

GENDER EVALUATION

Final Report on Phase 2 – Projects Review

of

GOVERNANCE EQUITY and HEALTH PROGRAM

INTERNATIONAL DEVELOPMENT RESEARCH CENTRE



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List of Acronyms

CAF	Corporate Assessment Framework
CIET	<i>Centro de Investigación de Enfermedades Tropicales</i> (Tropical Disease Research Centre)
CS+PF	Corporate Strategy and Program Framework
DPA	Director of Program Area
ENRM	Environment and Natural Resource Management
GE	Gender equity/equality
GEH	Governance, Equity and Health Initiative
GEM	Gender Evaluation Methodology
GHRI	Global Health Research Initiative
ICT	Information and Communication Technologies
ICT4D	Information and Communications Technologies for Development
IDRC	International Development Research Centre
LAC	Latin America and the Caribbean
MDGs	Millennium Development Goals
MGC	Memorandum of Grant Conditions
MINGA	Alternative Approaches for Natural Resource Management in Latin America and the Caribbean
PA	Program Area
PI	Program Initiative
PAD	Project Approval Document
PAN	Pan Asia Networking program initiative
PBR	Peacebuilding and Reconstruction
PCD	Peace, Conflict and Development
PCR	Project Completion Report
rPCR	Rolling Project Completion Report
PM	Program Manager
PO	Program Officer
RFP	Request for Proposal
RHE	Research for Health Equity
RITC	Research for International Tobacco Control
RO	Research Officer
RPE	Rural Poverty and Environment
SEE	Social and Economic Equity
SEP	Social and Economic Policy
SMC	Senior Management Committee
TEC	Trade and Economic Competitiveness
TL	Team Leader
UPE	Urban Poverty and Environment
WHO	World Health Organisation
WRC	Women's Rights and Citizenship program

*Health Systems promote health equity when their design and management specifically consider the circumstances and needs of socially disadvantaged and marginalized populations, including the poor and groups who experience stigma and discrimination, enabling social action by these groups and the civil society organizations supporting them.*¹

Challenging Inequity Through Health Systems - Final Report Knowledge Network on Health Systems, WHO Commission on the Social Determinants of Health, June 2007

*The emphasis on women in the context of gender equity in health is frequently questioned. Why women, it is asked, when they outlive men, visit the health services more frequently, and represent the majority of health sector personnel?*²

Equity, Policy and Health Sector Reform in Latin America and the Caribbean, PAHO

*Sex and gender are major determinants of health in both women and men. They are closely linked with other variables such as age, race and socioeconomic status in shaping biological vulnerability, exposure to health risks, experiences of disease and disability, and access to medical care and public health services. Researchers who ignore these differences run the risk of doing bad science. Failure to incorporate sex and gender in research designs can result in failures of both effectiveness and efficiency.*³

Sex, gender and the 10/90 gap in health research, Global Forum for Health Research

1. INTRODUCTION

This second report represents the findings of the Kartini International team of consultants, during the second phase of the gender evaluation of the Governance, Equity and Health (GEH) programme at the International Development Research Centre (IDRC). GEH originally commissioned the evaluation and the subsequent gender training to take place from February to June, with a recent extension to September 2008.

The first phase of the evaluation assessed institutional commitments to gender equity and processes at IDRC's corporate level, in other IDRC programs and the GEH. As well, the evaluation team conducted interviews with the GEH team to assess their perception of IDRC and GEH's level of commitment to gender equity and equality and its implementation in practice. An integral part of the interview process was to solicit the team's recommendations for projects for review, by the evaluation team, for the second phase of the evaluation, and conduct a gender training needs assessment of program officers, to enable them to build the capacity of their partners in social and gender equity.

The second phase of the evaluation builds on the first phase and examines the level of gender analysis and gender integration in a selected sample of GEH projects, closed and on-going, in all four regions – Global, Asia, Sub-Saharan Africa (SSA) and Latin America and the Caribbean (LAC). The second report outlines the methodology used for the project review: the project selection criteria; the documents reviewed; the criteria used for the gender analysis; and a detailed gender assessment of each sample project

¹ Lucy Gilson et al, Challenging Inequity through Health Systems - Final Report Knowledge Network on Health Systems, WHO Commission on the Social Determinants of Health, Centre for Health Policy at the University of Witwatersrand, South Africa. June 2007

² PAHO, Equity, Poverty and Health Sector Reform in Latin America and the Caribbean, January 2000, <http://www.paho.org/English/HDP/HDW/cepalgenderreform.pdf>

³ Global Forum for Health Research, Sex, gender and the 10/90 gap in health research <http://www.globalforumhealth.org/filesupld/sex%20gender.pdf>

with related recommendations. Some of the projects reviewed will also be used as case studies in the gender training for GEH staff in September 2008.

The third report for the GEH evaluation and training will be produced after the gender training, planned for September 8-9, 2008. It will synthesize and summarize:

1. The findings and recommendations of the first institutional assessment phase of the evaluation, revised with comments from the team;
2. The findings and recommendations of the second phase of the evaluation, the project reviews, as detailed in this report, revised with comments received;
3. Feedback received from the GEH team after the training; and
4. Recommendations for a way forward on gender analysis and integration for the GEH team.

2. SOCIAL AND GENDER DIMENSIONS OF HEALTH SYSTEMS

“The World Health Organizations’ Commission on the Social Determinants of Health identifies health systems as a site for action to promote greater equity in health.”⁴ Health systems not only provide services and influence health, they also reflect social values and culture.

According to a report⁵ produced by the Health Systems Knowledge Network, critical health system features that generate preferential health benefits for socially disadvantaged and marginalized groups, as well as general population gains and may address health inequity:

- Leverage intersectoral action;
- Involve population groups and civil society organizations (particularly those working with socially disadvantaged and marginalized groups);
- Aim at universal coverage and offer particular benefits to socially disadvantaged and marginalized groups;
- Revitalize the comprehensive primary health care approach into other equity-promoting features.

It also outlines actions to address health inequity in health systems:

- Secure political commitment;
- Establish legal provisions and policy frameworks;
- Secure increases in government expenditure on the health sector;
- Reallocate government resources;
- Remove user fees;
- Prioritize primary health care;
- Empower and enable local public sector managers to re-orient towards equity goals;

A social view of health is one that concentrates on improving the health and wellbeing of a population through addressing the social and environmental determinants of ill health concurrently with the biological and medical factors which influence health and wellbeing. It draws on key social factors or social determinants that influence broader patterns of health and illness within any given population. Key social determinants

⁴ Gilson, Final Report on the Health Systems Network, 2007, pg vii

⁵ Gilson, Final Report Knowledge Network on Health Systems, 2007, pg v-vi

include socio-economic status (of which income is an indicator), race, ethnicity, gender and geographic location.

Women and men experience health differently. Biological sex differences are responsible for health issues traditionally regarded as men's health or women's health issues, like reproductive health and sexuality. Gender refers to the different social and cultural roles, expectations, and constraints placed upon men and women by virtue of their sex. When analyzing the different experiences and impacts of health on men and women, differences relating to gender, in addition to biological sex, need to be considered.

Historically, men have been the investigators and participants of health research and the data arising from this work has been extrapolated to represent the experiences of both sexes. Due to biological, genetic, socio-economic and behavioral differences between men and women, this extrapolation has resulted in policies and programs that may be unsuitable or even harmful.

Neither women nor men should be treated as another special interest group. Nevertheless it is indisputable that there are substantial differences in the lives of women and men, even within the same cultural, ethnic, age, and religious groupings.

A gendered policy framework is a tool that enables the development of policies and processes that make up health systems and takes into account and is responsive to gender. It is predicated upon the following:

- All policies have an impact on men and women;
- Policies and programs affect women and men differently;
- Women and men are heterogeneous groups of and within themselves.

3. METHODOLOGY

3.1 Evaluation Team

The initial gender evaluation team from Kartini International comprised of Neena Sachdeva, Clara Jimeno and Dana Peebles. The makeup of the team changed in March 2008 because Clara Jimeno could not continue due to health reasons. The three consultants who worked on this part of the evaluation were:

- Neena Sachdeva - Associate, Kartini International, as the Team Leader, and the Senior Gender and Social Analyst/Evaluation Specialist and co-trainer.
- Dana Peebles - Director, Kartini International, as the Senior Gender and Social Analyst/Strategist, to provide oversight and guidance to the evaluation team, review projects in the Latin America and Caribbean and to serve as the lead trainer.
- Kisanet Tezare - Staff, Kartini International, Gender and Social Analyst, to review projects based in West Africa.

3.2 Project Selection Criteria

The project reviews include a sample of projects from a list of both on-going and closed GEH projects. The evaluation team strategically included completed projects to enable them to assess gender analysis and integration throughout the project cycle. As well, reviewing on-going projects allowed the evaluators to assess initial project documents

and make recommendations on monitoring the projects for gender analysis and integration. No projects were selected from the list of declined projects provided by GEH.

The criteria used for the selection of the projects were

- regional representation;
- recommendations by program officers;
- sector/activity focus; and
- size of grant

Projects were selected from all except one region in which GEH funds research projects. Global, sub-Saharan Africa (SSA), Asia and Latin America and the Caribbean (LAC) were the regions included. Projects in the Middle East and North Africa region were not included because of the limited GEH activity in the region. In keeping with GEH's level of focus and distribution of research funding, a larger number of projects were selected from the SSA region as this forms 70% of the GEH portfolio of projects. Only one project was included from Asia based on the same reasoning.

The majority of the projects selected for review by the evaluation team were those recommended by the program officers, in interviews conducted in February and March 2008, and in subsequent email communication with them. The evaluation team leader made a fairly comprehensive initial selection of projects for review. The advisory and steering team recommended that this list be cut down to keep the review realistic. Some projects were also dropped because the program officers said that they were unsuitable.

The final selection was made on the basis of reviewing two to three projects per project officer, projects recommended by them, projects slated for a further phase and the need to cover a variety of projects funded by GEH. The last criteria included global projects, closed projects (Gouvernance qualities in Benin et, Etude du conseil Guninee), projects in different regions with common research themes (Strategies for Health Insurance in Ghana, South Africa and Tanzania – SHEILD, Health financing, equity and poverty in Latin America), and foundational projects which have the potential for future expansion (Afghanistan-CIET). In some cases, both the RFP and the project were reviewed (HIV Monitor and Launch), and in others, reports from earlier phases were reviewed to assess progress on gender considerations (Global Forum, Politiques Publiques, Equinet, Municipal Services in South Africa).

In addition to the projects listed below, the evaluation team reviewed *The Knowledge Translation Toolkit*, a major publication output for Research Matters for gender analysis and integration.

GEH projects reviewed are listed below.

Global – Appendix A				
1	102037	CZ	Global Forum for Health Research Alliance	NS
2	103297	SM	WHO Social Determinants of Health Systems	NS
Asia				
3	104963	PN	Demonstration CB social health services in Afghanistan	NS

Latin America Caribbean (LAC) - Appendix B				
4a/b	102107	RB	Extending Social Protection in Health in LAC – with PAHO	DP
5	103211	RB	GRADE - Raising Awareness on the Connection between race/ethnicity, discrimination poverty and health inequities in Peru	DP
6	103905	RB/MC	Health financing, equity and poverty in Latin America	NS
West Africa - Appendix C				
7	103085	JM	Gouvernance qualities in Benin et	KT
8	101465	JM	Etude du conseil Guninee	KT
9a/b	103861/ 101160	ED/JM	Politiques Publiques	KT
Sub-Saharan Africa (SSA) - Appendix D				
10	103201	SM	Maternal Death Review in Tanzania and South Africa	NS
11	104298	GR	REACH Policy	NS
12	103457	MC	Strategies for Health Insurance in Ghana, South Africa and Tanzania - SHEILD	NS
13	103148/ 103853	SM	Launching the HIV Monitor and HIV Monitor Project	NS
14	102041/ 103277	JM	Equinet	NS
15	101644	JM	Municipal Services and Health in Southern Africa	NS

GEH Team - ED: Ernest Dabire; GR: Graham Reid; JM: Jean Michel Labatut; MC: Marie-Claude Martin; PN: Pat Naidoo; RB: Roberto Bazzani; SM: Sharmila Mhatre

Kartini Gender Evaluation Team – DP: Dana Peebles; KT: Kizanet Tezare; NS: Neena Sachdeva

3.3 Project Documents Reviewed

As requested in the ToRs and outlined in the methodology, the evaluators examined project documents throughout the project cycle, examining projects *ex post* (looking back at the thinking behind research design and preparation) and *ex ante* (looking forward at the implementation).

The following documents were reviewed for each project as a part of the project cycle: the proposal, emails from GEH team members commenting on the proposal and requests for additional information from research partners, Project Approval Documents (PAD), progress reports submitted by the research partners, occasional papers, brochures and communication material produced, research partner websites and rolling PCRs or PCRs when available.

3.4 Summary Project Review: Descriptive and Analytical Overview

As required by the evaluation ToRs, the evaluators have provided a systematic and detailed descriptive and analytical overview, for each project.

First, each project detailed in the Appendix of this report provides a descriptive overview of the project as outlined in the ToRs. The *Background* provides a short summary of the research project and its partners and the *Documents Reviewed* examines the social and gender analysis, gender inputs and gender integration, at various points of the project cycle. For easier reference, the projects were classified into five regions: Global; Asia; East and Southern Africa; West Africa; and Latin America and the Caribbean.

Second, an analytical overview of the quality of the social and gender analysis in the project documents is presented as per the gender-sensitive design features outlined below.

Projects were assessed for gender-sensitive design features using the following design criteria:

- Goal/Objective and the presence and degree of gender focus
- Social analysis
- Gender analysis based on sex disaggregated data currently available
 - Quantitative
 - Qualitative
- Target policy of research (health, MDGs, HIV, reproductive health)
- Gender strategy articulated, including training, collection of sex disaggregated data
- Constraints/risks to including gender equality/equity identified
- Mitigation measures
- Participation of researcher with gender experience in design
- Gender specialist or gender/health organisation listed as team member on PAD
- Gender parity on research project team
- Participation of Ministry of Health/Women/Social, or civil society organisations
- Reasons why gender is not a factor articulated
- GE analysis effect on research and policy recommendations
- Monitoring for gender inputs

The evaluation highlights various strategies, good practices and challenges in gender analysis and integration, as well as specific gaps. Extensive web-based research by the evaluators informs this analysis.

Third, the evaluation outlines feedback on gender support and gender integration from three project partners on the findings of specific project evaluations: 1) the Maternal Death Review in Tanzania and South Africa (review #10 – project no.103201); 2) the HIV Monitor Project (review # 13 – project no.103853); and 3) the Municipal Services project in South Africa (review # 15 – project no.101644).

Fourth, the evaluation makes recommendations on identifying and meeting the challenges for each project, that could support on-going as well as future projects.

3.5 Categorisation

As per the ToRs, five categories of analysis and criteria to measure the level of gender inequality/inequity in research work are included in the project review. After the first report was submitted, these categories were slightly revised and clarified by the evaluation team, to reflect the findings of the project reviews. The categorisation refers to the project documentation and project cycle at the time of review, in April–June 2008, and therefore, should be weighted accordingly.

IDRC's 2000-2005 Corporate Assessment Framework (CAF) supports gender transformative research projects as an indicator of good performance as follows: *Definition of Good Performance for the Consideration of Gender.*

In order to contribute to the achievement of gender equality in developing countries, IDRC ensures that its funded research projects, including those that do not focus specifically on gender inequality, include gender analysis in project design and appraisal processes so as to avoid gender-blind research that can inadvertently reinforce gender inequality. Further, good performance is evidenced by program funds going to support gender-transformative research that is not only cognizant of gender-specific needs and constraints but also aims to transform existing gender relations in a more egalitarian direction. IDRC also recognizes the importance of gender equality as a goal of the development process by supporting a specific program of research on gender issues.⁶

The evaluation team does not suggest that *all* the projects have the need or ability to be gender transformative, or only those that are, signal good research. However, the GEH team needs to target some projects to be specifically gender transformative, as indicated in IDRC's CAF, with the majority being gender integrated. Gender integration can also take two forms: either gender is integrated into targeted and significant objectives of the project or it is mainstreamed through the research project. The first is easier to monitor than the second. The scope, partner capacity and the budget of the project would define which option is feasible.

The categorisations used include:⁷

Gender-transformative research: Project contributes to a deeper understanding of gender inequality. It has the potential to improve the lives of large numbers of women, and relations between women and men, through significant policy influence nationally, regionally or globally. Gender transformative projects are recommended in the CAF.

Gender-integrated research: Project includes a gender analysis or outlines a process for conducting a gender analysis including an examination of socially constructed relations between different categories of women and men, relations of power, differential access to and control over resources and benefits, etc. within the context of the project's overall research questions. The social and gender analysis should be based on a quantitative and qualitative analysis of sex-disaggregated data, illustrate how this data will be treated in the methodology and included in the strategy for implementing the

⁶ IDRC. 2004. Development of the Corporate Assessment Framework (CAF). Report to IDRC's Board of Governors. Evaluation Unit (March 2004).p. 23.

⁷ Singh, Navsharan. March 1999. Thinking Gender in Development Research: A Review of IDRC Funded Projects 1996-1997 from a Gender Perspective <http://idrinfo.idrc.ca/archive/corpdocs/112826/112826.pdf>

research methodology. Either specific objectives, or other means of monitoring social and gender inputs and outputs, need to be outlined.

Women-specific research: Project focuses on women but does not show evidence of a detailed analysis of gender relations, including power relations, between different categories of women and men. Women are designated as the focus (participants, beneficiaries, target group) of the project.

Women-inclusive research: Women are included as one of the target groups (beneficiaries or participants) in the project.

Women-incidental project: Women are incidental to the project. Women may be mentioned in passing, but there is no analysis of women as a target group. This could also be deemed gender-blind research, where no differences between men and women are mentioned.

3.6 Limitations of the Evaluation

Key documentation was missing for some projects, such as the original project proposal. The original documentation was at times still in the regional offices, not available or on the website of the partner organisations.

A debriefing of the evaluation team's findings and recommendations in regards to individual project reviews could not be shared with team members due to time constraints.

4. PROJECT REVIEW FINDINGS and RECOMMENDATIONS

The evaluation team found that GEH supports a number of very innovative research projects that examine the functioning of health systems at various levels – global, regional and national. The team found varying levels of attention to gender analysis and integration, within the cluster of projects selected for the evaluation, (between GEH projects and within projects which dealt with multiple country research). Of the 15 projects chosen for review 3 are classified as gender-integrated, 4 women-specific, 2 women-incidental, 1 women-inclusive while 5 had mixed classification (women-specific, inclusive and incidental). The last category mostly contains multiple country research projects or those addressing multi-pronged issues.

The project review results complement the findings and recommendations of the institutional assessment carried out in Phase 1 of the gender evaluation and will form the basis for the gender training planned for September 2008.

A brief summary of some of the findings of the project reviews are presented below, in table and narrative form. These will be further refined and synthesized with the findings of the institutional assessment report, and the comments from the GEH team after the gender training workshop.

Summary of Project Review Results

	Project #	Project Name	Region	Stage in Project Cycle	Gender Research Classification
1	102037	Global Forum for Health Research and the Alliance for Health Policy and Systems 2003-2004	Global	Complete Project Cycle	Gender-integrated research
2	103297	WHO Commission on Social Determinants of Health – Health Systems Knowledge Networks	Global	Complete Project Cycle	Gender-integrated research
3	104963	Demonstration community based social audit of health services in two districts of Afghanistan	Asia	Proposal and PAD	Women-inclusive research
4a	102107	Extending Social Protection in Health in LAC: Bridging Research and Practice (Phase II) - Jamaica	Caribbean	Complete Project Cycle	Women-specific research
4b	102107	Extending Social Protection in Health in LAC: Bridging Research and Practice (Phase II) - Argentina	Latin America	Complete Project Cycle	Women-inclusive Research
5	103211	Ethnicity, Poverty and Health Inequalities in Peru	Latin America	Complete Project Cycle	Women-specific research
6	103905	Health Financing, Equity and Poverty in Latin America	Latin America	Proposal and PAD	Women incidental research except in Peru, which is gender-integrated research
7	103085	Étude du conseil-dépistage volontaire du VIH à Conakry (Guinea) Study on voluntary HIV counseling-screening	West Africa	Complete Project Cycle	Women-specific research
8	101465	Gouvernance et qualité des soins au Bénin - Governance and quality of care in Benin	West Africa	Complete Project Cycle	Women-specific research

9a	101160	A. Politiques publiques et lutte contre l'exclusion - Phase III Public Policy and Protection from Exclusion - Phase III Benin, Burkina Faso, Côte d'Ivoire, Mali, Senegal	West Africa	Complete Project Cycle	Women-incidental research ⁸
9b	103861	B. Politiques publiques et lutte contre l'exclusion - Phase III Public Policy and Protection from Exclusion - Phase III Burkina Faso, Ivory Coast, Senegal, Benin, Mali	West Africa	Proposal, PAD and some reports	Women-inclusive and gender-integrated (Côte d'Ivoire) research
10	103201	Strengthening Health Systems Through Maternal Death Review in Kenya and Zimbabwe	Sub-Saharan Africa	Proposal and PAD	Women-specific research
11	104298	REACH – Policy Initiative Phase Consolidating the Regional Hub and Developing Country Nodes	Sub-Saharan Africa	Proposal and PAD	Women-incidental research
12	103457	Launching the HIV Monitor and HIV/AIDS Monitor Country Studies	Sub-Saharan Africa	Proposal and PAD, first report, Websites	Gender-integrated research
13	103148/ 103853	Strategies for Health Insurance in Ghana, South Africa and Tanzania - SHEILD	Sub-Saharan Africa	Proposal, PAD and initial reports	Women Inclusive (Tanzania) Women Incidental (South Africa)
14	102041/ 103277	Equinet	Sub-Saharan Africa	PAD, Report, Publications	Women-incidental research

⁸ Two phases of this project were reviewed: The first phase was categorized as gender incidental. By the second phase, gender analysis and integration had progressed - it was both gender inclusive - and the country study, Côte d'Ivoire was deemed gender integrated. The projects may have reached the stage of gender integrated at the field level but the documents we reviewed did not accurately capture that. A final project report for the second phase was not received. The two reviewed reports included an activity and a progress report. One of them states that although the user-fee system was put in place, there are inconsistencies in how it was administered. This can dilute the equity, fairness and access objectives of the project.

15	101644	Municipal Services and Health in South Africa	Sub-Saharan Africa	Complete Project Cycle, Publications	Women-incidental research, with one component of women-specific research
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Project analysis by category

1. Global Projects

Overall, the global projects such Global Forum, Social Determinants of Health – Knowledge Networks were gender integrated. They included gender objectives, gender in the workplans and the budget which were then monitored. The HIV Monitor project also provides a good gender analysis, gender themes and gender objectives and gender strategies for integration, that could be used as models for other GEH supported research projects.

One result of the Global Forum was a paper entitled Challenging Health Inequity Through Health Systems, which focuses on the social determinants of health inequity, which in turn are central to the GEH programme. The paper is complementary to the one produced by the Network on Women and Gender Equity, which looks specifically at gender inequity and provide useful tools for the gender integration into research on health systems. (See Pg 23 - Appendix A for detailed recommendations.)

GEH's institutional framework now needs to incorporate the lessons learned from these projects and build partner capacity to do the same. For example, the lack of sex-disaggregated data collection is a major challenge to effective gender health policy development.

Recommendations:

- **Consolidate and synthesize** the wealth of relevant social and gender research information and resources available in GEH-funded project files for easy access to gender analysis by the GEH team. Present them as briefing notes, situational analysis, and gender impact assessments. These can be good resources to assist project partners to build their own social and gender analysis capacity. (Refer to short briefing on Gender and HIV/AIDS at the end of this report – before the appendices).

2. Importance of Gender Considerations

The evaluation team found some reference to gender considerations in almost all the projects. The project correspondence following the proposal, and the project approval documents (PADs), illustrate various levels of awareness within the GEH team on the need to address gender considerations. However, while the project documents often outlined gender considerations as important, and indicated that they should be addressed, or that progress on gender integration would be monitored, there were limited gender strategies provided, and it is not clear how this was actually done by the research teams.

This supports the results of the interviews conducted earlier with the GEH team, where POs preferred that the partners own the project research methodology. The general opinion was that the imposition of mandatory requirements usually leads to lip service being paid, rather than an integrated understanding and approach to gender considerations. POs also noted that there was limited time and capacity, in the team, to pursue gender analysis and integration, at any depth, with GEH research partners.

Recommendations:

- **Institutionalise** an explicit equity focus by developing a clear social and gender strategy for the GEH or wider RHE program unit. The gender strategy should signal that gender analysis is a standard work requirement in the GEH program. And it must be supported by tools and guidelines that are simple to follow, both for staff and for partners. It also needs to provide a clear process and timeline for implementation.
- **Increase** GEH human resources and time allocations for building capacity in social and gender analysis.
- **Hire** a gender specialist to support the team for social analysis and provide technical expertise on gender analysis and integration for an initial period of 2 years.
- **Consider** the various mandatory requirements outlined in subsequent sections below.

A gender strategy needs to develop team consensus on various contentious issues such as:

- Should every project include a full social and gender analysis?
- What is a gender transformative project for the GEH team?
- Should there be a separate budget for gender transformative projects or should each cluster have a gender specific project?
- Is a two pronged gender strategy which integrates both women's and men's concerns in all policies and projects, as well as specific activities aimed at not only empowering women/girls but men/boys viable?
- Could the move to multi-disciplinary teams consisting of biomedical scientists, clinician scientists, social scientists, and epidemiologists be considered an approach to equity?
- Would it be useful to ask partners to prepare gender assessment papers examining existing policies and programs from an evidence-based gender perspective?
- Would it be useful for the GEH to have gender assessment briefing papers as reference guides?
- Should gender objectives be mandatory for some or all projects so that monitoring is easier for both, the partners and the POs?
- Is building partner capacity in gender a priority – for old partners or new ones?
- Should resources be included for gender training in project budgets?
- Should partners be asked to identify a gender specialist/advisor or social scientist on the project?
- Are more partnerships with gender and health organisations in all the regions a possibility and of interest to the team?
- What kind of health and gender research results would the team like to see?
- Could projects be categorised to monitor gender progress in gender transformative, gender-focused, women inclusive, women specific and women incidental? Taking the example of the PAN Asia program, the objective would be to improve gender integration in certain projects.
- Should monitoring and evaluation from a social and gender perspective be required of a certain percentage of projects?
- Should knowledge translation work include the collation of topic-based gender impact

3. Gender Relevance

GEH team members interviewed also expressed the opinion that gender was not relevant to some of the research supported by GEH. In the mix of GEH projects reviewed, the evaluation team did not find any projects where gender equality/equity issues were not relevant to the overall analysis. Gender considerations should have formed an integral part of all the projects reviewed by the evaluation team, as illustrated by the evaluators social and gender analysis and recommendations for each project. In more projects than not, gender considerations did not form an integral part of the analysis. This indicates a capacity gap in the understanding and application of gender concepts in the program team.

Recommendation:

- **Require** (potential) project partners to explicitly state and provide reasons in the proposal for why they think gender considerations are irrelevant for any particular project. If the GEH review team agrees with their assessment, then the same should be reflected in the PAD. This requirement is included in the gender guidelines for partners recommended in the first phase of the evaluation.

4. Sex-Disaggregated Data

The evaluation team also found that the commitment to collect or analyse sex-disaggregated data in the research projects is uneven and not conducive to a gender analysis. Where the research team has collected statistics, they have tended to consult a greater number of women. This marginalises the views and inputs of men, in understanding access and control over some aspects of health systems.

Recommendation:

- **Require** mandatory sex-disaggregated data collection and quantitative and qualitative analysis for every project unless gender irrelevance has been established.

5. Gender Parity and Gender Expertise

Gender parity in the research teams was, in some projects, seen by the researchers and GEH team, to address the issue of integrating gender into projects. Although gender parity on the team is important and necessary in terms of fairness, there seems to be an assumption that women are automatically more gender-sensitive than men. Without access to a gender specialist or gender training in concepts and perspectives, this is highly unlikely. Gender expertise on the team is sometimes explicitly illustrated as in the HIV Monitor project. This is one of the rare projects with a dedicated gender theme and a well-known partner organisation that conducts extensive research on gender equality/equity in many fields, including health policy. However, how this expertise will be transferred to the field during implementation of the HIV Monitor research phase requires diligent follow: gender fade is common from proposal/PAD to implementation stage. Surprisingly, some project teams with strong gender or expertise, do not clearly demonstrate it in the project documents, for e.g. the CIET, SHEILD.

Recommendations:

- **Continue** to include and monitor for gender parity in the project proposals submitted.

- **Include** gender expertise on the research teams and explicitly state if this informed proposal development and will continue to do so during implementation of the research.
- **Include** budget resources for gender sensitization and training for the research team to build partner gender and health capacity.

6. Social Analysis

The project reviews main finding reflects a similar finding outlined in the GEH program's external review in 2005: both social and gender equity analysis needs to be improved.⁹ However, improvement was noted in certain projects, from one phase to the next e.g. the Politiques publiques et lutte contre l'exclusion s programme in West Africa moved from a gender incidental to a gender inclusive programme with one project in Côte d'Ivoire, categorised as gender-integrated. In some cases, the gender evaluation team found little reference to, or any analysis of, the research target population, aside from a general socio-economic analysis, which mainly referred or alluded to the (generic) "poor" or "households" or "families". The social analyses usually did not disaggregate this term any further, or provide an "equity" focus to the projects, or outline social barriers to accessing health systems, such as gender, race, ethnicity, language, rural-urban, socio-economic status.

A good practice in a good social and gender analysis of the target population being researched was found in a research project funded through the Municipal Services Project (MSP). The research paper entitled *The Electricity Crisis in Soweto* provided a comprehensive social statistics (see Pg 99-102 – Appendix E), social and gender analysis of the impact of the privatization of electricity on different types of family units.

Recommendation:

- **Include** a mandatory requirement to develop a full social analysis of the target population, from available resources in the proposal requirements.

7. Gender Analysis and the Focus on Women

Of the projects selected by the GEH team, a larger number are women specific or women inclusive. As GEH's research focus it on equity concerns, it is not surprising that women are over-represented; there is a close correlation between women, poverty and poor reproductive health.

The project review also found that the partners have an extremely varied understanding of gender analysis as a concept. Many projects equate it with women and focus on their biological functions such as reproductive health - where sex and gender was equated with biology and culture. Therefore, any project that focuses on women as a target group is thought to be contributing to increased gender equality/equity, even if it does not do anything to address unequal relations or conditions between men and women in that specific context.. It was not recognized that men constituted an important part of reproductive health and therefore also needed to be consulted; or that in studying sex workers, the research needs to also consider children (girls and boys), male and transgendered sex workers, plus their partners. The main conceptual challenge is acknowledging the significant difference of access and control over health services,

⁹ External Review of the Governance Equity and Health Prospectus, 2005, p. 30

between men and women. The only way to gain this more in-depth understanding is through conducting an explicit gender analysis – which most of the projects did not do.

Improvements to women's health and well-being, and the success of treatment outcomes, depend on the consideration and inclusion of the social, cultural, medical and economic factors, which may affect their health. A more exclusive focus on the medical causes of maternal death fails to take important social factors into account. Some of these are: the lack of antenatal care, dietary insufficiencies, various forms of genital mutilation which may predispose women to infection; the impact of gender based violence; distance between habitation and health centers; rude and corrupt health workers; inadequately trained traditional birth attendants; and familial and cultural taboos, e.g., the appropriateness of seeing a male doctor.

This marginalisation of social causes in health research may lead to inadequate policy formulations.

Recommendation:

- **Include** both men and women, and possibly girls and boys in the research population – signifying a gender balance – to obtain scientific evidence on any particular health systems issue e.g. in HIV/AIDS related research themes, sexual and reproductive health, gender based violence. Women specific or gender specific projects must include the views of men. This allows them to participate and gives them an opportunity to become proactive. After all they are an integral part of the reproduction process. Much research has already been undertaken on this issue and GEH should consider reviewing this body of knowledge.

8. Gender Objective and Strategy

Few projects had an explicit gender objective or a gender strategy for addressing gender equality/equity considerations in the programme. The partners outline the research project objectives and therefore GEH has little influence over this area. However, the lack of explicit gender equality/equity objectives has created a dilemma when it comes to monitoring the project for gender inputs and outputs. Since gender objectives are rare, there seems to be little incentive or accountability for the partner research team to collect data, or the GEH team to monitor the project from a gender equality/equity perspective in the PCRs.

Recommendations:

- **Encourage** project partners to support the social and gender analysis with an objective for monitoring social and gender equity/equality in the projects.
- **Develop** a gender strategy within the research methodology on how this objective will be implemented e.g. including a gender and health organisation as a partner, having a gender specialist on the team, ensuring gender parity on the team, providing gender sensitivity training, addressing social/gender differences in questionnaires, focus group discussions, and analysis of statistics from available databases.
- **Include** monitoring for social and gender equity/equality activities in the (rolling) PCRs and in PO monitoring visits.

Summary and overview of Gender Analysis and Integration into the Project Cycle

As mentioned earlier, the evaluation team found that there was varying attention given to social and gender analysis and integration in the approved research projects.

As 12 of the 15 projects reviewed were women specific, inclusive or incidental, there is a strong need to improve the quality of gender considerations to enable more projects to be gender integrated. Two of the three gender integrated projects were global projects, which received some funding from GEH, but as it did not support the gender components of the research, the gender results cannot be attributed to it. We emphasize that it is not necessary for GEH to support the gender components of a program. The important thing is that they are included and possibly supported by some other organisation.

Both projects had a well framed gender objective and a gender strategy. In women-specific projects, men's concerns have been marginalised; in women inclusive research projects, women and men are included as participants, but the social and political power dynamics between men and women have not been addressed in terms of their needs and access to the health system; and in the women incidental project, there is no mention of leveraging government for action on gender-related needs or influencing government to improve gender related policy and practice.

Partners may already have the capacity to integrate gender considerations (Equinet but not do so explicitly) or they may have built their capacity from one phase to the next (Poliques publiques) or they need to build that capacity (Maternal Death Review, Municipal Services Project).

Sometimes, partners confused gender parity with gender expertise or even integration. It was found that the proposal is often reproduced in part or attached to the PAD. In some cases, there has been follow up on gender considerations between the proposal and the PAD. There is some reference to the importance of gender considerations in almost all of the project correspondence between team members or between POs and partners. However, often a social and gender analysis, based on sex-disaggregated data in the proposal, is incomplete and therefore continues to be incomplete in the PAD.

The monitoring framework is built into the PAD and there is little to monitor on gender, which is not included, and partner commitments for a gender analysis not adequately followed up, if it is not in the PAD. Gender considerations are difficult to add on to the research project and need to be included at conceptualisation. When gender considerations are irrelevant (as in 3 above), the proposal needs to provide an explicit rationale for this.

In some cases, the evaluation team found that the gender analysis was adequate in the proposal and PAD and there were gender commitments. However, the reports did not demonstrate that these commitments were followed through and implemented, resulting in gender evaporation or gender fade. This problem of gender evaporation occurs in programs/projects of almost all organizations, often because the authors of the proposals and the implementers in the field are different people. Often not included is a budget for gender training or a gender workshop to train the team to design and manage the research considering the circumstances and needs of the socially disadvantaged and marginalised populations, including poor women and groups who experience stigma

and discrimination. Policies and programs that do not account for gender differences may have a detrimental impact on both men and women. Given the social context of women's lives, women are more likely to experience more significant detrimental consequences as a result of policies that ignore potential gender impacts.

In view of the time constraints plaguing PMs to follow up and monitor partners, it was considered best to strengthen the Guidelines for Project Applications, which outline a methodological approach for project applicants. Project proposals are required to address dynamic interactions – analyses and relevant demographic factors which include:

- policy and political systems analysis;
- gender analysis; other inequalities as relevant - socio-economic, occupational, ethnic, gender and age;
- participatory approaches.

There are no specific guidelines on the modalities partners need to provide. The GEH team felt that this area could be further strengthened by providing grant applicants with guidelines on addressing gender concerns in their overall research topic.

Recommendations:

- **Strengthen** the social and gender considerations in Guidelines for Project Applications for prospective partners/grantees. The social and gender considerations provided by the applicants for research funding need to include:
 - A social and gender integrated analysis describing the specific characteristics of the population being researched (beyond being poor).
 - A tentative gender analysis based on information currently available and the provision of dis-aggregated data (if not available, this should be explicitly stated).
 - A gender strategy for how the gender analysis will be implemented and mainstreamed into the methodology of the research proposed.
 - A possible gender objective for a gender specific component, and related outputs.
 - The allocation of staff to work on mainstreaming gender (gender advisor or organisation on research team).
 - A reference to a targeted policy that is already in place and needs to be re-informed by this research or the potential for new policy.
- **Post** guidelines for a social and gender analysis based on sex dis-aggregated data on the website.
- **Develop** and post gender briefing notes on various themes of particular interest to GEH partners and team members.
- **Strengthen** the PCRs and rPCRs to monitor gender considerations.
- **Include** gender training for partners in project budgets or conduct training.
- **Set up** a fund that can be accessed by researchers interested in pursuing research on the complexities of addressing inequities in sex, gender and health research, by promoting research on men's health using a gender lens; while continuing to redress the gaps in our knowledge regarding women's health.
- **Focus** some of the health research resources to the widespread but rarely addressed issue of gender based violence, an epidemic ignored by researchers, policy makers and programmers.

5. OBSERVATIONS ON GENDER, HEALTH SYSTEMS & GOVERNANCE

Gender Mainstreaming and Democratic Governance

Gender mainstreaming as an institutional and cultural transformation process should include eliminating gender biases in national and international development frameworks and paradigms; incorporating gender awareness into health policies, programmes and institutional reforms; involving men to end gender inequality; and developing gender sensitive tools to monitor progress and ensure accountability.

UNDP

The aim of GEH's focus on supported research is influencing policy. National policy decision makers are not generally known to ask researchers to focus on gender issues. However, as GEH also funds strategic research on issues that may be neglected by policymakers as a means to highlight other perspectives, these additional observations by the evaluation team have been included to provide some insight on how gender affects decision-making or where power lies among men and women, in different groups.

These observations and recommendations have also been developed to complement the

work of the IDRC's Women's Rights and Citizenship Programme through gender sensitive budgeting processes. It is considered a useful resource in this area as their focus is to address citizenship rights. However, it is not their mandate to provide technical assistance to the other IDRC research programs or partners.

5.1. Gender and Health Systems Policy

The evaluation team found that the research partners did not generally target specific health policies to identify ineffectiveness and inefficiencies in health systems. The project team was participant and stakeholder in two of the 15 projects reviewed - Ministry of Health in the Maternal Death Review with UNICEF and REACH. It would make the work of the third project, Equinet, which specifically links with parliamentarians and health ministries easier if it evaluated health politics, but Equinet does not explicitly address gender considerations. Moreover, in REACH, the number of women policy makers in terms of gender parity is low – mostly confined to the donor agencies including IDRC – but not from the various Ministries. Gender analysis and integration would be easier to conduct if the projects targeted specific health policies, with research results intended to provide perspectives which suggest adjustments or reformulations to health policies already in place or alternatively, new policies that need to be devised.

Recommendations:

- **Strengthen** the focus on health policy frameworks.
- **Encourage** partners to target research on inefficiencies and ineffectiveness in the implementation of specific health policies and identify suitable partners.
- **Include**, where possible and especially in regard to women's health research projects, the Ministry of Women Affairs or organisations such as Parliamentarians for Women's Health Project (Social Determinants of Health project) and other influential organisations.
- **Use** available resources for gender perspectives and analysis on health policies to push the gender agenda in health reform, e.g., the Global Forum has supported research on gender and the MDGs that have been adopted for the health policies of most countries. Secondly, various countries have had their health policies analysed through a gender lens, e.g. by the Gender Situational Analysis conducted by the

World Bank, the African Development Bank, PAHO, UN agencies. Using these resources would provide some perspective on gender gaps in a particular health and governance issue in a national context.

5.2. Gender and Economics

GEH research partners have examined important issues affecting health systems in developing countries from a multiple lens, over the years. Although the projects reviewed included some research areas which are relatively well known, such as the ongoing and sometimes deepening challenges associated with reproductive health, there is a more recent group of projects that are cutting edge, such as mutual health insurance schemes. The evaluation team reviewed a number of projects in this area, which bases its analysis on socio-economic groups or those in the informal sector. Although a large number of women studied here are poor and work in the informal sector, the attention to gender equality/equity considerations was varied, with most giving only cursory attention to these issues. Although the SHIELD professed the importance of gender, its reports illustrate an inadequate analysis, with the Tanzanian report addressing gender considerations better than the South African one.

The categories of analysis in these projects focus on the “poor”, “households” and “families”. The data here is from secondary sources such as national demographic and health surveys. These categories are based on the premise of a unitary and monolithic economic unit that assumes a harmonisation and a pooling of resources within these categories, by macroeconomists and researchers. Various studies support the analysis that there may be significant variations in family members’ goals, access to resources and who makes the decisions about resource allocations, within households, and these are based on gender differences and roles. Gender is an important determinant of the distribution of rights, resources, and responsibilities within the household, but gender analysis frameworks recognize that it is not the only factor, and there is a need to also assess the influence of age, birth order, relationship to the household head, and position of the household in society, etc. on the allocation of household resources.

Attempts to estimate poverty levels that overlook inequalities in the household therefore provide a very incomplete picture. In particular, they had little to say about women’s experience of poverty relative to that of men within the same household.

The main focus of the health insurance schemes research is on health systems reform and its impact on the economic policy of various countries. It is widely acknowledged by the World Bank,¹⁰ and others, that mainstream economic analysis is essentially gender blind. (Gender equality/equity as a category of analysis in economics has a long history and began in the 1930s, over the equal pay controversy in Britain.)

A second theme in the projects reviewed was the impact of liberalisation and decentralization on municipal health systems and the health care workers who work in them. The multi faceted Municipal Services Project is an example of such a project. The project conducted at least one major research on the impact of privatization on women and men in waste management in the phase of the project reviewed. In a previous

¹⁰ World Bank, Poverty and Growth Blog, Fridays Academy: Gender and Macroeconomic policy, <http://www.google.ca/search?hl=en&q=gender+economics+and+household+analysis&start=0&sa=N>

phase, a paper on the electricity crisis in Soweto presented a very good social analysis and some gender analysis based on sex disaggregated data.

However, there is little overall gender analysis on the impact on the privatization of municipal services on gender relations in issues that are significant to GEH's focus such as water, HIV, and health care workers. The impact of these policies and off – loading to women – especially female headed households - needs to be better understood and more explicit. For example, women bear the brunt of when water is privatized. Inadequate access to water greatly increases women's burdens as caregivers and household and economic providers, thereby exacerbating gender inequity. Human rights advocates recognize water as a critical component of gender equality and women's empowerment, as well as environmental security and poverty eradication.

Recommendations:

- **Provide** a strategy for acknowledging the many different types of households and assess the intra-household dimensions of poverty adequately in the research methodology.
- **Encourage** partners to avoid using gender neutral terminology as far as possible to encourage gender analysis.
- **Supplement** information gathered from the national databases by using participatory approaches such as focus group discussions to gather the information on intra-household access to resources and decision-making.
- **Include** gender and statistics departments of universities or other research organizations which work in this area, as a partner in the next phase of the research where available or encourage them to partake in new analysis.
- **Build** a gendered economics perspective to bring a better understanding of the governance, equity and health issues. This research would be very useful to those working on gender sensitive budgets in the various regions. One of the main challenges faced by gender sensitive budgeting initiatives is the lack of adequate research as well as sex-disaggregated data to make policy recommendations, including those for health. This case is certainly extensively documented, for example, for South Africa.

5.3. Research Matters

Research Matters (RM) acts as the knowledge translation arm of the GEH with a focus on translating research in an innovative and easy to understand manner, for advocacy to influence government policy. However, RM is guided by its own prospectus and funds independent research with knowledge translation, as well as complements GEH-funded projects with the knowledge translation process.

The evaluation team reviewed a section of the Knowledge Translation Toolkit – A resource Guide for Researchers. Although the toolkit is a gender blind document, it does give examples of women in health care work (midwives and patterns of abuse of patients) and some of the policy issues which need to be addressed by specific governments.

The evaluation team expects the recommendations coming out of the gender strategy to help gender sensitize the work of Research Matters and therefore detailed recommendations are not developed here.

Recommendations:

- **Demonstrate** the disconnect between gendered evidence and policy and practice by working with civil society organizations working in the area of sex, gender and health.
- **Identify** specific topics – as an example bias and discrimination in the health care system and how gender shapes provider-client interaction, and the impact of these interactions in 4 areas: 1) differential patterns of care for men and women for the same health problem; 2) differential patterns of care by male and female health workers; 3) the gendered division of labour; and 4) patterns of abuse of patients.
- **Encourage** partners to consider gender impact assessments which examine existing policies and programs from an evidence-based gender perspective, as a knowledge translation activity.¹¹

6. PROJECT REVIEWS

Detailed project reviews are attached in the appendices. Program officers are encouraged to review them and discuss the findings with their respective partners. The analysis and recommendations provided for closed projects could be utilized for similarly funded issues in future programs.

¹¹ Women's Health Victoria, Gender and Health
http://www.whv.org.au/health_policy/gender.htm#impact

GENDERED IMPACT OF HIV/AIDS

The gender dimensions of the epidemic will have a serious impact on not only the population dynamics in the future but with the economy and the well-being of families and communities as a higher percentage of women are involved in the agricultural sector. Young women, aged between 15 and 24 are bearing the brunt of the new infections in SSA. Rates for women vary between 6.4% (low) and 11.4% (high) and for men in the same age group 3.1% (low) and 5.6% (high).¹² Younger and younger girls are affected¹³. Women and girls are generally additionally burdened with the care of the sick and dying, as well as care of the aged, siblings and orphans. In the name of empowerment and gender equality, community based approaches do inadvertently double the burden of these women and girls with volunteer work, but without adequately improving livelihoods.

Tracing studies of high school and university graduates by Bennell in four countries with severe HIV/AIDS epidemics, Malawi, Tanzania, Uganda and Zimbabwe, illustrate: university graduates have a lower mortality than high-school graduates; and women with university education has the lowest mortality of all.¹⁴ One of the ways in which the virus is spread is when young/poor girls pay for schoolbooks (and other support) through sexual favours to older men. This illustrates that an investment in girl child education could have a substantial impact on reducing the spread of the virus.

The growing population of female professional and elites in Africa is not a new phenomenon once class relations are taken into consideration. There are considerable regional differences in gender relations due to differential property rights. It was argued that there is a shift in power relations in countries, which have a high prevalence of the virus, towards women as male traditional elites die off.¹⁵ This is contentious and requires further study. Many countries including Burkina Faso, Tanzania and Uganda have reserved seats for women in national or local government, for example, Mozambique – 30%, South Africa – 29%. The way in which quotas are applied makes a difference to whether the presence is token, perhaps to meet international commitments, or a legitimate form of representation. However, further study is also required of countries such as Rwanda which has a 50% representation of women in parliament. Women who enter national parliaments tend not to be drawn from the ranks of the poor and there is no guarantee that they will be more responsive to the needs or priorities of poor women. Many that do try to enter politics have suffered from gender based violence. They do, however, provide possible powerful allies for innovative policies and programmes to curb the spread of the pandemic.

Intergenerational sex and an inability to negotiate sex by both married and unmarried women/girls is the most significant factor for the spread of the HIV/AIDs. South Africa has the highest per capital of reported rapes in the world. The high rate of HIV infection among women and girls has to do with the fundamental issues of power and how society condones the behaviour of how to exercise it. Among other interventions, there is an urgent need for devices where women can control their exposure to the virus such as microbicides.

Excerpt of a Report produced by Neena Sachdeva on the Seminar on HIV/AIDS as a Societal Systems Challenge, Joint Seminar, Policy Branch CIDA and the Global Equity Institute, Harvard University

¹² Contrary to an optimistic suggestion that women will become more valued in African society due to their scarcity, gender based violence is increasing and men are seeking younger women as wives and sexual partners. There is a large discrepancy in male-female ratios in India and China, due to sex selection and a preference for males, which has not led to an increase in the status of women in society nor are they valued more. Gender based violence has increased with more cases of reported rape. Education levels are the pivotal force for increased status.

¹³ Many rapes go unreported as law enforcement agencies treat perpetrators with impunity. A bizarre belief among many African men that sex with a virgin – even a child or a baby – can cure AIDs is fuelling what is already the highest child exploitation rates in the world. Over 15% of all rapes are against children under 11; 26% against children 12-17.

¹⁴ Josef Decosas, Comments on the Draft Concept Paper – Al Samarrai and Bennell (2003) page 30

¹⁵ A role reversal of kinds is taking place, for example, the new Vice President of Zimbabwe is a woman. This is not necessarily a major advance as the first woman Vice President in Africa was a Ugandan who was forced to resign after the public outcry against her for leaving her husband who beat her regularly for many years.

GLOBAL PROJECTS FUNDED

1. 102037 - Global Forum for Health Research and the Alliance for Health Policy and Systems 2003-2004

Partner: Global Forum for Health Research

Grant: \$ 300,000

Duration: 21 months

Approved: 2005/06/26

Phase: 4

Classification: Gender transformative research

Background

The central objective of the Global Forum for Health Research (GFHR) is to help correct the 10/90 gap in health research where 10% of health research funding worldwide is allocated to 90% of the world's health problems. The aim is to focus research efforts on the health problems of the poor by bringing key actors together and creating a movement for analysis and debate on health research priorities, the allocation of resources, public-private partnerships and access of all people to the outcomes of health research. A major output of the Forum is a bi-annual publication entitled "The 10/90 Report on Health Research".

The Alliance for Health Policy and Systems Research (Alliance HPSR) is an initiative to develop networks/partnerships in the priority areas of health research. The Alliance aims to promote the generation, dissemination and use of knowledge for enhancing health system performance. The Alliance was supported by GEH Funding.

Two phases of the project's reporting were reviewed.

Document Review

Proposal: The proposal was received as a letter requesting support from four Canadian partners (IDRC, CIDA, Health Canada, Canadian Institute for Health Research). The evaluator reviewed the letter as well as accompanying Workplans and Budgets of the Global Forum and Alliance including Strategic Orientations 2003-2005 for the Global Forum; Strategic Framework 2003-2005 for the Alliance, and the findings of an external evaluation (December 2001).

In all of the documents reviewed, gender forms a central focus for the GFHR to help correct the 10/90 gap. An evaluation conducted of the GFHR in 2001¹⁶ ostensibly represents the start of more serious attention on gender and health issues. The ToRs for the 2001 evaluation specifically included attention to gender and poverty and equity issues. The evaluation identified an important gap in the analytical work of the GFHR - the neglect of the linkages between gender, health and poverty in analysing the 10/90 gap. An interesting finding of the 2001 evaluation team's survey of GFHR partners was that 60% felt that sufficient attention was paid to cross cutting issues such as gender,

¹⁶ Binka, F., Holgren, J., & Murthy, N., Evaluation of the Global Forum for Health Research, December 2001

poverty and capacity strengthening, while the evaluation team assessed this attention as insufficient. It is relevant to GEH that respondents from developed countries gave lower scores on all three issues, than those from developing countries. This is evident from the statistics below:

	Developing	Developed
Gender		
Score 7+	49 (of out 85) 58%	12 (out of 39) 31%
Poverty & Equity		
Score 7+	62 (out of 94) 66%	21 (out of 38) 55%

In the Strategic Orientation, the GFHR believes in a systematic approach to gender issues in all of its activities, with an overall principle of mainstreaming both gender and sex as key variables in all strategies of the Global Forum. It stipulates that 60% of the world's poor are women: the health of these women is often adversely affected, not only by their poverty, but also by the gender inequalities that continue to divide many of the world's poorest countries. The two main arguments for highlighting gender issues are: *efficiency and effectiveness* which require *both* men and women at the heart of development; and *equity*, requiring both women and men to have equal opportunities to participate in their development and have equal access to its benefits.

The 10/90 Report by the Global Forum refers to some gender research issues undertaken in the year 2001-2002:

- Evaluating quality gender sensitive health services: the results, methodology and tools of an Asian study undertaken by the Asian-Pacific Resource and Research centre for Women (ARROW).¹⁷
- Moving sexual violence forward by Rachel Jewkes, Director of the Gender and Health Group, Medical Research Council, South Africa.¹⁸
- Accelerating microbicide development.¹⁹

The report acknowledges that although the relevance of sex and gender issues to health has become increasingly clear, new strategies on how these variables will be mainstreamed into research activities are less clear. This work is confined to the higher income countries but if the 10/90 gap is to be solved, they will need to be included in the reshaping of priorities and practices around the world.²⁰

The GFHR's Workplan and Budget identifies some objectives specific to both poverty and gender:

- Give special consideration to the health problems of the poor; and
- Ensure that gender analysis is consistently and systematically applied to all of its work on the 10/90 gap.

These objectives will be implemented through the following strategies:

¹⁷ Global Forum for Health Research, Report 2001-2002, p. 221

¹⁸ Global Forum for Health Research, Report 2001-2002, p. 216

¹⁹ Global Forum for Health Research, Report 2001-2002, p. 217

²⁰ Global Forum for Health Research, Report 2001-2002, p. 21

- Include gender issues as a major dimension of the application of the “combined approach matrix” for priority setting proposed for the Global Forum;
- Incorporate gender sensitivity in research design in all the funding criteria for all projects supported by the Global Forum;
- Disseminate guidelines for gender-sensitive work to health researchers; and
- Analyse systematically the interaction of poverty, gender and development through the studies related to poverty and health;

In contrast, gender is integrated into the Alliance HPSR simply as one value in a grouping committed to: sensitivity to gender, languages, diversity of disciplines, differential needs, and policies of related sectors and their implications for its mode of work.

PAD: Under social and gender considerations, the GFHR has identified gender as a particular area of emphasis across all of its core and special activities. It underscores GFHR’s strategic orientations to a systematic approach to gender issues and is central to reducing the 10/90 gap with the overall principle that both sex and gender are mainstreamed as key variables in all strategies of the Global Forum.

Reports: The 10/90 Report for 2003/2004 includes a separate chapter devoted to the analysis of gender gaps in each MDG, relevant for policy work. This report outlines why researchers need to be sex and gender sensitive:

Sex and gender are major determinants of health in both women and men. They are closely linked with other variables such as age, race and socioeconomic status in shaping biological vulnerability, exposure to health risks, experiences of disease and disability, and access to medical care and public health services. Researchers who ignore these differences run the risk of doing bad science. Failure to incorporate sex and gender in research designs can result in failures of both effectiveness and efficiency.²¹

PCR – Final Review – end of project: Dated 2006/08/11

The Global Forum has played a significant role in mobilizing and sustaining attention re the 10/90 gap, and the importance of global health research, especially in recent years, in terms of work with northern granting councils. Meanwhile, the Alliance has been an important flag-bearer – essentially the only global network consistently highlighting the importance of health policy/systems research and supporting it.

The project offers multi-phase support to researchers; therefore, the overall objective would be fully realized over a few phases of support.

Social and Gender Analysis

The GEH’s main focus was support to the Global Alliance and the 10/90 report addressed global issues through the GFHR. Since the evaluation of the programme in 2001, the GFHR has made a concerted effort to support researchers on both sex and gender issues, through institutional mechanisms such as the strategic orientation, objectives of workplan and its budget, with outputs reflected in the 10/90 Reports by the Global Forum. A plethora of well-researched papers are available on gender

²¹ Global Forum for Health Research, Report 2003-2004, Chapter 6, Gender, the MDGs and Health Research http://www.globalforumhealth.org/filesupld/1090_report_03_04/109004_chap_6.pdf

considerations on various health themes on its website, some with sex disaggregated data. The GFHR acknowledges that gender gaps in health systems in developing countries continue to need considerable more attention and research.

An important learning from the GFHR material is the marked difference in the perception of adequate attention to gender sensitivity and integration, in research projects, between partners in developing and developed countries.

Recommendations:

1. Use GFHR resources as an information base on gender and health issues for the development of concept papers and new research partnerships, especially related to gender and health.
2. Compile a list of gender and health research organisations from GFHR's vast collection of researchers who could provide partnership or network gender support for specific research initiatives through the GEH.
3. Consider setting a specific social and gender objective (equity) for its next prospectus, and encourage partners to do the same. The GFHR needs to identify research on poverty and gender as a specific part of its objective and develop a gender strategy to implement the objective, and gender mainstream it into its workplan and budget.
4. Adapt relevant sections of the BIAS FREE framework into gender guidelines for PMs and recommended it to partners as a resource for social analysis.

BIAS FREE Framework

A seminal study supported by the GFHR is the BIAS FREE Framework which stands for *Building an Integrative Analytical System For Recognizing and Eliminating InEquities*. This tool identifies and provides a methodology for avoiding biases in health research that derive from any social hierarchy. These biases could have been derived from gender, race and ability and is based on a rights based understanding of health. The framework identifies three major forms of biases – maintaining hierarchy, failing to recognize differences and using double standards – and employs a set of 20 analytical questions to alert users to their presence in research. It also points the way to preventive or counterbalancing solutions.

The framework addresses a common problem noted by the evaluation team among development practioners in the developing world which include: a perceived dysfunctional relationship between rights based approaches and commitments to gender equality. The concept of gender equality is perceived to privilege women whereas, we know that not all women may be equally disadvantaged; it also includes one or more significant issues of social exclusion such as ethnicity, caste, age, ability, sexual orientation, rural-urban divide. While the BIAS FREE Framework addresses three dimensions and has added ability to gender and race, development practioners have pointed out other intersections and perceived between frameworks such as child rights and gender equality/equity.

Workshops on the framework have been conducted in a number of countries, including Canada, Costa Rica, Germany, India, Mexico, Senegal, Switzerland and Tanzania, and at the United Nations.

The BIAS FREE framework is another name for a social and gender analysis as it takes into account three forms of social discrimination. Although race and ethnicity are significant social determinants of health, the framework's main weakness is that it is built on a western feminist model that fails to recognise that gender is a constant variable in developing country context. In many societies, women with a high education and socio-economic status continue to face many of the same discriminatory practices and disadvantage as poor illiterate women such as the inability to negotiate sex and condom use, domestic and sexual violence, forced marriage, boy child preference, as well as traditional and cultural practices. Once sensitised and analysed, these discriminatory practices are not always easier to address with men and women in a higher socio-economic groups than those who are poor.

The framework uses complex academic jargon (decontextualisation, stereotypes, hierarchy, dominant groups) and would take considerable time and effort to decipher, translate and internalise into non social science based research teams. There is an increasing awareness that plain and simple language which translates more easily into other (than English) cultural contexts and other languages is more useful for policy makers and programme implementers.

2. 103297 – WHO Commission on Social Determinants of Health – Health Systems Knowledge Networks

Partners: Centre for Health Policy at the University of Witwatersrand (South Africa), EQUINET (Zimbabwe and other SADC countries) and the Health Policy Unit, London School of Hygiene and Tropical Medicine (UK)

Grant: \$ 349,400

Duration: 18 months

Approved: 2005/08/29

Classification: Gender-focused research

Background

Health inequities within and between countries, and the quality of health systems, both account for most of the global burden of death and disease. These health inequities are derived from poverty and its many manifestations - inequality, social exclusion and discrimination, housing, early childhood development, employment conditions. They are socially determined and can be addressed by making available better societal choices.

In response to calls for research, advocacy and policy actions on the social factors which influence health, the WHO created a Commission on the Social Determinants of Health (CSDH). The Health Systems Knowledge Network (KN) is one of the networks of the WHO Commission and this in turn is comprised of eight knowledge networks including two funded by Health Canada and the Public Health Agency of Canada. To reduce overheads, the GEH offered direct support to the “Health Systems Knowledge Network” through a consortium of partners based in the south (not through WHO) which would feed into the work of the Commission.

Document Review

Proposal: Gender is an important social determinant of health, hence a women and gender equity knowledge network (WGKN) was created.

PAD: In relation to GEH objectives, the Commission and the KN emphasized the importance of research on gender and social inequities. Although gender is explicitly mentioned as one variable in the methodological framework for the social determinants of health, it was not possible to comment on the methodology, as new studies will be built on research that has already been done. The team will seek detailed information on the commissioned studies in the reports.

All 3 consortium partners are led by women. Gender parity is not maintained on the team as all three consortia members were women.

Reports: Address health issues by strengthening stewardship and management within the health system and building trustworthy health systems.

The first technical report outlines the KN's process for addressing gender in its work:

- A gender expert (who is approved by the Women and Gender KN) sits on the KN and is charged with mainstreaming gender through all of KN's work;
- A gender balance is reflected in the composition of the KN;

- A need to reflect gender considerations in the terms of reference of commissioned papers;
- Considerations of gender issues will be incorporated into the terms of reference for the review process of individual pieces of work and the KN's overall report;
- A joint paper on gender-related issues will be commissioned with the Women and Gender KN.

As promised in the first technical report, gender issues and concerns were mainstreamed into the commissioned literature review by the HSKN on the WHO website²². A report entitled "*Building equitable, people-centred national health systems: the role of parliament and parliamentary committees on health in East and Southern Africa*" presents evidence from published literature on parliament's work, its role in relation to policy, law and financing of government action on health, how parliaments can influence policy and law.²³

Musuka and Chingombe conducted a comparative study of parliamentary processes in various countries and highlight issues of gender and inequity in health. They promote the role of parliamentarians as "watchdogs" to ensure that gender issues that create health inequity are addressed and highlight certain good practices such as:

An example of the process that seeks to enhance the role of parliamentarians in addressing the gendered nature of HIV and AIDS is the Parliamentarians for Women's Health Project. This is a group of parliamentarians working to improve women and girls' access to health care and services, including HIV and AIDS prevention, care and treatment, within a three year initiative from 2005 to 2007. This group is composed of parliamentarians from Botswana, Kenya, Namibia and Tanzania. Partners in the project include the International Center for Research on Women (ICRW), European Parliamentarians for Africa (AWEPA), the Center for the Study of AIDS (CSA) of the University of Pretoria, International Community of Women Living With HIV/AIDS (ICW), and Realizing Rights: the Ethical Globalization Initiative (EGI). The project focuses on women and girls mainly because in many parts of Africa, the needs of women and girls are woefully underserved, particularly HIV and AIDS prevention, care, support and mitigation. Parliamentarians are best placed to promote gender sensitive policies and significantly address gender constraints by developing supportive actions in their constituencies.²⁴

This report provides a list of organizations that work with parliamentarians on health related issues including GEH supported EQUINET. It also provides an analysis of the health budgets and budgetary processes in the four countries, setting a foundation for conducting further research such as health allocations in a gender sensitive budgeting process.

Social and Gender Analysis

The evaluator identified a good gender integration strategy in this project – a gender expert and a gender balance on the team; gender considerations in commissioned papers; consideration to gender issues in the terms of reference in the review process

²² WHO, Health Systems Knowledge Network,

http://www.who.int/social_determinants/knowledge_networks/systems/en/index.html

²³ Musuku, Godfrey & Chingombe, Innocent, Building equitable, people-centred national health systems: the role of parliament and parliamentary committees on health in East and Southern Africa, A literature review commissioned by the WHO Commission's Health Knowledge Network (Undated)

http://www.who.int/social_determinants/resources/health_systems_musuka_paper.pdf

²⁴ Sekgoma B, Afuba MD, Eba PM, SADC PF Handbook on Gender, Human rights and HIV and AIDS, 2006

and a joint paper with the Gender KN. The last point was not implemented and a decision was made for papers to complement each other. The study on parliamentary processes provided some practical suggestions for the engagement of a network of policy makers, based on case studies of various countries, who would be interested in addressing gender inequities in health..

The main output supported by the GEH was the commissioned study “*Challenging Inequity Through Health Systems – Final Report Knowledge Network on Health Systems*” produced in June 2007. Although the consortium initially demonstrates a high level of commitment and understanding of the importance of gender issues in health systems research, this is somewhat diluted when it decided not to comprehensively mainstream social exclusion and gender into the report.

The study stipulates that the messages on important health system features are complementary to, and do not repeat those in the reports of the Women and Gender Equity network. This points to continuing the practice of treating social and gender analysis as separate, or an addendum to the analysis required for improving health systems. However, the authors of the report have generated a useful body of knowledge, which could provide a very useful resource base for GEH PMs.

*Health Systems promote health equity when their design and management specifically consider the circumstances and needs of socially disadvantaged and marginalized populations, including the poor and groups who experience stigma and discrimination, enabling social action by these groups and the civil society organizations supporting them.*²⁵

The report outlines the following critical health system features that generate preferential health benefits for socially disadvantaged and marginalized groups, (as well as general population gains and may address health inequity):

- Leverage intersectoral action;
- Involve population groups and civil society organizations (particularly those working with socially disadvantaged and marginalized groups);
- Aim at universal coverage and offer particular benefits to socially disadvantaged and marginalized groups;
- Revitalize the comprehensive primary health care approach into other equity-promoting features.

It also outlines actions to address health inequity in health systems:

- Secure political commitment;
- Establish legal provisions and policy frameworks;
- Secure increases in government expenditure for the health sector;
- Reallocate government resources;
- Remove user fees;
- Prioritize primary health care;
- Empower and enable local public sector managers to re-orient towards equity goals;

²⁵ Lucy Gilson et al, Challenging Inequity Through Health Systems - Final Report Knowledge Network on Health Systems, WHO Commission on the Social Determinants of Health, Centre for Health Policy at the University of Witwatersrand, South Africa. June 2007

- Build coalitions of support; establish policy goals, and demonstrate by personal example, the values of integrity and transparency as a means of creating the political leadership necessary, both inside and outside government.

A second paper, *Human Resources for Health: A Gender Analysis*, provides an impressive comparative analysis of the gender dynamics within and across health occupations in different countries.²⁶ Through an extensive literature review, the researcher examines gendered experiences in medicine, nursing, community health and home care; issues such as migration, as well as general violence in the health sector.

Some of the limitations outlined by the review by Asha George provide important insights for the GEH team and incentives for further study, namely:

1. The gender aspects of human resources in health presented in the articles reviewed were descriptive, with little documentation of interventions, programmes or policies aimed at addressing the issues that arose;
2. OECD countries produce most of the articles on gender and human resources and other health research communities with links to English language dominated areas e.g., Thailand, South Africa and India.
3. The methodological limitations included a lack of sex-disaggregated data; instead data is presented by health worker category which did not necessarily reflect gender realities.

A third report reviewed for this gender evaluation, but not funded by the GEH, is the Women and Gender Equity Knowledge Network's seminal study on gender issues in health systems: *Unequal, Unfair, Ineffective and Inefficient: Gender Inequity in Health: Why it exists and how we can change it*.²⁷ A separate section is devoted to health research and outlines how gender biases in research sustain a vicious cycle that serves to downgrade gender issues in health and perpetuate their neglect. It includes a "how to" list with prerequisites for conducting gendered health research, which is particularly pertinent to GEH:

- Collection of sex-disaggregated data which takes diversity into account;
- Recognition of women's health problems and gender equity concerns through effective research methodologies;
- Gender sensitized data managers and systems;
- The inclusion of women in clinical trials and other health studies in appropriate numbers and a gendered analysis of the data generated from such research ;
- Research funding bodies should promote research that broadens the scope of health research and links biomedical and social dimensions, including gender considerations. An example of a good practice is the Swedish Research Council which coordinates efforts of all research councils with regard to equality, gender research and interdisciplinary approaches.

²⁶ George, Asha, *Human Resources for Health: A Gender Analysis*, Review Paper prepared for the Women and Gender Equity, and Health Systems, Knowledge Networks (KNs) of the WHO Commission on the Social Determinants of Health, Review 2007, p.11

²⁷ Sen, G, Ostlin, P., & George A., "Unequal, Unfair, Ineffective and Inefficient - Gender Inequity in Health: Why it exists and how we can change it" . Women and Gender Equity Knowledge Network, Report to the WHO Commission on Social Determinants of Health, 2007, p.79
http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf

- Ethical and other review boards should include gender experts (not just for gender parity purposes), to ensure that gender dimensions of research projects are not missed.
- Medical and related journals should request that papers present data disaggregated by sex and explain observed differences adequately in terms of either biology (sex) or gender (social factors), or both.

Recommendations:

1. Draw upon this project's good practice – its strategy for gender mainstreaming and integration – to develop GEH's own gender strategy.
2. Synthesize the two reports, one funded by GEH on Knowledge Network on Health Systems and the report produced by the Gender Equity Knowledge Network (both for the WHO Commission) to generate a briefing paper on how gender equity can be better integrated to support research projects on health systems, through the GEH, to assist the team.
3. Encourage future research partners to investigate and seek network opportunities for policy making which involve Women Parliamentarian Caucuses, and other related networks, where they exist.
4. Use the section on health research in *Unequal, Unfair, Ineffective and Inefficient: Gender Inequity in Health: Why it exists and how we can change*, as a gender guide. *The* study is a very good resource and needs to be in the arsenal of reference material available for the GEH team, although the “how to” needs to be better defined.
5. Consider funding a study examining interventions, programmes and policies for addressing gendered issues in the human resources sector in Canada. This would allow POs to assist researchers in developing countries to make recommendations that are specifically guided by a Canadian policy where accountability standards are already in place. More research of gendered issues in health should be supported in developing countries and the provision of sex-disaggregated data should become mandatory.

PROJECTS FUNDED IN ASIA

3. 104963 – Demonstration community based social audit of health services in two districts of Afghanistan

Partner: CIET

Grant: \$ 150,000

Duration: 9 months

Approved: 2007/12/18

Classification: Women-inclusive research

Background

CIET Canada is based at the University of Ottawa and has an office in Pakistan which will lead a social audit to demonstrate health service performance in 2 districts in Afghanistan. The project complements, at the district level, the efforts of the University of Manitoba team which is working with the Ministry of Health at the national level. The aim is to improve health delivery for all citizens, especially the most vulnerable and offers an opportunity for IDRC to facilitate a more holistic building of a public health capacity that is both bottom-up and central level-down.

Document Review

Proposal: The social audit will include a baseline household survey, linked to informant interviews, institutional reviews and gender stratified focus group discussions in a limited number of sites in each district. The aim is to illustrate epidemiological analysis linking service delivery (government, private, traditional) with household experiences and other possible linkages.

The main focus of the methodology is focus group discussions by sex enabling the participation and stratification of responses. The focus group discussions field process starts with the recruitment of Afghan researchers. There is no reference to gender input or gender mix or a strategy to recruit female researchers. Under socio-economic and gender perspectives, user fees is deemed as one reason for the lack of access to basic services for lower income households. Household interviews are expected to gather information on differences in the sex of respondents to the lived experiences of women. However, there is uncertainty on the implementation of this strategy.

The voice of women is to be:

1. represented through indicators of users and non-users of health services;
2. participation in focus groups;
3. dialogue on solutions; and
4. communication strategies.

The communication strategies on evidence collected and analysed include the airing of a docudrama to be aired via TV networks.

PAD: The GEH has placed a specific emphasis on CIET's commitment and vast experience in gender based analyses, including previous work in Afghanistan under Taliban rule in 1997. The research at this time included several focus groups of women. The systematic discrimination against women, their restricted access to the already poor health system and socio-economic causes of women's disempowerment are mentioned. There is a reference to commonly known health indicators such as Afghanistan's very high infant and maternal mortality rates but no explanation of the main known sources for these rates e.g. social reasons such as early and forced marriage, domestic and sexual violence, low nutritional status, drug use.

Reports: There are, as yet, no reports due for this project.

Social and Gender Analysis

Sex-Disaggregated Data

The sole gender consideration in this project is that women will be included in the baseline social audit through focal group discussions stratified by sex. Based on this, it is assumed that sex disaggregated statistics, as well as health baseline data which is gendered will be presented in the report to GEH. This needs to be an explicit requirement, as well as the data needs to be analysed.

Research Methodology

Due to its previous experience, CIET has acknowledged they might encounter some difficulties in integrating women into their baseline study in the two districts. However, they have not mentioned how women will be included in other aspects of the project such as feedback to service providers and elected officials, as well as media training. Although the documents mention CIET involvement in other projects which address gender issues such as a large survey of gender based violence in Pakistan, its experience is not explicitly demonstrated in the proposal.

The location of the districts where the social audit will take place is unclear, e.g.:

- Are they in Nangrahar, Kunnar and Kabul?
- Are these poppy cultivating areas and is there drug use amongst the population for example?
- What is the socio-economic foundation of this area?
- It is clear that these districts are Balouch speaking – but are they Pashtun?

A social analysis accompanying the methodology would have been useful including the expected outreach to various groups e.g. the nomadic *kutchis* or repatriated refugees and their health concerns and access to the health system. The location has a significant impact on the research team's accessibility factor - to initiate focus groups and interview women in the households surveys, as well as disseminate the information to and with the participation of BOTH men and women.

To counteract the possible resistance to women's involvement and participation in the baseline study, a gender and governance analysis as well as strategies to address challenges needed to be formulated beforehand e.g. how would women headed households be reached, how would researchers address the important question of widespread gender based violence which has significant impact on women's health?

Gaps identified in the methodology include important questions such as: obtaining permission from the village elders (*shuras*) to interview men but especially women; a

strategy to involve elected women officials at the district level for input; seeking out the community development councils (CDCs) and their plans to improve health care if any; and involving women in the media to participate. Other gaps include a lack of attention to training women researchers as they alone would have access to women participants; and instituting strategies such as *meherams* (male relative) to accompany women researchers if they were to come from Nangarhar University which has implications for the project's budget. The methodology emphasises the importance of data collection through focus groups but many women will not talk in a group setting and would need to be interviewed individually.

As Pakistanis, the evaluator considers the CIET team to have the added disadvantage in gender analysis as they would be expected to understand the cultural restrictions on access to women better than other foreigners, and result in marginalising women's inputs once again.

Recommendations:

1. Develop an interim social and gender analysis as a part of the methodology based on available resource material, e.g., health surveys of most districts in Afghanistan have already been carried out, funded by USAID through capacity building of the Ministry of Health by the John Hopkins, as well as the WHO.
2. Link research with policies already in place such as the Afghanistan National Health Strategy 2005-2006 and identify gaps addressed by the research.
3. Demonstrate experience with gender sensitive research methodology and identify strategies to implement it, e.g., outline the gender mix of the team and identify all risks/difficulties (especially security risks in the Afghan context) which may be encountered to deter paying adequate attention to gender considerations.
4. Monitor to ensure that sex-disaggregated data is provided of the target population by CIET, and includes ethnicity, age, ability, socio-economic status, domestic and sexual violence and rural-urban differences in access to health services. A qualitative analysis should also include: accompaniment of women to health facilities; the challenges of staying overnight in health facilities; the quality of health services available to various ethnic groups; access to female health service providers; and how and if men and women of different backgrounds are treated.

PROJECTS FUNDED IN LATIN AMERICA & CARIBBEAN (LAC)

4a. 1002107 – Extending Social Protection in Health in LAC: Bridging Research and Practice (Phase II) - Jamaica

Partner: University of the West Indies, Jamaica

Grant: \$ 142,540

Duration: 24 months

Approved: 2004/09/08

Classification: Women-specific research

Background

The overall aims of the project are to:

- Analyse the impact of user fees for preventive care services on the health, health-seeking behaviour and coping strategies of patients and to develop alternative revenue generating options for consideration by policy makers
- Develop workable mechanisms to bridge the activities of researchers and policymakers in health

The data analysis was set up to provide evidence to inform policies on user fees and demonstrate the extent of unmet community needs.

The research used a multi-layered approach involving both quantitative (community-based cohort study), and qualitative (focus group discussions, elite interviews and mystery clients) methods. The cohort study was community-based and based on the questionnaires designed to identify health seeking and coping behaviour. Households in three geographical areas were selected and included the following groups:

1. All persons between the ages of 15 and 44 were selected for inclusion in the family planning component of the study
2. Women with children between the ages of 0 and 4 were recruited for the immunization component
3. Pregnant women who were due their second ante-natal visit
4. Those diagnosed with hypertension and diabetes.

The three areas were selected to represent the most urban, most rural and towns classified as Other Main Towns by Jamaica's Statistical Office.

Additional input was provided by a Project Advisory Committee whose members included policy makers, academics and front line health workers.

Document Review

Proposal: The methodology included a social audit that was to cover a baseline household survey, linked to informant interviews, institutional reviews and gender-stratified focus group discussions in a limited number of sites in each district. The focus group discussions field process was to start with the recruitment of researchers, but there is no reference to gender mix or related component of their recruitment strategy.

The research team was to use household interviews to gather information on differences in the sex of respondents based on the lived experiences of women. The voice of women is to be:

- 1) represented through indicators of users and non-users of health services;
- 2) participation in focus groups;
- 3) dialogue on solutions; and
- 4) communication strategies.

The proposal notes that the aggregative nature of the health behaviour data available does not permit an analysis of whether particular groups such as the poor are utilizing less care as a result of user fees. This is also challenge with regard to the existence of relevant sex-disaggregated data. The proposal also indicates that the project will restrict the family planning focus discussion groups to females due to financial constraints. In the Caribbean there are strongly differentiated patterns of sexual behaviour and moreso between women and men. Consequently, it is possible that the sex bias in this part of the study may skew the related results.

The proposal also observes that policymakers and health managers sought to minimize likely negative effects of users fees especially for vulnerable groups through various measures, but that many people are unclear about their eligibility for exemption and are called upon to pay when they should not. As a result, this level of uncertainty has become another key factor among the mix of social, economic and cultural determinants of health seeking behaviour. However, while the research methodology asks if respondents are male or female, with the exception of noting whether a household is headed by a woman, gender equality/equity issues have not been included as a variable in the overall methodological approach. The section on socio-economic and gender perspectives deems user fees as one reason for the lack of access to basic services for lower income households. However, the only real reference to gender analysis in the proposal is an observation that since female-headed households are poorer than male-headed households, they may wind up going to the heath centers more often and therefore end up paying more.

PAD: The PAD notes that the project's expected results are to promote specific strategies to increase equitable access to health services mechanisms oriented to highly vulnerable and undeserved populations, but although in the Jamaican component of the project, women comprised approximately 75% of the respondents, the PAD did not identify gender inequality as a factor that contributes significantly to the vulnerability of the different target groups identified as categories of analysis.

The research methodology proposed did take into consideration the need for both male and female focus group moderators in order to reach both men and women. However, there is no mention of any other need to ensure a gender balance in terms of the populations to be selected for participation in the different components of the study.

None of the objectives indicate an explicit intent or need to determine if there is a differential impact of user fees on women and men in the target populations or if men and women follow significantly different health seeking patterns and coping strategies.

Reports:**1. May 2007 Status Report**

The status report provides a succinct, but thorough summary of the research findings and implications to date. Only two of these findings noted any connection with gender equality/equity issues. These included the fact that:

- The Logit model found that the variables associated with hardship included age, female family headship, residence outside the capital, seasonal employment and chronic conditions.
- The Tobit Model confirmed a relationship between health related costs and the inability to purchase drugs, people's employment status, being female and having chronic diseases.

Given that the majority of the research subjects in this study were women, most of the findings needed to be systematically assessed from a gender perspective.

2. Final Report – June 2008

The final report presents similar findings to the interim report, but in much greater detail and includes detailed annexes outlining the research methodology and related questionnaires. There are currently plans to publish this report as a book. The report made multiple recommendations, but none of these recommendations addressed gender equality issues despite the fact that being female was considered a significant factor influencing vulnerability related to user fees.

Social and Gender Analysis***Research Methodology***

The categories of analysis used to select groups of research participants led to approximately 75% of those interviewed using the diverse research methodology being women. While in general the use of these criteria are logical (e.g., asking mothers about children's immunization records, and tracking pregnant women in antenatal care programs), it also meant that the majority of respondents were female. This is significant as there are strong concerns in the Caribbean about the fact that men do not tend to seek health care when needed due to how masculinity is culturally defined in the region.

Sex-Disaggregated Data

The research methodology included gender as a variable.

Gender Analysis

Despite this, and the conclusion that there was a relationship between health-related costs, the inability to purchase drugs and being female, the report does not analyze the underlying causes of this relationship or how this variable should be taken into account in the user fee debate. For example, the study found that where children were involved the parent (usually the mother) worked more actively to problem solve when user fees were a barrier. Conversely, among the elderly – where again the majority are women, the tendency was to adopt avoidant behaviour. A more detailed gender analysis of these issues could lead to alternative solutions and/or the discovery of additional barriers other than user fee and transportation costs (e.g., are female elderly more likely to adopt avoidant behaviour and accept the status quo than male elderly due to their more subordinate position in society or will the need to be demonstrate virility cause elderly men to demonstrate more avoidant behaviour even if not poor).

There was also a need to include more men among the research participants, particularly in the family planning groups in order to ensure that there are not significant gender-based differences in male and female health-seeking behaviours or their ability to negotiate fee waivers. For example, men who are assertive may be more successful at this type of negotiation or conversely may feel more ashamed to ask for this type of help as it does not fit in with the Caribbean definition of men as the family breadwinner. The final report recommendations also did not take gender equality into account despite it having been identified as a significant variable affecting access to health care services.

Recommendations

1. There is a need to develop a comprehensive vulnerability index related to user fees and health research in general that takes various factors into account, including (but not limited to) age, sex, ethnicity, race, education levels, employment and marital status, family size and situation, geographic location, differential nature of disease presentation for women and men, etc.
2. The proposal stated that new approaches must be adopted to forge closer links between researchers and policymakers so that 'empirical evidence' is more systematically used in policy decisions. These new approaches need to include gender analysis tools and variables in the research methodology that go beyond ensuring that both women and men are interviewed. In particular, there is a need to analyze all the key categories of analysis from a gender perspective to determine if there are significant differences in the findings that are gender-related that require follow-up action to mitigate in health policy and programming.
3. There is a need to expand the scope of some of the main research questions to include sub-questions that ensure that they also address key gender equality issues.

Table 2. Key Issues

Objectives	Key Questions	Data Needed
Specify factors leading to fees policy and structure of fees and exemptions	--what factors led to the new policy of fees for preventive care services in 1999, <i>including gender equality, age, poverty levels, employment, etc.?</i> --what are the specific provisions and fees relating to preventive care services -- <i>Do these distinguish between male and female priorities and needs?</i> --what are the exemption arrangements and procedures --what are the provisions for adjustment of the fee schedule	--Cabinet submission on user fees --Act and regulations on user fees --Fee collection procedures at health centers
Measure impact of fees on utilization of services and linkages to medical complications	--what does the data reveal on utilization of preventive care services before and after user fees, 1997--2002 -- which services have been most affected -- <i>Are these services that were used more by women or men?</i> --how successful were the exemption arrangements -- <i>Is there any difference between men and women's ability to access exemption</i>	--Annual reports of the Ministry of Health and Jamaica Survey of Living Conditions --Specific data from the health centers and hospitals

	<p><i>arrangements or their rate of application for these exemptions?</i></p> <p>--what is revealed in the relevant data from hospitals on complications which may be traced to inadequate preventive care</p> <p>-- <i>Are there any differences in the physical presentation of these complications between women and men?</i></p> <p>-- <i>Are there any differences in complication rates for women and men, and if so, why?</i></p>	
Ascertain the views and coping mechanisms of patients for specific tracer services	<p>--how has the imposition of fees affected health seeking behaviour <i>of men and women?</i></p> <p>--what are the coping mechanisms <i>men and women are using</i> to balance this new financial demand?</p> <p>--what might be an appropriate level to set fees</p> <p>--how workable and helpful are the exemption arrangements</p>	<p>--Cohort/panel study</p> <p>--Mystery clients</p> <p>--Focus group discussions</p> <p>--Interviews with frontline workers</p>
Identify policy options for further analysis	<p>--what policy options are suggested by patients, health workers and other stakeholders</p> <p>--<i>Are there any differences between the policy options and priorities suggested by men and women?</i></p> <p>--what are the main items of cost and benefit to be specified and quantified in these options</p> <p>--what is the most preferred option when compared to the current fee programme</p> <p>--<i>Which specific population groups will benefit from these options?</i></p>	<p>--Integration of suggestions made by patients, service providers and other stakeholders</p> <p>--Modeling of cost and benefits</p>
Develop workable mechanisms to bridge activities of researchers and policymakers	<p>--what is the current process of decision-making</p> <p>--<i>Are both men and women involved in the decision-making?</i></p> <p>--are there mechanisms and cases which have been used in the past to enhance the role of research and evidence in decision-making</p> <p>--what new or revived measures can be established to develop stronger linkages between researchers and policymakers in health</p>	<p>--Review of policy process</p> <p>--Discussions with policymakers and administrators</p>

4b. 1002107 – Extending Social Protection in Health in LAC: Bridging Research and Practice (Phase II) - Argentina

Partner: Institute of Health, Juan Lazarte, Argentina

Grant: \$ 8,900

Duration: 24 months

Approved: 2004/09/08

Classification: Women-Inclusive Research

Background

Project Title: *Analysis of the Institutional Capacities and Evaluation of the Performance of the Maternal and Infant Public Insurance of the Province of Buenos Aires (SPSMI).*

The purpose of the project is to:

- Develop mechanisms of collaboration and methodological transference between the investigators and the change stakeholders of the Health Public Insurance.
- Collaborate in the design and implementation of the SPSMI, analyzing the related institutional capacities and its impact on the improvement of the health care services, particularly from the perspective of accessibility.

It was developed in response to concerns about the accessibility of health care services by poor populations in Argentina where the majority of the population only has access to public health care. There was a particular concern with high rates of maternal and infant mortality. In response the Argentinean government introduced public health insurance in three stages: i) coverage for a sample group of 80,000 beneficiaries; ii) extension of the health insurance service to pregnant women and children under 6 years of age, covering approximately 900,000 beneficiaries; and iii) the balance of the population in the province of Buenos Aires without the formal health insurance coverage or the economic capacity to buy private insurance (2,400,000 people). This project assesses different aspects of the impact of this public health insurance scheme on the public sector institutions and target populations concerned.

Document Review

Proposal: The proposal outlines its specific objectives as being to:

- Describe the political and institutional process from the change stakeholders perspective, considering institutional innovations arising from the implementation of the SPSMI.
- Identify and measure the institutional capacities of the municipalities in relation to the effective fulfillment of the essential functions delegated from the provincial agency (enforcement) and their capacity to meet the community demands (democratic governance).
- Evaluate the improvement of the performance of primary health care, in terms of satisfaction and accessibility from the community perspectives, as the consequence of the implementation of the SPSMI.

The proposal indicated that it would analyze governance issues at three different levels:

- The institutional political level in which the capacities of the State and their bonds with the society are considered (political process).

- The evaluation of factors associated with mechanisms that foster development of institutional capacities, including the development of state capacity to respond to the necessities perceived by the population through social participation (i.e., democratic governance) and the institutional state capacities needed to meet its obligations.
- The improvement of the performance of the primary health care services.

Research Methodology Proposed

- Collection of secondary data on the demographic characteristics of the population concerned and about the structure and operations of provincial institutional health care systems
- Collection of primary data on these two primary research targets through interviews with provincial and municipal health officials, workshops with those responsible for the implementation of the public health insurance scheme at the central and local levels, individual and group interviews with managers responsible at the central level.
- Focus group discussions with beneficiaries of the SPSMI and domiciliary surveys by sampling, using structured questionnaires in two phases, at the beginning of the investigation, and thirteen months later.

The proposal does not indicate any intent to collect sex-disaggregated data at the community level nor any intent to examine gender equality or equity issues as a variable at either the institutional or community level.

PAD: The component of the project funded under this overall project was the creation of a website to help facilitate communication among the different overall project stakeholders. There was no stated plan to integrate or highlight relevant gender equality or equity issues on the website.

Reports:

Technical Reports – Dec 2005 & Jan 2007

Both these reports describe progress made on the development of the overall project website. There is no mention of the highlighting or integration of gender equality or equity issues in the website content.

Outcome Mapping Report: Concepts, description of tools and the experience of its application in the evaluation of the process of implementation of public health insurance in the province of Buenos Aires

This report provides a detailed outline of the Outcome Mapping methodology used to help assess the institutional and governance component of the study produced by the Institute of Health of Juan Lazarte. While it discusses the importance of involving the different decision-makers in this process, it does not identify the characteristics of these decision-makers (e.g., male/female, managers, etc.).

Draft Report: Project Research Results : Analysis of the institutional capacities and evaluation of the implementation of Public Health Security in the Province of Buenos Aires (Oct. 2006)

Research Methodology:

The research methodology had a strong focus on assessing changes with regard to institutional capacity of the relevant public health institutions to deliver public health insurance and to reach the targeted populations. Apart from the maternal health component, there was no other mention of sex-disaggregated data in this report, even for the case study sections that focussed on the impact of the program on public health

insurance beneficiaries. At the institutional level, there is no analysis of gender as a factor in the related decision-making, management and governance processes. Overall the report contains no gender analysis despite the fact that the main target group is the poorest population groups in the Province of Buenos Aires and that it is highly likely that women represent the majority of this population, particularly given the health insurance's original emphasis on increasing accessibility to health care of pregnant women in order to help reduce maternal and infant mortality rates.

The research approach is very process-focused and provides some innovative tools to make institutional assessments. However, these tools needed to also find effective ways to take gender equality and equity issues into account at the institutional level.

Research Findings

At the municipal case study level, while the report notes the extent and changes in the access of the target population to health care funded through their participation in public health insurance, it does not provide any analysis of whether or not there have been any significant changes in the access of women and men to health care in the target populations.

Recommendations:

1. Establish whether outcome mapping processes identify major groups of decision-makers and other stakeholders are male or female and if gender is a variable that affects decision-making within the institutions concerned.
2. Include gender as a variable in any health-focused impact research assessment process and collect sex-disaggregated data for the target populations, particularly when looking at health care access issues for poor communities. These assessment processes also need to analyze if there are any significant differences in male and female access and if so, why so that appropriate mitigation strategies can be developed for either group.
3. Examine institutional assessment processes in how they take gender equality/equity processes into account and how these affect institutional governance, e.g., nature of the decisions made, who is making key decisions, whether these decisions are being made in formal or informal settings and which groups have access to these decision-making processes, percentages of male and female staff at different levels, etc.
4. Integrate or highlight relevant gender equality and equity issues in project websites by developing a gender equality/equity discussion page and posting relevant documents, and issues there.

5. 1003211 – Ethnicity, Poverty and Health Inequalities in Peru

Partner: Development Analysis Group (Grupo de Análisis para el Desarrollo - GRADE)

Grant: \$ 330,650

Duration: 36 months

Approved: 2005/09/28

Classification: Women-specific research

Background

The project was designed to develop a better understanding and raise awareness of the importance of race and ethnicity as relevant factors contributing to the increase in health inequities in Peru. It focused on the relationship between race/ethnicity, discrimination, poverty, exclusion and health in Peru. The rationale for this work is that historically, Peruvian society has been marked by high levels of poverty and inequality, both conditions that have strong correlations with the systematic exclusion of the vast majority of the population with an indigenous ethnic background. There were still significant holes in recent relevant research with respect to the nature of ethnic gaps in health as well as the mechanisms through which ethnic and racial discrimination works within the health sector and in the society as a whole. For example, a recent qualitative study indicated that the urban population of indigenous background in Peru sees public health centers as the space in which they have faced discrimination more often or more severely and there is a need to examine this phenomena also in the rural areas.

This project therefore attempted to:

- measure the size of the racial/ethnic gaps associated with health status, access to health care, and health financing;
- identify the key determinants of these racial/ethnic gaps in health, to properly disentangle the direct effect of their ethnic background from those that are mediated through their disadvantaged economic status, lower education, etc.; and
- identify the way these different racial/ethnic groups suffer and cope with discrimination in different contexts, but especially in health facilities, and explore the connection between the exposure to discrimination and their health status.

The project also involved stakeholders including decision makers, organizations of ethnic groups, and human rights associations to help identify and propose policy changes to increase the access of these traditionally marginalized ethnic/racial groups to health care.

The PAD does not specifically mention gender equality or equity as a research variable.

Document Review

Proposal: The proposal for this project includes a specific section on gender equality/issues and recognizes the importance of taking these issues into account in the analysis. It observes that past studies on cultural barriers to the use of health services have focused on gender equity or poverty issues, as opposed to ethnicity or racial discrimination. In particular, it notes that it is necessary to have research

instruments/mechanisms that analyze the distribution of power within the household and its implications upon gender and health equity. The proposal notes the positive effect of women's bargaining power at the household level on her health and that of her children while the research reports observe that they found a potentially negative impact of power relationships between couples on the choice of birth control methods.

As target groups, the proposal also emphasizes the health status, access to health care and health financing of women of reproductive age and of children under five due to the high rates of mortality and morbidity among indigenous women and children. Consequently, very few men were interviewed as a part of the research process. This could possibly skew the research results. This decision was made despite the fact that the proposal states that many traditional risk factors affecting individual health are strongly associated with their social status and context, both of which are often significantly influenced by gender relations and roles.

Research Methodology

The research methodology was designed to contribute to the understanding of the connection between the different individual, family and social factors using both qualitative and quantitative approaches. The qualitative work included case studies and focus groups in three areas to learn about the perceptions of individuals, men and women, of their ethnicity, the relevance of particularly stressful discrimination events, the strategies they follow to cope with discrimination and exclusion. Research questions focused on both general discrimination events and those that had occurred in relation to the utilization of modern health care services. The three areas selected for the case studies were a hospital in the periphery of Lima, another in Cusco and a health center in the rural area of Cusco. The case studies followed the therapeutic itineraries of five indigenous women and five indigenous men, as well as five non-indigenous women and five non-indigenous men.

The proposal states that the study would take gender into account in both the quantitative and qualitative sections. In the qualitative component it was to focus on how women and men's traditional roles and relationships have an impact on their ability to attain good health and to highlight the cultural, economic, social and political causes behind indigenous women's consistently high rates of morbidity and mortality, as well as the interplay between gender and ethnicity on the quality of health care provision. The research reports did not, however, appear to report on these variables in any detail.

The quantitative research analyzed data from three existing household surveys: the Living Standards Measurement Survey; the National Household Survey; and the Demographic and Health Survey (DHS). The idea was to use the surveys to collect data from persons who had either identified themselves as speaking an indigenous language as a mother tongue or who self-identified as being indigenous or from a specific ethnic group. To address gender issues in this part of the research the research team placed emphasis on mother-child health, particularly with the DHS survey.

The study also used outcome mapping processes to monitor and evaluate the involvement of different stakeholders in the project. No mention is made of any gender-related institutional stakeholders in this process.

Reports:

Narrative Reports – March 2007 & Feb 2008

Both these reports note the limitations of using mother tongue as a determinant of ethnicity. Instead the researchers observed that there was a need to use a combination of variables, including the mother tongue of ancestors, links to and association with specific geographic locations and self-identification as being from a particular ethnic group. Using this broader set of variables they found much higher numbers of the population who could be classified as indigenous as in many previous studies. They also correlated research results with education and economic levels.

The researchers also found that indigenous women, even those living in the urban areas, were less likely to use modern methods of contraception than non-indigenous women. One report suggested that this might be in part due to cultural patterns that persist among women of Aymara or Quechua origin. Another noted that the issue might actually be more related to the fact that the women's spouses did not want their wives to use forms of birth control that the men could not control for fear that this would encourage the women to be unfaithful to them. Neither report examined the underlying issue of power relations in the household nor how this affected women's choices.

The reports also noted the use of questions related to how the men and women interviewed dressed, and spoke and how this affected discrimination levels with regard to health care access.

Final Report: Ethnicity, Language Background and Maternal-Child Health in Peru

The final report focused strongly on women and children under five as the target group. None of the quantitative data presented is disaggregated by sex, possibly because of the homogeneity of the target group. It does, however, provide some analysis of statistics about specific groups of women. Without comparative statistics for men, however, it is not clear if the experience of indigenous men and women in accessing health care is significantly different. The absence of data on men in the component on choice of birth control methods is particularly important as gender relations could be a significant determinant of these choices as opposed to it being a case of women "hanging on" to traditional cultural beliefs as one of the reports suggests. In general, despite the stated intention to factor in gender relations as a factor in the research, this aspect of the analysis is quite limited.

The report also observes that 75% of the women studied who speak Aymara and Quechua have a maximum of primary education and 93% live in the lowest two quintiles related to poverty. The report does not note that there are also significantly higher levels of illiteracy among indigenous women than among indigenous men. This means that there are also higher numbers of indigenous women who only speak indigenous languages. This latter factor could have a significant impact on their access to health care. Therefore this differential between indigenous women and men needed to be taken into account in the research findings. This gap is mitigated to some degree by the fact that the research found that even when the women concerned were based in Lima and did speak more Spanish, they also reported experiencing considerable discrimination.

The final report also noted other patterns such as the fact that only 42% of the indigenous women had access to institutional natal care. The research also found that their education levels and migration to the city did not necessarily make a difference to

their access to health care and that the group of women who spoke Spanish use health services more.

Annexes

The various annexes focus on different aspects of the study, including perception of discrimination, ethnic identify, language background and maternal and child health in Peru. They do not include any specific sections or analysis of related gender equality/equity issues.

The preliminary conclusions reiterate the need to have broader definitions of characteristics that define ethnicity than mother tongue and note the importance of controlling for other factors that can contribute to discrimination such as women's education, economic levels and the availability of health care infrastructure in the areas where they live. It also concluded that cultural factors appear to be more influential in determining the behaviour of Quechua or Aymara women related to their sexuality and gender relations and that these cultural patterns persist over generations, and that consequently, there is a need to take gender equity factors into consideration when developing family planning policies and programs.

Rolling PCRS: The Rolling PCR notes that gender was not incorporated in the first version of the proposal but that this gap was addressed and had become a very important variable in the project design. In particular, it attempted to look at the loss of cultural identity, especially of women's exposure to increased gender inequalities in the urban context and the association with other social determinants.

Social and Gender Analysis

Although the proposal stated that it would examine gender equality/equity issues in both the quantitative and qualitative components, the actual gender analysis done is quite limited and mainly qualitative in nature. In general, there is a lack of sex-disaggregated data and the selection of maternal and child health as the focus meant that there was little analysis of men's experience. In general, there was a need to define more clearly what the study's gender analysis would cover at the project's beginning and to find a way to include men in the analysis. This would allow the researchers to determine if the different life conditions and power relations of indigenous men and women are a significant additional factor affecting their access to health care.

Although the project's main target group was women, this does not necessarily mean that the research was automatically conducting a gender analysis. Rather it simply meant that women were the main research subjects.

Recommendations

1. Health research related to ethnicity and discrimination needs to ensure that a significant number of both women and men are included as research subjects in order to determine whether gender equality/equity is also a significant variable affecting levels of discrimination related to access to health care.
2. In health research where women or men are the primary research subjects, there is still a need to conduct a gender analysis that assesses how gender relationships affect health behaviour and access. Where possible there is also a need to provide a sex-disaggregated comparative on key background data such as education levels, economic status and dominant language levels.

6. 103905 – Health Financing, Equity and Poverty in Latin America

Partner: Fundacion Mexicana para la Salud, (FUNSALUD), Mexico

Grant: \$ 751,300

Duration: 30 months

Approved: 2007/06/12

Classification: Gender integrated (Peru) and Women incidental (the rest) project

Background:

The aim of the project is to study household spending on health in seven countries in Latin American and to relate this to the organisation of the health system and health financing. Some of these countries are at the entry point of reform of health financing (Mexico, Columbia, Chile) and others where health reform systems have been organised in a more fragmented way (Brazil, Argentina and Peru). Costa Rica is included in this grouping because it has a unique social insurance that has been successful in preventing catastrophic expenditures but has been little studied.

The research will involve quantifying and analysing household impoverishment from health spending, including both the distributional and equity aspects (relative impoverishment) and the implications for poverty (absolute impoverishment). The research intends to assess the determinants of family impoverishment from the level of the family and the organisation of the health system, comparing and simulating different finance structures in a variety of scenarios of population health needs. These include common phenomena such as ageing and epidemiological transition in middle income countries.

The project will undertake comparative analysis of health systems and identify policy lessons that can be used to strengthen health systems. Outputs include the improvement in the quality of the data and methodologies for analysing household spending through a through use of available data bases and increased capacity of human resources for the study of health system financing.

Document Review

Proposal: While FUNSALUD is the coordinator of the project, it works with a core group of six principal investigators affiliated with a local institution in the countries. FUNSALUD is a private sector centre for analysis and critical opinion.

The project title refers to the impact of health financing and “household” health spending on equity and impoverishment. The focus is on workers who generally receive limited health benefits through under-funded schemes in various countries and therefore, exacerbate inequalities both in income and health as they resort to out of pocket health expenses. There is (no?) specific gender analysis and no objective is identified to study the gendered implications of households being impoverished.

However, there are specific references to women and children and their access to entitlement to various healthcare schemes and services as well as sources of data in the proposal.

1) Peru

First attempts to set up universal insurance mechanisms to protect the poorest and most vulnerable among women and children from 1997 and 1999 resulted in the Integral Health Insurance (Seguro integral de Salud – SIS). The research will examine existing literature which has focused on the ability of SIS to reduce or eliminate the financial barrier for access to reproductive healthcare.

By analyzing out of pocket health expenditures by those who can actually afford it, this project will determine the incidence of health catastrophic outcomes across the income distribution and by access to health insurance. The methodology will involve using household data from the Demographic and Health Survey (ENDES) for 2000 which covers 27,843, 15-49 year old women and 28,000 households and for 2004 which covers 6,251, 15-49 year old women and 6,377 households. The National Household Survey (ENAH) will be used to analyze household health care use, health expenditures, and poverty profiles.

2) Colombia

The universal healthcare system falls within one of two regimes: Contributory Regime (SR) which is geared to income and financed by mandatory payroll contributions; and the subsidized regime which is affiliated with people identified as poor which has a much more limited benefits package. The SR includes total coverage of all benefits for children under one and pregnant women, as well as coverage for several frequent procedures requiring hospital care. A 2005 study indicates that being affiliated with the SR increases medical care utilization among mainly poor women, children and the elderly but less so among poor men.

PAD: This project is based on a RFP for the development of the initial proposal with FUNSALUD, which entailed the identification of project partners, the research strategy and framework, identification of data bases and a review of national and international literature. A review of the extensive Bibliography produced during the initial stage of proposal development yielded many results for social analysis on the “poor” and research on “equity” in various countries but no gender specific health reform analysis. There is no mention of gender considerations in the PAD.

Reports: This project has just commenced and therefore, no progress reports have been submitted yet.

The project review was conducted in conjunction with the SHIELD-Sub Saharan Africa and the findings and recommendations for the two projects are similar

Social and Gender Analysis:

Gender Analysis

The project generally refers gender neutral categories of analysis such as “households” and “families”. The focus of the study is the segment of the population which is outside the public social security system, i.e., the informal sector, which generally has a proportionally higher number of female workers.

The level of gender considerations differs widely between countries e.g. with Peru providing an excellent focus on a scheme covering reproductive health services and infant health forms as a baseline for a wider study on access to healthcare; in Colombia

there is a mention of the impact on men, women and children of the two types of public health schemes including women specific data source; in Brazil, Argentina and Chile – there is no mention of gender. although research indicates that there are efforts to incorporate women advocates in dialogue for health sector reform.

It is important to do a gender analysis of the health insurance schemes as patterns of insurance coverage are different for women. Although men and women are at similar risk of not having health insurance, women—whether insured or uninsured—are more likely to report cost-related access problems.

Women differ a lot in their experiences and needs. Even though they are more likely to need health care, women are more likely than men to encounter barriers to receiving it. Women, who more often than men are caring for a child or aging relative, are thus less likely to have good access to health care themselves. Due to cultural upbringing, men tend to avoid health issues until they are critical. Both elderly men and women, unless they are cared for, also tend to ignore their health concerns.

Various sources of information can be tapped into on gender analysis and health reform e.g. the Economic Commission for Latin America and the Caribbean which held its Conference in Peru in 2000 on “Equity, Gender and Health Policy Reform in Latin America and the Caribbean”; PAHO has done similar work on gender equity in health and health system reform but this body of work has not been integrated into the bibliography.²⁸

Amanda Glassman wrote the first proposal for the structure of the health systems background paper for this project, but it makes no mention of gender considerations. This is quite surprising as a study on *The Health of Women in Latin America and the Caribbean* was carried out in 2001 by Ruth Levine, Amanda Glassman and Miriam Schnediman. This study broaches the advantage in the involvement of gender specialists in health sector reform and specifically refers to financing options for women's health in light of their less access and control over household income. This study is also not included in the bibliography of the initial phase of the project.

Research Methodology

The research methodology focuses on an assessment of socio-economic status, based mainly on a review of relevant literature and household survey datasets. A large number of people in these three countries are poor and there are more poor women than poor men?. Gender is generally a missing element in household surveys. The gender dimensions of poverty are closely tied to unequal gender relations within the household. Household surveys using conventional economics saw the household as organised around the pooling of income and meeting the welfare needs of all members. However, studies from various parts of the world suggest that, on the contrary, there are widespread and systematic inequalities within households. Gender is an important determinant of the distribution of rights, resources, and responsibilities within the household but recognizes that it is not the only factor. Age, birth order, relationship to the household head, and position of the household in society are some of the factors that also influence the allocation of household resources. Attempts to estimate poverty that overlooked inequalities in the household therefore provided a very incomplete picture. In

²⁸ <http://www.paho.org/English/HDP/HDW/cepalgenderreform.pdf>

particular, they had little to say about women's experience of poverty relative to that of men within the same household

The research methodology needed to provide a strategy for acknowledging the many different types of households and assessing the intrahousehold dimensions of poverty.

Recommendations:

1. Justify why gender analysis and integration is important to the study of health insurance schemes – in addition to socio-economic analysis, e.g., due to their reproductive functions and gender inequalities women are in a position where they have to use health services more than men. This represents a high cost for the insurance scheme. Women are also less likely able to be able to afford user fees.
2. Analyse the household datasets for sex and gender related statistics. Identify departments in Universities working on developing gender statistics, for example, the National University of Lujan, Argentina.
3. Seek and consult resources available resources familiar with gender and health systems reforms (mentioned above), and/or gender economics models in health research. These should not be difficult to find as the many countries in LAC have national gender sensitive budgeting initiatives which depend on gender statistics and modeling.
4. Provide gender training to researchers based on a common understanding of the gender considerations of this project.
5. Include gender as a variable in any health-focused impact research assessment process and collect sex-disaggregated data for the target populations, particularly when looking at health care access issues for poor communities. These assessment processes also need to analyze if there are any significant differences in male and female access and if so, why so that appropriate mitigation strategies can be developed for either group.
6. Include as a part of the methodology, a strategy to address gender more systematically within the research and do a gender analysis e.g. by focusing on field visits and focus group discussions to supplement the (probable lack of data in the) household surveys. Much can be learned from short field visits, particularly when accompanied by a local expert who is sensitive to gender issues. The bottom line is that some attention to gender issues—even very informally—is likely to pay off in terms of the relevance and usefulness of the research.
7. Many tools are available to do such an analysis such as: participatory research analysis (PRA) and participatory monitoring and evaluation (PM&E).
8. Share gender strategies between the researchers of insurance schemes in all three regions – LAC, West Africa and SHIELD.

PROJECTS FUNDED IN WEST AFRICA

7. 101465 - Étude du conseil-dépistage volontaire du VIH à Conakry (Guinea)/ Study on voluntary HIV counseling-screening

Partner: International Health Unit, University of Montreal
Grant: \$25,000
Duration: 36 months
Approved: 2003/05/11
Classification: Women-specific research

Background

The International Health Unit at the University of Montreal has been lending technical support to the fight against AIDS in Africa since 1990. Partners of this project include the Ministry of Health and Project AIDS 3.

Purpose:

- to strengthen systems of control and prevention of sexually transmitted diseases (STD) and HIV/AIDS in West Africa through a study of current voluntary HIV/AIDS counselling-screening programs

Expected Results:

- A socio-culturally appropriate training kit for counselling-screening service providers developed
- Socio-demographic profiles defined
- Extent of patient's likelihood to participate in the program
- Changes in unsafe sexual behaviour as a result of the intervention over a time period

Document Review

Proposal: As Project AIDS 3's partners are community-based organizations, it will apply participatory approaches, thereby enabling it to supplement its medical component with community support. The research will take place in two phases;

- 1st: field visit where interviews would be held with field workers, the population at risk and key contacts in the research area;
- 2nd: data collection from health structures and NGOs working in the area.

Data collection to include socio-demographic information on patients at healthcare centers; along with qualitative questions on their perceptions on a variety of HIV/AIDS risk management issues.

The proposal includes a brief gender analysis explaining how women and men's gender roles have a differential impact on their sexuality and their risk to HIV/AIDS infection. It also establishes the link between violence and STDs. The proposal states that the research would pay greater attention to gender relations and their potential impact on risk management and infection of the disease. This insight is not however followed through the proposed methodology.

While attention to cultural appropriateness in the research process is highlighted, the proposal did not state how that would be ensured and whether the research would be

conducted using a gender sensitive approach. It is also unclear if socio-demographic information would be collected on interviewed service providers.

PAD: States that the project seeks to identify how health providers influence the rate of acceptance of counselling-screening programs; as well as determine to what extent gender dimensions play a role in the decision to participate in such programs

- The research methodology is gender-blind; it only describes the two phases of the research, specifically already identified data sources.
- Includes a brief statement on need for the research to address gender equality issues in HIV/AIDS screening, but does not elaborate further, i.e. whether at research team or patient level

Reports: There were two reports dated 2006 and 2007 submitted for review. Both are essentially similar, with the 2007 being the final version.

The purpose of the study, according to the report, was to:

1. Describe the acceptability of voluntary counselling-screening programs among (female) sex workers
2. Measure the incidence of sexually transmissible infections within a specified cohort of sex workers; and specify risk factors linked to new sexually transmissible incidences and unsafe sexual behaviours
3. Study the social effects of screening

Methodology involved a multi-layered approach:

- 420 [female] sex workers monitored in health centres for a period of time (one year) where they were offered Voluntary counselling-screening (VCS) twice - before the start of the project and a year later.
- During each visit, a questionnaire was administered; and blood and vaginal fluid samples also taken in order to test for various STIs as well as to assess the presence of sperm as evidence of unprotected sex.
- Semi-structured interviews and focus-groups
- Psychosocial and medical support provided to HIV positive participants

Study Findings:

- The first screening saw a 99% acceptability of VCS
- On the second round, fear of undergoing the HIV screening for a second time a year later was visible; fear due to positive results on first screening test, death of close relatives/friends, as well as sex partners
- 75% increase in perception of HIV infection
- 38% HIV prevalence
- STIs found in more than 90%, especially in the final 3 months of the project
- High condom use among clients but not with steady partners (1/3 of interviewed persons expressed desire to have children with their boyfriends)

The report explains that the HIV/AIDS epidemic is concentrated around a high risk "core group" - female sex workers - with a prevalence rate of 42% (based on 2001 survey on 344 sex workers). It also recognized that this group is particularly vulnerable, as women in Guinea are generally less educated and more likely to live in poverty.

Survey team composed of: 3 female counsellors trained in VCS; 3 researchers; 3 supervisors (of which one counsellor is a woman). Female researchers were in charge of sample collection and provide pre-screening counselling

Social and Gender Analysis

In general, the proposal and the report include sex-disaggregated data, especially in explaining the proportion of high-risk group (42%) who are female sex-workers. However, there is disconnect between the proposal, the PAD, and the report in terms of the study targets. While the first two are consistent in terms of the methodology and general study targets, both do not explicitly state the target population for the study. The report on the other hand has a clear bias, as it focuses on sex workers only. In fact, the report does not explain why the study targeted female sex workers. Was it a question of reporting only on this part of the study? Was it based on an assumption that sex workers are all women and that male sex workers are not visible or present in the study area? Or was it a need for the study to only focus on female sex workers? What was the reason for doing so? How could the study have addressed the question of sexual orientation in order to include gay/lesbian sex workers' experiences? In the proposal, it is mentioned that various health centers would be selected to ensure inclusion of male and female clients, but clearly, this was not followed during the study.

The proposal and PAD only indicated health centers as study locations. The report talks about "bars", with a brief justification for doing so, but without providing a methodological description of how the study was carried out in targeted bars.

Poverty issues are largely addressed in all documents as affecting female sex workers more, but it is unclear to whom they are compared. The report states that women in Guinea are less educated and therefore more likely to feel the effects of poverty. Is there sex-disaggregated data to uphold this analysis? None of the reviewed documents analyze this further nor do they provide viable recommendations other than suggesting have sex workers educated or have them involved in choosing the type and methodology of interventions. While the report concludes with a call for a more in-depth study to look into contextual factors that lead to prostitution, it does not bring out any insight into gender-based barriers or impacts resulting from counselling-screening programs.

The study had a clear intent to investigate the social impact of counselling-screening programs. This was only done to a certain extent. The report could have included findings from the perceptions of sex workers themselves, as to how they perceive the program and what impact it has in their personal lives, especially with respect to gender dynamics. The report presents the general observations made during the study, so it begs the question that more issues could have been unearthed if participants' perceptions were reported on. It is also unclear to determine what measures were taken to ensure socio-cultural sensitivity during data collection.

In general, the final report is partially completed, as it excluded information related to counselling-screening training for health service providers, if the latter were trained at all. It would have been useful to also report on the gender breakdown of trained health officials in order to monitor the potential impact on service users' decision to participate and remain in the study or similar future interventions.

Recommendations

1. Define clearly the sample population targeted in the study at the proposal and PAD stage. Such definition should include a social and gender analysis - quantitative and qualitative factors (number of women and men of each target group in a multi-component study) - age group, socio-demographic data, specific group or quality of group.
2. Identify the gender-related reasons that the target population engages in sex work and which make them more susceptible to HIV/AIDS e.g. socio economic reasons AIDS as well as refugee or immigrant communities who may not be eligible for VCT.
3. Factor in socio-cultural and gender sensitivities in the proposed research approach and clearly state parameters or guidelines that should be followed during the actual research. These approaches and their impact/usefulness during the research should also be analyzed and reported on after project completion.
4. Utilise fully an opportunity to assess the gender-related impact of voluntary counselling-screening programs. A more in-depth analysis that also included men, particularly the partners and long-term boyfriends of sex workers, could have strengthened the findings of the research, as well as provided a useful insight into power relations between sex workers and their partners, and consequently how their decision to remain in the program is influenced.
5. Develop a gender sensitivity and analysis to the level of social stigma attached to HIV/Aids in the implementation of VCT programming: in the location and access to VCT centres; need for anonymity for girls and women; counselling and resources available for treatment, care and livelihood support if found to be positive.

8. 103085 - Gouvernance et qualité des soins au Bénin - Governance and quality of care in Benin

Partner: Association béninoise des chercheurs (ASSOBREC)
Grant: \$188,930
Duration: 36 months
Approved: 2005/06/22
Classification: Women-specific research

Background

Despite the principles set forth in the 1987 Bamako Initiative for greater community involvement in health management committees, there has been little concrete progress to that end. Healthcare is not accessible to all; the poor remain marginalized and hardly benefit from healthcare reforms. The aim of this project is to document the relationship between governance and quality of care with a view to recommend ways of increasing community involvement and responsibility. The grant will support research on planning activities in the area of care management, as well as identification of internal and external partnerships.

Documentation Review

Proposal: There was no proposal included in the documents reviewed.

PAD: The research is based on the outcomes of an earlier research conducted on vaccination policies in Benin, where findings showed vaccinations to be inaccessible to children from poor families, hence calling for the need to pursue further research on governance related issues in public health. The document outlines several project objectives that would facilitate the collection of relevant data in establishing the link between governance and quality of care in Benin's decentralized healthcare system.

Methodology

The research will use a combination of surveys, interviews, focus groups discussions as well as secondary data collection at the level of the Ministry of Health, and draw out qualitative and quantitative findings.

- Location: 2 hospitals in Cotonou and 2 other government departments (urban & rural)
- Special attention to be accorded to gender equality issues with the aim of better understanding of any gender differentials in healthcare supply and demand.

Expected Results

- Identify sources of dysfunctional management committees in Benin's decentralized health system, especially in relation to governance issues in decision processes and transparency in service provision.
- Reformulate more efficient strategies to promote community involvement towards good healthcare governance.
- Outline potential training needs of the diverse actors in public health.

Reports:

August-December 2006 Report

The research involved the recruitment of 15 female healthcare users, randomly selected in each village to help in data collection. A total of 304 female health service users participated in the survey. It is unclear if the study involved male participants.

Six Months Report (March 2006)

The methodology section indicated that two young female doctors joined the team. Their role was to collect data in public and private hospitals. The report did not further elaborate their involvement.

According to the report, maternal mortality and stillborn incidence rates provide a useful insight into the performance of health systems and the use of and quality of prenatal services received by expectant mothers. In the case of Benin, their high trend points largely to the lack of a substantial improvement in the quality of maternal healthcare. The report does not provide measurements to gauge the quality of care provided to men.

Annual Report (August 2005-2006)

The two female doctors, mentioned above, were reported to have left the research positions (one due to sickness, the other was promoted in the Ministry of Health). The report does not indicate if any replacements were made.

One of the study's focus areas was maternal health, especially obstetrics. The findings indicate that women avoid using the services of maternal healthcare during the first trimester. It is also noted that pregnant women from poor households are less likely to show up for prenatal care. The report attributes this trend to superstition, particularly in rural areas. As well, it was found that women who sought prenatal care were not given consistent or welcoming service, thereby reducing their likelihood of returning for further prenatal care. In general, the report concludes that socio-economic status plays an important role in determining the chances of a pregnant woman seeking prenatal services.

In terms of participation levels in health committees, members indicated never to be informed of their roles and responsibilities. Women members reported not to know what they are supposed to do outside of meetings. Another barrier is language used in meetings: French. Members who do not understand French, especially in rural areas, are relegated to second place, often not informed of major changes or decisions passed. The report does not acknowledge that women (in both urban and rural areas) would be most affected by language barriers due to their lower education levels than men.

Final Report (August 2007)

A chapter in the report summarizes the implication of gender equality in governance and quality of healthcare. The analysis presents findings from women who associated good governance with the way a director runs his hospital, whereas men reported collegiality in decision-making to be a key factor. As well, surveyed women indicated the need for transparency in healthcare structures and the application of rules and regulations in management.

In terms of management, the report noted gender disparity, with only 21% women being members of management committees of visited hospitals. The chapter did not provide any analysis as to why women are under-represented in all key healthcare management structures. It only concluded that women should be engaged in healthcare governance if any equity in power is to be attained in basic healthcare systems.

In some centres, women seeking health services reported that they were treated badly. However, the report did not explain the reasons for this or suggest recommendations for curbing the practice.

Other documents: Interview guidelines - None of the questions were gender-sensitive or sought to collect sex-disaggregated data, except for issues concerning pregnant women.

Social and Gender Analysis

Research Methodology

The methodology is designed as an institutional assessment of hospitals and government health departments. While it is explicitly mentioned that gender equality issues would be taken into account, the reports do not consistently discuss how gender considerations were made, or if they were made at all. There seems to be a definitive urban-rural divide of services offered and used. Some of the reports indicate the involvement of female doctors, but do not give the overall size of the team or the number of male doctors and how their experiences or perceptions or interactions with rural women differ from those of male colleagues. The representation rate of women as researchers is therefore inconclusive. Once the female researchers left the project for personal reasons, none of the reports indicated whether they were replaced, nor did they provide the reason for not including more female researchers.

The methodology does not clarify how care users from various socio-economic strata would be included in the research process. This is actually an important variable, given the likelihood of social class and ethnicity/clan questions to pose significant impact on perceptions of health service users.

Sex-disaggregated Data

There is sex-disaggregated data provided as far as female members in health governance structures, which gives a good indication of the level of their involvement. The proportion of men is not indicated.

Gender Analysis

In general, this project makes a visible effort to address gender issues. It even includes a gender analysis, albeit brief and at times cursory. Nonetheless, there is explicit recognition that women's inclusion in the process is crucial in assessing the quality of health care. While the project justifies its focus on maternity care, it could have done more to also assess the role of men in decision-making related to healthcare, especially as it affects their wives' prenatal and maternity care needs. There are also other services where explicit and sex-disaggregated analysis on men and women's perceptions and attitudes could have been teased out.

In general, a consistent and thorough gender analysis could have painted a balanced picture of governance and quality of care in Benin. The outcomes of such an analysis could feed the reformulation of national development strategy on healthcare, in a way that addresses concerns that are specific to women and men.

Recommendations

1. Ensure consistency and link documents in including social and gender variables; particularly in the PADs and project reports.

2. Define and describe which groups of male and female research participants would be selected and how. Even if the methodology explicitly mentions that gender equality issues would be explored, it does not back up this statement with a gender strategy for the research e.g. including the number, sex, age (disability, ethnicity, language, etc) of intended participants.
3. Gather data from men and women to see how health systems could be improved in projects that may appear to be gender-specific. Surveys suggest that men have a keen interest in family planning and other reproductive health issues such as contraception use, family size, sexually transmitted diseases, etc but few men are reached by reproductive health care programmes.²⁹ Individual attitudes and behaviours among men vary enormously, of course. On balance, however, the evidence suggests that many more men would participate if they had more opportunity to do so. Access and control issues to and over health care services need to be explored for both men and women.
4. Maintain a gender balance in research teams in a systematic way. Sensitivity to socio-cultural issues is useful to understand participant's views and attitudes to healthcare, as these ultimately shape their health seeking behaviour.
5. Define gender sensitive data collection and analysis at the beginning of the project and ensure that the research team, both men and women, are aware this is not a women only project.
6. Maintain a focus on possible gender differentials, especially when it comes to access barriers, (e.g., language barrier in health committees may have a more negative impact on women). How could this be analyzed further and eventually addressed?

²⁹ Family Health International, Male Participation in Reproductive Health, Network: Spring 1998, Vol. 18, No. 3, http://www.fhi.org/en/rh/pubs/network/v18_3/nw183ch3.htm

9a. 101160 - Politiques publiques et lutte contre l'exclusion - Phase III

Public Policy and Protection from Exclusion - Phase III

Two phases of this project were reviewed: The first phase was categorized as gender incidental. By the second phase, gender analysis and integration had progressed - it was both gender inclusive - and the country study, Côte d'Ivoire was deemed gender integrated.

The projects may have reached the stage of gender integrated at the field level but the documents we reviewed did not accurately capture that. A final project report for the second phase was not received. The two reviewed reports included an activity and a progress report. One of them states that although the user-fee system was put in place, there are inconsistencies in how it was administered. This can dilute the equity, fairness and access objectives of the project.

Benin, Burkina Faso, Côte d'Ivoire, Mali, Senegal

Partner: Centre Hospitalier de l'Université de Montréal (CHUM)

Grant: \$368,770

Duration: 18 months

Approved: 2001/11/13

Classification: Women-incidental research

Background

In line with the changes instituted in developing countries' public healthcare systems, most African countries have been introducing user fees for services. While this has led to additional resources and increased geographic coverage, it has also inadvertently reduced healthcare accessibility to the poor segment of the population.

The first phase of this project was made up of three activities focusing on the research agendas of three countries. In Burkina Faso, the Burkinabe Association of Public Health undertook an evaluation on measures of exemption from hospital fees for obstetric emergencies, with a key finding that these were poorly designed and targeted. As a result, poor women were often shut out of surgical services at the regional level.

In Côte d'Ivoire, local university researchers evaluated exemption mechanisms in three health facilities in Abidjan. The study results pointed out that managers often administered these mechanisms at their own discretion, with little regard to eligibility factors.

The Senegal study focused on mutual health insurance, the various actors in the field and barriers to improving access to services by the poorest. In all these projects, the outcome of each study was put forward to relevant government ministries, thereby stimulating changes in government public health policies and application of the same.

The second proposed phase seeks to build on the momentum gained during the first phase, with the aim of establishing a network of research-analysis and policy formulation to promote equitable access to healthcare.

Document Review

Proposal: There was no proposal included in the documents received for review.

PAD: The general objective of the project is to launch a network of research/analysis and formulation of policies that promote equal access to healthcare in West Africa. As such, the project will contribute to the formulation process of public policies and validate research results on health services while reinforcing local research capacity in health systems. The PAD spells out the five countries mentioned above and calls for greater intra and inter-country exchanges in sharing experience and knowledge and strengthen mutual insurance programs. The project will also seek to determine the feasibility of establishing a research institute on health policies and systems in the region.

Research Methodology: The study is to be carried out on a voluntary basis of sharing common research concerns. Multidisciplinary teams in each country will have a leeway in determining their own research approach and methodology. A workshop would be organized in Dakar to enable team members to exchange ideas on the general organization of the project, as well as on the objectives and methodologies proposed for each country.

The outlined research methodology did not include gender considerations.

Reports:

Final Synthesis Workshop Report (December 2003)

The report pertains to a workshop where each project team presented their findings. The summary is descriptive of the research process and is also clinical in nature. While the report included reference to socio-economic factors in healthcare access, it did not accommodate any gender-related perspectives.

Final Report (January 2005)

The report covers three countries only, Burkina Faso, Côte d'Ivoire and Senegal. It sets the context of the research project and outlines the challenges related to lack of reliable and adequate data in public health systems in West Africa. In its overview, the report states that the higher the rate of poverty, the higher health problems become; that essentially inequalities in access to health care are based on a socio-economic hierarchy. The analysis is aggregate in terms of its description of marginalized groups. However, it recognizes that falling sick for these groups is a source of further impoverishment, often exposing them to poor quality care and non-ethical practices, such as overcharged service fees. The assessment did not however go beyond lumping together all poor people, despite the varying degree and intensity of healthcare inaccessibility among poor women and men.

Methodology/Findings

- No definite number or size of sample of population to be targeted in study
- Except in cases where the project is gender-specific, no explicit indication to collect sex-disaggregated data
- No clear description of data collection method

In outlining the objectives of the Burkina Faso research project, the report states the need to assess the socio-demographic and professional profiles of women who underwent caesarean surgery at hospitals, as well as those who have benefited from exemptions from service fees. The nature of data sought was more quantitative than qualitative. Although this could be due to the clinical focus of the study, qualitative

information could have shed some light on the actual perceptions of women seeking obstetric care on topics that cover a wide range of issues related to quality of care and motivation to obtain prenatal care.

In the Côte d'Ivoire case, the socio-demographic profile reveals that poor patients reporting to hospitals consisted of women, youth and the unemployed. The report does not provide sex-disaggregated statistical data to support this statement. In general, reference to the poor is made in an aggregate fashion, focusing on exemptions and social services used by the poor. Furthermore, this part of the report does not include a definitive section on results or findings. As such, it is not possible to accurately determine if there are any gender differentials in how service fee exemptions are offered and administered.

In Senegal, the study assessed the type of mutual insurance providers along with their subscribers. It also included sex-disaggregated data on the proportion of female managers in these institutions. For example, about 40% of community-based mutual insurance entities are led by women. This is of significance importance especially in a country where mutual insurance companies are far and few between; and where women's health needs are inadequately met. Apart from presenting statistical data, the report did not offer an analysis of the implication for female subscribers of women-led community-based mutual insurance companies. Such analysis could have also brought out that there may not be a significant impact. Whatever the underlying situation, the report falls short of providing a complete picture of gender based tensions that may exist in mutual insurance, and their exclusionary or inclusionary impact on health care access.

PCR (Report on end of project): A response to a question on research capacity of women indicates that a female team member of the Burkina Faso team played an important role in the research project of her country. She also participated in an international meeting in Durban. The response concludes by acknowledging that gender equality issues should be better addressed in subsequent phases of the project.

Social and Gender Analysis

Research Methodology

The methodologies described for each research project did not explicitly outline how gender or socio-cultural related data would be collected and analyzed. In one of the reports, it is mentioned that a female researcher was involved in the project. However, this information is only mentioned in passing. None of the methodology descriptions had previously disclosed the gender composition of the research teams. Given that the project's objective is closely associated to capacity building of West African researchers, it would have been useful to add a requirement of ensuring gender balance among researchers.

Sex-disaggregated data

In the Senegal research findings, sex-disaggregated data were widely used, which helped to understand women's representation level in mutual insurance entities. The use of sex-disaggregated data, if coupled with a qualitative analysis, could have been more effective to identify health and social/gender determinants that should be addressed by health public policies.

Gender Analysis

The research served an important purpose in attempting to define the socio-economic factors that keep marginalized groups out of affordable healthcare. The primary objective of the research was technical in nature, i.e. establishing a network of research-analysis that could feed the formulation of public health policies. To that end, at least three of the five projects were successfully completed. While each research had a strong element of incorporating social and gender issues, the analysis of these was often superficial and quantitative. It is true that quantitative analysis could provide a better insight in terms of use and access to health care, but without a thorough gender and social analysis of qualitative nature, important gaps could be missed.

Recommendations

Given that Project 101160 and 103861 (following review) are part and parcel of the Public Policy research program, recommendations for both are combined in order to present effective suggestions as well as to avoid repetition. Please see end of following section.

9b. 103861 - Politiques publiques et lutte contre l'exclusion - Phase III

Public Policy and Protection from Exclusion - Phase III

Burkina Faso, Ivory Coast, Senegal, Benin, Mali

Partners: Centre Hospitalier de l'Université de Montréal
Association Burkinabé de Santé Publique
École nationale supérieure de statistique et d'économie appliquée (Ivory Coast)
Cabinet d'Étude HYGEA (Senegal)
Grant: \$877,011
Duration: 36 months
Approved: 2006/06/28
Classification: Women-inclusive and gender-integrated (Côte d'Ivoire) research

Background

In earlier phases of this project (see review of Project 101160 above), researchers and health experts from Burkina Faso, Senegal, Ivory Coast, and Université de Montréal established a network to research and analyze how policy affects fair access to healthcare in West Africa, as well as to develop new public policies to protect the exclusion of the poorest from healthcare services. In Phase III, two additional countries were included, rendering the research program more ambitious.

Document Review

Proposal

The proposal provides a detailed overview of the proposed project's preceding phases, which have facilitated the establishment of a network of researchers and decision-makers to study public policies' effect on healthcare accessibility to all. The research program encompasses five mutually exclusive projects in five West African countries. In two projects, namely in Burkina Faso and Mali, the research will focus on maternal mortality programs. In the rest, the study will concentrate on cost factors, care quality, user fee exemptions, and reduction of inequities in healthcare access through health insurance initiatives.

The document provides a summary of findings from Phase I, where it was determined that hospitals offering obstetric emergency services applied user fee exemptions haphazardly. This in turn had a negative impact on women's access to critical care. In Mali, the project would also attempt to suggest ways to improve obstetrics care in order to reduce maternal and child mortality rates. The proposal establishes a link between women's low education level and their likelihood to use prenatal and obstetrics services. To that end, a wide range of statistics is provided, including some comparing the use of obstetrics care by women with little education (0.5%) and those with secondary school education (4%).

The research program does not allude at any point to taking into consideration gender issues in its approach. Nor does it suggest undertaking a gender analysis in each country, which constitutes a significant flaw in the research process.

PAD: The research program calls for specific purposes in each country:

- Benin: to evaluate the impact of health insurance initiatives on health care costs and quality, support services, and funding of health care structures
- Burkina Faso: to assess the requirements for implementation of government measures in obstetrics to reduce maternal mortality
- Ivory Coast: to design a national strategy on user fee exemptions for the poor
- Mali: to assess and document the effects of a maternal mortality reduction program
- Senegal: the project will seek to direct health insurance towards reducing inequities in access to healthcare.

Given the coverage of five countries, the research methodology involves multiple and combined approaches relying on primary and secondary data.

The PAD does not contain any gender related references.

Publication: Équité et Mutualité au Sénégal - Summary

There are three types of mutual health insurance providers in Senegal, including community based, professional, and protection/indemnity companies. Women are significantly represented at executive levels in community-based insurance entities (51%), with 40% of this type of insurance being also headed by female directors. The document calls for more mutual insurance companies that collaborate with women's associations.

Evaluation methodology development - Benin

This document is a protocol detailing how the evaluation of the impact of mutual insurance companies would be conducted. It also indicates that the study would involve women, especially pregnant women, and to that end, includes a brief gender analysis of mutual insurance subscribers. The analysis highlights that women are under-represented both as insurance holders as well members elected to decision-making posts; and that efforts to promote women's interests in mutual insurance companies have generally failed. The protocol document includes a good social analysis, and some gender analysis, which could have, at times, gone beyond a brief statement on the situation of women. Gender parity among participants is expected to be maintained. The questionnaires call for the collection of sex-disaggregated data.

Analyse d'implantation du système de référence-évacuation dans la région de Kayes - Mali

This evaluation provides data on maternal mortality and morbidity rates and explains that maternal mortality rates, especially those resulting from obstetrical complications, affect 100% more women in developing countries than in industrialized nations. The analysis touches on the socio-economic effects of maternal mortality, especially at household and community levels. Aside from medical causes of procedural nature, the analysis does not delve into gender-based barriers or causes that lead to maternal deaths.

Reports: The only type of reports included in the evaluation pertained to technical progress and activity reports, one of which (Côte d'Ivoire) went into great detail in defining "marginalized patients" by including a breakdown a range of possible groups that would fall under this category. It also explained that only social workers and hospital officials would be targeted in the survey.

Rolling PCRs: This document did not make any mention of the need to undertake gender or social analysis as part of the research program.

Social and Gender Analysis

Research Methodology

In general, the research program did not provide a systematic definition of sample or targeted participants. The project aims to propose ways to protect exclusion of the poor from healthcare services. However, without giving adequate attention to gender dynamics, gender and power relations, not to mention that at least 50% of poor populations are women, it is difficult to see how the research would obtain a balanced view of female and male users that would allow it to develop appropriate and effective public health policies.

Such information was not readily available in the documents included for review. The only progress report included on Côte d'Ivoire offered an excellent definition of patients who would be categorized as poor. Given that this research did not directly seek the input of these patients, the report listed potential participants who were social workers and managers and staff at hospitals. There was no indication if any effort would be made to maintain some degree of gender balance in participants surveyed.

Sex-disaggregated Data

In at least one non-gender-specific project, sex disaggregated statistics were provided, but were not accompanied by a gender analysis.

Gender Analysis

A lot of statistical evidence is included in the proposal, showing women's use of obstetrics care. There is some effort to analyze the trend in the proposal, but the assessment solely assumes many variables keep women from making use of prenatal and obstetric services. While the statistics indicate a stark contrast between poor and rich mothers, educated and non-educated women, and those living in urban and rural areas in their usage of obstetric care, there are many other gender and socio-economic factors that determine health seeking behaviour and decision-making at household levels. For example, a gender analysis could have brought out power relations and gender dynamics at household level, who finally decides on how and on what household income is spent, which ultimately has a significant impact on women's likelihood to go to prenatal and obstetrics clinics.

Recommendations

The following encompass suggestions for both projects reviewed above (101160 and 103861).

1. There is a need for a clearer definition (in all project documentation) of gender and socio-cultural related data that has implications for the design and formulation of public policies.
2. Make more explicit clarification of gender and socio-culturally acceptable approaches, both in terms of the gender balance in research team and sensitivity to gender and social norms.
3. Ensure that there is consistent reporting on the level of involvement of female researchers and the quality of their contribution.
4. There is a need for a better synthesis of sex-disaggregated data, with qualitative gender analysis.
5. Include male participants, even in projects that may appear to concern women only. This will help uncover the power relations that interplay between women and men and which ultimately affect their decisions about and ability to use healthcare.

PROJECTS FUNDED IN the rest of SUB – SAHARAN AFRICA

10. 103201 – Strengthening Health System Through Maternal Death Review in Kenya and Zimbabwe

Partner: UNICEF ESCARO

Grant: \$ 243,500

Duration: 24 months – 2006 to 2008

Approved: 2007/06/27 (approx.)

Classification: Women-specific research

Background

The general objective of the project is to improve the accountability of the health system and quality of maternal health care through maternal death review (MDR) in Kenya and Zimbabwe. Based on a successful model of MDR in South Africa, the aim is to reduce maternal mortality rates by recommending and implementing policy actions at various government levels, increasing health resource allocations, and strengthening the design and implementation of health programs.

Kenya and Zimbabwe both have high maternal mortality rates (MRR) but these ratios provide health care practitioners with little insight into avoidable or remedial actions.

UNICEF's national offices in both Kenya and Zimbabwe have ongoing maternal health programs and partner with the Ministry of Health and other development agencies. Both countries have conducted the national baseline assessment on emergency obstetric care and have been supporting national policy development, as well as district level implementations. The MDR will be integrated into the routine maternal health programs and district and national health systems.

From GEH's programming perspective, institutionalising MDR would be one way of improving the quality of care and accountability of the health care system.

Document Review

Proposal: The overall policy framework for the MDR is coordinated with a key international development goal - Millennium Development Goal (MDG) 5 which aims to reduce child mortality by 2/3 and maternal mortality by ¾, between 1990-2015.

The proposal argues that although the majority of obstetric complications cannot be predicted or prevented, the outcomes are different for those with and without access to life saving services. In reference to gender considerations, it was acknowledged that men and family members are important to ensure recognition of referral and obstetric complications. The aim is to benefit all women suffering from obstetric complications especially poor women from remote areas seeking health care in time.

Proposal Review: The team identified an important gap in the analysis - data from home deliveries as only cases reported in hospitals and health care centres were going

to be captured. The main methodological challenge identified in the proposal was a weak gender analysis.

PAD: An analysis of governance and gender has been stipulated in the reporting from the partner. A caveat in the PAD stated that MDR has been carried out on a small scale in many countries in the region but these activities were purely academic without generating necessary actions to improve the situation.

Reports: No reports have been received for this project. Delayed or the lack of reporting was identified as a risk.

Social and Gender Analysis

The proposal's commitment to place the MDR research program within a specific international policy framework is positive, as is the close collaboration with the Ministry of Health in both countries. It is also appropriate since UN statistics confirm that little progress has been made to reduce MMR in sub-Saharan Africa with an average risk of 1 of 16 women dying in child birth.³⁰ It would have been beneficial for the proposal to outline the latest health plans of the two countries including current programs aimed at reducing MMR such as Emergency Obstetric Care (EmOC) or lack thereof, as well as targets, current research on possible shortcomings. Was the research targeted for a Averting Maternal Death and Disability Program (AMDD) proposed to improve the availability, utilization and quality of EmOC, which is now recognized by broad consensus in the maternal health field to be a critical, necessary part of any effective strategy to reduce maternal mortality?³¹

The project review team rightly pointed out that an analysis of gender and health governance systems should have benefitted the research methodology. This analysis could have been based on data available with the Ministries of Health in both countries, including some basic variables such as ethnicity, age, location, socio-economic status, number and spacing of previous pregnancies, etc. The question raised by the GEH team on how accurate the information collected will be in terms of reporting of maternal deaths occurring outside formal health institutions remains unclear.

It is assumed that the MDR review is based on and constrained by the definition of maternal death as adopted by the International Federation of Gynaecology and Obstetrics and recommended in the "International Statistical Classification of Diseases, Injuries and Causes of Death", i.e., "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes".³² South Africa's first MDR in 1999 focused on the medical causes of both direct (hemorrhage, sepsis, eclampsia, obstructed labor and complications of unsafe abortions) and indirect obstetric deaths

³⁰ Un Statistics Division , Progress Towards the Millennium Development Goals, 1990-2005

http://unstats.un.org/unsd/mi/goals_2005/goal_5.pdf

³¹ AMDD, Mailman School of Public Health, University of Columbia, Averting Maternal Death and Disability 1999-2005, New York, October 2006

http://www.amddprogram.org/resources/1999_2005_report.pdf

³² Melrose, E.B., Maternal deaths at King Edward VIII Hospital, Durban: a review of 258 consecutive cases. South African Medical Journal, 1984 Feb 4;65(5):161-5.

(e.g., diseases such as malaria, anemia, HIV/AIDS and cardiovascular diseases) and well as some limited causes termed as “administrative” e.g. a lack of transportation to health facilities.

This definition limits attention to “incidental causes” of maternal death which are significant. Important insights through a gender analysis of data collected for: a lack of antenatal care, dietary insufficiencies caused by the inequitable distribution of food, various forms of genital mutilation which may predispose women to infection, the impact of gender based violence on MMR. Other gendered factors, which cause delays in women receiving timely care during delivery, are distances to health centers, inadequately trained traditional birth attendants, poverty and inability to afford cost and familial and cultural taboos (e.g. seeing a male doctor). While it is possible that all these factors including the existence and level of care available at health centres will be taken into consideration by the researchers under the guidance of UNICEF's national offices, an understanding or sensitivity to these factors are not demonstrated in the proposed research.

Partner Consultation

A questionnaire was emailed to the partner, UNICEF:

Dr. Luwei Pearson
Section Chief, Health
UNICEF Addis Ababa
Ethiopia
Office: 251 11 518 4235

Dr. Pearson's answers have been italicized below the evaluation's questions:

1. Did you receive sufficient guidance from IDRC/GEH proposal guidelines to prepare a tentative social and gender analysis and a gender integration plan into the MDR's proposal? Please explain.

(Social analysis in the context of the circumstances and needs of socially disadvantaged and marginalized populations including ethnic differences, urban-rural location, age, disability, socio-economic status.)

The IDRC guideline was clear that gender is an important issue. During the proposal development, the concerned IDRC staff also helped us to make the gender issue better articulated.

2. Is there sufficient guidance for progress reports in the grant approval documents from IDRC/GEH and from program officers to provide research design and implementation of relevant social and gender equality issues for this research?

The general guideline was clear. However it is also important for each proposal to get the gender issue right for the specific country settings.

3. How is data being collected from outside the official health systems e.g. from home deliveries, if at all, or are only cases reported to the hospitals and health care centres collected?

For the facility based MDR, we are collecting data from health facilities only.

4. Will data also be collected from men as they play an important role in reproductive health?

During the analysis of avoidable causes of maternal death, such as delays in recognition and referral of obstetric complications, men's views (family members, relatives) are collected.

5. The project's close collaboration with the Ministries of Health of both countries is a positive capacity building exercise. However, is there a governance and health analysis such as the latest health plans of the two countries including current programs aimed at reducing MDR/MMR such as Emergency Obstetric Care (EmOC), or its lack there, and current research on shortcomings.

Both the countries have developed the roadmap for RH/Maternal health/EmOC --- reaching MDG 5, based on a national EmOC assessment. MDR is part of the roadmap in both country's roadmaps.

5. Does UNICEF regional and national offices have sufficient capacity for gender analysis and integration to assist?

Can be further strengthened. There is a gender specialist in the regional office to advise country offices.

6. Is there a gender focal point or gender specialist who could assist the team?
Yes as above

7. Was gender training provided for the project for a consensus on data collection?

Not specifically. Although MDR is all about women.

8. Would the researchers collect data on the indirect causes (FGM, gender violence, lack of transport) of obstetric deaths as well as direct?

Yes, both direct and indirect causes are collected and analysed. See a sample report.

Aside from malaria as an indirect cause of MDR, the evaluation did not find any other analysis of indirect causes in the reports referred to by the partner. Although a gender specialist is available at the regional office, it does not seem that gender advice has been sought or received on this project. The reports made no mention of consulting both men and women for the causes behind the high rate of MDR. MDR has been minimised to a women specific issue, discounting the social determinants for the high level of MDR in these two countries. However, UNICEF did provide positive feedback on the development of national plans for EmOC to reduce MDR. It is not known if the social determinants of high MDR are also recognised and addressed in these plans.

Recommendations:

Strongly encourage research partners to:

1. Develop a gender analysis from currently available resources to help inform research design and findings.
2. Collect data from both men and women for MDR as men play an active role in reproductive health and need to be involved and aware. Report on sex disaggregated data and any differences in attitudes and experienced on MDR between the two.
3. Provide an initial governance and gender analysis before the PAD is approved, i.e. health policy and programmes that are in place and how these can be improved by the research suggested.
4. Promote gender parity in the research team in order to build equity and equality in capacity building. Report on composition of team including age and ethical considerations.
5. Undertake a short gender training session specifically tailored to the research in order to build capacity. The training should include all the stake holders. UNICEF national offices generally have a roster of national or regional gender consultants.

11. 104298 – REACH – Policy Initiative Phase 11: Consolidating the Regional Hub and Developing Country Nodes

Partner: East African Community
Grant: \$ 205,073
Duration: 12 months
Approved: 2007/01/25
Classification: Women Incidental Research

Background

REACH's implementer is the East African Community (EAC) made up of Kenya, Tanzania and Uganda. The main aim of the REACH is to strengthen regional health policy and practice in the three countries based on the effective use and application of knowledge. The REACH policy initiative was intended to serve health researchers in East Africa by converting their research into useful policy relevant evidence through simple language so that it was easier to communicate for policy making. As well, it will also serve to answer scientifically or support for further investigation the questions and practical policy-making needs of government officials and other health care professionals.

The phase was designed as the launch of the REACH and designed to cover essential start-up costs for the first year of operations, mainly setting up a regional hub in Arusha. This hub will initiate a strategic and directed approach to solicit funding from international donors. In addition, this launch phase will continue to develop national nodes in the three EAC partner states, starting with holding consultative workshops with the Ministries of Health, other ministries, academic institutions, research organisations and professional bodies.

Document Review

Request for Funding: A letter from EAC to Christina Zarwosky for funding of the REACH policy initiative on authority of the REACH Synergy Group and the Regional Steering Committee. In assessing gender parity, it was found that the Synergy Group consists of 14 members, one of whom is a woman, Dr. Miriam Were of National AIDS Control Council (NACC) and African Medical and Research Foundation (AMREF) in Nairobi.

The request for funding includes a report produced for the EAC International Partners Conference on the Regional East African Community Health (REACH) Policy Initiative held in Arusha in October 2006. Except for those representing foreign donors and foreign organisations such as IDRC, all those present from the EAC seemed to be men. This could be because medicine continues to be a male dominated profession in the developing world while the trend has changed in the developed world. A presentation on reaching health policy outlined similarities in preventable disease burden among the EAC partner states which include financing mechanisms, district health planning, community based primary health care and policies on malaria and HIV prevention. The strengths and challenges in the health sector in the region were also outlined including: 1) strengths such as training infrastructure for human resources, strong health research traditions, a history of regional cooperation and the political will to create

REACH; and 2) challenges such as difficult local research priority setting within limited resources.

PAD: There is no reference to social analysis or gender analysis or that partners will be encouraged to pay more attention to it and address it. It highlights a need to focus on capacity development of female researchers and to raise awareness of gender issues in research design.

Reports: None found or reviewed.

Social and Gender Analysis

The PAD highlights an important need to support the capacity development of female researchers and to raise awareness of gender issues in research design. It is unclear if it the exclusive role of women researchers to raise awareness of gender issues under the assumption that gender is equivalent to women. A strategy for how this would be done is not outlined.

The article on the following page by Eunice Ndirangu of Kenya highlights some of the cultural challenges and gender concerns of young researchers in developing countries such as research as a male dominated field.³³ During the conference in October 2006, one of the group commented on the “need to take into account the social and political evidence as well as medical and logical evidence”.

Of the various partners, Dr. Miriam Were who represents both AMREF and the National Aids Control Council (NACC) of Kenya is the only woman representative. Although the evaluators do not endorse the opinion that women are more gender sensitive than men but by not including a critical number of women in meetings has certain pitfalls such as no reference to the crisis in sexual and reproductive health (large numbers of maternal deaths) and gender related health issues in the region (the impact of gender based violence, higher numbers of women affected with HIV/AIDS, disproportionate burden on healthcare on women, higher poverty levels) which is rampant across the region on health and health systems. A gender strategy for the network would need to consciously include women from various sectors including students.

Recommendations:

1. Increase the participation of women on REACH and include both men and women who can bring both a gender perspective to equity in health.
2. Create a gender strategy so that all health research disseminated for policy making has a gender perspective similar to the Global Forum on Health Research.
3. Encourage more research on social/gendered health issues in terms of access and control over health services.

³³ Eunice Ndirangu, Challenges for Health Research in Developing countries: Sterotypes and Cultural Issues, Global Forum for Health Research, Young Voices in Research for Health 2007
http://www.globalforumhealth.org/filesupld/Young%20Voices/07/art/YoungVoices07_Ndirangu_ChallengesforHealth.pdf

CHALLENGES FOR HEALTH RESEARCH IN DEVELOPING COUNTRIES: STEREOTYPES AND CULTURAL ISSUES by Eunice Ndirangu, Kenya

In my view, the challenges for health research in developing countries go far beyond factors such as limited resources and in particular human resources in health and health care-related institutions. These challenges are more ingrained in the stereotypes and cultural issues that affect who does research, when research is done, how it is done and where it is done. In this paper I look at issues such as mystification of research, publishing of research from developing countries and evidence-based practice in the context of developing countries. In my view these issues, among others, will still serve as barriers to research in developing countries even if resources were to be made available.

Having sat through a research class as a nursing student, I felt that rather than getting familiar with research and feeling comfortable with doing research I found it difficult. On reflection I see that, at the time, I was taught research as something that was difficult and no one made an effort to simplify it or bring it down to my level of comprehension. I also realize that research is often taught by male tutors/lecturers and usually by the senior-most in a given institution. This gives the impression that research is a male field that is for those who are highly experienced in a particular field. To make the situation worse, the importance of research among various health workers is not emphasized during the training and students are not taught how to critique or apply research in practice. More often than not, students are asked and taught how to write research proposals and do research before they can even appreciate the importance of research in the nursing profession. This situation can be seen as a case of learning to run before you can even crawl or walk. Ultimately, the nursing students find the module difficult and go away with the impression that research is difficult and this is reinforced further because even when they go into practice they do not find nurses doing research on a wide scale in developing countries.

For a very long time in developing countries, research has been seen as a difficult process that is only done at a certain level of experience or by certain professions who are viewed as important. For example, when health research is done in a given institution doctors take the leading role while nurses do a lot of the data collection but are left out of the whole process. Could this have something to do with the fact that medicine is a male-dominated field while nursing is a female-dominated field? Culturally, men have been seen as the source of authority and their word was viewed as true even in cases where they may have been wrong. Look at it this way: the end result of a research is findings that are viewed as evidence and hence as facts that are true and that will require one to change his or her practice. Hence, the cultural domain is threatened because if a nurse finds evidence that requires a doctor and other health-care providers to change practice or even for the sake of argument requires nurses to change practice and inevitably affects medical care, will other health-care providers accept this? Chances are they will not and hence even in the few cases when nurses do research in developing countries, their findings are neither shared nor are they published because they are seen as threatening to the norm. However, I feel nurses are the best people to get involved in health research because they constitute the largest proportion of the health workforce. Therefore, there is a need to look at how research is taught and how health educators and practitioners portray the importance of research in

12. 103148 - Launching the HIV Monitor and 103853 - HIV/Aids Monitor Country Studies

103148 - Launching the HIV Monitor

Partner: Centre for Global Development (CGD)

Grant: 60,240

Duration: 6 months

Approved: 2005/06/29

103853 - HIV/Aids Monitor Country Studies

Partner: Centre for Global Development (CGD)

Grant: \$ 720,000

Duration: 36 months

Approved: 2006/06/26

Funded jointly with the Women's Rights and Citizenship program (\$100,000)

Classification: Gender-Integrated Research (at point of entry -PAD)

Background

The HIV/AIDS Monitor Project, is coordinated by the Center for Global Development (CDG). It aims to improve the ability of donor countries to respond effectively to the HIV/AIDS pandemic by examining the operations and impacts of three major funding initiatives: the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); the President's Emergency Plan for AIDS Relief (PEPFAR); and the World Bank (MAP).

The project partners with local research institutions in four countries (Miz Hasab in Ethiopia, Austral Consulting in Mozambique, Makerere University in Uganda and University of Zambia).

Through systematic research and analysis, coupled with complementary research and assessment at the global level, the project will strengthen the organization, management and delivery of foreign assistance to maximize its impact in supporting HIV/AIDS programs worldwide.

The CGD purports to undertake analytic work in seven areas: 1) tracking the funding; 2) women and gender; 3) relationship between funding and performance; 4) HIV/AIDs and reproductive health; 5) national vs. parallel systems; 6) recurrent cost burden and sustainability; and 7) the impact on labor market for health care workers and managerial talent. IDRC will fund three themes but the CGD would report to all seven. Other funders for the larger global project include the Bill and Melinda Gates Foundation and William and Flora Hewitt Foundation. The Gates Foundation also supports 4% of the budget for the Global Fund.

By partnering with the International Centre for Research on Women (ICRW) in the HIV/AIDS Monitor Project, CDG demonstrated that sex and gender were not only relevant but an important part of the research project. ICRW's role is to provide technical direction and assistance in conducting a gender analysis of the three funding mechanisms' operations in the four focus countries.

Both CGD and ICRW are influential American based organisations and they were approved for funding based on the understanding that they would most be able to generate knowledge through comparative analysis of the three major sources of

international funding for HIV/AIDS prevention, treatment and care. The HIV Monitor project aims to focus less on health systems per se but make a special contribution to aid coordination and effectiveness and through this route influence the policies of the three international institutions.

Document Review

RSP: Based on a RSP # 103148 “Launching the HIV Monitor” which provided background analysis and proposal development, this initial phase included Rwanda and Malawi in addition to the four countries chosen for the project. Findings included high levels of coordination between the different funding mechanisms, one with strong government leadership and the other without but with the support of NGOs. The major gap in this very short paper presented to the GEH at the end of the research was a social, sex and gender analysis of the reasons why HIV/AIDS was so rampant, within which communities, or affected one sex more than the other and the reasons for the difference. A case study, for example, of the implementation of HIV/AIDS policy and programming inputs and outputs of the 3 global funds to assist the high numbers of women who survived the genocide but contracted HIV/AIDS in Rwanda would have outlined some of the gendered aspects of a HIV monitor. The RSP’s report mentioned that the HIV Monitor program will examine the 3 funds orientation toward women and other vulnerable groups.

Proposal review process: The GEH team raised various concerns with the researchers including how the research will ensure gender and equity is addressed in the analysis and data gathering. Their tenacity, documented through many emails and conference calls with the researchers. There were two sets of detailed written responses to detailed analytical concerns raised by the project review team.

Revised Proposal:

1. Gender disaggregated data - the proposal provides general sex-disaggregated data – more than 60% of those infected with HIV/AIDS virus in SSA are women and girls. Specific baseline data has not been provided for the four countries to be reviewed although the RSP covered an initial assessment.
2. Equity concerns – The proposal did not outline a social analysis of those that are vulnerable and those presently infected with the virus or such basic information such as sex, demographics, ethnicity, disability, migrant and refugee status.³⁴ Equity concerns are based on a social analysis and how policy and programs funded through the three initiatives address these target populations.
3. Objective – One (#2) of the seven key themes is women and gender equality. Through a set of questions, the research will examine the policy relevance of the three institutions in light of the evidence that the pandemic is both fuelled by and reinforces fundamental gender inequalities in health systems, family structure, and economic relations. The main data sources will include women’s organisations and beneficiaries. A second theme focusing on women (sex) is theme # 4 - HIV/AIDS and reproductive health.

³⁴ In Zambia, the HIV prevalence rate among girls under 18 is 4 to 7 times higher than for boys and the most affected age group is girls between the ages of 15-19.³⁴

4. Gender analysis – Under the section on gender considerations, key themes related to gender and HIV – stigma, care, livelihoods, sexuality and power, property rights and violence against women for prevention and mitigation. This listing is comprehensive. ICRW is responsible not only for the inclusion of gender analysis but to channel up findings to special initiatives such as HIV and development. Claims that ICRW has strong partnerships at country level implementing agencies, are not supported by any evidence.
5. Gender capacity – The research team has a strong base in various health related fields related to women: reproductive and adolescent health (project director Nandini Oomman); health of women in Latin America and the Caribbean (Ruth Levine); women's empowerment (Anju Malhotra); and gender and mitigation of HIV and AIDS and inter-relationship between gender and infectious diseases (Jessica A. Ogden). The question raised by the team members and the gender evaluators is how this team supports and transfers its knowledge and capacity to the field director in order to support the four implementing partners.

PAD: The PAD specifically calls for ensuring that a strong gender equality approach and analysis is included, as well as monitored. The ICRW is acknowledged as a partner with a strong reputation for gender analysis but at the same time a concern that it did not have an office in the region was acknowledged. The importance of gender and equity in the design, implementation and analysis are one of three issues raised and highlighted in the PAD. The issue of technical oversight for the in-country researchers generally but especially in gender analysis was raised and it was suggested that the project seek a field director who also had some gender expertise. The expected results include an introduction of specific gender and equity related criteria in the evaluation of the projects supported by the three international initiatives.

Progress Reports: An interim progress report dated February 2007, provided an update on funding including efforts to procure more funding for the gender theme from the Ford Foundation, as well as a request to the ICRW to explore possibilities with their existing donors to procure more funding for the gender theme.

Web-based research was conducted to verify and assess publicly available information especially on gender analysis related to the project on CGD's website.

Web-based research: As outlined in the proposal, one of avenues for knowledge sharing is the CGD was through its website and blogs. The website profiles the HIV Monitor Project under "Health".

Nandini Oomman, the project's program manager posted some of the following information on the HIV Monitor's blog that relate specifically to gender issues:

1. New policies to improve Global Fund operations such as a forthcoming comprehensive gender policy can present challenges the key principle of country ownership. There are many good reasons to adopt a gender policy but it should be designed to encourage countries to address gender issues in a way that is consistent with national strategic plans.
2. The World Bank MAP had a busy year. In July 2007 it released its first comprehensive review of the Multi-Country HIV/AIDS Program (MAP) for Africa, one of the first major donor initiatives to tackle HIV/AIDS on the continent. As Steve Rosenzweig noted in an earlier blog the report was not able to tie MAP activities to outcomes (more knowledge about preventing

HIV) or impact (lower prevalence) but, recognizing this limitation, the report's authors called for better measurement and evaluation in the future. This recommendation was further developed in An Agenda for Action 2007-2011, launched in November 2007. At the time of release of this agenda, Nandini Oomman summarized the 4 key pillars of the new Agenda for Action: 1) Focus efforts on evidence-based strategies appropriate to the country context, 2) Fund a comprehensive approach that includes activities like increasing awareness and promoting gender equality, 3) Improve Monitoring and Evaluation in order to improve results; and 4) Help all donors work better together.

3. March 19th, 2008 – PEPFAR ReAuthorisation Responds To Some Evidence from First Five Years

- ***Addressing the Vulnerabilities of Women and Girls:*** Several recent reports, including CGD's Girls Count have showed the unique vulnerabilities faced by women and girls to HIV. The epidemic is not gender neutral and the new bills recognize this by calling for gender to be a high priority in all aspects of PEPFAR, from the five-year strategy to the evaluation that will be conducted during its fourth year. With the overall PEPFAR strategy, the Senate bill asks for "a description of the specific targets, goals and strategies developed to address the needs and vulnerabilities of women and girls to HIV/AIDS." In addition, the proposed legislation authorizes that a new evaluation report include an assessment of gender specific aspects, including the constraints to accessing services and underlying social and economic vulnerabilities.
- ***Anti-prostitution pledge:*** Both versions of the bill propose no changes from the current law. The confusion caused by the current law about what PEPFAR implementers and their sub-recipients can and cannot do with sex workers still persists. Clarifying the language in the new bill may be helpful to recipients and sub-recipients to understand how one can effectively prevent infections from being transmitted to and from women in sex work and their clients.
- ***Family planning:*** The Senate bill makes no reference to the family planning issues in the current law, while the House bill adds another layer of restriction to the use of PEPFAR funds for family planning activities. It authorizes family planning organizations to conduct HIV testing and counseling, but there is some uncertainty over whether organizations will have to comply with the Mexico City policy. This is a step backwards and any negotiation to better include family planning as an integral component of PEPFAR prevention programs may be a deal breaker. So it looks more and more like this issue will at best use the current House language to restrict the effective provision (and use) of family planning services and HIV/AIDS services where needed, a policy that will limit the effectiveness of the PEPFAR program in its prevention efforts. The HIV/AIDS Monitor will have field-based data on this topic later in the year to add to the ongoing debate about better linkages between HIV/AIDS programs and other health service delivery programs.

For a more detailed and interesting analysis of the Senate and House bills and the current law, and their relative emphasis on women and girls and related gender issues in prevention, prostitution, family planning and microbicides see a chart by Kathy Selvaggio at ICRW. (See Report appended at the end of the detailed project analysis – this table is included because it gives the GEH team a good example of research to policy making.)

Social and Gender Analysis

Sex-Disaggregated Data

The project documents did not supply specific sex disaggregated data on the prevalence of HIV/AIDs in the 4 countries or people living with HIV/AIDS. This data is quite easily available from UNAIDS and other organisations including some Ministries of Health. Women now make up 61% of those living with HIV and young women make

up 70% of young people living with HIV in Sub Saharan Africa.³⁵ An analysis of the baseline data and the impact of the three international donor programs over this period of time would have been useful.

Social and Gender Analysis

The HIV Monitor project is an important endeavor for the GEH – it aims to examine national and global policies, coordination and aid effectiveness and connects it with a US think tank said to have considerable policy influence with at least two of the three global initiatives.

Overall, the project team has necessary capacity and experience to carry out a good gender analysis of the three funds: the project includes a well-known partner organization, ICRW, with vast experience in research on gender equality/equity issues in many sectors including health; two themes are devoted to sex and gender; and one objective will examine policy relevance of the three institutions in light of the evidence that the pandemic is both fuelled by and reinforces fundamental gender inequalities in health systems. Except to involve local organizations, a strategy for how this will be implemented is not outlined and from the interim report there seem to be concerns regarding the availability of adequate funds for this theme.

It is crucial that knowledge be generated about how sex and gender issues are addressed by these three large initiatives but there is a caveat in the proposal that gender issues will only be addressed where considered relevant. We are not told exactly on what basis or when these issues are not considered relevant and this leaves a large gap in the gender strategy. In addition, Nandini Oomman's blogged comment observes that:

“there are many good reasons to adopt a gender policy but it should be designed to encourage countries to address gender issues in a way that is consistent with national strategic plans, is problematic because it leaves governments not accountable for the gender equality commitments made. This is reflected quite blatantly in the slow progress in reducing MMRs. Who was allowed to participate in the national strategic plans; and why would women not want to have a gender policy on HIV/AIDS in any country? Research and statistics consistently confirm that worldwide, violence and the threat of violence increase women's risk to HIV. How do the three programs address these issues?”

Aid Coordination and the Paris Declaration

The project team's vigorous perusal of gender and participation issues is highly commendable in light of the debates over the feminization of the HIV/AIDS pandemic and the Paris Declaration.³⁶ The aid effectiveness agenda of the HIV Monitor is tied to the Paris Declaration, which is problematic in terms of gender equality and equity as it is not explicitly addressed in this Declaration.

³⁵ UNAIDS (2007). 2007 AIDS EPIDEMIC UPDATE. [Online]. Available at:

<http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2007/default.asp>

³⁶ The *Paris Declaration on Aid Effectiveness* which established aid effectiveness targets and progress indicators that were endorsed by member states at the September 2005 World Summit of the United Nations.

Tracking the funds

Explicitly missing from the CGD's proposal in theme # 1 - tracking the funding - is how commitments to gender are tracked and measured. Many countries have embarked on developing gender sensitive budgets and this monitoring process is crucial.

Partner Consultation

A questionnaire was emailed to the partner, Centre for Global Development :

Nandini Oomman, PhD

Director, HIV/AIDS Monitor

Center for Global Development

1776 Massachusetts Avenue

Washington, DC

T: 202.416.5620

F: 202.416.5630

www.cgdev.org

NOomman@CGDEV.ORG

No response was received from the partner despite follow up from the evaluation team.

1. Did you receive sufficient guidance from IDRC/GEH proposal guidelines to prepare a tentative gender analysis based on available sex disaggregated data and a gender integration plan into the HIV Monitor's proposal? Please explain.
2. Is there sufficient guidance in the grant approval documents from IDRC/GEH and from project officers to provide as a part of progress reports - research design and implementation of relevant social and gender equality issues for this research (how the global funds are addressing these issues) - as well as provide sex-disaggregated data, gender analysis and disbursements of the funds for these issues?
3. The project proposal has one objective for women and gender equality issues (#2) and another (#4) related to HIV and reproductive health. What were the reasons for not mainstreaming gender throughout the entire project, specifically in tracking funding for gender related projects (#1) by the three initiatives and the relationship between funding and performance (#3)? Or is this implicit?
4. Do the objectives of the project, including # 2 and # 4 arise from the research carried out in Launching the HIV project which precedes this one? If so, could we have the relevant reports for the Rwanda and Malawi, the countries assessed to have good coordination on HIV/AIDS.
5. A caveat in the proposal states that gender issues will only be addressed when considered relevant. Could you outline the criteria for when these issues are not considered important?
6. The aid effectiveness agenda of the HIV Monitor is tied to the Paris Declaration which does not explicitly address gender equality or equity. How will the project address this issue in aid effectiveness and coordination of the three global projects?

7. Although the ICRW is considered to be a strong partner on HIV and gender related issues, it does not have a regional office. A major concern highlighted in project documents by the team was gender equity in the design, implementation and monitoring frameworks of the project. How has this concern for oversight of in-country researchers by ICRW been addressed in the project currently?

8. Your team in the US has a strong base in various health related issues related to women. How will the team transfer this knowledge and capacity to the field director in order to support the four implementing partners?

9. Have sufficient funds been raised to implement the gender related research activities?

10. What kind of support would you like to receive from GEH project officers related to strengthening gender equality/equity issues in the HIV Monitor project?

Recommendations

1. Define clearly what constitutes a relevant gender equality issue for this project and how the global funds are addressing these issues.
2. Monitor this project closely at implementation to ensure that gender fade does not occur. Monitor for collection of sex-disaggregated data and social and gender analysis and trends.
3. Ensure that vulnerable groups are clearly defined by variables such as sex, demographics, ethnicity, disability, migrant and refugee status and that the research design is set up to correlate these variables with other key research findings.
4. Track the international funds for gender equity/equality programming in HIV/AIDS.
5. Document the good practices in this project related to gender equality to share with the rest of GEH and partners.

Comparison of Select Provisions of Current PEPFAR Law, and House and Senate PEPFAR Reauthorization Bills ³⁷		
Current law (PL 108-25)	House bill (HR 5501)	Senate bill (S 2731)
<p>Women and Girls</p> <p>_ Overall PEPFAR 5-year strategy should include specific strategies, with focus on women, among other groups</p> <p>_ Report on the 5-year strategy should include description of: 1) strategies to empower women in interpersonal situations, and to reach victims of the sex trade, rape, sexual abuse, assault, and exploitation; 2) strategies to encourage men to be responsible in their sexual behavior, child rearing and to reduce sexual violence and coercion; 3) strategies to increase women's access to employment opportunities, income, productive resources, and microfinance; 4) efforts to educate women and girls about HIV infection</p> <p>_ Assistance authorized for prevention activities that 1) address behavior change, including reducing sexual violence and coercion, child marriage, widow inheritance, and polygamy"; 2) encourage men to be responsible in their sexual behavior, child rearing, and to respect women; 3) increasing women's access to employment opportunities, income, productive resources, and microfinance programs</p> <p>_ Annual report to Congress should include</p>	<p>-Requires President to formulate and submit to Congress within 6 months a separate prevention strategy that seeks to reduce the factors that lead to gender disparities in the rate of HIV infection. The strategy must include:</p> <ul style="list-style-type: none"> - Specific goals and targets under the 5-year strategy - Empowering women and girls to avoid cross-generational sex and reduce child marriage - Increasing access to currently available female-controlled prevention methods (including female condoms) -Accelerating the destigmatization of HIV/AIDS among women and youth - Addressing and preventing the consequences of gender-based violence and rape - Promoting changes in male attitudes and behavior - Supporting micro-enterprise initiatives, job training programs, and other economic empowerment efforts - Supporting expanded educational opportunities for women and youth - Protecting the property and inheritance rights of women. 	<p>_ Overall PEPFAR new 5-year global strategy must include:</p> <p>_ Reduction of behavioral risks, including "educating men and boys about the risks of procuring sex commercially and about the need to end violent behavior toward women and girls" and reduction of rape, sexual assault, and sexual exploitation</p> <p>_ A plan to address women and girls which includes, specific goals and targets, provides operational guidance to field, sets forth gender-specific indicators, and highlights the issues of inheritance rights, life skills training, preventing gender-based violence and assisting GBV victims.</p> <p>_ Accountability measures on women and girls strengthened through report on the 5-year plan and annual report to Congress, which must now include the number of women and girls reached, information about the types of programs</p> <p>_ Authorizes bilateral assistance for activities to address "underlying vulnerabilities. . . , especially those of women and girls, through structural prevention programs "; provide male and female condoms; address the stigma and discrimination; facilitate widespread access to</p>

³⁷ Kathy Selvaggio, ICRW, March 17, 2008

http://www.icrw.org/html/getinvolved/PDF/Chart_comparing_current_law_House_and_Senate_bills.pdf

<p>a detailed assessment of the effectiveness of the program in reducing the spread of HIV infection, particularly in women and girls</p> <p>_ Pilot program authorized for care and treatment of orphans, should "ensure the</p>	<p>_ Coordinating HIV services with existing services targeted to women and youth, such as family planning, comprehensive reproductive health services, and programs to reduce MTCT</p>	<p>microbicides; and referrals/coordination between HIV and GBV services, including screening for GBV in HIV/AIDS services, and HIV counseling, testing, treatment in</p>
<p>Microbicides</p> <p>_ Report on the 5-year strategy should include description of programs promoting research on microbicides</p> <p>_ Commitment to bulk purchases, distribution, and training for use microbicides, when proven effective</p>	<p>No reference to microbicides (jurisdiction of a different Committee)</p>	<p>_ Authorizes NIH Office of AIDS Research and CDC to expedite research and development of microbicides, in consultation with OGAC, USAID, the scientific community and health advocates</p> <p>_ Authorizes funds as necessary to carry out such research - USAID and OGAC to develop and implement a plan for distribution of microbicides, once available</p>
<p>PMTCT</p> <p>_ Policy statement asserting strong priority for PMCTC and requiring that the US government aim toward the goal of meeting 20 percent PMTCT coverage by 2005, and 50 percent by 2010, including drug treatment, where necessary, and expanding programs for orphans.</p> <p>_ Reporting on the extent to which they have met these targets every 5 years.</p>	<p>_ Five-year strategy shall set a target of 80% coverage of pregnant women in countries most affected by AIDS by 2013</p> <p>_ Set a target for 15 % of children receiving care and treatment services under 2013</p> <p>_ Develop a timeline of for expanding PMTCT, consistent with national plans</p> <p>_ Ensure that women in PMTCT programs have adequate access to family planning or maternal/child health services, either directly or by referral</p>	<p>_ Target for reaching 80 percent of pregnant women with prevention and treatment of MTCT within five years, in PEPFARfunded countries</p> <p>_ Creation of a PMTCT Expert Panel which will report to OGAC and the public within a year on a plan for the scale-up</p>
<p>Travel Ban for HIV-positive people</p> <p>No reference in original 2003 PEPFAR bill. 1993 amendment to the Immigration and Nationality Act requires HIV-positive foreigners to obtain waivers from the Dept Homeland Security before they can receive visas.</p>	<p>No reference to travel ban in PEPFAR reauthorization.</p> <p>Stand alone bill by Rep. Barbara Lee (D-CA) to repeal the travel restriction.</p>	<p>Repeals the 1993 travel restriction</p>
<p>Funding</p> <p>\$15 billion total for fiscal 2004-08</p>	<p>\$ 10 billion for each of fiscal 2009 to 2013, including a total of \$4 billion for tuberculosis and \$5 billion for malaria</p>	<p>\$50 billion over fiscal 2009 to 2013, including \$4 billion for tuberculosis and \$5 billion for malaria</p>

13. 103457 – Strategies for Health Insurance Mechanisms to Address Health System Inequities in Ghana, South Africa and Tanzania (SHIELD)

Partner: University of Cape Town (South Africa), Ghana Health Service (Ghana), Ifakara Health Research and Development Centre (Tanzania)

Grant: \$ 334,800

Duration: 18 months

Approved: 2007/12/21

Classification: Women inclusive (Tanzania) and Women-incidental (South Africa)

Background: This project forms the foundation (phase 1) of a larger proposal submitted to the EU to examine health care in Ghana, South Africa and Tanzania. The two main objectives of the research are to: evaluate existing inequities in the health system; and the extent to which health insurance mechanisms could address equity challenges. The key focus will be on understanding options for policy design for mandatory health insurance mechanisms specifically for those outside the formal sector. However, both private and public sector schemes will be analysed.

Specific components of the IDRC funded research will include: overview of current financing and delivery; factors driving inequity; regulatory and policy context; stakeholders views on current health system; and future equity goals.

The experience of mandatory insurance schemes in Latin America and Asia will be drawn upon as well as questions addressed on practical implementation. The trend towards increased private health care financing has contributed to exacerbating the plight of the poor, restricting access when needed the most and deepening household impoverishment. In addition, it has contributed to the movement of substantial numbers of health care professionals into the private sector, limiting the ability of the public sector to provide essential health services.

Documentation Review:

Proposal: The proposal connects achieving health system equity as a means of achieving the MDGs.

The focus of the equity analysis is on the socio-economic status (SES) as financing incidence studies traditionally categorize individuals and households according to their ability to pay, based on income and/or consumption expenditure estimates. Household surveys and their variables are also expected to be drawn up and their use of deprivation and asset indices as alternative SES measures. A limited comparative analysis of SES measures (income, expenditure, asset index, deprivation index, etc.) will be a part of the methodology.

Contribution to health schemes and out-of-pocket payments will draw on existing national household survey datasets, which contain information about household health expenditure and health services utilization.

The following surveys will be used: in South Africa - the Census 2001, 2000 (or 2005, if available) Income and Expenditure Surveys, 2002 Gender Household Surveys; for Tanzania - the 2002 Census, the 1999 Tanzanian Demographic and Health Survey (or 2003-2004 if available) and household health surveys available for specific areas. Third

party databases which contain information on members incomes and insurance contributions will also be accessed.

A key component is to elicit community (and other stakeholders) views on moving towards an equitable health system, to improve the ability to identify the poor and other vulnerable households in order to ensure that they receive publicly subsidized cover.

Under ethical, gender and capacity strengthening issues – The researchers acknowledge that gender issues are of considerable importance to the research as it has critical implications for women and gender relationships. Women's lack of control over household resources create challenges in accessing health services which need out of pocket payments. Women's current access to health services will be a focus as will the implications for women in health insurance developments. The proposal purports that health insurance can improve access to health services if all members of the household are covered and if there are no or low co-payments involved.

Secondly, in the proposal, women comprise a larger proportion of the research team and these women will lead some of the components of the research.

PAD: The PAD refers to the proposal in addressing gender issues and no additional gender analysis is provided. The objectives of the study focus on "socio-economic" groups in their distribution of health care financing burden and health care benefits. The "actual and potential equity" impact of the health insurance mechanism in place in the three countries and recommendations for those that will most appropriately address "health system equity challenges". One of the expected results is a list of factors outlining "inequity".

Reports: The evaluation team reviewed reports for the Tanzania and South Africa research projects.

South Africa

Final Narrative Report: A Critical Analysis of the Current South African Health System, May 2007; and
SHIELD Package 1 Report: A Critical Analysis of the Current South African Health System, Undated

Both reports do not provide sex disaggregated data, gender analysis or other social data analysis.

Although the definition of equity is not defined, equity challenges are outlined as follows:

- 14% of the population covered by 131 medical schemes;
- 46% of all health expenditure flows through private health insurance organizations;
- Low income populations faces considerable out-of-pocket expenses;
- Huge disparities in the distribution of health professionals in the public and private health sectors;
- Huge discrepancies in the distribution of health care in rural and urban areas;
- Limited cross subsidies;
- Tax deduction of insurance payments benefit high income earners;
- Uncontrolled cost spirals in the private insurance schemes.

There is reference to gender differences in the equity challenges. The restructuring of the health department in 1994 resulted in the removal of user fees for public sector health care services to: children under the age of six; pregnant and lactating women; and later, for primary health care services; and most recently for pregnancy services incorporating prenatal, obstetric and postnatal care. The report does not provide an analysis of the level and quality of implementation of these services, as they would have indicated how public health schemes are meeting the needs of specific services to women and children.

The report promises to provide, in future phases of SHIELD, a detailed evaluation of financing and benefit incidence and the potential for alternative health care finance approaches more systematically. The evaluation team hopes that it will provide a full gender analysis of the services already provided by the public health care schemes.

One major challenge outlined by the report was the lack of a body of critical evaluation of the African experience with health insurance in general and there is almost no literature on the potential and actual impact of mandatory health insurance in the African context.

Tanzania

Report on SHIELD Package 1: An Assessment of the Health Financing System in Tanzania: Implications for Equity and Social Health Insurance, May 2007

This report explicitly defines equity as the requirement that individuals of unequal ability to pay make different payment (vertical equity) or those of the same ability to pay make the similar contribution (horizontal equity). The central idea of “equity” is the notion of “fairness”. In analyzing the equity implications of existing health financing initiatives in Tanzania, it is important to analyze the barriers to access to health services of vulnerable groups, namely, the poor, children, women and disabled people. An analysis of barriers to access will outline how different methods of financing will suit and impact different groups in terms of: rate and terms of contributions; benefit package; type of providers; and quality of care.

The report provides a cursory social and analysis on sex related health needs but focuses on maternal care; and the discrepancies between the rich and the poor and the rural – urban divide.

An analysis of issues relevant to benefit incidence outline access to care for health services such as delivery by a skilled assistant and those that deliver at home and receive no post natal check up for their infants. Richer women are 40% more likely to receive treatment for fever and 20% more likely to receive any ORS for diarrhea. Other statistics include 59% of pregnant women in urban areas slept under a insecticide treated net (ITN) compared to 10% in rural areas. Distance and the lack of transportation were important variables for access to health care facilities especially in rural areas. However, the differential in access to and control over health service resources between men and women is not discussed.

There is strong support for the retention of user fees in Tanzania from a group of donors. The donors generally maintain that it is not user fees at primary care services, which impoverish households but rather larger fees for inpatient hospital and surgical care combined with disability and long-term illness such as AIDS. The elimination of fees at

lower levels does not address the need to protect households from impoverishment due to illness.

The report admits that there are many gaps in determining who is paying and who is benefitting from health care in Tanzania. SHIELD's next phase will synthesize and analyze primary data to provide insights into the precise nature of financing and benefit incidence.

Social and Gender Analysis

Gender Analysis

Both country reports represent phase one of a much larger research project. Despite the project proposal's reference to critical implications for women and gender relationship, there is varying gender analysis or integration in the reports and no strategy of how this will be addressed systematically in future research. A reference to gender parity or more women on the team seems to identify gender sensitivity in the team. Particular issues, which need to be addressed in a gender analysis and a strategy for its systematic integration in the research methodology, were some of the main challenges identified in this project review. The evaluators understand that future reports on the nature of financing and benefit analysis may address equity as well as gender considerations but this is not specifically elaborated.

While neither of the two country reports reviewed provide a full gender or social analysis, the focus of the analysis being socio-economic groups, the Tanzanian case study demonstrates a clearer understanding of social as well as gender equity issues especially in relation to socio-economic class and location; age and race are not addressed. As well, the Tanzanian case study focuses on reproductive health issues but acknowledges that greater analysis is required on equity issues. It does not, however, provide a gender analysis on the user fees issue: user fees has profoundly influenced the extent of poverty in Sub-Saharan Africa and in Tanzania, user fees has reduced the number of hospital admissions of pregnant women, increase in maternal deaths and a decline of the Maternal and Child Health services.³⁸ With its access to numerous health surveys for specific areas, it possibly afforded a unique opportunity to multiple levels of analysis, which may include some intrahousehold indicators and analysis.

The South African report does not include a gender dimension in its reporting of equity challenges.

It is important to do a gender analysis of the health insurance schemes as patterns of insurance coverage are different for women. Although men and women are at similar risk of not having health insurance, women—whether insured or uninsured—are more likely to report cost-related access problems. For example, what is the level of access and quality of implementation of the public health services offered in South Africa in meeting the needs of specific services to their target populations - pregnant women and children?

³⁸ UNRISD, Gender and Health Sector Reform: Analytical Perspectives on the African Experience, may 7, 2004.

Women differ a lot in their experiences and needs. Even though they are more likely to need health care, women are more likely than men to encounter barriers to receiving it. Women, who more often than men are caring for a child or aging relative, are thus less likely to have good access to health care themselves. Due to cultural upbringing, men tend to avoid health issues until they are critical. Both elderly men and women, unless they are cared for, also tend to ignore their health concerns.

A fuller gender analysis of health insurance schemes would need to keep in mind and provide evidence to approve or disapprove the following issues:

- There are many different forms of household, and inequalities within those households. The extent of pooling of those household resources to meet family healthcare needs should be determined.
- Women are more likely to have lower incomes than men due to the care they provide to the household but higher out of pocket expenses to pay for health care.
- Women are less likely to have coverage through their own employer and more likely to obtain coverage through their spouses as dependents making them vulnerable.
- On average, women use more health care services. Women are more likely than men to need health care throughout their lifetimes due to their reproductive healthcare needs.
- Women, in general, bear the greater burden of care of the sick and elderly, and therefore have lesser resources.
- Women are more likely than men to have a chronic condition requiring ongoing treatment.
- Certain mental health problems, including anxiety and depression, affect twice as many women as men. While more women attempt suicide, more men die of suicide.
- Women are more likely to avoid needed health care because of cost
- Women and girls experience widespread gender violence and abuse requiring health care services.
- Women are more likely to have medical bill and debt problems and depend on remittances.
- Many women are involved in private community based savings schemes to try to anticipate future family health issues.

Research Methodology

The research methodology focuses on an assessment of socio-economic status, based mainly on a review of relevant literature and household survey datasets. A large number of people in these three countries are poor. More women than men are poor. Gender is generally, a missing dimension in household surveys. The gender dimensions of poverty – more women than men are poor - but also relates to the ideas about relations within the household. Household surveys using conventional economics saw the household as organised around the pooling of income and meeting the welfare needs of all members. However, studies from various parts of the world suggest that, on the contrary, there are widespread and systematic inequalities within households. Gender as an important determinant of the distribution of rights, resources, and responsibilities within the household but recognizes that it is not the only factor. Age, birth order, relationship to the

household head, and position of the household in society are some of the factors that also influence the allocation of household resources. Attempts to estimate poverty that overlooked inequalities in the household therefore provided a very incomplete picture. In particular, they had little to say about women's experience of poverty relative to that of men within the same household

The research methodology needed to provide a strategy for acknowledging the many different types of households and assessing the intrahousehold dimensions of poverty.

Recommendations:

1. Justify/provide rationale why gender analysis and integration is important to the study of health insurance schemes – in addition to socio-economic analysis. Namely that women use health services more than men which entails a higher burden on the insurance scheme. They are also less likely able to be able to afford user fees.
2. Analyse the household datasets for sex and gender-related statistics (e.g., the Tanzanian case study already provides some statistics).
3. Seek and consult resources familiar with gender economics models in health research. These should not be difficult to find as Tanzania and South Africa both have national gender sensitive budgeting initiatives which depend on gender statistics and modeling.
4. Include gender as a variable in any health-focused impact research assessment process and collect sex-disaggregated data for the target populations, particularly when looking at health care access issues for poor communities. These assessment processes also need to analyze if there are any significant differences in male and female access and if so, why so that appropriate mitigation strategies can be developed for either group.
5. Include a strategy to address gender more systematically within the research and do a gender analysis, e.g., by focusing on field visits and focus group discussions to supplement the (probable lack of data in the) household surveys as a part of the methodology. Much can be learned from short field visits, particularly when accompanied by a local expert who is sensitive to gender issues. The bottom line is that some attention to gender issues—even very informally—is likely to pay off in terms of the relevance and usefulness of the research.
6. Make use of the many tools available to do such an analysis such as: participatory research analysis (PRA) and participatory monitoring and evaluation (PM&E).
7. Share gender strategies between the researchers of insurance schemes in all three regions – LAC, West Africa and SHIELD.
8. Compile available resources on insurance schemes in Africa and gender considerations. The Gender and Health Sector Reform in Africa by UNRISD (May 7 2004) offers a list of useful resources and recommendations on health sector reforms in Africa.

14. # 103277 – Equinet Phase IV: Strengthening Equitable National Health Systems in East and Southern Africa

Partner: EQUINET for TARSC UK (Component 1) and TARSC Zimbabwe (Component 2)

Grant: \$ 600,800

Duration: 24 months

Approved: 2006/12/14

Classification: Women-incidental project

Background

The Regional Network for Equity and Health in East and Southern Africa (EQUINET) is dedicated to influencing and supporting national and regional policies and practices to promote equity in health. Equinet is a mature network that has become a GEH flagship project as it directly addresses all of the GEH's program objectives. According to GEH's external review, Equinet has emerged as one of the strongest South based and led networks supporting research and the development and assessment of policy on equity in health.

Equinet links with parliamentarians and health ministries in the region as well as multilateral institutions such as the WHO and the Global Fund to enable it to bring research closer to health policy and systems decision makers. It links with decision makers, health workers, community and civil society organizations to enable it to bring concerns of the "real world" to researchers.

Equinet's secretariat is based in TARSC which works mainly in southern Africa and networks with non government, government and academic organisations.

Document Review:

PAD: The PAD does not include any social and gender analysis.

Reports:

Programme management and regional work Report for year 2: December 06 to November 2007 – November 25 2007

Annual Report January – December 2007

The focus is on a network of organisations support a people centred and community led changes in the functioning of health systems at district, national and regional level.

Not one of the six priority areas focus on gender. Cross – cutting work is said to have been highlighted but there is no mention of gender considerations. The annual report mentions a few random activities to build capacity on gender and health issues including but not restricted to: a workshop on the BIAS FREE Framework; technical input on health and gender policy for the African Development Bank in Tunis; a seminar and a paper on reproductive health and midwifery.

Publications:

Equity in Access to AIDS treatment through stronger health systems – Parliament Briefing No. 1 – October 2006

The briefing refers to a series of issues which indirectly address gender relations - education, access to primary health care, fair access to drugs/ART, access to VCT, fair

and transparent funding to the health sector, and care for caregivers. The briefing does not however specifically acknowledge gender concerns: more young women than men are infected and likely to be infected with the virus; impact of gender based violence on spreading HIV/Aids; social stigma that affects women more; loss of trained women health workers and traditional care givers; and impact on older relatives such as grandparents of care giving responsibilities.

Fair Financing for Health – Parliament Briefing No. 2 – October 2006

By highlighting an issue such as reproductive health and comparing the rates of maternal and infant mortality rates in the three countries, the briefing could have more effectively highlighted dis-functional health systems.

Social and Gender Analysis

A review of the PAD and publications of the network yielded no gender analyses of important gender differentials and biases in health in the region which are impacted by poor health systems (e.g.: high numbers of female headed households outside the formal employment system with few resources for healthcare; high rates of maternal and infant death; a higher portion of young women contracting HIV/AIDS; high rates of gender based violence; cultural practices such as female genital mutilation and cutting which affects women's health; disproportionate number of women in care work both inside and outside the home and its implications on health systems; etc), related priorities for the network or a gender strategy in its documentation. The review cannot determine if social and gender concerns are of any importance and have been addressed in the support of equity.

There are no explicit references to gender considerations although Fahamu is well known for its website Pambuzuka.com for gender relate Fahamu is well known for its website Pambuzuka.com for gender related information and organizations in Africa but gender has not been outlined as a priority d information and organizations in Africa but gender has not been outlined as a priority on EQUINET's website.

The network is well established and its website lists the following specific areas of theme work which are co-ordinated by institutional members:

- The Health Economics Unit, University of Cape Town co-ordinates work on Resource Allocation and health equity
- CHESSORE, Zambia and TARSC, Zimbabwe co-ordinate work on Governance, equity and health
- The Centre for Health Policy, Wits University, South Africa co-ordinates work on Policy analysis
- SEATINI, Zimbabwe co-ordinates the work on Trade and health
- Health Systems Trust, South Africa co-ordinates the work on Human Resources for Health
- The Malawi Health Equity Network co-ordinates the work with parliamentarians and the student grants programme
- CHESSORE Zambia co-ordinates the work on cross border disease surveillance
- University of Cape Town School of Family and Public Health co-ordinates the work on Health Rights
- TARSC, Zimbabwe co-ordinates the work on Equity in HIV/AIDS in a co-operation with Oxfam GB
- Fahamu (UK/SA) manages the EQUINET website and newsletter
- University of Zimbabwe Medical school, Zimbabwe co-ordinates the work on Monitoring equity

These theme area programs which collectively network institutions across all SADC countries.

Recommendations:

1. Encourage the network to consider creating a strong commitment to addressing gender related concerns in health research at the community level – specifically addressing gender in governance. Fahamu could take on this role easily due to its extensive reach within women’s organisations in Africa.
2. Consider developing a gender policy for its support and outline activities for its implementation.
3. Include gender and health networks or institutions need to be included to provide that perspective such as the Women’s Health Research Unit (WHRU) at the Faculty of Health Sciences at the University of Cape Town, School of Public Health and Family Medicine. (See Appendix F for a short list of such institutions).

15. 101644 – Municipal Services and Health in Southern Africa (MSP II)

Partner Recipients: Southern Africa Research Centre, Queen's University; International Labour and Research Group (ILRIG), University of Cape Town;

Collaborating Institutions: Graduate School in Public and Development Management, University of Witwatersrand; South African Municipal Workers Union (SAWMU); CUPE, Ottawa; EQUINET; Human Sciences Research Council of South Africa.

Grant: \$ 676,000

Duration: 36 months

Approved: 2003/01/16

Classification: Women incidental research with one component, Dumping on women, women-specific research

Background

The MSP II is a research, policy and capacity building initiative examining the restructuring of water services such as water, sanitation and electricity in southern Africa. The first phase was approved in 2000 and completed in 2002 and a third phase will commence soon. A review of the research reports was undertaken for both phases.

The goal is to explore the links between health and municipal services restructuring in the region specifically the impact of service delivery restructuring (e.g. privatization, decentralisation) on health status. The overall objectives are to develop a better understanding of the complexities of the health service links with a focus on vertical and horizontal equity, and relationships of power between citizen and state; and to examine and evaluate the potential of different delivery service models to be pro-equity, participatory and health orientated.

The main objectives are to:

1. build capacity amongst academics, NGOs and government, to strengthen the potentially positive health and equity benefits of these models based on the project's research, and links between researchers/practitioners working on municipal services and those working on health;
2. develop comparative data from the region and internationally;
3. evaluate links and develop research methodologies between municipal services and health;
4. influence policy debate on municipal services and health; and
5. assist with the building of a national, regional and international network of researchers.

Document Review

Proposal: The comprehensive proposal refers to the investigation of multiple case studies and research in making the links between health and services. One of the four gaps in information identified for investigation was in "public health" e.g. Aids opportunistic infections, epidemics, hazards and special needs of women and children and the elderly, "mental health" and "industrial health" (e.g. frontline municipal workers), and how these health outcomes relate to aspects of vertical and horizontal equity.

Melanie Samson - researcher responsible for addressing gender issues.

In making the links between health and services, the methodology focuses on three illnesses – HIV/AIDS, TB, and cholera. In order to better understand social and political dynamics, the data collection includes household interviews to gather information on inter and intra household dynamics around service provision and health. The plan was to run workshops in the early part of the programme to ensure methodological consistency and participatory research implementation.

The link and the gaps between service delivery and “mental health” particularly in relation to women, children, pensioners and the disabled are highlighted for research. Case studies were proposed for both rural and urban contexts and the gendered nature of these mental health links.

Under “industrial health” gendered aspects of health and safety concerns, issues such as rape and harassment, e.g. reported by female street sweepers who work night shifts in Johannesburg.

The health of low income families and especially women and children affected by free water services and progressive block tariffs was to be gauged in one municipality in Cape Town.

The strategy for integrated development planning, links physical planning with that of socio-economic needs. The gender focus and the role of women in the IDP process is highlighted as a special interest. Its potential implications for “gender” headed households, as well as in both rural and urban IDP processes. Investigating barriers (economic, cultural and linguistic, transportation, etc) to participation in the IDP process in each municipality - particularly for women.

A potential contributions of the research are more equitable and affordable, increased gender sensitivity and more environmentally sustainable service delivery.

In reference to gender considerations, the proposal outlines the following methodology: The research would be designed to draw out the gendered aspects of the service/health links, and would be greatly enhanced by the recently established “Gender Analysis of Local Government Restructuring in South Africa” project. Based at SAMWU, with a full time project coordinator, this gender project is run collaboratively with MSP and is funded by the Finnish government for the first two years. The project has a national reference team and is establishing links with researchers in South and Southern Africa. The intention is to build the long term research capacity of SAMWU. This team of researchers will assist with all of the gender specific work on Phase II and the coordinator will sit on the project’s Steering Committee. The SAMWU researcher will meet with CUPE’s research team.

In the appendix of the proposal, a sample of research methods for evaluating privatized services in phase one of the project includes “Gender Impacts”: impacts of privatization on users of services, gender relations in the household, and women as service providers e.g. workers). Possible research tools included: 1) a review of official documentation on anticipated gender impacts (if any); 2) interviews with union officials, women workers and women service users; 3) review of secondary literature; and 4) interviews with private sector service providers.

PAD: There is no reference to gender in the PAD. However, the proposal is attached to and a part of the PAD.

Reports:

The MSP produced a large volume of reports generated by this project, many of which were reviewed by the evaluation team. Due to time constraints, findings from an analysis of a small sample of reports are outlined below based on the May 2007 Report from ISER:

1. Dumping on women – gender and privatization of waste management.

February 2004 The research resulted in the publication of a book written by Melanie Samson which examined the gendered nature and implications of local government privatisation with a focus on workers. The book was unavailable but a Newsletter for the MSP “Services For All” and the May 2007 report provides some details. The research methodology examined the differences between men and women workers in the recently privatized waste management sector. The research identified that women’s this type of work was seen as a natural extension to women’s work in the home, as well as that although all workers were negatively affected by the privatization women workers were more negatively affected than men. These included differences in wages and benefits, violence experienced on night shifts etc. The gendered nature of this sector was well developed in the research but all the provincial SAMWU representatives and shop stewards involved in the research were female. The secondary research objective, to build capacity within SAMWU to conduct further research, education and policy issues related to gender and privatisation, was less successful as the other projects conducted by SAMWU illustrate.

The research involved who was interviewed as a partner on this project.

2. Who Cares for Health Care Workers – The State of Occupational Health and Safety in Municipal Health Clinics in South Africa. Occasional Paper Series No.8 January 2005

Funded and published by EQUINET in June 2006, the research was to investigate the role of SAMWU with regard to the occupational and health safety needs of municipal health workers and secondly, those specifically related to the impact of the HIV/AIDS crisis. The concern of the research was to explore the experiences, behaviors, needs and recommendations of frontline health care workers. The main finding was that health care workers felt no one cared about them, not all workers belonged to SAMWU, SAMWU was not visible in the sector and lacked capacity to force compliance from municipalities to adhere to health and safety laws and regulations. However, they found that although trade unions needed to be actively involved in health and safety, they had no legal obligations. The research showed that the legal obligation rests solely with the employer and the local authority employers have been negligent and at worst abusive in their disregard of OH & S rights.

The methodology refers to the health care workers as gender neutral and sex disaggregated data is not presented to enable any gender analysis. The impact of the HIV/AIDS section of the research was similarly gender blind.

By not acknowledging the higher number of women in health care systems, as well as failing to accurately describe the gendered nature of health and care work, we

cannot ascertain if gender played a role in the neglect of the OH & S rights both at municipal level and SAMWU. Women's contributions to health systems continue to be unsupported, under-valued or not recognized at all. The first form of gender bias that must be addressed pertains to describing who does health work and how it is done. The omission of sex-disaggregated data (252 workers with 123 with SAMWU) and the biases involved in conceptualizing and measuring health work either hide the presence of women entirely or misrepresent their work. The research methodology also needed to have outlined the gender of the SAMWU and program participants and the reference group and the interactions between them.

Despite increased attention to human resources in health, the lack of research dedicated to documenting its gendered nature and in assessing interventions that redress gender inequalities must urgently be rectified. Multiple forms of gender bias exist simultaneously to constrain the capacity of women and men working in health systems. Such biases require holistic approaches that address the personal and professional struggles of health workers at both local level and higher levels of health systems management.

3. The Electricity Crises in Soweto, by Maj Fiil-Flynn with the Soweto Electricity Crisis Committee (Occasional Papers Series #4) reproduced below, illustrates a good data collection good practice for the team. This report conducted a thorough social analysis – providing a quantitative and qualitative assessment of the sample population in Soweto – a random selection of 200 households in Soweto. The data was sex-disaggregated, broken down by male and female headed households, by employment and socio-economic status and their ability to pay for electricity. In terms of gender, data has also been provided on how the lack of electricity affects households including domestic violence. However, although the social analysis was very good, the gender analysis based on a qualitative analysis of the sex disaggregated data is not provided e.g. does the electricity crises in Soweto disadvantage a larger number of female headed households or a greater number of pensioners?

Social and Gender Analysis

Sex-Disaggregated Data:

Sex-disaggregated data and analysis along with more accurate measurement of the diverse range of health care tasks that make up health work must be supported so that women's contributions to health work can more accurately be represented and recognized.

The only significant report that examined gender relations in the workplace was the Dumping on Women research report.

The main gap was in the lack of a gender methodology in the various research themes, with gender segregated under one theme only. This impact of this segregation was that the social and gender issues were not addressed consistently throughout all the research themes.

Research Methodology

Although the proposal aims to mainstream gender perspectives throughout, it does not present a cursory gender analysis or highlight the higher female representation in the health care sector or the greater burden of care on women through privatization. The various calls for research proposals did not outline the importance of including social and gender analysis or express a need for gender disaggregated data

Violence in the health work place, in the home and in the community must be recognised as an important priority. Interventions must address both the normative values that naturalise and sanction such violence, as well as the structural biases that place female health workers at greater risk through poor working conditions and gender blind management practices.

Good practice

The Soweto Electricity Crisis is a good practice for social analysis.

Gender versus Social analysis

If certain social determinants are more important in the South African context than others, such as race or socio-economic issues as opposed to gender, then the programme and the various research projects it hopes to support need to outline an argument for this line of reasoning and analysis.

Consultation with Researcher

A phone interview was conducted by the evaluator with Mrs. Hameeda Deedat who worked on a MSP research project examining the shrinking state sector and the impact of privatization on basic services e.g. cost recovery scheme under the pre-paid water meters in Soweto, and the subsequent outbreak of cholera in two Cape areas as a result. Through a three month internship at the Africa Gender Institute, Hameeda focused her research in the area of trade and gender and specifically on the gendered impact of basic water outsourcing. She has concentrated her research on issues such as the feminisation of poverty, shrinkage of space for state structures and a lack of social security. The impact on women of scarce resources in urban areas and a lower household income, how privatization of basic services such as water controlled people's lives, especially those of the poor and women in issues such as menstruation, homecare, caregiver for AIDs survivors. A book was published on this case study.

Hameeda felt that there was a lack of capacity for gender integration on the programme and a deeper level of understanding on gender issues was needed. A positive aspect of the MSP was that there was a commitment to gender at the management level of the programme but this commitment and capacity needed to be built at the project level with various project partners such as SAMWU and research institutions.

While it was important for a gender specialist to provide gender inputs into the proposal and PAD process, it was even more important to have a gender specialist on the programme to monitor implementation. This observation was supported by the evaluation team which felt much of the analysis presented in the research was gender neutral. When asked if she would be interested in this position, she felt she lacked adequate experience in this field and would be more comfortable sharing the job and learning from a more senior gender specialist.

Each research project in the new phase of the MSP required a gender perspective and the project steering committees were therefore, a strong entry point with a gender objective to support this aspect of the research for monitoring purposes. The gender specialist as a cross cutting specialist would have the opportunity to attend the all or most of the project steering meetings for each cluster of research activities. S/he would have the opportunity to facilitate discussions on gender impacts of various privatization schemes at the level of the household which is usually overlooked by the research teams, as well as the community.

Recommendations:

1. Include a senior gender specialist on the team to mainstream and monitor gender considerations within all aspects of the next phase. Focus on building the capacity of local gender specialists in municipal affairs and privatization.
2. Integrate a social and gender perspective into the proposal based on available knowledge in the MSP as well as outside sources (e.g. there is a fair amount of literature on the impact of the privatization of basic services worldwide).
3. Follow through with a gender strategy in each aspect of the research including asking potential researchers to outline their social and gender data collection and analysis in the call for proposals.
4. Support a gender workshop to enable the team to come up with a consistent understanding across the project components of gender perspectives and considerations into the workshop.
5. Involve prominent local civil society organisations and male champions to build a participatory approach into the gender workshops so that there is an understanding of the support.

The Electricity Crisis in Soweto

**By Maj Fiil-Flynn with the Soweto Electricity Crisis Committee
Occasional Papers Series #4**

Participatory approaches and social and gender analysis highlighted in yellow.

THE CASE OF SOWETO

In early 2001, detailed interviews were conducted with a random selection of 200 households in two areas of Soweto: Pimville and Orlando East. The residents in these areas are predominantly working-class pensioners or unemployed and most reside in council houses,^{1[i]} which is reflective of Soweto as a whole (Morris 1999, ix). Household selection was discussed with municipal planners and local Soweto residents in order to get a fair representation of family structures in the two sample areas. However, only council housing and private housing dwellers were chosen for interviews because they have generally resided in Soweto for a longer period of time and could provide more detailed historical accounts of their access to electricity. In cases

where backyard shacks were accessing electricity from the formal dwelling, the number of residents in these shacks were accounted for, but only members of the main household were interviewed. On average, the main households consisted of 5-6 people, while backyard dwellings brought this average up to 7 (see Table 1). While all households had electricity infrastructure, some had their electricity supply cut off by Eskom at the time of the interview.

Pimville and Orlando East were separated into five areas representing different socioeconomic and demographic profiles. In the five areas, streets were selected randomly and every tenth house was approached for an interview. In cases where the potential respondent was not at home or did not want to participate (this only happened in two cases) the next adjacent house was chosen.

Table 1: Size of Households in Pimville and Orlando (%)					
	Number of residents (main house)				
Area	1 or 2	2 or 4	5 or 6	7 or 8	9+
Pimville	6	16	15	8	5
Orlando East	10	14	13	8	5
TOTAL	16%	30%	28%	16%	10%

N=200

The aim of the survey was to establish a better understanding of the problems experienced by households with respect to electricity supply and the extent to which these problems constitute a social and economic 'crisis'. The preferred respondent in interviews was the person in the household responsible for electricity management. All interviews were conducted face-to-face in the respondent's home and in the respondent's first language, using a mix of quantitative and qualitative questions.

Fieldworkers were selected from the community and went through extensive training and pilot testing of interviews. Both the questionnaires and the survey results were workshopped with fieldworkers several times and a public meeting based on preliminary results was held in Soweto to get feedback from residents. A pamphlet explaining the findings was also circulated to respondents with an invitation to a public meeting. Furthermore, a discussion workshop was held for academics and the electricity industry before this paper was finalised.

Individual, semi-structured interviews were also carried out with representatives at the National Electricity Regulator (NER), Eskom, the Department of Minerals and Energy and several other government agencies (please refer to "List of Interviews and Workshops" at the end of this report).

Composition of Households

Of the 200 people interviewed, 72% were women and 28% men, figures that reflect the fact that many township homes are female-headed as well as the fact that women were more often the managers of energy consumption and payment in the household. It is also worth noting that the women who participated in the survey provided more detailed information than male respondents. In 73% of the cases the respondent was also the breadwinner in the household, while 50% of household breadwinners were mothers (see Table 2).

Table 2: Breadwinner's Status in Household	
	%
Mother	50
Father	24
Child	9
Retired family member	15

Other person	2
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N=198

Table 3: Main Breadwinner's Employment	
	%
Pensioner	40
Unemployed	22
Professional	10
Business/self-employed	9
Skilled labour	6
Unskilled labour	11
Informal	2
Other	1

N=197

Note: All figures rounded to the nearest percent and may not add to 100.

In 62% of cases the main breadwinner was unemployed or a pensioner, suggesting that incomes in most of the surveyed households are low. The 9% of interviewees that report having a business or being self-employed are street vendors, 'sheeben' (informal bar) owners or have small 'spaza' (convenient store) shops that typically generate small incomes. Fieldworker observation confirmed that over three quarters of the households interviewed live in poor economic conditions, a point further reinforced by a 1998 survey which found that 40% of households in the area had a family income less than R1000 and over half had less than R1 500 per month (Morris 1999, 10). (It should be noted that in Johannesburg a household income of less than R1 000 per month entitles a family to deductions in their service charges, but none of the participants in this survey received these deductions.)

Reflecting the modest income in the two areas, a common income-generating strategy is renting out backyard shacks. Three quarters of respondents have shacks in their backyards, most consisting of a single room. In Soweto as a whole, 97% of all backyard structures are found behind council houses (Crankshaw *et al.* 2000, 845; Morris 1999, 14). The residents of the main house decide if they want to extend the electricity service to the backyard residents and if so, at what price. According to the Soweto Electricity Crisis Committee (SECC), shack residents often complain of unfair billing, while main households often feel that the services are mis- or overused by shack dwellers, resulting in overloading and blackouts.

With formal employment such as the categories "professional" or "skilled labour" the households tend not to have shacks, while lower-income households such as "pensioner" or "unemployed" more frequently have shacks. Female-headed households also had to rely on the backyard economy more often, as women more commonly have less income than their male counterparts, creating additional energy-related complications for women.

Township housing structures in South Africa often lack essential ventilation and insulation needs, increasing electricity bills for heating needs and aggravating indoor pollution from fuel combustion. Households in our survey were no different in this respect with a quarter of the homes lacking any form of insulated ceiling. Material luxuries, meanwhile, such as indoor toilets and electric appliances, are few and mainly exist in the households where the main breadwinners possess a job that is relatively well paid. Fieldworker observations showed that 95% of households own only basic appliances. Ten percent of households did not have any kind of refrigerator, while 60% only possessed a small refrigerator. Eleven percent of those with a fridge

turn it off occasionally to save on electricity.¹[ii] Six percent of respondents do not own any form of electric cooker, while only 40% own hotplates and ovens. Eleven percent lack television sets and 38% do not have any form of electric heating. Many of those who have electric heaters still use coal in winter as it is cheaper.

Respondents often said that they use less electricity than they need in order to save money (although many also complained that they did not see a corresponding decline in their electricity bills). Thirty-eight percent of respondents, for example, said that they cooked less than they wanted, especially traditional (and time-consuming) dishes for their families.

Health and Safety Impacts of Electricity Cut-offs

The loss of dignity referred to earlier is only one of the many consequences of electricity cut-offs identified by respondents in our survey. When asked a series of questions about what happens when electricity is cut off in their homes respondents provided a litany of concerns, from increased domestic violence to the spoiling of food (see Table 9).

Table 9: Effects of Electricity Cut-offs	
When electricity is off...	Percent of respondents who “agree” with the statement
Food gets spoiled	98
We cannot cook food properly	90
Our personal hygiene is negatively affected	88
We spend more money on alternative fuels	84
The children cannot study properly	81
It increases crime in the area	73
It is degrading to my family to live without electricity	70
Women have more work to do	65
It is bad for our working life	62
It disrupts home business	41
It increases domestic violence in the neighbourhood	36

Appendix F

Networks of Women's Organisations

*The Women Won't Wait campaign is an **international coalition of organizations and networks** working to promote women's health and human rights in the struggle to address HIV and AIDS and end all forms of violence against women and girls.* For more information on the Women Won't Wait campaign: www.womenwontwait.org **Women Won't Wait** is an international coalition of organizations and networks from the global South and North working to promote women's health and human rights in the struggle to comprehensively address HIV and AIDS and end all forms of violence against women and girls. The coalition members are: ActionAid; African Women's Development and Communications Network (FEMNET); Association for Women's Rights in Development (AWID); Center for Women's Global Leadership (CWGL); Center for Health and Gender Equity (CHANGE); Fundación para Estudio e Investigación de la Mujer (FEIM); GESTOS-Soropositividade, Comunicação & Gênero; International Community of Women Living with HIV&AIDS Southern Africa (ICW-Southern Africa); International Women's AIDS Caucus; International Women's Health Coalition (IWHC); Latin American and Caribbean Women's Health Network; Open Society Initiative for Southern Africa (OSISA); Program on International Health and Human Rights, Harvard School of Public Health; SANGRAM; VAMP; and Women and Law in Southern Africa (WLSA).
