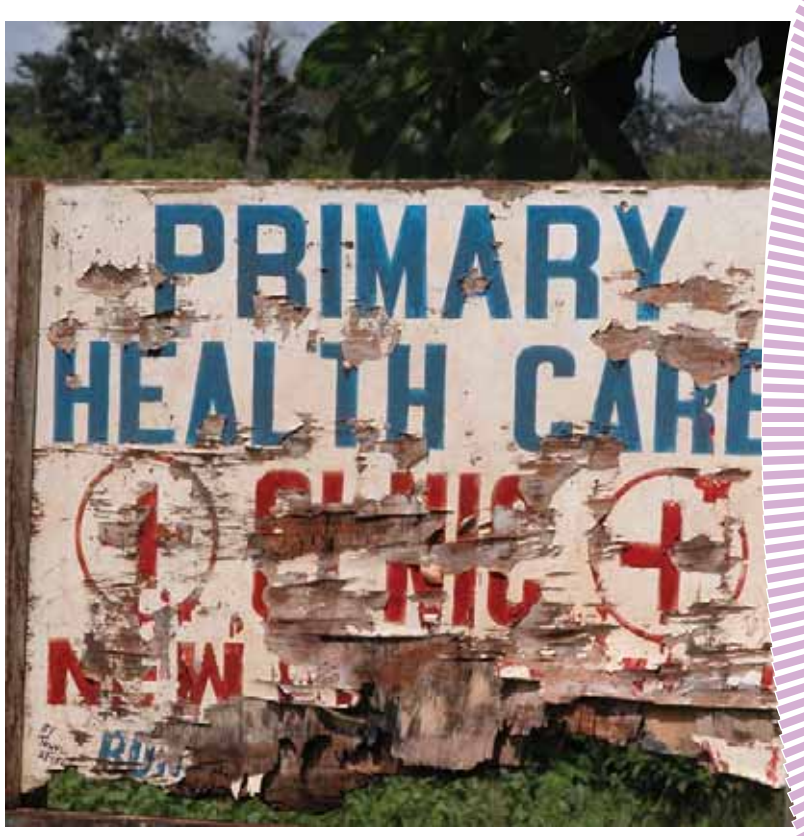

Gender, women and primary health care renewal

a discussion paper

World Health Organization

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Contents

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Abbreviations

AIDS	acquired immune deficiency syndrome
DOTS	directly observed treatment, short course
ESP	essential services package
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
MCH/FP	maternal and child health/family planning
MDG	Millennium Development Goal
NGO	nongovernmental organization
PAHO	Pan American Health Organization
PHC	primary health care
STI	sexually transmitted infections
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Introduction

The goal of equality between women and men is a basic principle of the United Nations (UN), which is set out in the Preamble to the Charter of the United Nations. This commitment to promote gender equality and women's empowerment was reaffirmed in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979; the Programme of Action of the International Conference on Population and Development (ICPD) in 1994; the Beijing Platform for Action in 1995; and in outcomes of other major United Nations conferences such as the World Conference on Human Rights in Vienna in 1993 and the World Summit for Social Development in Copenhagen in 1995. Then, the United Nations Economic and Social Council (ECOSOC) adopted in 1997 a resolution calling on all specialized agencies of the United Nations to mainstream a gender perspective into all their policies and programmes.

Promoting gender equality and women's empowerment is the third of eight Millennium Development Goals (MDGs). In setting this goal, governments recognized the contributions that women make to economic and social development and the cost to societies of the multiple disadvantages that women face in nearly every country. Following the ICPD, the World Health Organization (WHO) created a women's health unit, which in 2000 evolved into the Department of Gender, Women and Health (GWH). The Commission on Social Determinants of Health set up by WHO in 2005 created a Knowledge Network on Women and Gender Equity to systematically examine gender as one of the determinants of health inequalities.

In 2007, following these series of commitments and mandates, the Sixtieth World Health Assembly adopted resolution WHA60.25 noting with appreciation the strategy for integrating gender analysis and action into the work of WHO (*1*). The WHO is scaling up its work to analyse and address the role of gender and sex in all its functional areas: building evidence; developing norms and standards, tools and guidelines; making policies; and implementing programmes.

The World Health Organization has currently embarked on an ambitious course of transforming health systems towards primary health care (PHC) to make them more equitable, inclusive and fair. The integration of a gender perspective within PHC reforms is one of the major challenges facing Member States. This document aims to outline the basic elements of gender-equitable PHC reforms. It starts with an overview of information on whether and how women and men may be differentially and/or unequally affected by the four primary health care reforms, which were suggested by WHO in 2008:

- universal coverage reforms
- service delivery reforms
- public policy reforms
- leadership reforms.

Then drawing on case examples from different countries, it proposes measures within the six building blocks of the health system, articulated by WHO in 2007, and larger policy reforms that promote gender equality and health equity and, at the minimum, prevent exacerbation of gender-based health inequities.

There are four chapters. The *first* chapter describes the new PHC approach and the four reforms; it then presents gender concepts and discusses the health equity implications of gender inequalities. The chapter ends with an overview of progress in addressing gender inequities in health and makes the case for integrating gender perspectives into PHC reforms. The *second* and *third* chapters examine universal coverage and service delivery reforms, and public policy and leadership reforms, and outline, with some case examples, what it would mean to 'engender' these reforms. Chapter *four* summarizes the main findings and makes action-oriented recommendations to WHO on the overall implications for policies and programmes.

Information used in this document is from published sources in English. The search strategy adopted was as follows: Google, Medline and WHO web sites were searched for review articles and publications that examined the gender dimensions of the four PHC reforms. Reviews carried out as part of the Women and Gender Equity Knowledge Network of WHO's Commission on Social Determinants of Health, were also used. However, in the final analysis, only a small number of such reviews were available.

The next step was to carry out searches related to each of the major topics and subtopics discussed in this paper. For example, for information pertaining to universal coverage reforms, we used the following keywords: universal coverage, health financing, health insurance, health micro-insurance, community-based health insurance, health equity funds, social protection health schemes, conditional cash transfers and health, social franchising and health, public-private partnerships and health, essential services packages (ESPs), priority-setting and health. The publications were scanned for information relevant to the analysis of universal coverage reform from a gender perspective,[1] and relevant publications were used. This was done for each of the suggested reforms.

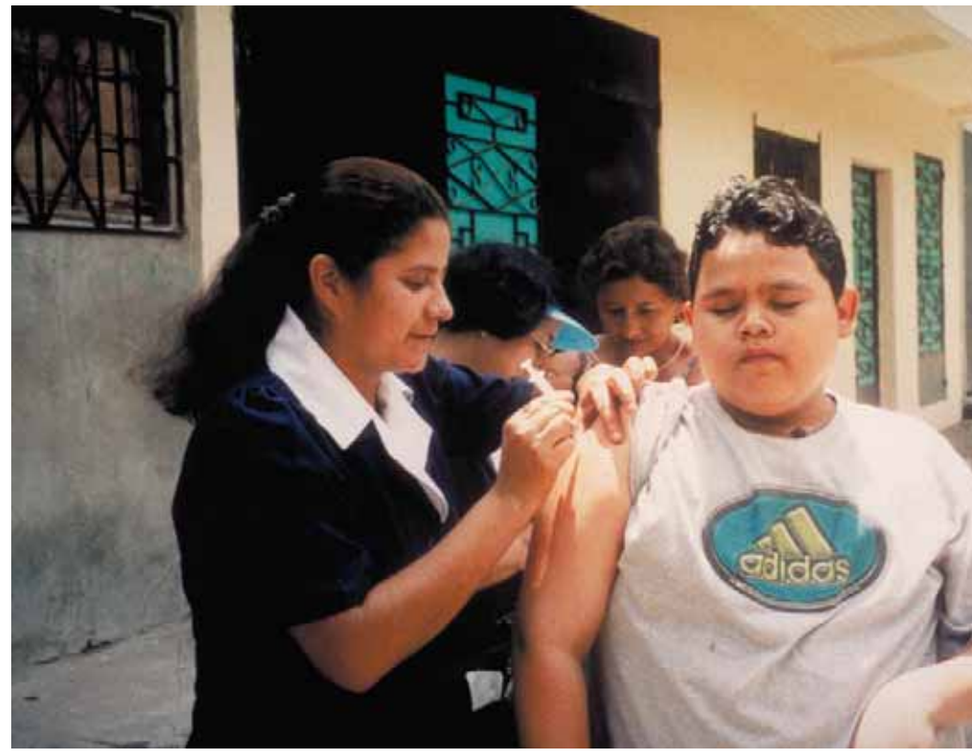
Characteristics of health systems that would promote gender equity were identified through an analysis of information from a gender perspective. We then looked for case examples of policies and large-scale, system-wide interventions that had these characteristics as illustrative examples of the kind of health system changes that promoted gender equity in health.

[1] Analysing health system features from a 'gender perspective' refers to examining them for their implications for women and men, boys and girls, of different social and economic groups. We, therefore, looked for publications that included such information.

1 Addressing gender within primary health care reforms

1.1 Primary health care reforms thirty years after Alma-Ata

1.1.1 The primary health care approach of 1978



The Alma-Ata Declaration in 1978 calling for Health for All by the year 2000, and the primary health care (PHC) approach that it outlined was a response to perceived dissatisfaction on the part of populations that their health services were expensive, inaccessible and inappropriate.

The PHC approach was not only concerned with the poor health status of a large population, but also with the indignity of health and health care being enjoyed by some but denied to others. There were three major facets to the PHC approach. These included:

- identifying health as an integral part of development;
- moving the focus from making further advances in medical technology to making existing technologies available to all;
- recognizing the key role of the participation of people in the promotion of their health status (*2*).

Each of these implied some fundamental changes in the ways in which health systems functioned. There was a shift in focus from curative to preventive and promotive care, from specialists to primary health-care providers, and to recognition of the social determinants of health and intersectoral cooperation.

Primary health care itself was conceived of as comprising eight essential elements:

- education regarding prevailing health problems and methods of preventing and controlling them
- promotion of food supply and nutrition
- adequate supply of safe water and sanitation
- maternal and child health including family planning
- immunization against major infectious diseases
- prevention and control of locally endemic diseases
- appropriate treatment of common diseases and injuries
- provision of essential drugs (*2*).

1.1.2 The four PHC reforms of 2008

In 2008, the World Health Organization reaffirmed its commitment to the principles of PHC, as something that was needed "now more than ever" (*3*). During the 30 years that have elapsed since the Alma-Ata Declaration, substantial improvements in health have been made globally.

Life expectancy has increased, there have been major reductions in infant and child mortality, access to safe water and sanitation has improved, and coverage of the population by immunization and antenatal care services has increased significantly. The concept of making essential drugs available to all has gained acceptance. In addition, the right to health of all people is recognized as the duty of national governments to guarantee.

At the same time, many of the concerns that had originally given rise to the PHC approach continue to be present and have in many instances been accentuated. There is substantial evidence pointing to growing inequities in health status and in access to health care between and within countries. Health sector reforms of the 1980s and 1990s were driven by considerations of cost-containment and reducing the role of the state. These contributed to undermining the modest progress towards universal coverage that many countries had made. Professional interests of the medical profession combined with the profit motives of the health technology and pharmaceutical industries to make health systems focus on specialized curative care. More and more vertical programmes have emerged as 'cost-effective' solutions to control specific diseases, supported by international donors interested in seeing visible returns on their investments. Health systems have become overwhelmingly commercialized with, on the one hand, the expansion of health in the private sector and, on the other hand, the increasing use of market mechanisms for health in the public sector (*3*:11–13).

Four areas of reform were outlined by WHO to achieve health equity and people-centred health care, and to secure the health of communities and meet these considerable challenges to achieving health for all (*3*:xvi).

- *Universal coverage reforms*
  These include reforms that address inequities in access to health-care services. Three sets of issues need to be addressed within these reforms: (i) reducing the proportion of total health costs from out-of-pocket health expenditure at the point of service delivery; (ii) increasing the range of services that are available as part of a basic essential package available to all irrespective of ability to pay; and (iii) identifying population groups that are considerably disadvantaged in terms of access to health services and ensuring their coverage.

- *Service delivery reforms*
  These include reforms that would make health services people-centred and driven by their needs rather than by the compulsions of the market; comprehensive; and integrated vertically and horizontally.

- *Public policy reforms*
  These include health systems policies to support universal coverage and effective service delivery; public health policies to address priority health problems through the continuum of promotive, preventive and curative care; promoting intersectoral collaboration to achieve better health outcomes; and, finally, ensuring that all public policies do not have negative health impacts.

- *Leadership reforms*
  These are reforms that move in the direction of striking a balance between *laissez-faire* disengagement of the state from the health sector and a command-and-control approach that relies on exclusive state control over financing and provision of health-care services. The aim is to achieve a pragmatic leadership in health that is inclusive, participatory and negotiation-based, working with the diverse interests of the multiple stakeholders involved in the health sector.

1.1.3 Primary health care reforms and the six building blocks of the WHO Health Systems Framework: the interlinkages

The four PHC reforms clearly call for major changes in countries' health systems. According to WHO, they cut across all the six building blocks of national health systems (*3*:xv).

What is a health system and what are the six building blocks of WHO's Health Systems Framework?

A health system "consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health" (*4*:2). In 2007, WHO outlined a Health Systems Framework consisting of six building blocks, in an attempt to spell out in more detail the various areas in which action was needed in order to strengthen health systems.

These six building blocks were:

- *service delivery* that is effective, safe and provides quality services;
- *health workforce* that performs well, and is responsive, fair and efficient;
- *health information system* that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status;
- *medical products, vaccines and technologies* that are equitably accessible to all;
- *health financing* that raises adequate revenue, enables use of needed services and protects from catastrophic costs;
- *leadership and governance* including effective oversight, coalition-building, appropriate system design and accountability (*4*).

There are many ways in which the four PHC reforms and the six building blocks of the Health Systems Framework are interlinked.

Universal coverage reforms: require working with health financing for equity and with priority setting, especially in the design of essential service packages.

Service delivery reforms: include attention to issues of target group and content, vertical and horizontal integration of service delivery, and to who provides services at different levels (health workforce), availability and continued supply of medical products, vaccines and technology.

Public policy reforms: call for attention to public policies within the health sector, including the development of a health information system, which enables the monitoring of health equity. They also include ensuring the monitoring of the health impact of policies, and structural and environmental factors, such as climate change, globalization and recession, and policy action to mitigate the negative health impact of these.

Leadership reforms: ensure that a balance is struck between command and control, and *laissez-faire*, and include aspects of both leadership and governance.

In other words, PHC reforms imply working with the six building blocks of national health systems to bring about appropriate changes.

Primary health care reforms are the latest attempt at guiding health systems reforms to promote health equity and mitigate the worsening of inequities. Gender is one of the major axes of health inequities. Such reforms aimed at promoting health equity are, therefore, concerned also with ensuring that factors within health systems that contribute to gender-related health inequities are addressed.

The next two sections lay out the need to address gender within primary health care reforms. Section two contains basic definitions and a brief overview of the interlinkages between gender-based differences and inequalities and health outcomes. Section three presents an overview of attempts to address gender-based inequities within the health system, and ends with a description of what it would mean to address gender-based inequities within the context of PHC reforms.

1.2 Gender as a determinant of health

1.2.1 Sex and gender

'**Sex**' refers to the different biological and physiological characteristics of males and females, such as reproductive organs, chromosomes, hormones, etc., that define men/boys and women/girls.

'**Gender**' refers to socially constructed norms, behaviours, activities, relationships and attributes that a given society considers appropriate for men and women.

Aspects of sex will not vary substantially between different human societies, while aspects of gender may vary greatly (*5*).

The concept of gender has five basic elements. Gender is:

- about how women and men interact and the nature of their relationships (relational);
- different across contexts in the specifics of what is considered appropriate for women and men due to different cultural traditions and practices; however, in almost all societies, gender norms vest in men and boys

greater privileges, resources and power as compared to women and girls (see section 1.2.2 below);

- not only about women and men but about all the multiple identities women and men have (age, ethnicity, sexual orientation, etc.);
- based on historical traditions and practices that evolve and change;
- firmly ingrained and perpetuated in society through social institutions including the family, schools, religion and laws (*6*; Box 1).

1.2.2 Gender inequalities

What is at issue is not that there are socially constructed differences between women and men but that these differences have often given rise to discrimination and inequalities. There is now considerable evidence from around the world to show that women and girls on average have lower educational attainment than men and boys; own less property than men; are less likely to be engaged in paid employment; and earn only a fraction of men's income. Even in societies where there is apparently greater gender equality, women's participation in political institutions is extremely low (*7:* 41, 56).

Social and cultural norms restrict the mobility of women and girls, and deny them the right to take decisions concerning their sexuality and reproduction. In many instances, violence against women by their intimate partner is considered part of the natural order of male-female relationships. In a 10-country study on women's health and domestic violence conducted by WHO, between 15% and 71% of women reported physical or sexual violence by a husband or partner (*8*).

Discrimination against girls and women has been recognized as a violation of women's human rights. The Convention on the Elimination of All Forms of Discrimination against Women, adopted in 1979 by the General Assembly of the United Nations, defines what constitutes discrimination against women and sets out an agenda for national action to end such discrimination (*9*).

1.2.3 Gender-based differentials and inequalities can be detrimental to health

Women and men are biologically different, and this results in differences in health risks, conditions and needs. A review of research from the United States of America shows that women are at significantly higher risk of autoimmune diseases as compared to men (*10*). The incidence of hip fractures is much higher among women than among men. This is in part due to the changes in bone metabolism in postmenopausal women, and also because women live one third of their lives after the menopause (*11*).

On the other hand, rates of cancer mortality are 30–50% higher among men than among women (*12*). Men are known to have higher blood pressure than women throughout middle age, but after the menopause, systolic pressure increases in women to even higher levels than in men (*13*). On average, women have cardiac infarction 10 years later than men, because estrogen protects them from coronary heart disease in their childbearing years (*11*:13).

In addition to biological factors, gender-based differences in access to and control over resources, in power and decision-making, and in roles and responsibilities have implications for women's and men's health status, health-seeking behaviour and access to health-care services. Men and women perform different tasks and occupy different social and often different physical spaces. The gender-based division of labour within the household and labour market segregation by sex into predominantly male and female jobs, expose men and women to varying health risks. For example, the responsibility for cooking exposes poor women and girls to smoke from cooking fuels. Studies show that a pollutant released indoors is 1000 times more likely to reach people's lungs since it is released at closer proximity than a pollutant released outdoors. Thus, the division of labour by sex, a social construct, makes women more vulnerable to chronic respiratory disorders, including chronic obstructive pulmonary disease, with fatal consequences (*15*). Men, in turn, are more exposed to risks related to activities and tasks that are by convention male-dominated, such as mining.

In many instances, both 'sex' and 'gender' interact to contribute to avoidable morbidity and mortality on a large scale. For example, women's higher risk of depression is influenced by genetics and hormones, but gender plays a major role in magnifying the relative risk (*14*). Similarly,

Box 1. Gender concepts in the context of health

Gender equality means equal chances or opportunities for women and men to access and control social, economic and political resources within families, communities and society at large, including protection under the law (such as health services, education and voting rights). It is also known as formal equality. In fields other than health, gender equality implies gender justice. However, this is not the case in health, because biological differences between the sexes give rise to differential health needs. Women's specific health needs arising from their biological role as reproducers cannot be met if women and men have equal investments in health-care services. Further, equality in health outcomes such as infant or child mortality rates may in fact be an indicator of gender bias, given the inherent biological advantage that girls have over boys in survival (*18*).

Gender equity is more than formal equality of opportunity, etc. It refers to the different needs, preferences and interests of women and men. It means fairness and justice in the distribution of benefits and responsibilities between women and men (*19*). This may mean that differential treatment is needed to ensure equality of opportunity. This is often referred to as substantive equality (or equality of results). Gender equity is a more appropriate concept to use in the context of health. Policies and programmes should aim at achieving gender equity in health through appropriate investments and design to be able to meet the differential health needs of women and men; and to overcome the effect of discrimination (*18*).

Gender sensitivity in health refers to perceptiveness and responsiveness concerning differences in gender roles, responsibilities, challenges and opportunities in the functioning of health systems including in the collection and analysis of evidence, programming, policies and in the delivery of health-care services (*20*).

Gender perspective in health is a way of analysing and interpreting health issues and situations from a viewpoint that takes into consideration gender constructs in society (i.e. notions of appropriate behaviour for men and women, which may include issues of sexual identity) and searching for solutions to overcome gender-based inequities in health (*20*).

A policy or programme is **gender responsive** if it explicitly takes measures to reduce the harmful or discriminatory effects of gender norms, roles and relations (*6*).

Gender mainstreaming is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated (*5*).

To illustrate this in the context of the health sector: if health care systems are to respond adequately to problems caused by gender inequality, it is not enough simply to 'add in' a gender component late in a given project's development. Research, interventions, health system reforms, health education, health outreach, and health policies and programmes must integrate gender equity from the planning phase. An approach such as this will also ensure that gender perspectives are reflected in health policies, services, financing, research and in the curricula of human resources for health.

Gender is thus not something that can be consigned to 'watchdogs' in a single office, since no single office could possibly involve itself in all phases of each of an organization's activities. All health professionals must have knowledge and awareness of the ways gender affects health, so that they may address gender issues wherever appropriate and thus make their work more effective.

The process of creating this knowledge and awareness of - and responsibility for - gender among all health professionals is called **'gender mainstreaming'** (*21*).

women's longer life expectancy, a biological factor, may underlie the higher burden of chronic and degenerative diseases among women, but women's lack of resources to care for themselves as they grow older contributes to more severe and poorer outcomes.

Girls and women bear the brunt of the negative health consequences of gender inequalities, but the social construction of masculinity also takes a toll on the health of boys and men, often resulting in reduced longevity.

Gender and health status

Differences in the way society values men and women and accepted norms of male and female behaviour influence the risk of developing specific health problems as well as health outcomes. Studies have indicated that preference for sons and the undervaluation of daughters skew the investment of households in health care. This has potentially serious negative health consequences for girls, such as lower levels of immunization and avoidable mortality. Significant gender differences have been reported in the immunization rates of boys and girls from Africa and Asia. Immunization rates among girls are 13.4% lower among girls as compared to boys in India, 7.2% in Gabon and 4.3% in Ethiopia. A 2004 study in 16 Indian states found that girls were five times less likely to be fully immunized than boys. In Nigeria, on the other hand, immunization rates among boys were 7.2% lower than for girls (*16*).

On the other hand, social expectations about desirable male behaviour may expose boys to a greater risk of accidents, and to the adverse health consequences of smoking and alcohol use. Globally, cigarette smoking is much more common among men, contributing to lung, mouth and bladder cancer and to one third of the male excess reported in tuberculosis cases (*17*). The practice of unsafe sex by large sections of men who are aware of the health risks cannot be explained except in terms of gender norms of acceptable and/or desirable male sexual behaviour.

Cultural norms often deny women the right to make decisions regarding their sexuality and reproduction, and could underlie the non-use of contraception and frequent pregnancies. Death from unsafe abortion is a typical example of avoidable mortality in women as a result of state policies that deny women the right to make decisions about reproduction. Gender-based violence, which affects a significant proportion of women worldwide, puts them at risk of many sexual and reproductive health problems. One example is sexual abuse leading to sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) or unwanted pregnancies.

Gender and health-seeking behaviour

Because men and women are conditioned to adhere to prevailing gender norms, their perceptions and definitions of health and ill-health are likely to vary, as is their health-seeking behaviour. There are variations across settings in women's health-seeking behaviour as compared to men's. A number of studies from South Asia report that women do not recognize the symptoms of a health problem and do not treat it as serious or warranting medical help, or perceive themselves as entitled to invest in their own well-being (*22*). Studies from other settings, however, found that on average, women reported more symptoms than men even when their illness status was similar (*23*).

Most studies of men find them less likely to use preventive care (*24*), and men with tuberculosis and mental health problems have been found to seek health care at later stages and at a higher level of health care as compared to women (*25*). A qualitative study carried out in the United States with boys aged 15–19 years old reported that participants consistently equated health with physical fitness. They had to be physically and severely ill before they felt justified in seeking health care (*26*).

Gender and utilization of health-care services

Women's limited time and access to money and their restricted mobility, common in many traditional societies, often delays their seeking health care. They may be allowed to decide on seeking medical care for their children, but may need the permission of their husbands or significant elders within the family to seek health care for themselves (*7*:17, 25). Data from demographic and health surveys show that, in some countries of sub-Saharan Africa and South Asia, women were not involved in decisions concerning their health in 50% or more of the

households. In Burkina Faso, Mali and Nigeria, almost 75% of women reported that their husbands alone took decisions concerning their health care (*7*:19).

Interestingly, the opposite is true for many other countries. Women have been reported to use more services than men (*27–30*), and this was related to a significantly lower self-reported health status for women as compared to men (*29, 30*), or to a greater number of chronic health problems and lower health-related quality of life (*31*).

It is not uncommon to encounter interpretations of all differences in health outcomes between girls/women and boys/men as the 'natural' consequence of their biological differences. However, even in the case of women-specific health needs, such as maternal health care, outcomes are substantially influenced by gender-related factors such as workload during pregnancy and domestic violence. Where there is no plausible biological explanation for differential health outcomes between girls/women and boys/men, gender-based inequalities and differences are most often a major explanatory factor (Box 2).

Box 2. Gender equality is an imperative for realizing the right to health

The Universal Declaration of Human Rights (1948) and WHO's Constitution affirm the right to health of all persons. Non-discrimination and equality are fundamental principles in human rights and are crucial to the enjoyment of the right to the highest attainable standard of health. Gender (and other social) inequalities in society constitute a major barrier to realizing the right to health because of their impact on equitable access to health-care services and consequent impact on avoidable morbidity, mortality and well-being. Promoting gender equality in health is thus a major component of promoting the right to health of all people.

1.3 Integrating gender perspectives into health: experience so far and the way forward

In order to integrate gender perspectives into health, there is a need for gender analysis of all information, policies, programmes and interventions within the health sector; as well as of the functioning of health sector institutions. This analysis will examine how gender roles and norms impact factors identified by WHO:

- protective and risk factors;
- access to resources to promote and protect mental and physical health, including information, education, technology and services;
- the manifestations, severity and frequency of disease as well as health outcomes;
- the social and cultural conditions of ill-health/disease;
- the response of health systems and services;
- the roles of women and men as formal and informal health-care providers (*19*:6).

Having identified areas of gender-based inequities in health, gender analysis will identify ways to overcome these, so that better health outcomes for both women and men may be achieved (*19*:6).

Attempts at addressing gender inequities in health started several decades ago, but progress has been modest.

The PHC approach of 1978 was a significant advance in the way it linked health and development and prioritized health equity through policies and programmes that involved the community centrally and was based on people's felt needs. Such an approach had considerable potential for being sensitive to the ways in which gender inequalities affect health. However, this potential remained largely unrealized in the implementation of the approach. Critiques have pointed out that the approach inadvertently confined women's health needs to maternal health, and its community participation strategies expected women, already overburdened with work, to be available as volunteers to implement local initiatives (*32*).

The economic crises and structural adjustment programmes which affected many developing countries in the early 1980s led to the gradual demise of the PHC ap-

proach even before it had gone beyond the early piloting stages. There was, therefore, little scope for addressing the gender gaps in the approach.

During the 1970s and 1980s, attempts at highlighting the neglect of women's issues and concerns within the health sector had focused on women's health. Women's health projects and programmes, and in some instances women's health policies, emerged as a result of the combined efforts of those within the health sector and the women's health movement, where there was a positive political climate for reforms.

It was soon realized that this approach resulted in the formulation of a small number of women-only projects and programmes, while it was business as usual within the sector as a whole. The need to 'mainstream' gender within all sectors began to be articulated widely.

In the years following the International Conference on Population and Development (1994) and the Fourth World Conference on Women (1995), the agenda shifted from an exclusive focus on women (in all sectors including health) to 'mainstreaming', or integrating gender into the mainstream.

Two dimensions of gender mainstreaming in health have been identified by WHO, namely programmatic gender mainstreaming and institutional gender mainstreaming (*21*).

Programmatic gender mainstreaming does the following:

- addresses how certain health problems affect women and men differently;
- examines the ways in which gender norms, roles and relations influence male and female behaviour and health outcomes;
- focuses on women's empowerment and women-specific conditions as a way of addressing the historical discrimination that women and girls have faced, and continue to do so in many settings;
- adopts a broad social equity approach, looking at issues of age, socioeconomic status, ethnic diversity and other sources of social stratification that may lead to health inequities;
- provides an evidence base disaggregated by sex and (other social stratifiers as appropriate) to enable health planning, policy-making and service delivery to correct gender and other biases, and promote equity in health (*21*).

Institutional gender mainstreaming is complementary to programmatic gender mainstreaming. It involves addressing:

- the organization of human and financial resources: sex parity and gender balance in staffing; establishment of work-life balance; creation of mechanisms for participation by male and female staff in decision-making; and equal opportunities for career advancement;
- inclusion of gender equity goals on strategic agendas, in organizations' policy statements and in monitoring mechanisms;
- allocation of adequate financial resources for integrating gender concerns and investing in capacity building of staff to carry out programmatic gender mainstreaming (*21*).

The health sectors of most WHO Member States have made very limited progress in mainstreaming gender perspectives in policies, programming and service delivery. A recent review of gender mainstreaming in countries' health sectors found that, barring a few exceptions, mainstreaming had happened in form rather than in substance (*33*). In terms of programmatic gender mainstreaming, small steps had been taken. Training on gender and health had been undertaken in many countries for in-service health professionals, but there were relatively fewer examples of mainstreaming gender in the pre-service training of health professionals. There were also many examples of the integration of gender equity concerns into service delivery, but these were usually small-scale interventions implemented by nongovernmental organizations (NGOs). There were only a couple of examples of planned system-wide initiatives for mainstreaming gender, guided by policy and implemented by the state. In many countries, 'gender gaps' in policies related to specific health conditions had been identified, but very little action had been taken to bridge them (*33*).

The review also found that in terms of institutional gender mainstreaming in countries' health sectors, a gender policy was usually adopted and a few structures created

for working on gender issues, without investing financial or human resources to take the work any farther. These weaknesses contributed to difficulties in carrying out programmatic gender mainstreaming on a sector-wide scale (*33*).

Health sectors of many countries are faced with some specific challenges in taking forward the mainstreaming agenda. Given the biological differences between women and men in health needs and experiences, there is a tendency to assume that maternal health programmes are an adequate response to addressing differences in health between the sexes. Also, women's longer life expectancy as compared to men's makes it difficult to convince decision-makers of the need for gender mainstreaming. Other dimensions of gender inequality in health – such as morbidity, access to health care, and the social and economic consequences of ill-health – are seldom examined. It is also possible that health providers view gender mainstreaming as the diversion of valuable time and resources away from the far more important task of 'saving lives' (*33*).

The significance of gender equality as a crucial determinant of maternal, reproductive and child health has been ignored in interventions and approaches to achieving the 'health' MDGs 4, 5 and 6[2] (*34*). Not only will it be impossible to achieve the goals of the health-related MDGs without attention to gender equality overall and gender equity in health, but "*huge inequities in maternal and child health within and between countries will be perpetuated*" (*35*:1939). This will endanger the mission of PHC reforms.

One of the important tasks ahead is to ensure that gender equity issues are identified and included in all strategic agendas in the health sector: this would constitute an important step forward in institutional gender mainstreaming in WHO and in countries' health sectors. Hence, this paper on gender issues within PHC reforms. Addressing gender equity concerns within the four PHC reforms would mean, among other things, ensuring that each of the six building blocks of the WHO Health Systems Framework integrate a gender perspective to guarantee gender equity in health. The next two chapters examine each of the four PHC reforms from a gender perspective and outline ways in which they could become more gender equitable.

[2] MDG4 is reducing under-five mortality by two thirds between 1990 and 2015. MDG5 includes reducing the maternal mortality ratio of countries by three quarters and achieving universal access to reproductive health services by the year 2015. MDG6 is halting and reversing the spread of HIV by 2015.

2 Integrating gender perspectives into universal coverage and service delivery reforms

2.1 Universal coverage reforms

Health-care services in most developing countries are underwritten by a mix of financing mechanisms. Usually there is a basic package of services financed by tax revenue, which are free at the point of service delivery. The costs of other health services have to be met by out-of-pocket payments, or through a combination of different types of health insurance. In some countries, there are, in addition, social protection schemes covering specific population groups identified as 'vulnerable', for example, low-income groups, indigenous populations, and mothers and children. Services covered by social protection schemes vary across settings.

Tax revenue is the main source of public financing for health in most countries of Africa and Asia. The government allocates a share of the tax revenue to the public health sector to pay for and provide health-care services and other essential functions. This is considered to be an equitable financing mechanism for two reasons: (i) because it offers an essential package of services that are free at the point of service delivery; and (ii) because in many countries taxation is progressive, i.e. the rich pay a higher proportion of their income in taxes compared to those with lower incomes.

However, in many developing countries where public funding for health care is exclusively through tax revenue, the health sector is severely under-resourced. Health facilities or qualified health providers are not available to a large section of the population, especially those living in rural areas. The result is that people are mainly dependent on often less than fully qualified private providers, and have to make out-of-pocket payments for services.

2.1.1 Out-of-pocket payments for health widen gender inequities in ability to access care

Out-of-pocket expenditure in health are usually incurred:

- to pay fees for services at the time of availing health care;
- as co-payment for insurance when not all costs of care are covered; and

- for purchase of drugs and supplies.

In addition, there are transportation costs and incidental expenses related to seeking health-care services.

In many low-income countries, out-of-pocket spending by households already constitutes a significant proportion of health spending. Data based on national health accounts for 191 countries show that in 60% of countries, which have a per capita income of below US$ 1000 per year, out-of-pocket spending is 40% or more of the total outlay (*36–37*). When out-of-pocket expenses for health are high, the ability to pay becomes the major determinant of whether or not a person is able to seek health care (*38*).

A study based on surveys in 89 countries, covering 90% of the world's population found that a larger proportion of the population in countries with high out-of-pocket expenditure in health was at risk of financial catastrophe. Overall, 2.3% of the households (about 150 million people) experienced financial catastrophe because of health-care costs. About 100 million people were impoverished because of catastrophic expenditure on health (*39*). In Latvia, women-headed households were among population groups with a higher likelihood of incurring catastrophic health expenditure (*40*).

Women incur more out-of-pocket expenditure than men

Household surveys that include data on total individual spending on health from Brazil (1996–1997), the Dominican Republic (1996), Ecuador (1998), Paraguay (1996) and Peru (2000) have found that women's out-of-pocket payments were systematically higher than those of men (*41*). One of the factors contributing to the increased spending may be women's specific health needs related to pregnancy, childbirth, contraception and abortion. The higher prevalence of a number of chronic diseases among women is a contributory factor.

Paying for delivery care and other reproductive health services places a high financial burden on women

Childbirth services, which a large majority of women in the reproductive age group need, are unaffordable to many women even in settings where services are nominally 'free'. In Dhaka, Bangladesh, a 1995 study found that the cost of 'free' maternity care in public hospitals was catastrophic for many, because they still had to pay for drugs and supplies, blood, travel, food, tips and, in some cases, wages for a hired caregiver. It cost 21% of the families 51–100% of their monthly income, and 2–8 times their monthly income for 27% of the families. More than half the families did not have enough money to pay for these services and, of this group, 79% had to borrow from a moneylender or relative (*42*).

A 1999 household survey from Rajasthan, India, reported that the cost of normal delivery in a health facility was unaffordable to women from the poorest groups. The cost varied from more than 1.5 to about 4 times the average per capita monthly income of the lowest income quintile (Rs. 400 or US$ 8.5), depending on whether the delivery took place in a public or private health facility. The mean cost of treating a road traffic injury was Rs 440 (US$ 9.5) in a public hospital and Rs 1035 (US$ 22) in a private hospital. These costs include travel and lodging but not loss of income (*43*).

Out-of-pocket expenditure may prevent more women than men from utilizing essential health services

The higher burden of out-of-pocket payments is likely to deprive more women than men from utilizing health services. Econometric studies based on household survey data have found that vulnerable groups without access to financial resources, e.g. adolescents, the elderly and women not engaged in the formal economy have greater price elasticity for health-care services as compared to the rich (*44*). Greater price elasticity means greater sensitivity to price changes. When fees are introduced or increased, those with limited ability to pay are discouraged from using health services – both preventive and curative.

For example, a study from the People's Republic of China, which surveyed 687 women of childbearing age in 1993, found that because child delivery services involved fees for services, none of the 175 low-income women had hospital deliveries; while 14% of middle- and high-income groups did not utilize these services (*45*). In the United States, studies have consistently shown that low-income women experienced a delay of up to three weeks in obtaining an

abortion. A 2006 study reported that 67% of poor women having an abortion said they would have preferred to have the procedure earlier. Because second trimester abortions cost about four times more than first trimester abortions, the delay increased the financial burden for poor women. Other studies indicate that 18–37% of women, who would have terminated their pregnancy if the government had paid for it, continued their pregnancies because they could not afford to pay for an abortion (*46*).

While costs definitely discourage the use of services by women from the lowest income groups, gender-based inequalities in access to and control over resources is also a factor. In Bangladesh, when user fees were introduced for family planning services, men expressed unwillingness to pay for preventive care and treatment for women, including for family planning, despite their awareness of the importance of fertility control (*47*). A review of experiences with cost recovery in family planning programmes in sub-Saharan Africa concluded that the introduction of user fees for contraception for those with any revenue generating potential could dampen demand significantly. It observed that, unlike curative health care, improvement in quality of care does not counteract the negative effect of user fees on utilization (*48*).

Gender power inequalities may underlie differences in unmet need for health services between women and men in Latvia. Unmet need for health services is higher for the lowest income quintile and decreases with increasing income, but women have a higher unmet need for health services than men in every income quintile (*40*, Figure 1).

2.1.2 Moving towards universal coverage

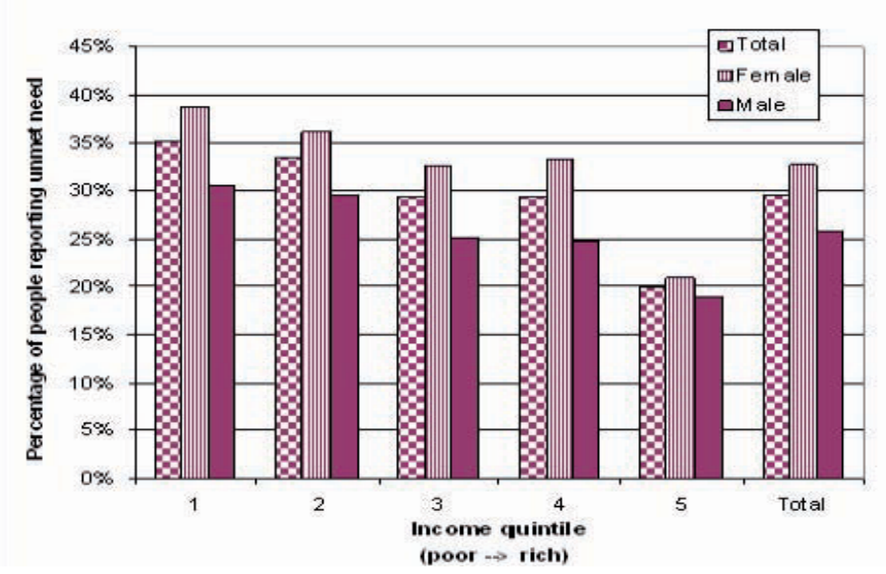
In recognition of the formidable financial barriers to health care caused by out-of-pocket payments, the World Health Assembly in 2005 adopted a resolution encouraging Member States to develop health financing systems that would provide universal coverage to all persons (*49:*124, 126).

Universal coverage is defined as "access to adequate health care for all at affordable prices" (*50*). Universal coverage by health services is now widely perceived to be one of the core obligations that any legitimate government should fulfil in respect of its citizens.

Achieving universal coverage involves progress in three dimensions:

- *removing financial barriers* to accessing care and providing financial protection from catastrophic costs to users of care;
- increasing the extent of health-care coverage by identifying the *services* to be included in an essential services package and provided at subsidized or no cost;

Figure 1.
Unmet need for health services by sex and income quintile, Latvia



Source: World Health Organization (40).

- increasing the extent of population coverage: *who is covered* (*3*).

In order to achieve universal coverage, health-financing mechanisms in a country would have to reduce the proportion of out-of-pocket payment in total health expenditure and increase the share of health expenditure financed by insurance or pre-payment mechanisms (*51*).

During the period of transition and perhaps even thereafter, social protection schemes targeting vulnerable population groups would be needed in order to bridge the gaps in health status resulting from social and gender inequities. These are not substitutes for universal coverage, but need to complement the adoption of financing mechanisms that promote universal coverage (*3*:33).

Insurance mechanisms may cover fewer women than men. Further, the range of services covered by these financing mechanisms may have different implications for women and men.

For these reasons, the following section examines insurance mechanisms along all three dimensions of universal coverage: whether they offer equitable coverage and financial protection to women and men; whether they cover essential sexual and reproductive health needs and chronic diseases; and whether they exclude specific groups of women. Case examples are also presented of countries and schemes including social protection schemes, which are more gender equitable, or franchising schemes, which contribute to bridging the gender gap in access to health services. Then, on the basis of these, it outlines essential characteristics of financial mechanisms and arrangements that 'work' for women.

2.1.3 Implications of health insurance mechanisms for gender equity in health

Health insurance is a mechanism that pools funds from public and/or private sources and pays for all or part of members' health care according to a specified benefits package. Insurance funds are used to purchase services from public or private providers, or both. They allow for risk pooling and cross-subsidizing across income groups, and eliminate or substantially reduce out-of-pocket payments at the point of service delivery. They are, therefore, an important mechanism for financial protection.

Types of health insurance schemes

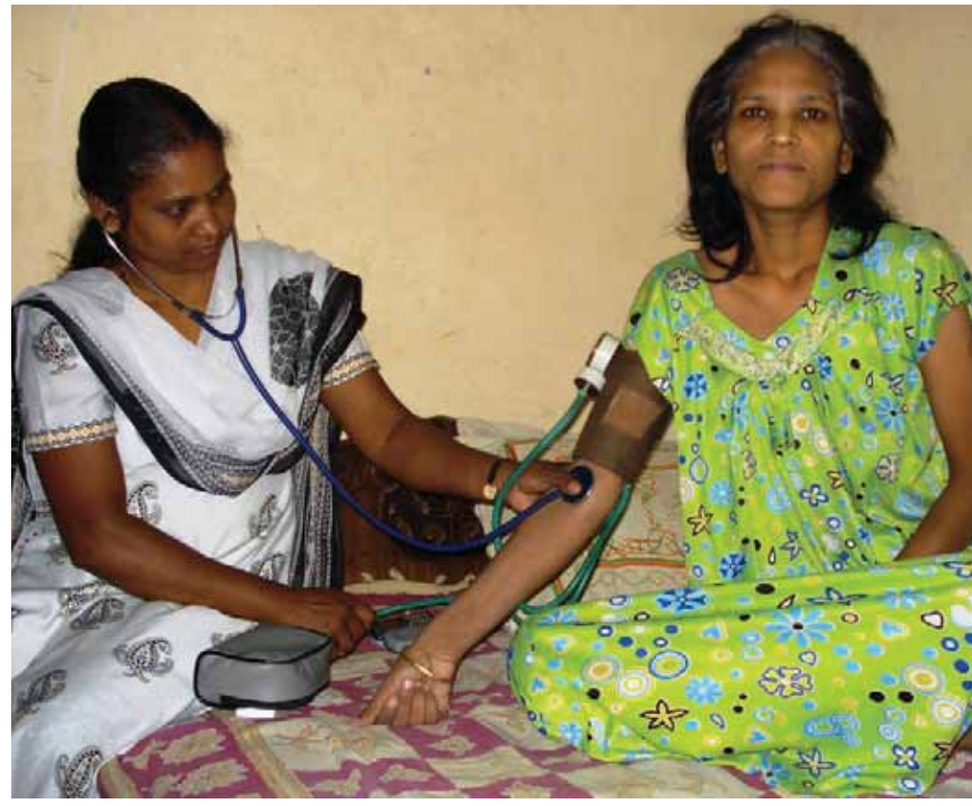
Insurance schemes may be classified into private insurance schemes, social insurance schemes and micro-insurance schemes.

Private insurance is based on voluntary contributions by individuals or by individuals and their employers jointly. They are often operated on a for-profit basis, and compete with each other for customers and offer different plans with varying price tags. The benefits package – the range of services covered by the insurance – depends on the price tag. In addition, premium contributions for a given benefits package are frequently linked to the individual member's risk of ill-health.

Unlike private insurance, *social health insurance* (SHI) is based on mandatory membership. Although SHI started as a compulsory insurance scheme for those employed in the formal sector, many countries are moving towards compulsory membership of the entire population. Contributions are made by workers, the self-employed, enterprises and government into a social health insurance fund (*52*). For workers in the formal sector of the economy, a standard payroll deduction is made from both employers and employees, and premiums are based on income levels. The self-employed either pay a flat rate or a premium based on estimated income. Premiums for the unemployed and those from very low-income groups are paid by the government. The contributions of the better paid subsidize the lower paid. All insurees have access to the same range of services. They may receive services from the SHI's own network of providers, or from accredited private and public providers, or a combination of the two (*52*).

Micro-insurance schemes are another form of pre-payment mechanism that operates on a smaller scale. Unlike SHI, membership is voluntary. There are many different names by which micro-insurance schemes are known: community-based health insurance, mutual health organizations, and pre-payment plans. They are intended to be complementary to SHI, mainly to cover those who are not part of the formal sector of the economy. They

are operated on a not-for-profit basis, and members' contributions are often heavily subsidized by contributions from the government and/or donors. They may be initiated by health facilities, NGOs, trade unions, local government or cooperatives, and owned and run by any or a combination of these (*53*).



Coverage of women by insurance schemes

In terms of coverage, the poorest and those without access to cash – including women – are less likely to be able to participate in voluntary health insurance schemes, even when these involve relatively modest payments as in micro-insurance schemes. Premium payments by the indigent and those with limited ability to pay need to be partially or completely subsidized in order to cover the most vulnerable sections of society, of which women constitute a large component.

In many developing countries, social health insurance covers only those working in the formal sector of the economy and their dependents, and is likely to exclude a vast majority of women who work mostly in the informal sector, unless they are covered as dependents of formal sector employees.

Moreover, private health insurance schemes may have gender-discriminatory dimensions that act as barriers to coverage. A 2008 report from the United States based on the analysis of 3500 individual insurance plans found that women who bought individual insurance coverage – about 18% of all women in the country – faced many forms of gender discrimination (*54*). Many insurance plans practised 'gender ratings' and charged women higher premiums than men of the same age. Insurance companies could reject applications for reasons specific to women, for example, women survivors of domestic violence and women with a previous c-section (*54*).

Inclusion of services for women-specific health needs in benefit packages

Insurance plans typically cover health conditions that are low-probability, random events, such as an accident or a surgery. High-probability and non-random health events are considered uninsurable. Services that are very low-cost are also uninsurable because the administrative costs of insurance may exceed the number of individuals who would pay to be covered against it.

Many reproductive health services are uninsurable as stand-alone benefits. For example, pregnancy is a non-random event; contraceptive services are high-probability services. They can only be efficiently covered if they are part of a broader benefits package.

Individual private insurance plans in the United States do not usually cover maternity services, and those who wish to be covered have to pay an additional premium and yet have coverage only for a limited number of maternity-related services (*54*). Many plans cover only some of the reversible contraceptive methods for women, and so on.

With the rapid increase in the importance of chronic diseases in almost all countries of the world, the need for insurance to cover the cost of long-term treatment, including drugs, becomes very important. Studies from some settings indicate that women are more likely than men to discontinue treatment for chronic health conditions requiring long-term intake of drugs. For example, in Mulago hospital, Uganda, women were almost three times as likely as men to not adhere to diabetes treatment (*55*). In Kerala, India, among those under treatment for type-2 diabetes, 70% of men reported no default in compliance with drug intake as compared to only 52% of women. Lack of money was cited as the reason for default by 19% of men and 31% of women (*56*). Besides a lack of access to resources, older women may also discontinue treatment because they do not feel entitled to spend money on themselves (Box 3).

Box 3. Gender and treatment adherence

Shakeela, now 65 years old, had a heart attack 10 years ago. She prefers going to the nearby pharmacy, even if it costs more, than going to the hospital and waiting in line for hours to get her medication. The downside to this alternative is that, for financial reasons, Shakeela is not buying a sufficient amount of medication and therefore not taking the prescribed dose. "I know I should be taking my medication every day but this way I can also save some money for my grandchildren – they are young and have a future" she argues (*57*:81).

Micro-insurance schemes may also be similarly limited in the benefits packages that they are able to offer. In most instances, these mechanisms do not include coverage for a wide range of essential reproductive health services, such as normal delivery, contraception, inpatient gynaecological care and some of the most risky health events for women, such as delivery complications. A study of 13 mutual health organizations, which are community-based pre-payment schemes in West Africa, found that only some of them included family planning services as part of the benefits package. Inclusion of family planning services in the benefits package was more common in mutual health organizations initiated by women, and influenced mainly by demand from members. Those organizations that did not offer family planning services were initiated by men or mixed groups (*58*).

The Self Employed Women's Association (SEWA) in India runs a large pre-payment scheme with close to 25 000 low-income self-employed women subscribers. The scheme covers limited indemnity insurance for inpatient care at public, private for-profit or charitable facilities. A study evaluating this scheme concludes that the need to strike a balance between financial viability and protection of its members from catastrophic health expenses has meant that, while poor women do benefit from the scheme, there are still many women who incur substantial debts paying for services not covered by the fund (*59*). Thus, the principal objective of financial protection to subscribers could not be achieved by this micro-insurance scheme.

We have thus far pointed out the limitations of health insurance schemes in covering women and their specific health needs. All the same, experience from some countries illustrates that it is possible to design insurance mechanisms that address these limitations. Brazil and Thailand are examples of countries that have achieved universal coverage and expanded the range of health services to include a wide range of services that women need.

Insurance schemes that work better for women: country examples

Insurance schemes that work better for women share some common features.

1. They are not restricted to those working in the formal sector of the economy and their dependents, but are either open to all households, or specifically target households that are not covered by other insurance schemes. This means that single women and women who are not part of the formal employment sector can obtain coverage.
2. They are either completely paid for from public sources or involve a very nominal premium, and those unable to pay are paid for by the government or donors.
3. They enrol entire households, so that women are not excluded because the household does not pri-

oritize their health or because they are unable or unwilling to pay for themselves.

4. They cover a wide range of sexual and reproductive health needs including non-random and routine needs such as contraception, which are usually excluded in many schemes.
5. They do not exclude those with pre-existing conditions so that middle-aged and older women, and men with chronic health conditions, are also covered.

Brazil

Brazil has a Unified Health System (*Sistema Único de Saúde* – SUS) offering comprehensive and free health services for all. Created in 1988 within the new Constitution, the SUS is based on principles of universal coverage, equity and integrated care. The system covers medical care at all levels: PHC units, clinics, emergency services, hospitals and laboratories. A wide range of medicines are also provided free of cost (*60*).

It is fully financed by public sources: the federal government (55%), district governments (22%) and municipal governments (23%). Services are provided by an extensive network of public and accredited private providers and facilities, and cover over 70% of inpatient and outpatient care (*61*:2).

The system covers a wide range of women's health-care services that were originally part of the Comprehensive Women's Health Program (*Programa de Assistência Integral à Saúde da Mulher* – PAISM). Services provided include prenatal care, delivery and postpartum care; breast and cervical cancer screening; STI care; adolescent and menopausal care; treatment of reproductive tract infections; infertility services; family planning education; and contraceptive products. Women and adolescents of all ages are covered by these services. Two years after PAISM was integrated into SUS, prenatal consultations had increased by 51%; legal abortion services were available at several facilities; coverage of cervical and breast cancer screening had increased; and adolescents were being served by family planning and STI/HIV prevention services (*61*:3).

The effectiveness of SUS in providing financial protection has recently been called into question, after a study found that Brazil had among the highest proportion of households suffering from catastrophic health expenditure. The increasing burden of chronic diseases in Brazil is also straining the finances of the SUS, and there are gaps in the quality and comprehensiveness of care for noncommunicable diseases and mental health. However, the SUS appears to be effective in providing financial protection to women seeking safe delivery services. A 2004 study of all births in that year in Pelotas found that 81% of the deliveries were financed by the SUS. Among mothers from the poorest 40% of the population, 95% of the deliveries were financed by SUS. Less than 1% of all mothers had to incur any out-of-pocket expenses to meet the cost of delivery care (*60*).

Thailand

Thailand has recently joined the ranks of countries with universal coverage of health services. This has been achieved through three major insurance schemes: the Civil Servant Medical Benefit Scheme covering 9% of the population; the Social Security Scheme covering 13% of the population, and the Universal Health Care Scheme covering 78% of the population (*62*).

The Universal Health Care Scheme was introduced in 2001, and covers all those who were not included in the Civil Servant Medical Benefit Scheme or Social Security Scheme. The scheme is financed by tax revenue. Each insured person receives a universal health card or 'gold card' to be produced when utilizing services, which are available free of cost at the point of delivery. The vast majority of facilities covered through the insurance schemes are in the public sector, but accredited private providers are also included in the scheme if they can provide the full range of services in the benefits package. Providers are paid on a capitation basis, which is 2100 baht (US$ 65) per head, per month. This includes costs of curative, preventive as well as promotive care (*63*).

A special feature of Thailand's insurance schemes is that they are among the few in developing country settings to cover a comprehensive package of sexual and reproductive health services (*64*).

- *Preventive services* include family planning; antenatal care; sex education and promotion of condom use; screening for syphilis; HIV testing; prevention of moth-

er-to-child transmission among pregnant women; pap smear; clinical breast examination; and general counselling services for sexual and gender-based violence.

- *Curative services* include abortion in cases of rape and risk to maternal health; treatment of abortion complications; essential and emergency obstetric care for the first two deliveries; treatment of reproductive tract infections; definitive treatment and care for opportunistic infections for HIV/AIDS patients; and reproductive cancer treatment.[3]

2.1.4 Public-private partnerships to expand women's access to essential sexual and reproductive health services

Many developing countries have a significant private sector in health. Partnerships between the public and private sectors in health are seen as having the potential to increase the supply of health services in underserved areas, thereby expanding access to health-care services and contributing to universal coverage. Another benefit of public-private partnerships is that by shifting users who can pay to the private sector, it may relieve the patient and financial burden on the public sector (*65*).

Many innovative public-private partnerships have emerged during the past decade in the area of sexual and reproductive health. These include social marketing networks, and private provider networks some of which operate as social franchising networks.

Social marketing

Social marketing may be described as the application of market tools, concepts and resources to effectively deliver health products and services and motivate their use. Products are charged at subsidized prices and distributed by commercial distribution systems to retail outlets. Many social marketing programmes are dependent on government or donor subsidies to cover costs (*66*).

Contraceptive social marketing programmes have been operational in many countries in Africa, Asia and Latin America for several decades. Social marketing of condoms has become an important component of AIDS control programmes since the mid-1980s. Many new health products are also being distributed through the social marketing channel. Pre-packaged therapy, a package of standard medication, which can effectively treat STIs, and the clean delivery kit for home births are among recent products being marketed by Population Services International (PSI), an international NGO (*66*).

Private provider networks and social franchising

Private provider networks consist of an affiliation of private providers who are members of an umbrella organization. Members usually offer a standard set of services under a shared brand. The brand name serves as a guarantee of the availability of a defined package of high quality services at clearly determined prices. Some networks evolve into 'franchising' programmes in which there is a controlling organization, the 'franchiser' who provides ongoing monitoring and technical support to the franchised providers (*67*).

Social franchising programmes in reproductive health are now found in several countries, predominantly in Asia and to some extent in Africa and Latin America. Some examples of social franchising networks offering reproductive health services include the Janani programme in India and Green Star in Pakistan providing mainly outpatient contraceptive services and treatment for gynaecological problems; the Gold Star network in Kenya providing subsidized antiretroviral treatment (ART) services for HIV/AIDS patients in the private sector (*68*); New Start centres in Zimbabwe, which are integrated into existing health facilities (both public and private), providing rapid HIV testing (*69*); MEXFAM, an affiliate of the International Planned Parenthood Federation (IPPF) in Mexico, providing a package of MCH/FP services to women in low-income urban and periurban areas; and the IXCHEN social franchising network in Nicaragua providing adolescent sexual and reproductive health information and services (*70*).

Contributions of franchising mechanisms to expanding population and health–care coverage

In settings where there is political opposition to the provision of publicly funded contraceptive services, franchising

[3] Antiretroviral therapy (ART) is not a part of the universal coverage package, but is available free of cost through public hospitals to low-income patients. By using generic drugs and allocating an earmarked fiscal year budget, the government has been able to expand substantially ART coverage.

mechanisms in the form of public-private partnerships have made contraceptive services available. The Sun Quality Network (Myanmar), RedPlan Salud (Peru) and Friendly Care (Philippines) are examples of these. In other words, they have contributed to expanding health-care coverage (*68*).

Franchising mechanisms also have the potential for expanding access to hitherto undercovered population groups. For example, in the Philippines, PhilHealth, a government corporation managing the country's social health insurance has enrolled the Friendly Care social franchise as its provider of family planning and other health services to the poor. PhilHealth reimburses the network clinics for services provided free at the point of delivery to users from low-income groups (*68*).

Adolescents are a typically underserved group in terms of sexual and reproductive health services. In Nicaragua, IXCHEN, the not-for-profit organization mentioned above, reaches adolescents through its network of youth organizations, with a wide range of sexual and reproductive health services: information, education and communication (IEC); family planning; STI treatment; emergency contraception; antenatal care; and counselling and advice on relationships and family problems (*70*, *71*).

Dynamic franchising networks help promote innovations. In Kenya, K-MET, an NGO, operates the Private Providers Health Franchise Network. The network includes some 250 private clinics throughout western Kenya. The NGO serves as an 'incubator' for best practices and reproductive health models. Its services go well beyond sexual and reproductive health to include primary health care, prevention of malaria and waterborne diseases, youth-friendly services and home-based programmes for people living with AIDS (*68*).

However, franchising mechanisms that provide sexual and reproductive health services operate amidst considerable challenges. Historically, social franchising and marketing programmes providing sexual and reproductive health services have depended on government or donor support. In order to become self-sustaining, franchises are compelled to diversify the range of services offered to include those that are more 'lucrative', to allow for cross-subsidizing those that are highly price-elastic, such as contraceptive services. Franchises would also find it economically unviable to reach low-income groups. If low-income populations are to be reached, then cost-recovery may have to be subordinated to achieving the social goals (*68*).

In conclusion, if universal coverage is the goal, there is a role for franchising mechanisms especially in the provision of sexual and reproductive health services. This is particularly true in settings where the public sector provides only a limited range of services or has limited population coverage. However, it needs to be acknowledged that there are trade-offs between serving the poor, providing a full range of sexual and reproductive health services and financial sustainability. Ongoing government and/or donor support, and the enrolment of franchises as providers in social insurance schemes would help advance the goal of universal coverage.

2.1.5 Social protection health schemes and conditional cash transfers

Social protection health schemes

Social protection health schemes are "public interventions directed at allowing groups and individuals to meet their health needs and demands through access to health care goods and services in adequate conditions of quality, opportunity and dignity, regardless of ability to pay" (*72*). They are targeted interventions catering to vulnerable populations with a view to bridging the gap in health care access created by social and gender inequalities. Social protection health schemes are most common in Caribbean and Latin American countries where they have been implemented since the 1990s to protect vulnerable populations, including mothers and children.

Bolivia

One of the poorest Latin American countries, Bolivia has had a series of publicly funded social protection health schemes aimed at mothers and children under five since 1996: the National Maternal and Child Insurance (*Seguro Nacional de Maternidad y Niñez* – SNMN) scheme, followed by the Basic Health Insurance (*Seguro Básico de Salud* – SBS) scheme and, since 2003, Mother and Child Universal Insurance (*Seguro Universal Materno Infantil* – SUMI) scheme. The latter (and the earlier schemes)

covers all pregnant women until six months after childbirth and children below five years of age. While earlier schemes provided only primary and secondary level care, SUMI has comprehensive coverage and includes complex care and dental care. Services can be availed from public sector health facilities, health facilities under the social security system and private establishments assigned as providers (*73*).

Social protection health schemes have been successful in increasing equity and access to appropriate health-care services, and expanding coverage. The scheme covered 74% of the target population by 2004.[4] An assessment of the impact of the three social protection health schemes found that they had increased access to maternal health care of previously excluded groups by reducing economic barriers. Coverage of technically appropriate health services had also increased significantly. Between 1994 and 2003, health service utilization through SUMI (and its predecessors) increased significantly, from 3.6% to 53.4%. Use of public services by mothers with no education increased by 300% as compared to 2% among mothers with post-secondary education. The lowest income quintiles registered the highest rates of growth in health-care utilization. Use of skilled birth attendance registered a fourfold increase in the lowest income quintile, from 5.3% in 1994 to 21.1% in 2003. This is believed to be one of the major factors underlying the reduction in the maternal mortality ratio in Bolivia from 390 per 100 000 live births in 1998 to 229 per 100 000 live births in 2003 (*73*).

China

Another example of a social protection scheme that has expanded access to a broad range of health-care services, especially for low-income women, is the Medical Financial Assistance (MFA) scheme in China.

The Medical Financial Assistance scheme is being implemented in rural townships of 71 counties, which are among the poorest in China's poor provinces. All residents of these counties are eligible to receive a subsidy to enrol in the Co-operative Medical Scheme (CMS), partial fee waivers for inpatient and outpatient services, and exemptions for selected services such as maternal and child health services (*74*). The poorest 5% of the population are exempt from CMS premiums but still benefit from the priority services (*75*). By 2004, close to 32 million residents of the 71 counties were covered by MFA. Maternal health services available free of cost to all women include standard prenatal visits, hygienic delivery and postnatal care (*75*). Four of the 71 counties had a Reproductive Health Improvement Project, which included in addition to maternal health care, prevention and control of road traffic injuries, promotion of safe childbirth practices in remote rural areas, and development of men's active participation in reproductive health (*76*).

The Medical Financial Assistance scheme has improved access to services for the poor by removing economic barriers and especially by improving their ability to receive services from township clinics. However, because many of those covered by the scheme were vulnerable to serious, complicated health problems of long duration, the scheme did not offer adequate financial protection. Many people continued to incur high medical expenditure for health conditions not covered by the MFA (*77*). In order to achieve its objective of social protection, the scheme would have to expand the range of services included in its benefits package and perhaps decrease the extent of co-payment.

Conditional cash transfers

Countries have introduced conditional cash transfers to increase underserved groups' demand for health services. These typically consist of a cash payment to a household or individual conditional on their adopting desirable health behaviours. Some of the best-known conditional cash transfer initiatives have been in Latin America, where cash payments are conditional on children's school attendance and children's and pregnant women's attendance at preventive health services. A review of six conditional cash transfer programmes in Latin America found that they consistently increased use of health services. Their influence on health outcomes was, however, unclear (*78*). Evidently, for an increase in utilization of preventive health services to translate into better outcomes, the services provided would have to be of high quality. Moreover, action would be needed on other social determinants of

[4] Despite these gains, important gaps still remain between rural and urban areas and the highest and lowest income quintiles.

health, which create and maintain health inequalities. All the same, conditional cash transfers seem to be a useful tool to compensate for non-medical costs of seeking health care including loss of wages.

Conditional cash transfer programmes to promote institutional delivery were introduced by the governments of India and Nepal in 2005. In India, the cash transfer is available to all women in low-performing states and, in other states, is restricted to women from households living below the poverty line. In Nepal, the programme covers all women.

In India, the *Janani Suraksha Yojana* (JSY) was launched under the National Rural Health Mission in 2005. An evaluation carried out in five states showed that the proportion of institutional deliveries had more than doubled, from 23.5% (for all five states combined) between 2005 and 2006 to 55% in 2008. One issue of concern was that 66% of women were discharged from the health facility within 24 hours after a normal delivery, as against the recommended 48 hours. No information was available on the proportion of total costs covered by the cash transfers, or the outcome of deliveries (*79*). The second concurrent assessment in Rajasthan, India, pointed to persistent major health system gaps. This assessment found that 35% of first referral units (FRUs) meant to provide emergency obstetric care did not have a blood bank, 70% of FRUs did not have an anaesthetist and 50% had no specialist obstetrician/gynaecologist (*80*). The result was avoidable delays in emergency obstetric care and overcrowding of the district hospital. An important gap in the JSY scheme is that the incentive is available only for the first two deliveries. Given the association between high fertility and low socioeconomic status, this inevitably results in the exclusion of the most needy from the scheme.

The Safe Delivery Incentive Programme (SDIP) in Nepal faced other problems. A study to assess the impact of SDIP carried out in 2008 in one district found that the programme had more than doubled the rate of institutional deliveries and substantially increased the use of skilled birth attendants. However, the better off had benefitted more than the poor. This was because there was no targeting, and the wealthiest 20% of the women had received 60% of the conditional cash transfer. Also, the SDIP offered little protection against catastrophic payments, because the cash incentive amount of NPR 1000 (US$ 13) covered no more than 25% of the cost of a normal delivery and 5% of the cost of a caesarean section (*81*).

Experiences in India and Nepal, while reaffirming the potential of conditional cash transfer programmes to increase the use of institutional delivery services by low-income women, highlight the need for targeting and for simultaneous investments in health system strengthening.

2.1.6 Expanding health-care coverage: limitations of essential services packages

Essential services packages include services identified as high priority to be publicly funded (by tax revenue or through national health insurance) and available free at the point of delivery, while other services have to be paid for out of pocket, or availed through insurance mechanisms. Reproductive health services that only women need are often inadequately covered by ESPs. This is an area that needs to be addressed when considering expanding health-care coverage.

Although the concept of a basic package of health services has been discussed since the Alma-Ata Declaration, it is only since the World Development Report of 1993 (WDR 93) that many countries have embraced the concept. Services within an ESP outlined by WDR 93 are chosen based on criteria such as cost-effectiveness, services with externalities, services that are pure public goods, or services whose benefits may be underestimated.[5] These services are publicly financed either because of market

[5] **Public goods** are a special class of goods which cannot practically be withheld from one individual consumer without withholding them from all (the 'non-excludability criterion') and for which the marginal cost of an additional person consuming them, once they have been produced, is zero (the 'non-rivalrous consumption' criterion). One example of a public good is health education.
Externalities are benefits or costs generated as the result of an economic activity that do not accrue directly to the parties involved in the activity. For example, environmental externalities are benefits (e.g. tree planting) or costs (e.g. pollution) that manifest themselves through changes in the physical or biological environment regardless of the relationship of the parties to the environmental regime impacted.

failure or with a view to protecting the poorest groups from catastrophic costs.

In practice, few countries engage in a priority-setting exercise using the WDR 93 methodology, and have tended to be guided by 'model' ESPs outlined by various World Bank documents (*82–84*). Resource crunches in the health sector have caused essential services packages to be rather narrow. Overall, they fail to respond to the specific health needs of women and men.

Many of the packages do not cover, among others, essential sexual and reproductive health services, and women have to incur sizeable out-of-pocket payments to receive these services.

In an assessment of what was included in the publicly financed ESPs in about 152 countries that received support from the World Bank for health sector reform during the period 1993–1999, two major findings emerged (*84*).

- Only 20 of 152 countries assessed included in their ESPs all of the following: family planning; prenatal and delivery care; clean/safe delivery by trained attendants; postpartum care; and essential emergency obstetric care. Delivery care and emergency obstetric care were missing in a large number of ESPs.
- Forty-four out of 152 ESPs included prevention of HIV/AIDS. The most frequent intervention was condom promotion. Out of 152 projects, 51 included treatment for STIs, but usually through the HIV/AIDS programme. Control of STIs was rarely an integral part of antenatal care, family planning services and other reproductive health services (*84*).

Safe abortion services are rarely part of essential services packages, although abortion is legal in almost all countries in specific circumstances, e.g. when the pregnancy is the result of rape or endangers the mother's life. This means that even when a woman is legally eligible to have an abortion, she will not have access to services unless she pays for them. These packages also rarely include services for the reproductive health needs of men, older women, and young women and men. Treatment for chronic diseases such as common mental disorders, which affect a large proportion of women, and for cardiovascular diseases, from which men suffer disproportionately, are not part of the ESPs in most settings.

An exception to this general situation was the ESP designed by Bangladesh as part of its Health and Population Sector Programme (HPSP) implemented from 1998 to 2003. Reproductive health services included in the ESP elaborated under this programme comprised of five elements working in concert to save and improve lives: contraception; maternity care; safe abortion; prevention and treatment of STIs including HIV; and comprehensive sexuality education. Attention to violence against women in public health facilities was also included as a part of this package (*85*).

* * * * * * * * *

In summary, financing mechanisms that would ensure universal coverage of women and men alike would be a combination of tax revenue and social health insurance, with government subsidizing premium payments for those with limited ability to pay. In addition, the benefit packages of insurance schemes would include sexual and reproductive health services, many of which are 'non-insurable', and drugs for chronic diseases, which can involve considerable costs. These would need to be subsidized by public funding.

In settings where population coverage by sexual and reproductive health services is low and the expansion of services is constrained by resource availability, social franchising arrangements have been found to be useful. Another situation where social franchising has been useful is where political sensitivities constrain access to abortion or contraceptive services. However, social franchising arrangements are unlikely to reach the poorest or to be able to provide a comprehensive range of sexual and reproductive health services unless subsidized for reasons of financial viability.

Social protection health schemes and conditional cash transfers are an important mechanism for increasing utilization of health services by underserved populations. More research and experimentation is needed to ensure that they also improve health outcomes and health equity.

Priority setting criteria, mechanisms and processes currently in use result in narrow ESPs, which do not meet many important health needs of women or men. There is need for re-evaluation of these criteria and mechanisms in order to increase health coverage so that it is gender equitable.

2.2 Service delivery reforms

Service delivery reforms have been described by WHO as "reforms that reorganise health services as primary care, i.e. around people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world, while producing better outcomes" (*3*:xvi).

People-centredness constitutes the core of service delivery reform, with a focus on health needs of the individual rather than on curing a disease or health condition. The aim is to provide a comprehensive range of services that are available closer to home. Primary care services are to be well integrated with other levels of care to ensure continuity of care. Enduring personal relationships are to be established with users, improving the quality of provider-patient interactions and promoting effective caregiving (*3*:43).

The meaning of 'people-centredness' would be different for women/girls and men/boys, given sex and gender-based differentials in health needs and in responses to treatment. Women and men are known to differ in terms of their health-seeking behaviour, their ability to access and to complete treatment, and in their expectations from health services.

In this section, we start with some ideas on the meaning of people-centredness in service delivery that takes into account gender-based differentials and inequalities between women and men. We then examine from a gender perspective two building blocks of national health systems that have a major influence on health service delivery: health workforce, and drugs, vaccines and technology.

2.2.1 Engendering people-centredness in service delivery reforms

Concern that gender inequalities in health were affecting disadvantaged women prompted the development of the concept of 'women-centred' health services in the 1980s and 1990s. A meeting organized by WHO and the United Nations Children's Fund (UNICEF) to arrive at a consensus on the meaning of 'women-friendly' health services identified four main characteristics: accessibility; respect of technical standards of health; motivation and support of staff; and empowerment and satisfaction of users (*86*). Other frameworks for women-centred health services comprise similar elements but may be more elaborate (*87*, *88*). The Irish Women's Health Council published *A guide* for *gender-sensitive health services*[6], with a checklist for identifying and responding to the differential needs of women and men (*89*), and illustrating their message with examples of why and how service delivery would differ for women and men being treated for cardiovascular diseases and mental health problems. We draw on all these and other sources to outline how gender considerations may be taken into account in:

- deciding the range and content of services;
- the organization and modes of service delivery; and
- patient-provider interactions.

A word of clarification regarding terminologies used is in order here. While we draw on descriptions of 'women-centred'[7] health services, our discussion is not about making services women-centred. It is about making health services gender responsive, i.e. ensuring that they take into account the differences between women and men in health needs, health-seeking behaviour, access to health services, and so on, even while striving to redress gender inequalities in health.

Deciding on the range and content of services to be provided

Taking into account sex and gender differentials when addressing the health needs of a population is more than the addition of maternal and child health (and, sometimes,

[6] WHO uses the term 'gender sensitive' to mean awareness of gender differentials, and the term 'gender responsive' when referring to action to correct gender inequalities. Thus, in this paper, we use the term 'gender responsive' rather than 'gender sensitive' in the context of health services and health policies/programmes.

[7] 'Women-centredness' has been described as a situation where "the needs, values, information, experiences and issues from the point of view of women are included in the planning, implementation and evaluation processes of policies and programmes which affect women's lives" (*88*).

family planning) services to basic curative care and/or control of priority communicable diseases.

It implies, for example, including counselling, medical care and referral services for women survivors of gender-based violence, and services for major chronic diseases in services available at the primary care level.

Universal access to a comprehensive range of sexual and reproductive health services is one of the Millennium Development Goals. Achieving this would require expanding the range of services beyond maternal health and family planning services. It would also call for the sexual and reproductive health needs of those currently underserved to be addressed, e.g. older women, men, adolescents, young women and men, and people of different sexual orientation.

But differences in health needs between women and men extend beyond sexuality and reproduction. Given that women outlive men in most societies, services for the health problems experienced by elderly women should feature in the range of services provided at the primary care level. There are a number of health conditions that affect women and men differently, and may have to be managed differently. For example, there are gender differentials in mental health needs: depression is more common in women and substance use more common in men. Therefore, a service aiming to address mental health needs would have to tackle both of these. Malaria, although more prevalent among men, has serious and potentially fatal health consequences for pregnant women – this would call for the integration of malaria screening into maternal and child health services, which pregnant women may be more likely to access. Women who have suffered a stroke have greater pre- and post-stroke disability and greater mental impairment than men and, therefore, are in greater need of rehabilitative care (*90*). Women with type-2 diabetes have been found to suffer disproportionately from the disease when compared to men (*91*). There are also differences in the way women and men respond to medical procedures. For example, angioplasty – a procedure to clear blocked arteries – is riskier and less successful for women than men, because women's arteries are smaller (*89*:13). Both type-2 diabetes and angina in women may need different therapeutic strategies than men and, hence, make different demands on the service delivery system.

Organization and modes of service delivery

Addressing sex and gender differences in the range of services provided is only one dimension of gender-sensitive health services. A second dimension is the organization and modes of service delivery that acknowledges and responds to gender differentials in roles and responsibilities, and access to resources and power.

This section will address two aspects of organization and mode of service delivery that would contribute to increasing access to health services for women and men:

- offering services at appropriate location and time
- integration of services.

Offering services at appropriate location and time

Attention to gender differences in health-seeking behaviour could influence where services are delivered. Women's lack of physical mobility in traditional societies, their limited access to means of transportation because of financial as well as cultural barriers and, in some instances, lack of time and money are barriers to their seeking care from a health facility. In such settings, health programmes would have to invest in outreach services in order to be effective.

For example, studies from Bangladesh and Viet Nam indicate the possibility of under-diagnosis and under-notification of women with tuberculosis (TB), contributing to a lower-than-actual reported prevalence of tuberculosis in women (*92–94*). This is corroborated by other studies on active case-finding. A 1982 study from Nepal found that when active community-based case-finding was adopted through mobile testing services, a far higher proportion of women and older persons were identified as being infected with tuberculosis (*95*). More recently, a study carried out in a high TB incidence area in Lima, Peru, in 2005 found that when house visits were made to the households of tuberculosis patients and their immediate neighbours, the odds of case detection (as compared to self-reports) was 5.5 for those aged over 55 years and 3.9 for women (*96*).

Another example of the need for alternative strategies in order to be able to reach women is in the case of cataract blindness. A much smaller proportion of women than men access cataract surgery, although the prevalence of cataract is found to be similar in men and women. In southern China, an intervention providing free cataract testing in the community followed by low-cost and high-quality surgery found that after five years of exposure to these interventions (2001–2006), women were as familiar as men about cataract surgery and as willing to pay RMB 500 (US$ 65) for surgery. The gender differences found in the baseline had been reversed at the end of the five years (*97*). Another example of a larger scale intervention to narrow the gender gap in uptake of cataract surgery is from the United Republic of Tanzania (*98*; Box 4).

Reaching men with preventive and promotive health services is known to be difficult. For example, a study in two regions of Kazakhstan and Uzbekistan found that men used primary health-care services significantly less often than women, and that reproductive health visits only partially explained women's more frequent use of such services (*99*). Creative modes of service delivery are needed, in settings where men are more comfortable or more commonly found, such as workplaces, cafes, social clubs and sports venues (*100*).

Among pioneers in catering to men's specific health needs are NGOs working on sexual and reproductive health. Men's access to sexual and reproductive health services has been limited by the organization of these services as part of maternal health care. Although condoms are available in MCH/FP clinics, the clientele as well as staff are almost all women. One of the best known and often-quoted examples of services oriented to men's needs is the PROFAMILIA men's health clinics in Colombia. The first of these clinics started in 1985 and, by 1995, there were seven men's clinics. A comprehensive range of services was provided, including general health care, sexuality counselling, urology services, vasectomy, ambulatory surgery, dental care and plastic surgery (*101*:49).

A review of experiences with men's involvement in sexual and reproductive health, however, concludes that clinics that have successfully adapted women-oriented settings to cater to men do as well as 'men-only' clinics, and this may be a more feasible option for adoption on a large scale. Adaptations include change of decor, training staff or adding new staff sensitive to men's health needs, having men-only hours and separate entrances and waiting areas for men (*101*:48).

Box 4. Gender-responsive services for prevention of cataract blindness, Kilimanjaro, the United Republic of Tanzania

Since 2001, The Kilimanjaro Centre for Community Ophthalmology (KCCO) has implemented a gender-sensitive cataract blindness prevention intervention. The intervention includes community-based screening for cataract blindness by local field assistants of KCCO and government health staff, followed by counselling for women and family members at the time of recognition, to encourage uptake of cataract surgery. Assistance is provided for transportation to the Kilimanjaro Christian Medical College Hospital with whom KCCO is associated. Gender concerns have become a central component of all programming and staff training for implementing VISION 2020 in this district. Utilization of cataract surgery by women increased substantially, and the male to female ratio of cataract surgery cases changed from 2.6 males to 1 female without the intervention, to 1.3 males to 1 female after it. In early 2008, KCCO appointed a gender coordinator to be, among other things, a resource person to district and national health sector personnel to address gender equity issues when programming for VISION 2020 (*98*).

Another aspect is the level at which a particular service is offered. Too often, minimal curative and preventive services are offered at the primary care level. This leaves people with no option but to seek care from formal or informal private sector providers or travel long distances to secondary or tertiary care facilities. It also crowds secondary and tertiary care facilities with patients seeking basic curative care, while those who need

specialist care may not receive the time and resources they need.

A basic package of promotive, preventive and curative care has to be available at the primary care level in order to increase access to care. Delivery care services are an example of much needed services that are most often unavailable at the primary care level. The availability of delivery care services in 24x7 Primary Health Centres in the State of Tamil Nadu, India, increased the proportion of institutional deliveries from approximately 80% to 98% between 2004 and 2008. Almost all the increase in institutional deliveries was accounted for by deliveries in primary health centres. The new users of institutional delivery services were from the poorest and most marginalized communities (*102*). This was made possible by the appointment of three nurse-midwives to provide round-the-clock services. An earlier attempt to have physicians available on all three shifts did not meet with much success. In the current set-up, physicians are available during the day. Those requiring emergency obstetric care alone are referred to a secondary or tertiary hospital.

Timing and duration of services are also important. Women and men are often unable to access health services because they operate during their working hours and days. Scheduling clinics locally at times suitable to both women and men at least one or two days a week could considerably increase access and utilization. The timing as well as duration of outpatient services in many hospitals is scheduled to suit the staff rather than the patients. Even outreach services when badly timed, result in poor utilization – as in the case of immunization or screening services organized during the busy agricultural season.

Another issue, especially in large hospital settings, is the long waiting time. When basic services are available at the primary care level, the overcrowding in hospitals may be considerably reduced. Other innovative measures to reduce waiting time adopted by some countries are worth emulating. In Malaysia, primary care centres fix hospital appointments for their patients, who are expected to adhere strictly to the referral chain. There is also a system of triage through which patients who need urgent attention are identified and given immediate attention (*103*).

Integration of services

Horizontal as well as vertical integration of services form a crucial component of service delivery reforms. Horizontal integration of services may include multipurpose clinics, multipurpose staff, adding new services to serve a more diverse population (e.g. older women, men, adolescents and young people of both sexes), and adding a new reproductive health service (e.g. STI or HIV/AIDS services) to existing reproductive health services (*104*).

One-stop access to a comprehensive range of services would go a long way in increasing access to care, especially for women. For example, rather than scheduling child health, antenatal care and family planning on different days or times of day, providing all of these at all times would enable a woman who comes to immunize her child to also have a pregnancy test or get her contraceptive supplies. In addition to the time convenience, integration of some services could enhance privacy and/or reduce stigma as, for example, when STI or HIV/AIDS services, abortion or infertility services are made available in the sexual and reproductive health clinic.

Horizontal integration of services across traditionally vertical programmes would be a further advance that would greatly enhance patients' and especially women's ability to access these services, for example, making directly observed treatment, short course (DOTS) services for tuberculosis available in the same facility as maternal and child health care, or providing testing and care for diabetes or hypertension under the same roof as sexual and reproductive health services.

Providing integrated services could also mean giving information proactively and encouraging patients to seek preventive or screening services. Examples include offering information on contraception to all women and men attending a clinic backed up by service provision; voluntary counselling for HIV to all clinic attendees, backed up by testing services; screening for cervical and breast cancer; or counselling against smoking.

Horizontal integration is not only about having a wider range of health services available under one roof while all the rest is business as usual. It calls for a different way of organizing care. For example, patients being treated

for diabetes should be referred for ophthalmic check-ups, and also be provided with counselling to deal with any sexual dysfunction that may accompany the condition. Another example relates to record keeping. Patient records and documentation would have to be sent from one provider to another, so that the patient would not need to repeat her story from one provider to another. The patient's case would have to be discussed jointly with the different providers caring for her so that treatment could be cohesive and not at cross-purposes. Such reorganization is essential both from an efficacy and a patients' rights perspective.

Integrated functioning at different levels of health-care services is important for continuity of care to the user in order to improve health outcomes. Primary health care reforms envisage a situation where primary care providers not only refer patients to higher levels of care but also receive feedback from higher levels of care on the outcome of the referral and the nature of further care to be provided at the primary care level. A starting point could be trying to achieve vertical integration in maternal health care. Women may be in a situation where antenatal care is provided at the primary care level, delivery services at the secondary level and emergency obstetric care at the tertiary care level. The same woman may go to different secondary and tertiary care facilities, in the public or private sector, for successive childbirths, and seek care from yet another source for any delivery-related morbidity or for contraception. Patient-held maternal history records have been adopted in many settings, and these could be extended to include the entire reproductive health record to ensure continuity of care.

One of the major challenges to integration of services is the acute shortage of health-service providers willing to serve in rural and remote areas. And yet, it is these same populations that are most in need of integrated services. If health equity were a priority, then more resources would be allocated to such settings, with an attractive remuneration package for health-service providers.

Provider-patient interactions

For most patients, providers represent a powerful authority with training and social position far removed from their own lives and realities (*25*:185). Patient perspectives on quality of care are shaped profoundly by the nature of their interaction with the health-care provider.

There is some evidence to indicate that the gender of the provider and the patient has a bearing on provider-patient interactions. Studies show that providers may treat women and men with the same condition differently. Differential treatment for women and men presenting with symptoms of heart attack have been extensively documented in the United States (*24*:31). Men presenting with psoriasis or eczema in Sweden were reported to receive more intensive treatment than women with the same condition (*105*). However, men have been reported to be under-diagnosed for depression (*106*). There may be two reasons why this happens. One is that women may have different presenting symptoms from men for certain conditions such as heart attack or stroke, and medical training does not prepare health-care providers to take note of these. The second reason may be gender-role stereotyping, which leads them to overlook depression as a likely problem in men. Medical educators have begun to talk of the necessity for 'gender competencies' in medical education to overcome or at least reduce such biases on the part of physicians.

The lower social status of women, especially women from low-income and socially marginalized communities leads to lack of assertiveness. They may have difficulty in communicating with the provider about their health problems, and in expressing opinions or taking decisions. A study from the United States reported that women were more embarrassed than men to report certain symptoms such as problems with bowel functioning (*107*). Women in many developing country settings have been reported as having difficulty in reporting vaginal discharges and other gynaecological symptoms (*108*).

Women patients' difficulties in communicating with the provider may be magnified when the provider is a man, especially for women from traditional societies where segregation between the sexes is the norm. However, preference for a physician of the same sex is found also in other settings. A study in the Netherlands found that for physical examinations that required complete disrobing, were invasive or required examination of the genitalia, both women and men preferred to have a physician of the

same gender (*109*). In the United Kingdom, 35–45% of women preferred to have women obstetricians and nurses (*109*).[8] Physicians in turn, may not be comfortable with performing body-intimate examinations on patients of the opposite sex: this was found to be the case among final year medical students in an Australian university (*110*).

Women and men in specific situations and settings and for specific types of health care may prefer sex concordance. Some studies indicate that women patients seen by women physicians are more likely to receive preventive services such as breast and cervical examinations, PAP smears, mammograms and preventive counselling (*111–112*).

However, being examined by a same-sex provider does not in itself guarantee better quality of care. There is a large amount of literature on the physical and verbal abuse of women in labour, and women seeking abortion and STI services by women health workers. A number of possible reasons for the abuse have been identified: the overworked health worker may be passing on her frustrations to patients; it may be a case of discrimination against women from low-income or marginalized communities; and, in the case of services, such as contraception, abortion or STI/HIV care, the health worker may be judging the patient as having transgressed gender norms (*25*:192–193).

Models of women-centred care as well as WHO's definition of patient centredness in service delivery emphasize 'empowerment' of the patient, and enabling them to take an active role in their own health care. However, 'patient empowerment' does not have the same connotation for women as for men. Empowerment of women patients is also about making a conscious effort to alter the power inequalities between women and men that the status quo perpetuates (e.g. requiring a husband's permission to provide his wife with contraceptives). The following may be some of the steps that could be taken towards empowering the participation of both women and men patients, and reversing the disadvantages that women face in service delivery settings.

- At the minimum, there should be no physical or verbal abuse of any patient by any member of the health team. The provider-patient interaction should be governed by respect for patients.
- Patients need to be given information to enable meaningful participation, not always through the written word, but by using communication modes that are suitable to women and men. Health literacy initiatives would constitute an important component of empowerment. One example is the 'Smart Patient' initiative in Indonesia that provided contraceptive information to women and men in community-based outreach programmes so that they could make informed choices (*113*).
- Providers need to ask questions about the patient's overall well-being without focusing only on the presenting condition. In one setting, "What would you really most of all want me to do for you today?" elicited more detailed responses from women patients, than a series of questions related to diagnosis of the medical condition (*114*).
- Providers also need to encourage patients, especially women who may not feel confident to do so, to ask questions and seek clarifications, and listen to what patients have to say.
- Because they have not been traditionally encouraged to take decisions, women may often request the health provider to take a decision on their behalf. Rather than try to 'fix' the problem for them, providers would help the woman most by assisting her to assess her choices and make an informed decision.
- Provision of both visual and auditory privacy when examining the patient and taking patient history is crucial. This is especially important not only for women seeking sexual or reproductive health services, but also for men seeking services for socially stigmatized conditions, such as tuberculosis and STIs/HIV.
- The provider needs to assume the possibility of gender-based violence in every woman being examined, and adopt a policy of upholding the woman's safety above all else. This would mean, for example, not permitting anyone else to be present during the consultation with the woman: the companion may be a perpetrator controlling the woman's responses to the provider. More and more countries are also adopting

[8] In contrast, men in the same study preferred to be seen by women nurses and social workers for nursing and psychosocial support.

a policy of routine screening for intimate partner violence within health-care settings.

- In some situations, the husband or partner may be present in the consulting room when their wives seek care. The husband may speak on behalf of his wife, reporting symptoms and responding to the physician's questions. This is a disempowering setting for the woman, even assuming that she is not experiencing intimate partner violence. It would be good practice to have complete privacy with the patient without anyone else present. If the situation requires that the health provider talk to the couple together, then it would be appropriate to ask the woman if she is comfortable with having her husband present.
- It is good practice not to make assumptions of heterosexuality in patients being examined, and to be open to the possibility of diverse sexualities.
- Feedback on the extent of satisfaction with services as well as what patients – both women and men – want from service delivery and provider relations needs to be gathered, considered and acted upon.

2.2.2 Addressing gender equality issues related to the health workforce

Health workers are the chief actors in the task of transforming the health services so that they put people first. In this section, we examine three areas in which action is necessary to enable health workers to be more gender-responsive:

- creating a gender bias-free working environment for health workers;
- training health workers in 'gender equity competencies', i.e. awareness of gender differentials and inequalities that impact on health, and skills to respond to these in their health work.

Creating a gender bias-free working environment for health workers

Heath workers who are expected to have respectful, bias-free and empowering interactions with patients require a working environment that nurtures these same values and is supportive of them.

Women health workers at all levels – from physicians to community health workers – are constrained by gender inequalities within society. Women physicians who have to balance their double work burdens as homemakers and professionals often resolve this by choosing specialities or positions that are less demanding of their time. Their ability to rise to leadership positions may be constrained by discontinuity in service to bear and raise children; men-oriented work cultures with extended working hours; meetings outside routine working hours; and the requirement to travel, transfer or relocate (*115*, *116*). The effects of gender on career may vary according to the woman physician's area of specialization. According to a 2003 study from Norway, women physicians in hospital-based specialties tended to postpone having children and have fewer children, and were less likely to work part-time, conforming to employers' expectations. Women general practitioners were more than four times as likely as those in hospital-based specialities to shift from full-time to part-time work to accommodate child care and other family responsibilities. The study also found that family obligations had not constrained the choice of speciality and career options of their male colleagues to the same extent (*117*).

Nurses and community health workers appear to suffer from the double disadvantage of a lower position in the entrenched medical hierarchy as well as female gender. Nursing has been stereotyped as an occupation secondary to the curative and healing role of the doctor, and concerned chiefly with caring, nurturing and menial tasks (*105*:218). There are social divisions within the nursing profession between clinical nurses with curative roles and the less-trained auxiliary nurses. The self-confidence of those at the lower levels of the nursing profession is often undermined by the physician-centred hospital culture that allows them little decision-making power and makes them into mere appendages of the physicians and clinical nurses. Their disempowered position in the medical hierarchy makes them exert their authority on those less powerful than themselves: the patients (*106*:218). Research documenting verbal abuse of women in labour in South Africa suggests that health workers' own experience of abuse in their homes or community, or within the health facilities by their bosses or other staff, may underlie such behaviour (*118–120*).

Community health workers are a diverse group ranging from professionally trained auxiliary nurses who are part

of the formal health system to volunteers with brief training who carry out health education activities and act as a link between the community and the formal health system. The small numbers of studies on community health workers who are part of the formal health system show that they often have poor salaries and unsatisfactory working conditions with little support or supervision from health workers further up the hierarchy. In a study from Pakistan, women health workers faced multiple disadvantages: hierarchical management; disrespect from men colleagues; lack of family support; and hostility from the community. They reported that these frustrations negatively affected their interactions with patients (*100*). Lack of proper housing, lighting and transportation facilities for auxiliary nurse midwives in India who are required to live in the village health sub-centres threatened their personal security, and contributed to their reluctance to stay in villages (*115*:231).

Creating a gender bias-free working environment requires action at multiple levels (*115*:232–233).

- All health workers should be eligible for maternity and paternity leave for biological as well as adoptive children.
- Health workers with small children and with caring responsibilities for older family members need provision for parental leave. In order that this does not translate into only women having to take leave to attend to family responsibilities, parental leave should be available to both women and men.
- Child-care support is required at the workplace, and also when training programmes are organized, so that women with young children can also participate.
- Promotion policies need to be changed so as not to disadvantage those with discontinuity in service because of family responsibilities.
- New ways of working need to be fostered that discourage hierarchical modes of functioning and foster respect for and participation in decision-making across all levels of health workers. Opportunities need to be created for career development of those with less training.
- Investments need to be made in providing professional support to community health workers, as well as infrastructural support that ensures safety and security.
- Policies need to be in place that discourage and take serious action against sexism and gender discrimination in the workplace.

Training health workers in gender competencies

A good deal of effort has focused on in-service training of health professionals on gender equity issues, often at a local level. However, there have been few assessments of the impact that these have had in changing attitudes and practices. The World Health Organization and its regional offices have also initiated several in-service training programmes for health workers that are multi-country initiatives involving health workers and managers in the formal health sector.

The Health Workers for Change (HWFC) project aimed at training health workers in primary health clinic settings uses participatory research and learning approaches. It focuses on the improvement of the overall quality of care, and emphasizes gender sensitivity as an important element of good quality health care (*121*). The Pan American Health Organization (PAHO) was among the first to develop and implement training courses on gender, health and development. The World Health Organization has conducted training on Gender and Rights in Reproductive Health in more than 10 countries and provides skills in integrating gender concerns into evidence gathering, programme planning, and policy and service delivery. It continues to run annual workshops on mainstreaming gender in health for health managers and policy-makers from many regions. The WHO Western Pacific Regional Office (WPRO) has produced a series of resource guides in gender, poverty and health for training health professionals (*122*). At WHO headquarters in Geneva, the Department of Gender, Women and Health (GWH) is engaged in capacity building to support governments and WHO staff to mainstream gender into the health sector. Tools have also been developed (*6*).

Work on pre-service training of health professionals has focused mainly on the undergraduate medical curriculum. In the United States, the work relates to women's health specialty and several medical schools have in-

tegrated women's health into the curriculum. Attempts to integrate gender, rather than women's health, into the medical curriculum are more recent. There are only three known examples of curriculum development and course implementation. Monash University in Australia has integrated gender into the curriculum of its new five-year patient centred and problem-based curriculum. The problem-based format lends itself to creating cases that require a gender analysis. The Chulalungkorn Medical School in Thailand has also made a similar attempt. In both instances, a set of 'gender-competencies' has been spelt out and students are assessed on it. The Gender and Health Collaborative Curriculum Project in Ontario, Canada, has developed web-based modules as resources for faculties who wish to integrate gender issues into their teaching, and for interested students who may also want to use them. Besides these, there are a large number of initiatives in Europe, southern Africa, Australia and India aimed at creating an enabling environment for medical educators to integrate gender issues into their teaching more informally (*33*).

Three factors have been identified as facilitating the mainstreaming of gender in medical curricula. One is the window of opportunity provided by larger curricular changes, especially towards problem-based learning or including social sciences in the curriculum. The second is the presence of dynamic leadership committed to mainstreaming gender. The third factor is the extensive preparatory work carried out by such leaders: well-thought out and sustained advocacy with decision-makers; capacity building and introductory workshops for medical educators and students; devising ways of integrating gender without overloading the existing curriculum; and making available ready-to-use teaching and learning materials that medical educators can use in their teaching (*33*).

Training health workers in gender competencies is vital in making health services more gender-responsive. However, this very important area has not received the policy and political support it deserves, and efforts are fragmented and under-resourced. Concerted action is needed to ensure that pre-service as well as in-service training of health managers and health workers at all levels prioritizes those who interact with patients on a daily basis. We have barely made a beginning in this regard.

2.2.3 Recognizing the contribution and reducing the burden of unpaid and invisible health work

Unpaid heath work is the informal care provided to a person who is unwell or disabled by a member of the same household or community, or a friend, without financial compensation. It also includes voluntary work carried out by members of a community for health promotion or prevention. Unpaid health work includes personal care such as bathing, feeding or providing company; medical care such as bandaging, dispensing drugs or monitoring temperature; and domestic services such as cooking, cleaning or shopping. Most unpaid health work is carried out by women, and is invisible because it is seen as an extension of women's domestic responsibilities within the home, or as part of their role as mothers and caregivers. The burden of unpaid health work is likely to be highest in low-income households that cannot afford paid home care, and may also have a higher incidence of illness and long-term disability (*123*).

The demand for unpaid home care is on the rise due to a number of factors. The demographic transition has led to an increase in the proportion of older people in the population and, with it, the increased need for care for the elderly. Changing life styles have added to the burden of communicable diseases and a new range of health conditions: chronic diseases; mental ill-health; and accidents and injury. Reforms in the health sector aimed at reducing costs have led to the reduction of hospital beds, early discharges from hospital as well as cost-sharing measures, which may discourage low-income groups from seeking health care outside the home.

The contribution of unpaid health work to overall health care is significant. An estimated 88% of all health work in Spain is unremunerated. A 1997 survey of research in Canada and the United States showed that 70–80% of nursing and personal care for the elderly was carried out by family members. In Canada, a Saskatchewan province study estimated that people caring for an elderly person saved the health system about US$ 24 000 per person per year. And yet, this significant contribution is nowhere recorded and remains outside the purview of national health accounts (*123*).

Unpaid health work has a number of negative consequences. Early discharges from the hospital or treating some conditions on a outpatient basis places patients at

risk of poorer quality of care, often in a physical environment that cannot ensure aseptic conditions. When women from low-income or nuclear households are discharged within 24 hours of childbirth or a tubal ligation, they may receive no care at all when they get home. Providing care for long-term illnesses greatly increases women's burden of domestic responsibilities. Caring for an HIV patient at home may require fetching up to 24 additional buckets of water to wash the sick person, clean soiled sheets, wash dishes and prepare food (*124*). Catering to special dietary needs of the sick person likewise increases cooking time, and so on. The complexity of care that has to be provided in the case of chronic health problems adds to the stress experienced by those providing home-based care. Most importantly, unpaid and unrecognized care work at home jeopardizes the health and well-being of caregivers.

A study in Japan revealed that women caregivers had poorer emotional health than men carers although nursing needs of the recipients of care did not vary significantly by sex of caregiver. This was probably because women caregivers cared for persons with more severe cognitive disorders; spent more time providing care and performed a much greater number of care activities; and used home-helpers' service less often than men caregivers (*125*). When compared to men caregivers, women caregivers in the United States were similarly found to have poorer emotional health because they provided more intense and complex care; were primary caregivers with little support from others; and were more likely to be aged 65 years or older (*126*). Older women caring for HIV patients at home in Botswana reported feeling overwhelmed with their caregiving responsibilities and feeling exhausted, malnourished and depressed (*127*).

In the United Kingdom, a 2004 survey in Wales of the impact of caring found that the more hours a carer provided, the more likely it was that they would be in poor health. This was particularly so for the nearly 63% of carers who provided more than 100 hours of care a week, of whom 77% were women and 23% were men (*128*). Nearly one in four carers (24%) providing substantial care also suffered from ill-health (*129*).

Action is needed on a number of fronts to recognize and ameliorate the unequal burden of unpaid health care shouldered by women.

- National health accounts need to reflect the unpaid health work carried out in order to get a more accurate picture of the economic contribution of households and women to the health sector.
- Community home-based care programmes need to be aware of the unequal distribution of care work within the household to the disadvantage of women. More investment is needed in community care centres and local health centres to provide care for long-term illnesses and disabilities.
- Unpaid health work should be factored into social protection health schemes, and provide compensation for caregivers.
- Special interventions are needed that address the specific needs of caregivers for emotional and social support. A special project in Wales is a good example (Box 5).

2.2.4 Drugs, vaccines and supplies

Gender concerns related to drugs, vaccines and supplies in service delivery reforms may be grouped into those related to:

- availability and affordability of drugs, vaccines and supplies;
- issues concerning the differences in responses to drugs and vaccines.

Availability and affordability of drugs

WHO implemented its Action Programme on Essential Drugs in 1981, as an initiative to promote the availability of drugs and supplies that meet the priority health needs of the population. Essential drugs are to be available at all times in adequate quantity and quality at prices that individuals and communities can afford. A WHO *model list of essential* medicines is produced every two years, and countries use this as a guide in developing their own list of essential medicines, for different levels of health care. The essential medicines list includes generic drugs that cost between 50–70% less than brand-name drugs (*130*).

There are important differences between men's and women's priority health problems and needs. Essential drugs lists have, therefore, to include drugs, vaccines and sup-

plies to meet these different needs, in adequate quantities and at appropriate levels of health services. A study from Cochabamba in Bolivia noted that the essential drugs list at the health post level did not include contraceptive pills, diaphragms or condoms (*130*).

Box 5. Caring for caregivers in Wales: The Ceredigon Investors in Carers project

The Ceredigion Investors in Carers is a project for caregivers in one county of Wales. The project has three partners: the Cardigan Health Board (Wales' primary care trust equivalent), the county's social services department, and the Red Cross Carers Fieldwork Project, which delivers some services for the council.

The project has established a framework of good practice among general practitioners (GPs) in the county, with its bronze, silver and gold awards. Practices are assessed on whether they actively encourage patients who are carers to identify themselves, so that doctors are better aware of the patients' special health needs. This is done by GPs usually through dedicated notice boards, information on their web sites, or when registering new patients. Practices are also required to have someone leading on carers' issues, have their policies for carers summarized in a protocol, and facilitate their health-care seeking, for example, by giving carers some flexibility in their appointment times.

The project also organizes a monthly support group for carers, which may include a speaker on a health or financial issue, a book-swap, or just tea and a chat. Meeting others in similar situations has been one benefit of the project. There is also provision for caregiving through day homes when the carers themselves are in need of medical treatment.

The project is widely appreciated by caregivers, and within a year of starting included 14 of the 16 GPs in the county, all of whom were found eligible for bronze awards (*129*).

The availability of reproductive health commodities needed for pregnancy and delivery-related care, contraception, prevention, diagnosis and treatment of reproductive tract infections, STIs and HIV is not guaranteed in many countries. In 2002, the United Nations Population Fund (UNFPA) estimated that developing countries faced a resource shortfall of US$ 125 million creating a shortage of essential reproductive commodities. There has been a phenomenal increase in the need for reproductive commodities. The world has the highest number of young people in the population, contraceptive use is on the increase, condoms for safe sex are needed in unprecedented quantities, and the demand for antiretroviral drugs is on the increase. Although the cost of these supplies will increase by 40% between 2000 and 2015, donor support to ensure commodity security is on the decrease (131). The female condom is a case in point. An effective technology that is controlled by women, it offers effective prevention against pregnancy, transmission of HIV, and other STIs. Unfortunately, it has yet to be used extensively because not enough investment has gone into promoting the method and subsidizing its cost to make it affordable (132).

Affordability of essential drugs for noncommunicable diseases is another major challenge. For example, the lowest priced generic combination regimen for diabetes is estimated to cost as much as eight days' wages in Ghana. The ongoing nature of treatment and the need for combination therapy considerably increases the financial burden of continuing treatment. Strategies are needed to improve the affordability of drugs for chronic diseases, especially for those with a limited ability to pay, such as women from low-income groups (*133*:54).

Maintaining a reliable supply of essential drugs and commodities and making these available at affordable prices is vital for a functioning health system. The non-availability or high cost of drugs at primary care levels is seriously detrimental to users' trust in health services and discourages utilization. It also causes economic hardship for patients who may have to buy drugs and supplies on the private market, and is likely to disproportionately affect women for two reasons: (i) in most settings, women use more drugs than men because of their biological role in reproduction and also because of a higher prevalence of chronic diseases (*7*:32). In the

United States, a nation-wide survey reported that women consumed 60% of all medications (*134*); and (ii) they also have less access to resources. An offshoot of this may be inappropriate drug-use, for example, discontinuing the use of drugs as soon as symptoms disappear, resulting in drug resistance.

Differences in responses to drugs and vaccines

Drugs act differently in women and men because of biological differences in body weight, fat composition, hormones and metabolism. There may also be gender differences related to diet and exercise, smoking and alcohol consumption (*7*:32–33).

Pharmacological treatment is also more complex in women than in men because of hormonal changes related to menstrual cycles, and the detrimental effects of some drugs on the fetus or infant when a woman is pregnant or lactating. Moreover, if a woman is using the contraceptive pill, it may interact with other medications.

A review by the US Food and Drug Administration (USFDA) of 300 drug applications between 1995 and 2000 identified 163 studies where sex-disaggregated data were available. Of these, 11 drugs showed a greater than 40% difference in pharmacokinetics between women and men (*7*:33). In terms of service delivery, awareness of the differences between women's and men's responses to drugs is important in deciding on choice of drugs as well as appropriate dosages. Clearly, this highlights the importance of including a large enough number of women in clinical trials to facilitate the analysis of any differences in responses and side effects, as well as routine sex-disaggregated analysis of data. Efficacious dosages of vaccines for boys and girls may also have to be re-evaluated. Differences have been documented between boys' and girls' responses to a number of vaccines for infectious diseases, for example, measles and hepatitis B. More recently, HSV-2 vaccine trials found major differences in responses between women and men (*135*). The World Health Organization has advocated the importance of including larger numbers of women and young people of both sexes in HIV vaccine trials so that a globally effective vaccine that caters to all groups may be developed (*136*).

* * * * * *

Summary

Making service delivery reforms gender responsive requires action on multiple fronts. The package of services to be provided has to be determined on the basis of evidence on the health needs of women and men across the life-cycle in a given setting. Location, timing and modes of service delivery need to be planned on the basis of information about what women and men do, what their time commitments are, and what locations and times would be best in order to reach different cross sections of women and men. Service delivery settings will have to be redesigned and offer specific timings and settings within which women, men and young people of both sexes would feel comfortable when seeking services.

Radical changes in patient-provider interactions are called for with specific attention to empowering women to communicate their health needs; they should receive appropriate information and be able to make informed decisions about care and treatment. Health providers need to be aware of and respond to the fact that, because of their subordinate social status, women from low-income groups may feel intimidated in health-care settings, have difficulty in interacting with the physician confidently, and feel unable to state their opinions. Health providers also have the responsibility not to jeopardize the safety of women survivors of domestic violence due to lapses in privacy and confidentiality.

Gender-responsive service delivery that meets the health needs of men and women also means changing the working environment to free it from gender bias, and investing in the training of health workers to develop gender competencies. Investments are also needed to ensure that drugs and supplies meet the differential health needs of women and men and are regularly available at affordable prices, and that health providers are knowledgeable about differences in responses to drugs and vaccines between women and men, and young people of both sexes.

3 Integrating gender perspectives into public policy and leadership reforms

3.1 Public policy reforms

Public policies that promote health and well-being are the third pillar supporting the move towards primary health care (*3*:63). A supportive policy environment that facilitates the implementation of reforms towards gender-equitable universal coverage and social protection in health is one where gender equity is a component of all policies within the health sector and beyond. This section first presents some crucial areas of reform needed across health systems' building blocks that would enable progress towards gender equity in health. It then outlines larger policy reforms needed to remove barriers to health and well-being for women, and to pursue health for women and men across all sections of society.

3.1.1 Reforms within the health sector

Three areas of reform within the health sector are needed at the minimum, to integrate a gender perspective into the sector. These include:

- gender mainstreaming health information and research;
- examining all health-related laws, policies and strategies for their gender equity implications and reforming gender-inequitable policies and strategies; and
- putting in place policies and mechanisms for promoting gender equity within health sector institutions.

Gender mainstreaming health information and research

Data and indicators

Information is a vital tool enabling the pursuit of gender equity in all areas including in health. The limited availability of good quality data on health disaggregated by sex and age has been a major obstacle to gender-responsive planning and policy-making. Without knowing whether and in what dimensions of health, and in which population subgroups disadvantages exist, there is no way to begin redressing gender or other inequities in health. The urgency of collection, analysis and publi-

cation of data disaggregated by sex and age cannot be overemphasized.

The need for statistics that are disaggregated by sex and age, and for indicators of gender inequality and monitoring systems to evaluate changes in the health situation of women and men has been affirmed by numerous international forums. As early as 1992, the Forty-fifth World Health Assembly expressed concern that there was lack of information on compliance with previous WHO resolutions on women and health, and called on Member States to establish adequate information systems and to develop health indicators disaggregated by sex (*137*). Yet only a small number of countries, especially from the developing world, have made progress in producing sex- and age-disaggregated health statistics. Sweden is an example of a country where all official statistics have been disaggregated by sex as a main measure to integrate a gender perspective into every policy area (*18*:27).

The collection, analysis and publication of health statistics disaggregated by sex and age are only the starting point in the process of creating gender-responsive information. These data help identify whether there are differentials between women/girls and men/boys in various dimensions of health and access to health resources. Gender-sensitive indicators help ascertain whether these differentials are the result of inequitable access to resources and conditions that are necessary for well-being (*138*; Box 6).

One of the requirements for the construction of gender-sensitive indicators is the availability of integrated data that make it possible to relate health indicators by sex and age to social determinants, which reveal gender and other differences in risks and opportunities. In most countries, health statistics focus on mortality and birth because data disaggregated by social and economic determinants are scanty. This means that even if we know that the prevalence of a particular disease is higher in one sex, we may not be able to find out whether this is a result of biological differences, unequal burden of risks and vulnerabilities, or unequal access to health-care services.

The WHO Centre for Health Development (WKC) developed a set of gender-sensitive health indicators to inform national policies and programmes through a participatory process during 2000–2003. The consultative process involved stakeholders from different sectors, such as government officials, academics and civil society organizations, and used multiple mechanisms, such as international meetings, meetings with experts and online voting. A set of 36 indicators was selected pertaining to three areas. These were: health status (12 indicators); determinants of health at the individual, household, community and national levels (13 indicators); and health and welfare systems performance (11 indicators). As far as possible, indicators were selected from existing indicator sets for which data collection processes were already in place, but not necessarily always available as public information (*139*).

These sets of indicators were field-tested in Manitoba, Canada, to assess the feasibility of monitoring gender equity in health using them. The field test found that data to assess gender equity in health were available for 23 of the 36 indicators, and for one indicator with some modification in definition. No information was available for 13 indicators, of which five were related to health and welfare systems' performance (*139*). Experts participating in this exercise emphasized the importance of collecting health information beyond vital statistics and disease surveillance to include upstream determinants of health (*140*). The WHO Commission on Social Determinants of Health has repeated this plea, and has urged governments to look at gradients and social causes of illness.

A number of countries in the WHO Region of the Americas (AMR) have made progress in the production of sex- and age-disaggregated statistics and gender-sensitive indicators to inform decision-making in all areas including health. For example, in Ecuador, the National Council of Ecuadorian Women (*Consejo Nacional de las Mujeres* – CONAMU) has, with support from the Economic Commission for Latin America and the Caribbean (ECLAC), put in place an information system that collects, analyses and publishes data on gender inequalities including in health (*141*). The Council signed an agreement with the National Statistics and Census Bureau (*Instituto Nacional de Estadística y Censos* – INEC). Workshops and round tables were held involving principal technical staff of INEC to firmly establish the need for collecting data that would provide information on gender inequities. The Council signed an agreement with the Ministry of Health (among others) and made a commitment to provide technical assistance for the incorporation of a gender focus into their

Box 6. Developing gender-sensitive indicators

Globally, work on developing gender indicators for health is still in its early stages. Attempts have been made to identify a set of core indicators at national and global levels that indicate progress made towards gender equity in health. Indicators have also been developed to assess progress made towards gender mainstreaming within institutions, but not specifically for the health sector. A bigger challenge is to construct gender-sensitive indicators at a programme or project level. This involves ensuring that indicators constructed to measure whether specific project objectives have been met are also able to capture whether the programme or project has differently affected women and men (girls and boys).

Developing 'gender-sensitive' indicators

- In the case of health problems affecting women and men, the first step is to have data on all indicators disaggregated by sex.
- Construct new indicators on those dimensions of health where gender differentials occur (or are likely to occur) most often. *Example: indicators on social and economic consequences of a health condition by sex, and on access to appropriate and timely treatment by sex.*
- Additional variables, across which data on the indicator would be disaggregated, need to be included. The choice of variable will be based on the analysis of gender factors likely to impact on the health dimension. *Example: infant mortality rate (IMR) by sex analysed by cause of death (was it an 'avoidable' cause?); IMR by sex analysed by place of death (was medical help more often unavailable to girls?).*
- Asking questions pertaining to an indicator from both sexes. *Example: contraceptive prevalence rate in men and women.*
- Developing new indicators to be used concurrently with others already in use, based on the same sources of information. *Examples: indicator 1 – proportion of pregnant women who are seropositive for syphilis; indicator 2 – proportion of pregnant women who are syphilis seropositive, and who report that their partners have symptoms.*
- Most of the above steps may be applied also to sex-specific conditions. For example, maternal mortality analysed by place of death, and time between admission to a health facility and death, could give some indication of the lack of or delay in appropriate medical help. In addition to the indicator: *proportion of women receiving skilled attendance at birth,* an additional indicator could be*: proportion of women who did not receive skilled attendance for reasons related to gender (no permission, money not available, needed escort, etc.).*

Source: (*138*).

plans and programmes, the analysis of data, and for the creation of new indicators to aid this process (*141*).

The Mexican National Institute of Statistics, Geography, and Informatics (*Instituto Nacional de Estadística, Geografía e Informática* – INEGI) has successfully incorporated a gender perspective into the National Statistical Information System. In 1993, in response to an invitation from the Mexican Office on Women to provide statistics on women and men to prepare for the Fourth World Conference on Women (1995) in Beijing, China, INEGI created a unit that analysed existing data by sex and developed specific indicators to capture gender inequities. In 1996, INEGI, in collaboration with the United Nations Development Fund for Women (UNIFEM), was engaged in the collection, analysis and publication of information to help with the planning, monitoring and evaluation of Mexico's National Program for Women (*Programa Nacional de la Mujer* – PRONAM). A System of Indicators for Monitoring the Situation of Women in Mexico (*Sistema de indicadores para el seguimiento de la situación de la mujer en Mexico* – SISESIM) was created. A total of 370 indicators relating

to women's health and well-being were developed and organized around seven subtopics: addiction; violence; health and morbidity; total mortality; social benefits; occupational risks; and reproductive health (*142*:6).

Overall, few countries are engaged in the systematic collection, analysis and publication of sex- and age-disaggregated health data and statistics on gender-sensitive health indicators, although there have been a number of promising initiatives. Significant advances have been made in developing a core set of gender-sensitive health indicators. The task ahead is for countries to use these and adapt them to specific contexts.

Countries where progress has been made in integrating a gender perspective into health information appear to have followed a similar trajectory, which provides some guidance on how to go about this task. The initiative comes from the women's bureau or a body within the government responsible for gender equality. They work with national statistics offices or similar bodies responsible for collecting information on a broad range of indicators for planning, usually with technical support from a specialized agency of the United Nations, to start, at a minimum, with collecting, analysing and publishing sex- and age-disaggregated data. The initiating group is able to influence the development of new indicators by participating in the planning and implementation of national surveys on education, housing and other welfare indicators. The availability of integrated data sets that enable the linking of health outcomes to social determinants make possible the analysis of the underlying 'gendered' determinants of health inequalities. The process is sustained because collecting sex- and age-disaggregated data on gender-sensitive health indicators becomes a part of the mandate of national and sub-national agencies responsible for the routine collection and analysis of data on health.

Health research

Gender biases permeate health research in a number of ways. These include, for example:

- the non-collection of sex-disaggregated data in health research at the individual or institutional level;
- research methodologies that are not sensitive to gender and other social disparities;
- methods used in medical research or clinical trials for new drugs that exclude women and girls from study populations and lack a gender perspective;
- gender imbalance in ethical committees, research funding and advisory bodies;
- differential treatment of women scientists (*18*:27).

Gender-sensitive health research "investigates how sex interacts with gender to create health conditions, living conditions or problems that are unique, more prevalent, more serious, or for which there are distinct risk factors for women or men"(*143*:9). It involves applying a gender- and sex-based analysis to research and evaluation to improve our understanding of sex and gender as determinants of health and their interactions with other determinants. It also facilitates the evaluation of health policies and programmes aimed at promoting gender equity in health (*143*:1).

Research that fails to examine the role of sex and gender in health is both unethical and unscientific. The absence of research on gender and health may mean that national priorities do not accurately reflect the incidence, prevalence, or the social and economic impact of specific health problems. In addition, they may not reflect priorities arising from the experience of citizens, including women and other disadvantaged groups. Hence, an issue that has not received attention is not likely to receive further attention. The silencing of gender issues thus becomes an ongoing cycle.

Initiatives to integrate a gender perspective into health research have been undertaken by several countries as well as international organizations. Only a few of these have been evaluated for their impact, and findings show progress to be limited. For example, the National Institute of Health (NIH) in the United States set up the Office of Research on Women's Health (ORWH) in 1990. The mandate of ORWH included: ensuring that research conducted or supported by the NIH addressed women's health issues; ensuring that women were appropriately represented in biomedical and behavioural research studies supported by the NIH; and supporting research on women's health issues and activities related to the advancement of women in biomedical careers (*144*).

A 2003 review of experiences in promoting gender-sensitive research reported that ORWH had contributed significantly to championing the women's health re-

search agenda and networking with researchers within and outside the NIH. Its success in increasing the number of women in clinical research studies was modest. While there were increases in the recruitment of women in clinical trials, major one-sex (women) studies accounted for one half of the increase in enrolment (*144*).

The same review also noted that, in the European Union, efforts at mainstreaming gender into health research had been effective in addressing issues of the participation of women in science (research **by** women), but not as effective in addressing issues of research **for** and **about** women (*144*).

The UNICEF-UNDP-World Bank-WHO Special Programme for research and training in Tropical Diseases (TDR) has supported research on gender and tropical diseases since 1994. Its Steering Committee on Social and Behavioural Research (SEB) is committed to funding research and training in the following areas:

- examining how gender inequalities affect the transmission dynamics of infectious diseases, their control, and people's access to health care;
- developing guidelines for gender-equitable interventions;
- supporting research on equity in health and health care, of which gender is an important and neglected aspect (*145)*.

Practical tools and guidelines are available to guide the integration of a gender perspective into health research. For example, the WHO Department of Gender, Women and Health has produced a series of booklets on integrating gender into health research. The series includes booklets providing conceptual guidance, and illustrating the application of these principles to specific health issues, such as tuberculosis, mental health and lung cancer (*146*). Another tool, produced by the Global Forum for Health Research, is the *BIAS FREE* Framework: *a practical tool for identifying and eliminating social biases in health research*. This tool helps to detect methodological and other types of biases that are the result of gender and other social hierarchies. The tool employs a set of 20 analytical questions to detect the presence of bias arising from maintaining hierarchy, failing to recognize differences, and double standards (*147*).

The Canadian Institute of Health Research (CIHR) has implemented a set of policies and practices to promote gender and sex-based analysis (GSBA). It encourages applicants for CIHR grants to include GSBA in their grant requests. The presence of GSBA is also a criterion for review of research grant requests. The CIHR has developed a resource guide on criteria for assessing GSBA across the full spectrum of research (*148*; Box 7).

Besides the dimensions included in the CIHR checklist, one also needs to take into account whether and how women and men may be differentially affected by participating in the research process; and the potential benefits arising from the research for women and men.

It is clear from the review of available information that we do not lack the know-how either on how to integrate a gender perspective into health research, or on the policy structures and mechanisms necessary to systematically adopt this in countries' health systems. For example, resources need to be allocated and specific initiatives implemented to ensure the integration of gender concerns into all health research being implemented with public funding, and policy directives have to be in place in national institutions responsible for medical and public health research. More needs to be done in this regard, in many more countries, and as part of a cohesive policy to promote gender equity in health. There also needs to be comprehensive action plans, agreed to by all stakeholders, which address gender inequality and health equity, and are reported on, monitored and evaluated for progress.

Examining all health policies and strategies for their gender-equity implications and reforming gender-inequitable policies and strategies

Health policies are often 'gender-blind'. They make references to general categories such as 'communities' or 'the rural poor', without making any distinctions by gender. In effect, they are implicitly male-biased. For example, because women are seen mainly as homemakers, they are often invisible in occupational health policies.

Approaches to women and gender issues in policies, including health policies, have been classified in many different ways. The WHO Department of Gender, Women and Health has constructed a user-friendly tool, drawing on many of these approaches and schemas, to assess the level of gender responsiveness of policies and programmes (*6*:69 participant note; Box 8).

Box 7. Applying sex- and gender-based analysis in health research

Research question

- Are sex and/or gender identified and defined? Are the definitions supported by recent academic literature?
- Does the proposal demonstrate awareness of what is known about sex, gender and diversity (ethnicity, socioeconomic status, sexual orientation, migration status, etc.) in this area of research?
- Are the concepts of sex, gender and diversity taken into account in the development of the research question(s)?
- Are the concepts of sex, gender and diversity applied clearly and appropriately?
- If used in the study, does the researcher identify and justify the choice of the sex of cells, cell lines, and/or animals?
- If the applicant asserts that sex and/or gender and diversity are *not* relevant to the proposed research, what evidence is presented?
- Does the research question reflect the diversity in and among females and males?

Data collection

- Does the sex/gender/diversity composition of the sample reflect the research question?
- Does the sample match the researchers' plans for generalizing from the data?
- Have research instruments (i.e. surveys, measurements) been validated to reflect gender/sex and diversity?
- If sex is used as a proxy for weight, height and body fat/muscle ratios, is there an explicit explanation and analytical strategy provided for employing this approach?
- In the case of clinical trials, does the sample reflect the distribution of the condition in the general population? For proposed clinical trials, are sufficient numbers of women and men included in the sample to enable safety as well as efficacy analysis? Where appropriate, how will the clinical trial track and account for female menstrual cycles? Does the applicant plan to analyse the results in the context of known sex-specific adverse effects, height-weight-sex relationships, and interactions with commonly used drugs?

Data analysis and interpretation

- Will the researchers disaggregate and analyse data by sex/gender?
- Does the use of gender as a variable mask or intersect with other potential explanatory factors, such as socioeconomic status, physical attributes and/or ethnicity?
- What assumptions are being made about gender and/or sex, especially as they intersect with other diversity indicators, such as ethnicity, sexual orientation, socioeconomic class, etc., while formulating the research problem, sampling, data collection, analysis and interpretation?

Source: (*146*).

According to this scale, the extent to which a gender perspective has been integrated into any policy may be seen as a continuum ranging from gender-unequal to gender-transformative. The process of integrating gender concerns into health policies implies a progressive move from a gender-unequal or gender-blind policy towards gender-transformative policies.

Box 8. Gender-responsive Assessment Scale criteria: a tool for assessing programmes and policies

Level 1: Gender unequal

- Perpetuates gender inequality by reinforcing unbalanced norms, roles and relations
- Privileges men over women (or vice versa)
- Often leads to one sex enjoying more rights or opportunities than the other

Level 2: Gender blind

- Ignores gender norms, roles and relations
- Very often reinforces gender-based discrimination
- Ignores differences in opportunities and resource allocation for women and men
- Often constructed based on the principle of being 'fair' by treating everyone the same

Level 3: Gender sensitive

- Considers gender norms, roles and relations
- Does not address inequality generated by unequal norms, roles or relations
- Indicates gender awareness, although often no remedial action is developed

Level 4: Gender specific

- Acknowledges different norms and roles for women and men and how they affect access to and control over resources
- Considers women's and men's specific needs
- Intentionally targets and benefits a specific group of women or men to achieve certain policy or programme goals or meet certain needs
- Makes it easier for women and men to fulfil duties that are ascribed to them based on their gender roles
- Does not address the underlying causes of gender differences

Level 5: Gender transformative

- Acknowledges differences in the norms and roles for women and men and that these affect access to and control over resources
- Considers women's and men's specific needs
- Addresses the causes of gender-based health inequity
- Includes ways to transform harmful gender norms, roles and relations
- The objective is often to promote gender equality
- Includes strategies to foster progressive changes in power relationships between women and men

Source: (*6*:69 participant note).

Integrating a gender perspective into health policies is different from the adoption of a 'women's health policy'. It refers to the development of health policies that address not only women's special needs but also the health needs they share with men, taking into account gender differences in aspects such as health risks, determinants of health, and health-seeking behaviour.

For example, a gender-specific health policy would examine environmental health hazards separately for men and women, and devise programmes to prevent and control exposure accordingly. It would provide for active tuberculosis case-finding to minimize under-reporting of infection in women, and examine whether or not women's biological differences contribute to their greater vulnerability to the infection, or to its consequences.

A gender-transformative health policy would examine and correct gender disparities in human resources within the health sector and gender biases perpetuated by medical education. It would address the practical health needs of women in a way that challenges existing gender roles and stereotypes transforming women's situation with respect to men. A 'safe motherhood' policy, for instance, would not assume either that women alone are responsible for child care, or that they have access to the resources to ensure their own as well as their children's well-being. It would be designed with the awareness that women often do not have a say in whether and when to get pregnant. It would acknowledge that many pregnancies are unwanted or ill-timed from the woman's point of view, and would provide women with the option of safe pregnancy termination. Indeed, the policy would not even be called a safe motherhood policy, but a safer pregnancy policy, allowing for the possibility of safe pregnancy termination.

A gender-transformative health policy would not be blind to other forms of social inequities, and would treat women or men as homogenous groups. It would be based on the understanding that women and men are divided along class, caste, and religious and ethnic lines, and would ensure that the poorer and marginalized groups were not implicitly excluded.

There are very few examples of national health policies that have integrated gender considerations. Sweden's public health policy, which came into force in 2003, is an exception. Formulated by a commission consisting of experts as well as representatives of all political parties, the policy is based on evidence gathered on socioeconomic, ethnic, regional and gender-based inequalities in health. Unlike most public health policies, in which objectives are based on diseases or health problems, Sweden's public health policy addresses the broader social determinants of health. Gender is woven integrally into the public health strategy. The policy document specifically highlights its commitment to a gender perspective and to reducing gender-based inequalities in health alongside reductions in inequalities by socioeconomic groups, ethnic groups and geographical regions (*149*:20, 21). Thus, gender is a cross-cutting category within other dimensions of inequalities that the policy seeks to redress.

In the United Kingdom, a regulation to promote gender equality within all public services requires the adoption of plans to promote gender equity in health at all levels of the health sector (*150*). This example is discussed in more detail in the next sub-section.

However, there have been a number of isolated attempts, not guided by any policy framework, to identify and advocate for action to address gender gaps in a national health policy or strategy. For example, in Kenya, a Gender and HIV/AIDS Technical Sub-committee was formed in 2002 to integrate a gender perspective into the National HIV/AIDS Strategic Plan two years after it had been formulated (*151*). The sub-committee started by conducting field studies to collect data and information on the gender dimensions of HIV/AIDS in the country, based on which it carried out a gender analysis of the strategic plan. This helped identify several gender gaps, for example, the availability, accessibility and affordability of the female condom had not been prioritized. There was not enough attention to gender-based violence, rape and incest as pathways to HIV infection; and health education materials did not address gender-specific concerns. Gaps were likewise identified with respect to treatment and in the areas of socioeconomic impact, and monitoring and evaluation. The sub-committee then outlined activities within the priority areas of the strategic plan that would help address these gaps. The extent to which these recommendations were implemented is not known (*152*).

In Ghana, the Ministry of Health undertook a number of steps to mainstream gender into the sector-wide approaches (SWAp) process. An analysis of gender issues in the health sector was completed and the results published in *Promoting gender equity in health – a framework for action* (1998). A consultation with stakeholders was held in 2002 to advocate for and secure the commitment of senior managers within the health sector to gender main-

streaming. A draft health sector gender policy was developed by a working group to readdress gender gaps as part of the SWAp (*152*). The Ghana Health Sector Gender Policy was issued in April 2009 in order to promote gender equality and health equity and to recognize the ways in which gender relations, roles, responsibilities, and access and control over resources impact on women's and men's health. To further guide the implementation of the policy, the Ministry of Health and Ghana Health Services have developed the *Health sector gender policy (HSGP) strategic plan* and *Guidelines for operationalizing gender mainstreaming in the Ghana Health Service (GHS)*. These documents outline strategies for mainstreaming gender focusing particularly on addressing access to health care, quality of care, reproductive health needs and gender-based violence, among others. They are also expected to serve as a resource for advocacy and capacity building for the promotion of gender sensitivity in health-service provision. Strategies to promote the engagement of stakeholders and collaborators across the different sectors or mass drug administrations (MDAs) that share the goal of improving the health of men and women are also highlighted (*153*).

Other examples of attempts to identify and advocate for the redressing of gender gaps within health policies include a gender analysis of Ireland's Cardiovascular Health Strategy conducted under the Gender Mainstreaming Programme of the WHO Regional Office for Europe (*154*) and Canada's Federal Mental Health and Addictions Policy (*155*).

The journey towards making health policies gender-transformative, or even gender-specific has barely begun. The usual pattern appears to be for academics or civil society actors to engage in a gender analysis of existing policies. They then advocate with senior decision-makers within the health sector for action to redress gender gaps. The government has no obligation to heed this. What is needed, however, is for the government to make it mandatory to have a technical committee examining the evidence on gender-based inequalities in health and proposing actions to address these and documenting their proposals in a national action plan. Identifying and addressing gender issues has to become an integral part of the policy-making process, an essential indicator of good practice.

Policies to promote gender equity within health sector institutions

A number of interventions and policies necessary in health sector institutions for the integration of gender into service delivery reforms were discussed in Section 2. In order to be systematic and cohesive rather than ad hoc, and to be sustained rather than sporadic, these interventions need to be supported by a policy commitment to gender equity within the health sector, and by suitable structures and mechanisms. These include, for example, the establishment of a lead agency responsible for coordinating all gender mainstreaming efforts, the allocation of adequate financial and human resources, and the establishment of monitoring and evaluation systems to track progress.

In the late 1970s and early 1980s, the US Department of Health and Human Services, under the leadership of Patricia Roberts Harris, its first black woman Secretary, convened the Secretary's Advisory Committee on the Rights and Responsibilities of Women (SACRRW) with 12 women members. One of the many contributions of the SACRRW was to review the proposal for the National Health Insurance (NHI) system being discussed then, pointing out major gaps in addressing women's specific needs and outlining proposals for bridging these (*156*).

One of the most comprehensive attempts to promote gender equity within the national health sector has been attempted in South Africa, although we do not have information on the extent of its success in achieving gender equity in health.

South Africa's *Gender policy guidelines for the health sector* were developed in 2002 in order to support the Department of Health and public health institutions to systematically identify and address gender considerations in health and within the organizations responsible for managing and delivering health-care services (*157*).

The guidelines outline structures and mechanisms for gender mainstreaming. These include the appointment of full-time gender focal points at national and provincial levels, and the setting up of a Health Sector Co-ordinating Committee (HSCC). The HSCC is chaired by the National Gender Focal Point located within the Office of the Director General for Health Services. It is constituted of rep-

resentatives from all health departments from national, provincial and local levels, as well as civil society actors. It is responsible for guiding gender analysis; developing a gender action plan, and a framework for monitoring and evaluation; and facilitating the development of a Management Information System. Accountability for ensuring that gender mainstreaming is achieved rests with senior management (*157*).

The role of gender focal points was to achieve 'operational' gender mainstreaming in health. They were to provide support to senior management in implementing gender policy through: gender analysis of existing policies, strategies and programmes, and integrating a gender perspective into these; ensuring capacity building for gender mainstreaming at all levels within the health sector; monitoring and evaluation; and advocacy (*157*).

A series of objectives were also set for 'institutional' gender mainstreaming, i.e. promoting gender equity and equality within institutions of the health sector. These included the elimination of gender-discrimination in human resources procedures, such as appointments, promotions, pay, conditions of employment and disciplinary procedures; creating an equal balance between sexes in decision-making positions; and ensuring that institutional rules and culture promoted participative decision-making and an environment supportive of gender equity and equality (*157*:39–40).

In the United Kingdom, work on promoting gender equity within health sector institutions has been greatly facilitated by the Equality Act 2006, which placed a statutory duty on all public authorities to "promote equality of opportunity between women and men" and to "prevent unlawful discrimination and harassment" (*140*). The "gender equality duty" stipulated by the Act came into force in April 2007 and represented a radical new approach to gender equality – one that placed the onus on service providers to address the different needs of women and men and promote gender equality rather than leaving it to individuals to challenge poor practice (*150*:2).

The gender equality duty is applicable at all levels of health service delivery. A gender equality scheme has to be published and its performance evaluated, all the way down to the local level. Health organizations have also to conduct gender impact assessments of all new policies, strategies and interventions. The health sector's action plan for 2006–2009 spelt out targets regarding equality, including gender equality in health systems, indicators for monitoring, actions to be implemented and those responsible for carrying them out. Gender has to be considered in everything that a health organization does, and is located within a larger equality agenda (*150*:14, 15).

South Africa and the United Kingdom are good case examples of what political commitment can achieve in promoting gender equity in health. Trying to promote gender equality within a single sector may not be the best option, although it may be better to start somewhere if conditions are favourable for change in one particular sector. The advantage of having an overarching gender-equity policy applicable to all sectors is that it creates a culture of gender equitable functioning in all public institutions, thereby increasing the feasibility of sustaining the change.

3.1.2 Promoting gender equity in health through public policy

Public policy can contribute to promoting gender equity in many determinants of health, and thus contribute towards the achievement of gender equity in health. This may be done, for example, through:

- reforming gender-discriminatory laws and policies;
- promoting equal opportunities; and
- assessing the impact of all public policy on health equity with special reference to gender.

Reforming gender-discriminatory laws and policies

There are at least three major areas in which laws and policies are often to women's disadvantage: family laws and other laws that impact on sexual and reproductive rights; land and property rights; and labour market and employment policies (*158*).

Laws restricting access to safe abortion services are prime examples of gender-discriminatory legislation. Freedom from discrimination is enshrined in every international human rights document. Since only women need abortion services, restriction of access to abortion services may be viewed as discrimination against women

(*159*). Five million women – or 1 in 4 – who have unsafe abortions are likely to suffer severe complications. Almost 70 000 women die from these complications every year (*160*).

Recognition of women's right to make decisions regarding their own bodies – including the right to physical integrity, and the right to decide freely and responsibly on the number and spacing of their children – is found in many international documents. Many governments have committed themselves to respecting, protecting and fulfilling these rights. In order to do so, they have to reform family laws and policies denying women the right to choose their marriage partner and the right to divorce; laws restricting access to sexual and reproductive health services; and laws discriminating against sexual minorities.

Inheritance and property laws that treat men and boys preferentially need to be reformed and, at the same time, land reform and housing-support policies have to guard against inadvertent discrimination by giving title deeds or ownership to the man who is 'head of the household'. There are labour market policies that do not guarantee equal wages for equal work and prevent women from entering certain occupations; hiring policies that prefer not to employ married women or women with young children; and human resources policies that do not provide maternity benefits for pregnant women, which are fairly widespread. Each one of these places women at a disadvantage in terms of finding employment and earning a reasonable income. Law and policy reforms are needed to end such discrimination, and introduce mechanisms that support women's equality. Complementary measures are needed to inform women of their rights and enable them to realize these.

Putting in place gender-equitable public policies

Enacting and effectively enforcing laws to protect women from domestic violence is an instance where a legal measure can directly benefit women's health. India is one example of a country with strong legislation to prevent the misuse of preconception and prenatal diagnostic techniques for determining the sex of the fetus, in an attempt to discourage sex-selective abortion of the female fetus (*161*). Similarly Kenya, among others in the African region, has enacted legislation in Section 14 of its Kenyan Children Act of 2001 prohibiting female genital mutilation, early marriage or other traditional or cultural practices that may be harmful to a child's health and well-being, or affect his/her dignity (*162*).

Another area for policy reform relates to financial laws and regulations. Women's access to credit to start small businesses can be improved by making available small loans that can be obtained without formal, legally secured collateral, and by offering relatively flexible repayment terms. Deregulation of the microenterprise sector would also facilitate women's entry into the workforce (*158*).

Public investment in social services that would directly bridge gender gaps in education and employment are other examples of gender-equitable public policy. Making primary schools available within every community, and waiving school fees for primary education are reforms likely to promote girls' education. In addition, targeted interventions may be needed to influence household decision-making in favour of girls' schooling such as cash incentives for girls' completion of schooling. As is well known, mothers' literacy improves infant and child survival and has many indirect benefits also for women's health. Other crucial areas for investment in sectors other than health include the provision of child-care facilities, capacity building, vocational training to facilitate entry into the labour market, occupational safety, maternity benefits, and other social security measures by the labour sector.

Investments in infrastructural facilities can make significant contributions to gender equity in health and well-being. These include providing safe water and electricity supplies close to home, which would help reduce women's water and fuel collecting workload; improving sanitation and toilet facilities, which would greatly reduce infant and child morbidity and, hence, the time women spend caring for the sick, as well as prevent gastrointestinal and genitourinary tract infections in women themselves; tackling indoor air pollution caused by smoke from cooking stoves would help reduce respiratory infections in women and others who spend most of their day indoors; and improving roads and transportation would mean better mobility for girls and women, increasing their access to schooling and health-care facilities, among other things.

Assessing the impact on health equity, with special reference to gender, of all public policy

A number of macroeconomic policies in areas such as trade, development and employment have an impact on health. Proactive measures are needed to ensure that the impact is not negative. One approach in this direction is the Health Impact Assessment (HIA), which is defined as *"*A combination of procedures or methods by which a policy, programme or project may be judged as to the effects it may have on the health of a population*" (163).*

The introduction of HIA is based on the recognition that many of the determinants of health, such as housing, transport, working conditions and the physical environment, are influenced by public policy. The purpose of HIA is to reduce the potentially harmful effects on health of any policy or programme and to maximize their benefits. The assessment is based on a very broad model of health, which includes the physical, psychological and social dimensions. Health Impact Assessment uses both quantitative and qualitative data to consider the effects of the actions of government on different cross sections of the population (*163*).

Health Impact Assessment is now widely used in the United Kingdom and in a number of European countries as well as in Australia and Canada. The assessment is usually done prospectively, before a policy is introduced, and is limited to government policy. All stakeholders participate in the assessment process, and an attempt is made to rework the policy or intervention to minimize or eliminate any negative impact (*164*). The approach used by HIA offers a great deal of promise in terms of preventing any negative impact that the policies and programmes might have on gender and social inequities in health. In addition to government policies yet to be implemented, the assessment is applied to past government and private sector policies and programmes. The impact of these on health is assessed, and gender-specific consequences examined. The results of the assessment are used to inform policy change, or as evidence to support advocacy for policy change.

3.2 Leadership reforms

As pointed out in the *World Health Report 2008 – primary health care, now more than ever*, PHC reforms towards universal coverage and people-centred health care demand new forms of leadership for health that are collaborative, engage multiple stakeholders, and are effective in steering major changes in the way the health sector functions (*3*).

The preceding sections outlined how health systems can be transformed to deliver better health in ways that close gender gaps and promote gender equity in health. For such transformation to be facilitated, there is a need for a better gender balance in leadership structures and mechanisms at all levels. Better representation of women in decision-making structures as well as better representation of gender-equity issues in health is needed, starting from the top echelons of government, senior decision-making positions in the health sector and in academic medicine, right down to health management and governance structures at local levels.

Although women form 75% of the health workforce in many countries, they are under-represented in managerial and decision-making positions in the health sector. Under-representation of women in leadership may inadvertently result in a lack of attention to women's specific health concerns, and to a lack of appreciation of the specific problems and challenges faced by women in the health workforce. Women leaders in academic medicine in many parts of the world have been at the forefront of championing gender equity in health through policy advocacy, research on gender issues in health, and advocating for the integration of gender and women's health into the curricula of health professionals.

As important as changes in leadership at the top, is pressure from the bottom. Members of the constituencies that the policy change is meant to benefit need to be involved in setting the agenda for change. Accountability mechanisms need to be in place to hold the health sector and government as a whole accountable for closing the gender gap in health. In an article entitled *The evaporation of policies for women's advancement*, Longwe argues that policies promoting gender equality run contrary to the interests of bureaucracies, which are inherently patriarchal in nature. She talks about the endless capacity of the bureaucracy to evaporate policies for women's advancement (*165*).

The active involvement of the women's movement and civil society institutions is essential, and not just to ensure that policies are engendered. Without the continued involve-

ment and independent monitoring by these actors, the chances are high that gender equality policies will never be seriously pursued but given a quiet burial.

Therefore, in this section, we focus on these two complementary areas for intervention to promote gender equity in health:

- promoting leadership for gender equity in health within government and in academia;
- working in partnership with and promoting accountability for gender equity in health through civil society organizations, especially women's organizations.

3.2.1 Promoting leadership for gender equity in health

Involving government leaders in promoting gender equity in health

Political leadership is essential to gain and sustain a place of priority for gender equity in health in countries' policy agendas. The Council of World Women Leaders has addressed this need through various initiatives at the level of ministers of health and their senior staff (*166*).

One example is the Ministerial Initiative for Women Ministers of Health established in 2004. The aim is to build a critical mass of global leaders who can inform and shape policy-making on women's health. This initiative convenes annually in conjunction with the World Health Assembly in Geneva (*166*).

In 2006, the council and the ministerial initiative, together with Realizing Rights, an international human rights NGO, launched the Ministerial Leadership Initiative for Global Women's Health (MLI) in Maputo, Mozambique, on the occasion of a Special Session of the African Union Conference of Ministers of Health. This initiative aims to "facilitate the collective power of a network of women ministers of health to promote evidence-based, innovative national and global policy action in key policy areas". It is endeavouring to build the capacity, political leadership and expertise of ministries; co-ordinate donor aid; establish equitable health budgeting; and strengthen relationships between government and civil society organizations so that grassroots voices may be connected to policy-making (*166*).

Another innovative programme of the Council of World Women Leaders to build leadership for health – this time among young graduates – is the Public Health Fellows Program. This is a summer fellowship programme that places graduates in the ministries of the members of the Ministerial Initiative for Women Ministers of Health. Participants have the opportunity to receive firsthand experience of international health issues and policy-making, and learn about leadership in health (*166*).

Promoting gender balance in leadership in academic medicine

In a number of countries around the globe, the proportion of women entering medical school has been increasing during the past decades. However, their representation

in leadership positions in academic medicine has neither kept pace with the availability of talent nor with the requirement for gender balance. For example, in most countries in Europe, and Latin and North America, there is an almost equal proportion of women and men medical students, and this has been the case for many decades. In the United States, while 49% of medical school applicants in 2002 and 2003 were women, only 13% of full professors for basic and clinical sciences in 2002 were women. According to a 2005 study, only 14.4% of all physicians in Japan were women and they held only 4.1% of the faculty positions in medical schools (*167*).

Studies in Canada and the United States examining factors underlying women's under-representation in academic medicine identify the following: lack of mentors; sex discrimination, often covert; difficulties in reconciling the demands of career and familial responsibilities; lack of spousal support to renegotiate their homemaking and child-care responsibilities; and the rigidity of the structure of medical careers shaped around men physicians supported by stay-at-home spouses (*168*).

While there may be a number of efforts to promote women's leadership in academic medicine, most of the published examples are from the United States, and to a lesser extent, Canada. In the former, the National Institute of Health (NIH) has a set of strong recommendations to promote women leaders at all levels and move towards greater representation and inclusiveness (*169*). The Office of Women's Health (OWH), within the US Department of Health and Human Services created in 1998, has four innovative programmes, one in each of the four medical schools. Faculty members of both sexes were helped to obtain mentors who would be role models and guides, and would thereby facilitate their career advancement (*170*).

In Canada, concern about the decline in membership if women did not see the association as addressing their needs, the Canadian Medical association (CMA) implemented several measures to promote the leadership of women. This included annual leadership conferences for women in medicine; publishing a book on the status and concerns of Canadian women in medicine; and the inclusion of women physicians' specific issues in their draft policy on physician stress. The CMA also has a Gender Issues Committee (*171*).

Gender equality in leadership in academic medicine is an important concern of the Association of American Medical Colleges (AAMC), a non-profit association of medical schools, teaching hospitals and academic societies in Canada and the United States working towards excellence in academic medicine. Its recommendations for increasing gender balance in leadership in academic medicine include:

- a system for developing and mentoring women in medicine – medical students, residents and faculty members;
- the establishment of programmes promoting women's leadership in medicine; one example is the Executive Leadership in Academic Medicine (ELAM) programme established in 1995, which is a one-year, intensive programme of personal and professional development with extensive opportunities for mentoring and networking;
- better representation of women on policy-making committees and boards;
- a change in criteria for promotions: moving beyond research publications as the major deciding criterion, to reward excellence also in teaching and clinical activities (*171*).

3.2.2 Working in partnership with civil society organizations, especially women's organizations

The role for civil society organizations and women's organizations

People form the core of health systems as users of care, contributors of finances and caregivers. It goes without saying that people, represented by civil society organizations, ought to form an integral part of the process of PHC reforms. Women's organizations have a special role to play as leaders in advocacy for gender equity in health.

Civil society organizations have contributed to a wide range of health system functions: health services; health promotion; policy setting; resource mobilization and allocation; standard setting; and the monitoring of quality of care and responsiveness. They have also worked towards holding national governments and health institutions accountable for upholding people's right to health (*172*:6, 8). The People's Health Movement is an example of a global

alliance of civil society organizations engaged in policy setting, standard setting, and monitoring and enforcing accountability.

Women's health movements in many countries of the world have been responsible for putting gender equity in health on the policy agenda. For example, the Canadian Women's Health Network, with a membership of over 2500 organizations has established a national presence for women's health issues, and is on the consultation list of the federal government and national organizations when health issues are being discussed (*173*). A vibrant women's health movement in the United States has been responsible for integrating women's health issues into research and medical training, and legislating to remove discrimination against women in personal health insurance plans (*165*). The Latin American and Caribbean Women and Health Network (LACWHN), with thousands of members throughout the region, has been an active player in defining the gender and health agenda in the region, and works collaboratively with governments and intergovernmental organizations while, at the same time, acting as a pressure group to ensure accountability. The LACWHN is a recognized NGO partner of PAHO and actively collaborates with the Gender, Ethnicity and Health Office in implementing its workplan (*174*).

By far the most significant contributions to health of women's organizations globally have been in the area of sexual and reproductive rights and gender-based violence. They have advocated for and, in many instances, succeeded in making safe abortion services legal; in challenging coercive population control policies; in highlighting the violation of human rights represented by maternal mortality; and in putting consideration of the gender dimensions of HIV/AIDS firmly on the agenda. The international women's health movement played a significant role at the International Conference on Population and Development (ICPD) in Cairo in 1994, and at the Fourth World Conference on Women in Beijing in 1995, events that changed the course of the history of sexual and reproductive health and rights for women.

The Asia-Pacific Research and Resource Centre for Women (ARROW), a regional women's organization, together with its partner organizations in different countries of the region regularly monitors progress towards implementation of the Programme of Action of ICPD. In 2009, it published a comprehensive ICPD+15 report drawing on information provided by countries, identifying achievements and gaps, and setting out a road map for future action (*175*).

Women's organizations have succeeded in changing public attitudes and the discourse around wife beating and female genital mutilation, and making prevention of these priorities in women's health. They have been leaders in initiating gender training in health and in identifying and highlighting gender gaps in health policies and programmes.

There are relatively fewer organizations focusing on the disproportionate risk to men's health from 'masculine' behaviours promoted by gender-role stereotyping in society. One example is the Men's Health Forum founded in 1994, which is an independent body that works in England and Wales with a wide range of individuals and organizations to tackle this problem. The Men's Health Forum works to develop health services that meet men's needs and enable men to change their risk-taking behaviours (*176*). The Global White Ribbon Campaign begun in Canada is perhaps the largest effort in the world of men working to end violence against women. In over fifty-five countries, both men and women lead the campaigns, even though the focus is on educating men and boys (*177*).

In its 2009 *Plan of action for implementing the gender equality policy,* PAHO identified as one of four strategies to increase and strengthen civil society participation, especially among women's groups and gender equality advocates, "identifying priorities, formulating policies, and monitoring policies and programs at local, national, and regional levels" (*174*:5). It proposes the following:

- leaders of civil society organizations, especially women's organizations should participate as members of the Technical Advisory Group on Gender Equality and Health (TAG GEH);
- civil society organizations (of women, men, ethnic groups and human rights, among others) should be empowered to participate on national multisectoral teams that support ministries of health in implementing, monitoring and evaluating gender equity in health policies and programmes (*174*:5).

3.2.3 Promoting accountability to citizens for gender equity in health

Accountability to citizens on gender equity in health has been defined as:

> ...processes by which power-holders in the health sectors engage with and answer to women, men and transgender people who make demands on it, and enforce actions in such a manner to reduce gender inequalities in health and address gender-specific health concerns and rights of women, men and transgender people.

This definition includes three elements: engagement of citizens with power holders; answerability of power holders to citizens; and enforcement of action by power holders (*144*).

Civil society groups have used several strategies to demand accountability on gender and health: progressive national legislation; constitutional rights and international human rights instruments; national and international spaces and mechanisms available for civil society participation; and community-level structures and health-audit tools.

One example of accountability for sexual and reproductive rights enforced by civil society organizations through the use of international human rights mechanisms is from Peru. The Ombudsmen Centre in Peru filed a case with the Inter-American Human Rights Commission against a policy that restricted women's access to contraceptive and abortion services. Civil society groups also applied pressure against the policy through other modes of protest. This resulted in a reversal of this policy to allow for the availability of a broad range of contraceptives including emergency contraceptives (*178*:247).

In South Africa, an example of progressive legislation relates to the reform of the abortion law. Nongovernmental organizations involved in health and women's rights and the Medical Research Council used the constitutional provision relating to public participation in legislative and other parliamentary processes to press for changes in the law on abortion. Thus, the present abortion law in South Africa is one of the most liberal in the world. It frames abortion as an issue of women's reproductive choice, permits abortion on request in the first trimester, and does not require parental consent for adolescents' access to abortion (*178*:253).

In Bolivia, space was available within a new legislation on the elderly through provision for a monitoring mechanism (*Committee de Vigilencia*), which included older women and men, and organizations representing them. HelpAge International, an NGO, trained four local organizations of older people to monitor the financing and delivery of insurance and health services. Local organizations in turn trained older women, including members of the committee to play an effective monitoring role (*178*:257–258).

In addition to these, there are community health structures in many settings pressing for accountability to citizens on health. There are a small number of examples of community structures that include gender and social equity in health as an issue on which accountability needs to be enforced. One example from India is that of the Gender and Health Equity Network (GHEN), an international partnership. The GHEN team in India worked in the Koppal district of Karnataka with the government and initiated women's empowerment through an education programme called *Mahila Samakhya*, to form neighbourhood groups to monitor health-service coverage. The information is shared with community-level providers of the government health sector and doctors from Primary Health Centres to bring about changes that increase access to care. Women from the programme are also involved in 'verbal autopsies' of maternal deaths conducted by the government (*178*:259, 260).

The accountability mechanisms and strategies described here have scope for wider application in many other settings. This requires political will and leadership reforms that prioritize the participation of civil society groups, and invest time and resources to make them functional.

There are three important pathways through which accountability to gender equity in health may be enforced.

- Monitoring mechanisms with agreed indicators of progress have to be created within the strategies for implementing policies and programmes that provide space for participation by those directly affected by

them, and especially civil society organizations representing their interests. Investment is also needed in capacity building to enable meaningful participation of representatives from among the non-elite.

- All existing accountability mechanisms within the health and social sectors need to integrate gender equity into health as one of its mandates. Gender balance in representation within these mechanisms is also essential (*178*:268, 269).
- Monitoring mechanisms need to extend from the local community level to the province/district, state and national levels. Community-level accountability mechanisms offer greater potential for women's participation, and can pave the way for their active participation in mechanisms at other levels.

In some settings, civil society organizations and women's health advocates report being consulted in the initial phases of policy development, but being relegated to marginal positions when the policy is finalized and implemented (*85*). It is important for civil society organizations to assess the time available for advocating gender equality within specific contexts and plan their interventions accordingly. Very often, there is a need to move several interconnected agendas simultaneously in order to make progress on gender equity in health.

Countries where gender equality is upheld by legislation and enforced through appropriate structures, and where international human rights conventions, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), have been ratified, may be in a relatively advantageous position from which to promote accountability to citizens on gender equity in health. They have, at least on paper, committed to gender equality, which can be effectively used by civil society actors.

The promotion of accountability to citizens on gender equity in health – or for that matter, accountability on any aspect affecting their lives – is only possible in political settings with vibrant democracies. Essential features of a society that is able to promote such accountability to citizens include: independent judiciary and media; the conscious creation of spaces for democratic participation by all sections of society in policy-making; a governance culture recognizing the legitimacy of civil society organizations and actively consulting them; and respect for human rights in all legislation, policies and programmes. These are also conditions that would promote a more equitable society overall.

4 Making health systems gender equitable: an action agenda

Forty years after the Alma-Ata Declaration on achieving Health for All by the year 2000 through primary health care, the World Health Organization has reaffirmed its commitment to PHC. The transformation of health systems towards primary care involves four major areas of reform: universal coverage reforms; service delivery reforms; public policy reforms; and leadership reforms.

Primary health care reforms are aimed at achieving equitable, fair and inclusive health systems. Integrating a gender perspective into PHC reforms and promoting gender equitable health systems is one of the major challenges facing Member States. This paper examined the challenges to gender equity within each of the four PHC reform areas. It drew on case examples to outline measures to ensure that the project to transform health systems places gender centrally on its agenda. This concluding section highlights major areas for intervention within each of the four PHC reforms.

4.1 Action agenda for gender equitable PHC renewal

4.1.1 Universal coverage reforms

Addressing gender issues within universal coverage reforms implies identifying health financing mechanisms that do not exacerbate gender inequality, and essential services packages that cater to women's and men's sex-specific health needs. Some essential measures are outlined below.

- Reducing the proportion of health expenditure from out-of-pocket payments is important for promoting gender and social equity in health.
- When implementing insurance reforms, such as the introduction of social health insurance or micro-insurance or promoting private insurance, special attention should to be paid to the coverage of women. Partially or fully subsidizing premium payments for those who cannot afford to pay, and being aware that women, even when they belong to better-off households, may fall within this category, is important. Enrolling households as a unit in insurance schemes would help extend insurance coverage to women and other household members with low decision-making making power and financial resources.

- Insurance reforms should allow for the fact that many sexual and reproductive health services fall under the 'non-insurable' category because they include non-random and high-probability events. Insurance schemes are needed that are large enough to ensure effective risk pooling and cross-subsidizing. Micro-insurance schemes are, therefore, not the most appropriate option from a gender equity perspective. In many countries, micro-insurance schemes mark the first stage in the transition, with the intention of consolidating the various funds after a certain stage. In such circumstances, public funding may have to subsidize the inclusion of sexual and reproductive health services in the benefits package.
- Social franchising mechanisms for the provision of sexual and reproductive health services can play an important role in expanding health coverage as well as population coverage in specific circumstances, such as when contraceptive or abortion services are not provided by the publicly funded services, or when reaching those located away from urban centres, but with the ability to pay. If they are to reach the poorest or provide a comprehensive package of services, i.e. contribute to universal coverage, then they need to be subsidized by public financing, to ensure financial viability.
- Social protection health schemes and conditional cash transfers are important mechanisms for increasing the utilization of health services by underserved populations, including women. However, these schemes may have to be supplemented by action to address the social determinants of health, including gender discrimination and the lack of decision-making power, if equity in health outcomes is the ultimate objective.
- Expanding health-care coverage is one dimension in achieving universal coverage. Priority setting criteria, mechanisms and processes based on the calculation of the burden of disease and the identification of cost-effective interventions result in narrow essential services packages, which do not meet many important health needs of women and men across the life-cycle. Alternative priority-setting mechanisms are needed that are based on the health needs of women and men of different age groups and from different settings. Specifically, non-reproductive health needs of women and men need to be included, and the range of reproductive health services in ESPs need to go beyond antenatal care and family planning to include, at the least, skilled attendance at delivery and essential gynaecological services.

4.1.2 Service delivery reforms

Integrating a gender perspective into service delivery reforms involves intervening in at least three health systems building blocks: service delivery; health workforce; and drugs, vaccines and technologies.

Service delivery

Making 'people-centred' service delivery work for women as well as men requires intervention in a number of priority areas.

- The range and content of services provided need to address differences between women and men in terms of conditions that occur exclusively in women or men; are more common; manifest differently; are more severe or with more serious consequences; and have different risk factors.[9] Also, the health needs of traditionally underserved groups, such as older persons, adolescents and transgender groups, need to be addressed.
- Attention to gender differences in factors affecting health-seeking behaviour should inform the location and timing of services. Services available closer to home or the workplace and at times suitable to women or men are more likely to be utilized, and could make a big difference to the identification of morbidity and effective treatment and cure. Another dimension is the creation of exclusive spaces and timings within service delivery settings to make services more 'acceptable' to women, men and young people of both sexes.
- Primary health care reforms propose the integration of services to provide one-stop access to a comprehensive range of services at the primary care level. The integration of some services could enhance privacy

[9] The Irish Women's Health Council has developed a checklist for identifying and responding to the different health needs of women and men (*89*). Developing such checklists for specific health conditions and adapting them to suit different contexts may help to make the transition towards more gender-responsive health services.

and/or reduce stigma as, for example, when STI or HIV/AIDS services, abortion, especially medical abortion, and infertility services are made available in the sexual and reproductive health clinics. The horizontal integration of services across traditionally vertical programmes would be further advanced by, for example, the availability of DOTS services for tuberculosis in the same facility as maternal and child health care.

- The vertical integration of services is a priority, especially for but not confined to, maternal health care, where antenatal care is provided at the primary care level, delivery services at the secondary level, and emergency obstetric care at the tertiary care level. Services may be obtained in the public or private sector at each of these stages. Reforms need to address measures that best ensure continuity of care, for example through patient-held records of reproductive history, and an integrated system of referrals and follow-up across levels of care, and public and private sectors.
- By far the most important changes in service delivery need to happen in the realm of patient-provider interactions, especially those that enable empowered participation of both women and men patients in the service-delivery setting.
    - At the minimum, there should be no physical or verbal abuse of any patient by any member of the health team. The provider-patient interaction should be governed by respect for patients. Meaningful participation may be enabled through adequate information, not always through the written word, but by using communication modes that are suitable to women and men. Even when women are hesitant to take decisions, providers would be helping them most if they facilitated their decision-making rather than fixed their problems for them. Visual and auditory privacy needs to be ensured.
    - Non-discrimination should be an essential value guiding all service delivery. There should be no discrimination by health-service providers towards those from socially and economically deprived groups, or from groups whose beliefs and practices may conflict with their own.
    - The possibility of gender-based violence needs to be assumed in every woman being examined, and a policy of upholding the woman's safety above all else adopted. Health providers need to be trained to recognize gender-based violence, appropriately screen or query suspected cases and to sensitively respond to and consistently document gender-based violence. These should be required competencies for health providers at all levels.
    - It would be good practice to have complete privacy with the patient without anyone else present. If the situation explicitly calls for talking to the couple together, then it would be appropriate to ask the woman if she is comfortable with having her husband present.
    - It is good practice not to make assumptions of heterosexuality in patients being examined, and to be open to the possibility of diverse sexualities.

Health workforce and unpaid and invisible health work

Gender inequalities within the health workforce and women's disproportionate burden of unpaid health care at home should be addressed within policies, for example, by:

- creating a working environment free of gender bias through:
    - human resource policies that are supportive of women's childbearing and nurturing roles while at, the same time, facilitating men's participation in child care and homemaking responsibilities;
    - professional support and opportunities for career development;
    - accountability and redress mechanisms against sexism, sexual harassment and gender discrimination in the workplace;
- integrating a gender perspective into the pre-service and in-service training of all health professionals, which is a major priority for reforms in health workforce policies;
- taking action to recognize and ameliorate the unequal burden of unpaid health care shouldered by women, for example, by:
    - reflecting women's unpaid health work in national health accounts;

- investing more in the creation of community care centres and local health centres to provide care for long-term illnesses and disabilities;
- providing compensation for caregivers within social health protection schemes, and catering to their specific needs for emotional and social support through the primary health care facilities.

Drugs and vaccines

- The list of essential medicines should reflect and meet the differential health needs of women and men. Providers and policy-makers need to be aware of biological differences contributing to differences in the way technology, medicines and vaccines affect women and men, and draw up protocols accordingly.
- The supply of medicines, vaccines and technology should be planned to ensure that essential drugs needed by both sexes are regularly available. Pricing policies should be informed by awareness of gender inequalities and disadvantaged women's lack of access to resources. One example is that of the female condom, which has the potential to save women's lives by preventing the heterosexual transmission of HIV.

4.1.3 Public policy reforms

Engendering public policy reforms includes reforms within the health sector to integrate a gender perspective into all areas of work; reversal of gender-discriminatory policies and laws irrespective of sector; and ensuring that all public policies are 'healthy', for both women and men.

Reforms within the health sector

- An area of maximum priority within the health sector (in collaboration with other sectors) is the production of essential information for gender-sensitive policy-making and programming. A core set of gender-sensitive indicators in health need to be adopted across countries. Data disaggregated by sex not only on health outcomes and coverage but also data that links the social determinants of health to these needs should be routinely collected nationally, and information on gender-sensitive indicators used for monitoring progress.
- Health research systems in all countries should set up mechanisms to systematically integrate a gender perspective into health research, for example, by making it mandatory for all publicly funded research to reflect a gender perspective, and by building researcher capacity to do so and making it one of the criteria for the assessment of research by peer review. A research culture needs to be promoted that would reject any gender-biased or gender-blind research as unscientific as well as unethical.
- All health policies and programmes need to be reviewed from a gender perspective and any gender gaps identified and corrected. This requires not only building the capacity of health managers but also political support from the highest level, so that financial and human resources are committed to this end. More importantly, monitoring and evaluation of programme and policy performance needs to include indicators that track progress towards gender equity in health.
- Institutional changes are needed within the health sector that would support the system-wide integration of a gender perspective. These are ideally implemented as part of overall public policy reforms supported and enforced by legislation that hold public officials to account for ensuring gender equality.

Reforms in other sectors

- All gender-discriminatory policies and legislation need to be reformed. These range from policies that deprive women and young people of both sexes access to essential sexual and reproductive health services, to those that discriminate against equal opportunities in education, employment, ownership of property, and equal power and status within marriage.
- Analysis of the differential impact by sex and gender of all policies should become standard practice in Health Impact Assessment exercises.

4.1.4 Leadership reforms

Leadership reforms to support the engendering of health systems would include enhancing gender equality in overall decision-making structures especially within the health sector; including women and men in all participatory and negotiating processes; and promoting accountability to citizens of power holders within the health sector for health equity, including gender equity.

Specific measures include:

- creating opportunities for capacity building and networking among health leaders from within government and from other stakeholder groups at national, sub-national and local levels;
- promoting a gender balance in leadership in academic medicine, public health and nursing through specific initiatives to nurture and mentor leadership capabilities;
- providing for the systematic representation of women in all accountability mechanisms within the health sector, especially from among community members;
- creating structures and mechanisms for the active and gender-equitable participation of civil society organizations in the processes of planning, implementing and monitoring health policies and programmes, and nurturing these structures to be vibrant contributors through appropriate capacity building of representatives from civil society.

4.2 Concluding remarks

The World Health Organization needs to act now in conjunction with Member States, to deliver on the many commitments made towards promoting gender equity in health and mainstreaming gender perspectives in all aspects of its work. Gender considerations need to inform every aspect of health systems reforms towards PHC, as outlined in some detail above. There is already a great deal of experience in addressing gender concerns within each of the areas of reform, what is needed is the political will to emulate good practices and to upscale smaller scale experiments system-wide.

Of the many areas for intervention discussed in this document, five stand out as urgent priorities in which immediate action by WHO is warranted.

- The collection, analysis and publication of national (and sub-national) health information on health outcomes, coverage and social determinants disaggregated by sex and age. The Pan American Health Organization has considerable experience in this area and has facilitated the process in several countries in its region. Other regional offices could adapt their strategies.
- Agreement of a core set of gender-sensitive health indicators, data for which will be available once sex-disaggregation and social determinants data become part of routine data collection by national health information systems. The WHO's Centre for Health Development in Kobe, Japan, has done commendable work in this area, and arrived at a set of gender-sensitive health indicators through an extensive review and consultative process. This could be adapted to suit other country contexts.
- Mainstreaming gender in pre-service and in-service training of all health professionals has to become an organizational priority for WHO and substantial investments are being made both technically and financially to help Member States in this regard. WHO

headquarters as well as regional offices have engaged in several initiatives to facilitate this process, with considerable success, but these have remained small-scale and ad hoc in the absence of an Organization-wide strategy.

- Helping Member States integrate a gender perspective into all health policies and programmes, with the active involvement of all stakeholders, should be high on the agenda of all WHO country offices. A first step in this direction would be to establish a lead agency within the health sector to coordinate all gender mainstreaming efforts, so that efforts are not ad hoc and sporadic but systematic and sustained. The lead agency would begin by carrying out gender analysis of health financing mechanisms and service delivery arrangements, followed by major programmes and policies. This would help identify major areas of gender inequality in health. A suitable plan of action would then have to be drawn up, with a road map outlined and indicators developed for monitoring progress towards major milestones.
- Personnel and financial resources need to be allocated to make this happen.
- The performance assessments of staff and programmes within WHO and Member States' health sectors should include their contributions to gender mainstreaming as an important criterion.

To conclude:

> Gender inequality is not a problem that has no solution.... Ultimately, political commitment and determination at the highest levels of international agencies and national governments are required to end gender inequality and empower women.[179]

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Gender, women and primary health care renewal – a discussion paper brings together evidence and experience from around the world focusing on making health systems more gender responsive. There is a need to re-examine the various barriers and opportunities in order to make health systems work better for women by using a gender equality and health equity perspective.

This paper uses a framework that combines the World Health Organization's six building blocks for health systems and the primary health care reforms propounded in the World Health Report 2008 on primary health care. It also provides examples of what has worked and how, and ends with an agenda for action to strengthen the work of policy-makers, their advisers and development partners as well as practitioners as they seek to integrate gender equality perspectives into health systems strengthening, including primary health care reforms.

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