

# **GENDERED RESEARCH IN HEALTH**

## **A TRAINING MANUAL**

**RENU KHANNA**

SAHAJ- Society for Health Alternatives, Vadodara, Gujarat

and

Women's Health Training, Research and Advocacy Centre (WOHTRAC)

Women's Studies Research Centre (WSRC)

The Maharaja Sayajirao University of Baroda

Vadodara, Gujarat

**Sahaj**

towards alternatives in health and development



# **GENDERED RESEARCH IN HEALTH**

## A TRAINING MANUAL

**RENU KHANNA**

SAHAJ- Society for Health Alternatives, Vadodara, Gujarat

and

Women's Health Training, Research and Advocacy Centre (WOHTRAC)  
Women's Studies Research Centre (WSRC)  
The Maharaja Sayajirao University of Baroda  
Vadodara, Gujarat

**Sahaj**

towards alternatives in health and development

# GENDERED RESEARCH IN HEALTH

A TRAINING MANUAL

## CREDITS

### Author

**Renu Khanna (MBA)**

### With assistance from

**Mrudula Tere**

**Pallavi Gupta**

**Jaya Singh**

### Course Coordinators

**Renu Khanna (MBA)**

**Shagufa Kapadia (PhD)**

### Course Advisor

**TK Sundari Ravindran (PhD)**

(Honorary Professor, Achutha Menon Centre for Health Science Studies,  
Sree Chitra Thirunal Institute of Medical Sciences and Technology, Thiruvanthapuram)

### Course Faculty

**Dr. Abhijit Das** (Director, Centre for Health and Social Justice, New Delhi)

**Ms. Anuj Kapilashrami** (Program Coordinator, SAMA - Resource Group for Women and Health, New Delhi)

**Dr. Bhamini Mehta** (Lecturer, Department of Human Development and Family Studies, Faculty Home Science,  
The M.S. University of Baroda, Vadodara)

**Ms. Bhavna Mehta** (Lecturer, Department of Social Work, The M.S. University of Baroda)

**Ms. Jhanvi Andharia** (Coordinator, ANANDI, Vadodara)

**Dr. Lakshmi Lingam** (Professor, Women's Studies Unit, Tata Institute of Social Sciences, Mumbai)

**Dr. N. Rajaram** (Professor, Department of Sociology, The M.S. University of Baroda, Vadodara)

**Dr. Padma Prakash** (Editor, eSocialSciences, Mumbai)

**Dr. Prakash Kotecha** (Professor, Department of Preventive and Social Medicine, Medical College, Vadodara)

**Dr. Sandhya Barge** (Associate Director, Centre for Research and Training, Vadodara)

**Dr. Shagufa Kapadia** (Reader, Department of Human Development and Family Studies,  
The M.S. University of Baroda, Vadodara)

**Dr. Shubhada Kanani** (Reader, Department of Nutrition, The M.S. University of Baroda, Vadodara)

**Dr. Sunita Bandewar** (Program Director, Centre for Studies in Ethics and Rights (CSER),  
Anusandhan Trust, Mumbai)

**Dr. T K Sundari Ravindran** (Honorary Professor, Achutha Menon Centre for Health Science Studies,  
Thiruvanthapuram)

**Dr. Trupti Shah** (Lecturer, Department of Commerce, The M.S. University of Baroda, Vadodara)

**Dr. Uma Nayak** (Associate Professor, Department of Pediatrics, Medical College, Vadodara)

**Ms. Urvi Shah** (Field Coordinator, Population Research Center, The M.S. University of Baroda, Vadodara)

**Dr. Yogesh Marfatia** (Professor, Department of Skin and VD, Medical College, Vadodara)

### Proof Reading

**Vaishali Zararia, Hemal Shah**

(SAHAJ, Vadodara)

### JUNE 2008

(Updated and reprinted August 2020)

Design and Layout:

**Sanskriti Designers and Printers, Pune**

Mobile : 9822784115 Email : sanskruti2012@gmail.com

# Contents

■	Why Gendered Research in Health?	1
■	Gendered Research in Health: A Short Course	5
■	Course Schedule	9
■	<b>Module 1: Sessions 1-8</b>	
	Introduction to concepts and tools in gender, rights, development, and health	11
■	<b>Module 2: Sessions 9-22</b>	
	Researching gender and social issues in health	49
■	<b>Module 3: Sessions 23-27</b>	
	Taking research forward: communication, programme design and advocacy	127
■	Acknowledgement of Session Developers and Facilitators	143





# Why

**Gendered Research  
in Health?**

## Gender bias in research

Most health-related research continues to be carried out within the biomedical tradition. Although social factors affecting health are beginning to be considered seriously, a large proportion of resources are still spent on projects falling under the domain of biomedicine. Most medical research continues to state that men and women are physiologically similar in all respects except their reproductive systems. Traditional frameworks for analyzing women's health have often concentrated only on their childbearing years. The problems related to pregnancy and childbearing were considered important domains in women's health. Other biological differences and social differences affecting women's health are ignored. As a result, both preventive and curative strategies are often applied to women when they have only been tested on men. There is growing evidence that sex and gender differences may be important in a range of infectious and parasitic diseases including tuberculosis and malaria.

To change the inequalities in medical research, women's needs and desires must have a more prominent place in the research process. A formal set of policies will be needed to ensure that their interests are represented.

## Lack of sex disaggregated data

The basic problem with policy makers is the lack of information on the situation of women. It is difficult to make separate health policies for men and women due to failure of separate women from men in national and regional statistics. It is essential to collect sex disaggregated to locate differences in health status. This will enable policy makers to suggest healthy policies to improve health status of different population groups.

Data should be available on the basis of age, sex, gender, women who are migrant, refugees, women rearing their children single handedly, women with long term disabilities and coping with chronic diseases. Requirement of the above stated appropriate indicators for measuring different aspects of health and quality of life should be fulfilled. In many developing countries, the lack of data on women's health reflects in part the very limited nature of the vital registration system, which affects both sexes.

It is also observed that relevant authorities are unable to recognize importance of gender issues and a lack of understanding of the complex social pressures which affects women's health. Similar problems are evident in relation to the identification and measurement of domestic violence. This represents a huge public health problem which has not yet been adequately documented. Gaps in the availability of information women's lives are now beginning to be filled. The recent development by UNDP of a number of new gender related indicators offers important tools to collect data and achieve the levels of gender equality.

## Social determinants of health including gender

Health is a product of the physical and social environment in which we live and act. This environment is always affected by the global and local factors: social, cultural, economic and political. Studies conducted in diverse settings indicate that inequalities in health across populations are largely the consequence of differences in social and economic status and differential access to power and resources.



Substantial evidence exists to indicate that in almost all societies women and men have differing roles and responsibilities within the family and in society. Both men and women have unequal access to resources and power. Gender differences are observed in every stratum of society. In the domain of health too gender differences are found.

Differences in the way society values men and women, and accepted norms of male and female behaviour, influence risk of developing specific health problems as well as health outcomes. Studies have shown the preference for sons and the undervaluation of daughters in tasks like feeding and health care. This has potentially serious negative health consequences for girls. On the other hand, social expectations about male behaviour may expose boys to a greater risk of accidents, and to the adverse health consequences of smoking and alcohol use.

Coming to the access to health care and health care facilities, both women and men do not have equal access to and control over resources such as money, transport and time. Restrictions on women's physical mobility, common in many parts of India, often make woman dependent on men to accompany her to a health care facility. In many instances biologically determined differences between women and men interact with socially constructed behaviour to the disadvantage of women. There are other factors which compound women's vulnerability because of the way society expects women and men to behave.

## **Expanding the disciplinary boundaries in health research**

Social scientific research is needed if the full range of influences on human health is to be understood. In particular, governments need to support health related research to get an holistic view by anthropologists, sociologists and psychologists. Government can use their findings alongside those of biomedical scientists to develop more comprehensive health promotion policies. Both quantitative and qualitative approaches should be useful in collecting data on the aspects of gender inequality.

## **Getting the whole picture**

It is essential that the whole range of reproductive and productive activities undertaken by women across the lifespan should be considered. Femaleness can no longer be equated with motherhood and the scope of health research needs to shift accordingly.

Researchers have started documenting the 'black box' of the family. They have started documenting domestic violence, risks associated with domestic work. Women's work outside the home also needs much more attention from both researchers and policy makers. Dual responsibilities handled by women are making them vulnerable to many mental and physical health problems. If these issues are to be taken seriously, occupational health researchers need to develop greater gender sensitivity in their methods of investigation.

## How this manual came about

This Manual owes its genesis to the work of a group of health activists, researchers and women's health advocates who first came together in 1998 as the 'Gender and Social Issues in Reproductive Health Research Initiative'. This informal initiative was supported by the Ford Foundation. Its objective was to identify and address gaps in research on reproductive health in India from a 'gender and social dimensions' perspective. The first phase of this initiative lasted between 1998-2001, and culminated in the production of annotated bibliographies and overview papers on various aspects of sexual and reproductive health: sexuality and sexual health; reproductive health; abortion, HIV/AIDS, the interface between general and reproductive morbidity in women; and sexual and reproductive health services.

The second phase of this initiative began in 2001 December, with dissemination of the findings of the review of research and a call for research proposals on areas that were under researched. The small grants programme was administered by Achutha Menon Centre for Health Science Studies Trivandrum, Kerala. This programme was also supported by the Ford Foundation.

Several proposals were received for small grants and 11 of these were selected, six from institutions and five from individuals. A methodology workshop was organized for all the grantees in early January 2003 which was attended by grantees and the team of resource persons who had originally assessed the proposals.

### **The two day methodology workshop was organized with the following objectives:**

- To come to a common understanding on gender and gender sensitive research.
- To help each researcher clarify the methodology of his / her study through a peer review process within the workshop, freely exchanging ideas and opinions.

The experience of the small grants programme on these gendered research studies proved to be rich. The learnings were distilled for a short course titled 'Gendered Research in Health'. Two of these courses were conducted by WOHTRAC / WSRC in March 2006 and April 2007.

This Manual is the outcome of these short courses. Many of the original group were faculty for these two courses. Their session outlines were reviewed and supplemented with their lectures/presentations as well as the process documentation of the two courses. Several session outlines are based on the presentations of the participants and the resource person's feedback. Wherever available, the reading lists and other references are listed at the end of each session outline.

## Reference

- 1 Centre for Enquiry into Health and Allied Themes. (2002). Gender and medical education. Published by Achutha Menon Centre for Health Science Studies, Trivandrum, Kerala.  
<http://www.cehat.org/uploads/files/R%2025%20Gender%20and%20Medical%20Education.pdf>
- 2 Ravindran, T. K. S. (Year unknown). Engendering health. Seminar - web edition.  
[http://www.undp.org/content/dam/india/docs/engendering\\_health.pdf](http://www.undp.org/content/dam/india/docs/engendering_health.pdf)
- 3 Ravindran T.K. and Mishra U.S. (2000). What information do we need for understanding gender-based analysis for health? Paper presented at the Conference on Gender and Health Analysis, Geneva, June 28-30, (2000).

**Gendered Research  
in Health:  
A Short Course**

## Goal

The short course on Gendered Research in Health is aimed to empower researchers and practitioners to carry out gendered research in health.

## Objectives

**The objectives are to enable the participants to:**

- Be acquainted with the various concepts used in gender analysis.
- Locate gender-based inequalities within the context of other social inequities.
- Apply gender and rights perspective to epidemiological, quantitative and qualitative research.
- Use outcomes of gendered research to develop communication and advocacy strategies.

## Profile of Participants

The course is open for all genders familiar with basic concepts of gender and research and working in the area of health. Applicants must be graduates in any discipline, mid career professionals and understand English. Men and members of LGBTQI groups are encouraged to apply.

The first two courses were attended by persons from diverse disciplines like anthropology, clinical psychology, community health, pediatrics, preventive and social medicine, foods and nutrition, population studies and gerontology, social work, sociology, family and child welfare, history, journalism, organizational development and behavior. The participants were from academic, research institutions as well as NGOs. In addition to people from various states of India, a few participants also came from Bangladesh and Rwanda.

## Course Design

The course consists of three modules-

**Module 1:** Introduction to concepts and tools in gender, rights, development, and health.

**Module 2:** Researching gender and social issues in health.

**Module 3:** Taking research forward: advocacy and communication.

## **Module 1**

### **Introduction to Concepts and Tools in Gender, Health, Rights and Development**

#### **Learning Objectives**

1. Define the social construction of gender (including masculinity).
2. Identify the root causes of gender inequality – patriarchy in the Indian context.
3. Locate gender-based inequalities within the context of other social inequalities such as class and caste.
4. State the social determinants of health.
5. Work with a gender and rights approach to health.
6. Analyze critically gender and development.
7. Describe the manifestations and material consequences of gender inequality.

## **Module 2**

### **Researching Gender and Social Issues in Health**

#### **Learning Objectives**

1. Describe the paradigms of research.
2. Describe step by step the research process, beginning with identification of research gaps, developing research questions, selecting appropriate study design, data analysis and report writing.
3. Use the gender analysis tool in the research process.
4. Apply gender analysis framework to specific health conditions.

## **Module 3**

### **Taking Research Forward: Communication and Advocacy**

#### **Learning Objectives**

1. To learn strategies for communicating research results to relevant audience, formats and media for disseminating research results, and writing for journals.
2. Use of research findings for program designing.
3. Describe the nature and types of advocacy, necessary and sufficient conditions for successful advocacy efforts.
4. Evaluate advocacy strategies from a gender and social perspective.
5. State/explain the various campaigns and need-specific advocacy strategies.

# Detailed Contents of each Module

## **Module 1: Introduction to concepts and tools in gender, rights, development, and health.**

Session 1: What is Gender?

Session 2: Patriarchy

Session 3: Social Construction of Masculinity and Femininity

Session 4: Gender Inequalities, Power and Control

Session 5: Health as Development and Gender Issue

Session 6: Sexuality and Violence

Session 7: What are Rights?

Session 8: Applying the Rights Approach to Health

## **Module 2: Researching gender and social issues in health.**

Session 9: Research Process- Step by Step

Session 10: From Research Ideas to Research Questions

Session 11: Literature Review

Session 12: Paradigms of Research

Session 13: Overview of Qualitative Research Methods

Session 14: Secondary Data: A Useful Source in Research

Session 15: Gendered Research

Session 16: Gendered Indicators

Session 17: Gendered Study Designs

Session 18: Developing Gender Sensitive Data Collection Tools

Session 19: Analysing Qualitative Data

Session 20: Managing Data and Writing Reports

Session 21: Applying Gender Research Methods: Researching Men

Session 22: Ethical Issues in Conducting a Research Study

## **Module 3: Taking research forward: communication, programme design and advocacy.**

Session 23: Communicating Research

Session 24: Writing for Journals: A View from the Editor's Desk

Session 25: From Research to Program Design

Session 26: From Research to Advocacy

Session 27: Advocacy Tools and Strategies

**Number of hours: 45**

**Number of days: 8**

# Course Schedule

DAY 1	
<b>MODULE 1</b>	
09:30 am – 10:30 am	Welcome and Introductions Objectives and Design of the Course Administrative Matters
10:30 am – 11:00 am	Tea Break
11:00 am – 12:30 pm	Session 1: What is Gender?
12:30 pm – 01:30 pm	Session 2: What is Patriarchy?
01:30 pm – 02:30 pm	Lunch Break
02:30 pm – 04:00 pm	Session 3: Social Construction of Masculinity and Femininity
04:00 pm – 04:30 pm	Tea Break
04:30 pm – 06:00 pm	Session 4: Gender Inequalities, Power and Control
DAY 2	
<b>MODULE 1</b>	
09:00 am – 09:30 am	Feedback from Participants about Day 1
09:30 am – 10:30 am	Session 5: Health as a Development and Gender Issue
10:30 am – 11:00 am	Tea Break
11:00 am – 1:00 pm	Session 5: Health as a Development and Gender Issue (cont.)
01:00 pm – 02:00 pm	Lunch Break
02:00 pm – 03:30 pm	Session 6: Sexuality and Violence
03.30 pm – 04.00 pm	Tea Break
04:00 pm – 05:30 pm	Session 7: What are Rights?
DAY 3	
<b>MODULE 1 and 2</b>	
09:00 am – 09:30 am	Feedback from Participants about Day 2
09:30 am – 11:00 am	Session 8: Applying the Rights Approach to Health
11:00 am – 11:30 am	Tea Break
11:30 am – 01:30 pm	Session 9: Research Process: Step by Step
01:30 pm – 02:30 pm	Lunch Break
02:30 pm – 04:00 pm	Session 10: From Research Ideas to Research Questions
04:00 pm – 04:30 pm	Tea Break
04:30 pm – 06:00 pm	Session 11: Literature Review
DAY 4	
<b>MODULE 2</b>	
09:00 am – 09:30 am	Feedback from Participants about Day 3
09:30 am – 10:30 pm	Session 12: Paradigms of Research
10:30 am – 11:00 am	Tea Break
11:00 am – 01:00 pm	Session 12: Paradigms of Research (cont.)
01:00 pm – 01:45 pm	Lunch Break
02:00 pm – 03:00 pm	Session 12: Paradigms of Research (cont.)
03:00 pm – 03:15 pm	Tea Break
03:15 pm – 04:45 pm	Session 13: Overview of Qualitative Research Methods
04:45 pm – 06:15 pm	Session 14: Secondary Data: A Useful Source in Research

<b>DAY 5</b>	
<b>MODULE 2</b>	
09:00 am – 9:30 am	Feedback from Participants about Day 4
09:30 am – 11:30 am	Session 15: Gendered Research
11:30 am - 12:00 pm	Tea Break
12:00 pm – 01:30 pm	Session 16: Gendered Indicators
01:30 pm – 02:00 pm	Lunch Break
02:00 pm – 04:00 pm	Session 17: Gendered Study Designs
04:00 pm – 04:30 pm	Tea Break
04:30 pm – 06:30 pm	Session 18: Developing Gender Sensitive Data Collection Tools
<b>DAY 6</b>	
<b>MODULE 2 and 3</b>	
09:00 am – 09:30 am	Feedback from Participants about Day 5
09:30 am – 11:00 am	Session 19: Analyzing Qualitative Data
11:00 am – 11:30 am	Tea Break
11:30 am – 01:00 pm	Session 20: Managing Data and Writing Report
01:00 pm – 02:00 pm	Lunch Break
02:00 pm – 03:30 pm	Session 21: Applying Gender Research Methods: Researching Men
03:30 pm – 04:00 pm	Tea Break
04:00 pm – 05.30 pm	Session 22: Ethical Issues in Conducting a Research Study
<b>DAY 7</b>	
<b>MODULE 3</b>	
09:00 am – 09:30 am	Feedback from Participants about Day 6
09:30 am – 10:30 am	Session 23: Communicating Research
10:30 am – 11:00 am	Tea Break
11:00 am – 12:00 pm	Session 23: Communicating Research (cont.)
12:00 pm – 01:00 pm	Session 24: Writing for Journals: A View from the Editor’s Desk
01:00 pm – 02:00 pm	Lunch Break
02.00 pm – 03.30 pm	Session 25: From Research to Programme Design
03.30 pm – 04.00 pm	Tea Break
04.00 pm – 05.30 pm	Session 26: From Research to Advocacy
<b>DAY 8</b>	
<b>MODULE 3</b>	
09:00 am – 09:30 am	Feedback from Participants about Day 7
09:30 am – 10:30 am	Session 27: Advocacy Tools and Strategies
10:30 am – 11:00 am	Tea Break
11:00 am – 01:00 pm	Closing Session <ul style="list-style-type: none"> <li>• Weaving together major lessons learnt</li> <li>• Evaluation of the course</li> <li>• Distribution of certificates</li> </ul>
01:00 pm – 02:00 pm	Lunch Break



# 1

## Module

# Introduction to Concepts and Tools in Gender, Health, Rights and Development

### Learning Objectives

1. Define the social construction of gender (including masculinity).
2. Identify the root causes of gender inequality – patriarchy in the Indian context.
3. Locate gender-based inequalities within the context of other social inequalities such as class and caste.
4. State the social determinants of health.
5. Work with a gender and rights approach to health.
6. Analyze critically gender and development.
7. Describe the manifestations and material consequences of gender inequality.

# Session Outlines

# Session 1

## What is Gender?

### Learning Objectives

#### Participants will be able to:

- Differentiate between sex and gender.
- Describe how gender operates as a system.
- Define terms like: Gender norms, Sexual division of labor, Gender roles, Access to and control over resources.



**Time** 90 minutes

**Methodology :**



Roleplay and discussion



Quiz



Presentation

### ACTIVITIES



#### Roleplay

Participants are divided into four groups on the following situation given to them:

Twins (a boy and a girl, named Jack and Jill) are born in a family. Through the role play, show what happens in their family, neighbourhood, educational institutions through each life stage. Depict in what ways their personalities will be constructed throughout the life cycle. What will be the constructions and manifestations of gender roles and behaviors for the boy and the girl? Group 1 will show Birth of Jack and Jill till 5 years. Group 2 will show Jack and Jill ages 6 to 16. Group 3 will show Jack and Jill from 17 to 30 years. Group 4 will show Jack and Jill at the age of 70 years. Each role play should not be more than 7 minutes.

After 15 minutes of preparation time, each group presents their role play. The discussion after each role play picks up the differences in which family and society treats girls and boys. The facilitator points out the process of socialization and social control. The institutional nature of how gender operates is also pointed out – for example, within the educational system, in the market, in media as well as in the family.

The resource person can point out that the presentations made by all five groups shows a pattern in which it is clearly visible how from the very beginning and at every stage of life, girls and women are discriminated against. Discrimination occurs, even before birth in the form of pre-conception sex selection and selective abortion of female fetuses after sex determination. At every stage of life there is preferential treatment given to boys and men. The manifestation of discrimination against girls and women varies according to their context and class.



## Quiz

The role-play and discussion are followed by a quiz on sex and gender. A list of statements is given to the participants and they are asked to identify whether the statements are related to gender or to biological sex.

Following are the statements.

<b>Box 1 : Biological Sex vs. Gender: Participants' views</b>			
<b>Statements</b>	<b>Biological sex</b>	<b>Gender</b>	<b>Could be both?</b>
Women are better at caring for children than men.			
Men have lots of body hair.			
Man wanted to learn nursing, but was not allowed.			
Men impregnate women.			
Women neglect their own health needs.			
Women breastfeed babies.			
Male doctors do postmortem.			
Men's voices break at puberty.			
Boss makes sexual advances to a young married woman colleague.			
Women menstruate and also undergo menopause.			
Men are soldiers, because they are brave can use weapons to fight.			
Women are more at risk from RTIs /STDs.			
Men are better leaders than women.			
Men tend to bald faster than women.			
Women are better parents than men.			
Body hair is okay for men, but women have to remove it.			

The responses to each statement are discussed and participants are helped to gain clarity about the differences between gender and biological sex.

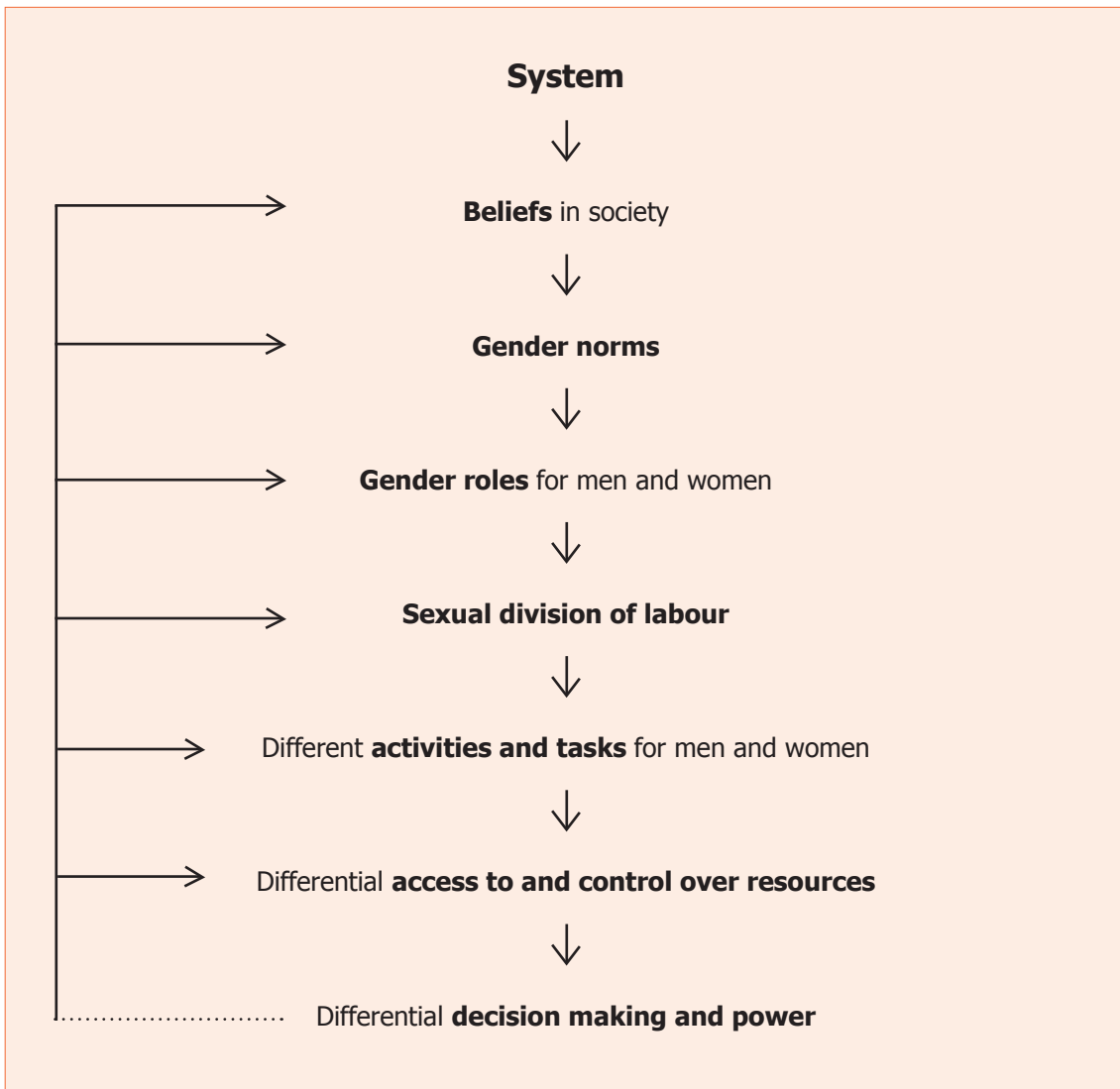
## Gender and Sex Differences

- Gender identifies the socially constructed characteristics that have come to define male and female ways of being and behavior within specific historical and cultural symbols, norms, institutional structures and internalized self-images, which through a process of social construction define what is meant by “masculine” and “feminine”.
- Gender role socialization also prescribes what are appropriate masculine and feminine sexual roles and behaviors. In many cultures, female resistance, male aggression, and mutual antagonism in the sex act is viewed as the norm.
- People’s understanding of sexuality is culturally conditioned and changes over time. The relationships between the constructs of gender and sexuality are strong, but many theorists believe that they are connected but not identical systems of meaning.
- Gender is a context-specific concept: gender relations vary according to ethnic group, class, culture, and so on. This underlines the need to incorporate diversity when we analyze gender.
- Gender relations have changed over time, because they are nurtured by factors that change over time. This means that current gender relations are not necessarily fixed, and can be modified through interventions.
- Gender relationships are personal as well as political. Personal, because the gender roles that we have taken on define who we are, what we do and how we think of ourselves. Political, because gender roles and norms are maintained and promoted by social institutions. Challenging these means challenging the way society is currently established.



## Presentation on 'Gender as a System'

Through this presentation the facilitator defines terms like Gender norms, Sexual division of labour, Gender roles, Access to and control over resources.



### Characteristics of Gender

- Relational** : Socially constructed
- Hierarchical** : Power relations
- Change** : Changes over time
- Context** : Varies with ethnicity, class, culture, etc.
- Institutional** : Systematic and organized



## Readings

1. Bhasin, K. (2000). Understanding Gender. New Delhi: Kali for Women, pp. 1-86.
2. Reeves, H. and Baden, S. (2000) Gender and Development: Concepts and Definitions. BRIDGE (development- gender), Report No. 55, Brighton, UK: Institute of Development Studies, pp. 1-37.
3. American Psychological Association. (2015). Key terms and concepts in understanding gender diversity and sexual orientation among students.  
<https://www.apa.org/pi/lgbt/programs/safe-supportive/lgbt/key-terms.pdf>
4. Johns Hopkins University Affiliate. (2020). Gender analysis toolkit for health systems.  
<https://gender.jhpiego.org/analysistoolkit/gender-analysis-framework/>

# Session 2

## Patriarchy

### Learning Objectives

The participants will be enabled to:

- Identify the root causes of gender inequality.
- Describe patriarchy in the Indian context.
- Describe the manifestations of patriarchy in daily life and medicine.



**Time** 60 minutes

**Methodology :**



Lecture and discussion

### ACTIVITIES



#### Lecture and discussion

The facilitator's lecture covers the following issues:

#### **Patriarchy as a root cause of gender inequality**

Patriarchy is a system that exercises control over:

- Women's labor power
- Women's sexuality
- Women's mobility and resources
- Women's reproductively

There are social institutions which enable men to control over women-

- Family
- Religion / ideology
- Legal system
- Economic system and economic institutions
- Political systems and institutions
- Media



## Patriarchy in the Indian context

- In India, motherhood is glorified in all customs and traditions and it finds expression in most folksongs. However, motherhood in an unmarried woman is unacceptable in society, because the child has to bear the name of someone who belongs to the same or a specific caste or class, or religious community. Similarly, being the mother of daughters and a woman's inability to bear sons are stigmatized. Motherhood is equated with being the mother of a son.
- The manifestation of patriarchy in India cannot be discussed without considering caste and class. For instance, there is greater control over upper caste women in terms of mobility and sexuality, whereas women of the low castes have greater mobility, because it would be impossible for society to function if low caste women were also confined to the four walls of their homes.
- The ideology of wifely fidelity and chastity (pativrata), practices such as sati, prescription of an austere life for widows, ban on their remarriage, were all aimed at controlling the sexuality of upper caste women.
- The form of patriarchy in India is described as brahminical patriarchy. According to Uma Chakravarti<sup>1</sup> it is a complex relationship between caste, class and gender. The brahminical social order was based on caste and gender hierarchies. Women were valued for their contribution as producers as well as their ability to reproduce. Therefore, we see the worship of female power. With the advent of the Aryans, who conquered vast tracts of land and subjugated the local inhabitants, the caste and class stratification of society evolved. Gradually, as agriculture replaced the pastoral economy and the labor of low caste men and women from the subjugated clans became available, the participation of Aryan women in the labor force discontinued, and they retreated into their households.
- In every culture and society there are many sayings about the woman. In Gujarati society one such adage is common. A Gujarati adage compares a woman's character with a pot of clay, implying that both tend to break easily.

## Manifestations of patriarchy in medicine

- Predominance of male bodies can be observed in illustrations on human anatomy. Female bodies are shown only on the topic of reproduction.
- Certain courses of study in medicine are pursued more by men than women. Male students usually opt for specializations like surgery or orthopedics while women opt for subjects that are less demanding on their time, or they study subjects which are suitable for jobs that do not require emergency duties, subjects such as ENT or Anesthesia.



### Readings

1. Bhasin, K. (1993). What is Patriarchy? New Delhi: Kali for Women, pp. 1-41.
2. Ehrenreich, B. (1974). Gender and Objectivity in Medicine. International Journal of Health Services, pp.617-623.
3. Hooks, B. (Year unknown). Understanding Patriarchy.  
<https://imagineborders.org/pdf/zines/UnderstandingPatriarchy.pdf>

---

1 Uma Chakravarti, "Conceptualising Brahminical Patriarchy in Early India: Gender, Caste, Class, and State," Economic and Political Weekly, April 3, 1993.

# Session 3

## Social Construction of Masculinity and Femininity

### Learning Objectives

The participants will be able to describe :

- The concept of masculinity and masculinities.
- Social construction of masculinity and femininity and how this contributes to maintaining gender-based inequalities.



**Time** 90 minutes

**Methodology :**



Participatory exercise



Presentation and discussion

### ACTIVITIES



#### Participatory exercise

Free Listing of words associated with the terms masculinity and femininity

Man	Woman
Strong	Emotional
Dominating	Caring
Aggressive	Long hair
Sports	Teacher
Macho	<b>Independent</b>
Protector	Provider
Head of the family	Preparer
Short hair	House wife
<b>Irresponsible</b>	Adjusting
Father	<b>Jealous</b>
Beard	Balanced
Pants/Shirts	Mother
	Saari
	<b>Manager</b>
	Sacrificing
	Tolerance
	Exhibiting



## Presentation on masculinities

This presentation is aimed to enable participants to:

- Understand the social construction of masculinities and how this contributes to maintaining gender-based inequalities.
- Understand how construction of masculinities at times disadvantages men and boys.
- Identify ways in which challenging dominant construction of masculinities can result in positive gains for women and girls, as well as men and boys.

The presentation highlights the following:

- The term masculinity may be defined as a way to explain men's behavior, power and responsibilities in relation to women, and to each other.
- There are three explanations: Biological essentialism, cultural or social construction, and power discourse.
  - **Biological essentialism:** Men and women are different due to their biology and hormones.
  - **Social constructionism:** Men and women are socialized differently and hence they are different.
  - **Power discourse:** Anything powerful is considered masculine and powerless is considered feminine.
- Masculinity is shaped in relation to:
  - A general symbolization of difference, i.e. the opposition of femininity to masculinity, and between different masculinities.
  - An overall structure of power: The subordination of women to men, and some men to others.

**Power:** The dominant construction and power discourse of masculinities places women in a powerless situation more often than men. At times it places men also in a disadvantaged and powerless position.

There are different institutions that shape the construction of masculinities: family, community, work place, religion, school, government. There is no one way of being a man, it varies with age, race, religion, caste, age, relation, position, as well as contexts at any given time. Hence the term 'masculinities' rather than 'masculinity' is preferred.

Given that men are disadvantaged there is scope for working with men and women in changing dominant construction of masculinities.



## Key Points

1. Similar to gender and patriarchy the concept of masculinity and femininity is also socially constructed.
2. The traits/attributes which are termed as masculine or feminine are not only due to biology but are also culturally and socially loaded.
3. Power again plays a central role in masculinities due to which women and men (who are considered deviant) are put into disadvantaged and powerless position. Although the situations are different for men and women.
4. The definition of gender is changing and the term masculinities is preferred over masculinity.
5. The construction of masculinity and femininity is closely linked, interwoven and influenced by different clothing of men and women (mainly sari for women and pants for men which restrict mobility of women and make them appear modest and feminine) and exhibiting the marital status of women by *sindoor* and *mangalsutra*, which signifies their chastity and identity dependent on men.
6. Different sexual identities should be respected and find place in research, NGO interacting, government policies, laws, etc.
7. Some thing to be careful about is that 'protectionism' is not promoted as the desired form of 'sensitive masculinity'. Men should not swing to the other extreme and start protecting women, they need to balance the respect for women's individuality and strength with caring for them.



## Readings

1. Grieg, A. Kimmel, M., and Lang, J. (2000, May). Men, Masculinities and Development: Broadening Work towards Gender Equality. Monograph # 10. UNDP/ GIDP.
2. Fausto- Sterling, A. (1997). How to Build a Man. In R.N.Lancaster and M. di Leonardo (Eds.), The Gender/ Sexuality Reader. New York: Routledge, pp. 244-248.
3. Edwards, A. (2015). It's a mans world: The effect of traditional masculinity on gender equality.  
<https://www.e-ir.info/2015/03/29/its-a-mans-world-the-effect-of-traditional-masculinity-on-gender-equality/>
4. Femininities and masculinities.  
<https://genderedinnovations.stanford.edu/terms/femininities.html>

# Session 4

## Gender Inequalities, Power and Control

### Learning Objectives

The participants will be able to:

- Describe the basis of discrimination.
- Locate gender-based inequalities within the context of other social inequalities such as class and caste.
- Understand the concepts of power and control.



**Time** 90 minutes

**Methodology :**



Participatory exercise – “Power Walk”



Discussion

### ACTIVITIES



#### Power walk

1. Inform participants that they will now play a game and take them to a place which is roughly 100 feet long and 50 feet wide.

Here distribute the individual slips of their identities to each participant (List 1). Inform participants that for the duration of the game they will assume the identity of the person written on their individual role slip. Some will have identities of women and some of men.

2. Line up participants in the middle (50 feet mark) of the field/hall. Inform them that they must take steps forwards or backwards depending upon what they think the person mentioned in the slip will be able to do or not do in response to each of the statements that the facilitator reads out. The objective of the game is to reach the end of the field (100 feet mark) first.
3. Now start reading out one statement at a time from the instruction sheet - giving the participants enough time to step forward or backward. (List 2)
4. After all the statements have been read out; inform the group who the winners are depending upon who is closest to the 100 feet mark.

- Now ask the persons who are closest to the finish line (the winners) to reveal their identities as mentioned on the slips and say how they feel. Then ask the others who are farthest away from the finish line (the losers) to reveal their identities and ask how they feel. Put this on the board as shown.

Winner's – Feelings	Identity	Loser's – Feelings	Identity

- Ask the participants pairs (male – female) about where the other member of the pair is – where are they placed with respect to each other.

*(Game takes around 45 minutes)*



### Discussion (45 minutes)

- Why did the participants get distributed in this way even though they had started at the same place in the game?
- What were the various bases of differences in the game? How did these differences affect each individual player? (Write on the board various bases of difference)
- Explain how each individual may be at an advantage on one basis but at a disadvantage on another basis – and how advantages along a particular basis – caste, class, religion, age etc is also a source of power.
- Establish the basic value of equality. *(See issues to be highlighted)*
- Facilitator concludes by stating that individuals are discriminated against on the basis of their class, caste, age, sex, educational levels, and physical abilities and so on. Power operates to keep discrimination in place.

### Understanding 'power'

- Power over** – (either/or) power in decision making processes in the family (man over his wife, parents over their children, mother-in-law over daughter-in-law), in the community, village, and also at the level of the State. One party or a person having power over another person.
- Power to** – (individual) power as ability to effect change: it can happen when the person with power comes down to the level of the powerless and understands their situation. The powerful can choose to involve the powerless and affect change in their social situation and thus "give them" power.
- Power with** – (collective) power as unity and common causes. The situation can change when individuals are able to speak up and unite to form a collective/team or solidarity group. When women are able to speak up, their husbands feel they are losing control and may resort to physical violence.
- Power within** – (spiritual/inner) power as respect for difference. This process will create transformation within oneself through internal realisation. Factors or situations, such as authority, position, and education gave the feeling of power or being powerful.



## Key Points

- Gender is one basis of discrimination. The others are caste, class etc. None of these operate independently of the other. They are interlinked. Each of these could be a source of power in different situations.
- There are social institutions (political, cultural, religious, social) operating in society, that further discrimination. For instance, availability of educational opportunities for adivasi women is not the same as an urban man or woman. Similarly, in the case of health, employment opportunities, and adoption laws.
- Discrimination is also reinforced by cultural and religious practices, such as male preference, death rites and restrictions on women after marriage.
- The Indian Constitution gives every citizen of this country equal right. However, if this is to materialize, we would have to change all social institutions that discriminate.
- If we want to bring about equality among all men and women, we would have to put into place mechanisms that make sure women are able to operate in society without restrictions to their mobility, without questions about safety, or abuse. We would also have to challenge the institutions of caste and class.

## List 1

### Identities that the participants have to take

- |                                   |                              |
|-----------------------------------|------------------------------|
| • Male doctor                     | • Woman doctor               |
| • Man sarpanch                    | • Womans sarpanch            |
| • Poor rural woman                | • Poor rural man             |
| • Illiterate dalit woman          | • Illiterate dalit man       |
| • Adivasi woman                   | • Adivasi man                |
| • Single woman                    | • Single man                 |
| • Christian woman                 | • Christian man              |
| • Muslim woman                    | • Muslim man                 |
| • Illiterate wife of money lender | • Money lender               |
| • Mother of three daughters       | • Father of three daughters  |
| • Undergraduate female student    | • Undergraduate male student |
| • Female judge                    | • Male judge                 |

## List 2

### Instructions for the game

1. If you have studied up to class VII, please take two steps forward, If you have not then take two steps back.
2. You need Rs 2000 for some personal work, and you do not want to ask your partner for it. If you can arrange a loan from a bank take one step forward. If you cannot take one step backward.
3. If you know how to work on a computer take one step forward, otherwise take one step backward.
4. There is a rumour that there is rioting in the city. You are stuck out of home. If you feel frightened in going home take one step backward, if you do not, take one step forward.
5. You do not want a child. If you can convince your partner to use a contraceptive take two steps forward, otherwise take two steps back.
6. There is a party/cultural programme at a friend's house tomorrow night. If you can go on your own, take one step forward otherwise take one step back.
7. If you have ever raised your hand on your partner take two steps forward, otherwise take two steps back.
8. If you read the newspaper every day take one step forward, otherwise take one step back.
9. Two men are bullying a little girl on the roadside; you see it and do not like it. If you can go and stop them take one step forward otherwise take one step back.
10. You like singing, if you were able to take classes to fulfill your ambition, take one step forward otherwise take one step back.
11. You do not like washing dishes, there is a pile of dishes to be washed. If you do not need to wash these dishes take one step forward otherwise take one step back.
12. Your father died recently. If you were allowed to perform the last rites take two steps forward, otherwise take two steps back.
13. You had to go out of town/village on some work and the work has taken longer than you thought. If you think that you will get permission to stay out of the house at night take one step forward otherwise take one step back.
14. If you ride a cycle/or any vehicle to work, or for daily errands take one step forward, if you do not, then take one step backwards.
15. Nearby, there is a new factory to manufacture parts for automobiles. They are hiring personnel. If you think you can get a job, take one step forward, if not take one step backward.
16. You and your partner have decided you want to parent a child. You would like to adopt a baby girl. If you think this is possible take one step forward. If not, take one step back.
17. Your parents have died. If you think you will get a share in their property take a step forward, if not take one step back.





## Readings

1. Liddle, J. and Joshi, R. (1998). Daughters of Independence: Gender, Caste and Class in India. (Chapters 6-10), pp. 49-83.
2. Human Development Report. (2019). Gender inequalities beyond averages: Between social norms and power imbalances.  
[http://hdr.undp.org/sites/default/files/hdr2019\\_chapter4.pdf](http://hdr.undp.org/sites/default/files/hdr2019_chapter4.pdf)

# Session 5

## Health as a Development and Gender Issue

### Learning Objectives

The participants will be able to:

- Differentiate between the biomedical and socio cultural approaches to health.
- Identify the determinants of health.
- Identify the gender dimensions of health.
- State the social determinants of health, analyze health from a development and gender perspective.
- Describe material consequences of gender inequality with respect to the household, community, market and state.



**Time** 180 minutes

**Methodology :**



Analysis of case studies



Presentations of readings by participants

### ACTIVITIES



#### Analysis of case studies

1. Group Exercise: Each group is given one case study: Lakshmi or Sheela. Participants have to answer the questions for each case study.
2. Presentations and discussions in the plenary.
3. Presentation by facilitator to highlight the following:
  - Health is not just absence of disease or physical symptoms; it is a composite of physical, mental and social.
  - There is difference between bio medical and socio-cultural approaches to health.
  - Health is a socially created reality, several micro and macro factors affect the health status of individuals and groups as shown in the table below.
  - Differences in people's health status including gender differences arise not only from biological differences but also from differentials in social and economic status.
  - Social determinants of illness can be confronted and modified by policy interventions.
  - Social causes of ill health are related to issues of social justice and equity. These can be changed if there is political will.

## Multilevel framework

Individual	Household	Community	National	International
Biological or genetic; age; parity; birth order; education; employment; decision-making power; material status	The social and economic status of the household within the community; the household's access to resources	Level of development; rural or urban; stratified or homogenous; having health resources or not; inheritance norms, norms for place of residence after marriage	Size of the country; population; level of development; type of governance; structure of the health system; extent to which dependent on the global market; nature of health policies and contours of health sector reform packages	Global economic scenario and dominant economic ideologies; balance of power between various geo-political forces; health sector reform; international human rights regime



### Presentation of readings

1. Group Exercise: Participants are divided into groups and each group is assigned one of the following readings on gender and health, as homework:

Pendse, V. (2001). *Maternal deaths in an Indian Hospital: A decade of no change?* Reproductive Health Matters, Special Supplement on Safe Motherhood Initiatives, Critical Issues, pp. 119-126.

Krieger, N. (2003). *Genders, sexes, and health: What are the connections — and why does it matter?* International Journal of Epidemiology, 32, pp. 652-657.

Doyal, L. (1995). *In Sickness and in Health*. In What makes women sick: Gender and political economy of health. New Brunswick, NJ: Rutgers University Press.

Verheij, R. A. (1996). *Explaining Urban-Rural Variations in Health: A Review of Interactions between Individual and Environment*. Social Science and Medicine, 42(6), pp. 923-935.

Each participant has to first read the paper individually as homework. The next day the groups are given one hour to prepare presentations as follows:

- A brief introduction to the paper: title, author(s), whether it is a research study, a review article, or chapters from a book.
- Outline of the main thesis or argument in no more than five or six lines: what is the paper about? What is it telling us about how social class, race/ethnicity or gender influences health status?
- Description of how the article builds the arguments towards the main thesis.
- Conclusion: the group's reaction to the paper. Did the group find the paper useful? In what ways? Are there some points they do not quite agree with? Why?

The groups are instructed to focus only on the main points in the paper and if necessary illustrate the arguments, with not more than three tables or graphs.

3. Group presentations on each paper. Responses by other groups following each presentation.
4. After each group makes their presentation, the facilitator summarises the Key Messages are pointed out as follows:
  - Health is not purely a biological issue but there are important social determinants of health. Health is a socially constructed reality, a product of the physical and social environment in which we live and act.
  - Many factors at many levels (starting from individual to household to community to national to international) affect health of an individual. A nuanced analysis is required of all these factors.
  - Differences in people's health status including gender differences arise not only from biological differences but also from differentials in social and economic status.
  - Social determinants of illness can be confronted and modified by policy interventions.
  - Social causes of ill health are related to issues of social justice and equity. These can be changed if there is political will.
  - Health care providers generally address only physical problems, and the underlying factors remain unnoticed.
  - A public health approach recognizes underlying factors. A public health approach will take into account that the woman must have adequate nutrition, what is going on in her family, her level of awareness and that of her family's. and so on. A public health approach recognizes that only giving iron tablets or micronutrients is a waste if the public distribution system does not facilitate access to food for poor women.
  - Health is a subjective experience. The researcher needs to take into account the experiences of people and respect their views. The idioms of the community and the perspective of community members need to be understood while designing a health programme.
  - Development is a multidimensional concept and economic development is just one aspect of it. Social sector indicators - access to health and education, respect for human rights, political rights in terms of freedom of expression, and so on are also important aspects of 'development'. Increasing GDP and economic growth of the nation do not really make the nation developed when a majority of the population is below poverty line, and there are gross gender disparities. It is interesting to note that Bhutan measures its growth by happiness, adequate food for all, shelter, number of schools, health, employment, democracy, freedom of expression and satisfaction of people.



## Readings

1. Verheij, R.A. (1996). Explaining Urban-Rural Variations in Health: A Review of Interactions between Individual and Environment. *Social Science and Medicine*. 42 (6), pp. 923-935.
2. Batliwala, S. (1994). The meaning of Women's Empowerment: New Concepts from Action. In G. Sen, A, Germain, and L, Chen (Eds.0, *Population Policies reconsidered-Health Empowerment and Rights*. Harvard Series on Population and International Health, Cambridge, Massachusetts.
3. Pendse, V. (2001). Maternal Deaths in an Indian Hospital: A decade of no change? *Reproductive Health Matters*. Special Supplement on Safe Motherhood Initiatives, Critical issues, pp. 119-126.
4. The George Institute for Global health, India. (2016). Framing women's health issues in the 21st century: A policy report.  
<https://www.georgeinstitute.org/sites/default/files/framing-womens-health-issues-in-21st-century-india.pdf>
5. Tiwari, A., Singh, SK., Manar, MK. (2020). Gender equality and equity in Indian healthcare.  
[https://www.gijhsr.com/GIJHSR\\_Vol.5\\_Issue.2\\_April2020/6.pdf](https://www.gijhsr.com/GIJHSR_Vol.5_Issue.2_April2020/6.pdf)

# Case Studies

## Case study 1: Sheela

Sheela belongs to Dhikiagaon, which is about 20 kms from the district headquarters (Sonitpur), in Assam. She is 19 years old and works as an agricultural wage labourer. Sheela grew up in another village. She was the first of the four surviving children – three girls and a boy. Her father lived with another woman. The family suffered a lot because of this. Sheela's mother had to go out and earn. Sheela had to stop going to school after class 1. She had to look after her brothers and sisters and do the household chores so that her mother could go and work outside. When she was 10 years old, she started working as an agricultural labourer.

When Sheela was only 15, she was married off to Mohun. Mohun was 24, and was also an agricultural labourer and hardly had any property. Sheela did not conceive for two years. Her mother-in-law got angry and started scolding her.

She became pregnant when she was 17 years old. Her first pregnancy was very difficult. Her arms and legs were swollen and something would cloud her vision. She would also vomit everything she would eat day in and day out.

But she never went to see a doctor because people said that this is how it is when one is pregnant. A baby girl was born to her. Her delivery took place at home, and the elderly women from the village attended it, as the doctor was miles away and there were no buses.

Within a year, a second baby was born. But he died in a few days: vomited once in the morning, was taken to the hospital immediately but died. The third was a daughter and she died a few hours after birth. Some said that the baby had a weak heart while others said that Sheela was very weak. The baby was very small and skin and bones. She felt very sad and was depressed.

After her third delivery, Sheela started having foul smelling white discharge frequently. She did not give much attention to it, and thought it was because of her weakness. Her fourth baby was born recently and is a boy. She wanted to have a family planning operation, but the family said that one more boy was required. However, Sheela feels that she is too weak and will not be able to survive another childbirth.

1. *What symptoms did Sheela present with?*
2. *How would a typical health care provider address these problems?*
3. *What are the causes of health problems? Categorize the causes into (a) those related to gender (b) others?*

---

## Case study 2: Lakshmi

Lakshmi belongs to a village in central Tamil Nadu, located about 15 km from the district headquarters. She is 27 years old, an agricultural wage labourer and belongs to the Scheduled Castes.

Lakshmi grew up in another village. She was the first of four surviving children – three girls and a boy. Her father had another woman. The family suffered a lot because of this. Lakshmi's mother had to go out to earn. Lakshmi was stopped from attending school after Class I. She would graze cattle and earn money, and when she was about 10, started working as an agricultural labourer.

When Lakshmi was only 14, she was married off to her uncle's son, Ramu, because there would be no dowry involved. Ramu was 25 and was also an agricultural wage labourer without any property.

When they got married, Ramu told Lakshmi that times had changed, and that they should have only two children. If they had a boy and a girl, she should have an operation. But somehow, Lakshmi never conceived for two years. Her mother-in-law started abusing her.

She conceived when she was 17. Her first pregnancy was very difficult. Her arms and legs and even her face was swollen, and something would cloud her vision. She would also vomit everything she ate, day after day. But she never went to see a doctor. People said this is how it is when one is pregnant. A baby girl was born to her. After the delivery, in a government hospital, all these problems went away.

The second baby was also born in a hospital. But he died in a few days: vomited once in the morning, was taken to hospital immediately but died. The third was a daughter, and she died a few hours after birth. Some doctors said the baby had a heart problem while another said that Lakshmi was very weak. Some others said that it was because she had married a close relative. But the baby was very small and only skin and bone. Lakshmi felt heart-broken.

After her third delivery, Lakshmi started having foul-smelling white discharge frequently. She did not do anything about, telling herself that this must be because of weakness. Lakshmi started a vrat, fasting once a week for a healthy birth the next time. Her fourth baby was born recently, and is a boy. Lakshmi wanted to have a family planning operation, and so did Ramu. But the doctors said that she was too weak, and sent her home. They asked her to come back after her health improved.

Lakshmi is now desperate. She does not want to conceive immediately and wanted to make sure that her son survives and grows into a healthy child. But knowing her husband she thinks abstinence is not feasible. She is afraid that if she refuses, he will take another woman just like Lakshmi's father did.

1. *What symptoms did Laxmi present with?*
2. *How would a typical health care provider address these problems?*
3. *What are the causes of health problems? Categorize the causes into (a) those related to gender (b) others?*

# Session 6

## Sexuality and Violence

### Learning Objectives

The participants will be able to:

- Describe the concept of sexuality.
- Describe violence against women in its various dimensions.
- Analyse the interlinkages of both with gender and health.



**Time** 90 minutes

**Methodology :**



Interactive lecture with presentations

### ACTIVITIES



#### 1. Construction of male and female sexuality

Ask participants what words come to their minds when they think of sexuality of men and women.

#### Participants' Responses

Male	Female
Dominant	Submissive
Freedom of expression	Shy
Aggressive	Hesitant
Force	Shame
Pleasure	Guilt
More preferences	Honour
Identity	Reproduction
Right	Fertility
Powerful	Duty
Polygamous	Beauty
<b>Active</b>	<b>Passive</b>
Desire	Rape
	Fear
	beauty



The facilitator points out that male and female sexuality is constructed as described above. What affects would this have on health of individuals?

- Wives cannot say 'no' to sex (duty), thereby subjecting themselves to unwanted pregnancies, painful sex.
- Men are supposed to be adventurous, risk-taking, experienced. They therefore have multiple sexual partners; have unsafe, unprotected sex leading to infections.



## 2. Facilitator presents some definitions and linkages of Sexuality and Health

### Sexuality

Sexuality refers to culture-bound conventions, roles, and behaviours involving expressions of sexual desire, power and diverse emotions, mediated by gender and other aspects of social position (e.g., class, race/ethnicity, etc.). Distinct components of sexuality include: sexual identity, sexual behaviour and sexual desire.

### Sexual identities

Contemporary 'Western' categories by which people self-identify or can be labeled include: heterosexual, homosexual, lesbian, gay, and bisexual, 'queer', and transgender, transsexual.

Heterosexism, the type of discrimination related to sexuality, constitutes one form of abrogation of sexual rights and refers to Institutional and Interpersonal practices whereby heterosexuals accrue privileges (e.g., legal right to marry and to have sexual partners of the 'other' sex) and discriminate against people who have or desire same-sex sexual partners, and justify these practices via ideologies of innate superiority, difference, or deviance.

### Sexuality and Health

Lived experiences of sexuality accordingly can affect health by pathways involving not only sexual contact (e.g., spread of sexually-transmitted disease) but also discrimination and material conditions of family and household life.

Power is a central concept in sexuality and affects how male and female sexuality is expressed. Gender power relations are central to sexual relations and also influence vulnerability to disease.



### 3. Facilitator generates a discussion on Violence against Women, its various forms and effects on health.

After an open discussion, the presentation highlights the following:

*What is Violence against Women?*

"Any act of gender based violence that results in or is likely to result in physical, sexual or psychological harm or suffering, including threats of such act, coercion or arbitrary deprivation of liberty, whether in public or private life" United Nations (1993).

*Forms of gender-based violence*

- Physical violence
- Sexual violence
- Threat of physical or sexual violence
- Psychological/ emotional violence
- Sexual harassment

*Violence throughout the Lifecycle*

**Foetus** - Sex-selective abortion.

**Childhood** - Deprivation of and discrimination against the girl child, child sexual abuse.

**Adolescence** - Trafficking of young girls, violence at workplace, sexual abuse and rape, unwanted pregnancy.

**Reproductive age** - Violence against pregnant women, wife beating, torture for dowry, dowry murder, marital rape, rape and sexual abuse, violence at work place, forced pregnancy, forced abortion, coercive population control and family planning programs sponsored by the State.

**Old Age** - Abuse of aged, desertion.

*Health Effects of Violence against women*

Types of Violence	Health Effects
Childhood sexual abuse	gynaecological problems, sexually transmitted infections (STIs), HIV, infertility, unwanted pregnancy, abortion, high-risk behaviors, substance abuse, attempted or completed suicide, death.
Rape	unwanted pregnancy, abortion, pelvic inflammatory disease, infertility, STIs, partial or permanent disability, chronic pain, gastrointestinal (GI) disorders, headaches, HIV, attempted or completed suicide, death.
Intimate partner violence	poor nutrition, exacerbation of chronic illness, substance abuse, obesity, GI problems, depression, brain trauma, organ damage, partial or permanent disability, chronic pain, unprotected sex, pelvic inflammatory disease, gynaecological problems, pregnancy complications, miscarriage, adverse pregnancy outcomes (including low birth weight and maternal death), attempted or completed suicide, death.

### *What prevents identification in the health systems?*

- Time constraints faced by health care providers
- Cultural reasons\gender bias within health providers
- Feeling helpless, isolated
- Notion that violence against a woman is a private issue
- Lack communication skills amongst health providers
- Poor referral services
- Bio-medical approach

### *Critical role of health providers*

- Overlooking abuse could lead to poor quality of diagnosis and evaluation
- Failure to recognize results in repeated visits
- Screening and early interventions are far less costly than continuing to treat injuries
- Chance of preventing even more serious physical, psychological and social consequences
- Inappropriate or unnecessary medical treatment may contribute to a woman's sense of revictimisation
- Battering escalates over time, if neglected and can result in death by murder or suicide



## Key Points

Both sexuality and violence against women are under studied and under addressed aspects of women's health, with far reaching consequences.

Gender and power relations are intrinsic in both sexuality and violence against women.



## Readings

1. TARSHI, (2001). Common Ground: Sexuality. Principles for Working on Sexuality. New Delhi: TARSHI and SIECUS, pp. 7-8.
2. World Health Organization & UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. (2017): Sexual health and its linkages to reproductive health: an operational approach. World Health Organization.  
<https://apps.who.int/iris/handle/10665/258738>.
3. Parker R. G. (2007). Sexuality, health, and human rights. American journal of public health, 97(6), 972–973.  
<https://doi.org/10.2105/AJPH.2007.113365>
4. Simon-Kumar, R. (2014). Sexual Violence in India: The Discourses of Rape and the Discourses of Justice. Indian Journal of Gender Studies. 21. 451-460. 10.1177/0971521514540711.  
[https://www.researchgate.net/publication/280771980\\_Sexual\\_Violence\\_in\\_India\\_The\\_Discourses\\_of\\_Rape\\_and\\_the\\_Discourses\\_of\\_Justice/citation/download](https://www.researchgate.net/publication/280771980_Sexual_Violence_in_India_The_Discourses_of_Rape_and_the_Discourses_of_Justice/citation/download)

# Session 7

## What are Rights?

### Learning Objectives

The participants will be able to:

- Describe the concepts of rights, human rights.
- Know the history of human rights.



**Time** 90 minutes

**Methodology :**



Participatory exercise



Presentation and discussion

### ACTIVITIES



#### Participatory exercise

Participants are asked to write on cards the rights that are most important to them. The cards are then categorized and put up.

Some of the following rights are listed by participants as most important.

Type of right
Right to speak/ Right to express oneself / Right to expression one's own opinion/ Right to speak, share / Right to express / Freedom of expression
Right to mobility/ Right to roaming/ Right to travel / Freedom of movement
Right to survival/ Right to life
Right to education/ Freedom of education / Educational right
Right to freedom
Right to livelihood / Right to employment / Employment right
Right to make my own choices / Freedom of choice
Right to health / Right to good health
Right to basic needs
Right to equality / Right to equality and justice
Right to vote
Right to dignity
Right to space

Right to all fundamental rights
Freedom of living
Right to equity
Right to living with family
Right to enjoy
Cultural right
Right to information
Right to decide my life the way I want
Selection of life partner
Right to resources
Rights to have rights and ask for them and express them in our way (Right to fight for rights)

2. Participants are divided in two groups. One group is asked to read Fundamental Rights guaranteed in the Constitution of India and the other the Universal Declaration of Human Rights. While reading, they are asked to reflect on the rights that they had written.
3. In the plenary, the facilitator discusses the important rights listed by the participants in relation to the Fundamental Rights and the rights mentioned in the UDHR.
4. Facilitator presents the history of human rights and the important human rights conventions.
5. Facilitator ends with

*In Germany, the Nazis first came for the communists, and I did not speak up, because I was not a Communist. Then they came for the Jews, and I did not speak up, because I was not a Jew. Then they came for the trade unionists, and I did not speak up, because I was not a trade unionist. Then they came for the Catholics, and I did not speak up, because I was not a Catholic. Then they came for me...and by that time, there was no one to speak up for anyone.*

-- Martin Niemoeller, Pastor, German Evangelical (Lutheran) Church

(Source: <http://www.hrweb.org/intro.html>)



### Key Message

- Human rights refers to the concept of human beings as having universal rights, or status, regardless of legal jurisdiction, and likewise other localizing factors, such as ethnicity and nationality.

### History of Human Rights

- In the eighteenth and nineteenth centuries in Europe several philosophers proposed the concept of "natural rights," rights belonging to a person by nature and because he was a human being, not by virtue of his citizenship in a particular country or membership in a particular religious or ethnic group. Some viewed it an underlying principle on which all ideas of citizens' rights and political and religious liberty were based.

- Out of the French Revolution came the “Declaration of the Rights of Man.” The term natural rights eventually fell into disfavor, and the concept of universal rights took root.
- Universal Declaration of Human Rights, and Human Rights covenants were written and implemented in the aftermath of the Holocaust, revelations coming from the Nuremberg war crimes trials, the atomic bomb, and other horrors of World War II.
- Collapse of Soviet Union and East European countries in 1990s saw the emergence of Human Rights in a big way in global discourse.

#### **There are 6 categories of rights in the UDHR**

- A. Security rights that protect people against crimes such as murder, massacre, torture, and rape;
- B. Liberty rights that protect freedoms in areas such as belief, expression, association, assembly, and movement;
- C. Political rights that protect the liberty to participate in politics through actions such as communicating, assembling, protesting, voting, and serving in public office;
- D. Due process rights that protect against abuses of the legal system such as imprisonment without trial, secret trials, and excessive punishments;
- E. Equality rights that guarantee equal citizenship, equality before the law, and nondiscrimination; and
- F. Welfare rights (or “economic and social rights”) that require provision of education to all children and protections against severe poverty and starvation.

### **Features of Human Rights**

- Human rights are political norms dealing mainly with how people should be treated by their governments and institutions.
- Human rights are minimal standards. They are concerned with avoiding the terrible rather than achieving the best.
- Human rights are international norms covering all countries and all people living today.
- Human rights have robust justifications that apply everywhere and support their high priority. Without this they cannot withstand cultural diversity and national sovereignty.
- Negative human rights denote actions that a government should not take. They include limiting freedoms of speech, religion and assembly.
- Positive human rights denote rights that the state is obliged to protect and provide. Examples of such rights include: the rights to education, to a livelihood, to legal equality.
- Rights imply that there are Right holders -- a person or agency having a particular right. – and Duty bearers – usually governments, who are assigned duties or responsibilities to protect, fulfill and promote rights.

## First, Second and Third generation of Human Rights

- First-generation human rights deal essentially with liberty and participation in political life. They are fundamentally civil and political in nature, and serve to protect the individual from excesses of the state. First-generation rights include, among other things, freedom of speech, the right to a fair trial, freedom of religion, and voting rights.

The International Covenant on Civil and Political Rights is a United Nations treaty based on the Universal Declaration of Human Rights, created in 1966 and entered into force on 23 March 1976.

- Second-generation human rights are related to equality. They are fundamentally social, economic, and cultural in nature. They ensure different members of the citizenry equal conditions and treatment. Secondary rights would include a right to be employed, rights to housing and health care, as well as social security and unemployment benefits. Like first-generation rights, they were also covered by the Universal Declaration of Human Rights. International Covenant on Economic, Social and Cultural Rights, 1966 (entered into force 1976).
- Third-generation human rights are those rights that began to be defined in the subsequent decades, in various UN Conferences, including the 1972 Stockholm Declaration of the United Nations Conference on the Human Environment, the 1992 Rio Declaration on Environment and Development. Examples of the third generation of human rights are the Convention on the Elimination of all Forms of Discrimination against Women (the CEDAW Convention) and the United Nations Convention on the Rights of the Child, often referred to as CRC or UNCRC.

## Women's Human Rights

- Political term used to underscore that women's rights are HUMAN RIGHTS, rights to which women are entitled simply for being human. This approach adds both a focus on women into the human rights movement and an emphasis on HUMAN RIGHTS PRINCIPLES into the women's rights movement.



### Readings

1. Fundamental Rights (From Part III of the Constitution of India).  
<https://www.mea.gov.in/Images/pdf1/Part3.pdf>
2. United Nations. (Year unknown). Human Rights: A basic handbook for UN staff.  
<https://www.ohchr.org/Documents/Publications/HRhandbooken.pdf>
3. Alam, Khabirul & Halder, Ujjwal. (2018). Human Rights and Right to Education in India. 5. 2183-2186.  
[https://www.researchgate.net/publication/327078996\\_Human\\_Rights\\_and\\_Right\\_to\\_Education\\_in\\_India](https://www.researchgate.net/publication/327078996_Human_Rights_and_Right_to_Education_in_India)

# Session 8

## Applying the Rights Approach to Health

### Learning Objectives

#### Participants will be able to :

- Describe right to health and health care, reproductive rights and sexual rights.
- Apply these concepts to maternal health.



**Time** 90 minutes

**Methodology :**



Individual or group reading



Group work on case study analysis



Presentations and discussion

### ACTIVITIES



#### Individual or group reading

Participants are given the readings for homework: (a) ICESCR General Comment-14, (b) CEDAW, (c) WHO Occasional Paper No. 5, Advancing Safe Motherhood through Human Rights. They have to familiarize themselves with the contents of the papers and be ready to apply them to the case studies the next day.



#### Group work on analysis of the case studies

Each group is given a case study of denial of right to maternal health care with questions to be answered. The case studies and questions are given at the end of this session. The group presentations should not exceed 10 minutes each.



#### Facilitator summarises with a presentation that highlights:

- Differences between right to health and right to health care.
- Components of the right to highest attainable standards of health.
- Reproductive and sexual rights.
- The right to health must be understood in indirect terms as a right to the enjoyment of a variety of facilities and conditions necessary for the realisation of the highest attainable standard of health.



- The effective realisation of the right to health is strongly related to and dependent on the realisation of other economic, social and cultural rights. E.g. *Rights to food, housing, safe working conditions, and education.*
- The notion of “the highest attainable standard of health” refers to both the individual’s biological and social preconditions and a State’s available resources.
- The components of the highest attainable standard of health are: Availability, Accessibility, Acceptability and Quality.

**(1) Availability** refers to the existence of health facilities, goods and services to meet the basic health needs of the people including hospitals and clinics, trained medical personnel, essential drugs, and so forth.

**(2) Accessibility** means that health facilities, services and goods *must be within physical reach* for all parts of the population, especially for vulnerable groups such as ethnic minorities and indigenous populations, women, children, adolescents, the elderly, persons with disabilities, and persons with HIV/AIDS and other diseases that have an element of stigma attached to them.

- Accessibility requires *non-discriminatory access* to health facilities, services and goods for all segments of the population.
- Accessibility also implies that medical services and underlying preconditions of health, such as clean water and adequate sanitary facilities, *are within reasonable distance* even in remote rural areas.
- Furthermore, accessibility includes the right to seek and be provided with relevant *information* concerning all kinds of health issues. However, accessibility of information may on no account impair the right to have personal health data treated with *confidentiality*.
- Requires that health facilities, services and goods be affordable for all.
- Arrangements for payment for health care services as well as services related to the underlying preconditions of health be based on the principle of fair financing ensuring that these services, whether privately or publicly provided, are affordable for all, including the socially disadvantaged groups.
- Fair financing means that poorer households should pay a smaller proportion of their income for health care services compared to richer households.

**(3) Acceptability:** Cultural appropriateness signifies that health policies must be at once respectful of the people’s culture and aimed at improving people’s health status. Health services should also be acceptable from the perspective of Medical Ethics.

**(4) Quality**

- Means that health facilities, services and goods must be scientifically appropriate.
- This requires skilled medical personnel, scientifically approved drugs and hospital equipment, clean water and adequate sanitation, sufficient information on environmental hazards and health risks.

## Women's Right to Health

Aside from the complexities associated with the right to health in general, consideration of the right to health of women needs to take into account at least two additional dimensions. Women's right to health must be considered from a gender perspective. In addition, the prohibition against discrimination must be kept in mind. Both dimensions are considered in article 12 (1) of CEDAW relating to guarantees of access to health services without discrimination, and article 12 (2) related to maternal health services. Access to reproductive health services is also referenced in the CRC. (article 24[2][d])

- **Reproductive rights** "embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health." (ICPD POA, para. 95)
- **Sexual rights** are a fundamental element of human rights. They encompass the right to experience a pleasurable sexuality, which is essential in and of itself, and, at the same time, is a fundamental vehicle of communication and love between people. Sexual rights include the right to liberty and autonomy in the responsible exercise of sexuality. (*Health Education and Research Association - HERA*)

The concept of sexual rights, like that of human rights, provides a framework to ensure non-discrimination, and therefore cannot be used to privilege one individual or group over another.

Sexual rights affirm entitlements, such as the right to bodily integrity, as well as rights that protect against violations, such as the right not to be coerced into sexual activity.

### Other Important Gender Terms

**GENDER DEVELOPMENT INDEX (GDI):** Measures developments of states according to the same broad factors as the HUMAN DEVELOPMENT INDEX, but highlights the inequality in these spheres between men and women.

**GENDER DISCRIMINATION:** Discrimination based on socially constructed ideas and perceptions of men and women.

**GENDER-NEUTRALITY:** Treatment of a problem without recognition of gender; myth of gender neutrality in human rights eliminates recognition that treating people identically despite unequal situations perpetuates rather than eradicates injustices.

**GENDER PERSPECTIVE:** Notion that problems and solutions should be examined with a sensitivity to the implications of gender in mind. This concept is based on an understanding that in all situations some perspective of interpreting reality is present. Historically, that perspective has most often been biased towards the male view and, accordingly, most perspectives on reality have not taken women's views and experiences into account, rendering the every day violations of women's human rights invisible.

**GENDER-SPECIFIC CLAIMS:** Human rights claims relating to abuse women or men suffer because of their gender, when HUMAN RIGHTS are being violated due at least in part to a person's gender and/or when women's experience of a human rights violation differs from men's experience due to gender-specific consequences or experiences.



## Key Message

### What is meant by a rights-based approach to development?

"As rights-based approach to development sets the achievement of human rights as an objective of development. It uses thinking about human rights as scaffolding of development policy. It invokes the international apparatus of human rights accountability in support of development action. In all of these, it is concerned with not just civil and political rights but also with economic, social and cultural rights. Further, the implementation of a rights-based approach implies that performance standards be set."

"A rights-based approach to development describes situations not simply in terms of human needs, or of developmental requirements, but in terms of society's obligations to respond to the inalienable rights of individuals, empowers people to demand justice as a right, not as charity, and gives communities a moral basis from which to claim international assistance when needed."

UN Secretary General, Kofi Annan

### Case study 1: Kokilaben

**Kokilaben Nayak**, age 30, resident of Jhapatiya village, Dahod district, Gujarat, was pregnant with her first child. As she had completed her term of pregnancy, and would soon go into labour, her husband, Maheshbhai, arranged for a private jeep to take her to the CHC by hiring a private jeep from Baria, spending Rs.500 on transport.

Soon after Kokilaben was admitted there, all the CHC staff left for the day. The gynecologist at the CHC (Dr. M) told Maheshbhai that his wife would have to undergo a caesarian operation, demanded Rs. 4000-5000. Maheshbhai's suspicions that the doctor was trying to make money was reinforced when he was asked to buy three 'labour-inducing' injections that cost Rs. 150 each from a medical store. He also observed that Kokilaben was not given the injections he bought. Finally, when a nurse manhandled Kokilaben and caused the bone in her leg to crack, he decided to shift her. The staff of the CHC tried to stop them, but Maheshbhai was defiant. They spent the night under a tree and in the early hours of the morning on the next day, he had his wife admitted in a private clinic in Baria, where Kokilaben had a normal delivery. The total expenditure at the private clinic amounted to around Rs.1500. Maheshbhai spent Rs.525 to take his wife to her natal home in a jeep.

---

## Case study 2: Reshamben

**Reshamben**, age 30, resident of Fangiya village of Dahod district, Gujarat, delivered a baby boy at her home. The birth was attended by an untrained 'dayan' (traditional birth attendant). Reshamben suffered postnatal complications. She became weak and listless, The placenta was not expelled even after seven days, her legs were swollen, and she became unconscious. Her husband rushed her to the CHC, in a private jeep, spending Rs.400 on transport. She stayed there for three days, during which period, her husband spent around Rs.1200 on buying all the drugs, IV fluids prescribed to her from pharmacies as the CHC did not have these in stock.

When her condition improved a little, Reshamben was taken home, but after two days her condition deteriorated again, and her family shifted her to the civil hospital at Godhra spending Rs.1500 on private transport. Meanwhile, Reshamben's neighbors victimized the birth attendant (as is common practice in this region), accusing her of being a 'dakan' (witch) and casting an evil eye on her.

At the Godhra civil hospital, the placenta was removed. Reshamben stayed there for four days, still unconscious, with hardly any improvement in her condition. As the medical staff was uncommunicative about her condition, her husband shifted her to a private clinic in Godhra. She recovered after 14 days of intensive medical care in the private hospital. By then her family had spent more than Rs.17000, having sold off their shop in the village, taking a loan of Rs.3000 from the self help group.

---

## Case study 3: Jashodaben

**Jashodaben**, age 28, resident of Santrampur (Panchmahals district), Gujarat, had a girl child. She registered under the local PHC for primary care including antenatal care. The health worker advised her to approach the CHC doctor if she had any complaints during pregnancy. When she consulted the CHC medical officer she was told that she was carrying twins, but later an ultrasound test done in a private hospital showed that there was no second twins, but the position of the fetus was not normal. She was advised to go for an operation immediately, which she could not follow due to acute financial constraints. On her way back home, she felt labour pains. As if it was midnight, her husband decided to shift her to the civil hospital at Godhra the following day. The nurse of the Godhra hospital informed her husband that the doctor was not available and could visit her only in the next day morning. There was no doctor for the emergency.

However, by midnight Jashodaben went into labour. The nurse helped Jashodaben in the emergency. She administered a saline intravenous infusion and assured them that the delivery would be safe. But it was a stillbirth. The nurse prescribed four injections, which cost Rs 90 each. She gave her some more IV fluids and prescribed another two injections that cost about Rs. 7000. Jashodaben's husband could not find one of the prescribed injections at such an early hour, as nearby medical shops were closed. Jashodaben's 'veins started straining' and she died because life-saving injections were not made available to her on time. Her husband paid Rs.650 to the hospital ambulance authority to bring home Jashodaben's body.

---

## Case study 4: Jiwiben

**Jiwiben**, age 40, resident of Santrampur (Panchmahals district), Gujarat, has a son and a daughter. She had undergone sterilization at a health camp, where she was operated upon by the medical officer of the CHC. The neither the camp organizers nor the CHC provided any transport facility to her to reach home safely. Three years later she got pregnant again and become very weak and this caused tension in the family. When she went to get her case number of her operation, which she needed for further treatment, the clerk demanded hundred rupees to release the case number. She paid the clerk with help from her village headman.

Later she was admitted in the same hospital for her delivery and she stayed there for a week. On discharge from the hospital she fainted. Her husband took her to a nearby private hospital. She was very weak and lodged a complaint against the doctor of the hospital for all the harassment.

Now, she thinks she has an abdominal tumor but does not want to go to the government hospital for treatment fearing that the doctors there would harass her as retaliation against the complaint she had lodged. She is also not in a position to go anywhere else due to acute financial crisis.



### Readings

1. The Right of the Highest Attainable Standard of Health, General Comment 14.  
<https://www.refworld.org/pdfid/4538838d0.pdf>
2. Right to Health in International Documents.  
<https://www.ohchr.org/Documents/Publications/Factsheet31.pdf>
3. Convention on the Elimination of All Forms of Discrimination Against Women.  
<https://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pdf>
4. UNICEF. (2011). CEDAW in brief for adolescents.  
[https://www.unicef.org/gender/files/CEDAW\\_In\\_Brief\\_For\\_Adolescent-Web\\_Version.pdf](https://www.unicef.org/gender/files/CEDAW_In_Brief_For_Adolescent-Web_Version.pdf)
5. UNICEF, Regional Office for South Asia. (2003). A Human Rights-based Approach to Programming for Maternal Mortality Reduction in a South Asian Context. A review of Literature. Geneva: UNICEF, pp. 100-106.
6. Mann, SP., Bradley, VJ., and Sahakian, BJ. (2016). Human rights-based approaches to mental health: A review of programs. Health and Human Rights Journal. 18/1.  
<https://www.hhrjournal.org/2016/05/human-rights-based-approaches-to-mental-health-a-review-of-programs/>



# 2

## Module

# Researching Gender and Social Issues in Health

### Learning Objectives

1. Describe the paradigms of research.
2. Describe step by step the research process, beginning with identification of research gaps, developing research questions, selecting appropriate study design, data analysis and report writing.
3. Use the gender analysis tool in the research process.
4. Apply gender analysis framework to specific health conditions.

# Session Outlines



# Session 9

## Research Process: Step by Step

### Learning Objectives

#### The participants will be able to:

- Define steps/stages in research.
- Identify research gaps.
- Formulate research questions.
- Select an appropriate study design and research methods to answer the research question.



**Time** 120 minutes

**Methodology :**



Interactive presentation and discussion

### ACTIVITIES



#### Presentation on

#### 1. Introduction: Difference between Basic and Applied Research

##### Basic Research

- Basic research is done to understand society and to be able to explain societies and their organization. It is also done to be able to predict and use research for ordering or organizing society.
- Several kinds of research are there- exploratory, descriptive, explanatory etc. These all are part of basic research. When one sees a new set of phenomena happening in a community one may want to know the reason for it. So, one goes into an exploratory phase to try and understand it.

##### Applied Research

- Large scale base line surveys to anchor programs and /or monitor changes (Census, NSSO, NFHS, DHS, etc.).
- Evaluation & Monitoring Research: to assess program performance and introduce course corrections or cease the initiative.
- Needs assessment and Rapid Appraisals.
- To understand and influence behavior, if necessary (social engineering; market research).

## Research for Change

- Research that involves the 'subjects' of research in the process of research.
- For facilitating awareness building through the production of knowledge ground up.
- For breaking the researcher- researched dyad.
- For stating that research, production of knowledge and theory building are political processes.
- To demonstrate that research can have emancipatory goals.

## 2. What is the Role of Theory in Research?

- Social Theory was defined as "a system of interconnected abstractions or ideas that condenses and organizes knowledge about the social world" (Lawrence Newman, 2000).
- Theory increases a researcher's awareness of interconnections and of the broader significance of data.

## 3. What is the Role of Concepts?

- Concepts are the building blocks of Theory.
- Concepts are on a continuum of being concrete to abstract (age, school, housing..... social control, autonomy, decision-making etc).
- Well defined concepts (where they exist) and operational definitions (where they are being explored) help link theory with research.

## 4. Research Objectives and Questions

- Research Objectives state the goals of doing the research, the relationship or association of which concepts is being examined.
- Research Questions pose not only the relationship of variables but also their direction and strength of association. For example, do older women in a household have more access to health services than younger women? Do educated women perceive more problems with menstruation than uneducated women?

## 5. What are the Sources of Research Questions?

- Past Research- comprehended through Literature Review
- Casual Observation of Human Behavior
- Social Policy
- Sociological Theory

## 6. Methodological Issues

- What is the universe?
- What is the sample?
- What is the study design?
- What are the sources of data?
- Where is the study located? - community based; hospital based

## 7. What is a Research Design?

- Research design is a term used for the steps that you follow to capture a replica of the larger universe that you are attempting to study.
- For a study on infertility: if your research questions make a distinction between literate – illiterate women; ‘employed’ women and ‘housewives’; women in nuclear and joint households. For example, then your design should capture all these categories through your house listing.

## 8. What is the Universe?

- Example: Study on treatment seeking behavior of infertile women.
- Operational definitions for: (a) what is considered “treatment seeking behavior”? (b) who are considered as “infertile women”?
- UNIVERSE is women currently married, co-habiting, not using any form of contraception for the past two years and not pregnant.

## 9. What is the Sample?

- Sample for a study is linked to the frequency of the episode (in this case infertility) in a population.
- The more frequent the episode, you will be able to capture it in a small sample. For example, gynaec morbidities vs. maternal mortality.
- If it is a community-based study, the sample will have to be selected after a house listing of all currently married couples and identification of households as per your definition.
- More the parameters of the study the more complex is your research design.

## 10. What are the Tools of Research?

- Survey Research
- Participant Observation
- Interviewing
- Controlled Experiments
- Content Analysis
- Comparative and Historical Research
- Evaluation Research
- Prediction and Probability

## 11. Frequently used Research Methods

- Quantitative Methods: structured, coded questionnaires, open-ended interview schedules. Ensure pilot tested and refined questionnaires.
- Qualitative Methods.
- Most studies use quantitative and qualitative (method mix).

## 12. Data Collection

- Not a value free exercise.
- Ethical issues need to be factored in.
- Gender, class, caste and other indices of social positioning get played out in the field- need to be alert.

## 13. Data Analysis

- Quantitative Data Analysis: Need to spend time to 'clean' the data; manually code or computerize the data. Recode open ended questions. Prepare a code book to correspond to the schedule. Simple to complex statistics are made possible with SPSS package to ascertain relationship and association of variables.
- Qualitative Analysis: Content analysis of interviews – taped and transcribed. Develop themes based on the content. Examine and rework the original conceptual map in light of the data. Present voices in the write up. Analysis can be done manually or through software packages like Atlas.ti, MAXQDA, NVivo 9 etc. Some free software packages are FreeQDA, Square Feedback, ConnectedText, QDA Minor Lite.

## 14. Interpreting Data

- Analyzing and Interpreting data is closely linked.
- Interpreting data is closely linked to the theoretical perspectives that you subscribe to.
- Going back to reading relevant literature and understanding how your findings are intervening in the existing debates or current knowledge or policies is important.

## 15. Report Writing

- Different outputs from research have to be planned before, while and after doing research.
- Reporting of research findings is basically part of communicating and sharing your work with the larger academic community.
- Accountability to the community from whom data has been collected is a neglected issue, but needs to be considered.
- One research often sows the seeds for the next enquiry!



## Readings

1. Bhopal, K. (2000). Gender, 'Race' and Power in the Research Process: South Asian Women in East London (Chapter 5). In C. Truman, C., D. Mertens, and B. Humphries (Eds.), *Research and Inequality*. USA and UK: UCL Press, pp. 67-79.
2. Health Canada. (2003). *Exploring Concepts of Gender and Health (Chapter 5: The Research Process and Gender-based Analysis)*. Ontario: Women's Health Bureau, Health Canada, pp. 12-15.
3. Kitts, J. and Roberts, J.H. (1996). *The Health Gap: Beyond pregnancy and reproduction (Chapter 3: The Research Process)*. IDRC.
4. Gilson, L. ed. (2012). *Health policy and systems research: A methodology reader*. WHO. [https://www.who.int/alliance-hpsr/resources/alliancehpsr\\_readerpart2.pdf?ua=1](https://www.who.int/alliance-hpsr/resources/alliancehpsr_readerpart2.pdf?ua=1)

# Session 10

## From Research Ideas to Research Questions

### Learning Objectives

#### The participants will be able to:

- Develop skills of translating research ideas into research questions.



**Time** 90 minutes

**Methodology :**



Group work around participants' own research studies



### ACTIVITIES

#### Group work

Each group is asked to select one research study from amongst the participants' own work. Once they decide on the Title, they should generate research objectives, research questions and prepare a presentation.

Each presentation is discussed and the resource person gives feedback to sharpen the research idea, the objectives and the research questions.

#### An example

Title: Evolving HIV/ AIDS Counseling Model for MSM population

#### Research objectives

- To study the sexual behaviour of MSM population of Vadodara city.
- To identify psychosocial issues of MSM population.
- To identify their coping mechanisms.
- Based on the above three, formulate a working model of HIV/ AIDS Counseling.

## Research questions

- Is the sexual behavior of MSM population different from heterosexual population?
- Are the vulnerabilities associated with the homosexuals different from heterosexual population?
- Are the psychosocial issues of MSM population different from heterosexual population?

**Methodology:** FGDs, In-depth Interviews, and Questionnaires.

## Possible feedback from the resource person

1. The title indicates a goal or an outcome. Title should be what one wants to explore. Here the title could be "to study the sexual behavior and psychosocial issues of MSM population in Vadodara city." Title should match with the objectives.
2. The research questions should be worded differently, looking at the relationships between variables.
3. It is important to keep checking whether the research questions are within the realm of objectives. Also, the research questions should be logically linked to the objectives. Objectives are at a higher level of abstraction and have a larger goal.

# Session 11

## Literature Review

### Learning Objectives

#### Participants will be able to :

- Write a good literature review.



**Time** 90 minutes

**Methodology :**



Group exercise



Presentation

### ACTIVITIES



#### Group exercise

Participants are given annotations of two or three articles. They are asked to read through the annotations and individually create labels to indicate what each paragraph talks about, i.e. each paragraph has to be given a title. Based on the type of group, articles can be selected. Given below are two examples,

#### **Paper 1- 'A Profile of Women's Work Participation Among the Urban Poor of Dhaka, Bangladesh'**

##### **Labels that could be given by participants**

- Profile and socio demographic characteristics of the participants in the study.
- Gender based restrictions on women being challenged though cultural practice of domination by the powerful continued.
- Gender division of labour.
- Variation in work participation by marital status and age.
- Men's control over women's work and mobility, gender and power, decision making.



## Paper 2- 'Intermittent Employment among Married Women: A Comparative Study of Buenos Aires and Mexico City, Latin America'

### Labels that could be given by participants

- Women's work participation in relation to presence of children in the household and support structure.
- Women's work participation with respect to husband's work status.
- Women's education and labour work participation.
- Traditional expectations and married women's work participation.
- Women's perception of their paid work and family circumstances, labour market, economic and social conditions.



### Presentation by Resource Person

#### (i) Purposes of Literature Review

- Find gaps in the literature
- Avoid reinventing the wheel
- Build on the platform of existing knowledge and ideas
- Learn about other people and networks in the same field
- Identify important works about your topic
- Provide intellectual context for your own work to position your work
- Learn about opposing views
- Identify research methods relevant to your research

#### (ii) Literature Reviews: Research Articles- Review Papers

- Literature Reviews attempts to capture the "big picture" of a field of research.
- Research Articles are based on empirical studies. The introduction provides a condensed literature review to provide the rationale for the study that has been conducted.
- Review papers provide the state of art in a particular area, along with an assessment of theory that is getting built or policy that the research does or does not support.

#### (iii) Steps in Developing a Literature Review

Three main steps:

- Select a research topic,
- Collect and read relevant articles, and
- Write the review.

#### **(iv) Literature Review is like 'Standing on the Shoulders of one's Predecessors'**

Nothing that a researcher sets out to do would be absolutely new. Some work would already have been done on the issue, though perhaps from different vantage points. There could be different disciplinary interventions.

#### **(v) Logical Order of Literature Review**

Through literature review the researcher would be able to say what was known and what was not known. Based on this, the researcher would narrow down on what s/he is interested in, giving the rationale for the chosen research problem. Then the researcher will state the objectives and formulate research questions. Finally, the research design will be generated so that all the information is put in place logically.

#### **An example**

The resource person gave an example of a study on 'breast-feeding practice' that she undertook with a colleague. While doing the literature review, they found that work on breast-feeding had been done mainly by three groups of people. One was the demographer who looked at the positive linkage between breast feeding and fertility decline. Thus their focus was exclusive breast-feeding for the purpose of population control. The second group of people was the pediatricians. For them breast-feeding was crucial for child survival and the woman's importance was only to feed the child. Thus the 'mother' as a 'woman' was absent from their point of view. The third group also focused on child survival and linked it with policy matters and issues like baby-friendly hospitals and large pharmacies advertising tinned food. Thus, it was found that focus on women was actually absent in all the work that had been done on breast-feeding. There was no talk of the support structures that women would need in order to breast-feed, especially those women who work outside the home. The resource person said that therefore a researcher needed to look at the existing literature from a perspective that came from the researcher's standpoint and theorizing. Thus, in their study on breast-feeding practice they concluded that enough of research was already done, and what was needed was a supportive policy and necessary enabling environment for women to be able to breast-feed.

#### **(vi) Literature Review has to be Organically Linked to the Study**

It should not be confined to, 'who said what is which book'. One should go through literature review in stages:

- Build a perspective
- Give an overview- what are the relevant policies, what data has been generated so far, etc.
- Give empirical studies (studies done in particular places)
- Make policy/ programmatic linkages

## (vii) While doing Literature Review one Could Write Annotations

Write down separately, what the paper is about, what are its research questions, and where the study is located. One could also do 'paper review at a glance' in a tabular form:

### Paper Review at a Glance

Sr. No.	Author	Journal	Location of study	Sample size	Remarks
					Put most salient points of the paper here

If the researcher has read 50 papers, s/he would not have to go back to all the 50 papers, unless any of them seemed really interesting or close to one's study.

## (viii) Organizing Literature Review

To organize the literature review, portions about the same aspect from different papers could be copied and pasted in one place under a suitable heading. For instance, portions related to 'cultural practices' could be copied and pasted from different papers under the head 'cultural practices and women's work', followed by the references of the papers.



### Readings

1. Neuman, L. W. (2000). Reviewing the Literature and Writing a Report (Chapter 16). *Social Research Methods: Qualitative and Quantitative Approaches* (4<sup>th</sup> Edition). Boston: Allyn and Bacon, pp. 445-480.
2. Bloomsberg University of Pennsylvania. Literature review. <https://guides.library.bloomu.edu/litreview#:~:text=A%20literature%20review%20is%20a,a%20particular%20area%20of%20research.&text=It%20should%20give%20a%20theoretical,the%20nature%20of%20your%20research.>
3. McCombes, S. (2020). How to write a literature review. <https://www.scribbr.com/dissertation/literature-review/>

# Session 12

## Paradigms of Research

### Learning Objectives

#### Participants will be able to:

- Describe the origin, types and paradigms of social science research.



**Time** 240 minutes

#### Methodology :



Small group exercise



Presentations



Revisiting the initial exercise



Participants' sharing

### ACTIVITIES



#### Small Group Exercise

The participants are given eleven statements and asked to indicate whether they agreed or disagreed with each of those, giving reasons for their responses.

1. Scientific research must be value-neutral.
2. The researcher and researched must maintain a distance.
3. Scientific research aims at control and prediction.
4. Scientific research aims at universal laws.
5. Methods of natural sciences can be directly applied to the study of human behavior.
6. Different social groups view the world differently.
7. The aim of scientific research with human beings is to understand and explain.
8. All research must attempt to change gender relations.
9. To do research, it is imperative to have been trained in scientific methodology.
10. Feminist research essentially means including women in the sample group.
11. Only women can do feminist research.



## Presentation

### (i) Defining Paradigm

"A [paradigm] is a shared way of apprehending the world. Embedded in language, it enables those who subscribe to it to interpret bits of information and put them together into coherent stories or accounts" (Dryzek, 97, p. 8).

Paradigm is the basic belief system or worldview that guides the investigator-the underlying layers at the back of the investigator's mind, using which s/he understands and interprets information. Theory is a subset of paradigm.

Paradigms are fundamental frames of reference used to organize observations and reasoning.

### (ii) Three important terms to understand the paradigms of social sciences

**Ontology:** This is to do with reality. If there is a "real" world, then what can be known about it? What is "real" is accepted.

**Epistemology:** This is to do with the relationship between the knower (researcher) and what can be/is to be known (phenomena being studied). The relationship is determined by the 'ontological' question. If we are studying the 'real' world, then as researchers we cannot influence, but if it is a 'constructed' world then the researcher can influence. If it is 'real', then the posture of the knower must be one of detachment so as to know how things work.

**Methodology:** This refers to the practical way of collecting data. If there is a "real" world, the "objective" researcher requires control of those factors which might influence the study.

### (iii) Paradigms of social science research

#### Positivism

With the assumption that there is a "real" world, it is aimed to study that world in order to control and predict. The researchers observe "reality", test hypotheses, establish cause-effect relations to arrive at universal laws. The researcher and researched are assumed to be independent entities without either having any influence on the other. When influence in either direction is recognized / suspected, various strategies are used to eliminate or reduce it.

The positivist paradigm has dominated the formal discourse in the physical and social sciences for the last nearly 400 years. But gradually people began questioning whether this is the only paradigm. As people started critiquing positivism, it gave rise to post-positivism.

#### Post Positivism

It believes in a critical realism, i.e. there is a reality independent of our thinking about it, which science can study. Post-positivist critical realist recognizes that all observation is fallible and has error and that all theory is revisable. The belief is that the goal of science is to hold steadfastly to the goal of getting it right about reality, even though we can never achieve that goal. It emphasizes the importance of multiple measures and observations, each of which may possess different types of error, and the need to use triangulation.

## Constructivism

It is based on relativist ontology, i.e. there is no 'one real world'. Realities are apprehendable in the form of multiple, intangible, mental constructions. They are socially constructed, and are experiential, local and specific in nature. The researcher and the researched are linked and the "findings" are "created" as the investigation proceeds. Methods used are dialectical or hermeneutical. This involves construction of the people's experiences with their "voices" through interactions between and among the researcher and respondents.

## Post modernism

Knowledge is linked to time, place and social position from which individual constructs it. Terms of analysis are:

- Text: The subject matter being analyzed is a text, like in a novel. The text has to be analyzed to find meanings that are mentioned and also those that are not mentioned.
- Discourse: This refers to the exchange of ideas and symbolic communication between participants and the thinking that underlies it.
- Simulacra: Simulation is such that there is no distinction between original and copy.
- Hyper reality: For example, a world where media, instead of reflecting reality, itself becomes reality.
- Deconstruction: To identify and unravel the various voices in a text and the differences that are not visible on the surface.

The question of emancipation does not exist in post modernist paradigm. Post modernists have no hope of change and are cynical. There are multiple realities, all truths co-exist and there is no coherence between them. Therefore, there is no one way of doing research in the post-modernist paradigm.

## Feminist Paradigm

Feminist epistemology is based on the feminist way of looking at the world and focuses on the salience of gender. Gender is used as an analytic category in discussions, criticisms, and reconstructions of epistemic practices, norms, and ideals. Feminist epistemology very consciously centers around women's perspectives.

Feminist scholars' criticism of social science research was that:

- Women have been largely ignored in the traditional approaches to knowledge.
- Andocentric bias: Even where women have been considered, their assessment has been done in masculine terms.
- Subject-object dichotomy: There are definite unequal power relations between the researchers and researched with the researcher having the powers by virtue of training, research tools, etc.

Therefore, the feminist approaches:

- Identify ways in which dominant conceptions of knowledge systematically disadvantage women and other subordinated groups.
- Study ways in which gender does and ought to influence conceptions of knowledge and practices of inquiry. Women's perspective has to be brought in to understand how knowledge is incomplete.
- Strive to reform existing conceptions and practices in order to serve interests of neglected groups. The aim is to change existing frameworks to understand the relations and behaviours such that the views and perceptions of hitherto neglected groups are mainstreamed.
- Ground inquiry in concrete experience and everyday lives of all people unlike the earlier researches that had been very elitist.

## Critical Theory

It rejects the idea of "objective" knowledge that was stressed upon in positivism. Instead believes that knowledge is socially constructed by people at a given point of time and is therefore relative. It is grounded in history and social structure. Critical theory aims to challenge prevailing oppressive social structures such as patriarchy. Its goal is to emancipate - it uncovers and questions aspects of ideologies that restrict or limit different groups' access to the means of gaining knowledge (for example, class and caste). It is the theory of, by, and for the participants of the study - the participants themselves say what their reality is. Voices of groups like women, dalits, tribals, are what matter the most.

Reform is a part of the agenda of critical theory. It moves a step ahead of constructivism to ask what should be done to bring about a positive change in the lives of the oppressed groups.

'Objective knowledge' implies that there is only one kind of knowledge and a single way of understanding situations/issues. This view is not accepted in critical theory. For example, the recent discourse in the arena of health, where allopathy is gaining supremacy over other systems of medicine is whether allopathic is the single way of healing. Similarly, while studying the health delivery system it is not only the health system's view that would be considered. The perspectives of service users, non-users and providers would collectively reflect the status of the system. If one wants to focus on a sub-set like single lesbian women then a married heterosexual woman may not be able to gather the necessary information effectively. Therefore, lesbian women would themselves collect data and bring forth their own perspectives. In that sense they themselves become researchers.

## Standpoint Epistemology- A Type of Critical Theory

A standpoint is a socioeconomic position from which social reality can be understood and from which emancipatory action can be undertaken. It can be literally understood as the "view from where I stand". For example, Dalit/tribal/rural/urban women would have different views of the world.

Members of more powerful and less powerful groups will have inverted or opposed understandings of the world. Less powerful members of society have the potential for a more complete view of social reality, precisely because of their disadvantaged position. For example, the domestic help who comes to work in the middle class households is in many ways less privileged than her employer. It is the domestic help who knows more about the

employer's life, home, family, and daily schedule than the employer knows about her and her life. The dominant group has a partial view because it is in the interest of the group members to maintain, reinforce and legitimize their own dominance and particular understanding of the world. They do not want to understand the problems of the 'other' as they are comfortable in their privileged position.

## **Feminist Standpoint Epistemology**

Feminist standpoint theory takes the standpoint of women. The grounds of Feminist Standpoint Theory are as follows:

### **Centrality**

- Because women tend to the needs of everyone else in the household, they are in a better position than men to see how patriarchy fails to meet people's needs.
- Men, by virtue of their dominant position, have the privilege of ignoring how their actions undermine the interests of subordinates.

### **Cognitive Styles**

- Development of gender identities leads males and females to acquire distinctively masculine and feminine cognitive styles.
- Masculine cognitive style involves being emotionally detached, analytical, deductive, quantitative, oriented toward values of control or domination.
- Feminine cognitive style involves being concrete, practical, emotionally engaged, qualitative, relational, and oriented toward values of care.
- Feminine cognitive style is considered epistemically superior because an ethics of care is superior to an ethics of domination.
- They will produce representations of the world in relation to universal human interests, rather than in terms of the interests of dominant classes.

### **Oppression**

- Women are oppressed, and therefore have an interest in representing social phenomena in ways that reveal rather than mask this truth.
- They also have direct experience of their oppression, unlike men, whose privilege enables them to ignore how their actions affect women as a class.

## **Feminist Postmodernism**

Within feminist paradigms also there are multiple views. Feminist Postmodernism emerged from a critique of feminism is that it is elitist in its approach. It raises the questions that how can western upper-class white women document realities of women from all over the world. It talks of the privilege that some women get over other women on the basis of their class and race. Therefore one group of women cannot have the privilege to research the realities of the other groups of women. Universal claims about gender and patriarchy are to be avoided. No single perspective is privileged above others; there is plurality of perspectives.



### **Core Features of Feminist Research**

- Acknowledges pervasive influence of gender
- Women are not viewed as a homogenous group but as representing human diversity
- Involves new ways of viewing human values
- Aims to create social change through empowerment and transformation. The purpose and end goal of knowledge is to change or transform patriarchy
- Includes researcher as a person. Distancing between researcher and researched is not accepted by feminist scholars

Qualitative methods provide more space for women's experiences to be shared. Quantitative research might not be considered very appropriate to study women's issues for the following reasons:

- Suppresses voices of women and ignores or submerges them in a torrent of facts and statistics.
- Turns women into objects. Knowledge and experiences are extracted from them with nothing in return.
- Emphasises on controlling variables, with the concept of control itself being a masculine approach.
- Uses predetermined categories. Emphasis is on what is already known, thus silencing women's voices.
- Stresses upon valid knowledge. It takes a value-neutral approach, whereas the goal of feminist research is to conduct research specifically for women. Feminist research is definitely biased towards women, by standards of a positivist.

### **Participatory Research (PR)**

Underlying perspectives of PR are:

- Paulo Freire's work in Latin America which raised the issue that traditional education does not address inequalities. It is restricted to the elite. It is important that the marginalized and the powerless groups get such education that helps them understand how they are being oppressed so that they can liberate themselves of the oppression.
- Concept of 'critical consciousness': Empowerment to think and act on the conditions around oneself and relate these to the larger contexts of power in the society.

Participatory and Conventional Research - A Comparison		
Dimension	Participatory Research	Conventional Research
What is the research for?	Action	Understanding
Who is the research for?	Local people	Institutional, personal, professional interests
Whose knowledge counts?	Local people's	Scientist's
Topic choice influenced by?	Local priorities	Professional interests, funding priorities
Methodology chosen for?	Empowerment, mutual learning	Disciplinary conventions, objectivity
Who takes part in the research process?	Local people	Researcher
Action on findings?	Integral to the process	Separate; may not happen
Who takes action?	Local people	External agencies
Who owns results?	Shared	Researcher
What is emphasized?	Process	Outcomes

*(Adapted from Cornwall Jewkes, 1995)*

Issue of validity in PR is very different from the way it is looked at in quantitative research. Some researchers have used the term 'trustworthiness' instead of 'validity'. In PR the researcher also goes back to the community and confirms that what she has written is in accordance with the people's responses and opinion.



## Revisiting the initial exercise

The facilitator discusses the initial statements that the session started with. The participants' responses change significantly. The meaning and context of the statements are clearer to the participants after discussing the various research paradigms.

Sr. No.	Statement	Participants' response
1.	Scientific research is an objective enterprise	Not necessary
2.	Scientific research must be value-neutral	From feminist point of view, it should be biased. The statement can be reframed - Scientific research need not be/ may not be value neutral
3.	The researcher and researched must maintain a distance	Not necessary
4.	Scientific research aims at control and prediction	No
5.	Scientific research aims at universal laws	Not necessary
6.	Methods of natural sciences can be directly applied to the study of human behavior	Not necessary, it can be so
7.	Different social groups view the world differently	Yes-Critical theory, Standpoint epistemology
8.	The aim of scientific research with human beings is to understand and explain	Yes-this is in contrast with the statement that scientific research aims at control/prediction
9.	All research must attempt to change gender relations	If from feminist paradigm, then yes
10.	To do research, it is imperative to have been trained in scientific methodology	Disagree, not necessary as in Participatory Research sub-altern groups are not trained to do research

The exercise looks different when it is done the second time. The exercise is an example of the fact that when human beings mediate, they bring in aspects that are not intended to by the initiators.

It is reiterated that the aim of the exercise is to:

- make the participants aware of different paradigms
- give their limitations and strengths
- establish that all theories are based in some or the other paradigm

The resource person stresses that one must learn to articulate what is the research paradigm that one is using, and how one may be diverting from the original paradigm.



## Participants' sharing of their research studies

Discussion on various research paradigms will help participants identify the research paradigms being used by them in their respective studies. Hence some of the participants are asked to present their research studies and identify the paradigm on which their study is based.



## Readings

1. Guba, E. G. and Lincoln, Y.S. (1994). Competing Paradigms in Qualitative Research. In N.K. Denzin and Y.S. Lincoln (Eds.), Handbook of Qualitative Research. Thousand Oaks: Sage Publication, pp. 105-117.
2. Nielsen, J.M. (Ed.). (1990). Feminist Research Methods. Exemplary Readings in Social Science (Introduction). San Francisco: West View Press, pp. 1-37.
3. Hall, R. (2013). Mixed Methods: In search of a paradigm.  
[https://www.researchgate.net/publication/259045135\\_Mixed\\_Methods\\_In\\_search\\_of\\_a\\_paradigm](https://www.researchgate.net/publication/259045135_Mixed_Methods_In_search_of_a_paradigm)
4. Willsher, K. and Goel, K. (2017). Feminist research paradigms.  
[https://www.researchgate.net/publication/319327025\\_FEMINIST\\_RESEARCH\\_PARADIGMS](https://www.researchgate.net/publication/319327025_FEMINIST_RESEARCH_PARADIGMS)

# Session 13

## Overview of Qualitative Research Methods

### Learning Objectives

The participants will be able to:

- Describe the basic principles of qualitative methods.
- Develop skills to use qualitative methods in a gendered way.



**Time** 90 minutes

**Methodology :**



Presentation and discussion

### ACTIVITIES



#### Presentation

##### (i) What is Qualitative Research (QR)?

QR a form of formative research with its own set of methods which seek to -

- Understand what people think and believe; their feelings and attitudes.
- Obtain insight regarding behaviors of the target groups, including home level practices, utilization of services.
- Provide the context in which people believe and act the way they do.

##### QR is useful because it is....

- Flexible - study design can be modified while in progress.
- Cost - effective, depending on the objective.
- Helps design further research; explore initial research questions.
- Valid – gives an insight into what people really believe and how they behave; data is often closer to the 'reality' compared to quick structured surveys.

## **(ii) Emergence of QR**

- Recent years witnessed strong pressure against the use of 'quantification' in research and the need to reconsider the utility of qualitative methods and question the superiority of quantitative methods especially when dealing with people and their lives.
- Need for qualitative research was felt due to disillusionment with quantitative research in its typical form on several accounts.
- In quantitative method, the 'Etic' i.e. outsider's perspective is dominant. In qualitative method the 'emic' i.e. insider's perspective is dominant.

## **(iii) Towards successful QR**

- Understand properly the objectives of the research.
- Have some level of technical understanding of the subject.
- Learn the art of asking "why"; to probe effectively.
- Learn the art of Listening; it is not easy.
- Minimize subjective bias .
- Do not use QR like QN research.
- Do not judge the 'quality of QR' against 'norms set for QN research'.
- Understand and maximize the validity and reliability of the tools used, as relevant. QR is more for validity; less for reliability.
- While being careful of the process, do not be excessively worried about the techniques of the tools; modify as needed provided it meets the objectives.

## **(iv) Towards gender sensitive QR**

- Methods are determined by the research questions- weave gender issues and concerns into the types of information generated from the methods as well as how the method is applied.
- Consider: to whom are the questions being asked (participants: men, family members, elderly females); when is data collection taking place (suitability to the women); who is asking the questions (men or women or both; young girls, or married women); who is influencing the responses.
- Let the 'data speak' –objectively and honestly understand what the people are conveying; not superimposing your own values/concerns on people's voices.
- QR data collection; probing and searching questions -can become, not just gender insensitive; but 'human insensitive' –hence collect the data with sensitivity; let us not forget that we are invading on people's time.
- We need to reflect: how ethical is it to go on and on collecting data without using it to better people's lives? Could we at least empower them with the knowledge?

## (v) QR methods: case studies

- A powerful type of QR, giving rich insights into people's feelings; perceptions; behaviors.
- Especially useful for gender focused research; as women or adolescent girls and the menfolk give information in the context of their lives; environment; social norms.
- Can serve as an advocacy tool.



### Readings

1. Attig, B.Y., Attig, G.A. Boonchalaksi, W., Richter, K. and Soonthornhdada, A. (2001). Qualitative Methods for Population and Health Research. Salaya, Thailand: Institute for Population and Social Research, Mahidol University at Salaya.
2. Pope, C., van Royen P., and Baker, R. (2002). Qualitative methods in research on healthcare quality. Qual Saf Health Care. 2002;11(2):148-152.
3. Kitzinger, J. (1995). Qualitative Research: Introducing Focus Groups. BMJ 1995; 311:299 .
4. Kanani, S., Maniar, S., and Venkatachalam, Y. (2007). Interactive Workshop on Qualitative Research: From Data Collection to Data Presentation. esocialsciences.com, Working Papers.
5. Dongre, A., Deshmukh, P., Ganapathy, K. and Upadhyaya, S. (2010). Application of Qualitative Methods in Health Research: An Overview. Online Journal of Health & Allied Sciences.  
[https://www.researchgate.net/publication/46142218\\_Application\\_of\\_Qualitative\\_Methods\\_in\\_Health\\_Research\\_An\\_Overview](https://www.researchgate.net/publication/46142218_Application_of_Qualitative_Methods_in_Health_Research_An_Overview)
6. Isaacs, A. (2014). An overview of qualitative research methodology for public health researchers. International Journal of Medicine and Public Health.4.10.4103/2230-8598.144055.  
[https://ijmedph.org/sites/default/files/IntJMedPublicHealth\\_2014\\_4\\_4\\_318\\_144055.pdf](https://ijmedph.org/sites/default/files/IntJMedPublicHealth_2014_4_4_318_144055.pdf)

# Session 14

## Secondary Data: A Useful Source in Research

### Learning Objectives

#### Participants will:

- Be introduced to sources of secondary data.
- Develop skills of interpreting large quantitative data sets from a gender perspective.
- Understand and differentiate between objective and subjective interpretation.
- Learn how to look at the data critically.



**Time** 90 minutes

**Methodology :**



Exercises



Presentation



Small group exercise

### ACTIVITIES



#### Exercise 1

This exercise is designed to help participants understand and differentiate between objective and subjective indicators/ information. They are asked to look at any individual in the room. For example, the course coordinator and asked to describe this person in one sentence. Each sentence is then analysed to see how 'objective' and verifiable it is. It is pointed out that while it is true that a lot of situations are relative, at the same time there are situations which can also be verified using the data that has been already collected. No matter who is analyzing that data, they would be able to verify the information.



#### Presentation

##### (i) What is secondary data?

- The process of gathering specific information to answer research questions is termed Data Collection. Data Collection can be primary or secondary.
- Primary data is that which is collected by the researcher to address the current research.



- Secondary data refers to data gathered by others or data from other studies. Secondary data is generally less costly and less time consuming than gathering primary data. To be able to use secondary data effectively, one needs to know its sources and the limitations of that data.
- A researcher should explore the existing data before initiating the research to understand the current knowledge/information base of the research question. So that s/he can build on the existing knowledge.
- Some important secondary data sources are official records, publications, documents, historical archives, service statistics maintained by PHCs and hospitals, etc.

### **(ii) In the context of population and health research**

- Secondary data provides an understanding of the dynamics of population over time, particularly the changes that occur in the age-sex structure, pattern of fertility and mortality, life expectancy, morbidity condition, vulnerability of specific sub-groups (children, women, tribal) which is critical for impact assessment of existing policies and programmes and vital for future developmental planning. For example, the census data can be used to know that which sex/sub-groups over a period of time, have become more vulnerable.
- Data required for the study of population and health research are obtained through three sources-Population censuses; Registration of vital events; Sample surveys.

### **(iii) Salient features of a population census**

- Individual enumeration-Each and every person in the country is enumerated.
- Universality within a defined territory.
- Simultaneity.
- Defined periodicity – It is better to conduct census over a fixed period of time repeatedly to allow for comparison. The U.N. also recommends that census be done at regular intervals so that comparable information is made available in a fixed sequence. Having started in 1881 the Indian census is decadal in nature, i.e. once in every 10 years. However, in some countries census is conducted at an interval of five years.

### **(iv) Registration of vital events (births, deaths, marriages, divorces)**

- The vital registration system, also known as civil registration, is an important tool for studying the dynamics of population.
- The complete registration and compilation of all vital events as they occur is of paramount importance otherwise information may be missed out.
- The vital registration system is almost perfect in developed countries such as the U.S., Canada, U.K., France, Sweden, Japan, Australia etc. While in developing countries like India, Pakistan, Bangladesh, Indonesia it is far from perfect. In the latter countries a sizable number of births, deaths, marriages go unreported and hence the records remain incomplete and imperfect. This happens because of low awareness, lack of information about where to register and also because of people's reluctance to register.
- In India, the administrative machinery for the registration of vital events has been in existence for over a century.

- The analysis of the data on vital registration is done by the Office of the Registrar General, India, which publishes the data in 'Vital Statistics in India'.
- Problem of Civil Registration is that though failure to register births and deaths is punishable by law, yet coverage of vital events is far from satisfactory. There is very high rate of non-reporting of vital events particularly in the rural areas.

### **(v) Sample surveys**

- The sample survey is another useful source of secondary data, being a large-scale survey for population studies.
- Sample survey gathers information only from a sample of the population, which is representative of the whole population/community. Conclusions are drawn using statistical methods for the whole population. Thus unlike census, it does not enumerate everyone but sample drawn is such that the data collected can be used for the entire community being surveyed.
- The sample surveys for generating population data include single & multiple round retrospective surveys.
- The 'Sample Registration System' (SRS), the 'National Sample Survey' (NSS) and 'Model Registration: A Survey of Causes of Deaths', are the three major surveys in India which provide data on population on a continuous basis.

### **(vi) The National Family Health Survey (NFHS)**

- NFHS is the largest ever population and health survey in the country.
- NFHS was first conducted in 1992-93 and that survey is popularly known as NFHS-1.
- NFHS-2 was conducted in 1998-99 to further strengthen the demographic and health database.
- NFHS-1 and NFHS-2 obtained data through two types of survey instruments, viz., household questionnaire (to be administered to the head of the household or any other responsible member) and women's questionnaire (to be specifically administered to the currently married women). A village schedule is also used to obtain information on village level facilities like sanitation, water, education, transport and communication, health, etc.
- NFHS-1 and 2 provide state and national level estimates of fertility, mortality, infant and child mortality, family planning and health service utilization and anthropometrics measurement (height and weight-malnutrition levels) of children less than age 5 years.
- NFHS-2 additionally provides information on women's reproductive health problems, domestic violence, women's autonomy, knowledge of HIV/AIDS, height and weight of women and children, prevalence of anemia among women and children through hemoglobin estimation, use of iodized salt at household level.
- In 2005-06 NFHS-3 was carried out in the country. In NFHS-3 interviews were taken with men also to obtain sexual and reproductive health information of men and women. NFHS-3 also tested more than 100,000 women and men for HIV.
- The fourth in the NFHS series, was carried out in 2015-16 (NFHS-4). It provides information on population, health and nutrition for India and each State / Union territory. NFHS-4, for the first time, provides district-level estimates (640 districts) for many important indicators. The figures of NFHS-4 and that of earlier rounds may not be strictly comparable due to differences in sample size. It will be a benchmark for future surveys. In NFHS-4, women aged 15-49 years and men aged 15-54 years are also interviewed.

## **(vii) District Level Household Survey (DLHS) under the Reproductive and Child Health Programme**

- The Reproductive and Child Health (RCH) 1 Programme was launched throughout the country on 15th October, 1997. The second phase, RCH – II was launched on 1st April, 2005. The main objective of the program was to bring about a change in mainly three critical health indicators i.e. reducing total fertility rate, infant mortality rate and maternal mortality rate. Next, RMCH+A approach was launched in 2013 to address the major causes of mortality among women and children and the delays in accessing and utilizing health care and services.
- The DLHS under the RCH programme uses the Rapid Household Surveys (RHS) conducted at a nationwide level to gain district-level data about service coverage of mother, child, and reproductive health initiatives. It is designed to provide information from the grassroots on family planning, maternal and child health, and reproductive health of married women and adolescent girls. Its most salient feature is gathering data on utilization and the perceived quality of maternal and child healthcare services.
- The first round of the DLHS in India was conducted during the year 1998-99 in two phases (each phase covered half of the districts from all the states/union territories). The second round was conducted in 2002-04. The survey interviewed both men and women in the age group of 15 to 49 years. In the third round, in DLHS-3 (2007-8), unlike the other two rounds DLHS-3 also interviewed ever-married women (age 15-49) and never married women (age 15-24). The focus of DLHS-3 is to provide health care and utilization indicators at the district level for the enhancement of the activities under National Rural Health Mission (NRHM).
- The fourth round (2012-14) was done in coordination with the Annual Health Survey (AHS), with the former not conducted in nine states covered by the latter. The AHS has been conducted in the less developed states of India (Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand).
- The main focus of the DLHS is on the following aspects:- Coverage of ANC and immunization services, proportion of safe deliveries, contraceptive prevalence rates, unmet need for family planning, awareness about RTI/ STI and HIV/AIDS, utilization of government health services and the user's satisfaction. In addition, DLHS-3 also provides information on newborn care, post-natal care within 48 hours, role of ASHA in enhancing the reproductive and child health care and coverage of Janani Suraksha Yojana (JSY). An important component of DLHS-3 is the integration of Facility Survey of health institution (Sub centre, Primary Health Centre, Community Health Centre and District Hospital) accessible to the sampled villages.

## **(viii) Example of some graphs and tables and how these can be read and interpreted**

1. Population pyramid of India, Census 2001 shows reduction of fertility as the bar indicating the population in 0-4 years age group is shrinking, Elderly population is increasing as shown by the bar representing the 80+ age group.
2. Broad age structure, median age, and young and old dependency ratio by sex and residence, India 2001 young population in the country is more. Data shows that the working age population has to support both the young and the elderly; 100 working age people are supporting 75 dependent people. This implies that if there is high unemployment in the working age population then their ability to support the dependent population will be less. In that case government's provision to support these groups would have to be more.

3. Neonatal, post neonatal, infant mortality and under-5 mortality by sex and residence, India, 1998-99. Post-neonatal mortality and under-5 mortality are higher in girls in the rural areas.
4. Percent of women married by exact age 18 years or before by current age and residence, India, 1998-99. Girls married before the age of 18 years are lesser in younger age group as compared to the higher age cohorts in 30s and 40s. Thus it may be concluded that the age at marriage of girls has been increasing.
5. Nutritional status of women, India 1998-99 Anaemia is less among pregnant women than those who are breast feeding. It could be so because iron prophylaxis is given during pregnancy and not given when breastfeeding.

Examination of demographic data from a gender perspective is critical to understand the impact of socio-cultural, economic and behavioral factors on women's health and well-being across the life cycle. Such an understanding would enable the formulation of policies and programmes which are sensitive to the needs of both women and men.



## Exercise 2

The participants are given tables with data from NFHS comparing women's status and maternal/reproductive health indicators in the urban and rural areas of the two States X and Y. The participants are divided into four smaller groups. Two groups-1 and 3 are asked to study state X and two groups-2 and 4 are asked to study state Y. The groups have to report on the following sections:

- Women's status- what can you say about how low or high it is in the State?
- Maternal and reproductive health status: what would you identify as major issues?
- Any readily observable linkages between women's status and maternal/ reproductive health status?

In each section, comment on the overall picture and also on the rural/ urban differences.



## Key Points

- Secondary data is the data that has been already collected and documented by someone else, for example, census, human development report, report on status of women, world fertility survey.
- To be able to use secondary data effectively, one needs to know its sources and the limitations of that data.
- A researcher should explore the existing data before initiating the research to understand the current knowledge/information base of the research question so that s/he can build on the existing knowledge. When doing primary research, secondary data could be helpful as it would not be necessary to collect information that is already available. Secondary data would help in identifying gaps in research and compare with the data that is being collected.
- Some important secondary data sources are official records, publications, documents, historical archives, service statistics maintained by PHCs and hospitals, etc.
- Secondary data provides an understanding of the dynamics of population over time, particularly the changes that occur in the age-sex structure, pattern of fertility and mortality, life expectancy, morbidity condition, vulnerability of specific sub-groups (children, women, tribal) which is critical for impact assessment of existing policies and programmes and vital for future developmental planning.

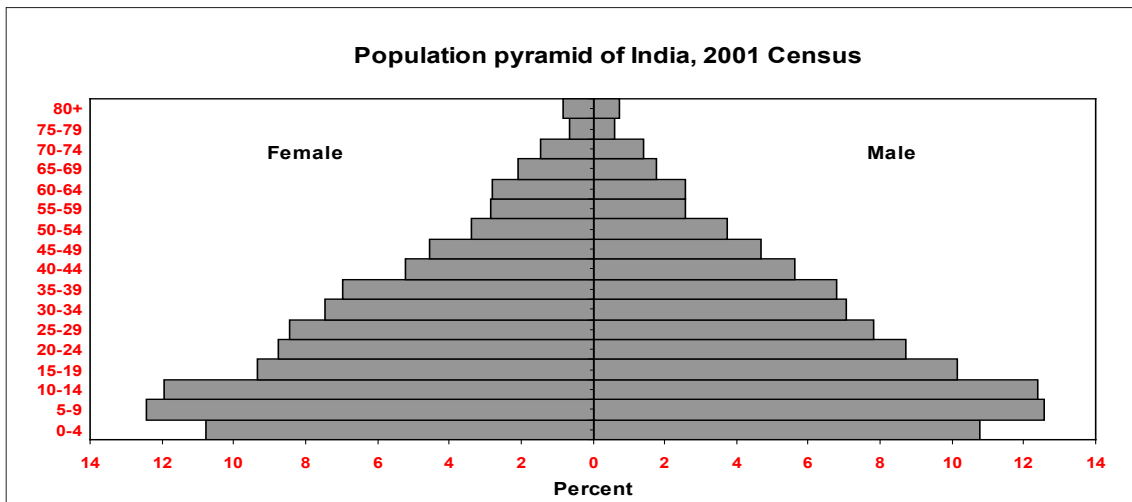


## Small Group Exercise

Examination of some health and demographic data using one or more of above sources

- Population Pyramid of India.
- Age Structure & Dependency Ratio.
- Vital Rates.
- Pattern of Infant Mortality.
- Sex Ratio.
- Expectation of Life at Birth.
- Marriage Pattern.
- Indicators of Women's Status.
- Nutritional Status of Women.
- Violence on Women.

## Some examples from Census 2001



### Broad age structure, median age, and young and old dependency ratio by sex and residence, India, 2001

Population parameter	Combined			Rural			Urban		Total
	Male	Female	Total	Male	Female	Total	Male	Female	
Age structure									
0-14	35.7	35.2	35.4	37.7	36.8	37.3	30.6	30.9	30.7
15-59	57.2	57.0	57.1	54.8	55.1	55.0	63.1	61.9	62.5
60+	7.1	7.8	7.5	7.5	8.1	7.8	6.3	7.2	6.7
Median age	21.9	22.6	22.2	20.9	22.0	21.5	23.8	24.0	23.9
Young dependency ratio (y)	62.5	61.7	62.1	68.8	66.7	67.8	48.5	49.9	49.1
Old dependency ratio (o)	12.4	13.8	13.1	13.6	14.6	14.1	9.9	11.7	10.7
Total dependency ratio (y+o)	74.9	75.5	75.2	82.4	81.3	81.9	58.4	61.5	59.9



## Readings

1. Bhende, A.A. and Kanitkar, T. (1992). Principles of Population Studies (5th revised edition). Bombay: Himalaya Publishing House, pp. 24-29.
2. WOHRAC. (2001). Integrating Qualitative and Quantitative Methods in Social Sciences. Vadodara: WOHRAC, WSRC, Home Science Faculty, The M.S. University of Baroda.
3. Bhasin, H. (2020). Sources of Secondary Data and its Advantages and Disadvantages.  
<https://www.marketing91.com/sources-of-secondary-data/>
4. Ajayi, V. (2017). Primary Sources of Data and Secondary Sources of Data. 10.13140/RG.2.2.24292.68481.  
[https://www.researchgate.net/publication/320010397\\_Primary\\_Sources\\_of\\_Data\\_and\\_Secondary\\_Sources\\_of\\_Data](https://www.researchgate.net/publication/320010397_Primary_Sources_of_Data_and_Secondary_Sources_of_Data)

# Session 15

## Gendered Research

### Learning Objectives

#### Participants will be able to:

- Understand the gender analysis framework/tool.
- Use the gender analysis tool to critique research on a variety of health issues.
- use the gender analysis tool or framework to identify gaps and generate research questions.



**Time** 120 minutes

**Methodology :**



Presentation



Group exercise and discussion

### ACTIVITIES



#### Presentation

#### Gender analysis not same as sex-disaggregated analysis

- Sex disaggregated information tells whether there is any difference by sex.
- Gender analysis says that whether and how socially constructed differences in women's and men's living conditions, roles, status, behaviour and perceptions affect a specific health dimension. It analyses whether the phenomenon being studied is affected by power relations between men and women or other differences between them. Gender analysis tells whether a condition is due to a biological cause or social difference between women and men.
- Gendered research does not mean only or necessarily collecting data for both men and women, though it might be the first step in certain researches.

#### Why do Gender analysis in applied health research?

- Gender differences in morbidity and mortality represent 'avoidable' and/or 'unfair' inequalities in health, unlike inequalities in health that are biological in origin. If an adverse health condition arises because of social causes it is definitely avoidable.
- Because gender is socially constructed, gender-based inequities in health are amenable to policy and programme interventions. Because society has constructed gender relations therefore society can very well change them.

## Gender analysis in applied research

- Gender analysis needs to be carried out even when there are no sex differences in a specific health dimension.
- Gender analysis is not restricted only to health conditions affecting both sexes, but also to sex-specific health conditions i.e. when studying conditions that effect only men or only women. For example, women dying during pregnancy because she was not taken to the hospital on time. So, though it is a condition that only affects women, the problem is that they are not given proper care by others in the family.
- Gender analysis in research makes a difference to its 'what', 'how' (process of research, is data collection done), 'who' (who does the research) and 'where' and 'when' is the research done.

## Gender analysis in applied health research

Is the health dimension under study likely to be different for women and men because of gender differences in:

- division of labour and activities, physical spaces occupied?
- valuation of males and females in a given society, self esteem and behaviour patterns?
- norms about male and female behaviour (especially socially sanctioned codes of sexual and reproductive behaviour)?
- access to and control over resources?
- decision-making power?

## Engendering research would also examine issues like

- Workload of women.
- Experience of domestic violence.
- Inadequate intake of nutritious food.
- Whether the pregnancy was wanted or planned.
- Sex composition of previous children.

## How can Gender analysis in applied health research be done?

- Literature review to include information from key people in the community or population under study - Gender may influence certain health dimensions in context specific ways. Therefore, going only by published material may not help; the researcher may have to do some formative research, some interviews or observation. For example, in a study on nutritional status the actual situation may be that girls are not going to school where nutrition is being given. So, boys have better nutrition than girls. Thus, variables chosen initially for research would have to be modified on the basis of this finding from the formative research.
- The variables chosen may have to be modified for example, Change from just male/female to urban/rural male /female as per need.
- Sample size will need to be large enough to permit analysis of gender differences in sub-categories.



- Integrate qualitative methods at different stages of the study.
- Gender is likely to influence informed consent procedures. Also, participation in the study may affect women and men differently. Women may be more affected than men by participating in the research. For example, in a study assessing people's perceptions/ knowledge about STIs, women participating in the research may be perceived to be having STIs and may therefore be discriminated / mistreated. Therefore, the researcher has to think whether s/he is doing well to the respondents or harm.

### **Gender analysis in applied health research- Who?**

- Both sexes need to be represented in the study sample unless the topic is sex-specific.
- Gender considerations may influence recruitment and drop out rates among men and women differently. In the initial sample itself it is important to think about drop-outs. In some studies, more men may drop-out, for example, if the time of data collection is such that midway men migrate for work purposes.
- Gender (among other variables) will influence the reliability of proxy reporting. For example, asking the male head of the household whether the woman had any reproductive health problem may not be useful as he may not know about it; similarly, for information about children's health. So, who does one talk to and for what kind of information, is crucial? Therefore, it would be advisable to have people of both sexes in the research team.
- Both sexes need to be represented, not only among field investigators, but also among other researchers.

### **Gender analysis in applied health research- When and Where?**

- The timing of data collection will have to take gender roles into consideration. When are men more likely to be available? When will they be able to speak at leisure? Similarly, for women.
- The place most appropriate for data collection may be different for women and men, for example, in terms of safety, convenience, comfort levels.

### **The costs of not doing Gender analysis in health research are**

- Failure to assess health risks for different sub groups, resulting in avoidable mortality, morbidity and disability.
- Possible delays in diagnosis or inappropriate treatment for certain disorders. It may be mistake to assume that men and women would have acquired the infection in the same way. For example, Men would have got the STI by extra-marital sex while women might have got it from their husbands. Accordingly, interventions would have to be planned.
- The implementation of health programmes and services which do not address the major factors associated with a health problem, or meet population health needs, resulting in wasted expenditures.

## Gender analysis frameworks

- Examine first the differences in biological vulnerabilities, susceptibilities, prevalence, outcomes.
- Examine the various gender factors: social beliefs, gender norms, roles, access to resources, bargaining power in the causality, treatment seeking, consequences of the health issue being studied. Examine how the biological and the social and gender factors interact.
- How are the health systems reinforcing/ perpetuating the gender inequities in health?
- What about macro factors – like the market, national and global policies. (Refer here to the multi level framework discussed in the session on Social Determinants of Health)



## Group Exercise and Discussion

The participants are divided into three groups. Each group is given a research study to examine the application of gender analysis to research in reproductive health. Each group has to find out how gender issues have been addressed in:

- Framing the research questions
- Constructing the study tools
- Methodology
- Analysis and discussion of results

The groups are also asked to mention if they will explore any additional research questions in studying the same issue. The group members are asked to prepare a brief group report for presentation the next morning.

## After the presentations and discussion, the facilitator concludes with the following points

- Creative adaptation of the gender analysis framework by the researcher show that certain standard tools and frameworks are just beginning points and can be modified to suit the specific purpose of one's study.
- Including gender at each step of the research study is a difficult task.
- If it is included in the research questions then it will reflect at all other stages as well.
- Inclusion of gender perspective has to be done consciously done at each step, especially in the tools. If the tools did not have the gender dimension then gender will get lost from the entire study. Then the data collection using a gender sensitive tool has to analyze so as to pull out its gender dimension.

# Session 16

## Gendered Indicators

### Learning Objectives

#### Participants will be able to:

- Understand what indicators are.
- Describe why indicators are needed.
- Identify and develop gendered health indicators.



**Time** 90 minutes

**Methodology :**



Quiz



Presentation



Small group exercise

### ACTIVITIES



#### Quiz

Participants are divided into two groups. Chits with indicators written on them are kept in a bowl. Each group has to pick up a chit alternatively and give a precise definition of that indicator.

- Infant Mortality Rate
- Fertility Rate in age group 15 – 19 years
- Maternal Mortality Ratio
- Literacy Rate
- Net Primary Enrollment Rate
- Contraceptive Prevalence Rate
- Doctor-Population Ratio
- Percentage of Births attended by Skilled Attendants

Each indicator is discussed in detail. The importance of the clarity and consistency in the denominators is very important. It is also important to know how the indicators have defined in a study. The researcher may use one particular definition while the reader may understand it differently.



## Presentation on 'Engendering Indicators'

### What is an indicator

- An indicator is a pointer. It can be a measurement, a number, a fact, an opinion or a perception that points at a specific situation or condition, and measures changes in that condition or situation over time. Indicators provide a close look at the results of initiatives and actions (CIDA, 1997). There are input, process and output indicators. These types of indicators are contextual and may change from study to study. What may be input indicators in one study may become process indicators in the other and like wise.

### Sex disaggregated vs gender sensitive indicators

- The two are often used interchangeably, but are in fact not the same.
- Sex disaggregated information tells us whether there is a difference by sex in a specific dimension of health. Gender sensitive indicators are meant to help us understand whether the problem or the sex differential is influenced by gender inequality. One can have gendered indicators even where separate data is not being collected for males and females.

### Indicators for assessing gender equity in health programmes

- 'Gender sensitive' indicators are needed in routine data collection in health, to:
  - identify the existence of a problem i.e., are there differences in male and female health that cannot be random?
  - gain some insight into whether gender role socialisation or discrimination underlies the cause of the problem.
- The above can help develop interventions to address the problem.
- The same indicators can then be used to assess whether the intervention has brought about the desired impact.

### How can indicators be 'gendered'

- New indicators on those dimensions of health where gender differentials occur (or are likely to occur) most often need to be brought into use. Example:
  - Indicators on social and economic consequences of STIs or infertility for women as compared to men
  - to ask not only whether medical help was sought but also what kind of medical help was sought because many studies show that women tend to use providers closer to home or who are less expensive, and this is because of gender factors
- Additional variables across which data on the indicator would be disaggregated, need to be included. Choice of variable based on analysis of gender factors likely to impact on the health dimension. Example: MMR analysed by place of death (home or health facility?); cause of death analysed by type of attendance at delivery.

- Analysis or re-analysis of existing data-sets across 'gender' factors. Example:
  - Demographic and health surveys provide information on non-use of antenatal care or non-use of contraception, and also on reasons for non-use. Some of the reasons asked are: husband does not permit, women do not think it is necessary, she cannot afford; the two can be cross-tabulated to see what proportion are not using for what reason for example, Unmet need not only because of unavailability but because of gender factors.
  - There is also data on whether the last pregnancy was 'intended' and separately, on experience of domestic violence. Cross-tabulating the two would expose if the two are related.
- Developing new indicators to be used concurrently with others already in use, based on the same sources of information. Examples:
  - Indicator: Proportion of pregnant women who are seropositive for syphilis  
Modified indicator: Of pregnant women who are syphilis seropositive, proportion who report that their partners have symptoms
  - Indicator: Proportion of women below 19 years who have had a child or been pregnant. Usually only woman's age is taken. If father's age is taken then one may be able to get gendered reasons behind teenage pregnancy, very early pregnancy, perhaps incest therefore, the following modified indicator can be used  
Modified indicator: Proportion of the above who report the age of the child's father to be 30 years or more

### Indicators for assessing gender-sensitivity of health facilities

- Do service timings take into account gender differences in relation to work schedules? For example, immunisation on Monday, ANC clinic on Wednesday-it may be difficult for women to come on separate days for routine services.
- Are services organised and delivered in such a way that they recognise how gender norms affect women's ability to seek health care and complete treatment?
- Are services priced in such a way that they consider gender differences in ability to pay the costs (transport, official and unofficial fees)? Are prescriptions made with this awareness?
- Do service practices take into account the consequences of women's lack of power for their health problems and their ability to comply with advice and treatment? For example, is the woman told things like 'do not get pregnant again', 'why are you coming again and again with pregnancy, you are supposed to use contraceptive'. Is the health facility taking into consideration gender relations effecting reproductive health?

### Developing and using appropriate indicators is a means, not the end

- Indicators are only a tool to assess whether there is a problem, and whether one is moving in the right direction towards addressing these problems.
- Unless acted upon, they remain useless. Collecting data is not enough, problem would not be solved unless action is taken on the data/indicators collected.



## Small group exercise on 'Developing gendered indicators'

The participants are divided into four groups. Each group is given a project on a Reproductive Health issue. The groups are asked to modify the given indicators so that the new set of indicators addressed gender/rights dimension of the problem.

### Group 1- Adolescent (and young people) reproductive health project

A new project for the improvement of the reproductive health of adolescents is being initiated in your district. The project is planned for a three-year period. The objectives are:

- To promote condom use.
- To prevent unsafe abortion.
- To promote postponement of childbearing.

The following are some indicators routinely used for monitoring this project:

- Proportion of (sexually active) adolescent boys reporting condom use (this may be further refined, for example to specify regularity of condom use, access to condoms, or whether a condom was used in their most recent sexual encounter).
- 15-19 years old as a proportion of all abortion related obstetric and gynaecology admissions.
- proportion of women in the 15-19 age group who have had one or more children or are currently pregnant.

### Group 2- Safe motherhood project

Concern has been raised about the number of maternal deaths reported in your area. A safe motherhood project aimed at reducing maternal deaths over the next three years is to be implemented very soon. The specific objectives are:

- To prevent delay between the development of a serious complication in pregnancy and reaching a health facility providing emergency obstetric care.
- To prevent delay within health facilities in initiating appropriate treatment.

The following are some indicators routinely used for monitoring this project:

- Proportion of women who died at home or on their way to the hospital.
- Percentage distribution of maternal deaths in hospital, by time between admission and death.
- Proportion of women reporting a delivery complication who delivered in a health facility.

### Group 3-Improving the quality of family planning services

In your province, more than 80% of contraceptive users have adopted female sterilization. Your brief is to improve the quality of family planning services offered in the five primary health centers under your supervision over the next three years. You design a project which aims to:

- Widen contraceptive choice for women and men.
- Improve follow-up services.
- Improve client satisfaction.

The following are some indicators routinely used for monitoring this project:

- Percentage distribution of all contraceptive users, by method used.
- Proportion of contraceptive users reporting at least one follow-up contact with the health facility or health worker.
- Proportion of satisfied users at the end of x months following acceptance.

#### **Group 4- Prevention and control of RTIs/STDs**

A new RTI/STD prevention and control project is being implanted in your health facility. The objectives of the project are to:

- Improve awareness of the signs and symptoms of RTIs/STDs.
- Promote treatment seeking among those with symptoms of RTIs/STDs.
- Encourage partner notification and treatment.

The following are some indicators routinely used for monitoring this project:

- Proportion of clinic users who are aware of the symptoms of one or more RTIs/STDs.
- Number (and/or proportion) of clients seeking treatment for RTIs/STDs.
- Proportion of clients (by sex) whose partners have also sought treatment.

#### **Possible responses of Gendered Indicators**

##### **Group 1 Young People's Reproductive Health Project**

###### **New indicators for safe abortion**

- Proportion of girls who know about facilities that provide safe abortion.
- Proportion of girls who get safe abortion services.
- Proportion of partners accompanying women for abortion.
- Of the abortion related admissions in OBGY department how many are second trimester abortions in adolescents/young people. This would be due to some gendered reason. Look at the gender dimension of postponement.

###### **New indicators to measure success in postponing pregnancy**

- Proportion of adolescents who can communicate with their families about postponing pregnancy.
- Number of women who report discussing condom usage with their male partners in last one month divided by total number of women, could help assess whether negotiation between partners has changed.
- Proportion of girls who say that their partners used condom.

## Group 2 Safe Motherhood Project

There is need to capture whether the woman had the decision- making power or not. Therefore, to see whether any gender related cause was responsible for delay the indicator could be the

- Percentage of women who were referred to the health center but did not go. But reason for not going may be poverty. So, another dimension would have to be added to get a gender sensitive indicator like socio-economic indicator.
- Proportion of husbands/decision makers aware of complications.
- Proportion of husbands/ decision makers accompanying the wife to the health centre (this is important because if the decision makers do not accompany then treatment may not start even after reaching the hospital due to lack of money or consent to do an operation, blood transfusion, etc.).
- Proportion aware of where to go in case of complication.
- Whether the attending doctor is a male or female.

## Group 3-Improving the Quality of Family Planning Services

- Percentage distribution of all contraceptive users, by method used for both men and women separately.
- Awareness of various contraceptives available for both men and women.
- Number of contraceptive users divided by the number of people who would prefer to use a certain method as their first choice but could not use it for some reason. For example, the husband did not want to use condom, so the woman was compelled to take pills.
- Availability and accessibility- 'number not using contraception because of cost divided by number not using contraception' would tell whether cost was a deciding factor.

## Group 4- Prevention and Control of RTIs/STDs

### Additional indicators

- Number of people suffering from RTI/STD and those aware of the same.
- Number of clinic users divided by total population suffering from RTIs/STDs (A prevalence study would have to be done to calculate the indicator).
- For the third objective also, an indicator can be added-Attitude of uninfected partner towards infected partner. This would need to be broken down further to measure attitude as attitude is a 'subjective' indicator.

Segregating data for the two sexes in each of the above indicators would give gendered indicators.

Often RTIs in women are asymptomatic. Therefore, awareness among men and women about asymptomatic RTIs in women would be useful. If men are not aware that wives may be infected without symptoms then it may be difficult for women to seek treatment.





## Key Points

1. An indicator is a pointer. It can be a measurement, a number, a fact, an opinion or a perception that points at a specific situation or condition, and measures changes in that condition or situation over time. An indicator is a numerical value representing broad social reality somewhere else. Any kind of marker in a situation is an indicator. Indicators are useful for comparisons, for understanding change; they are the references for reality.
2. The role of an indicator is to make complex systems understandable or perceptible. An effective indicator or set of indicators helps a community determine where it is, where it is going, and how far it is from chosen goals. Indicators of sustainability examine a community's long-term viability based on the degree to which it's economic, environmental, and social systems are efficient and integrated.
3. Usually indicators are expressed in numbers. For example, number of participants in a program, the proportion of which are male or female, or from different age groups or ethnic groups, or geographical areas, % of clients satisfied with the information provided or % of people who have stopped smoking.
4. It would be better to have as few indicators as possible, both for data collection and analysis. Though one may begin with a lot of indicators, it was always better to narrow down to a few indicators to make it easier and manageable.
5. The indicators could first be calculated when the project starts and then after one year so that the progress of project could be evaluated.

# Session 17

## Gendered Study Designs

### Learning Objectives

#### Participants will be able to:

- Know what are the various research designs.
- Develop skills to plan suitable research designs using either or both quantitative and qualitative methods.



**Time** 120 minutes

**Methodology :**



Presentation



Group exercises and discussion

### ACTIVITIES



#### Presentation

#### **Difference between action research, intervention, operations research, needs assessment.**

While doing 'Action Research', one makes an intervention. A baseline may be done, then intervention made, and then the change may be assessed. The whole process may be documented along with the outcomes. Such intervention researches are also called experimental intervention studies. An intervention research could be an action research, but an action research need not be an intervention research.

In 'Operations Research', the process is not documented in such detail. It involves: baseline, intervention and then end line.

**Needs assessment** is an open enquiry. Here the domain is not academic, rather it has practical orientation

#### **Quantitative Studies**

**Cross-sectional** studies are studies which compare characteristics among different age groups at one time.

**Longitudinal** studies involve observations of the same items over long periods of time, often many decades. Longitudinal studies are often used in psychology to study developmental trends across the life span.

**Cohort** studies are part of longitudinal studies, done with the same population over a period of time. These studies can have drop outs but cannot have new add-ons.

**Surveillance** is the monitoring of behavior, studying the behavior to track the pattern in a sample from the same population every year.

## Qualitative studies

Exploratory studies: In these studies, one does not begin with a theory. Instead, the data collected, after analysis, is used to develop a theory. One might then design a study to test the theory.

Descriptive studies: These studies describe phenomena systematically to reveal patterns and connections that might otherwise go unnoticed. Descriptive studies include normative, epidemiological, correlation, and non-intervention case studies.



## Group exercise

The participants are given a situation and asked to discuss the study design for it: *'In a large tertiary obstetric service, the health professionals suspect that the number of newborns of very low birth weight (LBW) is increasing. The service wants to know if this is true, and if so to have a better understanding of the social and economic situation of the women who are delivering low birth weight babies.'*

### Research questions

- What was the proportion of very LBW new born babies in March 2003?
- What is the proportion of very LBW newborn babies in March 2006?
- Is giving birth to very LBW babies associated with women's
  - a. education levels
  - b. caste
  - c. economic status

### Definitions of the terms

- Very LBW: Less than or equal to 1500 g.
- Indicators of socio-economic status: the indicators could be 'years of completed schooling', economic indicators to judge whether people are living in poverty and what is the extent of poverty. The most significant indicator of poverty would have to be used. For example, a fishing community would need things like boat and nets for their livelihood. If the respondent does not even own a net, then the family could be classified as being very poor.

### Evidence needed to answer the research questions

Number of live babies born and their weights would be needed to classify them as very LBW and not very LBW.

Preliminary analysis could tell whether the proportion of very low birth weight babies has increased. If the proportion is found not to have increased, then there is no need to move further. But if a seasonal variation is found then one has to consider the research question 'why is there high proportion of very LBW babies in those months'.

Secondly if a change in proportion is found but patients' socio-economic information is not available then primary data collection may have to be done. Primary data would need to be collected like 'nature of delivery- normal/caesarean', 'birth weight', and 2-3 indicators, like those mentioned above for SE status.

Further analysis could be done on 'What are the causes of very LBW babies?'

Proportionate weight gain by the mother or weight gain adequate during pregnancy-Yes / No

- Whether the woman has been given necessary ante-natal treatment for- anaemia, blood pressure etc.
- Presence of sexually transmitted infection, heart disease, tuberculosis.

Thus, a combination of demographic, social, economic, gender indicators would have to be developed.

### **Sample size**

Mothers of both very LBW babies and not very LBW babies would be part of the sample in order to compare.

### **Study design**

Some of the quantitative study designs related to the concerned study.

- **Descriptive study:** To begin with, data of all the deliveries occurring in the hospital is collected and compared. Suppose one finds that of the total 100 women who delivered, 80 women gave birth to normal birth weight babies and 20 to very LBW. Further it is found that of the 20 women, 18 are illiterate while of the 80 only 17 are illiterate. Thus, one observes a higher proportion of illiterate mothers in the group who delivered very LBW babies. It could therefore be concluded that there is some association between literacy levels of the mothers and birth weight of the newborn babies.
- **Case control study:** It starts after the event has occurred. For example, very LBW babies are already born and then their characteristics are studied. Very LBW babies are matched with normal babies. A third category could also be included, babies with birth weight ranging from 1500g to 2500g. Then one would compare the difference between the three groups of mothers. These women are called 'cases' and then 'controls' are chosen.
- **Cohort study:** It is usually prospective, that is, it would start now and go into the future. One group has the risk factor and one does not have the risk factor (tobacco chewing, poverty, smoking etc.). For instance, one group of women are tobacco chewers and the other group are non chewers. The outcome of the two groups of women are compared. There is an ethical issue in such a study. If the researcher knows that tobacco chewing would harm the child in the womb then should the researcher intervene during pregnancy period to reduce harm to the child? The intervention would influence the study result.
- **Intervention study:** Suppose the hospital has found out that socio economic status effects the birth weight of the new-born babies and wants to do an intervention. So, baseline is done and then an intervention is done in which women are registered on a feeding programme. Then an endline survey is done. Another way of doing it could be to do baseline surveys in this hospital and in another hospital, which would not have an intervention programme. After doing the intervention in one hospital, end line studies are done in both of them.
- There are problems with each of the two study designs. A better design would be one in which women in the same hospital are randomly included or not included in the feeding programme. For example, each woman is given a token-either red or green. Women with red token go to the feeding programme while women with green token do not go. But this too has ethical problem as both would have benefited from the feeding programme, so why deprive one group. Therefore, it is not ethical to do such a study.

- Cross sectional study: Such a study talks of situations at a point in time. For example, it would say that at present a certain group of children are well nourished and another group is malnourished. It would not tell that how did the children reach in either of the groups.
- Trends: Trends say how was the situation last year and how is it this year. It gives the pathway, and does not say what is the situation at this point of time.

One could do comparisons within qualitative framework also. One could get associations based on gender variables and then the reasons/ 'why' could be found through the qualitative study.

### Gender related variables

- Workload during pregnancy.
- Faced violence during pregnancy.
- Whether facing lack of partner's support/regard from husband.
- Food intake less because of being a woman.
- Lack of medical care due to her being a woman.
- Access to and control over resources.
- Whether the woman neglected herself during pregnancy because she did not want the pregnancy as she suspected the foetus to be female.



### Readings

1. Varkevisser C. M. et al. (1991). Designing and conducting health systems research projects. International Development Research Centre Canada. Health Systems Research Training Series, Vol. 2, Part 1, Ottawa, IDRC, pp.118-129.
2. Witkin, S. L. (2000). An Integrative Human Rights Approach to Social Research (Chapter 13). In C. Truman, C., D. Mertens, and B. Humphries (Eds.), Research and Inequality. USA and UK: UCL Press, pp. 205-219.
3. Day, S., Mason, R., Lagosky, S. et al. (2016) Integrating and evaluating sex and gender in health research. Health Res Policy Sys 14, 75.  
<https://doi.org/10.1186/s12961-016-0147-7>
4. Korsvik,TR., and Rustad, LM. (2018). What is the gender dimension in research: Case studies in interdisciplinary research.  
[http://kjonnsforskning.no/sites/default/files/what\\_is\\_the\\_gender\\_dimension\\_roggkorsvik\\_kilden\\_genderresearch.no\\_.pdf](http://kjonnsforskning.no/sites/default/files/what_is_the_gender_dimension_roggkorsvik_kilden_genderresearch.no_.pdf)

# Session 18

## Developing Gender Sensitive Data Collection Tools

### Learning Objectives

#### Participants will be able to:

- Develop study tools on the basis of the research questions.



**Time** 120 minutes

**Methodology :**



Exercise on questions



Group exercise and discussion

### ACTIVITIES



#### Exercise on Questions

The facilitator presents ten questions to the participants and asks them to improve upon the questions.

Sr. No.	Question	Participants' possible responses and discussion
1	Were you satisfied with the cleanliness and privacy in the health centre?	Talks of two aspects-cleanliness and privacy. If answer is 'yes', researcher will not know what the person has answered 'yes' to. So, it can be divided into two questions. Besides it has to be specified that cleanliness of what is being talked about. Similarly referring to visual or audio privacy- the person may be in a separate room (visual privacy) but others outside could listen, would it be privacy? Also, it is a leading question, 'were you satisfied...!', so it should be 'What is your opinion about...!'
2	What brand of computer do you own? a) IBM b) Apple	First it has to be asked that 'Do you own a computer?' There could be a third option in the response- 'any other, please specify'. This should be asked only if really needed as often this part is not analysed later.

Sr. No.	Question	Participants' possible responses and discussion
3	What cooking fuel do you use? a) Wood b) Kerosene c) Gas	Combinations are missing, there can be multiple answers. So, instruction could be 'Tick all that you are using'. There should be an option 'any other'. It can also be made a ranking question. Thus, depending on the study objectives, options may be given.
4	Mark the age group to which your child belongs: a) 0-1 year b) 1-2 years c) 2-5 years	Overlapping, if child is 1 year old, where would the person mark-in a or b? Option of 'above 5 years' is missing. For which child is the question being asked, if respondent has more than one child. 'Zero' is not understood by many, so first option could be 'less than 1 year'.
5	Are you against sexual abuse? (circle Yes or No)	Sexual abuse has not been defined; It is a leading question.
6	Are you satisfied with your current health insurance? (circle Yes or No)	Person may not have health insurance; 'satisfied' is subjective.
7	What percent of your budget do you spend on food?	What is 'food'? It may mean different for different people-milk, fruits, snacks may or may not be considered as food. But the basic problem is that most people would not know what percentage of their income is spent on food. House rent may be known as it is paid in bulk, but not food. If one is staying in hostel and paying fees, then it could be answered. If one says 'average' in response, then is it the average of lean month or better-off month? Question is not asked about a specific period. Many people buy certain cereals, pulses, etc in bulk for a year. This question is not a useful question to ask.
8	Are you in favour of the 2004 amendment to the MTP Act?	Respondents may not know what is MTP Act and the amendment to it. So when everyone answers 'No', the researcher would wrongly conclude that all these people are not bothered about such issues.
9	Do you think the two-child norm is violating people's rights?	What is 'two-child norm'? Who are the 'people' here? 'Rights' may be understood differently by the respondents.
10	Do you exercise regularly?	What is 'exercise', 'regular' (once a month could also be regular)?

Participants learn how questions should be framed through the above exercise.



## Group Exercise on Designing a Tool

Participants are divided into three small groups. Each group is asked to design a research tool according to the following situation:

“You are about to introduce a new counseling service for men in your STD clinics, which focuses on preventive behaviour, especially the use of condoms. This is a pilot project. The new service has cost a lot, and in order to justify its expenses you will need evidence demonstrating whether the new service has any positive health impact. Design a tool to evaluate the service assuming baseline data for the period before the service started is available.”

### Group 1- Design a Focus Group Discussion Guide (FGD)

#### Some tips....

- The tool should ensure that the pattern of communication is not question-answer between the facilitator and the respondents. Instead in a FGD one member says something, then another says something else, newer questions emerge from the group and the discussion moves on. Criss-cross, unplanned and unexpected responses are the value of FGD.
- In an FGD, questions should not be as though one is doing a group interview. Questions asking opinions, perceptions, beliefs, where respondents can provide normative, general patterns are to be asked.
- Nature of questions in the FGD should not be leading, for example, “Are you satisfied...?”, instead they should be probing.
- Terminology such as asking for “...correct usage...” may elicit expected answers. Thus, it is better to ask “What are some difficulties in using condom”, “How is a condom used?”
- Projective techniques could be used. For example, “There is a man, Ram who has received counselling but does not use condom, and there is a man, Shyam who has received counselling and uses condom. What do you think could be the reason for the difference between Ram and Shyam?”

### Group 2- Develop an Interview Guide

#### Some tips...

- Need to be more precise in an in-depth interview. Stick to the main focus which is about men’s existing knowledge and how has counselling influenced it.
- You can explore if there are any norms about gender effecting condom usage- for example The respondents use condom only with sex workers and not with wives or regular partner; wife might oppose condom use as it could be taken as an indication of sex outside of marriage by husband; any gender issues/marital factors/ notions about masculinity effect condom usage.

### Group 3- Develop an Interview Schedule

#### An example is provided for better understanding.

The research question is “Has counselling influenced condom use an operational, experimental/control design with an intervention area and a control area can be chosen to answer the question. It might be possible to conclude that counselling had made a difference in the intervention area. The sample can be 18-45 years old men. An interview schedule divided into five sections can serve the purpose.



**Section I - Identification of respondent**

ID No.- \_\_\_\_\_

1. Which is your place of residence                      a. Intervention area;                      b. Control area
2. How old are you? .....
3. Number of schooling years completed .....
4. What kind of work are you currently engaged in? .....
5. What is your family income .....

**Section II - Clinical information**

6. Are you currently suffering from any of the following problems-abdominal pain, pain in groin area, white discharge from penis, scrotal swelling, genital ulcer, burning sensation during urination?  
a. Yes                      b. No

**Section III - Condom use**

7. How frequently do you engage in sexual intercourse?  
a. Never                      b. Rarely                      c. Often                      d. Always
8. How often do you use condom?  
a. Never                      b. Rarely                      c. Often                      d. Always

**Section IV- Counselling**

9. Has anybody discussed with you the importance of using condom?  
a. Yes                      b. No
10. Has anybody demonstrated condom use to you?  
a. Yes                      b. No
11. Has anybody informed you about the places where you can get a condom?  
a. Yes                      b. No

**Section V - Gender perspective**

12. Does your wife/ partner have any objection to your using condom?  
a. Yes                      b. No

Additional question for post-intervention interview (the above is common to pre and post intervention interview)

13. During the last six months, have you heard / seen/ read any information on condom use through the following means:  
a. Radio (Y/N)                      b. Inter-personal, other than counselor (Y/ N)  
c. Television (Y/N)                      d. Newspaper/magazines (Y/N)  
e. Mass information (Y/N)



## Pointers for discussion

1. Did they explain how they would get control and intervention groups.
2. How is family income relevant? By classifying into three groups-low, middle, high-might be able to pin-point which income groups are coming for counselling and which are not, so intervention could be planned accordingly.
3. With respect to the frequency classification ask if the respondent has sex twice a week and uses condom once a week, then where would condom usage be put -`rarely' or `often'. Then point that the category can be concluded to be ambiguous. Instead one could ask "Out of the number of times you had sex, how often did you use condom?" Then the options can be given as- `never, more than half the time, less than half the time, half the time'. The response `never had sex' could be included as the opening question in the section, for example "Have you had sex in the last .....period?" Alternatively it could be, "How often did you use condom: never needed (did not have sex), used every time, some times (about more than half of the time), less than half the time, never despite having sex" or put in percentages- 25 to 50%, 50 to 75% etc.
4. The language of questions 9, 10 and 11 is centred around the person. It is better to rephrase it to, "Has .....been discussed with you?"; "Have you been ....."
5. Discuss about post intervention schedule. For example, regarding counselling, specific questions to assess the effectiveness of counselling, and knowledge that they would have gained from counselling can be asked, like, "Condom is used for....."
6. In case participants do not ask about availability of condoms, point out its relevance. People might say that they are not using condom, from which the researcher might conclude that counselling is not effective. But actually, it might be that condoms are not available. So, availability and affordability questions have to be definitely included in post intervention interview schedule.

The facilitator should conclude the session by saying that it is always better to show the instrument that one prepares, to as many people as possible even before piloting. Also, the facilitator should suggest not to be defensive about any comments/suggestions regarding group presentations. The presenters should take the opinion of others as a new set of eyes that gave new insights.

# Session 19

## Analysing Qualitative Data

### Learning Objectives

#### Participants will be able to:

- State basic principles of analyzing qualitative data.
- Recognize/identify common problems in qualitative data analysis.



**Time** 90 minutes

**Methodology :**



Presentation



Exercise

### ACTIVITIES



#### Presentation

##### Features of qualitative research

- Data collection is through close proximity with the respondents.
- There is a higher possibility of understanding the underlying issues.
- Data provides “thick descriptions”, respondent’s own view and perception.
- Data are collected over a sustained period of time.

(Miles and Huberman, 1994)

##### Data analysis

- While planning the research itself, the pattern of analysis should be worked out. It might be modified slightly later on but it would help to have a broad idea from the beginning about how the data is going to be analysed.
- Data analysis could involve descriptive explanation through micro analysis and gender analysis. Micro analysis involves careful minute examination and interpretation of data. It is necessary to generate initial categories and to suggest relationship among categories (Mason, 1996). Gender analysis helps to identify gender differences and patterns concerning specific issues. It also provides guidelines for examining the important social, cultural and economic factors that affect an individual (DFID, 1999).

## Steps in analyzing qualitative data

Data reduction: Reduce the data from all that has been collected so as to make it manageable. Data reduction refers to the process of selecting (the useful information on the basis of objectives, research questions, conceptual framework), focusing, simplifying, abstracting and transforming the data in the field notes or transcription in such a way that final conclusions can be drawn and verified.

- Formulation of categories and codes: One could have pre-formulated categories depending on the conceptual framework and could be modified later after data collection.
- Memoing: While reading field notes, the researcher might have ideas of how to analyse, some associations might emerge. Memo is the process of writing down those analytical ideas as one reads the field notes. Before beginning the process of coding, field notes are to be re-written to expand them, (do away with abbreviations), make them reader friendly and more analytical.

## Coding styles

- Start with some pre-formulated categories. These pre-formulated categories come from review of literature and conceptual framework.
  - Open coding- Data is broken down into discrete parts and closely examined and compared for similarities and differences. Subsequently similar events related in meanings are grouped together under the same categories (Strauss & Corbin, 1990). This is the first level of coding.
  - Axial coding- Data is reassembled. Categories are related to the subcategories to form precise and complete explanations about phenomenon (Strauss & Corbin, 1990). This is the second level of coding.
  - Selective coding- Categories are revisited for integration and refinement. If the researcher has pre-formulated categories then this last level of coding would take less time.

## Data reduction charts

- Responses of all the participants are put in data reduction charts to ease the process of data display.

## Gender analysis

- Re-read the data collected according to a gender analysis framework and categorise the data accordingly – for example, social norms affecting the phenomenon being studied, sexual division of labour, gender roles emerging in the data, access to and control over resources, power relations and exercise of power.
- One should do analysis and coding simultaneously and also from the very beginning one must start coding. It helps in refining your perspectives at every level.



## Exercise

Give participants excerpts from interviews and ask the group to mark the concepts mentioned above - gender norms and gender roles, access to and control over resources, power, that they find in those excerpts.

## Ensuring rigour in qualitative research

- Using a validity process: It is used in qualitative research wherein the same transcript is coded by more than one person and then the information, as seen by each one is pulled together.
- With respect to FGDs, a frequency table is useful. The table would show that, for instance, if 20 FGDs were conducted then how many groups expressed similar opinion; whether the opinion was the majority opinion, though it is not as if the minority opinion is any less important. Such a procedure makes the analysis transparent and confirms that the conclusion that the researcher is drawing, emerges from what the people have said. While writing about the FGD, in the discussion one could say that "Most people said..." and "Some said...". We can say that "Most (15 out of 20) said that...", and thus show how often an idea/opinion was expressed.
- No question/aspect of the research tool should be left unanswered. If the respondent is reluctant to answer a question, then that should be mentioned in the transcript.

## Towards gender sensitive qualitative research

- Methods are determined by the research questions: Weave gender issues and concerns into the types of information generated from the methods as well as how the method is applied.
- Consider to whom are the questions being asked (participants: men, family members, elderly females); when is data collection taking place (suitability to the women); who is asking the questions (men or women or both; young girls, or married women); who is influencing the responses.
- Let the 'data speak'. Objectively and honestly understand what the people are conveying; not superimposing your own values/concerns on people's voices.
- Qualitative research data collection; probing and searching questions can become, not just gender insensitive; but 'human insensitive'. Hence collect the data with sensitivity; let us not forget that we are invading on people's time.
- We need to reflect: How ethical is it to go on and on collecting data without using it to better people's lives? Could we at least empower them with the knowledge?

# Session 20

## Managing Data and Writing Reports

### Learning Objectives

#### Participants will be able to:

- Describe key steps in management of data.
- Describe the essential components of a scientific research report.



**Time** 90 minutes

**Methodology :**



Interactive presentation

### ACTIVITIES



#### Presentation: Managing data

Managing the data starts right from the beginning of the study and not after data collection is done. So, understanding the type of questions to be asked is important. Data questions are mainly of two types:

**Open-ended questions** need to be coded and are difficult and time consuming to analyse. There could be variation in analysis/interpretation of open ended questions by different researchers. The advantage is that the researcher can go in-depth using open-ended questions, which also enable collection of sensitive data. They are used in situations where one is trying to capture what one does not know much about, to get the 'why' of a situation for example, "Why are children not going to school?"

**Close-ended questions** are easier to collect, record, enter, analyse and they do not require any re-coding. Their disadvantage is that they give limited responses. Therefore, they are used to collect such information for which the researcher knows that there are only limited responses like sex, religion, caste, source of drinking water and an option of 'any other'.

#### Some common problems in data

- A lot of information is collected. One should remember the implications of collecting too much data, how is it going to be used, budget, etc.
- Volume of raw data is large.
- Uniform way of recording data is not maintained. This happens more so in qualitative data, in quantitative it happens when the data is open ended.

- All the raw data is not transformed into useable form. For example, the number of households contacted to get under one-year old children to find immunization status is often not recorded by investigators; so it is not known that those children were from how many households/ population. This happens more with qualitative data but in quantitative data also everything might not get coded if one has not planned it well in advance.
- Failure to capture/record all the data. Sometimes if there is delay in noting down the data, and the investigator relies on memory, then minute information may get lost.

### **Therefore, a good data set**

- is easy to use.
- documentation is clear and easy to understand how the data could be coded and maintained.
- users are able to access the dataset with relatively little start-up time.

## **Management of data**

Planning for the management and data collection is critical. Some issues are:

- File structure (assumption is that data is being transformed into computers).
- What is the data file going to look like? How will it be organized? What is the unit of analysis? For example, is it 'household' or 'women', this should be known from the beginning depending on the objectives of research. Will there be one long data record or several smaller ones?
- Naming conventions- How will files and variables be named?
- Data integrity- In a qualitative research one might be interviewing doctors, paramedics, also doing secondary data analysis-how would these different data be integrated. Also how will data be converted to electronic form. Checks/data monitoring need to be put in place to find
  - invalid values, for example, answer code is 3 when options were only 1 or 2 for M/F.
  - inconsistent responses/gender bias. For instance, a woman reports that she is a housewife and in next question some income is reported for her. Assumption is that housewife would not have any income, so need to check back in data whether actually woman has some income or it is misreporting.
  - incomplete records. Missing data could be because respondent did not answer. It is important to note/code incomplete data. For example, need to say that 'data is not available' or if data is not applicable to that respondent, then say 'not applicable', or 'investigator did not record', or 'data entry operator missed entering', depending on the situation.
- Preparing data set documentation: What will the data set documentation look like; how will it be produced to incorporate the gender aspects; who will produce it; will someone translate in the field itself; how will it be coded; what information will it contain?
- Variable construction: this is important for data entry and analysis. What variables will be constructed following the collection of the original data; how will these be documented?
- Some other issues to be considered are: What steps will be taken to document decisions taken as the project unfolds; how will information be recorded on field procedures, coding decisions, variable construction, and the like; which data programmes will be used for which tasks; what ethical guidelines will be followed; how to get it passed from an ethics committee etc.

## Remember

Sometimes projects go on for a long time especially the intervention projects. Meanwhile the staff in the project often keeps changing. If the variables were not defined properly in the beginning, or documentation was not done properly, then comparing the baseline data collected earlier and the endline data would be difficult for another person to do.

## Using integrated software

- Variety of programmes makes data entry a lot easier.
- Most large-scale data collection involve computer data entry.
- Carry out data integrity checks as the data are entered and create programming statements.
- A good data-entry programme will recognize automatic skips and fills, filling in missing data codes in intervening fields as appropriate.
- Software for data entry-Spreadsheet packages, Access, MySQL, Oracle etc. Most NGOs enter data in Excel sheets.
- It is good to consult a gender sensitive statistician during the tool development period itself. The statistician can guide in creating tools from a computer entry and analysis perspective and guide in the coding and survey development process.

## Need to check data for

- Wild codes (like the example of code 3 given earlier when options were 1 or 2 for M/F) and out-of-range values.
- Completeness of data and inconsistency checks- This requires knowledge of the substantive task at hand. Possible inconsistency can include:
  - Questionnaire not filled completely, will have missing data
  - In consistency in responses. If possible, go back to the respondent and ask for clarification
  - If not possible to correct, you may consider to exclude it
- Record matches and counts.
- Variable names. These can be of different types.
  - One-up numbers: Have the advantage of simplicity but disadvantage of lack of information. For example, each variable is numbered 1 through n. The usual format is V1 (or V0001) . . .Vn. But everyone would not understand what V1 means. It is important to define the variable, in this case variable 'V'.
  - Question numbers: Name variables corresponding to question numbers, for example, Q1, Q2a, Q2b... .Qn. This has the advantage of relating directly to the original questionnaire but disadvantage of not being easily remembered.
  - Mnemonic names: Names chosen to represent the meaning of the actual variable. Some advantages are that they are recognizable and memorable. Disadvantages are that what is an "obvious" abbreviation to the person who created it may not be obvious to a new user. With limited number of characters to work with, it is not easy to create names with immediately recognizable referents. Also, it is difficult to maintain consistency across variables that share common content, for instance, always to use ED for education.



- Prefix, root, suffix systems: To think of each variable name as containing a root, possibly a prefix, and possibly a suffix. For example, all variables with education have the root ED. Mother's education would then be MOED, father's education would be FAED. Suffixes are often used to indicate data in longitudinal studies, the form of a question, or other such information.

## Codes and coding

- Code categories should be mutually exclusive, exhaustive, and precisely defined.
- Identification variables: includes a study number and respondent number.
- Each interview response should fit into one and only one category.
- Preserving original information: for example, AGE-do not code it right away because one never knows for what kind of calculation one may need what data at what stage.
- Open-ended questions can either use a predetermined coding scheme or review the initial survey responses to construct the categories that emerge to ensure all the data is being transformed.
- Series of responses: Organizing the responses into meaningful major classifications is helpful. Responses within each major category can be given the same first digit. The second order or secondary digits can represent another category or be used to distinguish the specific response within the major category. This type of coding scheme permits analysis of the data in terms of broad groupings, individual responses or categories.

For example- Understanding from adolescents their reproductive health needs. Their responses can range from those related to contraception, menstruation, to how children are born. Now, all related questions/themes can be clubbed. For example, those related to contraceptives can be in one category, changes in adolescence in another category, menstruation related in separate category, family planning in separate category. Then within each category further coding can be done by listing the various responses.

For qualitative data, ATLAS Ti is a good software in which raw notes are typed exactly in the computer and in a way that they are coded simultaneously. For example, first part talks of background characteristics- age at marriage, number of children and so on. Data is sort of coded from the beginning. Suppose ten case studies are entered in this way; then if one wants to see only the source from where the women accessed ante natal care (ANC) service, then one can do a search with the code (say, ANC source) under which it has been keyed in.

In case of manual notes it is a good idea if investigators leave a lot of margin and leave alternate lines blank. This is because at times more information has to be put in later. In margins codes can also be prepared or different coloured pens could be used to highlight similar responses.

## Steps to lessen the incidence of error while creating data files

- Use a data-entry programme that is designed to catch typing errors.
- Consider double entry but this can be expensive and time consuming.
- If cost and time are limiting factors then carefully check the first 5 to 10 percent of the data.
- Separate the coding and data-entry tasks as much as possible so that same person does not do both.

## Management of qualitative data demands

- Advanced and more detailed preparation for filing notes, regular feedback on field notes, translation from local language to English such that nuances are not missed while translating.
- Type and nature of analysis intended need to be decided beforehand.
- Proper check during and after data collection.
- Using it most effectively in preparing report. It is good to pre-mark interesting/informative quotes during coding that can be then added as voices in the report. For example, marking quotes that reflect gender issues can be highlighted and used throughout the report under the various themes/categories.

## Advantages of manual analysis

- Immediate feedback can be given.
- Local terms and language make it powerful and effective.
- Researcher is directly involved.
- Does not necessarily depend on specialization for analysis.

## Disadvantages of manual analysis

- Reanalysis is difficult and time consuming. For example, if 25 case studies have to be reanalysed.
- Data storage is problem in terms of space as well as quality of paper and storage area.

## Difficulties in using computer

Though computers make data management easier, they cannot collect, translate, code or interpret data, neither improve its quality. Therefore, the researcher should be very careful during these steps. Some difficulties associated with using computers, mainly for qualitative data are:

- Computer analysis software demands text in English.
- So, field notes written in local language need to be translated in English.
- If the translator is not proficient with the local language, important data can be lost or data can be mis-interpreted.
- Entering and repeated proof reading of the text is time consuming.
- Immediate feedback is not possible.
- Indexing/coding of text in programme format is often difficult and time consuming.
- Computer and language expertise is required. Very few statisticians work on qualitative data in the field of social science. Most researchers are not adept in using qualitative software packages.

In an era of fast changing technologies (computer, networking technologies) proper data management and its analysis is fueling the transformation of research and its findings. The researcher should be able to produce the final result of the research in a reasonable period of time. If it takes too long then the findings would lose relevance.

## Presentation on Report writing

Project report is a documentation of

Project objectives, activities performed, process of implementation, impact assessment, findings and its programmatic implications.

Key contents of a good report are

- Executive summary
- Background or introduction
- Objectives of the study
- Methodology: Design, sample size, implementation
- Findings
- Discussion and Policy implication
- Lesson learned
- Possible steps to create condition of scaling up (study in another area) or enhancing utilization

## Common mistakes in writing a report

### A. Too lengthy and descriptive

- Often length of reports is 100+ pages
- Contains unnecessary details and repetition
- Ideally length of a report should not be more than 35-40 pages including tables, figures and appendices, for it to be used/read by policy makers and others

### B. Disproportional allocation of pages to different sections/chapters

- Lengthy introduction
- Short or vague description of methodology
- Long description of findings
- Short or no discussion on findings, lessons learned, suggestions for creating condition for pointing out gender gaps/scaling up

**Tips:** Background need not be very detailed. Rather the methodology should be well explained, especially 'sampling'. It is better to prepare the dummy tables right in the beginning, so that there is clarity on what analysis is required and according data is collected. Findings too need not be given in great detail, and there is no need to again explain what the table states. For example, in case of a study on the main sources of seeking ante-natal care, if the finding is that 60% deliveries still take place at home, then the discussion should be about what needs to be done to motivate women to deliver in institutions. Or, what can be done to make home deliveries safe.

It might be better to give the findings separately and organize the discussion according to the conceptual framework. Make sure the gender and rights perspective is well described in the conceptual framework. This would make the report more analytical.

There is no fixed guide line or set rule as to how many pages should be allotted to each section of a report, yet the following distribution of a 40-page report can be suggested:

---

Title page, content, executive summary	10 %
Background, context and objectives	15 %
Research methodology	10 %
Findings	35 %
Discussion	15-20 %
Lesson learned	5-10 %
Recommendation for creating condition for scaling up/addressing gender gaps	5-10%

---

The usual mistake is that there is more emphasis on background and findings, and less on discussion.

### **C. Presentation and description of findings from tables**

- No title or inappropriate table titles and numbering.
- Figures given in 2 decimal points are not reader-friendly. It is fine to round off the figures; slight change does not matter with respect to policy makers. For statistical data or reanalysis one decimal value might be enough.
- If the figures/percentages do not add up to the desired number (100%), indicate that 'percentages do not add up to 100 because of multiple responses'. Figures can be slightly changed to round off, for instance, 99.7 to 100.
- Describing all the tables and figures in the text is not necessary.
- Same findings need not be repeated in tables, figures and text.

An example of unnecessary description in a text:

'The end-of-project survey collected information on marital status of all household members aged 15 years and above. Table 2.4 shows the percentage distribution of household population by marital status classified by age and sex. Among male aged 15-19 years, only four percent are currently married while the rest 96 percent were unmarried. Among the females, 12 percent were married while the rest 88 percent were unmarried. The proportion of never married reaches very low among men by the time they reach the age of 30, while in the case of women, that stage comes by the time they reach the age of 25. The proportion of divorced, separated or widowed were 1.7, 0.9, and 1.1 respectively. Among the older age group more women were widow than men. The percentage of such women in the age group 59-64, 65-69 and 70 + were 6, 13, and 21 respectively.'

The italicised portions are unnecessary details that can be done away with.

## **D. Presentation of charts and figures**

- Complicated and difficult to understand.
- Difficult to read, example, font size being too small.
- Use of three-dimensional figures; two-dimensional figures tend to be clearer and easier to understand.
- No/Inappropriate titles and numbering.

### **Considerations in using figures**

- Position the chart in the text where it is referred to.
- Give a clear label on what the diagram shows.
- Choose the type of chart which best explains the findings.
- Be creative and try to use different forms of visual depictions/data infographics.
- Make sure that the chart clearly explains the findings and does not lose focus.

## **E. Lack or inappropriate statistical analysis**

- Too often analysis is confined to description of percentages.
- Lack of use of even common tests like Z- test, t-test, X2 test.
- Often use of "significantly different" without any statistical test are misleading.
- Use of sophisticated test without understanding and/or interpreting the findings of analysis.
- Statistical analysis lacks gender perspective.

## **F. Interpretation and use of qualitative data**

- Lack of understanding how quantitative data could be used to strengthen findings from qualitative survey data or analysis. Qualitative data can be strengthened if quantitative data is linked appropriately with it.
- Generalization and subjective use of qualitative data with limited observation should be done very carefully. Being biased and judgemental in presenting qualitative data should be avoided.

## **G. Lack or inappropriate interpretation of the findings**

- Reports end with description of findings with no or inappropriate interpretation and discussion on gender issues, or interlinkages between various factors. Basically, findings are not linked and interpreted in the social context of the setting.
- Generalization and subjective use of qualitative data with limited observation.
- No discussion on programmatic / policy implications or lessons learnt.
- Recommendations not based on findings given in text. Recommendations to address gender gaps are missing.

Every researcher need not be expert in statistics. But one could take the help of a statistician to use the collected data to do statistical analysis and strengthen the interpretation and discussion.

## H. Style of report writing

- Use of tense and reporting in first person. It is important to maintain consistency through the report.
- Avoid repetition of arguments and findings.
- Better to decide beforehand the sub-heads to present findings, so that there is logical flow in paragraphs and presentation of findings.
- Write crisp short to the point sentences so that there is clarity in the message of the report.

## I. Cover page and executive summary

- Avoid lengthy project title.
- Institutional affiliation, date/year of publication and proper credits should be mentioned.
- No executive summary (ES) or badly written ES: ES is often written at the end when the researcher has no time. But actually, ES is the first part of the report that would be read by the donor, policy maker. If they find it interesting, only then will they read the recommendations at the end, if they are still interested in it, only then will they read the findings etc. So sufficient time should be given to writing ES.

**Length of an executive summary should not be more than 2-3 pages and should comprise of:**

- Background information,
- Objective of the study / research questions,
- Methodology,
- Project intervention / activity,
- Key results,
- Lesson learned and
- Recommendations.

### **To conclude, a well-planned report should...**

- Give a gender, rights and inclusion perspective
- Be clear with what message one wants to give
- Use appropriate format, layout and structure
- Use correct tense
- Give proper titles to tables, figures and charts
- Interpret and discuss keeping the context in center
- Have a comprehensive executive summary
- Be strategic in what one wants to achieve

# Session 21

## Researching Men, Gender and Health - from a Gender and Rights Perspective

### Learning Objectives

#### Participants will be able to:

- Recognize how sex and gender affect health of both men and women.
- Recognize how construction of masculinity impacts on men's health.
- Identify gender differentials in prevalence/incidence, treatment seeking behaviour and consequences of certain health problems.



**Time** 90 minutes

**Methodology :**



Presentation



Group Exercise

### ACTIVITIES



#### Facilitator's Presentation on Gender Analysis of HIV/AIDS

***"It is a basic and tragic irony of human life that intimate and physical relations entail the risk of infectious disease."***

#### What is gender?

- Biological sex (ie. being male and female) + value = Gender
- Social construction of femininity and masculinity turns males and females into 'men' and 'women'.
- Defined as widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics and roles which ascribe to men and women differential access to power, including productive resources and decision-making authority.
- Gender roles vary over time and by class, caste, religion, ethnicity and age.

## Gender concepts

- Social beliefs about men and women
- Gender norms for behaviour
- Gender roles, sexual division of labour, different activities and tasks
- Access to and control over resources
- Decision making and power

## Gender is commonly reduced to 'women' but....

- Gender does not = WOMEN. It has to do with
  - Differences between men and women
  - Gender relations
  - Power
- Gender is one more basis of discrimination and inequality

## Sex, gender and health

- Biological susceptibilities and vulnerabilities - Interact with - Gender and social factors - To produce
- Health conditions which are
  - a. Sex Specific
  - b. Have a higher prevalence in one or other sex
  - c. Different characteristics for men and women
  - d. Generate different responses

## Sex, gender and HIV/AIDS

- Biological factors
  - A. Anatomy
    - Large vaginal mucosa to interact with infected material
    - Cervical ectopy – younger female have immature cervix and low vaginal mucous production which presents less barrier to HIV
    - Younger women more vulnerable
    - STDs in women often asymptomatic
  - B. Physiology
    - Menarche to menopause (pregnancy / delivery / abortion)
    - Menstrual cycle – HIV has been isolated from menstrual blood
    - Male to female transmission 24 times more efficient



- **Gender norms**

- High value placed on virginity of girls
- Girls/ women not supposed to know about sex, men expected to know much more
- Women have to please men, defer to male authority
- Notions of Masculinity – Virility
- Men socialised to be adventurous, risk taking
- Barrier in using condom
- Men have higher rates of partner change
- Men more likely to have concurrent or consecutive partners, women more likely to be faithful

- **Gender roles**

- Men as breadwinners: Migration of men for work
- Economic instability: Migration of women for sex trade
- Young women entering manufacturing sector
- Women as carers in HIV affected households
- Female headed households

- **Access to and control over resources**

- Awareness and information both in men and women
- Negative economic consequences of leaving hi risk relationships more serious than health risks of staying
- Laws and policies prevent women from owning property and productive resources
- Women denied opportunity of protecting themselves

- **Power**

- Violence against women
- Youth
- Stigma and discrimination

- **Other gender factors**

- Men – Less opportunities to benefit from RCH and other development programmes
- Women – face gender related barriers to their reproductive health

## Other factors related to HIV/AIDS

### ● Social status

- A. Power- Many times affected by women's lack of negotiation skill regarding
  - Type of sexual activity
  - Conception and contraception
  - Prevention of RTI/STI/HIV
  
- B. Socio-economic inequities
  - Commercial sexual activity

### ● Contraception responsibility

- Non-barrier contraceptives like hormonal contraceptives increase the risk of STD/HIV.

### ● Blood transfusion

- High number of females acquired HIV through blood initially.
- Females receive blood transfusions mainly for obstetric and gynaecological related indications.
- Presently the potential for transfusion induced HIV transmission during window period is more in females.

STD occupies second position among communicable diseases in India. Per-contact transmission for many sexually transmitted infections, like gonorrhoea, is higher in females.

## Consequences for women when HIV infected

- Impact on child bearing- 40% chances of mother-to-child transmission. But it can be prevented through the 'Prevention of MTC Programme' and chances reduced to 4%. For this the pregnant women should be screened for HIV which is not being done effectively right now.
- Issues of orphans after the death of both the parents due to HIV.
- Stigmatized for spreading HIV/AIDS.
- Considered reservoir of infection and vectors of transmission.

## Other impact on women

- Major brunt of all social inequalities is to be borne by women.
- Taking care of positive husband/child.
- Income generation.
- If couple is positive, then treatment opportunity is mainly for husband with few outlets for free anti retro viral therapies.
- Discrimination by husband, in-laws, doctor, employer, society. A participant said that the stigma is faced by men also, though it may be more for women.

## HIV prevention and women

Relevance of existing preventive messages for women

- A – Abstinence: Lack of power to negotiate
- B – Be faithful: They themselves are faithful but are infected by their single partners
- C – Condom: Male driven and less used with regular partners

*"Behind most females with AIDS there is a male without condom"*

## Empowering women

- Female condoms are less accessible due to high costs and limited availability. There are difficulties in insertion with most women not being aware of their own bodies. Issue of non-acceptance by male partner is also there. Potential for re-use must not be over-looked as reuse can be dangerous to men.
- Vaginal microbicides
  - Kill HIV and other pathogens
  - Can even offer contraception
  - There are other preparations which are under trial presently.

Earlier it was believed that the contraceptive pessary 'Today' kills HIV but now it is known that it does not.

Therefore, microbicides are still a contentious issue. They may cause inflamed, irritant vagina.

## Possible preventive measures

- From the Core Group (sex workers) through Bridge Population (customers) the infection is passed on to the General Population. It is therefore important to address all the three groups.
- For core group and bridge population the following are suggested
  - Periodic and presumptive treatment.
  - Periodic screening and treatment of specific infection coupled with syndromic treatment.
- For general population it is suggested
  - Syndromic treatment and screening before marriage and during pregnancy. The doctors are now legally protected to reveal the positive status of a partner to the prospective negative partner, if the positive partner does not himself/herself disclose.
  - Health care seeking behaviour.
- Low turnover of female cases in STD clinics. Some men are also not able to access services as the timings do not suit them. Also, though men are quick to take treatment for STI related problems they consult quacks more than qualified practitioner. So poor treatment seeking behaviour is true with respect to men also. Now general practitioners throughout the country are also being trained in the treatment of STIs. Thus, there is an attempt to decentralize the STI treatment so that people can access services from trained personnel everywhere.
- Low level of spousal communication.

STIs are not just biological and medical problems, but also social and political problems. Both medical and public health interventions fail to address the full complexity of these social diseases.

## Suggested steps to address HIV AIDS

1. Guarantee access to HIV/AIDS prevention and treatment
  - Availability of female / male condom to all.
  - Incorporation of gender balance and gender equality in all policies.
  - Set up women friendly centres for care.
2. Make research gender sensitive.
  - Accelerate research to develop women controlled preventive methods like microbicides and affordable female condoms. As of now the female condoms are seen as a premium, lifestyle product, and not as something to be used by all females, irrespective of their socio-economic status. Female condoms are a contentious issue. While they could be a means for women to protect themselves from infection, yet the other aspect is that the entire responsibility of contraception and protection is on women. Using condoms is the only active step by men. Thus, the issue is that would introducing female condoms absolve men of this single responsibility as well? Besides, female condom cannot be used without the knowledge of the man because of the type of material it is made of. So, in any case the man's consent would be essential to use the female condom. Thus, there are questions about the effectiveness and efficiency of investing in female condoms.
3. Educate and inform.
  - Disseminate HIV / AIDS and STD information to reach adolescent girls and women.
4. Address gender inequality in policy.
5. Address HIV transmission in conflict situations.
  - Ensure gender sensitive HIV/AIDS awareness and preventive care and treatment programmes in humanitarian assistance.



## Group Exercise

Each group is given a WHO fact sheet with instructions given below. Depending on the number of participants and the time available the facilitator can have more than two groups. There are a wide range of Fact Sheets on Gender and different conditions available on the WHO website – for example, Gender and Road Traffic Accidents, Gender and Mental Health, Gender and Malaria/ Tuberculosis and several others.

### GROUP 1: Gender, health and work

(Available from <https://www.who.int/gender-equity-rights/knowledge/gender-health-and-work.pdf?ua=1>)

### The Task

To study the fact sheet and answer the following questions:

1. What is the nature of the gender differences that emerges from the fact sheet with regard to men's work and women's work?
2. What are the various dimensions of gender differences that are related to occupational health?
3. What are the health implications for women? What are the health implications for men?

4. Would you like to suggest other themes or research questions?
5. Would you like to suggest additional policy measures and preventions programs keeping India in mind?

## GROUP 2: Gender, health and alcohol use

(Available from <https://www.who.int/gender-equity-rights/knowledge/alcoholfinal.pdf?ua=1>)

### The Task

To study the fact sheet and answer the following questions:

1. What is the extent of problems related to alcohol use?
2. How do gender norms influence alcohol use?
3. What is the relation between alcohol use and risk behavior?
4. What are the acute adverse consequences of alcohol use?
5. Would you like to suggest other themes or research questions?
6. Would you like to suggest additional policy measures and preventions programs keeping India in mind?

### Plenary presentations and summing up by Facilitator

- a. Each group makes their presentation
- b. Facilitator highlights the gender issues in Occupational Health and in Alcohol and Substance Abuse

#### Gender issues in occupational health

- Society defines what is "Women's" work and "men's" work – there are Gender differences with regard to men's and women's work
- Differences in education, socialization and upbringing may lead to differences in the way workers manage their illnesses, their perception of risk, and the propensity to take sick leave or to seek treatment.
- Hazardous work conditions can affect both women's and men's reproductive biology such as exposure to chemicals, vibrations and radiations.
- Work that exposes women to toxic chemicals and pesticides may cause poisoning, cancer, skin diseases, abortions, premature deliveries, malformed babies, contaminated breast-milk.
- At home women carry fuel and water from long distances. Washing and cooking expose women to water related diseases, toxic pollutants that may cause tuberculosis. Thus, there is gendered exposure to certain diseases like TB.
- Men have more occupational accidents and fatal injuries than women.
- Men in developed countries report greater exposure than women to noise, vibrations, extreme temperatures, chemicals and lifting heavy weights.
- Not much has been studied about the male reproductive health in relation to occupational exposures. However, many chemicals, radiations, toxins, high temperatures, sedentary work have been identified as hazardous to the male reproductive system.

## Gender issues in alcohol use

- The burden of disease attributable to alcohol use is higher in men than in women. The male: female ratio is 5:1 which clearly reveals that men are more involved in alcohol consumption than women. However, alcohol use in women is increasing steadily because of changing gender norms in the society.
  - Influence of gender norms on alcohol use - Historically drinking was socially accepted only for men. Now it is being increasingly accepted for women also. But still women who drink alcohol face social stigma. Because of social stigma women are less likely to drink heavily. Women who drink prefer to do so in private. Women are less likely to seek treatment for alcohol related problems.
- Alcohol use and risk behaviour. Alcohol consumption is associated with risky sexual behaviour. This connection is compounded by a common side effect of alcohol intoxication-loss of social inhibitions.
- In most societies women who consume alcohol are commonly viewed as being more sexually promiscuous and thus, may be viewed as “easier” sexual targets for men. This has implications for sexual and reproductive health more broadly.

Alcohol use can cause several forms of cancers, chronic liver disease, heart disease, damage to the central and peripheral nervous system. There can be alcohol induced unintentional injuries such as road traffic accidents and suicides, sports and leisure injuries.



## Conclusion

Facilitator concludes by emphasizing gendered research on men’s health conditions will investigate the biological aspects as well as how gender norms, masculinity, gender roles, sexual division of labour, and access to and control over resources interact with men’s biology, to produce health outcomes for men, their treatment seeking, compliance and adherence, and consequences for men.

# Session 22

## Ethical Issues in Conducting a Gendered Research Study

### Learning Objectives

#### Participants will be able to:

- Describe steps in conducting ethically sound research.
- Highlight issues related to ethics from a feminist perspective.



**Time** 90 minutes

**Methodology :**



Interactive presentation



Discussion, interspersed with examples of gendered research



### ACTIVITIES

1. The Resource Person first generates a general discussion on – what questions would you ask yourself before you undertake research on topics like Violence against Women, Child Sexual Abuse, Sexual Behaviour of Adolescents Girls and Boys, TB in Women. (These are examples – the facilitator can select three or four examples depending on the time available.)
2. After about 15 or 20 minutes the facilitator uses the responses from participants to illustrate the issues in her /his presentation.

### Ethical Issues in conducting a Research

#### Questions prelude to conducting any Social Science Research

- Why should I take up this topic for conducting a research? What new knowledge would it generate?
- Who should be my respondents?
- Why do I choose to make them my respondents?
- Would my research undertaking make any difference in their lives?
- How do I go about conducting this research?

- What is the best/good/desirable way?
- What kind of problems would I come across - before and during data collection, while processing data?

### **When/Why does an ethical dilemma arise?**

- When it becomes necessary to make choices in how to go about doing a research
- In a situation involving value differences
- where a researcher has to decide between two or more equally attractive or unattractive alternative courses of action

### **What is Ethics?**

- A branch of philosophy in which Moral Values are examined
- Concerned with the conduct of human beings
- What ought to be done in a given situation
- The 'Oughtness' is coloured by values believed to be 'Good' in a society
- So, what we value as Good will determine what we consider to be Ethically Good
- Decision making about achieving Good in a situation
- Self-regulation, Conscience checking
- What ought to be done is not necessarily what is easiest, efficient, effective, or economical.

### **Ethical Research may not be**

- easy,
- efficient,
- effective, or
- economical.

### **What are Ethical Principles?**

- Principles are rules or standards for good behavior.
- Ethical principles – those that inform moral choices, help guide discussion moral problems

### **Moral Principles for Ethical Research**

1. Non- maleficence: cause no harm
2. Beneficence: Positive contribution towards welfare of participants and society
3. Autonomy: Respect and protection of rights and dignity of participants
- 4 Justice: Fair distribution of benefits and risks



## **Ethical Principles for Social Science Research**

1. Essentiality
2. Maximisation of public interest and social justice
3. Knowledge, ability and commitment to do research
4. Respect and protection of autonomy, rights and dignity of participants
5. Privacy, Anonymity & Confidentiality
6. Precaution and Risk Minimization
7. Non-exploitation
8. Public domain
9. Accountability and Transparency
10. Totality of Responsibility

## **Ethical Guidelines based on Rights**

- Rights of Participants
- Rights and Responsibilities of –
  - Researchers and Institutions
  - Peer Reviewers/Referees
  - Editors and Publishers
  - Funding Organisations and Sponsors

## **Setting up Mechanisms**

- Institutional level
- Team level
- Individual/Researcher level

## **Feminist Ethics - Ethics of care**

### **Carol Gilligan (<https://ethicsofcare.org/carol-gilligan/>)**

- As an ethic grounded in voice and relationships, in the importance of everyone having a voice, being listened to carefully (in their own right and on their own terms) and heard with respect. An ethics of care directs our attention to the need for responsiveness in relationships (paying attention, listening, responding) and to the costs of losing connection with oneself or with others. Its logic is inductive, contextual, psychological, rather than deductive or mathematical.
- A feminist ethic of care guides the historic struggle to free democracy from patriarchy; it is the ethic of a democratic society; it transcends the gender binaries and hierarchies that structure patriarchal institutions and cultures. An ethics of care is key to human survival and also to the realization of a global society.

- Feminists have developed a wide variety of gender-centered approaches to ethics, each of which addresses the ways traditional ethics has failed or neglected women. Some feminist ethicists emphasize issues related to women's traits and behaviors, particularly their care-giving ones. In contrast, other feminist ethicists emphasize the political, legal, economic, and/or ideological causes and effects of women's second-sex status. But all feminist ethicists share the same goal: the creation of a gendered ethics that aims to eliminate or at least ameliorate the oppression of any group of people, but most particularly women (Jaggar, "Feminist Ethics," 1992).

(<https://stanford.library.sydney.edu.au/archives/win2018/entries/feminism-ethics/>)

### **Lessons learnt with respect to ethical research on women's health**

- Top down vs Bottom up: research on issues prioritised by women and communities.
- Process vs Outcome: research in ways which empowers women and respects their autonomy.
- Meaning of Informed Consent and Autonomy?
- How much research is needed before services are started? Examine the relevance of the research – is it adding new knowledge?
- Researcher-Community relationship?
- Issues of Power: Which women do we research and why?

### **Some recommendations for ethical research on women's health**

- Priority for vulnerable women's health issues: barriers and access to health services for disabled women, elderly, urban poor, tribal women, sexual minorities, etc
- Priority for public health priorities in women's health, eg. Anaemia in women, malnutrition in women, CA cervix etc.
- Intervention research on scalable models.
- Research on how to get policy change on women's health issues, and how to translate policy into public sector programmes.

Excerpts from Research on Women's Health: Some Ethical Concerns, a presentation by Renu Khanna at an ICMR Training Programme in September 2007, Bangalore.



## Key Points

- Before taking up any research issue we should think about why we want to do this research? Would the research make any difference in the respondent's life?
- Ethics could be understood as 'Code of Conduct'. All relationships in any profession are governed by certain norms fairly accepted by the community. Researchers are a community and as a community they are expected to abide by some standards - rights perspective, gender perspective. Thus, research ethics refer to a certain set of standards that the researchers do not want to compromise upon.
- Most of the research studies are done in the lower socio-economic strata because they are easily available and we know somewhere that they will not say no to participate in the research. This clearly shows the power relationship between researcher and the researched.
- Most of the time, researchers are hardly concerned with the respondent's rights. They are desperate to fill up the questionnaire or finish the interview and tend to not give respondents the space to say "No".
- Researchers should tell respondents the purpose of the research, research objectives, and their own introduction.
- Researchers have to take consent from the participant after explaining the purpose and modalities of the research. Participants' denial to participate should be respected and recorded.
- Do not ask unnecessary questions, just out of curiosity. Always examine your questions – how does they contribute to the research objectives. The question should not hurt the individual.
- Gendered ethics ensure that women's autonomy is not compromised in the research process. It emphasizes consciousness of power relations in the research process, and how power inequalities can be mitigated. All the principles – do no harm, confidentiality, informed consent etc. – are examined and implemented keeping in focus gender power relations.



# 3

## Module

# Taking Research Forward: Communication and Advocacy

### **Learning Objectives**

1. Know strategies for communicating research results to relevant audience, formats and media for disseminating research results, and writing for journals.
2. Know how to use research findings for program designing.
3. Describe the nature and types of advocacy, necessary and sufficient conditions for successful advocacy efforts.
4. Evaluate advocacy strategies from a gender and social perspective.
5. State/explain the various campaigns and need-specific advocacy strategies.

# Session Outlines

# Session 23

## Communicating Research

### Learning Objectives

#### The participants will be able to:

- Describe and use strategies for communicating research results to relevant audience.
- Develop formats and media for disseminating research results.



**Time** 120 minutes

**Methodology :**



Presentations



Discussion on participants' questions



Group exercise

### ACTIVITIES



#### Presentation

The resource person starts by asking the participants 'what makes for good reading according to you?' Or 'what kind of material do you like to read?' S/he builds on their responses through the following presentation.

- Communication strategies must become an integral part of the research right from the beginning. The writing up of the project is usually done at the end and only by a certain person(s) in the project. Every research project must also have a writing plan on how the writing will be integrated in the project as well as who will be writing. The writing plan must begin ideally at the time of planning the project.
- The research project may be divided into five phases and the writing output for each phase may be planned accordingly. In the first phase of the project, the writing output could be an exploratory article or essay on the field of study.
- In the second phase of the project, the output may be a literature survey paper based on the review of literature done as part of the research project or compiling a paper of abstracts.
- In the third phase of the project, during the process of data collection, the output may be in the form of feature writing on a particular area, or people or incidents, taking care of various ethical and copyright concerns.
- In the fourth phase, besides the research report, one could write spin off papers or presentations, press notes on the research (interview and be interviewed by the press), and organize book material.

- In the fifth phase, for the post project period, one can decide how many academic papers to write for the entire project, how many feature or popular media articles to write, whether these papers can form a book and whether the research report can be converted into a book.

The presentation is followed by a discussion on participants' questions related to writing.

## Writing tips for Press Notes and Feature Articles

### • Press Notes

Press notes are sent to media on research outcomes, findings, events, etc. A press note must be information rich. It should be concise, compact, limited to 200-300 words. It has to have a 'news' perspective, so that the journalist may find interesting concepts to publish in the newspaper or magazine. Press notes can be issued or sent to the press before or after the event.

While writing a press note,

1. Start with a paragraph, two or three sentences, which makes a reader want to continue to read.
2. Put all the important information in the middle or the core of the note. For instance, if one is reporting on a workshop, then one can put the important views expressed by people at the workshop, including direct quotes, in the core of the note.
3. Include relevant names and additional information, to enable the journalist to contact you for further inquiry.

### • Feature Articles

Feature articles are a good format to communicate research outcomes. Feature articles give the researchers an opportunity to communicate their research finding(s) or their observations during research to a readership that might never see an academic research report. The following must be taken into consideration while writing a feature

- Whatever the topic, find a news peg for your research. A news peg means something that is topical, something related to the research, e.g. World AIDS Day.
- The introductory paragraph of a feature is not a summary (unlike in the case of academic papers/journal articles) but an invitation to read further. So, the most interesting point should be highlighted in the introductory paragraph.
- Readers like information, but not as 'information'! Information should therefore be provided in attractive ways, in quotes, and figures, translated into everyday terms.
- Respect for the reader, there should be no 'talk down'.



## Group Exercise: write a Press Note

The participants work in groups to write press notes. Each group presents their press note to a panel of Editors of newspapers, who are volunteers from among the participants. This panel as well as the resource person give feedback on the press note.



---

## Media Rules: Some Dos and Don'ts for Writing

### **Vision Thing**

- It is important to ask: Who am I writing for? Why am I reporting this research? How will it affect the issue/people that I am writing about? Who will benefit from it directly, indirectly and inadvertently?

### **Fairness**

- Stop, look and listen to all sides, even if your research material is on only one aspect. This is what provides the grounding for the article, locates it in a relevant perspective, and even makes it lively.

### **Responsibility**

- Don't cover up unpalatable truths, even if they do not support your main hypothesis or finding. The exceptions are important. E.g. in your study of impact of mill closures on women, you find that because of this event women are now seeking and finding new and better paying jobs elsewhere. Will you write about it?

### **Don't wave the red flag!**

- Don't exaggerate or moralize.
- Your writing should speak for itself. You don't need to underline the facts or keep pushing your particular ideological or political perspective.
- If economic liberalization has had a negative impact on women's work in a particular situation, show it; don't wave the anti-liberalization flag.
- Refrain from polemical writing.

*Source: Adapted from Kunda Dixit's Dateline Earth: Journalism as if the Planet Mattered.*

# Session 24

## Writing for Journals: A view from the Editor's Desk

### Learning Objectives

The participants will be able to:

- Describe what constitutes a good academic paper.
- State important tips to increase the likelihood of their research/manuscript being published.



**Time** 60 minutes

**Methodology :**



Presentation and discussion

### ACTIVITIES



#### Presentation

The presentation by the resource person covers all the important stages and steps in writing a good academic paper, starting from conceptualizing the paper, identifying potential publishers, to structure and contents of a good paper. The presentation also discusses referencing and avoiding plagiarism.

#### Before the writing

One must start thinking about writing a paper at the beginning of the project, make a note of possible target publications and research them.

Choose a topic that will continue to engage your attention throughout the exercise.

Ask yourself: Why am I writing this paper? It is important to have fun while writing.

Keep a diary and make note of other ideas for writing as one goes along. It is important to keep a note about one's experience, people one may need to meet again and of course the reference material that is needed for the paper.

Researching the target publication is important so that the paper can be made relevant to the subject matter and style requirements of the publication. Examine its archives to see if anything similar (as the planned paper) has appeared in the past. Make a note of change in content trends, if any.

Get a toehold in the journal. This can be done by writing a discussion note or a letter to the editor, or offering to review a book related to the current research project. The aim is to establish a line of communication.

## Writing the paper

### Prepare an Outline

- Write a 100-200-word pre-draft summary of your paper. This can form the basis for your introduction.
- List out the subtopics – this is an aid to help you focus on the theme and subtopics which are not important to the construct of the paper finally.
- List the subsections under each of the sub-topics. It is useful to prepare a bibliography of each subsection. In a data based paper, list out what elements of the data analysis you will use in this particular subsection. Remember in a completed paper the sub-topics may run across the paper. The subsections are the mechanical devices for organizing the paper.
- Start filling out the subsections.
- Organize the subsections in a logical order so that one flows into the other.
- This will give you the core of a rough first draft. Add the introduction and the conclusion at this stage.
- Continue to revise the outline even while you fill out the subtopics or subsections. It may undergo a complete change by the time you finish. It is just a device to help organize your paper.

## Plagiarism: know it, spurn it

### Forms of Plagiarism

- Downloading paper from the web and submitting as your own
- Copying from earlier coursework by someone else
- Cut and paste jobs from the web
- Quoting less than the full quotation
- Faking a citation

### Detecting Plagiarism

- Mixed citation styles
- Lack of references
- Skewed formatting, anomalies of diction, sudden sophistication, anomalies of style
- Datedness
- Softwares and resources on the web to check if the paper has been plagiarized

[Taken from Robert Harris 'Anti-Plagiarism Strategies for Research papers'. [www.virtualsalt.com/antiplag.htm](http://www.virtualsalt.com/antiplag.htm)]

Plagiarism can be avoided by understanding what referencing is all about.

## Using a gender-sensitive language

- 'Inclusive' instead of 'exclusive' use: exclusive is words that by their form or meaning discriminate: for example, craftsmen, weatherman, forefathers, gentleman's agreement. Inclusive words instead of the abovementioned words are like, artisan, meteorologist, ancestors, unwritten agreement. Also, manufactured instead of manmade; average person instead of man in the street, maintenance hatch for manhole, chair instead of chairman/ chairperson.
- Assumed gender - nurse or secretary are assumed to be a woman; and doctor, or pilot to be a man. e.g. "the surgeon put on his gloves".
- Gender in pronouns
- Recast noun/pronoun in plural "as a doctor, he should..." to "as doctors they should..." ;
- delete pronoun altogether eg "a good health worker relies on his common sense." "A good health worker relies on common sense. ";
- replace masculine pronoun with an article; every trainee should bring his manual. to "every trainee should bring the manual"; and
- use first or second person instead of third person, e.g.: "a careful clerk checks his books" to "as a careful clerk you should check your books".



## Readings

1. Sarukkai, S. (2007). The Writing of the Social Sciences. [esocialsciences.com](http://esocialsciences.com), Working Papers.
2. Twenty steps to writing a research article. <https://www.unl.edu/gradstudies/connections/twenty-steps-writing-research-article>
3. Blocken, B. (2017). 10 tips for writing a truly terrible journal article. <https://www.elsevier.com/authors-update/story/publishing-tips/10-tips-for-writing-a-truly-terrible-journal-article>

# Session 25

## From Research to Program Design

### Learning Objectives

The participants will be able to:

- Use research findings for program designing.
- Apply the gender analysis framework to analyse programmes as well as the research design.



**Time** 60 minutes

**Methodology :**



Presentations of case studies



Discussion on applying gender analysis framework

### ACTIVITIES



#### Presentation

Invited resource people present their case studies of how different bits of research were the basis for the designing intervention programmes.



#### Key Messages

1. Research helps in finding out the gaps and where the program implementation is required. Research can also tell us about with what target groups we need to work with.
2. Research findings also work as a supportive document when one tries to convince some government or non-government agency for implementing any program.
3. Principles of using research for program design:
  - Every research report should include an action plan, or implications for action.
  - We need to articulate a clear perspective before beginning the research because it will influence the program designing.
  - Operationalisation of terms is very important.
  - Identifying different stakeholders is important.
  - Stake holder analysis should be done to identify the parties that can help in a particular problem.



## Application of gender analysis framework

The participants can be asked to identify gendered aspects of the research as well as the programme design in the case studies presented.



## Readings

1. Lood, Q., Häggblom-Kronlöf, G. & Dahlin-Ivanoff, S. (2015) Health promotion programme design and efficacy in relation to ageing persons with culturally and linguistically diverse backgrounds: a systematic literature review and meta-analysis. *BMC Health Serv Res* 15, 560.  
<https://doi.org/10.1186/s12913-015-1222-4>
2. Pronk, Nicolaas. (2003). Designing and Evaluating Health Promotion Programs: Simple Rules for a Complex Issue. *Disease Management and Health Outcomes*. 11. 149-157. 10.2165/00115677-200311030-00002.
3. Dickerson, D., Baldwin, J.A., Belcourt, A. et al. (2020) Encompassing Cultural Contexts Within Scientific Research Methodologies in the Development of Health Promotion Interventions. *Prev Sci* 21, 33–42.  
<https://doi.org/10.1007/s11121-018-0926-1>

# Session 26

## From Research to Advocacy

### Learning Objectives

#### The participants will be able to:

- Define advocacy and types of advocacy.
- Understand the relevance of research for advocacy.
- Describe the process of using research findings for advocacy.
- State the necessary and sufficient conditions for successful advocacy efforts.



**Time** 90 minutes

**Methodology :**



Presentations

### ACTIVITIES



#### Presentation

1. Resource person asks participants to state what they understand by the term advocacy, five words that come to their minds when they think of ADVOCACY.

2. Resource person uses those words to define Advocacy.

*A democratic tool to bring about change – social, political, economic.*

*Advocacy is an organized, deliberate, systematic and strategic process intended to bring about a positive change towards fulfilling, respecting, protecting and promoting human rights of marginalized individuals and groups.*

*Advocacy is about increasing the voice, access and influence of marginalized individuals and groups in all decision-making processes that affect their lives, towards changing existing power hierarchies and relations.*

3. Resource person asks participants what connection they see between Advocacy and Research.
  - Research can contribute to advocacy in number of ways like in identifying core advocacy issues or 'problems' and possible solutions; by being an advocacy tool, by substantiating advocacy efforts with data/evidence.

### *Research serves to*

- ~ make visible significant issues to policy planners and implementers (through for instance, community-based research)
  - ~ create recognition or awareness of the significance or prevalence or severity of a problem (through quantitative and qualitative research)
4. Resource person shares examples of how research in the area of women's health has contributed to advocacy.
- a. The Jan Swasthya Abhiyan (JSA) or People's Health Movement conducted state wise survey to assess the situation of state health services and to document specific cases of denial. This was followed by a public hearing along with National Human Rights Commission (NHRC) at the state, regional and national level. Following this prompt action on specific cases to bring justice and provide compensation was undertaken by the state commissions. This also triggered a process of developing Public Health Acts in different states.
  - b. Implications of the two child norm on women resulting from the law barring persons with more than two children from holding elected offices in local self-government: The study by SAMA – Women Resource Group, New Delhi, in 12 districts of Madhya Pradesh and the analysis done by Nirmala Buch – UNFPA in five states of India, brought out the specific violations of the Act, particularly on women and the marginalized sections. Subsequent lobbying resulted in the revoking of the Act in Madhya Pradesh.

5. Resource person presents a framework for evaluating the advocacy efforts

### *A Tentative Framework for Evaluating Advocacy Efforts*

#### *Constituency*

- Who was the constituency?
- Was it part of the advocacy effort?
- Where was it at various phases?

#### *Rights based Advocacy*

- Did the advocacy effort address specific rights' violations?
- Were the advocacy initiative rights based in its approach?
- Did the power relations change as a result of the advocacy effort?

#### *Research and Analysis*

- Was adequate research and analysis built into the advocacy?
- Were the advocates able to project themselves as informed, authentic and authoritative?
- Was the analysis of the original issue accordingly reformulated in the advocacy?
- Was the campaigning sufficiently fine tuned and proactive with respect to larger macro changes nationally and internationally?



### *Long-term Sustainable Processes*

- Was the advocacy effort able to create long term processes for continuing the work initiated?
- Were upward, downward and horizontal linkages created and sustained?

### *New Consciousness and Awareness*

- Was the advocacy able to bring new consciousness among more and more people, media, and people in the judiciary/legislature/bureaucracy?

### *Gender Aspects*

- How did the content and process of the advocacy effort see women and men?
- In stereotypical roles?
- What did it do address gender equations within the campaign and in the larger society with respect to the issue?



## Readings

1. Leah Marion Roberts & Robert A. Marx (2018) The persistence of policies of protection in LGBTQ research & advocacy, *Journal of LGBT Youth*, 15:4, 280-299, DOI: 10.1080/19361653.2018.1479325.
2. How to do Advocacy from a Gender Perspective: A guide and a checklist.  
<https://www.diakonia.se/globalassets/documents/diakonia/how-we-work/gender-mainstreaming-toolbox/how-to-do-advocacy-with-a-gender-perspective-guide-and-checklist.pdf>
3. Institute of Medicine (US). *Community Perspectives on Obesity Prevention in Children: Workshop Summaries*. Washington (DC): National Academies Press (US); 2009. 6, Research and Advocacy Groups: How Does Evidence Inform Policy? Available from: <https://www.ncbi.nlm.nih.gov/books/NBK219824/>

# Session 27

## Advocacy Tools and Strategies

### Learning Objectives

#### The participants will be able to:

- Design advocacy campaigns based on a research study.
- Demonstrate the use of various tools and strategies for advocacy.



**Time** 90 minutes

**Methodology :**



Group exercise

### ACTIVITIES



**Step 1:** Participants are divided into groups. Each group is given or asked to read a research paper or report related to their field before the course. They are asked to develop an advocacy plan based on the following framework:

#### **A Situational Analysis (Factors)**

1. What is the political, economical and social context?
2. What is the available evidence? Do we need to build more evidence?
3. What are the rights violations?

#### **B Stakeholder Analysis (Actors)**

1. Who will support the advocacy effort?
2. Who will oppose?
3. What are the skills, resources available?
4. What more is required?

#### **C Identification of Advocacy Issues**

1. What are the issues that need advocacy? What is the change you seek to bring about?
2. Advocacy:
  - To whom?
  - By whom?
  - For whom?

## **D Planning Strategies and Activities**

1. Following are the principles of rights-based advocacy:
  - Refine information base
  - Develop communications
  - Balance consensus building, negotiation and confrontation
  - Make linkages across issues and groups

## **E Mobilization, Networking, Alliance Building**

1. Who can be the allies? And for what?
2. Who can be potential allies?
3. What is required to bring them in?

## **F What Advocacy Tools will you use?**

1. Press release
2. Letter to the editor
3. Posters
4. Policy brief
5. Pamphlet
6. Signature campaign
7. Others

Participants are told to remember that their advocacy effort will be evaluated using the framework described in the previous session.

**Step 2:** Groups present and the other participants comment based on the Evaluation Framework.

**Step 3:** Resource person summarises as follows:

- As a researcher one may have identified the core problem or issue, identified a possible solution to the problem as well. What should one do as the next step? How does one put the findings to use? What is the larger aim of undertaking the research?
- One must have an in-depth understanding and clarity of the problem, its magnitude and severity, understanding of the existing policies and their implementation/non-implementation, the stakeholders, and the change required in legislation, policy, regulation, legal decision, committee action, institutional practice etc.
- To prove a point or argument, it is necessary to collect and disseminate evidence to substantiate the arguments and this can be done through research/ data gathering and analyzing. Secondary data can be used as an indicator, to prove or disprove, the arguments based on the data.

- Advocacy is an ongoing process rather than a single policy or piece of legislation. Planning for continuity means articulating long-term goals, keeping functional coalition partners together and constantly updating data and arguments. It is necessary therefore to evaluate outcomes. If desired changes occur, then the implementation of the advocacy strategy and action needs monitoring. If desired changes do not occur, the strategy or action must be reviewed and revised, and the advocacy process needs to be repeated accordingly.



## Readings

1. Kelly, M. (2017). 8 Strategies and techniques for running an advocacy campaign. <https://www.salsalabs.com/blog/advocacy-campaign-strategies-techniques>
2. UNICEF. (2010). Developing an advocacy strategy (pg 15-70). In: Advocacy toolkit. [https://www.unicef.org/evaluation/files/Advocacy\\_Toolkit.pdf](https://www.unicef.org/evaluation/files/Advocacy_Toolkit.pdf)

# Acknowledgement of Session Developers and Facilitators

Module and Sessions	2006	2007
<b>Module 1: Introduction to concepts and tools in gender, rights, development, and health</b>		
Session 1: What is Gender?	Renu Khanna Prof. N Rajaram	Renu Khanna
Session 2: Patriarchy	Dr. Trupti Shah	Jhanvi Andharia
Session 3: Social Construction of Masculinity and Femininity	Prof. N Rajaram Renu Khanna	Prof. N Rajaram Renu Khanna
Session 4: Gender Inequalities, Power and Control	Prof. N Rajaram Renu Khanna	Prof. N Rajaram
Session 5: Health as Development and Gender Issue	Jhanvi Andharia Renu Khanna	Jhanvi Andharia Renu Khanna
Session 6: Sexuality and Violence	NA - Session not conducted	Renu Khanna
Session 7: What are Rights?	Prof. N Rajaram	Prof. N Rajaram
Session 8: Applying the Rights Approach to Health	Renu Khanna	Prof. N Rajaram Renu Khanna
<b>Module 2: Researching gender and social issues in health</b>		
Session 9: Research Process- Step by Step	Prof. Lakshmi Lingam	Prof. Lakshmi Lingam
Session 10: From Research Ideas to Research Questions	Prof. Sundari Ravindran Prof Lakshmi Lingam	Prof. Lakshmi Lingam
Session 11: Literature Review	Prof. Lakshmi Lingam	Prof. Lakshmi Lingam
Session 12: Paradigms of Research	Prof. Shagufa Kapadia Prof. N Rajaram	Prof. Shagufa Kapadia Prof. N Rajaram
Session 13: Overview of Qualitative Research Methods	Urvi Shah Prof. Shubhada Kanani Dr. Uma Nayak	Prof. Shubhada Kanani
Session 14: Secondary Data: A Useful Source in Research	Prof Sundari Ravindran Urvi Shah	Urvi Shah

Module and Sessions	2006	2007
Session 15: Gendered Research	Prof Sundari Ravindran	Dr. Abhijit Das
Session 16: Gendered Indicators	Prof. Sundari Ravindran Renu Khanna	Dr. Abhijit Das
Session 17: Gendered Study Designs	Prof. Sundari Ravindran	Dr. Abhijit Das
Session 18: Developing Gender Sensitive Data Collection Tools	Prof Sundari Ravindran	Dr. Abhijit Das
Session 19: Analysing Qualitative Data	Dr. Bhamini Mehta	Dr. Bhamini Mehta
Session 20: Managing Data and Writing Reports	Dr. Sandhya Barge	Dr. Sandhya Barge
Session 21: Applying Gender Research Methods: Researching Men	Prof. N Rajaram	Prof. N Rajaram Dr. Y.S. Marfatia
Session 22: Ethical Issues in Conducting a Research Study	Sunita Bandewar	Dr. Bhavna Mehta
<b>Module 3: Taking research forward: communication, programme design and advocacy</b>		
Session 23: Communicating Research	Padma Prakash	Padma Prakash
Session 24: Writing for Journals: A View from the Editor's Desk	Padma Prakash	Padma Prakash
Session 25: From Research to Program Design	NA - Session not conducted	Archana Joshi
Session 26: From Research to Advocacy	Anuj Kapilashrami	Renu Khanna
Session 27: Advocacy Tools and Strategies	Anuj Kapilashrami	Renu Khanna



# Sahaj

towards alternatives in health and development

## **SAHAJ**

1- Shri Hari Apartment, 13 Anandnagar Society,  
Behind Express Hotel, Alkapuri, Vadodara,  
Gujarat-390022, India

Telephone : +91 265 2342539 (Admin Office)  
+91 265 2358307 (Programme Office)

Email : [connectwithsahaj@gmail.com](mailto:connectwithsahaj@gmail.com)

Website : [www.sahaj.org.in](http://www.sahaj.org.in)

Facebook : <https://www.facebook.com/sahaj.shishumilap>

Twitter : [@SAHAJVadodara](https://twitter.com/SAHAJVadodara)