) using a gender framework, (iii) incorporating gender analysis questions, (iv) incorporating gender analysis into data collection processes and (v) incorporating gender analysis in the research outcomes. [6] In the evaluation, the **gender integration continuum** [see Figure] was used to assess the extent to which IMCHA projects integrated gender, categorising approaches and outcomes according to the degree gender norms and relations were addressed.

How was gender integrated in the research processes?

Research design

Gender integration was a central objective of the IMCHA call for proposals, stating that implementation research can enrich the evidence base to inform the development and implementation of policies and interventions that address imbalances in gender power relations, and thereby the root causes of gender inequality. [7] The evaluation team assessed the gender sensitivity of research proposals using six criteria: [6]

Criteria	Proposals that met criterion
1. Women or girls are beneficiaries of the research	28
2. Research intentionally targets a specific group of men or women	21
3. Research considers the differences among men and women	17
4. Research addresses inequities created by unequal gender norms, roles and relations	14
5. Gender is included in the research objectives	20
6. Gender is included in the research question	12

Criteria adapted from Morgan et al [6]

Twelve (12) of the 28 original and synergy research proposals met at least 5 criteria and were rated gender transformative; 12 addressed between 2 to 4 criteria and were rated gender aware and 4 research proposals only responded to the first criterion and were rated gender blind.

In the inception phase for the original 19 projects, 11 research teams were encouraged to further improve gender integration. In response 6 teams strengthened gender integration, primarily by recognising differential gender power relations, improving data collection tools or bringing a gender specialist into the team. The other 5 did not make any changes. None of the proposals addressed people of diverse genders.

Data collection and analysis

During data collection, most research projects disaggregated the data on beneficiaries by sex or social stratifiers. Most data collection processes were considered **gender aware**. These included conducting surveys of women, including a sub-analysis on gender in the baseline surveys, including a women's economic empowerment survey tool in the end-line survey, separating focus group discussions by sex, and including monitoring and evaluation indicators assessing the level of participation of women and men. **Gender transformative processes** were used by 5 research teams and included assessing how gender norms and gender relations influence the behaviour of the beneficiaries, analysing key barriers for women and identifying strategies to overcome these, assessing the level of women's decision making power in the household, and monitoring the impact of the intervention on behaviours among both men and women.

RESEARCH OUTPUTS

At the time of the evaluation, outputs were available for 22 research projects. A disaggregated analysis of the gender focus in the available outputs highlighted that:

- 3 research projects had not (yet) produced any outputs that referred to gender norms, roles or relations and were considered gender blind.
- 9 research projects had produced outputs that were gender aware (4 gender sensitive and 5 gender specific).
- 10 research projects were found to have published gender transformative research outputs.

EXAMPLE: GENDER AWARE RESEARCH OUTPUT

A systematic review conducted by one research team identified how partner involvement in maternal health care and being a member of a 'women's development army' had protective effects in relation to maternal death.

EXAMPLE: GENDER TRANSFORMATIVE RESEARCH OUTPUT

A study published by one research team reported that universal home visits to pregnant women and their husbands reduced complications in pregnancy. It also reduced domestic violence during pregnancy as well as other risks for complications in pregnancy such as heavy work and lack of spousal communication.

Out of the 10 projects that were found to have generated gender transformative research outputs, 8 had a gender transformative research design, while the other 2 were gender aware. They had both strengthened their gender focus during implementation, and one had brought a gender specialist into the team. Only one of the 4 projects assessed as gender blind in its design added a gender lens to 2 of its research outputs (acknowledging a differential impact of the project on men and women), all outputs available for the other 3 remained gender blind.

WHAT STRATEGIES WERE SUCCESSFUL? WHICH ONES WERE NOT?

Most research projects framed **gender as a women's health issue**, focusing primarily on women in the context of reproductive health and childbearing. The strategies included a focus on women as the main beneficiaries of the project (as health workers, clients of maternal health services or as mothers) or on improving how services are provided to women. Some projects considered the focus on women's health as sufficiently integrating gender. The projects can be considered as being gender aware. The research teams, however, did not necessarily examine how gendered power relations influence the implementation of the interventions.

Successful strategies that address gendered power relations were formulated based on an analysis of the barriers that women face in accessing health services and included:

- **Strengthening women's role and participation in health services** (as service providers or community members): Projects in Tanzania, Uganda, Mali, Burkina Faso, and Nigeria used education to empower women and increase their capacity to decide on their own health.
- **Engaging men as champions** for delivering health messages, as supportive spouses of female community health workers or as active participants in their partners' pregnancy and maternity care.

However, male engagement strategies need to be put into a wider context of traditional gender norms and women's autonomy in order not to reinforce existing gender-based power imbalances by suggesting that women need support from men to make decisions about their health. [11] Several studies have documented that the strategy of male engagement is most successful when women are simultaneously empowered with more knowledge, confidence, and capacity to claim their rights. [8,9,10] The combination of empowering women and encouraging them to discuss their issues with men to find joint

SPOUSAL ACCOMPANIMENT POLICY

One research team documented how the policy that required men to accompany their partner to her first antenatal visit inhibited early attendance as men were reluctant to be tested for HIV or to be perceived as dominated by their partner. When their spouses refused to accompany them, women would either not access services, or they would enlist other men to go with them, defying the purpose of increasing spousal engagement in the pregnancy.

solutions was found to be a successful strategy, adopted by 4 research projects that were considered gender transformative in at least 3 research processes.

How was gender integration supported by the HPROs? Which strategies were successful and why? Which ones were not?

Gender integration in the research processes was encouraged by the HPROs using 3 different strategies:

- **Conducting formative research of the gender situation** in each country. These analyses were conducted at the start of IMCHA and shared with the research teams. While considered informative, they did not present any new information on gender according to researchers interviewed by the evaluation team. The West-African HPRO also convened a meeting to discuss these findings and encouraged participants to propose concrete changes for improving the gender focus of their research. It was, however, unclear to what extent changes were implemented.
- **Training on gender integration**. Both HPROs provided 5-day training workshops on gender which were generally well appreciated by the African researchers consulted by the evaluation team. In addition, two country specific gender training workshops were supported in Uganda and Nigeria. These workshops helped mainstream gender issues in the research. However, of the 15 African researchers who confirmed having participated in such a workshop, only 8 considered that their capacity had strongly improved as a result of the training.
- **Project specific mentoring on gender** was mentioned by several informants as a useful strategy in helping to ensure that gender issues were integrated in the project outputs. This tailored support was not provided to all research teams at the time of the evaluation. The West Africa HPRO, however, planned to support the research teams in conducting gender analyses of their data for publication in peer-reviewed journals as a follow-up to the gender training workshop.

What are the lessons learnt and recommendations around gender integration for complex initiatives such as IMCHA?

To integrate gender in implementation research, the research should aim at examining how gendered power relations influence the implementation of an intervention. Successful strategies were based on an analysis of the barriers to decision making in health, included initiatives that strengthened women's participation and capacity in health and encouraged male engagement for shared decision-making. Less successful strategies focused only on women as main beneficiaries.

⇨ Recommendation 1: At the start of an initiative to fund a programme of implementation research in health, clarify the intended purpose of gender integration in the research. Should the research be gender aware? Or should it address the causes of gender-based health inequalities and transform harmful gender norms, roles and relations?

⇨ Recommendation 2: For the technical review of research proposals submitted to such an initiative, explicit criteria for assessing the gender sensitivity of proposals and implementation plans should be developed and applied.

Training and mentoring of researchers on gender helps clarifying how gender can be integrated in their research projects. However, training alone did not necessarily translate into increased integration of gender dimensions. Project-specific mentoring on gender was more beneficial.

⇨ Recommendation 3: The gender focus of implementation research projects could be strengthened by providing access to individual project-specific mentoring by regional gender experts. Including a gender expert in the HPRO team would make this offer more accessible.

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