How a Gender-sensitive Quality Improvement Approach Supports Integrated People-centered Health Services

The WHO Framework on Integrated People-centered Health Services

The World Health Organization framework on integrated people-centered health services (IPCHS) supports increasing timely access to essential health services and making health care more people-centered through five strategic shifts in health care systems:

1) Empowering and engaging people
2) Strengthening governance and accountability
3) Reorienting the model of care
4) Coordinating services within and across sectors
5) Creating an enabling environment

This short report discusses why and how to address gender issues within the IPCHS framework.

A gender-sensitive quality improvement approach is people-centered

- Clients, family and friends, communities, and health providers are all influenced by the culture they live in and by that culture’s perspectives on gender. To ignore gender is to ignore a vital part of the people and their local context that the WHO framework aims to center. Gender must be considered in order to have truly people-centered health services.

- A gender-sensitive approach takes the different needs, constraints, and opportunities of women, men, girls, and boys into account and responds to them strategically in program design, implementation, and evaluation. By considering and responding to these differences, health services are more people-centered.

- The USAID ASSIST Project’s gender-sensitive approach facilitates analyzing the social and cultural influences that determine who has access to care, who remains in care, and who receives quality care, to be able to respond appropriately. By collecting and analyzing sex-disaggregated data, we systematically identify and analyze gaps in outcomes among women, men, boys, and girls, which allows us to evaluate what is causing poorer outcomes among one group and design activities to respond to the different needs of different groups and close gaps.

Gender issues in integrated people-centered health services

- **Stigma and discrimination:** Women, men, girls, and boys experience stigma and discrimination differently. Harmful cultural beliefs about people living with HIV, the transmission of HIV, nutrition, family planning, and other health issues are different for women, men, girls, and boys and thus affect their health, quality of care, and support systems differently.

- **Decision-making power:** Women, men, girls, and boys have different levels of decision-making power in their families and communities that affect their access, retention, and adherence to health services. For example, counseling a woman on post-partum family planning may not be as effective as couples counseling if they jointly make family planning decisions or her male partner has the final say. And in places where mothers-in-law make decisions about daughters-in-law’s health, they should be included in maternal, newborn, and child health programs.

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• **Policies and institutional practices:** The policies and practices of a health facility sometimes treat women and men, and girls and boys, differently, whether it is a formal policy or what happens in practice. For example, some health facilities counsel HIV+ women on the importance of disclosing their HIV status to partners but do not counsel HIV+ men the same way; some clinics even require HIV+ women to bring their male partner to the facility, which could lead to women not returning to care or being subjected to violence.

• **Access and time:** Women, men, girls, and boys spend their time in different activities and often have different levels of access to resources and health facilities. For example, women can be unable to access services due to a lack of money for transportation, the facility being too far away, or other household and child-caring responsibilities preventing them from leaving the home. Community or religious beliefs or other constraints on women may also make it challenging for them to leave the house or travel alone. Men can be unable to access services due to the inability to leave work to go to the facility, or a cultural belief that the health facility is a place for women.

• **Roles and responsibilities:** Cultural norms, traditional roles, and responsibilities inside and outside the home are different for women, men, girls, and boys. For example, women are often responsible for taking care of sick family members, so it is important they know how to care for them. When counseling a woman on improving her nutrition, it is important to involve her husband or mother-in-law in places where they are responsible for food allocation within the family. In other places, counseling a man on improving his nutrition may not be as effective if his wife is not involved because she is responsible for preparing his food.

**How to strengthen gender considerations in IPCHS**

Teams should consider what issues or beliefs within families and within communities limit access to and retention in care for women, men, girls, and boys. Some sample questions are listed below:

• Who makes decisions within families about who accesses health care?
  o Do men make decisions about their own health? Do women make decisions about their own health?

• What responsibilities do women, men, girls, and boys have inside the household that prevent them from accessing and utilizing health services?
  o Who takes care of sick family members?

• What responsibilities do women, men, girls, and boys have outside the household that prevent them from accessing and utilizing health services?

• Are health facilities accessible for and equally welcoming to women, men, girls, and boys?

• Do health providers behave differently towards women, men, girls, and boys?

• What opportunities exist in the community to promote healthy behaviors and health-seeking practices for women, men, girls, and boys?

**Do no harm approach**

• Health issues can be very sensitive, and it is important that health services do not increase inequalities or cause unintended negative consequences.

• Quality improvement should not create or increase risk for women, men, girls, or boys. Changes tested must be closely monitored for harm, and if any unintended negative consequences are identified they must be addressed promptly.

• The client should always have the final decision of whether to involve family members in their health care or not. For example, forcing female patients to disclose their HIV status to their partners or family members can result in them being subjected to violence or abandoned.

• Prioritizing couples in health services to increase partner involvement can lead to single clients, who may already be more disadvantaged, having to wait extended periods of time. It can also lead to clients bringing a family member, friend, or stranger to pose as the partner in order be prioritized and skip the line.