

**RHINO Gender and HIS Forum Transcript**

*These are all the postings that participants of this forum have posted each discussion day. The postings are organized by date of discussion (date of first post) and subject, so all replies related to a single subject are grouped together..*

Please contact [the\_rhino@jsi.com](mailto:the_rhino@jsi.com) with any questions.

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**July 14, 2015**

**Subject: RHINO Gender & HIS Day 1**

All,

Thank you for joining us today and the next several days for this forum on gender and HIS!

A special thank you to those who joined us earlier today for our Kick-off webinar. This webinar provided a basic introduction to gender concepts and integration into RHIS and a common language for us to use throughout the week. We will send out the link to the recording soon for those who missed it and would like to get some background information.

As discussed, given the evidence documenting the correlation between higher levels of gender equality and better health outcomes, it is necessary to incorporate gender into program planning, data collection, monitoring and evaluation, and every day program implementation. Gender-related information provides evidence to raise awareness of gender imbalances, advocate for change, address gender dimensions of health, and demonstrate program progress and impact.

During the on-line forum this week we’d like to hear from you as M&E professionals in the field. We are excited to hear about your experiences with integrating gender into RHIS, discuss the importance of gender in data collection and analysis, and share challenges and solutions.

DISCUSSION QUESTIONS FOR DAY 1:

To kick off discussion and get to know fellow participants, we would like to offer the following questions as a starting point:

1) Name and where you are working (location and organization).

2) What is your level of training or knowledge about gender in health? (Please remember that prior experience or gender-related training is not necessary to participate in this discussion. We hope to meet you where you are at, and tailor the discussion around your needs. We are simply trying to get an idea of what levels of gender experience participants have, to ensure we respond accordingly in our moderation.)

3) What have been your experiences in collecting, analyzing and using sex disaggregated and gender-sensitive data from RHIS?

Thanks again and we look forward to hearing from you!

Brittany Schriver & Jessica Fehringer

As promised- here is the link to the recording of today’s kick-off webinar:

<https://universityofnc.adobeconnect.com/p1jpfsjpabr/>

We’ll be digging deeper into the concepts presented in this short overview throughout the week. Please let us know if you have any issues accessing the above link.

**Responses**:

Hi

Thank you for the excellent introduction to the topic.

Jaakko Yrjö-Koskinen

Finland

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Hi

I work with the MEASURE Evaluation project at the University of North Carolina, Chapel Hill.

I have conducted formative research on issues related to equity and gender in health. In the past, I was also involved in creating internal equity and gender working group of my project to guide mainstreaming of equity and gender issues in project activities.

In my experience collection, reporting, analysis and use of sex disaggregated and gender-sensitive data from RHIS varies across health system levels and depends on country contexts.

I am looking forward to hear more on this issue from people in this forum!

Best,

Manish Kumar

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Hello,

My name is Bojo Samuel a Public Health Specialist working with CADA a humanitarian and development organization in South Sudan. I work as Director of Programmes with intensive training in gender mainstreaming in humanitarian interventions.

With respect to gender sensitive data collection and analysis, l quite often notice that most of the health data is collocated and analysed by sex with little insight into specific groups such as boys, girls, women and men. During programming, its not easy to visualise the needs of these specific groups. On the other hand most rapid needs assessment such the IRNA done prior to most humanitarian interventions do not or capture very little information on these specific groups and yet to the contrary, such data is required in project designs.

Your experiences are most welcome.

Kind regards,

Bojo

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Hi:

My name is Eva, I am from Spain, though I am temporarily at UK, and I am a PhD student in health psychology researching on psychological adjustment assesment methods (at UNED University). I am also an independent health psychologist councelor and I coordinate an online project about health psychology and health awarness and treatment (still developing the website).

I have a Master in gender and health (UCM University)where the needabout dissagregated measures and treatment

While my clinical psychology work (assessment, treatment and follow up) I pay much attention to gender and sex differences and wich influence it has on health (behaviors, emotions, cognitions, etc...). As time goes by I become more aware that gender has more influence in our health than many other facets in live, and according to this I plan my treatments in this directions which became a very effective method.

Regards

Eva Izquierdo-Sotorrío

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I am Jaakko Yrjö-Koskinen. A medical doctor by training, I am currently working as Ministerial Counsellor in the Health Services Group of the Ministry of Social Affairs and Health of Finland.

I don't have any formal training in the domain of gender and health. However, over the years I have gained knowledge about gender issues which were an important aspect of my work at the time when I was acting as public health advisor in Mozambique and Angola, and as a health information advisor in Rwanda.

While working in the above-mentioned countries, I tried to promote the analysis and use of routine health data, including sex-disaggregated data, to improve performance. As I wasn't very successful in Mozambique nor in Angola, I began wondering how cultural factors impacted data analysis and use. I ended up studying the influence of organizational culture on the use of routine health data in decision making at the district and health facility levels in the Nouna Health District, a rural area in north-western Burkina Faso. Gender Egalitarianism was one of the cultural dimensions that was identified as influencing information use in the study population.

Jaakko

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Welcome Jaako Yrjö-Koskinen, Bojo Samuel, Manish Kumar, Vishal Kataria and Eva Izquierdo-Sotorrío! We are so happy to have you join us for this forum and appreciate your contributions thus far.

Bojo Samual discussed his experiences in South Sudan with regards to the disconnect between collection and analysis of sex disaggregated data and use. Jaako Yrjö-Koskinen reflected this with his experience in Mozambique and Angola and how cultural factors may impact data analysis and use. We would love to hear from others about your background and experiences in collecting, analyzing and using sex disaggregated and gender-sensitive data from RHIS. Additionally, as a member of this forum, feel free to speak to any of these or other experiences that are shared.

As requested, I’ve included a link to a downloadable version of yesterday’s presentation for use and circulation among your peers. <http://www.cpc.unc.edu/measure/webinars/rhino-gender-and-health-information-systems-forum-kick-off-webinar>

Best,

Brittany & Jessica

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Hello folks,

I have strong admiration for Jaakko experience in Angola and Rwanda. Whereas routine sex disaggregated data analysis has predominated our health intervention in most development programming as the case in Angola and Rwanda, l noticed that in humanitarian programming as the case in South Sudan, sex disaggrated data is insufficient enough. A gender disaggregated data with in depth reflection on specific groups such as women, men, boys and girls play a fundamental role in understanding their needs and how interventions can be designed to address them. For example in a typical internally displaced persons ( IDP) Camp, younger boys and girls would not want to use adult latrines as they fear the bigger hole size and the depth and so may require smaller holed and shallow latrines. Women for example suffer from dispersion and stress as such may not exclusively breastfeed their infants for up 6 months period.

A clear analysis of the interplay between these specific groups and the design of health interventions is crucial.

What are your experiences!

Kind regards,

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Hello All,

Jim Setzer here and I am soon (starting Monday!) to be the HIS advisor in Namibia working for JSI but have been working with RHIS systems for many years with Abt Associates Emory SPH and Tulane SPH before my new gig!

My training is as an epidemiologist so it is second nature to me that we should ask (and RHIS should answer) “what about sex/gender”? So disaggregating data like this is second nature.

BUT:

I will admit that for many years I have been arguing against too much disaggregation (especially by many many age groups) and even sex/gender because for one the more categories and boxes to fill in the more work and chance for error on the part of clinic staff (even to the point where they give up and just fill things in haphazardly). The second and probably biggest reason that I was advocating dropping a lot of disaggregation was because I did not see the management or decision making processes/structures/ decision space for anybody to make any decisions based on the disaggregated data! This is the problem where so many places we work are really operating health REPORTING systems not health information systems. If there is no ability or intent to use the data in disaggregated format then perhaps we should just let the staff off the hook for collecting and reporting it as such.

Of course this is an intentionally provocative position to take! Those of you RHINOs that know me are not surprised. But it is my way of forcing an examination of the question as to how are we using data and how can we make the system responsive to that. People’s reaction when I say to drop sex/gender disaggregation is almost always one of shock/disbelief since it does go against our basic training and instincts. But then we can engage in a discussion where by the health system has to defend the disaggregation and they only way to do that (other than devotion to drudgery) is to show how they will begin to give people the ability and the decision space so that data on sex/gender make a difference in decision making and service delivery strategies.

So it is a bit of a chicken and egg situation as I see it. I think we need to continue to promote and demonstrate the need and the impact of better decision making and decision making which takes into account sex and gender differences in disease patterns/distribution, access and utilization of services and health outcomes. I think it is important that people see the need and the effect of collecting these data 9and the extra work required) in order to bring them on board and move from reporting system to information system. Getting people to really take these data and considerations into the decision making process requires stirring the pot a bit since the “way we have always done things” doesn’t necessarily do so.

I hope this diatribe is helpful in getting us to be creative and dedicated to this. People’s health counts on it.

Best to all,

Jim

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Dear Brittany & Jessica!!

Thank you and it is great to be part of this discussion!

My name is Vikas, with JSI and work on the Maternal and Child Survival Program (MCSP).

I wear different hats, as an RHIS systems person and a M&E person. I am curious in learning from country experiences on how RHIS are constantly evolving and there is more attention on improving these systems.

We at MCSP, constantly face the challenge of issues around gender in RMNCH and how to measure them on a regular basis, either routine HIS or surveys and assessments.

In terms of my experience with gender related data on RHIS, I believe that if it helps guide programmatic decisions/interventions, such data should be collected and analyzed. I would like to further learn from your experience and others in this group on collecting and using gender related data for other gender related services. This may be much broader than just sex-disaggregated data. Areas such as, male engagement in family planning, pregnancy, delivery, RMC, GBV and other related services. I hope there will be an opportunity to share and learn some lessons on such experiences.

Thanks again and look forward to an interesting discussion!

Best regards,

Vikas

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Hi Brittany and team:

It was a great forum this Tuesday, thanks for creating a platform for discussion on gender and RH.

Here's my input to your questions.

1) Name and where you are working (location and organization).

Aruna Bhattacharya, working with Public Health Foundation of India as Associate Professor at Indian Institute of Public Health-Delhi

2) What is your level of training or knowledge about gender in health? (Please remember that prior experience or gender-related training is not necessary to participate in this discussion. We hope to meet you where you are at, and tailor the discussion around your needs. We are simply trying to get an idea of what levels of gender experience participants have, to ensure we respond accordingly in our moderation.)

I am an Anthropologist by training and worked on TB in urban slums in Delhi for my doctoral work during 1998-2003. In my research work (current and past), I look at hierarchy and power relation that exist in the health systems, and gender is an important component of that. Most my work are community based with tribal and vulnerable population (people living with HIV, Injecting Drug Users, etc) and I use qualitative research methods.

3) What have been your experiences in collecting, analyzing and using sex disaggregated and gender-sensitive data from RHIS?

I do not directly work with survey data, but in my understanding, often we do collect sex disaggregated data without realising what is the imperative. In my sense, there is a dire need to discuss gender and bring in sensitization among researchers to be able to design research tools and thus create evidence in this domain.

Looking forward to more discussion.

Warmly,

Aruna

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Halo all!

It is really wonderful to be part of such a vibrant group.

My name is Ajay Kumar Singh and I work with John Snow (JSI) at its India office as M&E advisor.

I am a demographer by training and have been working on Gender and engaging men to promote women health by advocating more egaliatarian approach. I have been part of various Operations Research on such topics. We also developed and tested a gender measurement scale called Gender Equitable Men Scale (GEMS) in India.

But I have no experience in collecting routine data on these issues and I am sure, this forum will help me to educate on such an important issue.

Looking forward to learn more from you

Best wishes

Ajay

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Hi Everyone

1) Name and where you are working (location and organization).  
I am Debjani Barman working at Institute of Health Management Research, Indian for Future Health Systems ([www.futurehealthsystems.org](http://www.futurehealthsystems.org/)) .

2) What is your level of training or knowledge about gender in health? (Please remember that prior experience or gender-related training is not necessary to participate in this discussion. We hope to meet you where you are at, and tailor the discussion around your needs. We are simply trying to get an idea of what levels of gender experience participants have, to ensure we respond accordingly in our moderation.)

I am a Student of Economics and completed my PhD in Health Economics. Recently working with RinGs RPC where under small research grant will explore the gender issues in eye health care for the elderly in Indian Sundarbans.

3) What have been your experiences in collecting, analyzing and using sex disaggregated and gender-sensitive data from RHIS?

I never used data from RIHS but would definitely like to explore it further.

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Hi,

My name is Margaret Yamaha, I work for United Nation Office for Coordination of humanitarian Affairs in Juba South Sudan, as a Program Analyst.

I work more closely with humanitarian Actors in coordination of Humanitarian activities and more specially in gender mean streaming when it comes to allocation of funds in responding to affected population.

With the complex and unique emergency situation in South Sudan I feel than gender main streaming has been comprised, when I saw the advert on gender I felt I need to join this forum and try to understand more on gender especially when it comes to humanitarian respond in emergency.

Thanks

Margaret Yamaha

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Hi

My name is Evelyne Ofwona, living and working in Nairobi, Kenya. I am a gender and development practitioner particularly on sexual gender based violence.

I must say I am really excited to be on this forum.

I am currently working on a proposal on Maternal Neonatal and Child Health. We would like to incorporate nutrition and gender in our project. I would therefore like to learn how gender affects health in terms of nutrition especially for poor pregnant and lactating mothers and their children.

Evelyne

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Dear ,

I am Dr.Mahmood Iqbal Memon a senior Public Health Consultant from Pakistan, working in Public Sector , presently with an NGO which is working on Health System Strengthening in Sindh province of the country. I am working with RHIS in Pak since more than two decades.

Here the RHIS is gender sensitive at the data collection points in public sector health facilities but as for as reporting to middle and higher level of management is concerned,very little is desegregated from gender point of view.

Hopefully the moderators will keep the discussion on track to get interesting facts and experiences from the learned colleagues across the world, that could help many in getting idea about minimum set of information required for planning and management from gender point of view.

Thanks & best regards

Dr. Mahmood Iqbal Memon

Senior Public Health Consultant

Sindh,Pakistan

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Dear Evelyene,

Its exciting to learn you would like to know more about the link between gender and health outcome in terms of nutrition programming. I have just concluded a study on factors influencing premature initiation of complimentary infant feeding in Juba South Sudan. In terms of gender, l found out that during the first 6 months exclusive breastfeeding, the boy child is more vulnerability to premature initiation of complementary foods than the girl child.

On the other hand, it is important to note that for most pregnant and lactating women in Sub-Saharan Africa, certain nutritious foods such as eggs and chicken still remain restricted in certain cultures which continue to pose a high risk of malnutrition. You will also agree with me that women unlike men in most African societies do not have same adequate food intake as compared to their spouses (men); they will either eat the last and smallest portion of the nutritious food they have laboured to prepare at the expense of their spouses and children putting malnutrition a chance for women as opposed to men. These gender disparities still need to examined more to influence nutrition programing especially in Emergency context.

Excited though, l stand to be critique here!

Bojo Samuel

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Hi Samuel

Interesting findings! I couldn't agree more, I believe it is the same case here in Kenya. Generally, there is a perception that boys suckle/eat more and therefore they should be weaned earlier than the girls.

I wonder what were the recommendations of the report? I would also want to know what actions you or others are taking in terms of involving men in the case of nutrition.

Best

Evelyne

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Hi to all and to Jim especially

My name is Norah Stoops and I work in South Sudan, VERY pleased to see all the contributions from South Sudan, and I also work in the DRC.

I work for an organisation, Health Information Systems Program South Africa and I am based in Cape Town

I am passionate about ROUTINE health information systems, specifically in developing countries and how to make them relevant and functional and useful.

I listened/watched very carefully the Webinar and it confirmed my deepest fears about the serious lack of understanding of the purpose of a ROUTINE health information system.

A ROUTINE HMIS is to provide data/information for assessing a program progress towards achieving national objectives and targets, and is NOT just a reporting system as Jim so clearly states.

What we do know about routine systems, is that the more you collect, the poorer the data quality.

So are you really sure you want disaggregated by gender data that is of such poor quality that you cannot use it?

In a (nameless) country that I have worked in the gender activists have achieved such a great win that EVERYTHING is reported according to gender, even live and still births in all weight categories..

I am sure this is useful to someone, but no one has yet to claim ownership of this data. Again MUCH effort is put into collecting data that has absolutely no value. But the gender activists have won again.

In another country (nameless again) the donor DEMANDS Maternal mortality disaggregated into gender.

So please understand if gender activists do not appear on my popularity list.

I am strongly convinced that the gender activists have a large role to play in the degrading of the routine health information systems in many developing countries where they have indicated that money will only be released if the recipient provides gender disaggregated data. And the countries do not have the capacity to defend the decision as to why they do not need/cannot provide gender disaggregated data, or provide a mechanism for how they will handle this issue.

The donor has the money so they can demand anything, irrespective of the actual cost in terms of time, difficulty, resources, capacity and skill. And so the Country/Recipient caves in.

This not only applies to the information system of the country, but also for funding given for various projects that have nothing to do with any gender related activities.

I accept that there are some data elements that need gender disaggregation.

TB data for case finding is collected according to gender and I am OK with that as there are differences in New Smear Positives that needs to be taken cognisance of.

Collecting TB outcomes according to Gender – At present a TB form for Outcomes requires some 60 values to be reported, if we split that into gender, it becomes 120. Then data quality becomes a very serious issue.

I am prepared to think about the need for gender disaggregation for HIV testing, as there is a real difference, but unless there is a deliberate policy to improve male uptake, I do not think the ratio between male and female HIV testing is relevant.

What we are missing in this discussion is that fact that this is about ROUTINE systems.

In all of these cases there is register where we can go back and find the details of the gender, it is not as if the gender details are lost for ever. They can be found if needed.

I also understand that sometimes we do need to know the gender split, but the question is, how do we get this without overburdening the staff and getting poor quality data.

I have also seen in many places where the data is just split 50/50 between male and female. So that does not help us understand the issues either.

We appear to have forgotten, or cannot be bothered, to use other tools in the M&E system, that can provide good quality data that will give us the data that we require.

Why can we not use a sentinel site to collect some gender disaggregated data? In these carefully chosen sentinel sites there is obviously more capacity, more resources and staff with more skills. Get their buy in, support them, visit them, bring them cake every 2nd visit, and they will give you a sample of data that is of good quality that will tell you what you need to know.

The other option is to run a more extended data collection report for 1 month in a year from all facilities. Prepared the staff for this expanded list of data elements, and include in it some gender disaggregated data elements. And thank them afterwards.

In some countries there is a bias against the female child, and in those countries, obviously the gender issue is very sensitive and the issue of reporting gender disaggregated data needs to be considered very carefully.

But not all countries have this gender bias, so it is not advisable to try and make a ‘one size fits all’ approach.

But if you have an electronic system that automatically collects patient demographics, then you can disaggregate everything and make all the gender decisions you like.

GBV is mainly reported by females, but I have no problem with this being gender disaggregated.

My first choice is good quality data that you can use for decision making purposes, and the use of sentinel sites that provide you with more detailed data that can be extrapolated and give you a better picture of what is happening.

I can give you many more examples of the insanity of gender disaggregated data, but I think you have got the message.

Aluta continua to a minimum data set that does NOT collect gender disaggregated data

Norah

Please note that the opinions given here are solely the responsibility of the author and are not that of the organisation….

Norah Stoops

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Hi Norah and All!

One thing/question that comes to mind reading Norah’s thoughts regarding gender disaggregation is this:

Do we need to collect the data in a disaggregated manner every month at every facility OR would we not be better off in terms of the overall quality of routine data by not having so so many categories and boxes to fill in and establishing the necessary and relevant information on gender using periodic survey data at facilities chosen so as to give statistically significant estimates of the breakdowns and patterns of interest for use in decision making? I suspect that the gender breakdowns of most diseases etc where they exist do not change from month to month (assuming your RHIS reports on a monthly basis) so do we really need to collect this on a routine basis in al facilities? Do the types of decisions which might be made using the disaggregated data get made every month or are they more the types of programmatic decisions that are done as part of annual planning?

So I guess my question is how can we think of what needs to be routine? This is not to negate the potential importance and need for disaggregated data in decision making, monitoring and evaluation, etc. but it does mean we should think about what the real (and minimum) requirements for those data are. I would rather have good reliable survey/sentinel based estimates than poor quality data from everywhere every month.

This is good to think about and fu8n to discuss!

Best,

Jim

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**Hello All,**

**RHINO Greetings!**

I am Sangeeta Tikyani Singh working with Public Health Foundation of India as Head Monitoring and Evaluation Unit. I am glad to see the responses and enthusiasm across the globe talking about RHIS and Gender. Two things most important yet neglected.

I have been working in RHIS and Gender and this forum is at the right time.

Look forward to interact and learn from the group.

Webinar was very helpful to set the stage and initiate discussion.

**Thanks and Regards,**

**Sangeeta Tikyani Singh**

**Board Member- RHINO**

**Chair Capacity Building Committee-GEMNet-Health**

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Hello Evelyne,

My major recommendation was for more research on why the boy child is more vulnerable to premature complementary feeding. Advocacy and IYCF counselling ate what we are doing for the boy child Looking forward to sharing more.

Kind regards,

Bojo Samuel

**July 15**

Dear participants in the RHINO forum on gender and RHIS,

I am pleased to welcome you to this forum. Given the evidence documenting the correlation between higher levels of gender equality and better health outcomes, integrating gender considerations into how we collect, analyze and use RHIS data is critical. When gender is not well integrated into RHIS, gender norms and inequalities that influence health and health seeking behaviors may be overlooked in favor of issues currently supported by stronger data.

Hopefully you are already aware that gender plays an important role in health outcomes and are incorporating that knowledge into your work. I anticipate that this forum will help with that process and I look forward to learning from you and your experiences.

RHINO greetings,

Theo Lippeveld

President of RHINO and Chairman of the RHINO Board

**July 16**

**Subject: Striking balance between gender inclusion interventions and potential impact in gender equality**

My name is Chet Chaulagai, a freelancer Public Health Consultant, experienced in designing, developing, implementing, and evaluating RHIS in developing countries.

I would like to thank to organizers, moderators and entire RHINO family for initiating discussions on this very pertinent subject.

I have observed remarkable improvements in gender equality from the time of Women in Development through Gender in Development phases. Mainstreaming Gender into national policies have brought changes in thinking and practices in every walk of life. Despite those efforts, gender disparity continued to exist in every society with variation in types and levels. Therefore, reasonable interventions should be continually added to enhance gender equality to an acceptable standard. Collecting age and sex disaggregated data is the starting point for gender mainstreaming in RHIS. However, we need to strike balance between the cost of intervention and likely impact of such interventions in reducing gender disparities. If we disaggregate data by sex, the volume will be just double. If we add disaggregation by broader age groups, the volume multiplies by the number of such groups. The countries that have adapted electronic data collection system can easily accommodate any level of disaggregation in collecting, analyzing, and presenting data. The countries that have not been able to implement an electronic routine data collection system face enormous challenges in manually compiling disaggregated data. At the source in most countries, data are recorded by sex and age, which is sufficient for any level of disaggregation. As the volume of data to manually compile increases, the accuracy of data terribly declines. This is mainly due to the burden of work and lack of appreciation of disaggregated data. One country tried to address this dilemma by introducing annual compilation of age sex disaggregated data on numerous indicators from sampled health facilities and generalize the results into the annual statistics. I have not seen any appreciation of such reports by the people who can address the issues of gender disparity. I am a strong advocate of gender equality willing to strike balance between the cost of efforts and the impact.

I am hoping, from this forum, to learn the ways that could help us in addressing gender issues while restructuring RHIS in resource constraint setting.

Warm regards,

Chet

**Subject: Gender & HIS Day 3**

Thank to you everyone who has joined in the conversation!

We have heard from a number of people regarding the disconnect between data collection and use. We agree this is a challenge and MEASURE Evaluation does a lot of work on improved use of data for decision-making. Sex disaggregated and other gender-sensitive data will not get used if program and policy decision-makers do not appreciate its value to improvement of their programs and services. As we noted in the kick-off webinar, it is important to conduct advocacy training with M&E program and policy decision makers on the value of sex-disaggregated data and use to make policy/program decisions; this training also needs to include the basics of gender, gender equity and why it is important to health (as also suggested by the results of Jaako’s research in Benin showing that gender egalitarian beliefs affected gender-sensitive data use).

As participants have suggested, decisions about collecting and analyzing sex disaggregated data involve a balancing act. Decisions on how often and which indicators to disaggregate and analyze should be based on the nature of the program and services provided, any problems already identified that may relate to gender, resources, and priorities of countries. In many cases, the indicator cannot be expected to change in a month and would be best collected and analyzed quarterly, semiannually, etc. Also, you could initially decide to collect and analyze priority indicators by sex on a frequent basis, perhaps monthly, to improve services, but then choose to do so less frequently once your program is performing well. In addition, some outcomes are more influenced by gender than others – which varies over time and by cultural context; thus, it is important to involve someone with gender expertise in your context in decisions about selection of indicators and level of disaggregation.

Consider, for example, the high prevalence of HIV/AIDS in female adolescents in Southern African countries as compared to the males. This is a situation to be closely monitored and the best data source is RHIS. The question is, are the existing facility-based data collection systems taking this into account? Do they ask, in addition to gender, also a detailed breakdown by age groups in order to examine how/if HIV services are meeting the needs of adolescents? Or, what alternative ways of data collection can be proposed? Could it be done through a desk review of individual records of new HIV/AIDS cases and studying the break down by gender in the age groups 15-24 or in a sentinel survey?

Are there other examples of indicators that benefit from sex disaggregated information on a routine basis you have encountered?

Chet Chaulagi mentioned “one country tried to address this dilemma by introducing annual compilation of age sex disaggregated data on numerous indicators from sampled health facilities and generalize the results into the annual statistics” and that, unfortunately, the results were not used. We would be interested to hear more about that experience if there is more to share – notably, was there any education/advocacy done with decision makers who could act on any gender disparities identified? Also, were there certain indicators that you think clearly benefited from disaggregation more than others, and if so, which ones?

Best,

Brittany & Jessica

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Dear All,

What a vibrant discussion around gender and HIS! It is great to have so many experienced perspectives and questions being offered.

I also wanted to send a friendly reminder to the group to think about how gender includes more than only women. As Brittany mentioned in the webinar, gender includes men and transgender individuals, and it is important to think about how the social expectations and norms can impact them as well. Women are often the focus of gender-related interventions because of many historical disadvantages, but there are also ways in which attention to gender in HIS can be beneficial to men and boys. For example, in many cultures it is not masculine or it can be seen as weak to seek help for illness, injury, or disease prevention. If sex-disaggregated data reveals gaps in health services between men and women or boys and girls that indicate men are not accessing needed services, program managers could adjust programs or campaigns to increase male attendance.

We can also keep in mind that gender includes transgender persons and individuals that may not conform to typical gender identities, but these people are unfortunately not captured in most HIS data collection forms. Special studies or surveys are often used to capture health data with these key populations.

Can you think of any other examples that illustrate the added benefit to men or other populations of gender-sensitive HIS?

Regards,

Abby

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Hi

I agree with Brittany and Jessica that training with M&E program and policy decision makers on the value of sex-disaggregated data and their use is important. But it may not be enough to ensure that the collected data are put to effecitve use at the district and health facility levels. The study I conducted in Burkina Faso (not Benin) suggests that the values of health managers and employees may significantly affect the use of sex-disaggregated data and health information more generally in decision making. I can think of no better way to exemplify the influence of values than by sharing with you some of the results of the study. I thought some quotes from the interviews might also be useful.

The values of individual data collectors and users are recognized as having an impact on routine health information system performance. The literature on this topic is scant, however, and I am under the impression that cultural values are still largely overlooked in the promotion of the use of routine health data in decision making in low- and middle-income countries.

In the study in Burkina Faso in 2007, I explored the ways in which the shared values of employees influence information use at the district and health facility levels in one rural district. I interviewed a sample of 20 health managers working in the public sector in a conversational style with the aid of an interview guide. In the qualitative analysis of the interview transcripts, I identified dimensions of organizational culture and organizational practices affecting information use in decision making. One of the identified cultural dimensions was Gender Egalitarianism which is a measure of the degree to which a society or organization seeks to minimize gender role differences. Based on the findings, I suggested culturally sensitive strategies for promoting an informational approach to management in the local context.

(The study included a smaller component in which the extent of information use in decision making was assessed by analyzing the statistics for the previous years on the performance of both preventive and curative health services, and by looking for evidence of information use in locally produced documents.)

Before describing the findings regarding the gender egalitarianism dimension, I would like to provide some background information. Values refer to desirable goals that motivate action. Basic values are values that are relevant across virtually all situations. They often deal with fundamental aspects of life such as human relationships and the proper role of men and women. Operating partly at a subconscious level, they tend to be taken for granted by group members and are treated as non-negotiable. Behavior based on any other premise would be considered inconceivable. Basic values in societies are relatively stable and change slowly.

A number of dimensions of societal and organizational culture have been identified by different researchers for the purpose of comparing cultures. There is, however, no consensus on a comprehensive set of core dimensions for describing cultures. (In the study, I adopted the GLOBE Study definitions of the dimensions of societal and organizational culture.)

A ‘culture fit’ model has been proposed on the interaction between organizational culture and the effectiveness of human resource management practices: for management practices to be effective, the value assumptions underlying management practices need to be in sync with the basic values espoused by a society. Organizational practices which have evolved in the context of Western cultural values may fail in a very different cultural environment because they are not consistent with its values. The continuous exposure of managers and employees to the influence of the local societal culture is likely to enhance the effect of societal culture on organizational practices.

What is the relevance of the culture fit model to the performance of routine health information systems in non-Western cultural contexts? Promoting evidence-informed and performance-oriented decision making at all administrative levels in low- and middle-income countries is viewed as an essential strategy to achieve more effective and appropriate use of scarce resources and improved development outcomes. However, an increase in the availability of quality information has in many cases not resulted in more evidence-based decision making. In sub-Saharan Africa, evidence-informed and performance-oriented planning and management may constitute a major change in organizational culture. Health information systems are designed to increase transparency in decision making and resource allocation. Managers are encouraged to prioritize the achievement of organizational objectives, to take initiative and to be more willing to make risky decisions. Problems are expected to be shared with others and to be confronted openly. The resistance to change suggests that managers and health service providers may not be comfortable with this.

In the study in Burkina Faso, I explored the relationships between cultural dimensions at the organizational level, organizational practices, and information use by managers. The objective was also to identify culturally appropriate strategies for enhancing the use of routine health information in decision making.

You need to know that over 60 ethnic groups live in Burkina Faso (15 in the study area), the Mossi being the largest one comprising about half of the population. The adult literacy rate was 28% for males and 15% for females.

The network of health facilities was organized in four tiers. Authority for decision making in the health sector had partly been devolved to the level of health centers and the communities they served. Health center directors were required to hold monthly meetings with management committees that included six community representatives. These structures had the responsibility for the management of health centers, the elaboration of annual plans, and for community mobilization for health.

Aspects of a health system that are related to gender egalitarianism include the likelihood that women occupy management positions, the extent to which it provides equal opportunities for men and women to participate in decision making, and the responsiveness of the system to both men’s and women’s expectations. The observation that there were almost no women in management positions in the Nouna Health District, and that in many health facilities women were not engaged in decision making, led to a need to explore the influence of gender egalitarianism on the use of routine health data by managers.

The gender distribution of health managers and decision makers in the Nouna Health District was extremely skewed. All the managers at the district and health center levels were men. Of the managers in the district hospital, only the Head Midwife of the maternity was a woman. According to the interviewees, the lack of women in management positions within the formal health services was largely due to women’s obligations towards their families which often prevented them from accepting to become managers. One interviewee pointed out that the situation was different in cities such as Ouagadougou or Bobo-Dioulasso where perhaps the majority of health managers were female.

The disadvantaged status of women in society was reflected in the lack of representation of women in the management committees of many health centers. Some of the management committees did have one or two female members, but most of them were composed of men only.

The interviewees attested to the low status of women in society:

*Here the status of women is very low indeed. . . . They don’t have any decision-making authority, none.*

In the male dominated communities, it was commonplace for women not to participate in decision making even regarding matters concerning their own health. For example, the decision about whether she should deliver at home or in a health facility was usually made by their husband or mother-in-law.

According to some interviewees, it was often unacceptable for women to be involved in activities outside of the home if other men were present. When they were allowed to participate in meetings with men, in many societies they tended to remain silent.

Interviewee: *Well, here men are the ones who make the decisions. In general, men decide in our societies.When men are present, women don’t have the right to speak. Usually it is like that. Women may only bepresent.* *They cannot say a word. e>*

Interviewer: *Are these communities Muslim or–?*

Interviewee: *Well, . . . there are communities that are Muslim, Christian, Animist, all kinds of communities.*

However, the status of women in the societies seemed to vary within the Nouna Health District. One Health Center Director mentioned that women did participate actively in discussions that were organized during outreach activities even when men were present.

The local health authorities had encouraged communities to elect women to management committees of health centers, but men in the communities were said to usually object to women’s participation to management committee meetings.

Interviewee: *Therefore I believe the problem . . . is not necessarily the fact that women cannot read or write. In some cases [the problem] is linked to the culture of the community. You see, . . . if the notion is that a woman has to be at home, it’s a problem.*

The quality of the health services can be improved by increasing the responsiveness of the health services to people’s expectations. However, it seemed that only a minority of the health centers in the sample had made an effort to establish a dialogue with women in the communities to obtain their perceptions about the quality of the health services.

Interviewee: *[I]t is perhaps better to have men’s opinion because even when we inquire from women, they won’t even be able to speak in the [health centers]. I mean, it would be very difficult indeed for them to express themselves, to say what their problems are*

Yet the quality of the health services seemed to be an issue. Many health center directors complained about the shortage of health staff, the heavy workload, the unavailability of electricity, the lack of essential equipment, and about the difficulties in referring medical and obstetric emergencies particularly during the rainy season. The responses of a few interviewees suggested that failure to meet people’s non-medical expectations was a significant problem. Some managers mentioned about the disrespectful treatment of clients, and according to one respondent there had also been cases of physical abuse of pregnant women during delivery. A disrespectful attitude of health personnel towards clients and patients was identified as a major problem in the national quality assurance program.

The document review and the results of the content analysis of the interviews suggested that some health managers had a tendency to attribute problems to external causes rather than to deficiencies in the quality of the health services. Such a tendency seemed to have resulted in misguided efforts to increase service uptake by the target populations.

The generally weak engagement of women in the development of the health services in comparison with men was interpreted as an indication of fairly low gender egalitarianism within the health system. Given that the responsiveness of healthcare services to both women’s and men’s expectations is an important determinant of the performance of a health system, there was a need to promote women’s participation in the development of the quality of service provision.

In 2007, a government policy was introduced requiring health centers to make an inventory of civil society associations within their catchment area and to hold quarterly meetings with the associations. The possibilities of engaging representatives of women's

associations in the management committee meetings of health centers could also have been explored as a way of overcoming gender barriers to women’s direct participation in decision making.

Women’s participation in decision making in management committees of health centers and hospitals, and in quality assurance efforts in the facilities would have been likely to contribute to the effective use of information to improve health facility performance. In the study area, health center directors shared the statistics on the performance of the health services with the management committees of health centers. A greater participation of women in these committees would have increased women’s capacity to influence the development of the health services and to hold health authorities accountable. These factors would have given additional incentives for health care providers to use routine health data and other information sources effectively to meet women’s needs for healthcare.

The responsiveness of the health system to women’s expectations could also have been increased by encouraging women to accept management positions in the District. The Ministry of Health could have addressed the skewed gender distribution of health managers by exploring strategies for encouraging women to accept management positions. District Health Management Teams should have involved female employees in the identification of practical ways for helping women reconcile managers’ duties with the obligations of family life.

These recommended strategies would in themselves have been insufficient to increase the use of routine health data to better respond to women’s needs and expectations. In addition to gender egalitarianism, four other dimensions of organizational culture were identified in the study as influencing the use of routine health information in decision making (performance orientation, power distance, collectivism, locus of control). These dimensions of organizational culture seemed to be related to five organizational practices influencing information use. All of these cultural dimensions and management practices would need to be taken into consideration in the promotion of evidence-based and performance-oriented decision making.

For example, some interviewees highlighted the need for an outsider to help work teams identify performance deficiencies and their root causes. This recommendation is also relevant for increasing the responsiveness of the health services to women’s needs and expectations. One respondent specifically suggested the provision of such assistance by someone higher up in the organizational structure as a means for overcoming difficulties in undertaking critical self-assessment of performance. Where health facilities do not manage to use routine health information effectively to solve problems on their own, the participation of an external facilitator may make it easier for the health team to confront problems openly as a group in a process of joint problem-solving.

An external facilitator may also be needed to overcome communication barriers between community members and health center staff. Not only may some health workers find it difficult to invite critical feedback from the community on the quality of the health services, but community members themselves may hesitate to provide such feedback directly to health care providers. According to the experience of one respondent, a district level supervisor can help overcome such communication barriers.

In view of the limited understanding of the ways in which the shared values of employees affect information use in decision making in sub-Saharan Africa and elsewhere in the developing world, there would appear to be a need for more research to address this gap. Such research would have the added benefit of shedding light on organizational culture more generally. The findings could suggest ways of increasing organizational effectiveness and employee commitment in other sectors of government too by identifying culturally appropriate organizational processes and management practices for promoting information-based and results-oriented decision making.

I'm sorry for not managing to report clearly on these results in a more informal manner.

Best, Jaakko

**July 20**

**Subject: National HMIS of India - Use of disaggregated data**

Hi

I thought of sharing my experiences about the use of disaggregated HMIS data in India.

In a culturally and socio-economically diverse country such as India, disaggregated data becomes even more important. Aggregated data hides the fact that vulnerable population, especially poor women and children, and minority communities, remain beyond the reach of the health system. Among and within states access to health services widely varies.

India is extensively using gender disaggregated data from its national HMIS to monitor and expand coverage of health services to the village level. Standard and analytical reports from the HMIS are available in the public domain at <https://nrhm-mis.nic.in/SitePages/HMIS-Download.aspx>. The RCH register is a key data collection tool and collects [gender and age disaggregate data](https://nrhm-mis.nic.in/Part%20B%20Mother%20and%20Child%20Tracking%20MCTS/RCH%20Register/RCH%20Register%20Section-I.PDF). The RCH register captures data for men and women along with their age (current age and age at marriage)

The government also has another information system to track service delivery to mother and children under age 5 (for immunization). This system is called Mother and Child Tracking System and is different from the National HMIS web portal.

In the national HMIS disaggregation by sex and age is available for a defined set of indicators. For example, HIV test data is collected by sex. In-patient data is collected by both sex and age. Live birth data is disaggregated by sex. Mortality data is captured by age and sex. Utilization of family planning services is captured by sex. I think disaggregation is designed based on the program monitoring needs and demand from the decision makers at different levels of the health system. A limited set of data is reported to the national government while others are used by the states.

In order to institutionalize the use of HMIS data, government has also developed a [‘Score Card’](https://nrhm-mis.nic.in/hmisreports/analyticalreports.aspx) to assess and improve the service delivery through routine monitoring system. The, score card assists in comparative assessment of performance of States/centrally governed regions, Districts and Sub-Districts /Blocks. The purpose of this ‘Score Card’ is help monitor the implementation of the recent RMNCH+A (Adolescents) strategy of India that aims to reduce child and maternal mortality through strengthening of health care delivery system.

Undoubtedly, these efforts are resource intensive but critical to expanding availability of and access to health care services for those who need it the most. I think such data disaggregation is necessary to avoid institutionalization of inequity and gender inequality which can result in structural violence.

Best,

Manish Kumar

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Hi all

I am Tariq Azim, Senior Technical Advisor at JSI, based in US but looking after HMIS/RHIS projects in Ethiopia (APC) and Bangladesh(MEASURE Evaluation).

In Ethiopia, they have sex disaggregate morbidity and mortality data collected routinely using HMIS. For example, data from the electronic HMIS implemented in SNNP region shows that overall there are about 11-16% more male malaria patients over female female patients attending the outdoor services. This is more of less true for hospitals, health centers and health posts; and for cases of clinical malaria, and for falciparum malaria or non-falciparum cases. One can think that this might be due to males being more exposed to malaria. But if you compare across age groups, still males are more, e.g. for age groups 1 to 4

If we takes diarrhea cases as a contract to malaria cases, we see the same higher ratio of males attending the outdoors.

I do not know of any report published by the MOH that has such gender disaggregated data analysis.

In Bangladesh, again they also collect clinical services data disaggregate by gender. The yearly Health Bulletin published by the Directorate General of Health Services contains analysis of disease data by gender. They also show the top 15 diseases among males and females and the utilization of health services by gender. In Bangladesh, the use of public health services is higher among females. The bulletin also contains male and female distribution of doctors and other health staff.

Thus, what I see is the gender disaggregated data is available at the source and some of if is also reported and analyzed. May be we need to do some desk research to see if there are examples of any decision based on this gender disaggregated data.

Tariq

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Thank you for sharing your experiences, Tariq and Manish!

We would like to take one of the examples Tariq gives in Ethiopia with males accessing diarrhea services at higher rates than females and pose some related question to the group -- If you were faced with this data as a program manager, what could you do with this information? What other data might you look at? What kinds of questions would you ask and how would you answer them?

Best,

Jessica and Brittany

**July 20**

**Subject: Country Examples of gender-based analysis of routine and non-routine data**

# Hello forum participants,

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# For those unfamiliar with gender-based analysis, we thought it would be helpful to share with you a recent example using routine and non-routine HIV data from Rwanda. Please see the attached,” Know Your HIV/AIDS Epidemic from a Gender Perspective: Rwanda Report” (if attachment does not work, see website [here](http://www.cpc.unc.edu/measure/publications/tr-14-98)). We have also pasted below the executive summary from the report if you prefer to review that.

For this study, MEASURE Evaluation conducted a gender-based analysis using HIV-related routine and non-routine data. Sex-disaggregated variables from routine sources examined the difference, or the gender gap, between the number or proportion of men/boys and women/girls using services and reached by programs. Data from special surveys conducted during the past five years were used to explore structural factors related to gender and HIV. Working with a multi-sectoral national-level collaborative team in Rwanda, the activity was designed to enable program managers at the national level to understand how to use their data for a gender-sensitive and effective HIV response. The steps of this exercise can be repeated for other countries using a similar process.

One important finding from analysis of the routine data was that there was virtually no gender gap in the number of adult patients currently on ARV treatment. This was of concern because prevalence is higher among women than men, so presumably there should be a higher number of women in treatment than men. The most disproportionate burden of HIV is among young people aged 15–24. This is indicated by HIV prevalence as recorded by the RDHS and in the routine data on males and females testing positive for HIV through both VCT and PIT. For those enrolled in treatment and already on ARV, there were almost double the number of women than men. With RDHS indicating that women in this age group have prevalence rates up to almost five times that of young men, it is likely that enough young women are not being reached.

This finding is a good example of how data that, at first glance, looks like it shows men and women accessing services equally, can be deceptive without also examining the greater context of the disease dynamics. In this situation, women, especially young women, have a much higher HIV prevalence rate and so this should be reflected in service data. If more women have HIV, you would expect to see similarly higher levels of women on ARV treatment.

Thanks,

Jessica and Brittany

**Executive Summary**

Decades of research from around the world has demonstrated that gender inequality negatively affects a range of health outcomes for adults, and gender inequality has been recognized as a key driver of the worldwide HIV epidemic. Managers at the national and subnational levels need information on the intersection of gender and HIV to address gender in the planning and implementing of HIV programs. Policy makers need information on interventions that are effective in accounting for gender inequities for decision making on national and global levels. This report presents the results of a gender-based analysis conducted in Rwanda that used all HIV- and gender-related data made available to the MEASURE Evaluation team. The exercise was called “Know Your Epidemic from a Gender Perspective.”

In Rwanda, women and girls are disproportionately infected with HIV, comprising approximately 59% of all infections. The difference is particularly striking among young women aged 20–24, who have nearly five times higher prevalence than their male peers (2.4% compared to 0.5%), and the highest prevalence rate among women is the 35–39 age group, at 7.9% compared with 3.8% of men in the same age group. The government of Rwanda (GoR) has shown a strong commitment to promoting gender equality, and this has extended to the country’s HIV response. One of the major investigations of a mid-term review of Rwanda’s HIV National Strategic Plan (NSP) was the degree to which the NSP implementation addressed its overarching principles, including gender equity and human rights.

For the Know Your Epidemic from a Gender Perspective, MEASURE Evaluation conducted a gender-based analysis in Rwanda, using HIV-related routine and non-routine data. Sex-disaggregated variables from routine sources examined the difference, or the gender gap, between the number or proportion of men/boys and women/girls using services and reached by programs. Data from special surveys conducted during the past five years were used to explore structural factors related to gender and HIV. Working with a multi-sectoral national-level collaborative team in Rwanda, the activity was designed to enable program managers at the national level to understand how to use their data for a gender-sensitive and effective HIV response. Two sources of routine data were used for the analyses: TracNet, which is Rwanda’s national HIV-related clinical database, and CNLSNet, which is the database that stores all HIV-related community-based programmatic data. Survey data used for the exercise drew on four sources: one nationally representative survey (Rwanda Demographic and Health Surveys 2010), and three that were community-based probability samples of different populations: people living with HIV (People Living with HIV Stigma Index Study), school children (The School Children’s Survey), and workers on three coffee cooperatives in Rwanda (engaging men to prevent gender-based violence, The Coffee Cooperatives Survey).

The results from analyzing the facility-based data showed some consistent patterns. Among patients age 14 or younger, there was virtually no gender gap between boys and girls. Age 15 and higher, the burden of HIV is carried by women in all age groups. The most disproportionate burden is among young people aged 15–24. In general, there were about double the number of women than men in HIV treatment services. However, prevalence rates of young women relative to young men are up to almost five times 5 more. Thus, we would expect a higher ratio of women to men in services than what was observed, and it is likely that young women are not being reached by treatment. Among adults age 25–49, the gender gap observed was closer to the observed prevalence rates for this age group, indicating that these women are being adequately reached by services. Many of the programmatic reach indicators were difficult to interpret because the inconsistencies in the patterns and trends appeared to be a product of data or documentation error. The indicators that could be interpreted with confidence showed that more men than women were being reached. The numbers of people being reached by community-based programs appeared to be growing substantially.

The survey data also showed that girls and women were at a disadvantage in Rwanda, with prevailing norms and behavior reinforcing gender inequality and contributing to women and girls’ vulnerability to HIV. The Stigma study showed a consistent gap between women and men in all areas explored within the Stigma index, with a consistent gap of about 15 percentage points across indicators. From the School Children’s Survey, we learned that the roles and expectations related to household duties fall disproportionately on girls and their mothers, and beliefs and perceptions reflecting gender inequality persist in many areas. However, from the questions asked of respondents about how they would act in their future households, there appears to be a generational shift in gender-related attitudes when compared with what they believe their parents’ perceptions are. Large numbers of children witness verbal and physical abuse of their mothers, and even more children report experiencing it themselves. Data from the Coffee Cooperatives Survey indicate that the ideas expressed about adults in the School Children’s Survey were true to form: most of the men and women interviewed expressed beliefs and behavior that contribute to gender inequalities. Although none of the surveys were nationally representative, the findings from the Rwanda DHS 2010 mirror what was observed in all three of the surveys: there is a high level of gender-based violence in Rwanda, gender-inequitable norms are expressed with regard to the acceptability of intimate partner violence, and women’s autonomy in several dimensions is low.

There were several lessons learned pertaining to the process of the gender-based analyses (GBA) of existing gender and HIV-related data and important conclusions drawn based on the results of the exercise.

* Analyzing the routine and nonroutine sources of data together and employing a gender focus that used sex-disaggregated and gender-sensitive indicators offered important information about Rwanda’s HIV epidemic that would not have emerged from a traditional analysis. The government of Rwanda has demonstrated a strong commitment to addressing gender within its HIV response. The results of this report provide information the government can use for that endeavor.
* The steps of this exercise can be repeated for other countries using a similar process, yielding results that will enable program managers and policy makers at the national level to effectively address gender within their HIV response.
* Involving all stakeholders in the process is critical to success. The multisectoral team ensured that the exercise succeeded from accessing the data to interpreting and using the results.
* Data quality was an issue. In the routine data, there were some patterns that appeared to be caused by gaps in reports and other sources of error. In both routine and survey data, lack of adequate documentation meant that many indicators (and in some cases, whole sources of data) could not be used. Teams seeking to do this type of exercise should ensure that data are well documented, including questionnaires, variable names, the meanings of codes, and so on. Often, people working with the data are familiar enough with its structure that such documentation (e.g., codebook) does not exist and needs to be developed.
* In analyzing the gender gap in services and programmatic reach, there is only an inequity if the difference between the sexes does not mirror HIV infection rates and prevalence. In the case of Rwanda, though there was a gap between younger men and women using services and being reached by programs, the difference was much smaller than the gap in HIV prevalence. Therefore, not enough younger women were in services or being reached by programs.
* All survey data pointed to the high prevalence of gender-based violence (GBV) in Rwanda. Since GBV is a major driver of HIV among women, addressing GBV should be a priority for programs and policies.
* High proportions of individuals in all the surveys expressed norms and attitudes that perpetuate gender inequalities, directly contributing to outcomes such as intimate partner violence (IPV) and indirectly to HIV. However, the School Children’s Survey showed that there may be a generational shift taking place. This points to how powerful gender-transformative programs and policies can be among youth in Rwanda to support lasting changes and success into the future, improving HIV and other health-related outcomes

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Hello forum members,

In my last post on this subject, I mentioned about the availability of routine sex-disaggregated disease data from Ethiopia and Bangladesh. Similarly, sex-disaggregated data is also available through surveys. For example, the Demographic Health Surveys (DHS) in both Ethiopia and Bangladesh show gender-disaggregated data on immunization, treatment of childhood diarrhea and pneumonia. (In fact in Ethiopia and Bangladesh, the immunization coverage is higher in female children than in male; though the difference might not be statistically significant). However, I feel there's a dearth of documented evidence of strategic or policy decisions based on the analysis of that data. I think there's a need to increase the awareness of and the demand for sex-disaggregated data among health policy makers and managers and health data analysts. Analytic reports, dissemination seminars etc. on in-depth analysis of and recommendations based on sex-disaggregated data can be a way forward to promote the actual use of such data. Some attention and investment should go on that direction.

Tariq

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Hello,

My name is Mohammad Golam Kibria and working with MSH/SIAPS in Bangladesh as Senior Technical Advisor- Quantification and HIS.

I would like to share an experience while working with the National TB program in Bangladesh. The program has already moved towards to collect the individual TB patient's data through an electronic recording and reporting tool (eTBM) from 2010 and now have an huge amount of dataset of TB patients (for both DST and MDR). This age-segregate data are very important while the PSMWG does the forecasting of TB drugs (for determining the estimation by adult & child category). On the contrary, gender disparities in tuberculosis (TB) cases are reported worldwide, and socio-cultural factors have been proposed as possible causes. This gender dimensions data is critical to ascertain which sex has a higher prevalence rate, or a higher case fatality rate. The sex-disaggregated data from this routine source (eTBM) provides the gender-gap in treatment outcome, assessing health seeking behavior among women by age-category and push NTP to make appropriate planning to reach the unreached through IEC/BCC program.There are reports in Bangladesh that women with the symptoms of tuberculosis do not seek medical attention for fear of social stigma. It's very common among unmarried women. It's also realized that the effective use of HIS can facilitate to adopt a gender-specific strategies, including active case finding in elderly women and smoking cessation in male patient for optimizing TB management.

In an another experience, I have worked with UNDP in a post-conflict area (Chittagong Hill Tracts-CHT) where the program used to collect data by ethnicity (apart from sex and age-disaggregated data) for malaria, TB and other diseases . There are 13 ethnic groups in the CHT area and their health seeking behavior were diversified and this data were very useful for the program planning and reaching the target group for improving their utilization of health services. I believe, the dis-aggregated quality data (be it age, sex or ethnicity or socio-demographic factors) has the power to promote the better use of data for decision making at any level.

Regards

kibria

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Dear all,

I want to share one of my experiences in using gender dis-aggregated routine data in previous work in an HIV prevention project (through STIs syndromic case management) back in Guinea.

Through regular routine data monitoring, we realized that 86% of STI patients (over time) were women. Obviously, the rational question to ask in such a situation was the following: where do men go to seek STI care?

We hypothesized several options including the following: black drug market, traditional Healers and possibly Pharmacists. For feasibility options we decided to conduct a survey at the pharmacy (drug store) to assess the quality of counseling delivered to STI clients (proposed medication and infection control) in drug store (Pharmacies) in the town of Conakry.

The findings showed that not only the quality of counseling was extremely weak along with appropriate drug delivered (2%) and infection notification to the partners of the STI client was lacking at 100%.

As such, an intervention was planned to improve staff knowledge and the quality of counseling in this level and find a way to minimize complications consecutive to bad counseling.

The interventions included (1) training of pharmacists and drug sellers (both morning and evening teams) on STI syndromic case management, (2) introduction or establishment of STI kits for urethral discharge in collaboration with national drug Procurement Company and pharmacist board of directors, (3) institutionalization of a referral systems for any genital ulcers, vaginal discharge and lower abdominal pain encountered at the Pharmacy level.

This was an example of looking at routine data dis-aggregated by gender which led to management key decisions regarding STI care for HIV prevention in Guinea.

Regards,

M. Alimou Barry

Sr HIS Specialist

MEASURE Evaluation/JSI

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Regards,

M. Alimou Barry

Sr HIS Specialist

MEASURE Evaluation/JSI

**July 22**

**Subject: Gender and Mental Health Data**

Hello, all. Today we will circle back to a few open questions noted earlier in the forum and provide some information in response.

During the webinar, a participant asked about whether there was sex disaggregated routine data on mental health. Mental health data collection for both men and women, in general, is currently not standard in RHIS. In addition, indicators on mental health are not usually included on gender indicators lists (Buvinic et al, 2014)

The global health community, however, is increasingly noting the importance of attention to mental health in health systems and there is growing recognition of gender-related disparities in mental health. Such disparities include, for example, that certain subgroups, such as survivors of intimate partner violence and lesbian, gay, bisexual, and transgender persons, may be at higher risk of experiencing mental health problems. Also, women are two times more likely than men to become depressed and women typically live longer than men; therefore, women are more likely to experience higher morbidity and loss of DALYs (disability-adjusted life years) due to mental health problems (Buvinic et al, 2006 & Buvinic et al, 2014).

In the context of this increased recent attention to mental health, there are movements to address the lack of global standard data on mental health. For example, Objective 4 of the WHO Mental Health Action Plan: 2013-2020 is to strengthen information systems, evidence and research for mental health,” and the global target for this objective is for 80% of countries to “be routinely collecting and reporting at least a core set of mental indicators every two years through their national health and social information systems (by the year 2020).” (WHO, 2013). We are hopeful that mental health data collection, analysis, and use will improve in the near future.

Best,

Jessica and Brittany

References:

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**July 24**

**Subject: RHINO Gender and HIS Forum Close-out**

Dear Forum Members,

Thank you for joining us over the course of the forum. We’ve enjoyed discussing your experiences, challenges and successes in collecting and using sex-disaggregated and gender sensitive data in RHIS. We’d like to leave with some final thoughts based on the themes that surfaced during our discussion.

**Given the evidence documenting the correlation between higher levels of gender equality and better health outcomes, integrating gender considerations into how we collect, analyze and use RHIS data is critical.**

Gender inequality has been demonstrated to impact a variety of health risks and negative outcomes including HIV, TB, malaria, Alzheimer’s disease, dementia, and other disabilities. Data collection and analysis by sex can further investigate what differences exist and to what extent. Gender-based violence (GBV) and mental health are two additional areas that lack sufficient data despite their importance.

**Not all data needs to be disaggregated by sex all the time**

Without sex-disaggregated data, we can’t analyse differences in how males and females access and benefit from services and respond to those differences to improve health outcomes. However, collecting disaggregated data can be burdensome, so it may be necessary to prioritize indicators, complete more data collection with disaggregation periodically, or to consider alternative ways to get the answers to gender-related questions. Different users will have different needs, so it is important for stakeholders to prioritize what information is needed to determine what data should be collected and at what level. For example, not all users will need the same level of detail. Some might require data that are further disaggregated by other factors. National-level indicators may need to be drawn up to enable international comparisons; it is important to strengthen policy-makers’ ability to compare their own programs’ performance with those of other countries. Local-level policymakers are likely to need more detailed indicators that are broken down by socioeconomic, ethnic and geographical groups, matching the population they serve. It is important to consider the local context and what the data are being used for when collecting gender-related information.

**There is a disconnect in the collection and use of sex disaggregated data from RHIS.**

A number of participants have raised a concern that facility, district, and even national decision-makers rarely use routine data to identify performance gaps, make plans, and monitor progress. Information may be available, but it is only used to populate reports instead of also using it to drive decisions and program improvements. It is important to note that data use is an issue that transcends sex and gender data, and there are helpful resources that discuss data demand and use overall (see, for example: <http://www.cpc.unc.edu/measure/tools/data-demand-use/data-demand-and-use-strategies-and-tools.html> ).

Sex-disaggregated and other gender-sensitive data will not get used if program and policy decision-makers do not appreciate its value. Advocacy training with M&E program and policy decision makers can emphasize the value of sex-disaggregated data and its use to make policy/program decisions; this training also needs to include the basics of gender, gender equity and why it is important to health.

**There are other gender-sensitive indicators to consider when developing RHIS**

It is important to identify indicators which provide the most appropriate gender-related information in a given context.

Gender-sensitive health indicators encourage specific and measurable targets in relation to gender equality, and they can be used alongside other approaches. Again, selection of indicators woulddepend on programmatic or country needs and should include wide stakeholder involvement. For example, many countries have established policies and programs to decrease GBV and provide treatment for victims. Therefore, a country may want to monitor the number of GBV service encounters at a health facility to better understand disclosure of violence and access to treatment.

**Additional Resources**

Here are some additional resources if you’d like to continue learning about gender and gender-integration.

· MEASURE Evaluation gender website: [www.measureevaluation.org/gender](http://www.measureevaluation.org/gender)

· Gender and Health Systems Strengthening e-learning course: <https://www.globalhealthlearning.org/course/gender-and-health-systems-strengthening>

· Compendium of Gender Equality and HIV Indicators: <http://www.cpc.unc.edu/measure/publications/ms-13-82>

· VAW/G compendium: <https://www.cpc.unc.edu/measure/publications/ms-08-30>

· Gender M&E Online course: <http://www.globalhealthlearning.org/course/gender-m-e>

· Resource guide for gender data and statistics: <https://www.cpc.unc.edu/measure/publications/ms-12-52>

· Data2x Mapping Gender Data Gaps: <http://data2x.org/wp-content/uploads/2014/11/Data2X_MappingGenderDataGaps_FullReport.pdf>

The need for specific examples of sex-disaggregation and gender-integration has come up several times over the course of the forum. And while we received a handful here, there is certainly a need for continued discussion and sharing of experiences as we move forward.

Please note the forum will remain active if others would like to continue the conversation, however the official facilitated forum is closed. If you have additional questions about gender and M&E, feel free to email us at GenderM&E@unc.edu

Thank you again,

Brittany and Jessica