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**Gender perspectives on global public health:  
Implementing the internationally agreed development goals, including the  
MDGs**

**Written statement\***

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\* The views expressed in this paper are those of the author and do not necessarily represent those of the United Nations.

## Transforming health systems to meet the needs of women and girls

As we know, gender is a strong determinant of health and of access to services. Evidence suggests that gender-blind or gender-neutral health systems are harmful to the health of women and girls (and men and boys). Conversely, gender-responsive health systems are good for the health of women and girls (and men and boys).

Since transforming health systems to meet the needs of women and girls is a vast topic, starting with a real-life example might make the issue more concrete, by illustrating some key issues and ways forward.

The example is drawn from a review of the National Tuberculosis Programme in Viet Nam conducted in 2004. Viet Nam's is among the best-performing national TB programmes in the Region, and indeed globally, having long since achieved the global targets of 100% DOTS coverage, 70% case detection, and 85% cure rates. Under the directly-observed (short course) treatment, or DOTS, strategy, WHO recommends free diagnosis and treatment for TB. Diagnosis is conducted by analyzing sputum samples under a microscope, not just by x-ray.

TB is exemplary in being a disease programme that has already adopted one of the key recommendations for making health systems and policies gender-responsive, in that its routine recording and reporting system is set up to collect and report data disaggregated by sex. Globally, the male-female ratio in TB is about 2:1. The review in Viet Nam confirmed that the overall male/female ratio in TB incidence was indeed 2.1. Notably, although the programme meticulously collects and maintains sex disaggregated data, they were not being routinely analyzed for trends or variations across space and time.

Therefore, the **first lesson** this example suggests is that it is not enough to simply collect sex disaggregated data. These data need to be analyzed from a gender perspective, as well as a broader equity perspective, and the analysis used in policymaking.

For instance, upon analysis of the Viet Nam data, striking variations in trends in the male/female ratio were found, across time and across geographical areas. Further, the gap was found to have increased from 1.6 to 2.1 over 9 years. The evidence in the TB literature on the reasons for this observed gap is incomplete. However, it is thought to be partly due to biological or epidemiological factors and partly to sociological factors, such as gender- or poverty-related barriers to access to services.

Thus, **lesson 2** is that the evidence base for gender-responsive health policies is weak, since health information and research are frequently gender-neutral, gender-blind or even gender-biased. Nevertheless, the observed differences between men and women are typically related to the interaction of sex with gender, and these need to be explored through gender-sensitive methods. It is not enough to assume that the observed differences are purely biological and unrelated to health system constraints.

In searching for reasons for the variations, the review team found research suggesting that, men and women with symptoms tend to seek care at the same rates and equally early. However, women have longer delays before actual diagnosis. Distance may be a stronger barrier for women, given their mobility constraints and lower access to household transport. They face high opportunity costs in the form of household and child care duties. So, women

may consult less qualified service providers or self-medicate in the first instance. In contrast, men are likely to know about and reach qualified providers (such as a DOTS center) earlier.

Therefore, **lesson 3** is that women and men have different health-seeking behavior patterns that reflect their gendered circumstances and barriers to access to services. Even where services are free, non-financial barriers to access may operate. Health systems need to recognize and cater to these differences. For example, transport subsidies can be targeted to women, if lack of transport is identified as a key barrier for them in a given setting.

The review team in Viet Nam also found that, even when they reach a qualified service provider (such as a DOTS center), women and men may not be diagnosed equally promptly. The research suggested that women may not present the ‘classic’ or ‘typical’ TB symptoms—a productive cough, loss of weight and appetite and fever. Thus, providers may not immediately recognize women’s symptoms and refer them for TB testing.

**Lesson 4**, therefore, is that research on many health conditions takes men as the norm and fails to account for crucial differences between men and women. Another example is that heart attack signs and symptoms differ significantly between women and men. Thus, women and their particular health concerns should be included in clinical trials. Health research should use gender-sensitive tools and methods, such as gender-responsive indicators. The role of women in health research should be promoted. Related to this, **lesson 5** is that service providers and the health system may not be responsive to women’s needs. They may need training to recognize and cater to differences between men and women.

Moving further along the pathway from infection to diagnosis, the research from Viet Nam suggested that, even when women’s symptoms are recognized and they are correctly referred for TB testing, women may produce a sputum sample of poorer quality or quantity than men, decreasing their chances of diagnosis. The research speculated that this may be because, in the Vietnamese context (as elsewhere), it is culturally less acceptable for women to cough and hack loudly in public, although this may help to produce an adequate sputum sample.

Thus, **lesson 6** is that women face cultural barriers to access to services that may be quite distinct from those that men face and may not be immediately obvious. There is a need for systematic gender analysis using gender-sensitive methods.

This example illustrates differences between men and women with regard to their health conditions, health-seeking behaviors, and barriers to access; the gender differences in health systems responsiveness; and gender bias in health information and research. Evidence increasingly documents similar examples across other health conditions—such as HIV/AIDS, cardiovascular disease, mental health, and others.

Moving the discussion beyond tuberculosis, gender is a crucial consideration vis-à-vis other aspects, or building blocks, of the health system too.

For example, in the area of **health financing**, health costs are rising, while resources are inadequate and may even shrink drastically during financial crises. Health resource allocation may be inefficient or ignore the differential disease burdens of women and men. Health insurance and social protection schemes are not typically designed for the informal sector, where women predominate. Benefit packages may not cater to women’s and girls’ health needs. In households, women often have unequal bargaining power and lack access to or

control over household resources. In other words, they face gender-related barriers to financial access to health services.

Gender-responsive approaches in health financing can seek to ensure that resources for health are maintained, not reduced, during economic crises. Gender-responsive budgeting can help ensure adequate resources as well as promote accessibility and affordability of services for women. Health and social protection insurance schemes should be tailored for informal sector workers and include women as beneficiaries.

In relation to the **health workforce**, we know that women are overrepresented in health occupations characterized by less education, lower pay, and less security and face inequities (and inefficiencies) in their salaries, promotion, training, deployment, security, work/life balance and self-esteem. Care-giving is increasingly informalized, adding to women's and girls' home-based care-giving burden, especially with the rising burdens of HIV and chronic non-communicable diseases.

In response, the skills of health workers should be strengthened so they can understand and apply gender perspectives in their work. Training and affirmative action for women health workers need to be combined with measures to improve their work/life balance and access to mentoring, networking and other types of support. Health workforce policies need to recognize women's important contributions in formal and informal care. National health accounts should measure home-based care. Informal care-givers, who are mostly women, need to be linked to formal and professional sectors through training, referral systems and other forms of support. Men's equal responsibility in care-giving work needs to be promoted.

From the perspective of **leadership and governance**, health policies need to promote intersectoral action for gender equality, involving the private sector (often women's first point of contact) and strengthening the accountability of health policy-makers and service providers on gender. Involving women's organizations can help increase women's effective participation in health policy- and decision-making from household to national and international levels.

WHO's conceptual framework on health systems strengthening comprises 6 building blocks: financing, health workforce, information, medical products and technologies, service delivery, and leadership and governance; and 4 goals: equity, responsiveness, social and risk protection and efficiency. The core values and principles of primary health care—equity, universal access, community participation—inform WHO's work on health systems.

WHO's gender mainstreaming strategy aims to promote attention to gender in all health policies and programmes, and to develop tools and resources to support this work. For example, WHO's Western Pacific Regional Office has a publication series entitled *Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professionals*, which shows what the links are between poverty, gender and various health conditions, why these issues matter for health professionals, and how they can be addressed.

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