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FEMALE-FRIENDLY SERVICES: A RESEARCH/ACTION INITIATIVE

This document explores women's health care in Latin America and the Caribbean and discusses the differences and disparities that are observed in the delivery of health services and the resulting discrimination against women. Attention is drawn to the need to reconsider the health care model from the gender perspective in order to make it fairer and more effective. The concept of "female-friendly services" is explained, and research/action methods are proposed for evaluating the existing services from the gender perspective and promoting positive changes in them. To that end, elements for preparing research protocols are provided, and several instruments for examining the services from the gender perspective are suggested.

The document refers to the activities that PAHO might undertake as part of its technical cooperation and points out experiences that the Organization has supported in the countries of the Region.

The Subcommittee is requested to review the document and comment on the feasibility and desirability of promoting research-action in this field, as well as to suggest possible approaches for promoting acceptance of and commitment to these concepts in order to pave the way for mobilization of the necessary resources.

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1. INTRODUCTION

The integration of women into health and development as one of the strategic orientations of the Pan American Health Organization for the quadrennium 1991-1994 means recognizing the need for formulating and evaluating health policies, programs, and services from a gender perspective. The inclusion of this perspective, in its broadest sense, can be a vehicle not only for improving the situation of women, but also for helping to make society as a whole fairer.

In the framework of primary health care, the forms of intervention aimed at women must be urgently reconsidered, and those problems must be assessed that are not very visible in health statistics. Health care models must be designed to better serve the biological, psychological, and social needs of women. Ideas must be generated immediately and instruments proposed for the research and practical and program work needed to move forward in this field.

Approximate knowledge of the reality of the health situation of women in the Americas, the contribution of empirical observations, and the results of research concerning the way that the health services respond to women necessarily call for a new orientation of these services.

The reorientation of the health services to be more responsive to the needs of women should benefit families, as well, and should improve the quality--in terms of comprehensiveness--of care, which in turn will increase the coverage of health promotion and protection actions.

Incorporation of the gender perspective in the planning of local health systems and the process of decentralizing the sector will strengthen the possibility of meeting women's needs and will bolster a comprehensive approach to the provision of services to families and the community. The gender perspective aims to identify sexist practices and conceptions that affect the living conditions and health of men and women and that are reflected in health institutions, thereby perpetuating a set of standards, habits, and behaviors within the system that place women at a disadvantage.

Through the formulation of the "female-friendly services" initiative, PAHO is endeavoring to respond to this situation of asymmetry and lack of equity in service delivery. The initiative is a means or strategy for transforming health services, aimed at converting them into promoters of the complete development of women, in which the gender gaps present in the current model are reduced to a minimum. Accordingly, the basic purpose of the women-friendly services proposal is to bring about changes in the

health services, based on recognition of the gender-specific needs of women and the desire to contribute to their development as persons with rights in regard to health.

Obviously, a universal model cannot be proposed; rather, each community will have to develop its own culturally appropriate model. Thus, the word "friendly" implies a component of efficiency, a component of quality, and also a component of user-satisfaction, while at the same time not disregarding the perceptions of health personnel, which are reflected in their predisposition to providing care for people, in particular women.

This document will propose the basic elements for preparing research protocols that are appropriate to different scenarios and will present some instruments that have been used on a trial basis in countries of the Region. Copies of the guides and questionnaires can be made available to anyone needing them.

2. OBJECTIVES

2.1 General objective

To construct, in a process in which the health workers and women of the community participate, a model for examining health services that will facilitate a critical analysis of the quality of health care provided to women, with a view to transforming the system to better meet women's biological, psychological, and social needs.

2.2 Specific Objectives

a) To identify the factors that favor or impede the recognition of women as persons with health rights.

b) To identify the discriminatory barriers and gender gaps that detract from the quality of the care provided to women.

c) To provide the health services and the community with a qualitative and quantitative model for examining the services.

d) To recommend changes or reorientations in health care services that will contribute to the full human development of women.

e) To support, applying a gender perspective, transformation of the health services and optimization of their management through the impetus of participatory processes of critical observation of the quality of care, within the framework of development of local health systems.

3. RATIONALE

The gender perspective makes it possible to view women as health-service users with specific health needs. It is rooted in an awareness that biological, psychological, and social differences affect health-disease processes and shape the epidemiological profiles of males and females in distinct ways.

Women's biological, psychological, and social differences and disadvantages affect them in special ways in health systems. For example:

- Women's health care is generally limited to a focus on the reproductive function.

- Other health problems not connected with that function, such as those relating to physical abuse or violence, sexuality, aging, mental health, and occupational health, are ignored.

- The passive role imposed on patients by health services exacerbates the position of social disadvantage of women as a gender, particularly in the low-income social strata.

- The grouping of programs solely on the basis of age and rigid biological data does not take into account differences in psychological and social characteristics, which imply different experiences and therefore different specific health needs and demands on the part of women.

- Women predominate in the health services, whether as users, companions, or providers, in the formal system as well as in the informal system.

If these particular factors are considered, then the specific demands and real needs of women can be met in a more satisfactory manner by reorienting the services in accordance with a new vision of women's health problems, which will also increase democratization of the services, both in terms of accessibility and quality.

Most evaluations of the quality of health care suggest that the existence of difficulties in the user/provider relationship can impair quality substantially, even though

the technical and scientific quality of the service may be satisfactory. Currently there is no comprehensive model available to evaluate both the aspects of structure, process, and result, on the one hand, and the effect of the service/user and service/community relationships on the quality of the health care, on the other.

There is a close relationship between the quality of care and the type of relationship that is established between the health provider, the female user, and the community, and more needs to be known about this.

When a female patient comes to a health service, she is not viewed as being the bearer of a history of social disadvantage. The service, in turn, by reproducing the system of social disadvantage, perpetuates the subordination of women through discriminatory practices.

This initiative proposes a model for examining health services in order to determine the critical areas within the system of disadvantages and identify the factors to be addressed. This identification will serve to recommend changes in or reorientation of the services and suggest new types of care which will favor the full development of women and, therefore, have an impact on their quality of life and health.

Considering that women are proportionally the largest participants in the supply of, demand for, and interaction with health services, a model constructed from the gender perspective would make it possible to identify the specific health needs of women, their interests, and their difficulties, and would foster closer ties with the communities and democratization of the services in terms of knowledge, power, and access.

This proposal is aimed at getting health providers and users alike, in a joint process, to take a critical look at the provision of health services, in such a way as to foster community participation in the process of transformation of the services. Examination of the nature of relationships will lead to scrutiny of the power mechanisms that undermine the quality of service and lower the levels of satisfaction. It also proposes a process of democratization within the services.

This collective process, involving both health care users and providers, will make it possible to create opportunities for participation that will help in the search for and strengthening of common interests.

4. ELEMENTS FOR PREPARING A PROTOCOL

There is a consensus that the health services basically respond to the demands arising from illness. Despite recent trends to foster health promotion, the delivery of services and the allocation of resources continue to be geared toward the treatment of illness.

In general, evaluation models also adhere to this ideology. Most of them are aimed at evaluating the quality of curative care and pay little attention to the social milieu where the explanation for many pathologies may be found. In addition, they are limited to evaluating quality in a relationship of an individual nature and not in the set of relationships and interactions that intervene in the health/disease process, which frequently goes beyond the medical aspect.

The limitations of the prevailing biomedical model prevent recognition of the fact that the quality of health care is influenced by the different living conditions of men and women, and especially the perpetuation in the health services of the system of disadvantages that generally works to the detriment of women in society.

This model has an effect on the quality of the care provided to both men and women, but its effect is more specific and marked in the case of women. The frequent "uterization" of women is explained by the reduction of the female body to one organ and one function. The result has been a theory and practice translated into a limited supply of services associated basically with reproduction.

Furthermore, the services provided reflect the social view of women reduced to their role as mothers, which assumes the "natural" acceptance of this role by women. Thus, the biomedical focus on the woman/uterus is validated by the social perception of the woman/mother. They mutually reinforce one another. Health providers generally relate to women as an organ (uterus) or in terms of their function as mother/reproducer.

These two views fail to conceive of women as whole beings--that is to say, biological, psychological, and social beings who, because of their place in the hierarchy of the sex-gender system, occupy a position of subordination, which is translated into greater vulnerability to certain diseases or insufficient attention to others, or else neglect of proper prevention of female processes and pathologies. Some noteworthy examples of the various expressions of this subordination are:

- Anemia and malnutrition, with their disproportionately greater negative effect on women.

- Maternal morbidity and mortality, which are unacceptably high, considering that most of the causes are preventable.

- Cervical cancer, since this can be prevented.

- Mental disorders, particularly depression, owing to its association with emotional pressures resulting from the social definitions of the functions of gender.

- Violence against women committed by their mates.

- Additional physical and mental wear and tear resulting from handling a double work day.

- Disability from chronic diseases during old age, aggravated by the absence of social security benefits.

- Unwanted pregnancy and its social and emotional impact.

- Unwed mothers and early maternity.

- Bone and muscle diseases.

As may be noted, these health problem are inseparable from the psychosocial status of women, their roles, and their social functions. To make matters worse, women frequently do not look upon these conditions as health problems, and when they do, they themselves postpone seeking medical care or disregard the symptoms. If they eventually do visit a health facility, their symptoms are generally downplayed or they are given unsatisfactory care, confined to biological aspects.

The absence of a comprehensive approach in the care provided to women and the profit-oriented practice prevailing in the private sector marginalize women and discourage them from seeking help for other problems not associated with reproduction. As a result, there are a significant number of missed opportunities to fulfill other needs of women.

When a health facility discriminates against women it is denying them their chance or ability to exercise their rights. In regard to health, for example, when a woman is compelled to use a contraceptive method or if she is manipulated into adopting it, then her freedom and self-determination are being denied, perhaps because she is considered incapable of making a decision, or it is presumed that she does not understand the information, or it is believed to be the province of the medical profession to decide

on a woman's fertility. Power derived from knowledge is imposed as a medical act. Thus, the worth of female patients is diminished and they are mistreated at two levels:

a) The level of the hierarchies within a class structure where the expert, male or female, is the one who knows and the patient is the one who supposedly does not know.

b) The level of oppression of the female sex, which is expressed in the hierarchical relationship between men and women, in which women are subordinated and viewed as objects and not as subjects.

Health services reproduce and recreate discriminatory practices against women when they depreciate them or attach stereotyped roles to them and orient health practices towards those roles by espousing such ideas as:

- The experience of motherhood makes a woman complete (unwanted pregnancy, abortion, etc. are forgotten).

- No woman is completely happy if she is deprived of the experience of motherhood.

- Motherhood means happiness.

- Elderly women should no longer think about sex.

- Pregnancy is easier or more difficult depending on the sex of the fetus.

- Girls are more passive, etc.

- Women are hysterical, great pretenders, conflictive, very demanding, hypochondriac, etc.; this mind-set refuses to look at symptoms in a new light that would reveal situations of crisis, identity, and shifts in values, which can be expressed through numerous symptoms and/or diseases.

The social construct of what is female has revolved around motherhood. Women are viewed as a function and frequently women look upon themselves as a function. Their life is constructed as a response to the cultural imperatives proposed for what is female. The new social roles that women are taking on in great numbers (as professionals, active participants in the political process, income earners, etc.) present a situation of change that challenges the traditional conception of women's identity and gives rise to new questions, new social relationships, and new lifestyles. These changes, in turn, place new demands on the health services that transcend the framework of the

traditional medical approach that has been taken to maternal and child health. Some of the new problems and demands have to do with women's self-esteem (their perception and assessment of themselves) and the deterioration in women's mental health, the identity crisis and the emergence of new forms of autonomy and self-determination that imply substantial changes in the way women relate to their bodies and the body processes specific to them (menstruation, procreation, sexuality, aging, nursing), as well as the way they approach health-disease processes and their own lives.

This changing situation compels the services to reconsider the way they relate to women, provide nontraditional responses, be innovative in their health care practices, and change their perception of women in the various phases of their life cycle. This means no longer viewing women simply as patients, but accepting them as beings involved in a process of change, as subjects--that is to say, as biological, psychological, and social beings who historically have been impeded from attaining their full human development.

The proposal to transform health services into female-friendly services means conceiving of them as a vehicle for social mobilization aimed at bringing the health services closer to women in terms of offering suitable, effective, and timely responses, which not only repair injury but serve to endow women with rights in the area of health; in other words, it means viewing women as people who are able to decide freely and independently on matters concerning their bodies, sexuality, health, and life.

This empowerment of women refers both to individual beings and to groups, in accordance with the particular circumstances, for example: groups of battered women, where the health service's support process is aimed at fostering women's independence so that they can break free of the bonds of violence. The same can occur with groups of pregnant women, where the support process should respond to the needs stemming from physical changes, as well as needs relating to changes in body image, desire, sexual response, conscious and unconscious attitudes regarding motherhood, loneliness, disaffection, etc.

The model proposed here for examining health services seeks to identify the discriminatory barriers and gender gaps that impair the quality of health care. Based on the findings, recommendations will be made with a view to facilitating a shift in health systems toward female-friendly services (FFS).

A FFS in the framework indicated is one that:

- Provides a suitable, effective, efficient, and timely response to women's needs, both for health care and prevention, at the different levels of care.

- Fosters access to health services by groups of women traditionally excluded, extending coverage on an equitable basis.

- Is capable of communicating within the services and outside the services with the community (referral and counter-referral).

- Promotes the participation of health care providers and women in planning, deciding, and other aspects of the activities of the service.

- Contributes to the human development of women as persons with rights in regard to health, offering them humane treatment: respect, dignity, privacy, intimacy, confidentiality, security, identity, information, consent, freedom, ethical behavior, autonomy, comprehensive care, and new types of relationships between the health service and women and the community.

- Offers a comfortable environment, with structure and resources adapted to the needs of female users (facilities, bathrooms, waiting rooms).

- Fosters recognition of missed opportunities in terms of comprehensive care for women and the involvement of men in health care for women and families.

5. HYPOTHESES

a) The critical examination of health services through processes in which health workers and the women of the community participate helps to identify the gender gaps and barriers that impair the quality of health care.

b) The inclusion of the gender perspective in planning and optimizing of efforts to benefit women is directly related to the reorientation of the health services and the development of local health systems.

c) The "female-friendliness" of health services is directly related to the quality of the health care they provide.

6. METHODOLOGY

6.1 Type of Study

It is proposed to use a research-action-participation methodology, which is considered to be essential for carrying out health promotion and ensuring community participation within the primary health care strategy and the framework of development of local health systems. The research-action-participation methodology is based on the principle that health conditions depend not only on the presence or absence of the services, but also on how people live and what they think about health and diseases.

The research activities should be planned at the local level with participation by the community and all other interested parties. They should be interdisciplinary and intersectoral. The function of the outside investigators consists of guiding and supporting the process, promoting training and self-learning within the community and among other participants, making it easier to learn and use research procedures and methods, organize the results, and deliver them to the community.

Research/action, with a participatory approach, can be applied at the various levels of the health services system to identify and overcome the obstacles to participatory planning and administration and effective intersectoral coordination, which are so fundamental to local health systems and community participation. In this framework, the FFS research proposal is characterized by the following aspects:

a) It is participatory, providing for the involvement of women (users and non-users), health providers, (administrators and direct care providers), the community (nongovernmental organizations, people's committees, local councils, etc.), with institutional commitment.

b) It is a process of collective construction of the FFS observation model.

c) It seeks to promote transformations in the health services during the process itself, not just after the fact.

d) It is multicentric: preparatory activities have already been launched in the seven Central American countries (including Panama), the City of Cali (Colombia), and the Province of Córdoba (Argentina). It is also open to other countries or areas wishing to participate.

e) It is interdisciplinary: a team will be set up in each country with basic training in various health and social science disciplines.

f) It is institutional: it includes official and nonofficial, public and private entities, as well as nongovernmental organizations.

g) It is comprehensive: it calls for the inclusion of the three levels of care, in treatment as well as prevention.

6.2 Units of Analysis

These will be defined through selection of services, with the word "services" taken in its broad sense, not limited to establishments or parts of them.

At least one of the services selected should belong to an area other than maternal and child care, and at least one should be affiliated with a nongovernmental organization.

For purposes of this study, the primary health care unit will also be considered a service. The criteria for selecting the services should be specified in each case.

6.3 Methods of Examination

The methods proposed for examining the services are the following:

a) Rapid Assessment Procedures-RAP (compulsory).

b) Efficiency of maternal and child health services (supplementary/optional).

c) Survey of missed opportunities (compulsory).

d) Tracer diseases or conditions (complementary/optional).

This list does not exclude the possibility of applying other supplementary methods, but the participating entities are expected to definitely use the two that are listed as compulsory. A brief description of the four methods follows.

6.3.1 RAP Methodology

This methodology provides guides to health workers, investigators, and social scientists for making rapid assessments (observations) of patterns of behavior in the search for and maintenance of health and recovery in cases of disease, including the use of health services, both traditional and modern or alternative.

RAP was developed in the research program of the United Nations University to improve the understanding of successes and problems in implementing the recommendations of the Alma-Ata Conference.

The guides provide a variety of sample questions, outlines, check lists, tables to be filled out, and other information-gathering aids.

The guides for gathering information are grouped in three categories: community (C), home (H), and health providers (P). It is proposed that the guides be used to help focus the study, organize the information-gathering process, and standardize the information obtained. They should be used as outlines for preparing questionnaires, check lists, and other information-gathering tools. The questions should not be phrased exactly as they are in the guidelines. They should be adapted to meet the needs of the project.

6.3.2 The Evaluation of Efficiency of Maternal and Child Health Services

This method can help identify several aspects related to the care provided to women at the primary health care level (health posts and health centers); at pediatric, gynecological and obstetric, and family planning clinics; and in obstetric, pediatric, and neonatal hospital facilities. The evaluation looks at whether or not the minimum requirements that these services should fulfill in order to function efficiently are in fact being fulfilled in different areas: physical plant, material resources, human resources, standards and procedures, planning and administration, supplies, health education, and community participation.

Production data on the services are also recorded, which can be cross-referenced with the information obtained in order to permit a more specific analysis of the quality of health care.

In the evaluation of efficiency--a method that the Regional Program on Maternal and Child Health of PAHO has applied since 1985 in more than 3,000 services throughout Latin America and the Caribbean--questions can be selected that are directly related to the FFS study, and a more in-depth specific analysis can thus be obtained that will enrich knowledge about the characteristics of women's health care.

6.3.3 Survey of Missed Opportunities

It is proposed that the surveys used by the programs on maternal and child health, immunization, and growth and development be adapted to apply them to problems related to women's health. They could thus be used to detect missed opportunities for health education; prevention of gynecological cancer, sexually-transmitted diseases, and AIDS;

prenatal care; identification of women who are victims of violence or have mental health problems; involvement of men in women's various contacts with the health services, etc.

These are exit surveys in which women health service users are interviewed immediately after service delivery and questions are asked about the completeness of the care, its educational content, and whether or not their special needs as women were respected. The term "missed opportunity" is generally defined as any circumstance in which a person contacts a health service and does not receive the comprehensive treatment he/she should have taking into account age group, gender, and exposure to health risks. Similarly, a missed opportunity in women's health care may be defined as any circumstance in which a woman contacts a health service and does not receive appropriate care corresponding to her gender and the risks to which she may be exposed.

This method may also be used in hospital settings, where the conditions of care often overlook gender considerations and women are subjected to unacceptable humiliations.

6.3.4 Study of Tracer Conditions

This method was conceived by Kessner et al. in 1973. It was designed for the purpose of relating differences in health status to the characteristics of medical care and, above all, comparing the effect of various service delivery systems on specific population groups.

Together the instruments developed under this method focus on crucial aspects of health policy and seek to arrive at the essence of the evaluation process by attempting to identify and isolate the types of information needed in order to reorient existing programs, start new programs, and allocate resources. The method is based on the premise that certain specific health problems can serve as "tracers" for the analysis of service delivery when they are combined into groups that provide a frame of reference for evaluating the interaction between providers, patients, and environment.

According to the author, tracer conditions are discrete and identifiable health problems that shed light on the way in which the various parts of the health care system function and interact with one another. The basic assumption is that the way in which a provider or group of providers administers care for common diseases is an indicator of the general quality of care provided by the entire system. The whole range of activities of the health services and interactions between patient and health care provider are thus taken into account. Both patients and providers are essential participants.

The criteria for selecting tracer conditions should be borne in mind, in particular the following ones:

- Clear definition and easy diagnosis.
- Sufficiently high prevalence.
- Efficacy of medical and health care.
- Defined techniques for managing the condition which are accepted by professional consensus.

By way of example, the following conditions have been used or proposed as tracers: iron deficiency anemia, arterial hypertension, prenatal control, urinary infection, ischemic heart disease, vision problems, otitis media, neck cancer, breast cancer, diabetes, chronic rheumatic diseases, biliary lithiasis, epilepsy, pulmonary tuberculosis, renal insufficiency, prematurity, hearing problems, oral health problems, childhood burns, obstructive chronic bronchitis, asthma, malnutrition, illegal induced abortion, doubtful gestational age, and acute diarrhea. As may be noted, many of them are related to women's health and would therefore be applicable in this study.

6.4 Training of the Interviewers

In all cases, regardless of the method of examination selected, specific training workshops should be held to familiarize the interviewers with the instruments and their use and to standardize the criteria for using questions, according to the recommendations for each of the methods suggested. This is an aspect of crucial importance and sufficient time should be invested to ensure proper training of the interviewers and careful standardization of the criteria. It is recommended that in all cases this phase include on-site training, in which the questionnaires and guides are tried out by the people who will be applying them.

7. ACTIVITIES THAT PAHO MIGHT UNDERTAKE

Within the framework set out above, PAHO is in a position to begin a series of support activities, including:

- Motivation of the countries and sensitization of their health authorities to promote the study and the subsequent application of its results.

- Identification of institutions and investigators in the countries that can carry out the study.

- Support for those institutions and countries in developing detailed protocols, adapted in each case to their cultural and social reality.

- Preparation of questionnaires which, after they have been tested in various scenarios, can be used to examine health services.

- Preparation of computer programs for processing the data from each country and comparing them with those of other countries.

- Technical advisory services for analyzing and interpreting the data, as well as for preparing recommendations on how to rectify the defects or weaknesses found in the services.

- Dissemination of results through a publication that summarizes the experience with women-friendly services.

8. PRIOR EXPERIENCE

For the past few decades, PAHO has been developing methods and has been applying instruments for the study and evaluation of maternal and child health services and family planning.

Most of the countries of the Region have applied these instruments and quite representative data are available on their structure, process, and production. In contrast, studies on the psychosocial perspective and the perception of users are of more recent vintage and are in incipient phases in almost all the countries of Latin America. The inclusion of the gender perspective has been a recent concern that has emerged in part from prior experiences and from criticism of the fact that this perspective has not been taken into account in the existing health services in the Region.

In early 1992, at the suggestion of the Office of the Deputy Director of PAHO, the Programs on Women, Health, and Development and Maternal and Child Health initiated discussions on the subject and, with the support of investigators from the countries, prepared an initial document that was used as a conceptual framework for female-friendly services (FFS).

The first steps in developing this concept, which implies a link between the quality of health care and the gender perspective, were discussed with officials and investigators from several countries of the Region. These consultations culminated in August 1992 in a workshop held in Honduras and attended by professionals from 10 countries of the Region.

Conceptual elements and possible instruments for examining services were discussed at that meeting. Instruments analized were considered useful, but recognizing that adaptation, development and testing were necessary. This process will provide appropiate tools to include the gender perspective into the services offered to American women.

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