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Review

Bringing gender sensitivity into healthcare practice: A systematic review

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ABSTRACT

Objective: Despite the body of literature on gender dimensions and disparities between the sexes in health, practical improvements will not be realized effectively as long as we lack an overview of the ways how to implement these ideas. This systematic review provides a content analysis of literature on the implementation of gender sensitivity in health care.
Methods: Literature was identified from CINAHL, PsycINFO, Medline, EBSCO and Cochrane (1998–2008) and the reference lists of relevant articles. The quality and relevance of 752 articles were assessed and finally 11 original studies were included.
Results: Our results demonstrate that the implementation of gender sensitivity includes tailoring opportunities and barriers related to the professional, organizational and the policy level. As gender disparities are embedded in healthcare, a multiple track approach to implement gender sensitivity is needed to change gendered healthcare systems.
Conclusion: Conventional approaches, taking into account one barrier and/or opportunity, fail to prevent gender inequality in health care. For gender-sensitive health care we need to change systems and structures, but also to enhance understanding, raise awareness and develop skills among health professionals.
Practice implications: To bring gender sensitivity into healthcare practice, interventions should address a range of factors.

1. Introduction

Men and women are not the same when it concerns their health; risks, symptoms, (presentation of) complaints and experience of a disease may vary. That sex and gender matter in health(care) has been demonstrated in a vast amount of studies [1–7]. If sex and gender differences are not systematically taken into account by health professionals inequities may arise. Some recommendations have been given to enhance gender sensitivity in health care [8]. Gender sensitivity means that health professionals are competent to perceive existing gender differences and to incorporate these into their decisions and actions. It is commonly accepted that gender does not exist in a vacuum; gender is part of a socio-political and cultural context. Healthcare organizations are gendered, which means that male and female patients are treated differently and that male and female physicians behave differently [9]. Intersectionality goes beyond gender sensitivity and includes the consideration of other dimensions of difference, like social class and ethnicity. The interaction between these dimensions shapes patients' health needs [10–12].

Whereas concerns about gender and health(care) have come to the fore in the scientific arena, gender sensitivity will not automatically be adopted in health care [13]. Implementation literature suggests that innovations within health care generally require comprehensive approaches at different levels [14]. Ideally implementation on an individual professional level parallels implementation at organizational level [15]. For example, a gender-training program can raise the awareness and knowledge of professionals, but organizational learning is required to change working routines.

Despite the body of literature on gender dimensions and disparities between the sexes in health, practical improvements will not be realized effectively as long as we lack an overview of the ways how to implement these ideas [16]. Insight in the obstacles and facilitating factors to enhance gender sensitivity in practice is needed [17]. This article aims to fill that gap providing a systematic analysis of the opportunities and barriers for the implementation of gender sensitivity in health care.

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2. Methods

Articles were identified through searches conducted in five electronic databases: CINAHL, PsychINFO, Medline and EBSCO. A search in the Cochrane library was performed to find comparable review studies. Table 1 outlines the keywords/search terms and resulting output. All searches covered 10 years (January 1998–June 2008); it was expected that before 1998 not much would have been published in this domain. The searches were restricted to English articles for practical reasons, and conducted by two researchers (HC and SM). In total 752 articles were found.

The selection of articles took place in several steps (Table 2): (1) Screening of titles and abstracts (HC and SM); (2) screening of the full text (HC) and agreement between the authors (HC, TA and TLJ); and (3) snowballing (HC). During the first step articles without an abstract, method section and duplicates were eliminated. Articles without original empirical research (reviews, editorials, commentaries, and theoretical analyses) were also excluded. Based on this selection process, 51 articles remained. CINAHL produced the highest number of relevant articles (33), followed by Medline (8), PsychINFO (5) and EBSCO (5). No comparable review article was found in Cochrane. With help of an experienced librarian a protocol was developed for the second elimination step aiming to identify articles not relevant for our research question and of insufficient quality. The protocol was used to analyse the detailed full text and included a format to report the relevant features of the articles. The detailed full text review of 51 articles was conducted by three reviewers (HC, TLJ and TA) in order to decide about inclusion. When the reviewers did not agree on inclusion or exclusion of the articles, agreement was reached on the basis of discussion between the researchers. From the initial list of 51 articles, a total of 8 articles were selected and included in this review (Table 3).

Finally the snowball method was used to find articles by tracking the reference lists of the remaining 8 articles. Judgment of the references was based on the following exclusion criteria: not relevant for our research question, duplicates, not books or chapters and insufficient study quality. A total of 3 articles were initiated by snowballing. Ultimately, 11 articles were included in this review.

The data extraction from the 11 included articles was performed by HC and was subsequently checked by TLJ and TA. Additionally, the results were compared and discussed. Because of the small size methods such as quantitative studies pooling and statistical analysis were not performed. The review followed instead a content analysis.

Table 1
Search strategy and results.

No	Search strategy	Database	Output	Relevant articles
1	Gender-specific care OR Gender-specific patient care OR Gender-specific healthcare AND Gender appropriate care OR Gender appropriate patient care OR Gender appropriate health care	Cinahl Psychinfo Medline Ebsco Cochrane	246 15 29 0 n/a	21 0 6 0 0
2	Search 1 AND Mainstream OR Sensitivity	Cinahl Psychinfo Medline Ebsco Cochrane	15 1 3 n/a n/a	7 0 0 n/a n/a
3	Woman-centred care OR Woman focused care	Cinahl Psychinfo Medline Ebsco Cochrane	17 5 21 0 n/a	2 1 3 0 n/a
4	Health OR Healthcare OR Healthcare OR Health delivery OR Healthcare delivery OR Healthcare delivery	Ebsco	28,447	n/a
5	Gender mainstreaming	Cinahl Psychinfo Medline Ebsco Cochrane	38 34 31 26 2	5 4 3 3 0
6	Equity OR inequity AND Gender AND Implementation	Cinahl Psychinfo Medline Ebsco Cochrane	71 21 18 8 n/a	1 0 1 0 0
7	Equality OR Inequality AND Gender AND Implementation	Cinahl Psychinfo Medline Ebsco Cochrane	82 31 23 14 1	0 0 1 3 0
	Total: 51 articles (without duplicates)	Cinahl Psychinfo Medline Ebsco Cochrane		33 5 8 5 0

3. Results

3.1. Characteristics of the studies

Seven studies used qualitative methods, three were quantitative and one was a mixed-methods study. The studies all investigated the implementation of sex or gender related knowledge or theories. With some exception the majority of the studies focused on the healthcare sector. Most studies dealt with European countries. Concerning the implementation of gender sensitivity our results covered opportunities and barriers related to the professional, organizational and political level, as presented below.

3.2. Opportunities and barriers related to the professional level

3.2.1. Gender-sensitive medical curricula

In quite a few articles the lacking competence of health professionals to perceive gender issues is considered to be one of the main starting points to improve gender sensitivity in health care. The regular medical education is an important target to achieve gender equity in health, as it transfers norms, knowledge and skills. Two studies were performed to evaluate the integration of gender in medical curricula. One study investigated the inclusion of gender in educational materials for students in a Dutch medical faculty [18]. Motivated teachers proved to be as important as the practical relevance of educational materials to promote the adoption of gender among students. The second study, concerning a national project to integrate gender in all Dutch medical faculties, demonstrated that the support and commitment of educational directors and authoritative figures played a decisive role for the integration of gender [19]. Gender was more easily integrated in interdisciplinary case-based curricula than in traditional lecture-based, biomedical curricula. Gender issues conflict with a biomedical health model that promotes a neutral approach to gender, and fit better with a holistic health model. Furthermore, openness and a learning network between medical schools had a positive effect on the integration as actors discussed the results of gender implementation at conferences and meetings.