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

Written statement*

Submitted by

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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.

Introduction[1]

First of all, I'd like to thank the organizers for inviting me to participate in this important panel. I also would like to congratulate the organizers for the excellent Issues Paper prepared for this session. I've been asked by the organizers to talk about ways to strengthen health systems[2] so that they ensure equality in access to health care for all women and girls. To respond to this request, I've divided my presentation into two main sections:

- The health situation in the Americas; and
- Ways to strengthen health systems: the renewal of Primary Health Care in the Americas and beyond.

The health situation in the Americas

Important progress has been made in terms of health and human development in the region of the Americas. Average values for nearly every health indicator have improved in almost every country in the region: infant mortality has decreased by about one-third, all-cause mortality has declined in absolute terms by 25 percent; life expectancy has increased, on average, by six years; deaths from communicable diseases and diseases of the circulatory system have fallen by 25 percent; and deaths from perinatal conditions have decreased by 35 percent.

Considerable challenges remain, however, with some infectious diseases remaining as significant health problems; HIV/AIDS continues to challenge nearly every country in the region, and non-communicable diseases are on the rise. In addition, the region has experienced widespread social and economic shifts, with significant health impacts. These include aging populations, changes in diet and physical activity, the diffusion of information, urbanization, and the deterioration of social structures and supports which have contributed to a range of health problems such as obesity, hypertension, and cardiovascular disease; increased injuries and violence; and problems related to alcohol, tobacco, and drugs.

Unfortunately, these trends exist in the context of an overall worsening of health inequities. For example, 60 percent of maternal mortality takes place in the poorest 30 percent of countries, and the gap in life expectancy between the richest and the poorest has reached nearly 20 years within some countries.

During the past decade, economic adjustment practices, globalization pressures, and the impact of some neoliberal economic policies have, along with other factors, contributed to disparities in wealth, status, and power among and within countries in the Americas, which in turn, further exacerbated health inequities.

Midpoint evaluations on the progress made to attain the MDGs, without considering the impact of the current food, energy and financial crisis, signal that the Region of the Americas is making significant progress in reducing hunger, increasing primary schooling for boys and girls alike, reducing child mortality and combating tuberculosis. On the other hand, they signal that targets

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[2] WHO defines health systems as "all the organizations, individuals, and activities whose primary purpose is to promote, restore or maintain health".

on reducing extreme poverty, reducing maternal mortality and combating HIV/AIDS and malaria are not expected to be met by 2015.

In terms of health system performance, there is progress in coverage of key interventions such as immunization, attended deliveries and antiretroviral treatment, as well as increases in health expenditures. Many countries however, rich and poor, have poorly-performing health systems that are ill-equipped to deal with current challenges, let alone future threats. Among the many challenges facing health systems we can mention:

- Unacceptably low levels of coverage in many areas;
- Highly segmented and fragmented health care systems;
- A weakened or absent steering role of the national health authorities;
- Unacceptably low levels of available funding for health and very high levels of out-of-pocket payments;
- Severe shortages of health workers in some countries and inappropriate skills mix;
- Lack of preventative interventions targeted at individuals;
- Lack of health promotion services such as health education programs promoting healthy lifestyles; and
- Lack of public health interventions such as health situation analysis, health surveillance, infectious disease control activities, environmental protection and sanitation services, disaster and emergency preparedness and response systems, and occupational health services.

In response to this situation, over the past three decades a variety of health reforms have been introduced in most countries of the Americas. Reforms have been initiated for a range of reasons, including rising costs, inefficient and poor-quality services, shrinking public budgets, and as a response to the changing role of the state. Despite considerable investments, most reforms appear to have had limited, mixed, or even negative results in terms of improving health and equity.

Ways to strengthen health systems: the renewal of Primary Health Care in the Americas and beyond

The Alma-Ata Declaration of 1978 emerged from the International Conference on Primary Health Care (PHC) as a major milestone of the past century in the field of Public Health. Motivated by gross inequality in health status within and between countries, and arguing that health is essential to social and economic development, the Declaration identified PHC as the main strategy to the attainment of Health for All (HFA).

The Declaration was a distinct approach for its universal values of right to health care, equity, solidarity, social justice, universality, participation and intersectoriality; and its global vision. This vision was not an implementation plan but a political vision.

There are several reasons for adopting a renewed approach to PHC, including:

- A recognition that many conditions that led to the social and political goal of HFA and to the strategy of PHC still exist and are, indeed, even more pronounced.
- The rise of new epidemiologic challenges that PHC must evolve to address such as globalization, armed conflicts, job insecurity, feminization of poverty, migration, overcrowding, pollution and environmental degradation, domestic violence, human trafficking, street children, teenage pregnancy, HIV/AIDS, tobacco consumption and chronic conditions such as obesity;

- The need to correct weaknesses and inconsistencies present in some of the widely divergent approaches to PHC, mainly the adoption of selective PHC in many developing countries; and
- A growing recognition that PHC has led to considerable improvements in health in many locations and countries.

International evidence suggests that health systems based on a strong PHC orientation have better and more equitable health outcomes, are more efficient, have lower health care costs, and can achieve higher user satisfaction than those whose health systems have only a weak PHC orientation.

A renewed approach to PHC is viewed as an essential condition for meeting internationally agreed-upon development goals such as those contained in the United Nations Millennium Declaration as well as the Millennium Development Goals.

In the Americas, the efforts for renewing PHC started in September of 2003. That year, PAHO's 44th Directing Council passed *Resolution CD44.R6* calling for Member States and PAHO to adopt a series of recommendations to strengthen PHC, including the process for defining future strategic and programmatic orientations in PHC. As a result, in September 2005 PAHO's 46th Directing Council approved the *Regional Declaration on the New Orientations for PHC*, also known as the *Declaration of Montevideo*.

All over the world, there is a renewed interest in PHC. Under the leadership of the WHO Director General, Dr. Margaret Chan, many countries around the world are discussing the significance of PHC for addressing the health challenges of the 21st Century. During 2007 and 2008 regional meetings to discuss PHC were held in all six WHO Regions. These efforts have been complemented by the celebration of the 30th Anniversary of Alma-Ata in Almaty, Kazakhastan, in October 2008 and by dedicating the World Health Report 2008 (WHR 2008) to PHC. In addition, WHO is going to submit a Resolution on PHC to the World Health Assembly in May 2009.

In the following section of my intervention, I'd like to discuss the four sets of reforms to strengthen PHC proposed by the WHR 2008:

Universal coverage reforms

PAHO estimates that about 25% of the Latin American and Caribbean population (200 million people) lack access to essential health services. Inequalities in access to health care disproportionably affect the poor, uneducated, rural, afro-descendent and indigenous populations. For example, the lack of access to family planning services is considerable higher in women without education than in women with primary and secondary education. It is also higher in teenage girls, in women living in rural areas and in indigenous women. In countries such as Ecuador and Guatemala, the percentage of women reporting that they have never had a Papanicolaou is two times higher in indigenous people than in other ethnic groups. In addition, 60% of countries in the Americas have limited access to essential medicines.

In general, there is a lack of sufficient financial resources for health, as well as serious problems in health expenditures due to the disproportionate amount of direct out-of-pocket expenditures. In Latin America and the Caribbean countries public health expenditure, as a percentage of GDP, represents only 3.3% of total spending compared to over 7% in Canada, United States and the European Union. In addition, public health spending represents 48% of total health spending compared to more than 70% in Canada and the European Union.

According to PAHO, out-of-pocket expenses by women are 16% to 60% higher than by men, particularly during their reproductive ages. There is also a considerable gap in the levels of contribution to social security schemes between men and women. In the year 2002, only 19% of women contributed to social security compared to 32% of men. Moreover, in countries like Chile, the premiums paid to private health insurers by women in reproductive ages are 2.2 times higher than those paid by men. Another area of concern is the lack of comprehensive package of services and entitlements for women. For example, some family planning programs don't always cover the costs of services associated with complications of abortions or antiretroviral treatment. In addition, young and older women are usually not covered by insurance schemes.

In response to the above challenges, some countries in the Americas have opted for implementing comprehensive financing and health insurance reforms, with various degrees of success. These experiences include the creation of the Unified Health System in Brazil, the Social Protection Reform in Colombia and the Health Explicit Guarantees in Chile. On the other hand, other countries pursued health financing and insurance schemes targeted to specific population groups, and include experiences such as the Universal Maternal and Child Insurance Plan in Bolivia, the Comprehensive Health Insurance Plan in Peru and the Free Maternity and Child Care Law in Ecuador.

Like all aspects of health system strengthening, changes in health financing must be tailored to the history, institutions and traditions of each country. However, important principles to guide any country's approach to financing include:

- Raising additional funds where health needs are high and/or revenues insufficient, and improving accountability mechanisms in order to ensure transparent and effective use of resources.
- Contributing according to affordability (progressivity or fairness of financial contribution).
- Reducing reliance on out-of-pocket payments where they are high, by moving towards pre-payment systems.
- Taking steps to improve social protection by ensuring that the poor and other vulnerable groups have access to needed services and that paying for care does not result in financial catastrophe.
- Improving efficiency of resource use by focusing on the appropriate mix of activities to fund and inputs to purchase.

Service delivery reforms

Improving the quality of health services is particularly important in conditions such as maternal mortality. Although on average 91% of deliveries in the Americas are attended by trained personnel, approximately 7 in 10 deliveries in Guatemala and Haiti, and 4 in 10 deliveries in Bolivia, are performed by non-trained personnel. In addition, only 30% deliveries of indigenous women are made by trained personnel compared to over 80% in non-indigenous women.

In the Americas, service delivery arrangements for women are highly fragmented due to the predominance of disease-specific interventions and the predominance of acute, curative and hospital-centered models of care. Surveys conducted by PAHO show that the fragmentation of health care services is perceived as a major problem by managers and providers alike. Only 22% of respondents from first level of care and 35% of respondents from specialized care say that the referral and counter-referral systems between levels of care work adequately.

Health workers are the most essential component of a health system, but they are inadequately prepared to work in contexts based on PHC. We also need to take better care of our caregivers. In the Americas, 70% of the health workforce is composed of women. Moreover, the majority of the care provided at the household and community levels is given by women. Women usually take care of the children, the elderly and the sick, limiting their ability to find paid jobs and/or pursue other interests. Therefore, the out-sourcing of care at the community and household levels needs to be resourced so it doesn't become a disproportioned burden on women, particularly in the case of caring for chronic conditions.

Some of the service delivery reforms that could be considered by countries include:

- Implementing gender and culturally sensitive models of care which are person-centered (as opposed to centered on specific illnesses and risks).
- Strengthening the first level of care so it covers the entire population and provides comprehensive, integrated and continuing care over the life course.
- Supporting the integration of the first level of care, specialized care and the social protection network through the development of adequate referral and counter-referral systems.
- Implementing quality assurance and continuous quality improvement mechanisms across the entire spectrum of health care.
- Developing long-term, sustainable and comprehensive human resources policies directed not only toward improving traditional imbalances between education and services, but also toward solving problems of migration, multiple employment, civil service careers and improving the skills of the labor sector.

Public policy reforms

In the Americas, the integration of public policy-making across different sectors is more often an aspiration than a reality. Moreover, public policies within the same sector are often fragmented and disjointed. There is also a disregard for the importance of public health and health promotion in most health systems of the Region.

PHC-based health systems should be intimately connected to intersectorial actions and community approaches to promote health and human development. These actions are required in order to address the "up-stream" determinants of population health by creating links with other sectors and actors.

An emphasis on prevention and promotion is a paramount feature of a PHC-based health system and means going beyond a clinical orientation to embrace health education and counseling at the individual clinical level, regulatory and policy-based approaches to improving peoples' living and working environments, and population-based health promotion strategies carried out with other parts of the health system or with other actors.

In Brazil for example, a special program for empowering families in combating domestic violence was developed in Sao Carlos. The program started at the police station to attend the increasing cases of intrafamily violence, but was transferred to first level care services so that health works could better prevent and provide comprehensive care to women and their families. The model continues as a partnership with the university, the municipal health center and a women's health shelter. Results include improved capacity of health workers to detect and attend

family violence, improved referral systems for integrated care of affected women, men and their families, as well as decreased violence among the 800 users.

In this area, some of the reforms that countries should consider include:

- Legislating and enforcing measures that promote gender equality across all sectors of the economy;
- Setting up within the central administration and providing adequate and long term funding for gender equality units;
- Prioritizing the allocation of resources for health promotion and public health interventions, particularly for women and girls.
- Supporting innovative government management models and incentive structures that can encourage intersectoral cooperation across different sectors and actors.
- Implementing "health-in-all" policies across all government sectors and society at large.

Leadership reforms

Until recently, social participation in the Americas has been confined mainly to supporting the implementation of health programs through Community Health Workers, the majority of which are women, and contracting-out services to NGOs.

Local-level participation in the health system by individuals and communities needs to be strengthened in order to provide them with a voice in decision-making, resource allocation, evaluation and enforcing the accountability of the health system. In addition, more needs to be done in terms of informing women on their health care rights, as well as on their mechanisms for filling complains and managing conflict resolution.

In Bolivia, a special program involving the municipalities of Calamarca and Morochata sought to "build bridges" between the community and providers through an intercultural and gender approach. The program involved first level providers, community promoters, mostly indigenous women users, as well as men to address the high rates of maternal and infant mortality. The program trained users and promoters about women's human, sexual and reproductive rights and brought them together with service providers to express their needs and demand better services. Evaluation results showed that the program resulted in better care that culturally sensitive, higher attendance and satisfaction, and ultimately in reduced infant mortality rates and violence committed by partners.

The ultimate responsibility for organizing PHC-based health systems around the values that drive PHC belongs to government. In this regard, the mushrooming of initiatives and stakeholders working towards the health MDGs in low income countries overwhelms the limited capacity of their Ministries of Health. Coordination and alignment are necessary but not sufficient: there is an urgent need for a massive re-investment in government capacities.

Some of the leadership reforms that could be pursued by countries are:

- Implementing formal mechanism for social participation in health at all levels of the system.
- Ensuring that women and girls are fairly represented at the social participation bodies.
- Strengthening the steering role of health authorities at the national, regional and local levels of government so that they can perform their core functions.

- Disaggregating health data by sex and other variables such as age, place of residence and ethnicity.

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