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MAINSTREAMING GENDER EQUALITY
INTO HEALTH SYSTEMS

by Belkis Giorgis

CHAPTER 4 OF *HEALTH SYSTEMS IN ACTION*

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Management Sciences for Health
200 Rivers Edge Drive
Medford, MA 02155-5741 USA

Fax: +1.617.250.9090
Email: bookstore@msh.org
Website: www.msh.org

Tel.: +1.617.250.9500

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CHAPTER 4

Mainstreaming Gender Equality into Health Systems

Belkis Giorgis

The 2012 World Development Report *Gender Equality and Development* states that during the past three decades women's and girls' education and health levels have improved significantly. Two-thirds of all countries have reached gender parity in primary education. In addition, in over one-third of all countries, girls significantly outnumber boys in secondary education.

However, in many parts of the world, too many women suffer needlessly, both physically and economically, and they have limited opportunities to voice their needs to a responsive audience. Such inequality is not only an affront to human rights, it is also shortsighted: underinvesting in women obstructs poverty alleviation strategies by denying them the opportunity to achieve important gains in health outcomes and, more broadly, by limiting their overall advancement in economic and social development. Gender equality is a longer-term driver of community and country competitiveness, and equity is even more important in an era of increasingly globalized economies.

> For more information on the status of women and girls, please see the full WDR 2012: Gender Equality and Development and a *Harvard Business Review* blog with data on global gender equality, as well as an OECD report on tackling the root causes of gender inequalities in the post-2015 development agenda.

"Sex" refers to biological differences between men and women. "Gender" concerns the characteristics that are considered "masculine" and "feminine" in a society; it refers to an array of socially constructed qualities, behaviors, and opportunities associated with being male or female as well as with the relationships between men and women.

A wide range of attributes is associated with gender: dress, household roles, economic status, definitions of success, and so on.

The health conditions of men and women are a result of both biological and social factors. Biologically, although men and women share many health risks (e.g., TB, malaria, polio), there are sex-specific health concerns and threats unique to the biology of each sex (e.g., cervical and uterine cancer for women and testicular cancer for men). Socially proscribed gender roles can compound health risks, for example men work as drivers so are more likely to be in traffic accidents, and women are more likely to suffer lung damage as a result of exposure to smoke from traditional cooking practices.

BOX 1. Disease Burden Among Females and Males in Developing Countries

A World Bank study on health investment in developing countries found a clear differential in disease burden between genders. In adults aged 15 to 24 years, females experienced the greatest disease burden from maternal health issues, followed by sexually transmitted diseases (STDs), tuberculosis, HIV infection, and depressive disorders, respectively.

Males, on the other hand, were most affected by HIV infection, followed by complications from tuberculosis, motor vehicle injuries, homicide and violence, and war. This data provides a glimpse into the disparate biological and social factors that help define the health risks that men and women face.

Source: Fatalla, Mahmoud. "Issues in Reproductive Health: Health and being a woman." UN News Center. United Nations. Web. 26 Aug. 2014.

In the health sector, gender inequality contributes to health disparities in access to health care and health status. Conversely, well-designed health systems ensure men and women benefit equally from high-quality services, which ultimately contribute to family, community, and societal well-being. The range of factors that limit access for poor women includes time constraints, intra-household resource allocation and decision-making relating to health care, and legal and sociocultural constraints, as reported by Bridge (development–gender). This will require people to think differently, learn new ways of viewing gender, and adopt new behaviors that run contrary to what they have been socialized to believe and how they have been socialized to behave. As the manager of a health program or health services, you must challenge the often long-held, entrenched values of male-dominated power structures and patriarchal norms in order to achieve the goal of gender equality.

In this chapter we will review concepts, approaches, and tools that will help you bring about a change of perspective in designing and implementing policies and programs in health. Throughout the chapter we have included links to resources in case you want to explore a topic in greater detail. As any discussion about gender requires clarity about terms, in the glossary at the end of this chapter we have defined the relevant constructs.

For further exploration of gender-related terms and concepts, you can consult a USAID policy document on gender equality and female empowerment, some FAQs concerning gender-related concepts, and an extensive glossary prepared by the United Nations (UN).

The Leadership, Management & Governance project of Management Sciences for Health has a web page titled Gender, which includes links to many invaluable resources in support of work toward gender equality.

Myths and realities related to gender

One of the many challenges faced by those working to achieve gender equality are the myths and misconceptions surrounding the topic. Box 2 provides some common myths as well as language you can use to counter these misconceptions.

BOX 2. Myths and Realities Regarding Gender

Myths	Realities
"All this talk of gender, but what they really mean is women."	It is true that a lot of gender-related work focuses on women. This is primarily because women's development outcomes (e.g., health, education, employment) are more negatively affected than those of males. However, gender equality is not just about women and girls. It's about addressing the different needs of women, girls, boys, and men equally so that all members of society benefit from development strategies.
"We have a women's project, and therefore we have mainstreamed gender."	A gender mainstreaming strategy involves bringing gender analysis into all initiatives, not developing just an isolated subcomponent or project.
"Working with 'gender' rather than a 'women's' focus means that there is no place for 'specific actions' focusing on women as a separate target group."	There is a place for specific, women-focused interventions in a gender mainstreaming approach. However, such interventions are identified as a result of strategic choice rather than by default. A gender analysis may result in the formulation of interventions bringing women and men together, or concerning women as a separate group or men as a separate group.
"Gender equality means that women and men are the same."	Equality does not mean that women and men are the same, rather that their enjoyment of rights, opportunities, and life chances are not governed or limited by whether they were born female or male.
"We are here to save lives, not to ask whether someone is a woman or a man."	When we have limited resources, we must be even more vigilant to ensure that we use our resources to assist the most affected, which are often the most vulnerable, marginalized, and underprivileged. In this way, including findings from gender analysis as part of program design is simply about good programming and responsible stewardship of available resources that is accountable to improving overall health outcomes.
"Only gender advisors are responsible for addressing gender issues."	We are all accountable for improved health outcomes. When gender disparities exist, it is everyone's responsibility to address them. Program staff have to ensure the assistance and protection they provide meets the needs of all members of the population equally.
"Our problem is poverty. Once we reduce poverty, gender issues will not be relevant."	Gender inequality causes and perpetuates poverty and vulnerability. But greater gender equality can help to reduce the root causes of poverty and vulnerability and contribute to sustainable pro-poor growth (Overseas Development Institute 2008).

Source: Adapted from Mercy Corps, BRIDGE & Gender Mainstreaming: A Guide for Program Staff. *p. 6.*

The basics: gender mainstreaming

Gender mainstreaming was established as a global strategy for promoting gender equality in the Platform for Action adopted at the United Nations Fourth World Conference on Women, held in Beijing in 1995. The strategy recognizes that gender equality is a primary goal in all areas of social and economic development (e.g., health, education, employment). Mainstreaming gender is not merely about adding a "women's" or "gender" component to a program or increasing women's participation in an intervention. Gender mainstreaming is about including all members of society and all the experience, knowledge, and interests that they bring into setting and implementing the development agenda.

Gender mainstreaming suggests a need for changes in goals, strategies, and actions to allow both women and men to influence, participate in, and benefit from development processes. At an organizational level, gender mainstreaming requires a review of and subsequent changes in the organization's structures, procedures, and culture in order to create an environment in which all can contribute and flourish.

The Economic and Social Council of the United Nations defines gender mainstreaming as follows (UN 1997):

> *Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in any area and at all levels. It is a strategy for making the concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres, so that women and men benefit equally, and inequality is not perpetuated.The ultimate goal of mainstreaming is to achieve gender equality.*

Thus mainstreaming gender equality into the health system is a process that requires a major transformation of how we view the world and our and others' role in it and broadening the perspectives we bring to the table. Gender mainstreaming requires us to understand the socially constructed roles of men and women and how these roles impact their ability to access power and resources, including health care.

> You can also view the complete UN Council document from which the preceding definition is taken, as well as a fact sheet describing the UN's gender mainstreaming strategy.

Box 3 presents several statements that reflect the key principles of gender mainstreaming; use them to help you consider their application in your organization.

BOX 3. Gender Mainstreaming: Are You Advancing It?

Review the key principles of gender mainstreaming below and check which ones are relevant to your work and/or position. Then reflect on how well your organization is living by these principles:

I **recognize** that gender equality is critical to achieve all of my organization's goals.

I work to **ensure** that gender considerations, concerns, and experiences of women and men, girls and boys, are integral to the design, implementation, monitoring, and evaluation of all legislation, policies, and programs.

I work to **promote** equality between women and men, girls and boys, in all of my organization's policies, programs, strategies, and interventions.

I work to **ensure** that women and men equally participate in setting priorities and goals and in planning so that programs meet the priorities and needs of both women and men, girls and boys.

I **analyze** the potential positive and negative impact of all of our interventions in all areas on men and women, girls and boys.

I **require** that gender analyses be conducted prior to making important decisions on goals, strategic plans, and resource allocations.

After reviewing this list with your team and colleagues, identify areas where you could do better.

WHY AND HOW TO MAINSTREAM GENDER IN THE HEALTH SECTOR

Much of gender mainstreaming in the health sector is guided by the recognition of the central roles women play as both providers and recipients of health care at different levels of the health system. These roles include the following:

Women as health care providers in the household. Women are often responsible for health-related matters within the family. They care for the young, the sick, the elderly, and the disabled. Often women have to care for family members when they themselves are sick; data show that women's burden of disease and disability between the ages 15 and 49 is high (Fatalla 1998). In places where health systems do not deliver high-quality care and/or have limited points of access to care, women become the primary—and sometimes the only—providers of health care in their families. In turn, this socially constructed role for women as the household caretaker can translate into challenges to gaining education and employment. Although gender norms may leave family health issues as a woman's responsibility, it's also important to note that these responsibilities reduce time available for other health activities (e.g., breastfeeding) and may inhibit men from supporting women's and children's use of formal health services. Women may also have limited control over family resources (i.e., for health care) relative to men.

Women as health care providers in formal health systems. Gender segregation in medical or allied health education programs in most low-income

countries results in an unbalanced representation of women in the health workforce. Women are generally underrepresented in higher health posts or parts of the profession where income is high. Conversely, women hold most of the lower positions in the health workforce, those with the lowest pay and benefits. This disproportionate representation of women across the health care workforce can pose challenges to improving the quality of health care services for women. (Standing 2000)

Women as consumers of health care. Because of their reproductive and caregiving roles, the major users of health systems are women and their children. One would thus expect a "women-centered approach" but, sadly, that is rarely the case as there are many cultural, social, and economic barriers that keep women from accessing the services they need. Maternal and child mortality is high in most low-income countries; access to good health care is critical for improving the health status of women and children.

Mainstreaming gender equality into the health sector is therefore of particular relevance because gender plays such a key role in determining the health status of men and women and their access to health information and services.

The primary aims of gender mainstreaming are to:

- Recognize the different health risks men and women are exposed to so health program practitioners can make sure both receive the services and information that is most critical for them.
- Recognize socioeconomic and cultural factors that inhibit access to services in order to make changes to how, when, and where women and men are served.
- For example, for women, these factors include their heavy workload, lack of autonomy and income, and the unwillingness of their families to invest in their health.
- For men, the considerations might be their unwillingness to visit a clinic that is frequently used by women or where clinic hours do not accommodate their work needs.
- Collaborate with all stakeholders to fully understand the issues and specific needs of all beneficiaries, including those whose voices are often not heard, and to use that understanding to design, implement, monitor, and evaluate health programs.
- Strengthen capacity in different sectors (e.g., nongovernmental and governmental organizations, including women's organizations) and at different levels (local, regional, and national) to bring perspectives and contributions to policy development, program management and administration, human resource planning, service delivery, management information systems, and accountability.

CHALLENGES YOU CAN EXPECT

Gender roles and norms are deeply entrenched and culturally embedded values of societies. Therefore, as a manager of a health program or health services, you can expect many challenges as you attempt to mainstream gender into your organization, your programs, your project, and your everyday life. You should plan how you will address some of the common challenges you will encounter. For example:

- Health is determined by many factors that lie outside the sphere of influence of health professions.
  So how do you engage with actors from others sectors and ministries to reduce gender disparities in health outcomes?
- It is easier to talk about gender mainstreaming than it is to implement it.
  So how do you secure real political and resource commitments within your organization or in government, including at the highest levels?
- Health policy professionals and practitioners, both male and female, are all products of their culture.
  So how do you get them to examine their own attitudes toward their clients and patients, male and female, old and young?
- Gender mainstreaming may take a falsely simplistic approach to addressing health inequities by excluding other social determinants of health inequities, including race, class, ethnicity, and educational level.
  So how can you refrain from applying stereotypes and acknowledge the multiple identities that both men and women have?
- There is sometimes a perception that interest in gender equality and equity in low-income countries is championed by Western donors' agendas but is not independently present in the country itself.
  So how can you make the gender conversation relevant to all stakeholders and a local agenda rather than one that is perceived as being imposed from the outside?

It is important to acknowledge the validity of these tough questions and to prepare thoughtful and comprehensive responses that demonstrate an understanding of the issues and offer ways to address them. You will invariably find that each of these challenges require using one or more of the practices discussed in other chapters (especially Chapters 2 and 5): aligning, mobilizing, scanning, focusing, setting shared direction, engaging stakeholders, cultivating accountability, and more. Our experiences have shown that the conscious, intentional, and systematic application of these practices will help you face these challenges with confidence.

HOW TO CONDUCT A GENDER ANALYSIS

Gender analysis is a first step in gender mainstreaming because it provides the necessary information required for health policy, planning, and programming. Information not easily observed is often brought to the fore in the process of asking questions. A gender analysis reveals the consequences of gender inequality in relation to the vulnerability of men and women to different diseases and highlights the differences in access to health resources to prevent or treat disease and illness. The findings of a gender analysis will help you to improve the effectiveness and quality of health services by delivering appropriate services for men and women.

An example of a gender analysis matrix for health appears in a WHO learning module on sex and gender. In addition, Chapter 10 of the handbook, which has a section titled "Assuring Equitable Access for All People and Communities," concludes with Appendix A, "Framework for Gender Analysis."

BOX 4. How to Conduct a Gender Analysis

In a gender analysis, in addition to considering the biological risks of men and women for disease and disability, examine factors that relate to gender.

- Examine the roles, relationships, and differences between women and men as established by cultural norms and practices and whether they make them more or less susceptible to health problems.
- Highlight how inequalities impose constraints on seeking and maintaining good health, and/or identify ways to address and overcome these constraints.
- Analyze influences in decision-making and who makes decisions in the household and the related consequences with regard to access to quality care, health outcomes, and overall livelihood.
- Reveal the health risks and problems that men and women face as a result of the social construction of their roles, e.g., contact with waste water, fumes from indoor cooking fires.
- Analyze men's and women's position within the community and how this influences their assumption of leadership positions and participation in community activities.

WHO's *Gender Analysis in Health* is an invaluable resource for those working on gender and health; it includes a critical review of 17 widely used tools and their usefulness for gender analysis in health. In addition, USAID's Automated Directive System (ADS), includes Chapter 205, "Integrating Gender Equality and Female Empowerment in USAID's Program Cycle." Another USAID resource is its "Guide to Gender Integration and Analysis: Additional Help for ADS Chapters 201 and 203."

GENDER INTEGRATION IN THE PROGRAM CYCLE

By integrating gender considerations into the program design phase and throughout the entire program cycle, you will avoid making gender an "afterthought" inserted at the very end for compliance reasons. This "afterthought" approach does not give consideration for how the entire program might affect gender disparities. Take a look at the process outlined in Box 5 (next page) to see whether you are making gender considerations an integral part of the program cycle, and if not, what you can change to do so.

> To read more information on gender integration throughout the program cycle, you can consult a program guide prepared by FHI 360 as well as a manual prepared by the Interagency Gender Working Group.

BOX 5. Process for Integration of Gender in a Program Cycle

Assessment

First, collect or access available data on existing gender relations, roles, and identities in relation to the health needs or problems to be addressed by the program.

Second, analyze the data to assess any potential relationship between gender-based constraints and opportunities that may affect achievement of health objectives or the relative status of women and men.

The assessment phase is important to gaining a better understanding of the problems your program intends to address and the context in which you will implement the program. You will need to assess both the role gender plays in the problems you want to address and how your program is likely to affect gender norms and relations. This process is called *gender analysis*.

Strategic Planning

Examine program objectives for their attention to gender constraints and opportunities. This may require a restatement of objectives so that they strengthen the synergy between gender and health goals.

Design

Program approaches, interventions, and activities must support achievement of health and gender equity objectives. In the design phase, findings from the gender analysis must be used to consider the gender-related issues the program needs to address, and to design program objectives and activities for achieving those objectives. Often it is necessary to develop additional objectives that focus on gender issues; other times it may be more feasible to incorporate gender considerations as sub-objectives in activities that do not specifically target gender.

Monitoring

Develop indicators to measure gender-specific outcomes, especially the alleviation of gender-based constraints and application of opportunities.

Monitor process indicators regularly to ensure the program is functioning as planned, without any unplanned or unintended adverse effects to beneficiaries. In the implementation and monitoring phase, gender-related activities are implemented to ensure the full participation of and benefit to girls, women, boys, or men, as appropriate. It is necessary to continually collect and analyze data to track progress toward the gender-related objectives. Careful monitoring also helps identify situations in which midstream changes can be made to the program so that it has the intended effect on gender norms and relations.

Evaluation

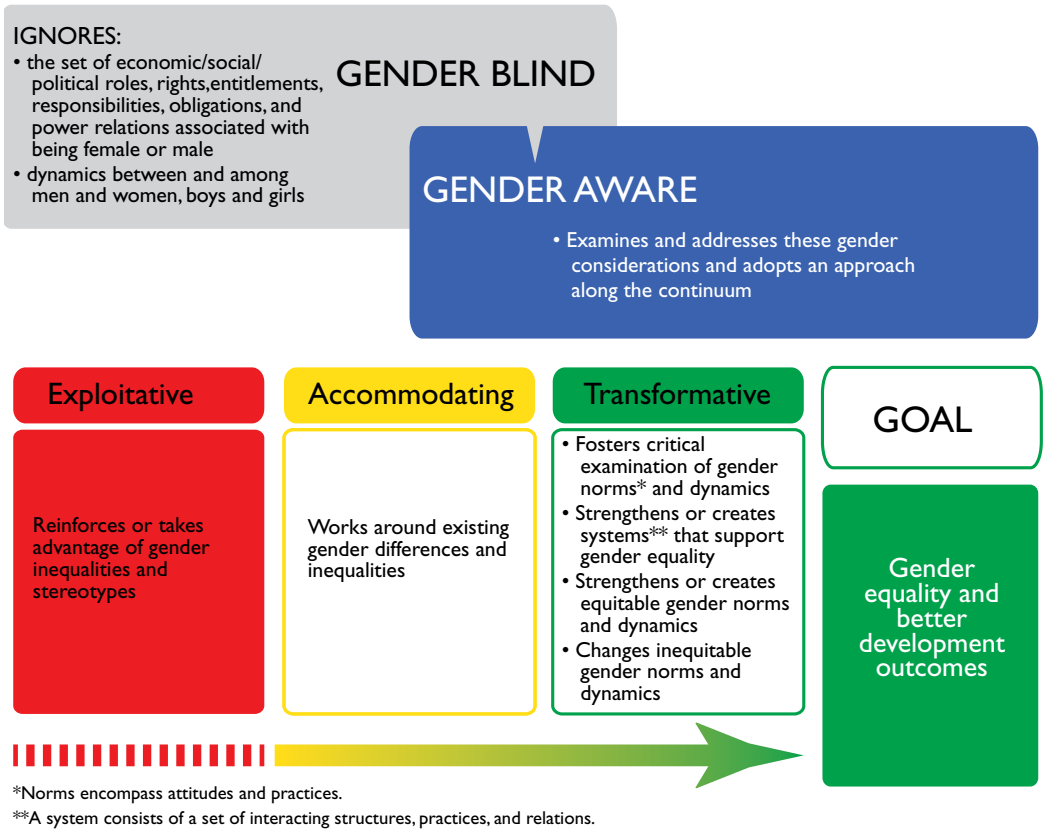
Collect and analyze baseline (perhaps including the assessment data from above) and end-line data to evaluate the effectiveness of program elements (i.e., to demonstrate that program objectives were met, or to document any changes in health outcomes that were a result of the program). It is also useful to consider a midterm gender analysis to identify any gender-related constraints not anticipated at the beginning that the program faces, and to adjust design and activities based on findings.

Adapted from: A Manual for Integrating Gender Into Reproductive Health and HIV Programs: From Commitment to Action (2nd Edition), The Interagency Gender Working Group, 2009.

GENDER INTEGRATION CONTINUUM

The Interagency Gender Working Group (IGWG) developed a Gender Integration Continuum conceptual framework (Figure 1) to use as a diagnostic tool for integrating gender analyses and findings into programs by determining whether they are "gender blind" or "gender aware." Among those that are gender aware (i.e., that explicitly recognize local gender norms, differences, and relations), a program can be exploitative, accommodating, or transformative.

FIGURE 1. The Gender Equality Continuum



Source: IGWG training module found at http://www.igwg.org/igwg_media/Training/FG_GendrIntegrContinuum.pdf.

The IGWG website and an IGWG handout on the continuum of gender strategies further describing the four categories.

Let us take a closer look at the various positions on this continuum with examples that have been collected by the Interagency Gender Working Group.

Gender-blind projects or programs use generic terms such as children, adolescents, youth, families, etc. They do not identify differences between women and girls and between men and boys with regard to their activities, access to and control of resources, and participation in decision-making. Gender-blind projects thus do not consider or address gender. A gender-blind strategy ignores gender implications and assumes that gender norms, roles, or power differentials are either immutable or do not influence who participates in or benefits

from a project or program. For example, a poverty assessment that does not consider differences between male-headed and female-headed households, or any of the gender-based differential effects of poverty, is an example of an approach that is gender blind.

Gender-aware programs or projects make explicit mention of gender issues and propose specific solutions to address the needs and concerns of women, girls, men, and boys who use the program or whom the project intends to serve. Here we would see recognition that activities benefitting men and women may require different inputs and designs, such as separate latrines, or bursaries or workshop schedules that accommodate women's special needs. Gender considerations are apparent when sex-disaggregated data are used to make decisions on how the work environment is being structured.

Gender-exploitative strategies exploit gender inequalities and stereotypes in pursuit of a program's or project's ultimate goal. This type of gender strategy reinforces gender inequities and perpetuates stereotypical images of women's and men's roles. For example, in the area of human resources for health (HRH), an educational recruitment strategy might (unwittingly) play on the stereotype of women in nurturing roles (in contrast to that of men in diagnostic and curative roles). Or, employers may assume that men are family "breadwinners" and that male employees therefore require higher compensation than female employees in the same cadre. Exploitative strategies in the area of reproductive health (RH) programming include appealing to male opinion leaders as gatekeepers of women's reproductive health behavior or alluding to male sexual dominance in marketing slogans aimed at encouraging men to use condoms. Practices such as these inadvertently reinforce male decision-making power and dominance. In clinical settings, we may see the good trend of involving men in their female partner's health care undercut by providers who direct all their attention to the man rather than the couple.

Gender-accommodating strategies recognize and account for gender differences in pursuit of program or project goals. Such strategies do not attempt to challenge inequitable gender norms. Instead, they may make it easier for women to fulfill the duties ascribed to them by their gender roles. At times, accommodation (or working within existing gender inequality/inequity) may be a faster way to achieve intended objectives than trying to change gender relations. It's important to note, however, that gender-accommodating interventions may result in short-term outcomes and are an important first step in the gender equality continuum. However, longer-term goals are best achieved through gender-transformative interventions. Health care professionals shouldn't stop at gender-accommodating strategies.

An example of this type of strategy is the creation of a day-care program in a hospital so that nurses can more easily combine childcare with paid work. Such a program supports women's continued workforce participation but does not challenge the prevailing norm that women are the sole providers of childcare. An example from the field of RH is delivering contraceptive supplies to women's doorsteps in places where their mobility outside the home is limited. Doorstep distribution of contraceptives has helped raise contraceptive prevalence rates in many countries and given many women the power to control their fertility as they desire—but in most cases, doorstep distribution does little to challenge the belief that women who leave the home without a male relative's permission are not respectable.

Gender-transformative projects and programs seek to transform unequal power relations between men and women through changes in roles and status, and through the redistribution of resources. Gender considerations are incorporated into the design of the project, and the causes of inequality are addressed directly to promote equity as a means to reach project goals. Transformative strategies attempt to overcome gender-related barriers to workforce participation or health service use by shifting the balance of power, the distribution of resources, or the allocation of duties between women and men service providers or beneficiaries. They may also work to build critical awareness of gender norms, for example, when there is a targeted recruitment of men for jobs that are traditionally considered "women's work." This can be gender transformative because it seeks to transform unequal power relations. In the area of RH programming, a transformative strategy might support community dialogue to rebalance gender relations so that women can get contraceptive services without needing the permission of their husbands.

Case studies that highlight the different stages of the gender integration continuum—Examples from Zimbabwe, Zambia, and Kenya

Gender Exploitative: Campaign to Increase Male Involvement in Zimbabwe

To increase contraceptive use and male involvement in Zimbabwe, a family planning project initiated a communication campaign promoting the importance of men's participation in family planning decision-making. Messages relied on sports images and metaphors, such as "Play the game right, once you are in control, it's easy to be a winner," and "It is your choice." The campaign increased the use of contraceptive methods. When evaluating impact, the project asked male respondents whether ideally they, their partners, or both members of the couple should be responsible for making family planning decisions. The evaluation found that: "Whereas men were far more likely to believe that they should take an active role in family planning matters after the campaign, they did not necessarily accept the concepts of joint decision-making. Men apparently misinterpreted the campaign messages to mean that family planning decisions should be made by men alone."

Gender Accommodating: Youth Roles in Care and Support for People Living with HIV (PLHIV)

In Zambia, one project has sought to involve young people in the care and support of PLHIV. This project carried out formative research to assess young people's interest and to explore the gender dimensions of care. The assessment explored what care-giving tasks young women and young men feel more comfortable with and able to carry out, as well as what tasks PLHIV themselves would prefer to have young women or young men carry out. Based on this research, the project adopted an approach that incorporates preferred tasks for young women and young men in order to develop youth care and support activities for PLHIV.

Gender Transformative: Female Genital Cutting (FGC) Prevention Program in Kenya

A FGC intervention in Kenya sought to reduce the incidence of harmful cutting. Project staff realized that legislation to prohibit the practice would not address the cultural and social motivations of the community and would likely result in driving the practice "underground." Instead, the project hired a medical anthropologist to work with the community. Through qualitative interviews with groups of women, men, and religious leaders, the project sought to understand the meaning and functions that the ritual provides to the community. Together with community members, the project staff adapted the FGC ritual by eliminating the harmful cutting but keeping the "healthy" cultural elements, such as seclusion of girls, dance, story-telling, gift-giving, health and hygiene education, etc. As a result, a new right-of-passage ritual has been created for girls called "circumcision with words," which has become accepted by the entire community.

Source: Interagency Gender Working Group and USAID, "Case Studies: Gender integration continuum"

A gender lens for viewing the health systems building blocks

To illustrate gender mainstreaming 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 programs must integrate gender equality from the planning phase. An approach such as this will also ensure that gender perspectives are reflected in health policies, services, financing, research, and health workforce training curricula (World Health Organization 2010a, 16).

In this handbook, other chapters take a closer look at each of the six building blocks that, together, make up the health system. Although there is now a greater effort to gather evidence on how gender considerations in programming influence each of the building blocks, the information gathered is neither complete nor comprehensive. For example, there is literature on how gender affects the ways and types of services that can be targeted to women and men, boys and girls, but there is less information available about how gender affects the other building blocks. Each of these building blocks is addressed in this section to demonstrate how gender considerations are important. Descriptions of the six health systems building blocks can be found on the WHO website.

As indicated in Chapter I, the ultimate aim of a health system is to equitably maintain or restore the health of all. This chapter focuses on equity regarding gender because, as has been discussed earlier, women and men have different problems and needs. Additionally, it focuses on gender equity because women are the major providers and consumers of health care in low-income countries. Taking these factors into consideration, the following sections provide a general discussion on how gender issues are relevant within the framework of health systems strengthening.

> A Gender and HSS eLearning course is available on the USAID Global Health eLearning Center site. This course is housed under the Gender and Health certificate program.

SERVICE DELIVERY

Good health services are those which deliver effective, safe, quality health interventions to those that need them, when and where they are needed, with a minimal waste of resources. Gender-sensitive service delivery is designed to address gender norms, roles, responsibilities, and needs that affect access and use of services. For example, a gender-sensitive PMTCT program explicitly acknowledges that women may not have the status, rights, and decision-making power to practice safer sex or adopt safer infant-feeding practices, but might not take action to overcome these barriers.

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 percent or more of the households. In Burkina Faso, Mali, and Nigeria, almost 75 percent of women reported that their husbands alone took decisions concerning their health care (WHO 2010a, 18).

Services become gender sensitive when measures are taken to act on that awareness by reaching out to the male partners of the women (with the women's permission, of course) to promote joint decision-making regarding safer sex or infant feeding (WHO 2009a). The most gender-sensitive programs deliver integrated and comprehensive health services that offer a complete package of health interventions ranging from promotion, prevention, diagnosis, treatment, disease management, and rehabilitation all the way to palliative care services. These services are also delivered at various levels and sites of care within the health system, catering to the needs of young and old, and men and women at all stages of the life cycle.

> Family Care International has prepared a PowerPoint presentation on the life-cycle approach to addressing the sexual and reproductive health of women.

Integrated health services address the needs of women to access services for themselves and their children at the same time, thereby saving effort, time, and money. 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 making child health care, antenatal care, and family planning available on different days or times of day, providing all of these services at all times would enable a woman who comes to immunize her child to also have a pregnancy test or get her contraceptive supplies within a much shorter time frame. In addition to the time convenience, integration of some services could enhance privacy and/or reduce stigma as, for example, when STI or HIV and AIDS services, abortion, or infertility services are all made available in the sexual and reproductive health clinic (WHO 2010a).

Additionally it is important to consider the health needs of the lesbian, gay, bisexual, and transgender (LGBT) community. Ensuring access to this marginalized group is a gender issue and should constitute part of the gender equality agenda. Studies show that LGBT people experience health issues and barriers related to their sexual orientation and gender identity, and that they avoid or postpone care or receive inappropriate or inferior care because of homophobia and stigma and discrimination by health care providers and institutions. This has been particularly important in the prevention, treatment care, and support for those infected or affected by HIV/AIDs where these groups have been marginalized in getting care.

HEALTH WORKFORCE

A well-performing health workforce is one that works in responsive, fair, and efficient ways to achieve the best health outcomes possible, given available resources and circumstances. This translates to services being provided by sufficient staff that is not only competent but also responsible to their clients. Women make up about 42 percent of the estimated global paid formal workforce, however in the health workforce they make up over 75 percent, making them indispensable as contributors to the health system (WHO, Dept. of Human Resources for Health, 2008). At the same time, unequal access to educa-

tion and training in low-income countries results in a disproportionate number of women in the health workforce at the lowest-paid levels. Gender stereotypes and practices keep women health care workers in certain occupations and bar them from others. Some of these occupations are poorly supported and are often unpaid, keeping women outside the formal employment sector. Last but not least, once in the workforce, women often run into a "glass ceiling," where social roles and expectations hinder their ability to advance to leadership positions. On the other end of the spectrum, where posts demand higher salaries, benefits, and prospects of supporting families and comfortable lifestyles, we see mostly men (Standing 2000; WHO 2009).

Cultural expectations about women's childbearing and child rearing responsibilities often result in women cycling in and out of employment. The assumption that a woman will become pregnant or that she is her children's primary caregiver directly affects her career prospects, a stereotype few men in those same cultures experience. It is therefore not surprising that fewer women than men progress to upper-level and management positions, even if family duties are shared or household help is possible—circumstances that are not typical. The following measures can be taken to bring about equality in the health workforce (WHO 2010a, 39–40):

Create a gender-bias-free working environment for health workers. Health 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.

Train 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.

Recognize the contribution and reduce the burden of unpaid and invisible health work. Unpaid health work is the informal care provided by a member of the same household or community, or a friend, without financial compensation, to a person who is unwell or disabled. 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.

HEALTH INFORMATION SYSTEMS

A well-functioning health information system is one that ensures the production, analysis, dissemination, and use of reliable and timely information on health determinants, health system performance, and health status; gender considerations must be incorporated into these systems. In addition to being left out of the data, women are not well represented within the field of informatics.

> *A gender perspective should be adopted in all processes of policy formulation and implementation and in the delivery of services, especially in sexual and reproductive health, including family planning. This includes the development and availability of sex-disaggregated data and appropriate indicators for monitoring progress at the national level.*
>
> —Key Actions for the Further Implementation of the Program of Action of the ICPD, Paragraph 46

Health information systems do not always contain sex-disaggregated data—the most basic requirement for a gender-based analysis and subsequent advocacy and policy interventions. Standardized, gender-sensitive health indicators exist in some areas, such as gender-based violence, but are lacking in others (Bloom and Arnoff 2012). When sex-disaggregated data are available, the analysis should link any differences in sex with the overarching program logic model or theory of change to demonstrate any effects of gender-related factors on the performance of health programs and health outcomes. If more women than men participate in training events, does it affect service delivery or health outcomes? How? Often this level of analysis is not conducted.

Box 6 (next page) presents some of the objections that are frequently put forward to deter the gathering of gender-related statistics. It also includes clear rationales to counter these objections.

BOX 6. Frequently Used Arguments against Producing Gender-Related Statistics

"We already have gender statistics—all our data are sex-disaggregated."

The production of gender-sensitive statistics does not involve only the production of sex-disaggregated datasets—although disaggregated data do form one important component of gender-sensitive statistics. For full gender sensitivity, the data collection system also needs to produce statistics that relate to all the key gender issues in the community or region, and to cover issues (such as maternal mortality or prostate disorders) that might affect only one sex.

"Women and men in this country already enjoy equality."

Women and men will never be exactly the same. Biological differences will persist, as will some social differences. Gender statistics are needed to illustrate both how women and men differ and how they are similar. It is only on the basis of this information that programs and organizations can make sensible policy and be sure that policies regarding gender equality are succeeding.

"It is normal to have differences in the labor market between women and men because women prefer to stay at home."

Gender-sensitive data do not present a value judgment on how the society should look. The task is to produce or access data that accurately reflect the situation among the population served by your health program or health services. It is then up to the policymakers and citizens more generally to decide whether the differences depicted between male and female are "normal" or desirable.

"Adding a breakdown by sex will cost too much."

For the most part, there is a minimal cost attached to producing gender statistics with existing instruments. In some cases, it simply involves the addition of an extra question or column specifying sex. In other cases, it might involve the addition of several questions. At analysis time, the main cost would be the time involved in running extra tabulations but, in many cases, sex can simply be added to existing tabulations. Significant cost is generally incurred only when a completely new investigation specifically to assess gender equity (such as a survey) is carried out.

"Disaggregating data by sex will adversely affect the quality of the data."

On the contrary, the integration of sex-disaggregated data will make it possible to review data from a gender perspective, thereby enriching the information available from the investigation and increasing its explanatory value. The disaggregation by sex also often provides the basis for a more thorough checking of the accuracy of data collection and recording, as it allows for additional logical checks.

Source: Developing Gender Statistics: A Practical Tool, *by the United Nations Economic Commission for Europe and World Bank Institute, 2010. Reprinted with the permission of the United Nations.*

Gender-specific health data can be used to generate studies and documentation of promising practices and thus inform health policies aimed at improving the health of women and families. Sharing this information, such as the sex-disaggregated data collected by MOHs, with stakeholders who need support in their advocacy and policy efforts provides them with "clear language that highlights gender based causes and consequences and their policy implications" (UN, Office of the Special Advisor on Gender Issues 2002, 23). Additionally, gender statistics can be used to identify inequalities resulting from existing laws or policies, and for the development of policies that are not explicitly related to gender but that may have a different impact on men and women.

Additionally, including gender-sensitive indicators in program monitoring plans will help the implementation team track to what extent the program affects gender disparities, particularly in gender-sensitive programs. As noted in a WHO policy brief (Payne 2009), "Indices of gender equality and gender equity are also valuable: they are compiled from data from a range of sources, including censuses, sample surveys and nationally collected statistics, in order to 'give shape' to gender-disaggregated data."

> A MEASURE Evaluation PRH web page has a list of sample gender-sensitive indicators for service delivery.

ACCESS TO ESSENTIAL MEDICINES

A well-functioning health system ensures equitable access to essential medical products, vaccines, and technologies that are of assured quality, safety, efficacy, and cost-effectiveness, and whose use is scientifically sound and cost-effective. When it comes to access to medicines, it makes a big difference whether you are a man or a woman. Successful policy and strategy implementation promoting access to affordable and reliable medicines requires that we take gender considerations into account. Studies carried out in developing countries reveal that gender-related barriers to access (both to health services and medicines) are greater for women than men, as women often do not have any control over family income and may not be able to purchase medicines without asking their husbands. Geographical constraints, such as long distances and transportation costs to reach health care services (where medicines are dispensed), also put them at a disadvantage (Baghdadi 2005).

Expanding access to high-quality, affordable maternal health medicines is critical to making progress in reducing maternal mortality. However, significant challenges often impede such access. Chief among them is a lack of data on the needs, systems, and financing for maternal health medicines. Inconsistent quality of medicines and lack of skills among providers on their administration also create considerable barriers to appropriate maternal care (UN Population Fund 2012). Many women in rural areas of low-income countries are often illiterate and therefore unable to read information on the leaflets found in some of the medicine packets. And yet women are often the first line of care for their families; outreach targeted to women on the safe use of medicines has been shown to benefit larger numbers of family and extended family members than outreach for which men are the target audience.

FINANCING

A good health financing system raises adequate funds for health in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them. For women living in poverty, user fees have direct and obvious links with the ability to pay out of pocket for health care. Where women are struggling to make ends meet, they have little to save for contingencies, including health care. Women may make trade-offs in not seeking health care in order to purchase food or fuel, or they may seek traditional health care that does not address their health needs adequately (Nanda 2002). Without access to the family's resources, and given the traditional decision-making power of the male head of household, out-of-pocket costs such as health care user fees can easily put even the most basic health care out of the reach of poor women. Even where they are exempted, this does not guarantee free care as supplies or drugs may not be included in the exemption, or under-the-table payments are required to be seen at all (Vlassoff 2007).

User fees create inequities not only because they may discourage poor people from accessing services but also because, in the case of catastrophic illness, they can deplete whatever meager resources a family has, pushing any preventive or "minor" health needs of women and children to the back burner.

LEADERSHIP AND GOVERNANCE

Leadership and governance involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design, and accountability (see Chapter 3). Lack of policies that ensure gender equity in hiring and lack of oversight boards that include women are particular challenges in leadership and governance in health systems. For too long, women have been poorly represented at the highest levels of government and in parliaments, as well as in the governing bodies of both public and private health care organizations at the regional, national, and local levels. Women—the major beneficiaries and consumers of health systems—do not have adequate mechanisms through leadership systems to have their voices heard.

Good governance is about making institutions accountable, transparent, and inclusive. Inclusiveness and transparency create equal opportunity for qualified staff to move into leadership positions. This sounds simple, but in reality is not! The path is full of land mines for the pioneering women who have to walk a fine line between being accepted (and thus conforming to norms and expectations created by the dominant majority) AND making use of their unique skills and viewpoints, which may put them at odds with their male colleagues. They are in a bind: young women look up to them and expect support and maybe even privileges, while their male colleagues or adversaries (of both sexes) point out their each and every mistake, blowing them up out of proportion. However, the effort is worth it; good governance goes hand in hand with good leadership, and women in leadership positions have shown that they are inclusive and collaborative (Wilber 2011).

Conclusion

The intent of this chapter is to help leaders and managers of health programs or health services understand why gender mainstreaming is important, how it is done, and how their leadership, management, and governance skills can support them in taking on the challenges that invariably accompany gender mainstreaming.

In the 1990s, gender equality became an international focus, highlighted in such meetings as the International Conference on Population and Development (ICPD 1994), the world Summit for Social Development in Copenhagen in 1995, and the Fourth World Conference on Women in Beijing in 1995. ICPD set out to provide universal access to family planning and sexual and reproductive health services and reproductive rights; to deliver gender equality, the empowerment of women and equal access to education for girls; to address the individual, social, and economic impact of urbanization and migration; and to support sustainable development and address environmental issues associated with population changes. The Beijing Platform of Action included recommendations aimed at empowering women to promote and safeguard their own health, and pointed to the need for mainstreaming gender into all policies and programs. The Millennium Development Goals established in 2000 at the Millennium Summit of the United Nations also specifically and directly address women and health through the goals of reducing maternal mortality and empowering women (Goal 3 and Goal 5).

> WHO's Department of Gender and Women's Health prepared a publication describing the gender considerations for work toward each of the health-related MDGs.

The documents coming from all of these meetings reaffirm women's equal rights and entitlements to social protection and participation. Despite these pronouncements, challenges remain. The Association for Women's Rights in Development highlighted lessons learned in gender mainstreaming and challenges to this process, which include some of the challenges outlined below.

The concept itself is unclear and misunderstood. Gender mainstreaming is still difficult because "gender" is still not understood as a social construction of roles and relationships but primarily as attention to biological women. Furthermore, "mainstreaming" has—at best—been viewed as the need to add "women's interests" to "refine" already established settings.

Mainstreaming has been reduced to a technique. Because gender mainstreaming seldom contains the necessary funding, staffing, or commitment, it is often reduced to a question of technique and "tool-kits." And far too often the technique is criticized for any failures in gender mainstreaming, whereas the real problems are lack of commitment and resources and a true acceptance of the equal worth of women and men.

Mainstreaming as a pretext for saving overall resources. Often agencies

claim that gender is successfully mainstreamed into their programs and use this to justify the lack of staff, resources, and program planning allocated to specifically address gender and women's issues. Thus, in some cases, gender work today may actually be less equipped in terms of staff and resources than it was in 1995. What we need today is to identify a measure or minimum criteria for what should be labeled as "gender mainstreamed."

Gender mainstreaming has not been transformative. Gender mainstreaming, as it is applied today, basically accepts the status quo and "business as usual"—and then adds gender. Much more far-reaching methods for transforming the agenda are required to put gender into the driver's seat and reorganize and redefine the structure and focus of current work. Current efforts appear to be insufficient.

An Association for Women's Rights in Development publication provides an in-depth consideration of each of these challenges.

Proven practices

As with any change, the first step is becoming aware of one's own behavior as it relates to gender. Only then can we address gender issues in ever-broadening circles of influence: our families, our communities, our workplaces, and our government.

Remember that:

- Gender is a social construct and therefore gender equality is not a static phenomenon. Look for how the roles of men and women in the context of health programs change, even if only slowly.
- Interventions designed to mainstream gender are best built on positive norms and behaviors that benefit both men and women.
- Transformation doesn't happen overnight because of long-standing beliefs related to women and men. Changes to bring about gender equality in health are incremental and build on the efforts of others in other sectors, not just health.
- Gender mainstreaming requires advocates who are willing and able to provide the justifications for promoting gender equality and can speak to both the economic, health-related, and moral imperatives for gender equality.
- Observation, collection of data and analysis, and evidence-based programming are integral parts of the work of gender mainstreaming.

The following are proven practices, which can be adapted, for mainstreaming gender equality in the health sector:

- Gently question gender stereotypes and suggest more equitable norms and practices to support and promote, rather than harm, men and women's health.
- Pay attention to the particular health risks associated with being a woman or a man because of social and biological roles in a particular society. Highlight these and enlist both men and women to reduce those risks.
- Expand the evidence base for informing policies and programs through targeted research showing the relationship between gender inequality and negative health outcomes.
- Support structures, incentives, and accountability mechanisms to empower women to access health care information and resources.
- Address gender inequality in health systems by increasing the awareness of how women and men, boys and girls are affected, both as consumers and providers of health care.

Glossary of gender terms

gender: Refers to an array of socially constructed qualities, behaviors, and opportunities associated with being male or female as well as with the relationships between men and women. Unlike biological sex, gender characteristics are learned from one's culture or society. A wide range of attributes is associated with gender: dress, household roles, economic status, definitions of success, and so on. Gender roles are not fixed; they can vary widely both within and across cultures, and they can change over time.

gender-sensitive indicators: Measure progress in the move towards gender equality. They include the wide range of factors that determine if females and males are treated differently based on gender alone, and can reveal the relative advantage or disadvantage associated with gender.

gender analysis: The collection and interpretation of sex-disaggregated data and other information regarding gender-sensitive indicators in order to determine any differential impact of an action on men and women and the effects of gender roles and responsibilities. It also involves qualitative analyses to that help to clarify why these differential roles, responsibilities, and impacts have come about. Gender analysis is often is a first step in gender-aware program design and development.

gender equality: The objective goal of equal enjoyment by women and men, and boys and girls, of access to services, information, and opportunities as well as socially valued goods, resources, and rewards. It allows all people the full and equal exercise of their human rights and the chance to achieve their full potential. Gender equality does not mean that males and females become the same, only that access to opportunities and life changes is neither dependent on nor constrained by their sex.

gender equity: Being fair to women, men, girls, and boys. To ensure fairness, strategies and measures must be available to compensate for historical and social disadvantages based on gender that prevent women and men from otherwise operating on an equal footing. Gender equity leads to gender equality. However, that there is some controversy in international human rights law concerning terms and a preference for the exclusive use of "gender equality."

gender disparities: Inequalities or differences that result from the ways men and women, and boys and girls, are treated based on the roles, opportunities, relationships, and so on considered appropriate for each. Examples are differences in health or educational status that stem from differential treatment based on gender.

gender perspective: A way of considering how a particular issue is related to the many aspects of gender and applying this to the design, planning, implementation, and evaluation of policies and programs. It is the notion that the implications of gender should be kept in mind when evaluating problems and proposed actions.

gender mainstreaming: A process of integrating the implications for women and men, and boys and girls, at all stages and at all levels of any planned action for the purpose of achieving gender equality. With gender mainstreaming, females' as well as males' concerns and experience are integral to the development, implementation, monitoring, and evaluation of policies, programs, and projects in all political, economic, and social spheres. Gender mainstreaming is a strategy for identifying and addressing gender disparities and inequities so that they are not perpetuated.

sex: The biological characteristics that differentiate males and females. Sex differences are related to males' and females' physiology and generally remain constant across cultures and over time.

sex-disaggregated data: Data that are collected and presented separately on women and men.

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