Guidance on Methodologies for Researching Gender Influences on Child Survival, Health and Nutrition
ACKNOWLEDGEMENTS

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On the part of LSTM, the lead author was Esther Richards, who drafted the guidance and then incorporated comments and suggestions to produce this final version. She was supported by Rachel Tolhurst and Sally Theobald, who provided substantive technical inputs.

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We are grateful for the assistance provided by gender and child health experts who offered advice and information on the issues outlined in the guidance. Details of these contacts are provided in Annex II.

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EXECUTIVE SUMMARY

Context to the literature review and guidance on gender and child health

There is increasing recognition in the field of international health and nutrition that gender inequities and dynamics are a major social determinant of health and nutrition outcomes. However, reviews of evidence to date have tended to concentrate on comparisons of health and nutrition outcomes, healthcare utilisation or coverage of services/programmes between boys and girls or women and men. This review of the literature and accompanying guidance document respond to a range of questions exploring more broadly the ways in which gender influences household dynamics in relation to aspects of young child health and nutrition.

The development of the literature review (“Gender influences on child survival, health and nutrition: a narrative review”) and accompanying guidance document (“Guidance on methodologies for researching gender influences on child survival, health and nutrition”) follows the publication of UNICEF’s operational guidance on gender analysis and programming on the Focus Area of Young Child Survival and Development (published in 2011). During the development of the operational guidance, it emerged that there is limited data on the impact of gender on child survival outcomes and that more tools would be needed to conduct quality gender analyses. Thus, the literature review was commissioned in order to gain a more systematic overview of the available research on gender influences on child survival, health and nutrition, with the express aim of identifying the relevant methodologies and tools for undertaking such research. The guidance document provides a step-by-step guide to these methodologies including tools and concrete examples to help UNICEF country offices initiate and support formative research on gender and aspects of child health and nutrition. The literature review and guidance documents drew on findings from academic and ‘grey’ literature, based on an extensive search using the following strategies: a systematic search of the Discover Database (which combines 33 of the leading health and social sciences databases such as Medline, CINAHL, Global Health, Science Direct, Scopus, Sociological Abstracts, among others); a ‘grey’ literature search of key health and development websites; contact with 42 leading experts in gender and child health; and hand-searches of four leading international health journals (Health Policy and Planning, Journal of Health, Population and Nutrition, Social Science and Medicine and Tropical Medicine and International Health).

While the review itself outlines the considerable range and breadth of research findings on different dimensions of gender, the accompanying guidance document focuses on the methods, tools and data sources used by the studies to usefully investigate these issues.

Gender influences on child survival, health and nutrition: a narrative review:

Section 1.1 of the literature review draws on studies investigating women’s status and intra-household bargaining in relation to child survival, health and nutrition. Overall the studies reviewed found that women’s bargaining power is influential in two main areas. Firstly the extent to which women are able to influence decision-making within the household influences how resources are channelled to children both in terms of nutrition and health inputs (i.e. feeding practices, prenatal and birthing care, treatment-seeking for child illness and immunisation). Secondly, women’s ability to access and control the use of resources for their own health and well-being impacts significantly on their children’s survival, health and nutrition.

Section 1.2 of the review focuses on some of the ways in which divisions of labour between women and men influence practices impacting on child survival, health and nutrition. Overall, the studies included in
this section demonstrated that women’s multiple responsibilities (which often encompass domestic tasks, child care and paid labour) present a heavy burden on women which has potentially negative impacts for child health and nutrition outcomes. Men, on the other hand, are often not expected to bear responsibility for domestic tasks or child care, which restricts the care options for children whose mothers are over-loaded.

**Section 1.3** of the review focuses on the influence of gender norms, values and identities in relation to child survival, health and nutrition. Overall, it was found that socio-cultural values which perpetuate certain expectations about women’s and men’s capacities, characteristics and social behaviour underpin many of the imbalances between women and men viewed in the previous sections. These have serious consequences for child survival, health and nutrition, especially in contexts where gender bias against girls exists. There are also serious consequences for children exposed to domestic violence, a phenomenon which reflects gender discrimination at its most extreme.

**Section 2** of the review focuses on evaluations of interventions which have used an aspect of gender-awareness in their intervention design with the aim of addressing issues around child health and nutrition. After an extensive search only five examples of relevant evaluations were identified. This is an area where further work is needed to design sufficiently sensitive strategies to evaluate gender-sensitive interventions. It is critical to explore the gender dynamics and processes leading to particular health service user outcomes in order to understand how gender roles and relations interact with interventions to influence child health and nutrition outcomes and service utilisation outcomes.

**Guidance on methodologies for researching gender influences on child survival, health and nutrition:**

The guidance on methodologies for researching gender influences on child survival, health and nutrition draws on examples from the review and from other sources, to identify key aspects in conducting gender-sensitive research. Although the methods outlined are largely the same as those used for researching other topics, the guidance highlights ways in which these methods and tools can be used to elicit gender-sensitive information on child survival health and nutrition.

At the heart of gender-sensitive methods, is the need to reflect on the potential for any research topic, question, method or tool to elicit information on the different ways in which girls, women, boys and men experience their status, roles, responsibilities, decision-making power and access to and control over resources. The guidance highlights the importance of incorporating these considerations at every stage of the study design - as well as other cross-cutting factors such as age and socioeconomic status, in order to successfully conduct gender-sensitive research. The guidance provides a step-by-step guide to methods and tools that can be used to explore and analyse how gender shapes child health and nutrition and also to design and evaluate responsive interventions from a gender perspective (including quantitative questionnaires, gender-sensitive indicators, qualitative interviewing techniques, Participatory Rapid Appraisal methods, among others). However it also highlights that the choice of method to use for a particular study will depend on a number of factors including: the setting, research question and topic, conclusions sought and logistical issues.

**Conclusions from the Literature Review and Guidance on gender and child health**

The literature review and guidance together highlight the urgent need for further use of gender-sensitive approaches to research that addresses child health and nutrition across a range of contexts. This is important because of the critical role that such contexts play in shaping the impact of gender dynamics. Efforts to address gender in health and nutrition programming need to be widely shared to
promote further learning and action. The consideration of gender is an integral component of UNICEF’s broader commitment to ensuring equity in child health and nutrition. Child health and nutrition interventions will be more effective, equitable and sustainable if they are designed based on gender-sensitive information and continually evaluated from a gender perspective.
INTRODUCTION

This guidance document has been designed to be read alongside “Gender influences on child survival, health and nutrition: a narrative review”. Both documents were commissioned by UNICEF to explore a range of questions addressing the ways in which gender influences household dynamics in relation to aspects of young child health and nutrition.

The development of the literature review and guidance document follow the publication of UNICEF operational guidance on gender analysis and programming on the Focus Area of Child Survival (published in 2011). During the development of the operational guidance, it emerged that there is limited data on the impact of gender on child survival outcomes and that more tools would be needed to conduct quality gender analyses. This literature review was commissioned in order to gain a more systematic overview of the available research on gender influences on child survival, health and nutrition, with the express aim of identifying the relevant methodologies and tools for undertaking such research. The guidance document provides a step-by-step guide to these methodologies and tools for countries to commission formative research on gender and aspects of child health and nutrition and to provide concrete examples of methods (including quantitative questionnaires, gender-sensitive indicators, qualitative interviewing techniques, Participatory Rapid Appraisal methods, among others).

The review responds to a range of questions exploring how gender influences household dynamics in relation to aspects of young child health and nutrition. We adopted a narrative approach to undertake the review of studies, which involves synthesising primary studies in order to explore heterogeneity descriptively rather than statistically\(^1\). The review draws on findings from academic and ‘grey’ literature, based on an extensive search focusing on the following research questions:

1. How do women’s status, agency and access to resources affect the health and nutrition of young children?
2. How do gender divisions of labour affect the health and nutrition of young children?
3. How do men’s roles and masculinities affect the health and nutrition of young children?
4. Which methodologies and data sources have been used to assess the impact of gender on the health and nutrition of young children and what are their strengths and weaknesses?
5. Which approaches to addressing the impact of gender inequalities, roles and relations on young child survival have been assessed and with what results?

While the review itself outlines the considerable range and breadth of research findings on different dimensions of gender, this guidance document responds to question 4 (see above) and provides insight into the methods, tools and data sources used by the studies to usefully investigate these issues. In section 1 the key messages from the literature review are presented. In sections 2 - 9 the relevant methods, tools and data sources are discussed in order to identify how these might be applied in further gender-sensitive research on child survival, health and nutrition.

\(^1\) For more information on this approach in reviewing literature, see Petticrew M, & Roberts H (2006) Systematic Reviews in the Social Sciences: A practical guide, Oxford: Blackwell Publishing.
The key messages from the literature review are presented according to the three broad themes against which the review was organized:

- women’s status and intra-household bargaining,
- gender divisions of labour
- gender norms, values and identities.

Section 2 provides a brief introduction to using different methods and why, based on examples arising from the review. This section also includes a summary table with some examples of the ways in which methods could reflect some of the research areas outlined in the key messages above. Section 3 discusses the main elements of a gender-sensitive situation analysis. Section 4 outlines key quantitative methods and tools and section 5 presents key qualitative methods and tools. Section 6 highlights the strengths and weaknesses in using these different methods. Section 7 presents gender sensitive approaches to qualitative and quantitative sampling strategies, and section 8 provides some suggestions on gender-sensitive strategies for data analysis, while section 9 introduces ethical dimensions of gender-sensitive research. The document is summed up with a brief conclusion following section 9. Annexes I and III provide exemplars of specific research tools. Annex II provides a list of gender and child health experts contacted. Annex IV provides a list of further resources for undertaking research from a gender perspective.

We did not find any studies that specifically used a gender-sensitive approach to document and evaluate an intervention to address child health and nutrition. This is an area where tools and methods urgently need to be developed and further work is needed to design sufficiently sensitive strategies to evaluate such gender-sensitive interventions. Such approaches must include both quantitative analysis of outcomes and process evaluations which investigate how an intervention works or does not work both from the perspective of health provider and form the perspectives of community members, such as mothers of different ages, grandmothers, fathers, women and men across urban and rural settings. It is critical to explore the gender dynamics and processes leading to particular health service use outcomes in order to understand how gender roles and relations interact with interventions to influence child health and nutrition outcomes and service utilisation outcomes.

1 KEY MESSAGES FROM THE LITERATURE REVIEW “GENDER INFLUENCES ON CHILD SURVIVAL, HEALTH AND NUTRITION: A NARRATIVE REVIEW”:

The review accompanying this guidance document is organised thematically. The key messages from each theme are highlighted below with a brief introduction to their significance for child survival, health and nutrition. These messages represent key points from the studies reviewed in the accompanying literature review: “Gender influences on child survival, health and nutrition: a narrative review”. Where studies from the narrative review are used in this document, they are cited and included in the References section following the Conclusion. The remaining studies are cited in the accompanying document. The studies represented below were identified based on an extensive literature search which combined the following strategies: a systematic search of the Discover Database (which combines 33 of the leading health and social sciences databases such as Medline, CINAHL, Global Health, Science Direct, Scopus, Sociological Abstracts, among others); a ‘grey’ literature search of key health and development websites; contact with 42 leading experts in gender and child health; and hand-searches of four leading
international health journals (Health Policy and Planning, Journal of Health, Population and Nutrition, Social Science and Medicine and Tropical Medicine and International Health).

### 1.1 KEY MESSAGES ON WOMEN’S STATUS AND INTRA-HOUSEHOLD BARGAINING

Section 1.1 of the review draws on studies that investigate women’s status and intra-household bargaining in relation to child survival, health and nutrition. This section explores bargaining processes through looking at the relationship between women’s relative decision-making and access to and control over resources. Overall the studies found that women’s bargaining power is influential in two main areas: first that the extent to which women are able to influence decision-making within the household influences how resources are channelled to children both in terms of nutrition and health inputs (i.e. feeding practices, prenatal and birthing care, treatment-seeking for child illness and immunisation). Second, that woman’s ability to access and control the use of resources for their own health and well-being impacts significantly on their children’s survival, health and nutrition. Below are the key messages from this section of the literature review.

**Key messages on women’s status and intra-household bargaining in relation to child survival, health and nutrition:**

- Maternal education correlates powerfully with child survival and there is evidence to suggest that women who are more highly educated have both greater earning power and improved status within the household which enables them to gain greater access to and control over resources for the benefit of their children. Education may also enable women to negotiate modern bureaucratic systems (such as health services) more effectively;

- While paternal education also has an effect on child survival, there is nevertheless a greater effect from maternal education;

- There is a virtuous circle in which women may benefit psychologically from education, which decreases their likelihood of depression and in turn reduces potential ill-effects on their children’s health (which has been shown to suffer in the case of their mother experiencing depression);

- Women’s increased access to and control over financial resources has also been associated with improvements in child nutrition and health preventative behaviours such as child and infant immunisation.

- Women’s ability to seek treatment for sick children often depends on their relationship with the children’s father and whether or not they are able to involve him in the decision-making process;

- Men’s involvement in decision-making can increase the likelihood of children benefitting from decisions which require a larger budget (such as a journey to a clinic), whereas women’s smaller budgets are a restriction on the type of health care women can access;

- Treatment seeking for child illness often relies on decision-making processes which are the culmination of negotiation between different household members, in many cases mothers and fathers, but also, older and young members (such as mothers and their mothers-in-law)
Decisions on other aspects of child health and care are also influenced by intra-household bargaining; for example infant feeding practices sometimes reflect the influential role of senior women and husbands which can lead to both positive and negative outcomes for child health nutrition outcomes. There is scope for more investigation of the potential benefits for child health of engaging with men and senior women for child feeding practices.

These findings nevertheless underline the importance of women’s financial and decision-making autonomy in relation to child health and nutrition outcomes.

In general, women’s access to and control over financial assets has strong correlations with improved nutritional outcomes and health preventative behaviours for their children, however, household structure can modify this correlation in important ways:

- Although access to financial resources is crucial in terms of women’s ability to care for their children, where women lack authority within the household, they may find themselves more constrained to act even despite this – access to does not always mean control over resources;

- There are benefits and disadvantages for children living in female-headed households as opposed to male-headed households, as the financial contribution of a working male remains an important source of income for children’s health and nutrition.

- Female-headed households can also exist in a variety of forms reflecting different levels of involvement of male and other senior family members.

- Furthermore, hierarchies of age which impact on women’s bargaining power can have a negative effect on their children’s nutritional and health outcomes, for example where women are significantly younger than their husbands, or where women live in households where considerable power is held by a senior female (i.e. mother-in-law);

- On the other hand the children of women who live with female peers or with senior females can also benefit from greater access to resources such as income, advice and alternative child care.

- Children living in polygamous households may also experience worse health and nutrition outcomes if they are the children of a less ‘important’ wife.

There is evidence from countries across three regions (South Asia, Sub Saharan Africa and Latin America and the Caribbean) that children’s nutritional status improves when women have greater decision-making power within the household although there are variations by region:

- Improvements in women’s decision-making power in the household had the strongest effect on child nutrition status in South Asia;

- The effect was less strong, though still significant for Sub Saharan Africa;

- In Latin America and the Caribbean there was only a positive effect on children’s short-term nutrition status effect and only in households where women’s relative decision-making power is very low.
These improvements in women’s status appear to have a stronger effect on child nutritional outcomes among poorer households;

The pathways to these outcomes include improvements in women’s own health and nutrition and improvements in caring practices such as prenatal and birthing care for women, in feeding practices, treatment of child illness and immunisation;

Breastfeeding is the only care practice which may become compromised by improvements in women’s status. The reasons for this are as yet unknown but may be linked to women’s exposure to marketing and promotion of breastmilk substitutes, including by health professionals, to a lack of knowledge about the benefits of breastfeeding, a shift in social norms around infant feeding accompanying economic development, urbanization and other social factors, or to inflexibility in paid work conditions.

Studies also show correlations between indicators of women’s autonomy and child health and nutrition outcomes, including increased maternal age, education and residence in a female headed household, women’s lifetime exposure to employment and whether they are part of a family structure amenable to empowerment and finally their ability to make decisions to travel outside the home to pay visits to health institutions and to make decisions about household purchases.

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**1.2 KEY MESSAGES ON GENDER DIVISIONS OF LABOUR**

Section 1.2 of the review focuses on the ways in which divisions of labour between women and men influence practices that impact on child survival, health and nutrition. Overall, the studies included in this section demonstrated that women’s multiple responsibilities (which often encompass domestic tasks, child care and paid labour) present a heavy burden on women which has potentially negative impacts for child health and nutrition outcomes. Men, on the other hand, are often not expected to bear responsibility for domestic tasks or child care, which restricts the care options for children whose mothers are over-loaded.

**Key messages on the impact of gender divisions of labour on child survival, health and nutrition:**

- Women’s responsibilities within the household encompass a considerable number of tasks in maintaining the household and its members, as well as responsibilities external to the household which can lead to women’s time poverty and thus impede the way in which children are cared for;

- Household structures which include more female members may mitigate some aspects of women’s time poverty by increasing the numbers of potential carers and workers available for household tasks.

- Breastfeeding practices are undermined by a lack of appropriate legislation for maternity entitlements and a lack of adherence to existing legislation (where such entitlements have not been communicated well to women and/or where employers are remiss in their fulfillment of such requirements);
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- Women’s paid labour can have positive outcomes for child health and nutrition by increasing the household income, however there can be negative effects on child health where women work outside the home and are unable to procure appropriate alternative child care.

- Both working and non-working mothers would benefit from access to appropriate child care support.

- Under-nutrition is linked in some cases to the lack of appropriate alternative carers within families due to precarious socio-economic circumstances and the pressure on parents and other members of the household to secure livelihoods.

- Although men have not traditionally fulfilled caring roles, there is evidence to suggest their greater input into child health/care could have positive outcomes for the health and development of their children;

- When men are involved in child care there is evidence to suggest that they tend to be involved in play rather than engaged in daily child care routines;

- Men’s roles are also context specific and should not be generalized, for example there may be important life stage and socio cultural influences that impact on their behaviour;

- It is important to find ways in which men can be encouraged to take a more active role in child health/care while also ensuring that existing power relations are not reinforced but challenged and transformed to become more gender equitable.

### 1.3 KEY MESSAGES ON GENDER NORMS, VALUES AND IDENTITIES

Section 1.3 of the review focuses on the influence of gender norms, values and identities in relation to child survival, health and nutrition. Overall, it was found that socio-cultural values which perpetuate certain expectations about women’s and men’s capacities, characteristics and social behaviour underpin many of the imbalances between women and men viewed in the previous sections. These have serious consequences for child survival, health and nutrition, especially in contexts where gender bias against girls exists. There are also serious consequences for children exposed to domestic violence, a phenomenon which reflects gender discrimination at its most extreme.

Key messages on the influence of gender norms, values and identities on child health and nutrition outcomes:

- In some contexts cultural norms about gender can influence the ways in which girls and boys are valued by their communities which can lead to preferential treatment of boys and reduced survival rates of girls.

- On the other hand, in some populations, fears about bio-medical interventions such as immunisations can lead to communities withholding key health services from boys.

- Different gender norms can produce similar outcomes for child health and nutrition;

- Infant feeding practices are powerfully influenced by prevailing cultural and gendered norms and recent research has highlighted the importance of including men and other supporting...
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members of households in breastfeeding education;

- The role of grandmothers as expert advisors to young women must also be taken into account in infant feeding and other aspects of child care;

- Addressing the challenge of infant feeding in contexts where HIV is prevalent requires a good understanding of the roles which supporting members of household may play, but also needs to take into account the difficulties women may face around disclosing HIV status to their family members;

- However it is vital that the inclusion of other members of the household in any aspect of child care is sensitive to gender discrimination against women and that interventions seek to foster collaborative care for infants, not undermine women’s roles as carers;

- Domestic violence presents a considerable risk to the health and well-being of women and their children. Recent research on this issue has demonstrated that child exposure to domestic violence presents risks to child survival due to the following factors:

  - Considerable negative effects on maternal health, including increased risk of depression and malnutrition, which can contribute to adverse pregnancy outcomes and negative responses to breastfeeding;

  - Considerable negative effects on child health, including higher stress levels and increased risk of morbidity, as well as low birth weight linked to their mother’s worse health during pregnancy and increased chances of stunting and wasting;

- In some contexts, domestic violence may be perceived as a legitimate form of ‘punishment’ especially where gender norms about women’s and men’s roles are particularly rigid.

2 WHICH METHODS, WHEN?

Before describing qualitative and quantitative tools in more depth it is important to note some of the ways in which quantitative and qualitative methods are complementary when exploring gender and child survival, health and nutrition.

The majority of the studies reviewed used these quantitative or qualitative methods independently. For example the studies reviewed in section 1.1.5 relied solely on quantitative methods (e.g. household surveys) to demonstrate associations between indicators of women’s bargaining power and child health and nutrition status. On the other hand, a number of studies using qualitative methods (e.g. focus group discussions) usefully elucidated intra-household decision-making processes in relation to treatment-seeking for child malaria (see section 1.1.3).

However, combining qualitative and quantitative research in a ‘mixed-methods’ approach can be useful for exploring questions which address gender issues, since, as the literature review demonstrates, the two approaches offer different perspectives on the issues. The diagram below illustrates how qualitative and quantitative methods can feed into one another or can be carried out independently and the
examples below describe when qualitative methods might usefully feed in to quantitative methods and vice-versa, or how both methods can be used simultaneously for good results.

For example it might be useful to carry out preliminary qualitative research in order to inform the design of a quantitative survey tool:

- e.g. it may be necessary to conduct some key informant interviews (see section 5 below) to develop a good understanding of the socio-cultural context, (e.g. women’s freedom of movement), in order to decide which gender-sensitive indicators are most appropriate for investigating women’s bargaining power (see section 4 below).

Alternatively a quantitative survey might point to a specific issue which requires more qualitative exploration:

- e.g. a questionnaire (see section 4 below) may reveal that women who are more educated are less likely to breastfeed their infants, yet give no indication why this is the case. This could be further investigated through focus group discussions and in-depth individual interviews (see section 5 below).

Finally, studies could be designed to include both qualitative and quantitative methods in order to cross-reference between methods and triangulate the findings:

- e.g. a study on the impact of domestic violence on young children may make use of a national-level survey in order to determine prevalence of a specific form of violence and then choose a sub-sample for further qualitative investigation to investigate the psychological impact on young children.

The following sections take a step-by-step approach through the methods and tools useful for undertaking research on gender and child survival, health and nutrition. The methods and tools outlined reflect those which are used generally in good research practice, but can also be useful for gender-sensitive research. While the majority of examples used are from the studies in the literature review, the guidance draws on additional examples from gender sensitive research approaches in other areas (for example tools used to research HIV/AIDS and gender-based violence outlined further in sections 4 and 5).

Table 1 below provides examples of methods and sampling approaches, which could be used to address research questions emerging from the literature review, and gives examples of studies which have taken this approach.
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| What is the correlation between mothers’ paid work and their children’s health and nutrition status? | To explore how women’s and men’s paid and unpaid labour impacts on child health and nutrition status | Mother’s and father’s socioeconomic status, employment status, type of work and income from paid work and other income | HAz, WAz, WHz scores, Immunisation coverage, Utilisation of prenatal services, Feeding practices, Mortality/morbidity, Treatment of child illness | Population-based sampling (e.g. DHS methodologies) and other randomised sampling processes | A study carried out by LaMontagne, Engle & Zeitlin (1998) used data collected from 12-18 month children from 80 households randomly selected across 10 different low income neighbourhoods in Nicaragua. It was found that children of paid working mothers in Nicaragua had greater weight for height than those whose mothers did not do paid work. An important aspect of the study design involved controlling for confounding variables of maternal differentiation, household wealth and child gender. |
| What is the correlation between fathers’ paid work and their children’s health and nutrition status? | To measure the prevalence and map the consequences of violence against women and children in a specific community | Mother and infant/child exposure to physical, sexual, psychological abuse | Birth weight at delivery, HAz, WAz, WHz scores, Immunisation coverage, Utilisation of prenatal services, Feeding practices, Mortality/morbidity, Treatment of child illness | Population-based sampling (e.g. DHS methodologies) and other randomised sampling processes | A study carried out in Uganda by Kaye, Mirembe, Bantebya, Johansson & Ekstrom (2006) investigated whether domestic violence during pregnancy was a risk factor for antepartum hospitalization or low birth weight delivery among a cohort of 612 women recruited during the second trimester of their pregnancy and followed up to delivery. The researchers assessed exposure to physical, sexual or psychological violence using the Abuse Assessment Screen and calculated the risks of low birth weights and hospitalization using multivariate logistic regression analysis. Among 169 women who reported violence, the relative risk (RR) of low birth weight was 3.78 (95% CI 2.86–5.00). These women also had a 37% higher risk of obstetric complications that required hospitalization [RR 1.37 (95% CI 1.01–1.84)]. |

| How prevalent is violence against women and children in a specific community? | To measure the prevalence and map the consequences of violence against women and children in a specific community | Mother and infant/child exposure to physical, sexual, psychological abuse | Birth weight at delivery, HAz, WAz, WHz scores, Immunisation coverage, Utilisation of prenatal services, Feeding practices, Mortality/morbidity, Treatment of child illness | Population-based sampling (e.g. DHS methodologies) and other randomised sampling processes | A study carried out in Uganda by Kaye, Mirembe, Bantebya, Johansson & Ekstrom (2006) investigated whether domestic violence during pregnancy was a risk factor for antepartum hospitalization or low birth weight delivery among a cohort of 612 women recruited during the second trimester of their pregnancy and followed up to delivery. The researchers assessed exposure to physical, sexual or psychological violence using the Abuse Assessment Screen and calculated the risks of low birth weights and hospitalization using multivariate logistic regression analysis. Among 169 women who reported violence, the relative risk (RR) of low birth weight was 3.78 (95% CI 2.86–5.00). These women also had a 37% higher risk of obstetric complications that required hospitalization [RR 1.37 (95% CI 1.01–1.84)]. |
### Table 2 - Illustrative Examples of Relevant Methodologies, Indicators, Questions and Sampling (Qualitative Approaches)

<table>
<thead>
<tr>
<th>Example of questions arising from the literature review</th>
<th>Research topic</th>
<th>Possible methods (qualitative)</th>
<th>Sampling suggestions</th>
<th>Examples from the literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who makes final decisions on emergency treatment-seeking for child illness?</td>
<td>To explore decision-making processes in relation to treatment-seeking for child illness</td>
<td>A range of in-depth interviewing techniques, including Key Informant Interviews, Focus Group Discussions (FGDs), Critical Incidence Interviews</td>
<td>Focus Group Discussions with different categories, i.e. young/older men, young/older women, married/unmarried women, female/male heads of household. Follow-on in-depth interviews/ Critical Incidence Interviews(number of interviewees can be quite small as these interviews would aim to be illustrative of the process and would pick up on issues from the FGDs to explore in more depth). The sampling process should reflect the community you are interested in and could be purposive, or could make use of a snowball method in hard-to-reach communities.</td>
<td>The study by Tolhurst et al. (2008) was part of a wider gender-sensitive Rapid Appraisal of socio-cultural influences on health-seeking behaviour for malaria and focused on the research question: How does gender influence treatment-seeking behaviour for children? Researchers carried out FGDs with a wide range of participants including: child-bearing women (24-45), grandmothers (aged above 50), young single women, ever married women, female traders with capital above a specific amount, female subsistence farmers, men between 25 and 40 and men over 40. In-depth interviews were carried out with a range of participants including: female heads of household, single mothers, women in polygamous marriages, women in monogamous marriages, married women not living with husbands and men between 18 and 80. In-depth interviews focused on 'critical incidents' when a child was ill, exploring the decision-making process for treatment. Findings revealed a range of decision-making pathways and processes which highlighted the significant role that authority structures related to gender and age played in relation to treatment-seeking for child fever.</td>
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<tr>
<td>Are decisions made jointly or individually by a particular household member?</td>
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<td>Who pays for emergency treatment (direct and indirect costs)?</td>
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<tr>
<td>Does the child’s mother or main caretaker have decision-making power, access to and control over resources to meet the costs of treatment?</td>
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<tr>
<td>How do these dynamics influence access to treatment?</td>
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<tr>
<td>What is the distribution of tasks, roles and responsibilities among different members of the household?</td>
<td>To investigate the gender division of labour in relation to child care and health practices</td>
<td>A range of PRA/PLA exercises using mapping tools, transect walks, calendars, etc. (see section 5.2) In-depth interviews and Focus Group Discussions</td>
<td>Key Informants to assist with the transect walks. FGDs or group interviews for the mapping/calendar exercises to be carried out with. Participants could include young/older men, young/older women, married/unmarried women, female/male heads of household. Follow up FGDs and In-depth interviews with interviewees in each category (number can be quite small as these interviews would aim to be illustrative of the process and would pick up on specific issues. The sampling process should reflect the community you are interested in and could be purposive, or could make use of a snowball method in hard-to-reach communities.</td>
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<tr>
<td>What are the gender norms related to the acceptability of violence against women? What are the socio-cultural norms influencing the authority structure of the household? Who is mainly affected by violence against women, e.g. young women or women who are HIV</td>
<td>To investigate the gender and socio-cultural norms and practices associated with gender-based violence, especially against women</td>
<td>FGDs and in-depth interviews with specific categories of women and men Key Informant Interviews with participants from NGOs and agencies working on the issues</td>
<td>FGDs and In-depth interviews with interviewees in each category i.e. younger/older/HIV positive/negative/women and men from different household structures. The sampling process should reflect the community/ies you are interested in and could be purposive, or could make use of a snowball method in hard-to-reach communities.</td>
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<tr>
<td>A study by Mwangome, Prentice, Plugge &amp; Nweneka (2010) explored constraining factors for mothers’ child health and nutrition practices in a rural community in the Gambia. 63 women took part in 8 focus group discussions, based on a purposive sampling process in order to achieve a certain level of homogeneity among the participants. The women had all attended a local clinic with their children within 12 months of the start of the study. The FGD guide was developed with the main research question in mind: “why is it that the mothers in this community cannot practise what they know about child health and nutrition?” Among other things, one of the main factors identified by women in FGDs was their heavy work-load – involving the sole care of the child as well as responsibility for other farm work. The women explained that because they were unable to ask their husbands for help with child care (as it is perceived to be the responsibility of the woman) their child care and nutrition practices were often constrained by their heavy work-load.</td>
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<tr>
<td>The study by Kapadia-Kundu, Khale, Upadhaye &amp; Chavan (2007) explored physical violence against young married women in relation to gender roles and household and family dynamics in two sites – one urban, one rural – in Maharashtra, India. The researchers interviewed 61 newly-married young women and conducted 32 FGDs: 12 with newly married young married women, 12 with husbands and 8 with mothers-in-laws. They also</td>
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</table>
positive? Women living in particular household structures, e.g. where norms are more rigid?

conducted 13 key informant interviews with community-level healthcare workers.
The data collected indicated two patterns of initiation of physical violence in young married women: within six months of marriage and after the birth of the first child. The study found that gender norms varied between households that were more stringent and those that were more flexible in their expectations of young women. Women were more likely to experience violence when they were perceived to have failed to carry out their duties in households that were more stringent.

3 GENDER-SENSITIVE SITUATION ANALYSIS

A gender-sensitive situation analysis represents the first step in researching any aspect of gender influences on child survival, health and nutrition. In some cases, the situation analysis may provide all the data needed in order to design an intervention more effectively. In other cases, it may lead you to unanswered questions which need to be researched in more depth.

What to include in a gender-sensitive situation analysis?

- Statistics from established data sources such as Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) or other available national or regional household surveys which contain indicators relevant to women’s status (e.g. Butajira Demographic Surveillance Site in Egypt);

- While finding, generating and analysing data disaggregated by sex is important, this only represents a first step in terms of ensuring the gender-sensitivity of a research project

- Other secondary materials which can be quickly accessed and scanned for information relevant to gender issues and child health and nutrition (academic or ‘grey’ literature, i.e. NGO reports, policy documents, etc.);

- Key Informant Interviews may be carried out with representatives of the communities or organisations of particular interest to the topic you are working on (see Box 1 below);
Importantly, an effective gender-sensitive research approach should draw on information about gender roles and relations with reference to men and boys as well as women and girls.

Box 1: Key Informant Interviewing

Key Informant Interviews are useful for obtaining information as part of a situation analysis or where there are few published data available, in order to gain an overview of the issues.

Key informants are usually people within a community or an organisation who have knowledge on specific topics relevant to the research project. Key informant interviews are useful for gathering information quickly and reliably. Below are some pointers to help decide who might be the most useful person in any given community/institution/organisation.

- Key informants should be well-established in their community/work-place/organisation and have good relationships with others in those places.
- Key informants should be able to act as a ‘gatekeeper’ who open pathways of communication between the researcher and the research environment.
- Key informants should be able to identify other potential research participants in the community they work or live within.

In order to explore aspects of gender and child survival, health and nutrition in depth there are a whole range of gender-sensitive methods that can be drawn on, on their own or in combination to gain further insights into gender and child survival, health and nutrition. Quantitative methods are outlined next, followed by qualitative.

*Please note that in the following sections, examples illustrating ways to use specific methods and tools are highlighted in colour.*

### 4 USING QUANTITATIVE METHODS IN STUDY DESIGN

Quantitative methods are useful for finding out the extent of an issue in a given population or its evolution over a given time period. Through quantitative analysis it may be possible to determine correlations between a gender-sensitive indicator or an index of indicators and specific health or nutrition outcomes for infants or young children. The following section provides some examples of the kinds of indicators useful for investigating gender and child survival, health and nutrition.

#### 4.1 QUESTIONNAIRES

The primary quantitative method used in the studies reviewed is the quantitative questionnaire or survey. Questionnaires or surveys involve structured interviews with participants who are required to provide restricted or closed responses to a set of questions (i.e. yes/no/how many/individual characteristics e.g. sex, age, occupation, etc).
These can be useful for investigating a range of intra-household and gender issues and have been used extensively in the studies reviewed on gender and child survival, health and nutrition. For example, a study in Bangladesh (Haider & Begum 1995) used a relatively small quantitative sample (n=238) in order to conduct a survey of working women and their breastfeeding practices and their knowledge of breastfeeding legislation (more information on sampling strategies can be found in section 7 below). The study found that 99% of the women surveyed were unaware of their maternal entitlements in the workplace, while only 2% had continued to breastfeed exclusively into the fifth month of their employment. These findings could be used to advocate with local health authorities to undertake awareness-raising activities about their entitlements in the workplace among women who are employed.

Questionnaires can also be used to elicit information on attitudes, using scales of opinion such as agree/partially agree/disagree (for example see Annex III for an example of a quantitative survey tool on attitudes among health workers towards sexual violence against women and children\(^2\)).

As described in Table 1, the majority of the questionnaires and surveys reviewed used a cross-sectional study design, which means that they provide a ‘snapshot’ of the context at a point in time. Longitudinal studies look at the issues over time. While cross-sectional studies provide opportunities for understanding in depth the ways in which gender roles and relations are context-embedded across different geographical or socio-economic strata, longitudinal studies provide the opportunity for exploring these issues through time. For example, a study which made use of longitudinal survey data was by Piperata & Mattern (2011) which traced Brazilian mothers’ subsistence work patterns in relation to their infant feeding practices over 18 months which was useful for understanding how those patterns were adapted and their impact on child health and nutrition outcomes.

Surveying methods based on nationally representative samples, such as Demographic and Health Surveys or Multiple Indicator Cluster Surveys usually include a large number of indicators, some of which can be used to generate data on gender issues. The next section discusses some of the ways in which gender-sensitive indicators have been used in the studies reviewed.

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### 4.2 GENDER-SENSITIVE INDICATORS

To gain insight into women’s status in a particular context the studies in the literature review have made use of one, or a combination of, the following indicators:

- **Women’s educational achievement relative to men’s** – through years of schooling, primary school enrolments or secondary enrolments (which has been found to be related to child survival and is also often used as an indicator of women’s empowerment);

- **Women’s life-expectancy relative to men’s** (when women’s life expectancy is lower than men’s, this is a strong indicator of women’s inequality);

- **The infant mortality rate disaggregated by sex** (which reflects infant and mother’s health status and availability of health services, the situation regarding water and environmental sanitation, and general socio-economic development, and is closely related to maternal education levels);

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\(^2\) This tool has been adapted by researchers at Liverpool School of Tropical Medicine for a UNICEF-funded situation analysis on gender-based violence in Malawi undertaken in 2011-12.
Child nutrition scores disaggregated by sex (which reflects the social and cultural norms regarding gender bias against female children).

However it is important to take care when defining the baseline for the indicator being used in order to clearly establish how change will be measured. When looking at the status of women are we comparing them with men within a particular country, or with women in other countries? When comparing gender equity across different countries, it is important to make sure that the indicators have been collected using similar definitions, for example how education is defined, or economic activity (Beck 1999).

The resources section in Annex IV provides links to useful manuals on gender-sensitive indicators and other resources.

The literature review revealed that a number of studies have developed gender indices, combining a number of independent variables in order to gain insight into women’s relative decision-making. The studies reviewed in section 1.1.5 of the literature review either used indicators available in existing data-sets, or developed new indicators which were added on to household surveys. There was a wide range of different types of indicators used, however they can be broadly categorized using the typology below which was developed by Kishor (2000) during her work on measuring women’s empowerment through Demographic and Health Surveys. The table below provides a guide to the kinds of direct and indirect indicators that could be used to measure women’s decision-making power within the household.

### TABLE 3: GENDER INDICATORS USED IN STUDIES ON WOMEN’S RELATIVE DECISION-MAKING POWER

<table>
<thead>
<tr>
<th><strong>Intra-household bargaining and power</strong></th>
<th><strong>Source</strong></th>
<th><strong>For example:</strong></th>
</tr>
</thead>
</table>
| *Studies made use of decision-making indices by combining the following ‘types’ of indicators: source and setting indicators through which it is possible to gain an indirect understanding of women’s decision-making; and those indicators which provide more direct evidence of decision-making power.* | *Source* (these are the “building blocks” of power and relate to advantages in access and control over resources) | *For example:*  
- Whether woman has independent access to income  
- Whether woman is educated  
- Access to pre-marriage assets |
| **Setting** | **For example:**  
- Age difference between partners  
- Woman’s age at first marriage  
- Whether household head is relatively older to whom?  
- Education levels of husband versus wife |
| **Direct evidence** | **For example:**  
- Ability to make decisions related to visiting friends and family  
- Ability to make decisions related to the household budget  
- Ability to make decisions related to fertility  
- Ability to make decisions related to children’s education and medicine  
- Ability to make decisions regarding own health  
- Participation in decisions regarding marriage  
- Attitudes towards wife-beating |
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**Gender indicators used in the review:** Shroff et al. (2009) and Hossain et al. (2007) developed gender indices using questions about women’s ability to negotiate travel beyond the household in India and Bangladesh respectively and found that the less freedom of mobility women had, the more likely their children were to have lower height-for-age scores (India) and higher post neonatal mortality rates (Bangladesh). Please see Table 1 below for different example of the use of these gender indicators and Table 1 in the accompanying literature review for more examples).

However quantitative methods may not always provide enough information in order to understand ‘why’ or ‘how’ an aspect of gender influences a particular outcome. For example, Smith et al. (2003) found that improvements in women’s decision-making power was related to improvements in all child care practices in 36 countries across South Asia, Sub Saharan Africa and Latin America and the Caribbean, except for breastfeeding, which suffered when women’s decision-making power increased in these contexts. In order to understand why this care practice is negatively affected by women’s greater decision-making autonomy, the study could have carried out some qualitative interviewing after these results were discovered to enable a better understanding of the causes for the lower rate of breastfeeding. The use of qualitative methods is outlined in the next section.

### 5 USING QUALITATIVE METHODS IN STUDY DESIGN

Qualitative methods provide opportunities to explore complex relationships between causes and outcomes in order to ask how or why gender roles and relations impact in a particular way and in a particular context on child survival, health or nutrition. They are increasingly recognised and used in health research and are especially useful in areas not amenable to quantitative methods, for example when issues are ill-defined, deeply-rooted, complex, specialist or particularly sensitive. Qualitative methods can be used on their own to explore in-depth a particular issue. They can also be used in combination with quantitative research, order to find out more about a specific issue before designing a quantitative survey or to explore relationships between causes and outcomes.

**Using qualitative research:** Devin and Erikson’s 1996 study carried out in Haiti, established quantitatively that child nutrition outcomes were worse when alternative carers were male. Through qualitative follow-up interviews with women and men it emerged that male carers, through their own work responsibilities, were often forced to pass on caring duties to young siblings, thus highlighting that children were disadvantaged not by being cared for by men, but through a shortage of appropriate adult carers.

For more discussion about the importance of using qualitative and quantitative methods together in gender-aware programming, see Operational Guidance: Promoting gender equality through UNICEF-supported policy advocacy and partnerships for children’s rights, pages 8, 9 and 10.³

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5.1 QUALITATIVE INTERVIEWING

Qualitative interviewing techniques allow researchers to collect richer data which explores issues in more depth. Qualitative interviews are also a useful tool for researchers to explore sensitive research topics in a more flexible way by leaving room for participants to raise relevant issues not necessarily captured by a survey or a questionnaire.

5.1.1 IN-DEPTH INDIVIDUAL INTERVIEWS

In-depth individual interviews aim:

- to obtain in-depth and contextual information about an individual’s experiences, beliefs, perceptions, motivations or values;
- to explore reasons, opinions and attitudes behind respondents’ answers through asking probing questions to gain a deeper understanding/ more information and explanation.

*Using in-depth individual interviews:* Tolhurst et al (2008) carried out in-depth individual interviews about illness and treatment seeking behaviour with husbands and wives from the same household. The interviews were able to elicit different perceptions of partners on issues such as which treatments were sought for adults and children in the household, the decision-making process and payment for treatment sought.

Individual interviewing techniques range from unstructured to structured:

Unstructured interviews are open-ended and explore in-depth a particular issue. They also include ‘oral/life history’ interviews to elicit broad information about people’s lives which enable researchers to elicit more detailed ‘life-course’ information which can be particularly useful, for example, for understanding changing social and gender norms which may have impacted on intra-household dynamics or women’s and men’s work responsibilities.

Semi-structured interviews rely on a topic guide, or a checklist of questions which allows the participant to talk more freely about the issues and does not impose a particular structure or agenda. It is important that prompting questions by the interviewer are open and judgement-free. This method can be useful for addressing issues which women or men might feel uncomfortable addressing in a group setting.
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Box 2: ‘Leading’ versus ‘open’ questions

‘Leading’ questions in interviews should be avoided and facilitators or interviewers need to be constantly checking themselves that they are not formulating such questions. These questions contain a researcher’s own assumptions or judgements, which can inhibit or ‘lead’ people’s responses. The responses to ‘leading’ questions are less likely to reflect the perspectives of the interviewee since they encourage people to respond with what they think the researcher wants to hear rather than disagree or say what they really feel and think.

For example: Why do you think breast milk is good for your baby? Why do think the three food groups are good for your child? Do you think it is good to have an MCH service in your area? Don’t you think you are lucky to have a clinic in your area? Do you use mosquito nets to avoid getting malaria? Why did you go to the clinic so late? Why is it unhygienic not to use a toilet?

Instead it is important to phrase questions in an ‘open’ and non-judgmental way in order to elicit responses which are less threatening for the participant and which do not suggest that there is a ‘right’ or a ‘wrong’ answer.

For example: What do you feel about breast feeding? What type of food do you think is good for your child? How do you feel about the MCH services in your area? What do you think about the clinic in your area? Why would you use a mosquito net if you had one? Why did you decide to go to the clinic at that time? What sort of purpose or use do you think a toilet has?

A critical incidence interview asks the respondent to describe in detail their actions in response to a critical incidence such as an illness episode, including all forms of treatment used or sought, and the interviewer probes for the reasons for these actions and the influence of others on decisions made. This can be a useful tool for reflecting on gender dimensions of decision-making, if the interviewer is probing using the right questions.

Using critical incident interviews: Tolhurst et al (2008) carried out critical incidence interviews with caretakers of children who had recently suffered from severe malaria. These interviews explored patterns of treatment for children and the factors that affect who seeks care when and where (such as access to cash, time, opportunity costs, perceptions of quality of services, and decision making power), all of which relate closely to the questions above on women’s decision-making power and their access to and control over resources.

5.1.2 FOCUS GROUP DISCUSSIONS

A popular method of qualitative research is the focus group discussion (FGD) which involves a group of participants who, guided by a facilitator, discuss particular issues relevant to the research questions with one another. FGDs are useful for eliciting a range of perceptions and opinions from different participants and can be used as a starting point for further analysis and action. It is important to remember that when undertaking a gender-sensitive FGD, participants and topics should be chosen with care. It is
generally accepted for example, that groups should be organised by sex, by age and by other socio-cultural markers, if possible, in order to avoid unnecessary problems with hierarchies between participants. For example it might be difficult for a young mother to talk freely about child feeding or breastfeeding in front of older women. It is important therefore in focus group discussions, participants have fairly homogenous characteristics, such as age, gender, status and background.

In contrast, group interviews also constitute a valuable form of qualitative interviewing, which may involve different members of a community in order to achieve a specific goal. Participatory Rapid Appraisal and Participatory Learning and Action techniques, such as those introduced below, often make use of heterogeneous groups of participants in order to carry out mapping exercises or other activities in which it is important to hear different perspectives simultaneously. On the other hand, it may still be appropriate to divide groups into different sexes even in group interviews, for example if gender norms dictate that women and men are not allowed to interact socially, or if women are not expected to speak in front of men.

**Using focus group discussions:** Tolhurst et al (2008) carried out focus group discussions with a wide range of participants. To reflect on perceptions of malaria, FGDs were held separately with older and young married men and women, while unmarried parents were interviewed separately since it would have been difficult for them to talk freely in front of people who were married (due to socio-cultural norms about the significance of marriage). Other FGDs were carried out separately with married men and women to discuss responsibilities and income/expenditure streams for women and men within the household. Participants in the group discussions were asked to role-play common discussions and negotiations between husbands and wives about treatment seeking for themselves and their children, which is a good way of both promoting dialogue on and action to change health-related practices.

An exemplar version of the topic guide used to inform these FGDS is included in Annex I.

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**5.2 PARTICIPATORY RAPID APPRAISAL (PRA) AND PARTICIPATORY LEARNING AND ACTION (PLA)**

Participatory Rapid Appraisal (PRA), and Participatory Learning and Action (PLA) evolved out of Rapid Rural Appraisal (RRA) which began in the 1970s as a group of methods that could be used quickly and economically, to replace a large questionnaire survey or in-depth social anthropology. The methods include semi-structured interviews, transect walk with observation, mapping and diagramming. PRA and PLA were developed in the late 1980s and early 1990s with the aim of engaging local people, especially the poor and marginalised, in participating directly in the research process. These methods were designed to generate knowledge and information that more closely represents the perceptions, understandings, concepts and practices of these groups (see Chambers 2007).

**Some key strengths of PRA/PLA tools:**

- **The methods can help to avoid biases** by using a ‘teamwork’ approach and approaching local knowledge holders in a participatory way;

- **They are flexible** and allow for new ideas to feed back into the research agenda;
PRA/PLA methods privilege the experiences of local actors (women and men, young and old) by approaching a range of respondents rather than just seeking opinions from professional ‘experts’.

The methods can generate a lot of useful data in relatively short periods of time (although they can also be used over longer periods for on-going engagement with communities).

However it is important to note that the use of these methods in itself will not generate gender-sensitive data, but applying the principles and by taking into account the research areas and questions appropriate for the topic, it will be possible to gain useful gender-sensitive insights greater understanding of the reasons and dynamics underlying some of the quantitative findings. A selection of the tools will be outlined in brief: mapping, the transect walk and calendars.

5.2.1 MAPPING
Maps can be used as a participatory way of compiling information about a community’s resources. There are different types of maps that can be constructed according to the information needed and can be more or less complex. Maps should be drawn up with community representatives knowledgeable about the natural and socio-economic resources and their related issues, perspectives, vulnerabilities, threats and opportunities. Maps can be drawn up according to sex, or among different sections of the community (i.e. younger people and older people). Prioritising maps from different groups will enable researchers to understand how resources are differently allocated and controlled.

Creating maps: talking to mothers of young children it would be possible to draw a resource map of the places where women know they can go for information and treatment. The map might highlight a local clinic or health post nearby – or equally, one which is far away and thus difficult to access. It might show that the traditional healer or local pharmacist provides the most accessible treatment and services. It might demonstrate the lack of transport available to reach health services, or that certain forms of transport are unavailable to women due to lack of funds, it might also highlight where funds are accessed from for child health if not from the mothers themselves, thus shedding light on bargaining processes, for example.

5.2.2 TRANSECT WALK
A transect walk simply refers to a structured walk through an area or a site which is of interest to your research project. It allows the researcher to make observations about the physical and socio-economic characteristics of a community and can highlight particular gender-related issues (threats and opportunities) which might otherwise remain obscured. The walk can be used to meet people and discuss these issues along the way and if the researcher is accompanied by guides it will be possible to ask probing questions along the route. The walk may raise issues which will feed into the social map and the two can inform one another.

Undertaking a transect walk: by taking a walk through a community accompanied by a guide who could explain what was being observed, it would be possible to understand more about the kinds of work carried out by women and men and to watch out for gender-related issues such as how infants are cared for if their parents are carrying out other work and noting which carers are available, where and how far the water supplies are, and/or other facilities within the local community.
5.2.3 CALENDARS

Participatory calendars provide information which enables researchers to understand when certain events occur. Calendars can show events on a daily basis, a seasonal basis or historically. Daily calendars can provide information on women’s and men’s activities and can provide a sense of their different uses of time and varied responsibilities and the impact of these on child health. Seasonal calendars can assist with understanding changes at particular times of year and the challenges and opportunities associated with certain days/weeks/months/times of the year, e.g. for finding money for treatment. Calendars are also useful for observing nutrition patterns and practices and food availability in a given season or across a specific time period.

**Drawing up a daily calendar:** by drawing up daily calendars with women and men, it would be possible to view who undertakes child care tasks, and whether there is a division between certain kinds of child-related activities. It would also highlight (lack of) opportunities for infant feeding, and would enable insight into daily patterns of work, leisure and rest for women and men. Understanding men’s and women’s time use could highlight threats and opportunities for programme design and delivery.

5.3 OBSERVATION

As mentioned above, PRA and PLA methods, such as the transect walk, can enable researchers to observe phenomena in the context of everyday life in a community. Observation is an implicit aspect of these methods, but is also a qualitative method in itself which has its roots in ethnographic research and which can be deployed for applied health care research in most contexts. *Participant observation* usually implies that the researcher gets involved to some degree with the phenomena they are observing, whether a group activity in an organisation or a meeting in a local community. *Systematic observation* involves a more passive approach to observing phenomena and requires that the researcher identify indicators in advance which are relevant to the research questions. As a tool useful for gender-sensitive analysis, observation can provide opportunities for researchers to critically reflect on the activities they observe in relation to their research questions.

**Carrying out observation:** observation can prove a useful method for triangulating the findings of data collected through other methods. For example a qualitative study carried out in Malawi to explore caregiver (staff and family) perspectives on quality of care for children in two Nutrition Rehabilitation Units (NRUs) made use of in-depth interviews, focus group discussions and observation in their data collection process. Using observation methods entailed a prolonged engagement on the part of the researchers with the research context which enhanced the trustworthiness and credibility of the findings.4

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6 STRENGTHS AND WEAKNESSES OF DIFFERENT METHODS

The methods outlined in the previous sections have strengths and weaknesses according to the research issues under investigation. For example, focus group discussions may not be the most appropriate method for addressing sensitive issues, for example, when discussing experiences of violence or abuse whereas individual in-depth interviews may allow for greater openness from participants. As mentioned previously, questionnaires and surveys are not always the most useful tools for understanding how or why people act as they do and may require complementary qualitative methods to generate more in-depth data. On the other hand, qualitative interviewing methods are not only time-consuming to carry out, but can also generate unwieldy levels of data which can become problematic and expensive to analyse. Other methods such as time-use studies, such as those referred to in section 1.2 dealing with gender divisions of labour, can also be very time-consuming to carry out as they require intense periods of time eliciting data on women’s daily routines, either through questionnaires or through direct observation.

There are also broader implications for working with different methods from a gender perspective. The table below highlights some challenges and opportunities for working with participatory approaches, qualitative research, and quantitative research in relation to gender analysis.
TABLE 4: METHODOLOGICAL CHALLENGES AND OPPORTUNITIES FOR GENDER ANALYSIS IN HEALTH RESEARCH

<table>
<thead>
<tr>
<th>Type of research approach</th>
<th>Examples of methods</th>
<th>Opportunities for gender analysis</th>
<th>Challenges for gender analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participatory approaches</td>
<td>An approach prioritizing participation of the ‘researched’ across the research cycle irrespective of methods</td>
<td>Increasing social recognition and empowerment of women and men</td>
<td>Full participation of women and men across the whole research cycle is very difficult to achieve</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enhancing the likelihood of research to promote change in lived experiences, policy and practice</td>
<td>Challenges of creating spaces for meaningful participation by women in different contexts</td>
</tr>
<tr>
<td>Qualitative research</td>
<td>In-depth interviews, focus group discussions, participant observation</td>
<td>The in-depth open and inductive approach can generate critical insights from women and men on the ways in which gender roles and relations affect health</td>
<td>A need to think carefully about how gender roles and relations can affect the entire research process (from the identity of the researcher, to sampling strategies, to analysis)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complementary to quantitative research – can explain the why behind gender differences in prevalence/outcomes</td>
<td>Difficulties of generalizing the findings from one context to another</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enables analysis of contextual factors beyond the individual</td>
<td></td>
</tr>
<tr>
<td>Quantitative research</td>
<td>Questionnaires, epidemiological surveys, data from Health Information Systems (HIS)</td>
<td>Comparative data on the prevalence of health experiences and problems that are reported by women or men</td>
<td>In many countries there are financial and human resource constraints to the collection of sex-disaggregated data from HIS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enable correlations between gender and other axes of inequality to be sought, and found or refuted</td>
<td>As with qualitative research a need to think carefully about how gender roles and relations can affect the entire research process and outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Translation of research instruments and findings raise the risk of assuming there is shared understanding of questions and shared meaning of answers across local languages and contexts</td>
</tr>
</tbody>
</table>


7 SAMPLING TECHNIQUES

After deciding which methods are most appropriate for eliciting the data required, establishing how many and which participants to elicit information from is the next step. There are a number of sampling techniques available for deciding who will be the target group for a survey or qualitative types of interviewing. Sampling strategies are an important part of study design and are very important to get right to enable gender sensitive analysis. They may require expert help to decide on the appropriate type of random sampling, purposive sampling, or the sample size however the following points may help guide the process.
Guidance on methodologies for researching gender influences on child survival, health and nutrition

7.1 QUANTITATIVE SAMPLING

If thinking about carrying out a survey among a specific target group in a situation where it is not able to reach the whole population, sampling strategies are required to decide who to approach. Quantitative methods rely on random sampling strategies which can be calculated in different ways. Sampling is random to avoid bias and ensure that the sample is statistically representative of a particular population. In simple random sampling each element of the larger population is assigned a unique number, and a table of random numbers is used to select from these one at a time, until the desired sample size is reached. A modification of this called systematic sampling, relies on a sampling interval in which every n\textsuperscript{th} individual is selected.

An important aspect of sampling when carrying out gender-sensitive research is called stratification. Populations consist of different strata (or groups) that are different to each other e.g. women and men, geographic proximity to services, wealth, etc. Stratification can be used with either systematic sampling or simple random sampling. The key point to bear in mind is that each stratum is treated as a separate population and that strata based on gender, age, education, household type and socioeconomic status are included. In order to determine statistically significant differences within stratified samples, a large sample is required. Hence in many of the studies reviewed the approach has been to either analyse large-scale national surveys (such as DHS) and/or to add questions to these types of survey.

7.2 QUALITATIVE SAMPLING

If access to more in-depth information is required it is advisable to use a qualitative sampling method which will provide data illustrative of the kinds of issues within a target population rather than their prevalence.

Qualitative sampling methods are particularly useful for finding out in-depth information from a small number of respondents for the purposes of a situation analysis. Choosing research participants for in-depth interviews, focus group discussions and other forms of qualitative data collection can be achieved through different methods. Two useful methods which are commonly used by researchers are the ‘snowball’ and ‘purposive’ sampling methods.

- The snowball method means that you identify other research participants through contacts you already have (e.g. key informants). Once a research participant is identified through a contact, it is then possible to ask that person to identify others, thus producing a ‘snowball’ effect of gathering new participants.
- Purposive sampling involves a more reflective approach and would require some planning, preferably with key informants. The method involves drawing up a plan of who the most relevant participants will be and usually reflects a range of different categories of participant, e.g. older/younger, male/female, nurse/doctor/midwife, representatives of the Ministry of Health/Education/Social Welfare or an NGO or donor agency working on the issues.
Guidance on methodologies for researching gender influences on child survival, health and nutrition

It may not be necessary to interview many people within these categories. It is possible to carry out key informant interviews with one or two representatives from a local NGO, or to conduct in depth interviews with a number of participants appropriate to answer your research question and achievable within your resources participants sampled purposively from a larger quantitative study, or to hold one focus group discussion with a group of young mothers in a local community.

**Using a purposive sampling strategy:** a study undertaken in an urban suburb in Tanzania used a purposive sampling strategy to identify 10 new fathers attending two reproductive and child health clinic with their partners. The interviews elicited rich data on the challenges perceived by the men in their roles as new fathers enthusiastic about supporting and helping their wives and yet felt excluded from traditional reproductive and child health services which focused solely on women (Mbekenga et al 2011).

It can be difficult to decide how many people to interview and which respondents to prioritise. As discussed in section 3 above it is possible to rely on ‘key informants’ in order to gather information quickly and reliably. For example if carrying out a project on child immunisation, it may be useful to interview a small number of ‘key’ service providers and users who can provide a good overview of the issues faced by the health workers and those using the services.

Bear in mind that to undertake a gender-sensitive analysis, it will be useful to understand why certain people do not use services, e.g. to understand why men are not more involved in attending. It is therefore important to seek out key informants from those categories, who may need to be found through means other than contacting health service staff. In her on study intra-household differentials in women’s status and treatment-seeking and care for children, Castle (1993) sampled a wide range of household types, including hierarchically-structured households (with a mother-in-law), laterally-structured households (with no mother-in-law) and nuclear households (with no mother-in-law).

Sampling strategies may also change according to the context you are working in. For example a breastfeeding study carried out in Brazil, in the Amazon, used a sample of 17 women to explore child nutrition outcomes in their first 16 months of life in relation to women’s work-loads. This study was carried out among a population that is homogeneous in terms of women’s work practices, in that most, if not all women in that community farm manioc as their main form of ‘production’ (alongside their household reproductive responsibilities) (see Piperata and Mattern 2011). A study undertaken in KwaZulu-Natal, South Africa, on the other hand, used a sample of 120 women to explore breastfeeding decisions and employment in a context with much greater heterogeneity, in that women were from a larger geographical area, and had more diverse socio-economic characteristics (see Seidel 2004).

Tolhurst et al (2008) conducted FGDs with a large range of different participants. The table below provides figures on FGDs and individual interviews undertaken. This study demonstrated the importance of sampling different types of women and men and shows that this is possible to do efficiently and effectively through combining FGDs and individual interviews (see below).
Guidance on methodologies for researching gender influences on child survival, health and nutrition

**TABLE 5: OVERVIEW OF FGDS AND INTERVIEWS UNDERTAKEN**

<table>
<thead>
<tr>
<th>Group discussions</th>
<th>Numbers of groups/ Respondents per group (in brackets)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child-bearing women (aged 24-45)</td>
<td>2 (12)</td>
</tr>
<tr>
<td>Grandmothers (aged above 50)</td>
<td>2 (11)</td>
</tr>
<tr>
<td>Female traders with capital above 250,000 cedis</td>
<td>2 (15)</td>
</tr>
<tr>
<td>Female subsistence farmers</td>
<td>2 (12)</td>
</tr>
<tr>
<td>Young single women (aged 17-21 years)</td>
<td>1 (7)</td>
</tr>
<tr>
<td>Ever married women (three widows and six divorcees)</td>
<td>1 (9)</td>
</tr>
<tr>
<td>Males aged above 40 years</td>
<td>2 (14)</td>
</tr>
<tr>
<td>Males aged between 25 and 40 years</td>
<td>2 (15)</td>
</tr>
<tr>
<td>Individual interviews</td>
<td></td>
</tr>
<tr>
<td>Female head of household</td>
<td>2</td>
</tr>
<tr>
<td>Single mothers</td>
<td>3</td>
</tr>
<tr>
<td>Women in polygamous marriages</td>
<td>3</td>
</tr>
<tr>
<td>Women in monogamous marriages</td>
<td>3</td>
</tr>
<tr>
<td>Married women not living with husbands</td>
<td>3</td>
</tr>
</tbody>
</table>

*Source: Tolhurst et al (2008)*

8 **ANALYSING DATA FROM A GENDER PERSPECTIVE**

Whether the data gathered by the research is quantitative or qualitative, it is important that all results and findings are disaggregated by sex. As discussed in previous sections, there are also other social stratifications by which data can be disaggregated such as age, occupation, location (e.g. rural or urban) and others. Deciding which of these are most useful to the research will depend on the questions being asked and the issues being explored. For example, if exploring decision-making in a context where senior females play a significant role in child care and nutrition, then distinguishing between younger and older women will be an important part of the analysis.

Quantitative studies usually provide detailed explanations of their choice of indicators and their analytical approach which often involved complex equations and calculations. Qualitative studies, on the other hand, do not always report details of how data was analysed. This was a weakness of a number of the qualitative studies reviewed. However there was a useful example from one study on new fathers’ perceptions of supporting their wives following childbirth, showing how data from a transcript was coded.
TABLE 6: EXAMPLE FROM MBEKENA ET AL.’S EXPLORATORY STUDY ON NEW FATHERS SUPPORTING THEIR WIVES FOLLOWING CHILDBIRTH

<table>
<thead>
<tr>
<th>Meaning unit</th>
<th>Condensed meaning unit</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewer (I): What about the mother (his wife) how do you help her? Any problem on that? Respondent (R): About my wife, she must be helped, she is a new mother and so there are certain activities I must help her like fetching water and washing dishes! I: Do you wash dishes? R: I do, I cook as well! I understand when the mother has just given birth, you know she stayed for nine months and so when she delivers, almost all the strength is exhausted and she has to start recovering it. And because my income is low, I have to help with household chores to comfort her and as compensation so that she gets to rest since I can’t feed her adequately.</td>
<td>When the mother has given birth, her strength is exhausted, and she has to start recovering. He helps with household chores to comfort his wife because he cannot afford to feed her adequately.</td>
<td>Helps with the household chores to compensate for poor maternal feeding*</td>
</tr>
</tbody>
</table>

*The code was later part of the category ‘Striving to meet the partner’s and infant’s needs’

Source: Mbekenga et al. 2011

A gender-sensitive approach to analysis prioritises the asking of gender-focused questions, such as those outlined in section 1 of this document. In the same way as these questions can be applied to the gathering of data, they will also usefully inform the analysis of those data. In addition, involving a group of people in the analytical process is useful for ensuring that bias is minimised, something particularly important for gender-sensitive analyses. Another good practice is to include research participants themselves in the final stages of analysis in order to gain feedback and learn from their perspective on researchers’ interpretation of the data gathered.

For example gender focal points from the Ministry of Health in Mozambique and programme managers meet on a regular basis with community representatives and health workers to discuss gendered data sets (both quantitative and qualitative) (Tolhurst, Leach, Price et al 2011). This proactive sharing of results can help to develop context specific interventions and to bring diverse perspectives into the analytical process.

9 ETHICAL DIMENSIONS OF GENDER-SENSITIVE RESEARCH

There are several ethical issues to consider when involving informants in research projects as researchers and practitioners have a number of responsibilities toward those who provide them with information. Any proposed research project should avoid causing harm to the participants by taking care to anticipate the risks and consequences of informant involvement; taking into account informants’ particular vulnerabilities (for instance, having a child protection policy in place); avoiding wasting people’s time or intruding into people’s lives unnecessarily and not raising expectations about what participation will bring (Laws, Harper & Marcus 2003). Communicating full and correct information about a study’s aims and intentions is also important, as is obtaining consent from informants for their participation and granting their right to anonymity. Critical to any research undertaking is that there is no exploitation of informants and that researchers take due consideration of the time constraints and other responsibilities of their participants (ibid).
Alongside these ethical considerations, it is important to remember that research questions which touch on gender issues such as social norms and values and women’s and men’s roles and responsibilities, are often sensitive topics and should be addressed with caution and tact. Particular care should be taken for example, when dealing with research questions around gender-based violence, sex-selective abortion, mother-to-child transmission of HIV, breastfeeding practices among others.

CONCLUSION

The Guidance on methodologies for researching gender influences on child survival, health and nutrition draws on the studies reviewed in the accompanying literature review: “Gender influences on child survival, health and nutrition: a narrative review”. The key messages in section 1 summarise the review’s findings, while sections 2 – 9 draw on examples from the review and from other sources, to identify some key aspects in conducting gender-sensitive research. Although the methods outlined are largely the same as those used for researching other topics, the Guidance has highlighted ways in which these methods and tools can be used to elicit gender-sensitive information on child survival health and nutrition.

At the heart of gender-sensitive methods, is the need to reflect on the potential for any research topic, question, method or tool to elicit information on the different ways in which girls, women, boys and men experience their status, roles, responsibilities, decision-making power and access to and control over resources. At every stage of the study design process it is important to think through implications for women, men, girls and boys, as well as other cross-cutting factors such as age, socioeconomic status, etc., in order to successfully conduct gender-sensitive research.

The methods outlined here can be used both to describe and analyse how gender shapes child health and nutrition and also to design and evaluate responsive interventions from a gender perspective. As shown in this guidance, the choice of method to use for a particular study will depend on a number of factors including: the setting, research question and topic, conclusions sought and logistical issues. The literature review highlights the urgent need for further use of gender-sensitive approaches to address child health and nutrition in specific contexts. This is important because of the critical role that context plays in shaping the impact of gender dynamics. Efforts to consider gender in health and nutrition programming from different contexts need to be widely shared to promote further learning and engender action. The consideration of gender is an integral component of UNICEF’s broader commitment to ensuring equity in child health and nutrition. Child health and nutrition interventions will be more effective, equitable and sustainable if they are designed based on gender-sensitive information and continually evaluated from a gender perspective.

A useful resource for researching gender-based violence can be found via the WHO website which provides a series of documents on ethical and safety recommendations for research on domestic violence against women. These are available from: http://www.who.int/gender/documents/vawethics/en/
REFERENCES


Tolhurst, Leach, Price, Robinson, Ettore, Scott-Samuel, Kilonzo, Sabuni, Robertson, Kapilashrami, Bristow, Lang, Romao & Theobald. 2011. Intersectionality and gender mainstreaming in international health: using a feminist participatory action research process to analyse voices and debates from the global south and north. *Social Science and Medicine (in press).*

ANNEX I: TOPIC GUIDE EXEMPLAR

FGD topic guide for women and men on aspects of intra-household bargaining in relation to the treatment of fever for children

Questions about work and income

- What work do men do in this community?
- What work do women do in this community?
- How do men get income?
- How do women get income?
- Do men routinely give any of their income to their wife or other senior family members? (e.g. parents, brother)?
- Do women routinely give any of their income to their husband or other senior family members (e.g. mother-in-law, older brother, father-in-law)?
- Are there any differences between monogamous and polygamous households?
- What are men’s responsibilities for expenditure in the household?
- What are women’s responsibilities for expenditure in the household?
- Are there any differences between monogamous and polygamous households?

Questions regarding women’s and men’s work responsibilities

- Do women always fulfil their responsibilities?
  - What happens when they don’t? (i.e. are others able to do it, do they need to look outside the household – e.g. who looks after children?)
- Do men always fulfil their responsibilities?
  - What happens when they don’t? (i.e. are others able to do it, do they need to look outside the household – e.g. borrow money)
- Are there any differences between monogamous and polygamous households?
- Whose responsibility is it to pay for treatment when a child is sick with fever?
  - Why?
  - Are there any differences depending on what kind of treatment is sought?
- Are there any differences between monogamous and polygamous households?
- What about where the mother and father of the child are not married?
  - Does this person always pay?
  - What happens when they don’t? (i.e. can treatment still be sought – does another family member pay or is money borrowed?)
  - Or is treatment not sought? Or delayed?)
- How can others in the household (e.g. mother of the child) persuade the person responsible (e.g. father of the child) to pay for care? (e.g. threaten non-co-operation in the household or relationship, appeal to other senior family or community members to intervene)

Questions about treatment-seeking

- Who decides where a child should be treated when they are sick?
o Why?
   o Does it depend on whether they also pay for the treatment?
• Are there any differences between monogamous and polygamous households?
• What about where the mother and father of the child are not married?
• What would happen if the mother of the child does not follow the decision of the decision-maker (e.g. father, mother-in-law)? (e.g. conflict in the family, violence, refusal to provide for other responsibilities)
• How can the mother of the child try to influence the decision-maker? (e.g. threaten non-co-operation in the household or relationship, appeal to other senior family or community members to intervene)
• Please can you role play a situation where the child is sick and the mother has a conversation with her husband or other people in the household about whether and where to take the child for treatment.
• Are there any other common scenarios?
ANNEX II: GENDER AND HEALTH/CHILD HEALTH EXPERTS CONTACTED (the date of contact refers to the date upon which a reply was received from the relevant person/people)

<table>
<thead>
<tr>
<th>Gender/Child health expert</th>
<th>Organisation</th>
<th>Data of contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ila Fazzio</td>
<td>Effective Intervention</td>
<td>17/05/2011</td>
</tr>
<tr>
<td>Rene Loewenson</td>
<td>Training and Research Support Centre</td>
<td>17/05/2011</td>
</tr>
<tr>
<td>Korrie de Koning</td>
<td>Royal Tropical Institute, Netherlands</td>
<td>17/05/2011</td>
</tr>
<tr>
<td>Louis Paluku Sabuni</td>
<td>The Leprosy Mission International</td>
<td>17/05/2011</td>
</tr>
<tr>
<td>Katie Bristow</td>
<td>Liverpool University</td>
<td>17/05/2011</td>
</tr>
<tr>
<td>Francelina Romao</td>
<td>Ministry of Health (Mozambique)</td>
<td>17/05/2011</td>
</tr>
<tr>
<td>Claudia Garcia-Moreno</td>
<td>World Health Organisation</td>
<td>17/05/2011</td>
</tr>
<tr>
<td>Lidia Farre</td>
<td>Universidad de Alicante</td>
<td>17/05/2011</td>
</tr>
<tr>
<td>Elizabeth Tolley, Peggy Bentley, Rose Wilcher, Donna McCarraher, Michelle Lanham</td>
<td>Family Health International</td>
<td>17/05/2011 – 18/05/2011</td>
</tr>
<tr>
<td>Christobel Chakwana</td>
<td>Southern African Development Community</td>
<td>18/05/2011</td>
</tr>
<tr>
<td>Caroline Sweetman</td>
<td>Oxfam</td>
<td>18/05/2011</td>
</tr>
<tr>
<td>Janet Seeley</td>
<td>University of East Anglia</td>
<td>18/05/2011</td>
</tr>
<tr>
<td>Catherine Locke</td>
<td>University of East Anglia</td>
<td>18/05/2011</td>
</tr>
<tr>
<td>Jasmine Gideon</td>
<td>Birkbeck College, University of London</td>
<td>18/05/2011</td>
</tr>
<tr>
<td>Laura Camfield</td>
<td>Young Lives</td>
<td>18/05/2011</td>
</tr>
<tr>
<td>Valli Yanni</td>
<td>Independent Consultant</td>
<td>18/05/2011</td>
</tr>
<tr>
<td>Cheryl Doss</td>
<td>Yale University</td>
<td>19/05/2011</td>
</tr>
<tr>
<td>Beryl Leach</td>
<td>Panos Institute</td>
<td>19/05/2011</td>
</tr>
<tr>
<td>Evelien Kamminga</td>
<td>Royal Tropical Institute, Netherlands</td>
<td>19/05/2011</td>
</tr>
<tr>
<td>Paul Dornan</td>
<td>Young Lives</td>
<td>20/05/2011</td>
</tr>
<tr>
<td>Nduku Kilonzo</td>
<td>Liverpool VCT and Care</td>
<td>23/05/2011</td>
</tr>
<tr>
<td>Sassy Molyneux</td>
<td>KEMRI, Wellcome Trust Research Programme</td>
<td>24/05/2011</td>
</tr>
<tr>
<td>Name</td>
<td>Organization/Role</td>
<td>Date</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Kelly Muraya</td>
<td>KEMRI, Wellcome Trust Research Programme</td>
<td>31/05/2011</td>
</tr>
<tr>
<td>Tom Barton</td>
<td>Creative Research and Evaluation Centre</td>
<td>02/06/2011</td>
</tr>
<tr>
<td>Janet Price</td>
<td>Independent Consultant</td>
<td>13/06/2011</td>
</tr>
<tr>
<td>Lakshmi Menon</td>
<td>World Alliance on Breastfeeding Action</td>
<td>14/06/2011</td>
</tr>
<tr>
<td>Renu Khanna</td>
<td>SAHAJ Baroda, India</td>
<td>14/06/2011</td>
</tr>
<tr>
<td>Radhika Chandiramani</td>
<td>Talking about Sexual Health and Reproductive Issues (TARSHI)</td>
<td>14/06/2011</td>
</tr>
<tr>
<td>Shubhada Kanani</td>
<td>University of Baroda, India</td>
<td>15/06/2011</td>
</tr>
<tr>
<td>Hilary Standing</td>
<td>Institute of Development Studies</td>
<td>16/06/2011</td>
</tr>
<tr>
<td>Jessica Espey</td>
<td>Save the Children Fund</td>
<td>20/06/2011</td>
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<tr>
<td>Anuj Kapilashrami</td>
<td>Edinburgh University</td>
<td>22/06/2011</td>
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<tr>
<td>Nancy Gerein</td>
<td>National Health Sector Support Programme, Nepal</td>
<td>29/06/2011</td>
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<tr>
<td>Mohga Kamal-Yanni</td>
<td>Oxfam</td>
<td>29/06/2011</td>
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<tr>
<td>Alice Welbourn</td>
<td>Salamander Trust</td>
<td>14/07/2011</td>
</tr>
<tr>
<td>Helen Derbyshire</td>
<td>Independent Consultant</td>
<td>14/07/2011</td>
</tr>
<tr>
<td>Sabina Rashid</td>
<td>BRAC</td>
<td>14/07/2011</td>
</tr>
<tr>
<td>Judi Aubel</td>
<td>The Grandmother Project</td>
<td>07/09/2011</td>
</tr>
</tbody>
</table>
ANNEX III: QUANTITATIVE SURVEY TOOL EXEMPLAR

Quantitative survey tool: This has been adapted from a tool kit designed to evaluate health services for survivors of sexual assault. The original survey focused solely on adult survivors, but it has been adapted by researchers at the Liverpool School of Tropical Medicine to include indicators relevant to adult and child survivors of intimate partner violence and sexual assault for a UNICEF-funded research project on gender-based violence in Malawi. For the full toolkit see Christofides, Jewkes, Lopez, Dartnall (2006) “How to Conduct a Situation Analysis of Health Services for Survivors of Sexual Assault” (available from: http://www.svri.org/analysis.htm)

SITUATION ANALYSIS OF HEALTH SERVICES FOR SURVIVORS OF IPV AND SEXUAL VIOLENCE

<table>
<thead>
<tr>
<th>QUESTIONNAIRE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victim Support Unit</td>
</tr>
</tbody>
</table>

GENERAL INFORMATION

1. If a health care facility
   - One Stop Centre----------------------1
   - Tertiary (level 1)-------------------2
   - District (level 2)-------------------3
   - Rural hospitals(level3)------------4
   - Health centres(Level4)----------5
   - Other--------------------------------6
   - Not a health care facility--------99

2. Name of facility

3. Date of interview
   ---/---/------
   DD    MM    YYYY

4. Name of interviewer
   A-----------------------------1
   B-----------------------------2
Demographic characteristics of health care provider I would like to ask you some questions about yourself

5. What is your position at this facility?

6. Sex of respondent
   Male-----------------------------------0
   Female-----------------------------------1

7. How long have you been in service at this facility (in years)?
   [   ][  ] years

Service provision I want to ask you some questions about the management of IPV, sexual assault and rape in your facility

8. Do providers conduct medico-legal examinations of adult and child rape and/or IPV survivors at this facility?
   Yes
   No

9. How often do you say that survivors come first to this facility before going anywhere else?
   Always------1
   Mostly------2
   Sometimes---3
   Rarely------4
   Never-------5
   Don’t know---98

Rape | IPV
---|---
Adult | Adult
Child | Child
Yes | Yes
No | No

Rape | IPV
---|---
Adult | Adult
Child | Child
Yes | Yes
No | No

Rape | IPV
---|---
Adult | Adult
Child | Child
Always------1
Mostly------2
Sometimes---3
Rarely------4
Never-------5
Don’t know---98
10. How many Survivors were seen in this facility in the month of January 2011?
   Adult    Child    Adult    Child
   Male ___  Male ___  Male ___  Male ___
   Female ___  Female ___  Female ___  Female ___

11. How many Survivors have you seen personally over the past month?
   Estimated -----  Estimated -----  Estimated -----  Estimated -----  
   -------------------  -------------------  -------------------  -------------------
   Checked  Checked  Checked  Checked  
   records------- records------- records------- records-------  

12. How long does an examination (management and documentation) take on average?
   (Minutes)   (Minutes)   (Minutes)   (Minutes)

13. Where do survivors usually wait before they are examined?
    Rape
    In a private room----------1
    In public examination room----2
    In a public waiting room------3
    In the corridor----------------4
    Other-------------------------5
    IPV
    In a private room---------1
    In public examination room-2
    In a public waiting room-3
    In the corridor---------4
    Other----------------5

14. Are support people allowed in the examination room if the survivor is a child/intellectually challenged?
    Rape
    Always-------------------1
    Most of the time----------2
    Sometimes----------------3
    Rarely-------------------4
    Never---------------------5
    IPV
    Always-------------------1
    Most of the time----------2
    Sometimes----------------3
    Rarely-------------------4
    Never---------------------5
15. What concerns about their health do adult survivors or children’s guardians express, if any

<table>
<thead>
<tr>
<th>Concern</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>a) Injuries</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>b) HIV/AIDS</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>c) STIs</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>d) Pregnancy</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>e) Mental health</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

16. Where are the kits kept after completion?

- In the examination room: 1
- In the facilities manager’s office: 2
- Other: 3
Protocols/clinical management guidelines:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Rape</th>
<th></th>
<th></th>
<th>IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Are there protocols /guidelines for the management of rape survivors?</td>
<td>Yes</td>
<td>1</td>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>98</td>
<td></td>
<td>Don’t know</td>
<td>98</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Rape</th>
<th></th>
<th></th>
<th>IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Where are they kept?</td>
<td>In the examination room</td>
<td>1</td>
<td></td>
<td>In the examination room</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Facility managers office</td>
<td>2</td>
<td></td>
<td>Facility managers office</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>3</td>
<td></td>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>98</td>
<td></td>
<td>Don’t know</td>
<td>98</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Rape</th>
<th></th>
<th></th>
<th>IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Are they displayed or kept in the drawer?</td>
<td>Displayed</td>
<td>1</td>
<td></td>
<td>Displayed</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>In the drawer</td>
<td>2</td>
<td></td>
<td>In the drawer</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>98</td>
<td></td>
<td>Don’t know</td>
<td>98</td>
</tr>
</tbody>
</table>

Training

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Rape</th>
<th></th>
<th></th>
<th>IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Have you ever received any formal training on the management of rape/IPV?</td>
<td>Yes</td>
<td>1</td>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
<td></td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Rape</th>
<th></th>
<th></th>
<th>IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. Have you ever received any formal training on child protection?</td>
<td>Yes</td>
<td>1</td>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
<td></td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Rape</th>
<th></th>
<th></th>
<th>IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. Was this undergraduate (Basic), postgraduate or in-service training?</td>
<td>Undergraduate (basic medical or nurse)</td>
<td>1</td>
<td></td>
<td>Undergraduate (basic medical or nurse)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Postgraduate (specialist/advanced)</td>
<td>2</td>
<td></td>
<td>Postgraduate (specialist/advanced)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>In-service</td>
<td>3</td>
<td></td>
<td>In-service</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>4</td>
<td></td>
<td>Other</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Rape</th>
<th></th>
<th></th>
<th>IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Did your training cover child sexual assault?</td>
<td>Yes</td>
<td>1</td>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
<td></td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>
**Attitude:**

*I am going to read some statements about rape. I would like you to tell me whether you strongly agree, agree, disagree or strongly disagree with the statements.*

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>24.</td>
<td>A woman who has been raped has a serious medical problem</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>25.</td>
<td>A person rarely dies from injuries after rape and so they should wait for their turn for care</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>26.</td>
<td>Some women lie about rape to punish men</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>27.</td>
<td>Rape is more serious for someone who is a virgin</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>28.</td>
<td>A child who has been raped is an emergency medical case</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>29.</td>
<td>Rape leaves obvious signs of injury</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>30.</td>
<td>Democracy or human rights and gender are responsible for soaring levels of IPV in Malawi</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>31.</td>
<td>IPV is a social and not a major public health issue in Malawi</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>32.</td>
<td>IPV survivors do not require special services as survivors of sexual violence</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>33.</td>
<td>Health services in Malawi will be overwhelmed if they are to start offering comprehensive services to survivors</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>34.</td>
<td>Increasing cases of GBV (IPV, rape and CSA) are not necessarily an indication of a growing problem but are an old existing problem</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>35.</td>
<td>CSA, adult sexual rape and marital/ intimate partner rape are public health problems requiring equal attention from health care service providers in Malawi</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>36.</td>
<td>Child trafficking does not exist in Malawi</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
<tr>
<td>37.</td>
<td>Children in homes with domestic violence are more likely to experience sexual abuse</td>
<td>SA (4)</td>
<td>A(3)</td>
</tr>
</tbody>
</table>

**Multi-sectoral:**
38. How would you describe the relationship between health care facilities and police?

<table>
<thead>
<tr>
<th></th>
<th>Good</th>
<th>Average</th>
<th>Bad</th>
<th>Non-existent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

39. How would you describe the relationship between health care facilities and NGOs over rape cases?

<table>
<thead>
<tr>
<th></th>
<th>Good</th>
<th>Average</th>
<th>Bad</th>
<th>Non-existent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Giving evidence in court:**

40. Are you aware of cases of yours going to court in the past year?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

41. How many times did you give evidence in court in the past year

<table>
<thead>
<tr>
<th></th>
<th>[ ] [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape</td>
<td></td>
</tr>
<tr>
<td>IPV</td>
<td></td>
</tr>
</tbody>
</table>

42. Is it easy to give evidence in court?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

43. Do people get paid to give evidence in court?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

44. Do people have to pay from their own pockets to give evidence in court?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV</td>
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</tbody>
</table>
ANNEX IV: RESOURCES FOR PROGRAMMATIC MONITORING & EVALUATION
RESEARCH FOR GENDER AND YCSD

UNICEF Operational Guidance documents

- Promoting gender-equality: an equity focused approach to programming

- Promoting gender equality through UNICEF–supported programming in young child survival and development

- Promoting gender equality through UNICEF–supported policy advocacy and partnerships for children’s rights

- Promoting gender equality through UNICEF–supported programming in basic education

- Promoting gender equality through UNICEF–supported programming in child protection

- Promoting gender equality through UNICEF–supported programming in HIV and AIDS

- Promoting gender equality through UNICEF–supported programming: special considerations in humanitarian action

BRIDGE Cutting Edge Packs

There are a number of ‘Cutting Edge Packs’ available from BRIDGE (a research and information programme located within IDS Knowledge Services which specialises in gender-related resources) one of which provides a collection of resources on Gender and Indicators (and collections on other aspects of gender, such as Gender and Care and Gender and HIV/AIDS).

http://www.bridge.ids.ac.uk/go/bridge-publications/cutting-edge-packs/
Gender-sensitive Indicators

The following two manuals provide guides to using gender-sensitive indicators but are not specifically focused on child health issues.


This guide aims to assist governments in the selection, use and dissemination of gender-sensitive indicators at the national level. The guide examines the main data sources available for developing a national-level database on gender sensitive indicators – including censuses and labour force surveys, household surveys, time-use studies and national account systems. It also provides a detailed examination of how to gather and use gender-sensitive indicators in areas such as population composition; learning in formal and nonformal education; access to land, equipment and credit; legal rights and political power; and violence against women (adapted from Gender and Indicators Supporting Resources Collection).


Designed to help CIDA staff understand how to use gender-sensitive indicators, this guide reviews techniques for choosing appropriate indicators and discusses specific methodological approaches to using them at the project level. It outlines what gender-sensitive indicators are and discusses why they are useful. It also differentiates between quantitative and qualitative indicators. The authors also review specific gender-sensitive indicators relating to education, health, participation, and empowerment (adapted from Gender and Indicators Supporting Resources Collection).


Gender Analysis

Guidelines for Gender Analysis and Action
The Gender and Health Group at the Liverpool School for Tropical Medicine has developed these “Guidelines for Gender Analysis in Health” to offer specific assistance to health professionals. The overall aim of the guidelines is to enhance the ability to understand and respond to gender issues amongst those involved in the planning, implementation, and evaluation of health care provision and health research.

http://www.lstmliverpool.ac.uk/research/academic-groups/international-health/gender-and-health-group/guidelines

Databases specific to gender statistics

The BRIDGE Publication on Gender and Indicators includes a useful list of statistical databases including:
The World Bank’s GenderStats Database of Gender Statistics
GenderStats is an electronic database of gender statistics and indicators which incorporates summary gender profiles and thematic data, in addition to national and regional data.

http://genderstats.worldbank.org

United Nations Statistics and Indicators on Women and Men
This website provides the latest statistics and indicators on women and men in six specific fields of concern: population; women and men in families; health; education; work; and political decision making.


Regional databases:

ECLAC Gender Statistics in Latin America and the Caribbean (English and Spanish)
This site provides sex-disaggregated data on the situation of men and women in Latin American and the Caribbean at the national and regional levels.

http://www.eclac.cl/mujer/proyectos/perfiles_en/default.htm (English)
http://www.eclac.cl/mujer/proyectos/perfiles/default.htm (Spanish)

ECLAC Use of Gender Indicators in Public Policy Formulation (Spanish)
This website presents information and documents relating to a programme led by the ECLAC. Publications downloadable from the website include minutes of meetings held as part of the programme, and other reference materials. Original title in Spanish: Uso de Indicadores de Género en la Formulación de Políticas Públicas.

url: http://www.eclac.cl/mujer/proyectos/indicadores/Default.htm

Observatory of Gender Equity in Health (Spanish)
This website aims to support civil society in Chile in monitoring whether policies within the context of the health sector reform integrate a gender equality perspective. It features reports as well as a wide range of indicators developed on a variety of entry points, including social and demographic context, quality of health care, participation and public budgeting. Original title in Spanish: Observatorio de equidad de género en salud.

url: http://www.observatoriogenerosalud.cl/

GenderStats
GenderStats is a research and information resource providing online quantitative and qualitative data on women’s and girls’ gendered positions in South Africa.

url: http://www.genderstats.org.za/