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GENDER AND INTERSECTIONALITY: A guide to support CHORUS researchers

Introduction

This guide aims to support CHORUS research partners to identify gender and equity issues relating to their urban health systems projects. The guide presents definitions of key terms such as gender and intersectionality. We also discuss why gender and intersectionality are important considerations in understanding health systems and share some frameworks which will help us to incorporate considerations of intersectionality and gender as we design, implement and analyse our projects. We can also draw on these concepts to help us reflect on how we work together in CHORUS, strengthening our own capacity to ensure we have equitable approaches within CHORUS teams and consider gender and equity in our research uptake activities. We aim to update these guidelines throughout the life of CHORUS to include examples and ideas of how we can address issues of gender and equity. The guidelines have been developed by CHORUS's gender mentor, Sushama Kanan and the CHORUS action learning group members, with particular inputs from Lauren Wallace.

Box 1: WHO's introduction to gender

"Gender refers to the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviours and roles associated with being a woman, man, girl or boy, as well as relationships with each other. As a social construct, gender varies from society to society and can change over time.

Gender is hierarchical and produces inequalities that intersect with other social and economic inequalities. Gender-based discrimination intersects with other factors of discrimination, such as ethnicity, socioeconomic status, disability, age, geographic location, gender identity and sexual orientation, among others. This is referred to as intersectionality." WHO 2021
For more resources and information from WHO on gender and health visit their webpage.

Defining Gender

The WHO definition of gender is given in box 1. Building on the WHO definition, understandings of gender have moved beyond the binary of male and female, to recognise and encompass transgender and intersex people who are often forced to live on the margins of mainstream society facing discrimination and inequity.

As shown in box 2, gender is fundamentally different from sex. This highlights the important fact that as gender-based inequities and discrimination are socially governed, so actions can be taken within and across societies to address these inequities.

Box 2: Differences between Gender and Sex

- Gender is a social phenomenon. The meaning of gender is negotiated by individuals and societies; therefore, it varies over time and across contexts.
- Sex refers to the chromosomal characteristics that distinguish men, women and intersex people.

(Sen et al., 2007)

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RESEARCH ON URBAN HEALTH

Intersectionality

Intersectionality is a theoretical framework which aims to understand how different aspects of a person's social and political identity might combine to create unique modes of discrimination and privilege. The concept highlights how people become more vulnerable, marginalized and at risk of greater inequity at the intersection of different social strata. The term was first coined by Kimberley Crenshaw, Professor of Law in the United States in relation to the double burden of racism combined with sexism experienced by African-American women in the United States (Crenshaw, 1989).

Rather than seeing a particular social category as uniformly negative, intersectionality considers the interaction of different social stratifiers (e.g. 'race'/ethnicity, indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion) and the power structures that underpin them at multiple levels. These social identities interconnect to create overlapping and interdependent systems of discrimination (or disadvantage) or privilege. This leads to a level of discrimination and vulnerability greater than the two separate disadvantages or a benefit/advantage. You can learn more about intersectionality in this Ted talk and a useful overview and further references in this paper (Larson et al., 2016).

Box 3: Comparing gender analysis and intersectional analysis based on (Larson et al., 2016)

Gender Analysis

Analyses differences between females and males and other gender identities; it looks at how gender and power relations affect people's lives, create differences in needs and experiences, and how policies, services, and programs can help to address these differences.

Intersectional Analysis

Examines how different social strata such as class, race, education, ethnicity, age, geographic location, (dis)ability and sexuality, including gender, dynamically interact, how power plays out at multiple levels and how a person experiences vulnerability as a result of these interactions.

Intersectionality is useful for health systems research as it allows us to improve our understanding of inequality through better reflecting the complexity of the real world. This understanding is vital is we are to develop and test public health and health systems interventions that 'leave no-one behind (LNOB)'. This principle underpins the sustainable development goals (SDGs) and shows a commitment from all UN Member States: "to eradicate poverty in all its forms, end discrimination and exclusion, and reduce the inequalities and vulnerabilities that leave people behind and undermine the potential of individuals and of humanity as a whole" (UNSDG)

Why are gender and intersectionality important in understanding health systems?

Gender and intersectionality are important considerations in understanding health systems. The power dynamics created by gender and its intersections with disability, wealth, occupation, education, ethnicity (and many others depending on context) influence how the health system operates, people's health seeking behaviour, vulnerability to risk factors and ill-health and their interactions with the health system. Many studies have been published which shed light on the relationships between gender and health systems. For a good overview see Morgan et al., 2016, and check below in the reference list.

Hay, et. al. (Hay et al., 2019) have produced a series of papers pulling together quantitative, qualitative and systematic reviews to better understand gender equality, norms and health. The papers summarise how health systems often reinforce traditional gender roles seen in society and neglect gender inequalities in health. Furthermore, they argue health system models frequently overlook the influence of gender and social norms in the frameworks they provide. Box 4 highlights the key points raised in the Hay et al (2019) series.

Box 4: Hay et al's summary of how gender interacts with health systems

- Health systems reflect and reinforce the gender biases and restrictive gender norms in society, and these biases and norms undermine the functioning of health systems and compromise the safety and wellbeing of providers and the health of communities.
- gender and social inequalities (based on class, race or ethnicity, etc) intersect and multiply these negative effects on both the health system and the communities they serve.
- health systems can be disrupted (e.g. from within, through social and economic policies, and through community accountability mechanisms) to shift gender norms and reduce inequalities.
- gender transformative approaches can help address gender inequalities in health and health systems.
- individuals working to change health systems should align and ally with social movements, community activism, and collective efforts for change and accountability.

Incorporating gender and intersectionality into health systems research

To understand the practical effect of intersectional and gender power relations in health policy and systems research (HPSR) and how this affects males and females differently, we need to include sex disaggregation, gender frameworks and gender analysis questions into HPSR content. Figure 1 was developed by WHO to show different types of health system research and how the way research is conducted can influence gender norms. While the diagram just focuses on gender, it could be used to consider any inequity such as the intersections between gender and occupation, disability or other social strata.

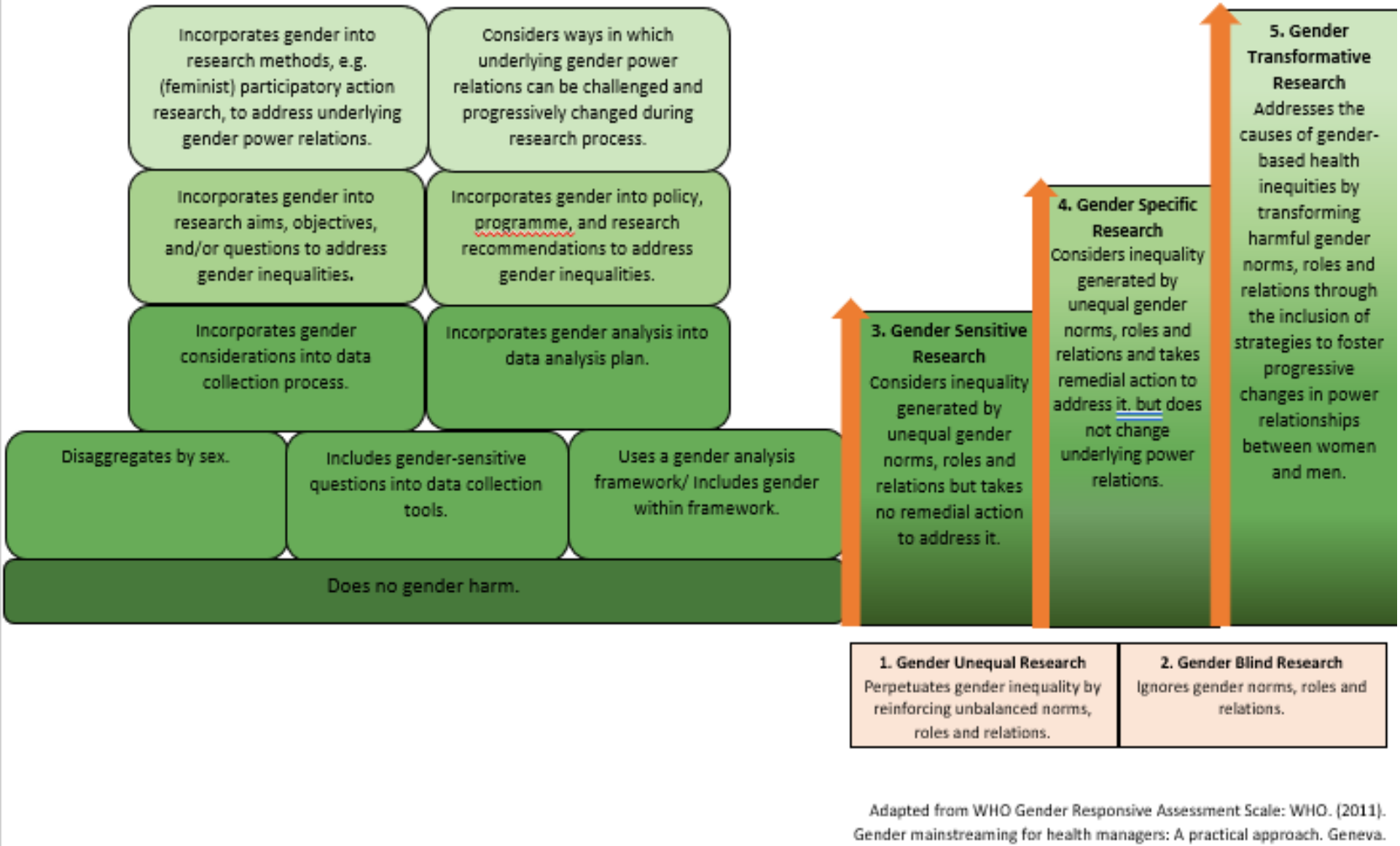

Figure 1: Types of Gender and Intersectionality Research (WHO, 2015)

The framework identifies five different types of research: i) gender unequal research which, consciously or unthinkingly, reinforces inequities, ii) gender blind research where gender norms or other differences in society are just ignored, iii) gender sensitive research which considers gender and intersecting issues e.g. by collecting gender disaggregated data, but then takes no further action, iv) gender specific research, which goes a step further and takes some action to try to create change, but may not address the underlying power dynamics, and finally v) gender transformative research, which takes strategic action to address underlying power structures to overcome inequities. How we develop and conduct our research determines where our work fits on this continuum and underlines the importance of thinking through gender and intersectionality at all points of the research cycle – i.e. developing the research questions, methods, data collection, analysis, dissemination etc.

One of the ways to include gender during data collection and analysis for HPSR is to collect and record data and information disaggregated by sex. Collecting sex-disaggregated data means distinguishing between males and females and other groups such as transgender and intersex populations. In addition, data should be collected on other background information such as age, educational status, occupation, marital status, race, ethnicity, religion, disability etc. so that no possible stratifiers are left behind.

Gender and Intersectionality Frameworks

Gender and intersectional frameworks can help researchers to organise their thinking, research questions, data collection, and analysis to ensure considerations of gender and intersectionality are incorporated throughout all phases of the research process. There are several gender and intersectionality frameworks researchers can follow or adopt for their study and researchers need to consider which are most relevant to their study and their context.

The framework, shown in box 5, was developed by Morgan et al (2016) and requires researchers to ask a set of questions about the setting where they are conducting or planning to conduct their research. The framework can be used at any stage in the research design or implementation process. For example, asking these questions during the design phase will help to focus the research questions to ensure that the project does not become gender blind or unequal. These questions can then be considered during data collection (i.e. in the qualitative or quantitative tools that you develop), analysis (in your quantitative analysis plan or your qualitative coding frame) and write up. We can also use the framework to reflect on our own organisations and on the workings of CHORUS as a whole.

The framework helps us consider gender as a power relation and driver of inequity in health systems and identify how power can be constituted and negotiated in the contexts where we work. The first set of questions focuses on access to resources by asking who has what, this could include money, transport, healthy food or any other resource that influences health that is relevant in the context being studied. The next question is who does what, guiding us to consider the division of labour and everyday practices, this could include how caring responsibilities or working outside the home influence access to care or who does the cooking. Then we need to consider how values are defined, what are the social norms, ideologies, beliefs and perceptions that govern how people live. Finally, who decides, what are the rules and decision-making processes that govern health and health seeking behaviour.

Box 5: Gender and Intersectionality Framework (Morgan et al 2016)	
What constitutes power relations among different social strata and genders	
Who has what	Access to resources (education, information, skills, income, employment, services, benefits, time, space, social capital etc.)
Who does what	Division of labour within and beyond the household and everyday practices
How are values defined	Social norms, ideologies, beliefs and perceptions
Who decides	Rules and decision-making (both formal and informal)
How power is negotiated and changed	
Individual/People	Critical consciousness, acknowledgement/ lack of acknowledgement, agency/apathy, interests, historical and lived experiences, resistance, or violence
Structural/Environment	Legal and policy status, institutionalisation within planning and programs, funding, accountability mechanisms

The next section looks at how norms can change by considering how power is negotiated among individuals and institutions and wider society. What are the individual power relations within households? This could be across genders, and as they intersect with age, marital status, disability and other strata. Then consider the institutional and societal levels and think through the power dynamics between different genders according to relevant strata. This could be within a health facility between staff, considering gendered hierarchies between front-line nurses or community health volunteers and managers or at societal level in terms of representation of women in political and decision-making positions. All of these domains can change as societies shift and power relations within health systems are negotiated across genders and by caste, ethnicity, disability and other stratifiers. Thinking about what has made change happen in the past can help us identify strategies and actions to take that will help to bring greater equity in the future.

Within CHORUS we will use these frameworks at every point of our research cycle and reflect on how well these frameworks can help ensure our research can understand and respond to inequity.

How Gender and Intersectionality affect health systems

The CHORUS gender action learning group have identified several specific examples of the ways in which gender intersects with other social characteristics to interact with health systems. We have used the WHO's six health systems building blocks (WHO, 2007)to organise these examples. More recent thinking on health systems goes beyond the building blocks to highlight the role of context and attitudes, behaviours and norms within the health system (Gilson, 2012; K Sheikh et al., 2011; Kabir Sheikh et al., 2014) and we have highlighted these aspects within the examples below. We see these examples as a work in progress, and as our insights on urban health grow, so we will add specific examples that emerge from our own work.

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Building Block 1: Health Service Delivery

Health Seeking Behaviour

Decisions about when, where and how to seek care are often affected by the gender norms and responsibilities practiced in communities. Men may not seek care as they feel out of place in health services, particularly those focusing on maternal and child health. Research in Nigeria found men did not want to get involved in services aimed at prevention of mother to child transmission of HIV (PMTCT) because they felt 'out of place'. They stated that maternal health services are not designed to promote/encourage male participation in maternal health care. The few men who overcame the access barriers and accompanied their female partners for maternity care (and PMTCT) were ridiculed by the community health workers and PHC workers (Ezumah et al., 2016; Morgan, 2018).

Women's daily roles and responsibilities of accomplishing household chores and taking care of the family, lack of decision-making authority, financial dependence on male members (often husbands) and lack of attention to their health issues by family members have played a dominant role in determining their health seeking behavior (Furuta & Salway, 2006).

Sexual and reproductive health (SRH) services provides a clear example. Talking about and accessing stigmatized among women in the Asian context, but it is more difficult for unmarried and single women to get SRH services because of the social context (moral policing, unnecessary personal questions (Hameed, 2018; Mohammadi et al., 2016).

Gender also influences which health care provider people decide to visit. In some social contexts, men may not seek care, particularly at lower levels of care, and may wait until they are very sick before going directly to the hospital whereas women are more likely to seek care early and to use primary care. For example, in a patriarchal society, males are considered as breadwinners of the family. They are supposed to remain healthy and strong enough to fulfil their family's needs and they are supposed to be tough, brave, strong and self-reliant. Hence, men may be reluctant to seek health care services in order to protect their masculinity and uphold respect for them as men (Baker et al., 2014). In Nepal studies have shown that women are more likely to visit traditional healers (Shrestha et al., 2017)

Gender also affects exposure and risk to both communicable and non-communicable diseases. Higher prevalence of tobacco use among men makes them more vulnerable to TB (Guerra-Silveira & Abad-Franch, 2013) and alcohol use and male social norms increases vulnerability to injury particularly in informal settlements in urban areas (Mberu et al., 2015). Migration status interacts with gender, with studies showing women migrating to the city are more likely to become overweight and obese (Peters et al., 2019) and to take up tobacco use (Williams et al., 2008).

Gender biasness continue through diagnosis and treatment. For example, women have been found not to be able to produce quality sputum required for the microscopic examination of TB and may require access to different diagnostic pathways(Guerra-Silveira & Abad-Franch, 2013; Kivihya-Ndugga et al., 2005). Service to support patients to adopt healthy lifestyles are particularly needed, for example tobacco cessation support which draws on male and female tobacco use norms was found to be more acceptable to patients wanting to quit tobacco use (Boeckmann et al., 2019)

Health workforce

Women make up the majority, 70% of the health workforce globally (Boniol et al., 2019). There is a clear gender hierarchy with women representing the majority of the nurses and mid-wives and front-line healthcare workers and perform most of the world's unpaid labour caring for children, the elderly and the sick (Boniol et al., 2019). In Nepal there are no front line male community health workers, nurses and midwives in context of Nepal. Despite of females being majority in terms of health workers and frontline workers, mostly males hold managerial and leadership position in Nepal's health sector (Nepal & Aryal, 2020). Tackling gender power relations is key to ensuring the safety and wellbeing of health workers and the ability to deliver quality care.

Taking on these front-line caring roles places women at risk of infection, over-work and exposure to violence and ill-treatment (Hay et al., 2019). Violence against female health workers in the workplace undermines their confidence and deteriorates their ability to progress in their careers or be promoted to the leadership positions (George et al., 2020). This inequity and imbalance in power relations impacts negatively on the care health workers provide. Hay et al's (2019) review identifies that high patient loads, lack of supportive supervision, opportunities for career and salary progression as well as sexual harassment by male health professionals and patients all influence female health provider behaviour and can lead to a 'kick-down' effect where the most socially marginalised (including women) are abused by these same female health workers that experience inequity themselves (Hay et al., 2019)

Health information systems

Most routine health systems now collect data disaggregated by gender, however health systems rarely have any information on people's income level or ethnicity or any of the other social strata that might influence their health and wellbeing. If this information is not collected then the health system cannot identify and respond to these inequities (Morgan, 2018). In Nepal, Health management information system (HMIS) is the only system to record data on health service utilization in public health facilities but, like in many countries, the system does not provide comprehensive information in relation to gender and intersectionality for all service use. Using this data within policy and planning is limited (Mirzoev et al., 2019). Considering this, there is growing concern and recognition that gender and intersectionality needs to be included in the existing. HERD International is conducting a case study to understand Gender and Intersectional Stratifiers in Information Management System of Nepal in both public and private sector. This study will engage relevant stakeholders and community people, to understand the gaps and need for gender disaggregated evidence and its use to inform the program to be inclusive. Further together with the stakeholders a framework on approaches to mainstream Gender and intersectionality in the IMS and its use to inform the programs will be developed.

Bias is also found within health research resulting in research that does not address questions relevant to certain vulnerable populations. Baur and colleagues (2009) demonstrate how the health research commonly assumes that all research participants gender identify matches that of their sex assigned at birth (cis sexual), leading to a lack of research

on trans lives and trans health issues (Bauer et al., 2009). Moreover, research may be generated without the input of communities being studied through processes that are stigmatizing and alienating to participants, further vulnerable populations. Drug trials across different clinical areas have been criticised for bias in recruitment, analysis and interpretation in relation to gender and other social stratifiers (Phillips & Hamberg, 2016)

Access to essential medicine, medical products and technologies

Gendered differences in access to medicines, products and technologies have been identified across diseases, conditions and contexts (Baghdadi, 2005; Bisilliat, 2001). Limited availability of appropriate technologies for sexual and reproductive health have been linked to limited emphasis on women's needs in low-income settings by the pharmaceutical industry a primarily due to their limited purchasing power (Cottingham & Berer, 2011). The COVID-19 pandemic has drawn attention to the gendered-design of personal protective equipment, with health care workers in the UK highlighting that PPE, such as respirator masks, are frequently designed to fit an average male body (Chakladar & Ascott, 2021).

Where gender intersects with disability, inequities are particularly evident. For example, access to different assistive devices for women with disabilities in the community is largely lacking in the context of Nepal (Karki et al., 2021).

Health systems financing

In India, health care expenditure is found to be systematically lower on females compared to male across all demographic and socio-economic group. However, female suffered higher ratio of major morbidity than male. The study concluded that female health is not prioritised as men's when it comes to spending (Saikia & Bora, 2016).

In Ghana, the National Health Insurance Scheme (NHIS) covers over 95% of disease conditions in Ghana, and the free maternal healthcare policy allows for the free utilisation of all maternal health services. However, despite the fact that preventive and promotive maternal health interventions and "free maternal care" are articulated as priorities in meetings and in health sector documents, the free maternal healthcare policy is not implemented fully. Dalinjong, Wang and Homer(Dalinjong et al., 2018) found that in the Upper East Region, the majority of women made direct out of pocket (OOP) payments for laboratory tests and drugs. The women who made payments were not formally employed and had limited cash income and used savings as well as assets to make the OOP payments. The weaknesses in the implementation of the free maternal health policy are linked to the skewing of health financing in Ghana towards curative care, which delays health facilities' payment of claims, pushing them into insolvency and creating stock outs of drugs.

Further, the free maternal healthcare policy, does not include family planning. Although the government of Ghana recently passed a law to allow the cost of contraceptives to be covered by the National Health Insurance Scheme, unfortunately the cost of treating side effects of contraceptives are not covered In Ghana, women are primarily responsible for adopting contraception, and these unexpected OOP may lead poorer women to make trade-offs, which can lead to neglect of other needs essential for daily survival (Wallace, 2017).

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Leadership and governance

In Ghana, there are more women than men working in the health system. The ratio of men to women in the whole Ghana Health Service is approximately 1:2. While 67% of professional nurses are female, however, there are more males in senior management compared to females. Gender disparities in leadership and management positions in Ghana's health sector point to subtle sociocultural factors, including a lack of social and family support for individual women who aspire to senior managerial roles, and at the institutional level, a lack of attention dedicated to gender mainstreaming, including deference to males by leaders due to cultural or personal biases and lack of flexible work hours, breastfeeding/baby changing/child-care rooms. A Health Sector Gender Policy has existed since 2009, its implementation has not been fully realised due to poor resource allocation to and prioritisation of gender mainstreaming activities (Arthur, 2018).

In context of Nepal, there is minimal participation of women in leadership positions in every sector including health and intersects with caste and religion exacerbate this issue particularly for Dalits, Muslims and Madheshis, with economically stronger women from hill communities being more involved in politics (Search for Common Ground, 2017). Therefore, variables such as education, socio-economic background, and ethnicity have serious implications on women's access to the limited social and political roles. In the Nepalese interim constitution signed in 2015, brought about greater inclusion of female, marginalized and disadvantaged group. Since, then, gender and social inclusion have progressed enormously on paper in the country, mandating civil society and economic participation and health service utilization of women. Although, gender and social inclusion polices are well adapted in the country, implementation has been more mixed. Problems continue to persist with the implementation of gender-sensitive and gender-responsive legislation, policies and acts, including intersectional recognition of the numerous of factors that affect women based on ethnicity, caste, religion, language, indigeneity, marital status, geographical location, ability, and access to health and education

A multi-country research that explored the influence of gender (and interactions) on the career progression and leadership experiences of senior health care managers revealed that although women make up the majority of health workforce, they were unequally represented in decision making positions. Female managers felt less accepted by their subordinates (male and female alike), and they desired validation more than their male counterparts. Furthermore, they were less likely to benefit from professional training and career development opportunities. However, the career progressions of the female health managers were influenced by the interactions of gender with other social stratifiers such as professional networks, social networks and family support (Mbachu C. & Uguru N., 2018)

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