



United Nations Nations Unies

---

United Nations Division for the Advancement of Women  
United Nations Economic Commission for Europe  
United Nations Development Programme

Expert Group Meeting on “The impact of the implementation  
of the Beijing Declaration and Platform for Action on the  
achievement of the Millennium Development Goals”  
United Nations Office at Geneva  
11-13 November 2009

## TRANSFORMING HEALTH SYSTEMS AND SERVICES FOR WOMEN AND GIRLS<sup>1</sup>

Expert paper prepared by:

**Piroska Östlin<sup>2</sup> \***

Karolinska Institutet, Sweden

Division for the Advancement of Women  
Department of Economic and Social Affairs  
United Nations, New York  
Fax: (212) 963-3463  
daw@un.org  
<http://www.un.org/womenwatch/daw>

---

<sup>1</sup> The main source for this paper is: *Unequal, Unfair, Ineffective and Inefficient: Gender Inequity in Health - Why it exists and how we can change it, Women and Gender Equity Knowledge Network. Final Report to the WHO Commission on Social Determinants of Health (1)*.

<sup>2</sup> The author would like to thank Professor Gita Sen, Indian Institute of Management Bangalore, India, and Professor Denny Vågerö, CHESS, Stockholm, Sweden, for their valuable contributions to this paper.

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

*“Where the right and needs of women are concerned, the gap between rhetoric and reality remains a yawning chasm.”*

Stephen Lewis. 2006. *Race Against Time: searching for hope in AIDS-ravaged Africa*. Toronto: House of Anansi Press Inc.

## **Health systems and services continue to fail women and girls**

Almost fifteen years after the adoption of the Beijing Declaration and Platform for Action, which identified important strategic objectives concerning women’s access throughout the lifecycle to appropriate, affordable and quality health care, information and related services (strategic objective C.1) and the need to strengthen preventive programmes that promote women’s health (strategic objective C.2), millions of women and girls across the globe have still no access to adequate health care and services.

Gender inequity in access to health services is pronounced in low- and middle-income countries, but it is prevalent in high-income countries too. These inequities often reflect two conceptually distinct dimensions: 1) insufficient acknowledgement of the biologically specific health needs of women and girls, and 2) biased health care services arising from unfair gendered power relations. The most obvious and striking expression of the failure to adequately address women’s biologically specific needs is the persistence of extremely high rates of maternal mortality in many parts of the world despite the widespread knowledge as to how to prevent such disasters. According to the recent report (2) by the WHO Secretariat to its Executive Board on “Monitoring of the achievement of the health-related Millenium Development Goals” and the United Nations’ “The Millennium Development Goals Report 2009” (3), the global maternal mortality ratio (MMR) of 450 deaths per 100 000 live births in 2005 has barely changed since 1990 and there is no measurable improvement between 1990 and 2005 in the African Region, where MMR is 900 per 100 000 live births. Moreover, MMR is among the health indicators that show the greatest gap between the rich and the poor – both between countries and within them. Recent reports present convincing evidence that health systems and services don’t only fail women in their reproductive years but throughout their life cycle (1,4,5,6).

This less than cheerful situation reflects serious failures of the chronically underresourced and pervasively inequitable health systems in all too many countries in the world, leading to lack of access and utilization of adequate care for women and girls. It also reflects bias in health systems linked to gendered structural determinants and processes; women’s and girls low economic, political, legal and cultural positions in families, communities and societies; biased values and norms; and pervasive inequities that permeate the organizational structures of many health systems, and the mechanisms through which health policies and services are designed and implemented.

The pupose of this paper is to discuss why health systems in many countries are unable to adequately deliver on gender equity and what actions can be taken to improve women’s and girls’ access and utilization of health services based on lessons from good practices from all over the world. In the final section there is a discussion on how different types of actions can accelerate achievement of the MDGs.

**Why are health systems and services in many countries unable to adequately deliver on gender equity?**

Gender inequities are endemic in health care systems globally. In part, this reflects insufficient attention by health systems to the needs of women and girls in planning and providing health services. For example, health services for women often focus on reproductive functions, and important women's and adolescent girls' health issues, unrelated to their reproductive role, tend to be shortchanged. Institutional indifference and lack of awareness of women's and men's specific health needs are reflected in the design of budget lines, supervision systems, staffing patterns, drug allocations and training curricula, which do not take this into account (7). Gender inequities in health systems also reflect more general gender inequities in society that impact on the utilization of health care. The root causes of these inequities are gender power relations that place women in subordinate positions and are reflected, among other things, in unequal access to and control over financial resources, strongly defined gender-based divisions of labour — also within health systems, unequal restrictions of physical mobility in some cultures, and unequal participation in decision-making at all levels. Many of these inequalities cannot be tackled by health systems on their own. Policies in sectors such as the labour market, social services or education are crucial for addressing gender inequalities, because these policies have direct and indirect impacts also on health risks and women's and girls' ability to access and utilize health care services.

Gender inequalities and gender power relations in health systems do not only impact on women as consumers, but also as providers of health care. The majority of the health work force is female, and the contributions of women to formal and informal health care systems are significant, but also undervalued and unrecognized (8,9,10,11). Health systems tend to ignore women's crucial role as health providers, both within the formal health system (at its lower levels) and as informal providers and unpaid carers in the home. It is estimated that up to 80 percent of all health care and 90 percent of HIV/AIDS related illness care is provided in the home (12). However, home carers remain unsupported and unrecognized by the health sector and policy makers. A recent review by George (8) examined the experiences of nurses, community health workers and home carers in health systems. The major finding is that these female frontline health workers compensate for the shortcomings of health systems through individual adjustments, at times to the detriment of their own health and livelihoods.

The politics of health systems may exacerbate inequitable access even further. In the past two decades, powerful trends in health sector reforms around the world involved increased emphasis on market-based solutions that characterised the era of structural adjustment. The era of structural adjustment may be over, but the effects of earlier damage continue to have fundamental consequences for women and girls. Reforms in Africa included the introduction of new financing mechanisms such as user fees, revolving drug funds, and other community-run financing schemes, as well as the use of essential drugs lists to ensure cost-effective use of resources. In the Americas, health sector reform is strongly focused on institutional change through decentralization, privatization, reform of social security systems and the separation between financing and delivery of health services (13). In Brazil, these reforms were implemented with strong involvement of civil society organizations, but this is not the case for all countries (14). Reforms in South East Asia have focused on decentralisation and

improvement of financing mechanisms (15). However, while health sector reforms have sometimes addressed their implications for the poor, consequences for gender equity in general and for health care specifically, are seldom discussed or taken into consideration in planning (16).

Available research on health system reform suggests that many of the reforms have raised barriers to access to essential care for the less well off, especially for women and children. For example, out-of-pocket expenditures for public and private health care services continue to drive many families into poverty in low- and middle-income countries (17,18). Women are more affected than men because of women's greater need for health care due to their reproductive functions and their greater social, cultural and financial vulnerability (19).

Evidence presented to the Commission on Social Determinants of Health strongly suggests that the direction of past health sector reforms was mistaken, and highlights the importance of recognizing and enhancing the redistributive nature of health care systems by emphasizing five policy goals: universal coverage; public financing; absence or near-absence of user fees for public services; access to a comprehensive range of services; and a private-sector role that clearly and equitably complements the public sector (20). These recommendations can be applied to health systems in rich and poor countries alike, and women and children especially would greatly benefit from their full implementation.

### **Example of good practices to minimize gender bias in health systems and services**

The Women and Gender Equity Knowledge Network, in its final report (1) to the WHO Commission on Social Determinants of Health, has identified a number of good practices to minimize gender bias in health systems. These policies and programmes have successfully contributed to the: (a) building of awareness and transformation of values among service providers, (b) removal of barriers to essential health services, and (c) development of effective mechanisms for accountability.

a) The lack of awareness and failures to recognize women's specific health needs are largely due to gender bias which leads to neglect and low priority. Developing skills, capacities and capabilities among health policy-makers and professionals at all levels of the health systems to understand and apply gender perspectives in their work is an important requirement for raising awareness and making health systems acknowledge women's and girls' health needs.

Transforming the medical curriculum is a key measure for building capacity of health care providers in gender analysis and responsiveness, as has been done in many countries, such as India, Argentina, Australia, Canada, the Netherlands and Sweden (21). In Kerala State, India, a three-year programme on gender sensitization for medical college teachers which complements the traditional medical texts has been developed. This initiative has now been rolled out to other Indian states. The Gender and Health Collaborative Curriculum Project includes faculty and students from the six medical schools of Ontario as well as members of the Undergraduate Education and the Gender Issues Committees of the Council of Ontario Faculties of Medicine (COFM) working together to produce a set of resources focused on the role of gender in medical education. The project aims to improve health care for both women and men through the development of a collaborative, web-enabled medical curriculum that

integrates gender and health into all aspects of medical education. This integrated curriculum will be a common provincial resource for use by all Ontario medical schools (22).

There are many more innovative approaches to gender sensitization of health care providers. For example, The Health Workers for Change project, which has been implemented in five African countries, Argentina and Pakistan, uses a participatory research and learning approach for bringing about improvements in quality of care with emphasis on the need for gender sensitivity in health services (23). Training programmes for primary health care nurses in rural South-Africa help them to acknowledge women's health needs and problems related to domestic violence and other forms of abuse (physical, sexual, psychological, and economic).

Patient education and health literacy is increasingly being emphasized as an effective measure to empower patients at all ages to demand the necessary information to allow them to make informed decisions about treatment options (21). The Convention on the Rights of the Child points at the obligations of health systems to treat adolescents and children according to their evolving capacity to understand the nature of health services and treatments. One example is the *"Smart Patient Coaching"* initiative in Indonesia - both women and men are trained to communicate more openly with family planning providers.

b) To build and strengthen equitable health care systems that meet the needs of women and girls requires the removal of financial, physical and cultural barriers of access to good quality care. User fees should not be collected at the point of access to the service and rules should be enforced that adjust user fees according to women's ability to pay. Available evidence creates a strong case for removal of user fees and provision of universal coverage for pregnant women, particularly for delivery care (24). Upgrading local health centres, setting up systems for reliable emergency transport, and making it possible for women and their attendants to stay near a health facility have yielded good results in countries such as Cuba, Sri Lanka, Uganda, China, and Bangladesh. Many lives could be saved by actions aimed at improving access to a skilled attendant at delivery and to emergency obstetric care, and by improving the referral system to ensure that women with complications can reach lifesaving emergency care in time.

The introduction of women- and adolescent-friendly services in some countries has helped to counteract judgemental attitudes of providers, and lack of privacy and confidentiality. These may include youth-only and men-only clinics, women-only services within existing services, or out-reach and community-based services. For example, Pakistan's "Lady Health Workers" programme provides door-to-door service for women whose mobility is constrained. As a result, uptake of services increased, adoption of contraceptives was improved as was community health in general (25). Establishing multipurpose clinics is also a good way of increasing women's and girls' access to health services. For example, integrating family planning services, reproductive health services and maternal and child health services increased women's access to care considerably as they are able to access various services in the same facility.

c) Measures to strengthen accountability of health systems to citizens are important for safeguarding access, quality and acceptability of health care services and treatment (26). Accountability processes should ideally involve citizens, including women and marginalized

men. For example in India, the Citizens' Campaign Against Sex-Selective Abortion uses several innovative strategies to monitor private health clinics' and providers' adherence to the Pre-natal Testing and Diagnostic Act. They work with pregnant women who are part of the campaign to bring those private clinics and providers who disclose the sex of the child or conduct sex-selective abortions to book, while protecting the right of women to abortion on other grounds (27). Health observatories have been set up in Latin America and elsewhere aiming at collecting data and to build accountability in order to reduce gender inequities in health. In Chile and Colombia these observatories are run by the ministry of women's affairs and in Spain by the ministry of health.

Based on the evidence reviewed, the Women and Gender Equity Knowledge Network has made the following recommendation regarding what health systems can do to improve gender equity (see box). Note that this recommendation concerns only one of seven approaches (including e.g. protecting and promoting women's and girls' human rights and engendering health research) to improve gender equity in health. All approaches and related action priorities are presented in the Final Report of the Women and Gender Equity Knowledge Network (1).

***Transform the gendered politics of health systems by improving their awareness and handling of women's problems as both producers and consumers of health care, improving women's access to health care, and making health systems more accountable to women***

**Action priorities:**

- Provide comprehensive and essential health care, universally accessible to all in an acceptable and affordable way and with the participation of women: ensure that user fees are not collected at the point of access to the health service, and prevent women's impoverishment by enforcing rules that adjust user fees to women's ability to pay; offer care to women and men according to their needs, their time and other constraints.
- Develop skills, capacities and capabilities among health professionals at all levels of the health system to understand and apply gender perspectives in their work.
- Recognize women's contributions to the health sector, not just in the formal, but also through informal care. Women as health providers in auxiliary, volunteer and informal care need multiple linkages to formal and professional sectors: training, supervision, acknowledgement and support, functioning referral systems linking them to drugs, equipment and skilled expertise.
- Strengthen accountability of health policy makers, health care providers in both private and non-private clinics to gender and health. Incorporate gender into clinical audits and other efforts to monitor quality of care.

*Source: Sen, Östlin and George (2007) (1)*

## Lessons learned

Although many of the underpinnings of women's and girls' health need to be tackled within the broader social and economic arena, the role of the health sector remains critical. The health system is a common good and a vital social determinant of health (28). In the short term, the health sector may be a promising entry point for gender equity-oriented policies and interventions, and for preventing impoverishment due to health care expenses. The evidence presented to the Commission on Social Determinants of Health and its Knowledge Networks on Health Systems and on Women and Gender Equity indicate that health systems are better geared to meet women's needs – in terms of access, comprehensiveness and responsiveness if they are organized around Primary Health Care (PHC). The *2008 World Health Report* (29) emphasizes the renewed relevance of PHC, which has the potential to deliver better and more equitably distributed health care to women if a) health care is organized around families and communities, b) prevention and promotion are in balance with investments in curative interventions, and c) mechanisms are in place to enable intersectoral action and women's participation in planning and designing health services. With effective leadership, well designed health policies and programmes developed by using the human rights framework and with the participation of women, institutional incentives and structures, and civil society linkages to ensure effectiveness and accountability, health systems can be transformed to better serve women (and men) at all ages.

## Accelerating achievement of the MDGs

Addressing the problem of gender inequality requires actions both outside and within the health sector because gender power relations operate across such a wide spectrum of human life and in such inter-related ways.

In particular, intersectoral action to address gender inequality is critical to the realization of the Millennium Development Goals (MDGs) as has been shown in the report of Task Force 3 on Gender Equality of the UN Millennium Project (30). Each one of the MDGs requires that strong efforts be made towards gender equality if the goal is to be achieved. Some of these efforts to achieve health goals need to be within the health sector, but many are outside as has been shown by Task Force 4 on Child Health and Maternal Health of the UN Millennium Project (31) and by the Countdown to 2015 group (32). The health sector may take leadership but it must also act in collaboration with other sectors. Failing that is probably what is behind the failure in achieving MDG5.

All MDGs are related to health, directly (MDGs 4, 5 and 6) or indirectly (MDGs 1, 2, 3, 7, 8). The different Millennium Development Goals are linked so that the achievement of one goal makes it more likely to achieve the others: a healthy population can move out of poverty; education of girls and women is going to promote their health as well as that of boys and men.

Transforming health systems for women and the girl child in order to achieve more equitable access and better quality health services thus contributes to all MDGs. Removing user fees for maternal and child care, providing affordable care to all women and preventing impoverishment due to "catastrophic" health care expenses contribute to the achievement of MDG 1 on the eradication of extreme poverty and hunger. Patient education and health

literacy programmes will empower female and male patients; education programmes for health care providers in both formal and informal care to better understand and apply gender perspectives in their work will bring in women's voices in the planning of health services, contributing to progress towards MDG 2 on primary education and MDG 3 on gender equality and women's empowerment. Investing in infrastructures that save on time and drudgery, and improve transports, contributes to the achievement of MDG 7 on environmental sustainability and to the removal of gender-based barriers to health care for women and girls at all levels.

Taking such actions is good for the health of all people - girls and boys, women and men. Global partnerships for development (MDG 8) will need women at the centre stage.



## REFERENCES

1. Sen G, Östlin P, George A. *Unequal, Unfair, Ineffective and Inefficient: Gender Inequity in Health - Why it exists and how we can change it*, Women and Gender Equity Knowledge Network. Final Report to the WHO Commission on Social Determinants of Health. Bangalore and Stockholm: Indian Institute of Management and Karolinska Institute; 2007.  
[http://www.who.int/entity/social\\_determinants/resources/csdh\\_media/wgekn\\_final\\_report\\_07.pdf](http://www.who.int/entity/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf).
2. World Health Organization. (2008). *Monitoring of the achievement of the health-related Millennium Development Goals. Report by The secretariat*. EB124/10. Geneva: World Health Organization.
3. United Nations (2009). *The Millennium Development Goals Report 2009*. New York: United Nations.
4. World Health Organization. (2009). *Women and Health: Today's Evidence Tomorrow's Agenda*. Geneva: World Health Organization.
5. Temin M, Levine R. (2009). *Start with a girl. A new agenda for global health*. Washington: Center for Global Development.
6. UNICEF. (2007). *The State of the World's Children. Women and Children. The Double Divident of Gender Equality*. New York: UNICEF.
7. George A, Iyer A, Sen G. (2005): *Gendered health systems biased against maternal survival: preliminary findings from Koppal, Karnataka, India*. Brighton IDS Working Paper No 23.
8. George A. (2010). Exploring the Gendered Dimensions of Human Resources for Health. In: Sen G, Östlin P. (eds). *Gender Equity in Health. The Shifting Frontiers of Evidence and Action*. New York: Routledge.
9. Ogden J, Esim S, Grown C. (2006) Expanding the care continuum for HIV/AIDS: bringing carers into focus. *Health Policy Plan*, 21, 333-42.
10. World Health Organization (2006) *The World Health Report - working together for better health*. Geneva: World Health Organization.
11. Joint Learning Initiative (JLI) (2004) *Human resources for health: overcoming the crisis*. Cambridge: Joint Learning Initiative, Harvard University Press.
12. Uys L. (2003) Guest editorial: longer-term aid to combat AIDS. *J Adv Nurs*, 44, 1-2.
13. Batthyany K, Correa S. (2010). Gender, Health, Poverty in Latin America. In: Sen G, Östlin P. (eds). *Gender Equity in Health. The Shifting Frontiers of Evidence and Action*. New York: Routledge. (forthcoming)
14. Tajer D. (2003) Latin American social medicine: roots, development during the 1990s, and current challenges. *Am J Public Health*, 93, 2023-7.
15. Sharma DC. (2000) WHO to support health reforms in South East Asian region. *The Lancet*, 356, 839.

16. PAHO. (2001). *Evaluating the impact of health reforms on gender equity - a PAHO guide*. Washington: Pan American Health Organization.
17. van Doorslaer E, O'Donnell O, Rannan-Eliya RP, Somanathan A, Adhikari SR, Garg CC et al. (2006). Effect of payments for health care on poverty estimates in 11 countries in Asia: an analysis of household survey data. *The Lancet* 368:1357-64.
18. Xu K, Evans DB, Carrin G, Aguilar-Rivera AM, Musgrove P, Evans T. (2007). Protecting Households From Catastrophic Health Spending. *Health Affairs*, 26:972-83.
19. Neema, S. (2005): *The impact of health policies and health sector reform on the readiness of health systems to respond to women's health needs, with special focus on reproductive health, reproductive rights and HIV/AIDS*. UN Division for Advancement of Women (DAW) Experts Group Meeting. Bangkok, Thailand. <http://www.un.org/womenwatch/daw/egm/enabling-environment2005/documents.html>
20. Gilson L, Doherty J, Loewenson R, Francis V. (2007). *Challenging Inequity Through Health Systems. Final Report of the Knowledge Network on Health Systems for the WHO Commission on Social Determinants of Health*. Centre for Health Policy at the University of the Witwatersrand, South Africa, EQUINET and the Health Policy Unit of the London School of Hygiene and Tropical Medicine, UK. [http://www.who.int/social\\_determinants/resources/csdh\\_media/hskn\\_final\\_2007\\_en.pdf](http://www.who.int/social_determinants/resources/csdh_media/hskn_final_2007_en.pdf).
21. Govender V, Penn-Kekana L. (2010). Challenging Gender in Patient-Provider Interactions. In: Sen G, Östlin P. (eds). *Gender Equity in Health. The Shifting Frontiers of Evidence and Action*. New York: Routledge. (forthcoming)
22. Ontario Women's Health Council. (2007). Gender and medical education toolkit. In: *Gender and Health Collaborative Curriculum Project*. <http://www.genderandhealth.ca/en/modules/>.
23. Fonn S, Xaba M. (2001) Health Workers for Change: developing the initiative. *Health Policy And Planning*, 16, 13-18.
24. Witter S, Adjei S, Armar-Klemesu M, Graham W. (2009). Providing free maternal health care: ten lessons from evaluation of the national delivery exemption policy in Ghana. *Global Health Action* Vol (2). <http://www.globalhealthaction.net/index.php/gha/article/view/1881/2128>
25. Douthwaite M, Ward P. (2005): Increasing contraceptive use in rural Pakistan: an evaluation of the Lady Health Worker Programme. *Health Policy Plan*. 20, 117-23.
26. Murthy RK. (2010). Accountability to Citizens on Gender and Health. In: Sen G, Östlin P. (eds). *Gender Equity in Health. The Shifting Frontiers of Evidence and Action*. New York: Routledge. (forthcoming)
27. Gupte M. (2003): *A Walk Down Memory Lane: An Insider's Reflections on the Campaign Against Sex-Selective Abortions*. Masum, Pune, India.
28. Commission on Social Determinants of Health. (2008). *Closing the Gap in a Generation: Health equity through action on the social determinants of health* (final report). Geneva: World Health Organization.
29. World Health Organization (2008). *World Health Report 2008: Primary Health Care – Now More Than Ever*. Geneva: World Health Organization.

30. Grown C, Rao Gupta G, Kes A. (2005). *Taking action: Achieving gender equality and empowering women. Report of the UN Millennium Project Taskforce on Education and Gender Equality*. London and Virginia: Earthscan.
31. Freedman LP, Waldman RJ, de Pihno H, Wirth ME, Chowdhury AMR, Rosenfield A. (2005). *Who's got the power? Transforming health systems for women and children. Report of the UN Millennium Project Taskforce on Child Health and Maternal Health*. London and Virginia: Earthscan.
32. Countdown Coverage Writing Group, on behalf of the Countdown to 2015 Core Group. (2008). Countdown to 2015 for maternal, newborn, and child survival: the 2008 report on tracking coverage of interventions. *The Lancet*, 371: 1247–58.