Why gender mainstreaming is important when planning and implementing health interventions: examples from COMDIS-HSD

POLICY BRIEF

Many of the projects undertaken as part of the COMDIS-HSD research programme consortium[1] have exemplified the importance of gender mainstreaming during health intervention design and assessment. This briefing outlines some relevant issues and examples, loosely grouped under the headings disease prevention; pre-diagnosis; diagnosis; and treatment.

The World Health Organisation provides substantial information on gender.[2] Three key definitions[3] are:

1: Gender analysis in health: examination of how biological and sociocultural factors interact to influence health behaviour, outcomes and services; and how gender inequality affects health and well-being.

2: Gender equity in health: a process of being fair to women and men with the objective of reducing unjust and avoidable inequality between women and men in health status, access to health services and their contributions to the health workforce.

3: Gender mainstreaming: the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes. This applies in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated.

POLICY MESSAGES

1. There are many instances when national health programmes need to identify different barriers to accessing health care for women and for men, and develop strategies to counter them.
2. The best way of identifying barriers and solutions is by talking directly to some of the women and men involved.
3. Ensuring a gender balance among programme staff charged with planning and implementing interventions can both facilitate the process of identifying barriers and solutions, and bring experience and understanding of barriers and solutions from different perspectives.
4. Well-designed 'gender awareness in health' workshops including locally-relevant scenarios, and reminders/ refreshers at key stages in intervention development, are essential to underpin planners' awareness of the importance of gender mainstreaming.

1 Disease prevention

Women and men generally have different risks of acquiring most diseases, and different prevalence of risk factors (including their sex). Although these differences in risk are partly due to biological factors, they are primarily due to differing social, economic and educational norms, which are themselves underpinned by unequal social relations between men and women. Solutions seeking to prevent disease need to respond to these differences, by developing interventions addressing both women and men, and targeting them appropriately. This is not an easy process, since planners may find it very difficult to see beyond their own unquestioned social norms. It is important to ensure they are involved in 'gender awareness in health workshops' including local scenarios and reminders/refreshers at key stages in intervention development.

Schistosomiasis in Mozambique

In Mozambique,[4,5] women are generally less knowledgeable about schistosomiasis then men, perhaps because they typically receive less formal education.[6] It is therefore important to develop health education and motivation strategies for women in particular. The *community dialogues* approach addresses this, as it involves the entire community in raising awareness and creating a sense of ownership of health issues.

Community dialogues primarily attract women, as they are generally in charge of their family's health. This approach appeals to women because of its interactive nature and because women tend to spend most of their time in their community.

Male circumcision in Swaziland

In Swaziland,[7] there is a nationwide strategy to encourage medical male circumcision as (partial) protection against HIV infection.

However, culturally, the mother has to consult the child's father. Some women say they have little power in this relationship, with the father and grandfather having the final say, while other women say the decision is collaborative.

Women may need to be provided with arguments (based on medical assessments and/or cultural norms) to support such negotiation; and health facilities must plan their services to give women time to negotiate.

CVD in China

In China,[8] among adults who are predicted to have a risk of 20% or more of having a cardiovascular disease (CVD) event within 10 years, women have a significantly lower smoking rate than men, but a higher 10-year CVD risk. This suggests that CVD prevention strategies might have different foci for women (eg healthy eating) and men (eg smoking cessation). During COMDIS workshops for health practitioners, participants were given gender-specific role plays addressing issues likely to affect women and issues likely to affect men.

Doctor measuring a patient's blood pressure during a health check-up procedure in China

An image from one of the smoking cessation materials developed in Nepal

Smoking cessation in Nepal

In Nepal,[9] smoking is more highly stigmatised for women than for men, so identifying women smokers is particularly difficult. To understand this issue in depth, during exploratory qualitative research we gave cameras to men and women smokers. The photos were then used to trigger discussion in later interviews.

The photos taken by women of other women smoking illustrated how they hid their cigarettes and found secluded places to smoke. During the design of materials as part of a smoking cessation intervention we explicitly included pictures of women benefitting from quitting. These issues were discussed with health workers during their training on the intervention. Women, as well as men, are thus encouraged to take up the intervention, leading to more equitable prevention of smoking-related illness.

'The photos taken by women of other women smoking illustrated how they hid their cigarettes and found secluded places to smoke'

2 Pre-diagnosis

As already noted, women and men generally have different risks of acquiring most diseases, and different prevalence of risk factors (including their sex); and also have differing patterns of accessing health care. Interventions seeking to identify people at risk of particular diseases need to address these differences.

In an ideal world, each intervention would be tailored to each individual, but resource constraints generally make this impossible. However, nearly always, such interventions need different approaches for women and for men, and these differences need to be made explicit in guidelines and training.

Diabetes in Bangladesh

In Bangladesh,[10] diabetes patients' awareness and understanding of care for diabetes were similarly poor for women and men. Here, at this early stage of development of the national diabetes programme, there are good opportunities to take a gendered approach to intervention development, since women do most of the food preparation, influenced by men's likes and dislikes. Further exploratory work is needed to understand the dynamics of how much influence different family members have over what is prepared, and how it is prepared.

Diabetes in Nigeria

The prevalence of undiagnosed diabetes in Nigeria[11] is significantly higher among men than among women. This suggests that health workers should be particularly aware of a risk of diabetes among men.

RTIs in Pakistan

In Pakistan,[12] provision of good syndromic case management for reproductive tract infections (RTIs) at government health centres leads to greater use by women than men, with 70% of clients being women. Men tend to use hakims (traditional doctors) or private injectors.

This suggests that the national sexually transmitted infection (STI) programme must ensure facilities are accessible and acceptable for both women and men.

Pre-diagnosis cont'd →

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TB in China

In China,[13] we have identified significant differences between males and females in TB prevalence in the general population. Male:female prevalence ratios were 5.5:1 for sputum positive cases and 2.8:1 in bacteriologically confirmed cases, and 6.0:1 and 4.1:1 respectively among those over 65 years. This suggests that the index of suspicion should be higher among men than women, particularly since smokers may assume coughs are due to tobacco rather than TB; and a need for additional general health education messages targeted at men to encourage men with a cough to seek diagnosis. Also, while in most low-income countries it is common to find a higher risk of TB among men than women, incidence of TB among men may be increased where men's tobacco use is particularly high, as in China: this further highlights the need for tobacco prevention and cessation activities targeted at men.

Researchers during a house-to-house census in China

3 Diagnosis

Women and men may require different indexes of suspicion and approaches to diagnosis. This may be due to physiological, social or disease factors. For example, it is well known that women find it harder to give a good sputum sample for TB microscopy[14] – this may be because they find it physiologically harder to cough up sputum; or because in many societies it is less socially acceptable for women to hawk and spit.

Understanding differing gender norms in accessing health care is also vital in responding to differences in diagnosis. A common observation is that women tend to use lower levels of care than men. Unequal gender relations mean that women have less autonomy over financial resources and decision making. They thus use services that are closer to their homes, requiring less time and money for travel. Men may take longer to admit to ill health, and when they do recognise the need for diagnosis, their preference is to attend tertiary levels of care and private clinics.

Disease programmes need to understand factors affecting diagnosis that may be different for women and men, and reflect these in procedures, guidelines and training.

Diabetes in Nigeria

In Nigeria[11] COMDIS research showed that the prevalence of dysglycaemia is similar for women and men, but women have a higher prevalence of isolated impaired fasting glucose (IFG) than men. This suggests that diagnostic guidelines need to take this into account.

TB contact tracing in Swaziland

In Swaziland,[15] COMDIS research found that during contact tracing of TB patients, women are more likely to attend hospital for contact screening than men. National TB Programmes that are considering using contact tracing need to be aware that women and men may experience different barriers and motivators to attend screening, and design intervention letters and approaches accordingly.

iCCM in Uganda and Zambia

In Uganda[16] and Zambia,[17,18] COMDIS work has shown that integrated community case management (iCCM) of common childhood illnesses is mainly of benefit to women as the main caregivers. iCCM saves them travelling to distant health facilities and improves the health of their children, thereby reducing time spent nursing sick children. Strategies for diagnosing and treating common childhood illnesses should always consider how these services can be brought as close as possible to children's homes.

4 Treatment

Women and men respond differently to care, and this is often for non-medical reasons, particularly for chronic diseases such as cardiovascular disease (CVD), diabetes and TB, where repeated visits to clinics are necessary.

These non-medical barriers include direct and opportunity costs (eg lost earnings if patients miss work due to clinic appointments). These barriers may have different effects on male and female patients' abilities to attend. The barriers may also be made better or worse by different motivators to achieve cure. We have found that women may act more explicitly on their (maternal) feelings and desire to care for their children. Unmarried women may be influenced by the need to maintain eligibility for marriage. Men's motivation to continue to support their families and protect them from infection has also emerged from our qualitative work as an important factor during treatment.

Community clinics in Bangladesh

In Bangladesh, our work with the Community Clinics programme has the potential to increase the access of women to quality care for themselves and their children.

Community Clinics are a new level of primary care situated in rural areas. Our evaluation will highlight the extents to which women and men use these services.

A community clinic worker with a real patient during role play training in Bangladesh

MDR-TB in China

In China,[19] even though barriers to MDR-TB treatment completion are greater for women than men, women are still three times as likely to complete treatment as men.

Women are more likely than men to report being afraid to reveal they have TB, and more often report serious difficulties in treatment, while costs are similar for men and women.

This suggests that although women appear to be more resilient, and thus achieve higher treatment completion rates, this may be at substantial hidden cost. The TB Programme needs to identify strategies to address those barriers for women.

Conversely, men are less resilient, so the Programme needs to develop better methods of quickly identifying missed appointments and strategies that especially encourage men to continue their treatment.

CVD in China

In contrast, in China[8] there were no significant differences in CVD medication compliance between men and women. This suggests that care is needed when extrapolating gender-related issues from one national health programme to another.

STIs in Pakistan

In Pakistan,[12] sexually transmitted infection (STI) treatment at rural health facilities was better for men than women, while at urban facilities, the converse was true. Further investigation is needed to understand why this is the case.

MDR-TB in Nepal

In Nepal,[20,21] our qualitative work highlights how married women encounter particular difficulties during treatment for multi-drug resistant TB (MDR-TB). This appears to be largely because single women receive financial and social support from their parents and men from their spouse. Cont'd....

+ Treatment cont'd...

However, married women in Nepal often do not receive adequate support from their husbands and in-laws, instead becoming destitute and isolated. Our work with the Nepal National TB programme to develop and test a package of psycho-social support is exploring different ways of responding to these differing needs. We are testing the feasibility of including an assessment of social support during consultations; this then allows health workers to signpost those with minimal family support to peer support groups and counselling as needed.

The COMDIS-HSD approach to gender

We explicitly adopt a gendered approach in our work. This ranges from ensuring that within each research study the needs of women and men are considered and assessed separately, to ensuring that capacity (including management) development provides equal opportunities for women and men. Supporting researchers across the consortium to look through a gender lens during qualitative data collection and analysis has been an important element of capacity building. We design interventions to be sensitive to needs of both women and men by ascertaining and addressing the views of both sexes. We pilot these interventions, collecting disaggregated data and determining appropriateness for both women and men; revise interventions as necessary; and analyse results for each sex separately to identify any residual differences. Our partners review their gender balance, and take steps to increase representation. In our experience this also helps inform development of appropriate strategies and methods of assessment.

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