Gender-Sensitive and Ethical Health Care: Policy and Standards

A Forum

Philippine Health Social Science Association

in cooperation with the

National Academy of Science and Technology

with funding from the Human Development
and Reproductive Health Program of the
Ford Foundation

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Welcome Remarks

Malaking karangalan para sa Philippine Health Social Science Association kasama ng National Academy of Science and Technology ang maging bahagi ng forum na ito tungkol sa mga patakaran at pamantayan ng pangangalaga sa kalusugan. Alam naman natin siguro ang pagpapahalagang ibinibigay ng PHSSA sa mga isyu ng etika at kasarian. Alam din naming maraming organisasyon at ahensya na nagbubuwis ng kanilang atensyon sa mga isyung ito sa kabila ng mga hakbang na naisagawa ng mga marami sa atin at ng pamahalaan na rin. Marami pang dapat gawin para maisulong ang makatarungang pamamalakad sa larangan ng kalusugan. Kaya naman importante ang mga forum na katulad nito. Umaasa ako na sa maghapong ito, ay matutukoy pa natin ang mga pagkukulang sa kasalukuyang sitwasyong pangkalusugan na pwedeng mabigyan ng solusyon. Sana'y makapagbigay din tayo ng mga epektibong rekomendasyon na maaaring maisakatuparan sa lalong madaling panahon para mapalapit pa tayo sa isang lipunang tunay na sensitibo sa mga isyu ng kasarian at etika. Sa ngalan ng Philippine Health Social Science Association ikinalulugod kong tanggapin ang mga kasapi sa forum na ito sabay sa pasasalamat para sa magiging kontribusyon ng lahat sa pagiging matagumpay ng ating mga hangarin.

Leonardo de Castro, Ph.D
President
Philippine Health Social Science Association

Orientation and Acknowledgments

I want to provide a brief orientation about the forum to place in context our discussion and exchange of ideas. This is the first ever partnership-activity of the Philippine Health Social Science Association (PHSSA) and the National Academy of Science and Technology (NAST). I hope this is not the last.

We are holding this forum because of a need for more concrete and more definite criteria and standards for health services and facilities in terms of ethics and gender sensitivity. For example, we do not know exactly what is a gender sensitive and ethical healthcare facility; what is a gender sensitive and ethical healthcare professional.

We do not expect that standards will be set or policy initiatives will be clearly defined this morning. But we hope that this forum will contribute to a process which will culminate in a set of indicators, perhaps a set of specific policy recommendations which can give us very clear ideas on what exactly should we look for when we want to know whether or not a healthcare facility or a service provider is gender sensitive and ethical.

Among us here are women activists, advocates, and community workers who can articulate their own views or who can voice the sentiments of poor women, sexual minorities, and poor men on this matter. We are sure that the forum will not only respond to a need for clear standards and criteria but will also address a need for multivocal discourse on healthcare

Sometime in February this year, when I talked to Dr. Perla Santos Ocampo, president of the National Academy of Science and Technology, about jointly organizing a forum on gender and

ethics in healthcare, she immediately said "yes, we should." In a matter of weeks, she was able to get the endorsement of the project from the NAST board. In August, the forum was held.

We were privileged to have in the forum, Dr. Sylvia Guerero, Dr. Susan Pineda Mercado and Ms. Aida Santos, who are among the most dedicated and respected advocates of women's rights and a just health system. The forum was keynoted by Dr. Santos Ocampo herself, who is a role model of women physicians for her academic and medical accomplishments.

The Philippine Health Social Science Association is proud to have partnered with the National Academy of Science and Technology in this project. We are publishing the papers of these four women not only to recognize the important contribution of their thoughts and writings, but to reach a wider audience who may find these useful in their own work. We are also very grateful to the panel of reactors to the papers: Ms. Zenaida Ludovice of the National Commission on the Role of Filipino Women and Ms. Mercedez Fabros of WomanHealth Philippines.

PHSSA is grateful to the Ford Foundation for funding the printing of this book.

Fatima Alvarez-Castillo
National Program Coordinator
Philippine Health Social Science Association

Keynote Address

Toward a Gender Sensitive and Ethical Healthcare in the Philippines

The time we have been waiting for has come.
A great wind sweeps through the old trees of the village,
Bending them and shaking their fruit.
One of the households has called the midwife...
It is the woman's time.

And now the house belongs to the women,
Busy whispering, heating water, warming oil.
The new father starts nervously as a horse
At each fresh sound from the house.

And we joke with him.
Yes, life is in the balance, but we have been through
It all before.

And now he is one with us.
For the mother in law appears and she is smiling
And the first high cries continue like a new bird chirping.
The first lamp is lit.
There is laughing and congratulations.
Quickly announce it with music to the village.
And invite the neighbors...

- *Aditi. The Living Arts of India.*

Birthing in early societies and in many rural communities is a happy, social event. It was an occasion for family and community bonding. For an affirmation, not only of the continuity of life but of tradition and relationships.

But more than this, traditional birthing provided the mother social and emotional support, which sad to say, is not always available in hospital birthing.

The history of the science of obstetrics is a microcosm of the history of social development which can be characterized as progress. But in the womb of that progress are changes which are not altogether humane or supportive of well being. Scientific knowledge and procedures in obstetrics have resulted to safer birthing. Countless mothers and babies have been snatched from death by the able and timely application of obstetric care.

But as hospital birthing became more focused on efficiency and hygiene, it also increasingly deprived mothers and fathers control over how they will experience the event. According to Karen Michaelson, in home births, women had control; in hospital births, physicians have taken over control of the entire event.

In 1957, the Ladies Home Journal in the US published a letter from a mother who urged an investigation of "cruelty in maternity wards". The Journal received hundreds of letters thereafter reporting dehumanization and lack of concern for mothers and babies. According to Dorothy and Richard Wertz: "Hospital delivery had become for many, a time of alienation – from the body, from family and friends, from the community, and even from life itself. The safe efficiencies had become a kind of industrial production – a woman was powerless in the experience of birth and unable to find meaning in it, for her participation in it and even her consciousness of it were minimal." Let me quickly add that the situation was such then.

I am using obstetrics to dramatize a number of issues which we need to address. By exemplifying birthing, I am in no way suggesting that gender issues in healthcare are found only in obstetrics, or in gynecology, for that matter. Ethical issues pervasively permeate all interactions between physicians and healthcare providers and patients. They cut across the wide range of health services and specialties. But I must also

point out that the Philippines is not the only country where these issues are relevant. They are also found even in the most developed countries and in the most modern facilities.

We know that much improvement in obstetrical services and procedures as well as in other specialties have been introduced in our health care facilities. There are now birthing homes which have been popularized. Hospitals have now become more parent-friendly and delivery rooms, more homey. But some basic questions continuously beg to be addressed:

- How enabling and facilitative are our health care facilities?
- How conscious are our service providers of the need to respect the dignity and privacy of patients?
- How aware are our health professionals of the rights of patients?
- How aware are they of the social dimensions and roots of diseases?

Clarification of Analytical Concepts

Before I proceed any further, allow me to clarify the basic concepts which will serve as the analytic terms during our discussions today. Our understanding of these concepts will help us later come to some consensus points regarding policies and standards which need to be set in place.

Gender refers to society's characterization of a person as well as its expectations of and prescriptions as to how that individual should behave and think. While sex is a biological identity, gender is a socially acquired identity. Gender roles and behavior are learned through the process of socialization which starts as early as infancy.

Gender categories may differ from society to society. Gender issues concern mostly women and sexual minorities such as gay men and lesbians because it is they who are mostly discriminated and disadvantaged in our society. The discrimination of women and sexual minorities is sustained by a patriarchal ideology or a belief system which considers men to be superior. According to Ritzer, *patriarchy* assumes that men are " the bearers of socio-cultural authority" and are the natural leaders of society.

Patriarchy can also be seen in relationships characterized by the domination of one party over the other or the absence of respect for autonomy of one party in a relationship. In the interaction of patient and health service provider, when the patient's autonomy is not respected by the health service provider, we can say that that service provider is patriarchal.

In discussions on bioethics, this is sometimes termed as ***paternalism***. Physicians in particular, historically believe that they have a right or duty to be paternalistic since they feel that their responsibility is beneficence and not autonomy.

Gender blindness is non recognition of the fact that crucial differences exist in how society treats men, women, and sexual minorities. It refers to a tendency to use male-oriented standards for all groups. This tendency does not lead to equal treatment because of the prior situation of inequality between women and men. In addition, gender blindness, by glossing over the discriminated status of women, may support the existing patriarchal social arrangements.

A Perspective

The issues confronting us which are related to gender and ethics in healthcare are complex, varied and multi-layered. When I say multi-layered, I am referring to levels of behavior and relationship which range from the personal/individual (e.g., the service provider's ideology), to the organizational (e.g., the procedures of the healthcare facility), to the systemic (e.g., policies of the healthcare system itself). Our attempt at understanding these various issues toward setting standards and policies for gender sensitive and ethical healthcare should consider these parameters.

According to Fatima Castillo, we must consider that beliefs and behavior about gender are not easily recognized or identified as they are deeply embedded in our psyche.

She noted that issues on gender, health, and ethics are inter-linked and meaningful changes can only come about through integrated, not isolated, piecemeal responses.

These issues cut across the realms of the cultural, economic, and political; changes in the healthcare system need commensurate changes in other systems as well.

The Issues

Male-female differences are evident in health risks, health seeking behavior, access, to and utilization of health services and health outcomes. Women are more prone to domestic violence, rape, and sexual coercion. Women generally delay seeking medical help due to their belief that the needs of other family members should come first. Their access to health services is hindered by unequal access to and control over time and money, and in many cases, by the absence of shared responsibility in household chores.

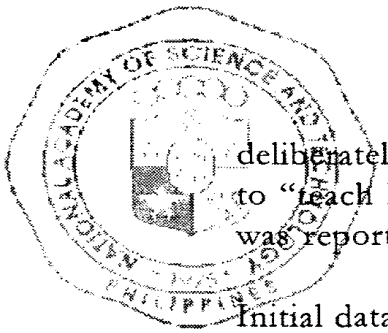
Reproductive health, despite the announced intention to apply a holistic approach, is still largely focused on fertility regulation. The technology for fertility regulation is focused on women. This deprives men the opportunity to play responsible roles in pregnancy.

But decisions regarding pregnancy are not made by women but by the men who are their spouses or sexual partners. Data show that most women want to limit the number of their children. But their needs are mostly unmet for various reasons. Many of them fear the side effects of contraceptives rather than the possible consequences of unplanned and frequent pregnancy. Data from literature show that much of this fear is related to negative experiences women had with contraceptives and the lack of information provided by health workers about their side effects. According to Rowland, witholding some information to women about contraceptives is a violation of their human rights.

Many unplanned pregnancies end up in induced abortion. About 300,000 to 500,000 Filipino women undergo induced abortion annually, according to Aurora Perez and colleagues. About 80,000 women are hospitalized per year due to complications resulting from unsafe abortion.

Gender Stereotyping among Health Workers

Health workers manifest in their behavior toward patients, their gender ideology. A case was reported in Cebu where health workers



deliberately delayed assistance to a woman who had induced abortion to "teach her a lesson". A private Catholic hospital in Metro Manila was reported to turn away women who had incomplete abortion.

Initial data on dental care in public hospitals indicate a failure among dentists to consider the gender basis of dental problems. Women's calcium deficiency during pregnancy could be worsened by eating last and least in poor families. Dental health can be influenced by gender inequality in the household. Physical violence inflicted on women can cause teeth loss, damage to facial bones and the ears.

Before I go on any further, let me interrupt the seriousness of our discussions by a quote from Golda Meir:

"Women's liberation is just a lot of foolishness. It's the men who are discriminated against. They can't bear children. And no one's likely to do anything about that."

Ethical Issues

Patients rights are human rights. If we use this statement as our framework for looking at ethical issues in healthcare, we have enough basis from a number of statutes and declarations, international and national.

International Declarations For Ethical Health Care

The Code of Hammurabi

The concern to establish ethical standards in medicine dates back to the Code of Hammurabi, 2500 years before Christ.

The Hippocratic Oath

The Hippocratic Oath reminds us to practice medicine with a conscience and dignity with the health of our patient as our first consideration. Formulated 2400 years ago, it is based on writings by Hippocrates and placed

certain obligations on doctors such as beneficence, non-maleficence, and confidentiality as well as prohibitions such as those against euthanasia.

The Nuremberg Code

"The voluntary consent of the human subject is absolutely essential."

The Constitution of the World Health Organization

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

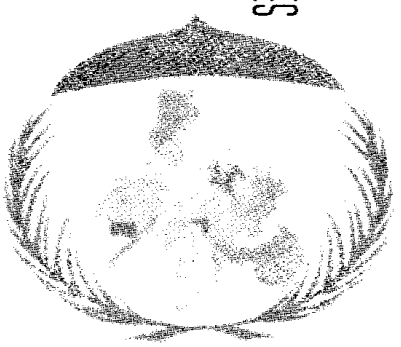
Universal Declaration of Human Rights

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

The World Medical Association Declaration of Helsinki

"The Declaration of Geneva of the World Medical Association binds the physician with the words, 'The health of my patient will be my first consideration', and 'A physician shall act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient."

The International Code of Medical Ethics
Helsinki Declaration, 1964



Amended
29th World Medical Assembly
(Tokyo, 1975)

35th World Medical Assembly
(Venice, 1983)

41st World Medical Assembly
(Hong Kong, 1989)

The introductory statements of the Declaration of Helsinki is adopted and subsequently revised a number of times are as follows:

> "It is the mission of the medical doctor to safeguard the health of the people.
> His or her knowledge and conscience are dedicated to the fulfillment of this mission."

The above international instruments are general in scope. Member nations must interpret and restate these precepts in keeping with cultural diversity. Later on, I shall give you a listing of international declarations focused on women.

National Statutes

The American Medical Association
The Medical Research Council of Great Britain Statement
The Code of Ethics of the Medical Profession, Philippine Medical Association approved by the Board of Governors,
15 November 1959.
Ratified by the House of Delegates, 27 May 1960
Amended by the House of Delegates, 21 May 1965, 25 May 1993

Apart from problems related to people's right to quality and affordable health services, there are ethical issues we find in our health care setting that are universal; however, they might mean different things to different cultures and peoples. Hence, the need for continuing dialogues, such as this forum. Basic ethical principles of privacy,

confidentiality, beneficence or nonmaleficence and autonomy or respect for patient's dignity, equity and justice should be our guideposts in looking at the ethics of our healthcare.

I will not go into the recurring debate on patient autonomy which we can find in the literature on ethics in health care. This debate has spawned various views on questions such as the nature of autonomy, the limits of autonomy, the impracticality of perfect autonomy (if it is possible at all) especially in the context of Asian cultures where individual autonomy can be taken to mean family autonomy. What is important to stress is that patients should be provided, in clear/understandable fashion, the information that will enable her/him to make decisions regarding treatment. Issues related to this are disclosure, truth telling, and informed consent. Of course, in situations of many poor patients, the provision of such information may not necessarily lead to wise decisions since their decision- making is severely constrained by limitations of funds with which they can explore options for treatment.

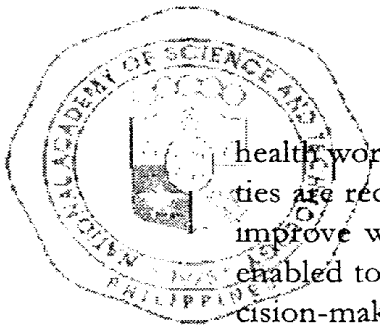
Recommendations for Gender-Sensitivity and Ethics in Healthcare

Gender-sensitive healthcare is ethical healthcare. It does not discriminate, abuse, nor oppress.

A gender sensitive healthcare facility, according to Emelyn Verzosa, has the following features:

- client–empowering
- non–judgmental
- non-blaming
- client-centered
- facilitative
- supportive
- sensitive to client's situation and feelings
- provides informed choices
- ensures confidentiality and privacy
- respects client's dignity
- uses gender-fair language

A *gender-sensitive healthcare* recognizes the critical roles that social and cultural factors between men and women, between patient and



health worker, play in promoting, protecting or impeding health. Inequalities are recognized and integrated into strategies, actions and services to improve women's health. Patients are treated with dignity and respect, enabled to make informed decisions, allowed to be equal partners in decision-making about their own healthcare and allowed to participate in planning and research.

Planning for health sector reform as well as for quality healthcare should utilize a gender framework and gender analysis. ***Gender analysis*** is a method for examining how differences in roles and power determine differential exposure to risks, access to technology, information and resources, and health care. It also considers how social class, ethnicity, education and other socio-cultural factors affect health. Gender analysis is useful in differentiating biological causes from sociological causes for health differentials between men and women.

International Statutes for Gender Sensitivity

If we look back to a hundred years ago, we should be happy to note that much has been achieved toward the provision of more competent, more accurate and more responsive health services and treatment. Especially in the last decade, much ground has been covered toward redefining the roles of healthcare in promoting human rights, especially women's health and rights. In our effort to start the process of setting standards and formulating policy initiatives for gender sensitive and ethical care, we have important national and international instruments which can serve as a basis.

- The International Conference on Population and Development in 1994 which redefined family planning/population control within the wider arena of reproductive health.
- The Fourth World Conference on Women in 1995 otherwise known as the Beijing Declaration which mandates signatory states to implement programs to improve women's health and the realization of their rights.
- The Convention on Elimination of all Forms of Discrimination against Women adopted by the United Nations in 1979 which urges governments to pursue policies to promote equal opportunities for women.

In our country, we have various efforts to respond to the needs of women.

The Family Code has instituted a number of provisions providing legal basis for women to redress wrongs. The mandate to integrate gender and development in all government institutions is an important political breakthrough (RA 7192). Although these instruments are limited and subject to the will of governments for their realization, we can use these in working for setting standards so that we can have a clear evaluative guide in examining our healthcare system.

Training in Ethics

Being an academician in addition to being a clinical practitioner, I cannot close this discourse without touching on training in ethics. This is a must for all our health professionals, lawyers, social scientists, religious, and even the general public.

We should sensitize every citizen to the need to quickly identify, reflect and help resolve ethical situations in clinical practice, public health, and everyday activities.

It is inspiring to note that all over the world, institutions of learning have focused on the critical importance of ethics. This emphasis on ethics contributes to our goal to instill desirable values and attitudes in our people, particularly in our students. This emphasis on ethics in the classroom can have invaluable implications on future decision-making, distinguishing between right and wrong, and upholding values such as love for fellowmen, respect for the environment, reverence for justice, equity, love of God and deference for honored traditional beliefs, customs, cultural practices, and religions.

Dialogues and Collaborative Process

It is also heartening to note that more frequent dialogues are being organized. Interactive presentations can always be more effective. We are to be reminded that specific instances which provoke discussion are always a better teaching method compared to didactic lectures. The application of principles to a case at hand can immediately reinforce learning. As much as possible, teaching should be integrated with all disciplines coming together in order to enhance learning.

Since not a single person can be imbued with the characteristics of an ideal observer, a collaborative approach through hospital ethics or hospital care review committees should be institutionalized in every hospital.

Ethics in a Flux ?

Scientific and technological advances in healthcare continue to bear on ethical principles. These recent developments, organ transplantation, assisted reproduction, cloning, genetic testing, genetic engineering, including the stem cell issue plus new diseases such as HIV/AIDS give impetus to more dialogues.

The challenge to all of us is that universal rights have been formulated but universal responsibility will be difficult to enforce.

What can be tragic, is when the existing codified rules are only as good as the paper they are written on. But neither observed nor implemented. ETHICS AND GENDER SENSITIVITY MUST BE PRACTICED. And this we must do with determination, with honesty, with passion and with courage.

Let me close by stressing once again that in espousing gender-sensitive healthcare, one must take into consideration a number of factors affecting women, their lives, and their health. Of all the passages I have encountered, which puts the woman in perspective, the following which I picked from UNICEF's Facts for Life evokes much pathos:

> *'Putting today's essential health knowledge into practice will be seen by many as 'women's work.'*
>
> *But women already have work.*
>
> *They already grow most of the developing world's food, market most of its crops, fetch most of its water, collect most of its fuel, feed most of its animals, weed most of its fields.*
>
> *And when their work outside the home is done, they light the third world's fires, cook its meals, clean its compounds, wash its clothes, shop for its needs, and look after its old and its ill.*
>
> *And they bear and care for its children."*

This is how the status of women may be depicted in developing countries especially in the rural areas. And this situation reflects the kind of health care women may get. Need I say more?

Introduction and Overview: WOMEN AND HEALTHCARE

My task in this forum is to identify gaps in government policies for gender-sensitive and ethical healthcare.

Let me begin with the bigger picture of Women and Health activities -- of gains and gaps - - since the two historic events: first in Cairo in 1994 that produced the ICPD Cairo Consensus and Programme of Action and second in Beijing in 1995 which adopted the Beijing Declaration and Platform for Action, committing the Philippines, along with more than 180 other countries, to "take swift and effective steps to improve women's health and well-being and their overall position in society" (Abdullah. 1996).

First, an assessment of healthcare systems in the Asia-Pacific region.

The Asia-Pacific Resource and Research Centre for Women (ARROW), May 2000 issue on Gender-Sensitive Health Care summarizes the current state as follows:

> *"...Although the 1994 Cairo Programme of Action and the 1995 Beijing Platform for Action made significant gains in women's rights, gender equality and reproductive health issues, Asia-Pacific healthcare systems remain insensitive to women's health needs. Women suffer inequalities in health status and treatment despite the availability of modern medical technology and overall increase in life expectancy..."*
>
> *"...Globally, and in the Asia-Pacific region, male-female differences are evident in the health risks, health-seeking behaviour, access to and utilization of health services and health outcomes...."*
>
> *"...Women are also more prone to domestic violence, rape and sexual coercion, which can cause serious health problems such as STDs, HIV/AIDS, depression, and anxiety. Women are known to delay seeking medical help due to their under-valuation of self and less belief in their entitlement to good health compared to men. Their access to services is further hindered by unequal access to and control over time, money and transport. Within*

the healthcare system itself, women face inequality in the roles they could play as health workers, and in their opportunities to influence the formulation of health policies and the focus of medical and health research. Women's health issues receive disproportionate research funding and women are often excluded from epidemiological studies and clinical trials. This is because healthcare systems have yet to recognize and address the impact of unequal male-female power relations on women's health risks and health-seeking behaviour. Usually, women's health problems are seen as narrowly related to the lack of health infrastructure and services, medical technology and health information. The traditional emphasis on women's biology and gender roles as determinants of women's well-being/ illness, is reflected in the focus of women's health matters such as pregnancy, childbirth, and contraception..."

Second, the global picture of women's health. The World Health Organization's (WHO) Beijing + 5 review cites the gains and gaps in concretizing women's health commitments:

Overall, several countries have developed policies and programmes based on gender considerations. Gender action plans, initiatives to promote women's participation in policy and decision-making, public awareness of women's rights, policy statements and some legislation -- all these "*have advanced the prospects of establishing a participatory process and approach which is at the heart of the women's health agenda.*"

But, "*overall progress on women's health has been patchy*" according to WHO. The many health indicators reveal a gloomy picture.

"*Bridging the gap between policy and implementation and between awareness and attitudinal changes is the challenge at this stage.*" An enabling environment which includes "a supportive legislative framework" is needed. Mainstreaming the gender perspective in all fields of health is urgent.

What about the Philippine situation?

The approval and adoption of the 448-page Philippine Plan for Gender-Responsive Development (PPGRD) for 1995-2025 is one major accomplishment. For this document incorporates Gender and Development (GAD) concerns in the planning, programming and budgeting efforts of government. One chapter is devoted to health, nutrition

and family planning: situationers, goals and objectives; and policies and strategies to achieve the objectives set, namely "*improving the overall health status of women.*"

In a policy research brief which the UCWS published in 1999, Dr. Junice Melgar highlights some of these achievements: "*At the policy level, government agencies – like the NCRFW, the DOH, POPCOM and Congress – enacted landmark laws and policies that echoed the ICPD. In 1997, the Anti-Rape Law was passed and so was the automatic 5% appropriation for GAD projects. POPCOM elaborated a gender-responsive population and development framework and the DOH in 1998 formulated the 10-element Reproductive Health Framework. The province-wide integration of these elements is currently being tried out in Nueva Vizcaya.*"

The DOH noted of course that "injecting a gender perspective into the various DOH programs will not be easy.... as gender stereotypes and disparities still exist". In November 1998, the DOH created the Women's Health and Development Program to take charge of assuring that women's health becomes a priority in all DOH programs and services and ensure that "existing gender issues and inequalities are addressed in all DOH program strategies and interventions".

Five years after Beijing, and nine years after the decentralization of health services, women's access to healthcare has not improved significantly according to The Philippine Post-Beijing Scoreboard (PPBS) on Women and Health.

On Beijing PFA Strategic Objective C 1: "access to appropriate, affordable and quality healthcare: decentralization of healthcare services has not resulted in better healthcare." Dr. Sylvia Estrada-Claudio presents the PPBS assessment:

"For example: LGUs have progressively reduced the share of health spending from 16 percent in 1991 to 13 percent in 1993, and 12 percent in 1994. The number of rural health units and barangay health stations in 1995 has also dropped 83 percent and 77 percent, respectively, of the 1991 figures.

Other highlights of the NGO review process paint a dismal picture:

- Discriminatory practices against the poor, unmarried women (e.g., they are asked to produce medical certificates to access RH services), youth, prostituted women, ethnic groups, disabled, women who have had abortions;
- Limited range of contraceptive choices when available and continuing reports of provider abuse;
- Government health personnel who are notorious for rudeness, indifference and the irrational use of drugs and medical procedures, and;
- Lack of health programs for indigenous peoples, lesbian women, overseas women workers, women in prostitution, internally displaced refugee women and women survivors of other human rights violations."

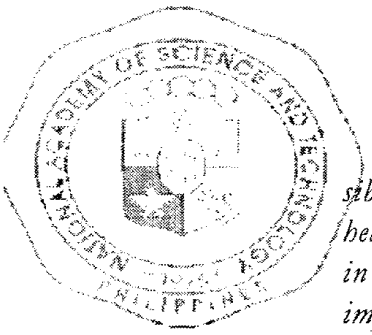
WHAT IS GENDER-SENSITIVE HEALTH CARE?

Earlier definitions of **quality of care** have placed more emphasis on the technical aspects of services such as 1] clients are properly screened for contraindications 2] clinical procedures are technically correct 3] aseptic precautions are taken and 4] services are provided in well-equipped facilities. These generally implied good service in terms of adequate technical competence of providers and availability of facilities, neglecting to a large extent, client perspectives and client-provider relationships (Donabedian 1988 in Khan, Boon-Ann and Mehta 1999).

Others have defined quality of care "*by the way the clients are treated by the system, or the actual process of care-giving, and by the focus on the client's or user's perspectives of services*" (Hull 1994 in Khan et al 1999).

Judith Bruce (1990) first proposed a comprehensive quality of care framework in the context of family planning. This included the following six programme elements: choice of methods, information given to users, technical competence, interpersonal relations, mechanisms to encourage continuity and appropriate constellation of services.

Adopting Donabedian's definition of quality of healthcare, Ma. Isabel Matamala (1998) incorporates the gender perspective in assessing health care services in three Chilean cities. In her view:



"Providing healthcare which assures the maximum possible well-being of women depends on the healthcare system, the healthcare providers and the women themselves. Any modification in the roles of each of these can impact on quality of care or impede women's human rights and development . . .

At the same time, the social construction of gender - - with its mandates and sanctions- - must be taken into account in relation to each step in the process of delivering healthcare. Health care must be analyzed in terms of whether it reinforces or weakens gender stereotypes, whether it perpetuates or undermines inequalities, and whether it encourages or discourages the exercise of rights, all of which are important aspects of trying to achieve the well-being of women service users"

Her study of public health services providers and users revealed gender-specific variables and indicators of quality of healthcare. Among these are: providers' use of both technical and human skills to address a woman's health problems; recognition; promotion and respect shown for human rights of the woman as an individual and the extent to which a woman's autonomy is strengthened and the woman herself empowered. Some concrete indicators which were tested included: number of times a punitive remark about a woman's sexuality is made or the waiting time before she is seen by a doctor, failure to encourage the woman to participate in decisions about her treatment, explaining and getting consent for medical procedures, and ensuring privacy for births and gynecological examinations and processes.

Policy Gaps and Concerns

In assessing policy gaps in promoting gender sensitive healthcare, it is helpful to remember the various levels within which policies exist. At the national level, policies determine the direction, organizations - - both GO and NGO - - would take. At the level of organizations and institutions, policies guide programs and services. At implementation levels, program policies would include technical aspects as well. It is important to stress that "*all kinds of health policies at various levels contain core beliefs and values on health and women's needs which are integrated into perspectives or conceptual frameworks*" (ARROWS for Change 1996).

Thus, when governments adopt and promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes as indicated in the Beijing PFA, they have to develop and operationalize this concept within their own contexts.

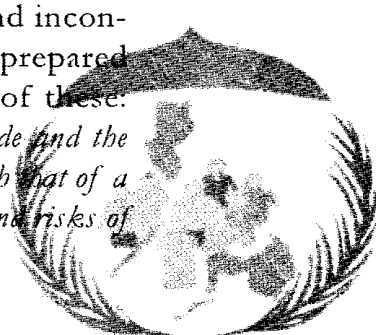
Central to the concept of women-centered and gender-sensitive health care are the beliefs in women's entitlement to appropriate, acceptable and affordable health services of a high standard to meet their needs, "*that women have the right to use their own experiences and understanding of their bodies to inform both themselves and health providers of their needs*" and that women's reproductive decisions must be respected. These beliefs have to be translated into concrete programs. Conventional health policies have generally considered the state and the medical profession as "*knowing best what women's needs are and what services should be provided*". Studies have shown the extent to which doctors exercise patriarchal control over female patients, sometimes trivializing women's complaints or expecting them to simply follow instructions.

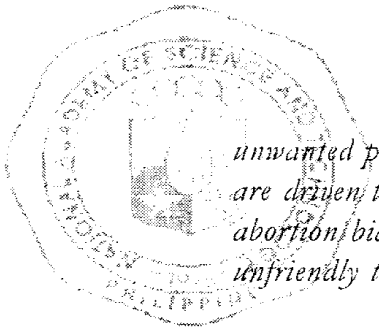
What policies do we need to strengthen a gender-sensitive healthcare system?

We have already a 30-year framework plan for gender-responsive development: a PPGD that will be updated every six years; a Women in Development and Nation-building Act (RA 7192), a constitutional provision on gender-equality; a DOH-WHD Program and a humane and gender-sensitive Population Management Program; and a vibrant women's movement that remains active and vigilant.

At the national level, the policy directions are quite clear. As signatory to UN declarations, conventions and instruments, the government is committed to implement these platforms and programmes of action — giving us reason to be hopeful about the future.

Some women NGOs reviewing policies and legislation, however, point to some provisions that run counter to the spirit of Cairo and incongruous policies that need reworking. Dr. Junice Melgar who prepared the UCWS policy brief on reproductive health, cites some of these: "*the very harsh and judgmental abortion provisions of the Penal Code and the section on the 1987 Constitution that equates an adult woman's life with that of a fetus. Both the Code and the Constitution are insensitive to the pain and risks of*





unwanted pregnancies and heedless of the fact that close to half-a-million women are driven to unsafe abortion on a yearly basis for complex reasons. This anti-abortion bias pervades even the healthcare provider who have been known to be unfriendly to, if not outrightly rejecting of post-abortion patients".

The State of the Philippine Population Report 2000 revealed the high level of unmet need for family planning brought about by lack of information and access to high-quality family planning services. Consequences of unmet needs in reproductive health are shown in high maternal mortality, increased number of induced abortions and teenage pregnancies and high rate of infant mortality. Indeed, the findings are "loaded with policy implications" for promoting healthcare services that are gender-sensitive and ethical.

I might also add here the policy and practices that are strongly biased towards keeping a family intact despite violence and assaults suffered by women and children within the family. More gender sensitive and child-friendly policies and laws have to be passed.

Cases of domestic violence, particularly wife-battering, child abuse, rape, and incest require gender-sensitive handling and ethical practices. Some of these policies and strategies are already in place (i.e., UP-PGH-CPU requires only women doctors to examine abused children; feminist counseling is done in Women's Crisis Center). There are, however, many more issues that need to be addressed.

The Beijing + 5 Philippine Scoreboard also considered quite urgent the need to "*take immediate steps, particularly through the Commission on Higher Education, to integrate changes in the curricula of the health professions that will better equip health professionals with both the knowledge and the attitudes to serve women's health needs*".

To my mind, so much more needs to be done at institutional and program levels (and community levels as well), to operationalize policy statements and directives and monitor implementation of policies, administrative circulars/orders and the like. The policy on sexual harassment (SH) in the workplace is a case in point. The Civil Service Commission adopted the anti-SH policy and issued a memo circular to all agencies on March 31, 1994. At the UP-UCWS we initiated a series of activities involving information dissemination, research, and implementing guidelines as well as legal and counseling services for victims. These

took several years of consultative meetings, crafting of guidelines and unfortunately, more victims before some level of institutionalization was achieved in the last two or three years.

Promoting a gender-sensitive healthcare system that would require the establishment of mechanisms that will include the "*formulation of enabling policies, intensive personnel capability-building and the provision of adequate facilities, equipment and supplies*" (Melgar 1999).

At this stage of policy development and program implementation of gender-sensitive healthcare systems, a continuing review of healthcare practices at primary and tertiary healthcare levels will be needed. Measures of the adequacy and women-friendliness of healthcare providers will be useful to craft new initiatives and approaches. The PPGD lists among the policies and strategies for gender-sensitive promotive/preventive and curative healthcare services and women's empowerment and participation, 17 major program areas, with consciousness-raising, IEC, training, research, and evaluation activities particularly a systematic gender-specific indicator system for monitoring women's health status. The creation of task forces and other mechanisms to see to it that laws and policies are enforced is also emphasized.

R. L. K. Rivera (1999) proposes a women-friendly health care approach based on their experience in a community-based women's clinic, with emphasis on "*a humanistic interpersonal relations between the health care provider and women seeking health care*". There is emphasis on information-education activities, consultation on needs and preferences, participatory approach to break the patriarchal relationship between the health provider and patient; dialogue, listening, and a rights emphasis in counseling women; a caring attitude where women are understood not judged, where privacy and confidentiality are assured and facilities, adequate and clean. Ideally, the clinic is a one-stop-shop where a range of health services are provided in one place and can be accessed by women and other members of the household. And "*beyond affordability and accessibility, the quality of care in clinics must reflect women's voices*".

We are now documenting, in our study of good practices in addressing/eliminating the problem of violence against women and children in hospital-based institution and community-based programs, innovative, effective, gender-sensitive, ethical and successful practices that can be readily replicated and expanded throughout the country. This in-

cludes gender-sensitive policies and practices in Women and Child Protection Units (WCPUs) that have been established in DOH-retained hospitals throughout the country. A gender-sensitive documentation and monitoring system is also being developed to assess the progress and impact of VAWC intervention programs. We are challenged by what Lisbeth Schorr, social analyst and director of a project on effective interventions, has said: "*we have learned to create the small exceptions that can change the lives of hundreds. But we have not learned how to make the exceptions the rule to change the lives of millions*".

I'd like to end this analysis with reflections on a positive mind-set-and outlook. In March, every year, we celebrate Women's Month and take pride in our gains in transforming development perspectives, population and health into rights, empowerment and gender-sensitive frameworks and feminist discourses — including sexual rights and a woman's prerogative to make informed decisions about her fertility, etc. We are aware of the realities and the gaps (particularly in "*enforcement mechanisms and resources needed to make politicians and clinicians more honest, and . . . to put their money where their mouths are*") as Rosalind Petchesky (1997) aptly put it. This knowledge has increased our resolve to face the new challenges. And the struggle continues. And we craft new policies and engender our institutions.

I like what Rosalind Petchesky has proposed, namely, a slogan for every March 8 celebration. "***Power and pleasure go together***". This means - - while saying that "*unbridled market* (capitalism) *is dangerous to women's bodies, we must link our reproductive rights work to pleasure — and construct a bridge from negative to affirmative rights*".

"*How much easier and more acceptable it seems to be to denounce the negatives than to demand the positives. . . We struggle fiercely against violations of our bodies, in the form of violence, abuse, coercion, and mutilation; but we are much more timid when it comes to struggling for the right to be free in our sexuality. . .*"

In the interest of enforcing an affirmative vision in the women's movement, she proposed a change - - "*Instead of the campaign against maternal mortality, I propose we institute a campaign for maternal wellness*. Instead of the 16 days of action against violence, I propose 16 days of action for women's safety and strength to fight back, which of course would mean kickboxing or other self-defense training as part of every girl's schooling. . .*"

My own efforts as I reach the sixth year of research, advocacy and action initiatives on VAWC is to engage in the healing process - -i.e., healing for wounded families and creating peaceful communities. It's far more satisfying and rewarding — and equilibrium-producing. This is good for my own health.

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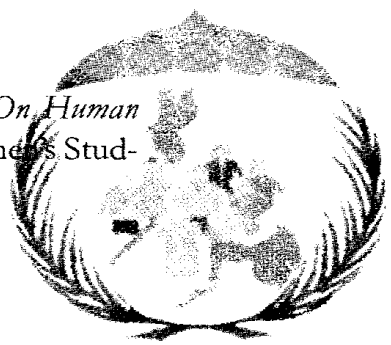

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Ethics is concerned with morality or moral philosophy; it is concerned with concepts such as 'right," "wrong," "permissible," "ought," "good" and "evil." It seeks to "establish principles of right behavior that may serve as action guides for individuals and groups...investigates values and virtues...." (Louis P. Pojman, quoted in Tong 1997: 13). This is one way of defining ethics which is generally approved by traditional ethicists.

Gender-sensitive ethics is based on an understanding of feminist bioethics. Under this, we need to discuss the theories of virtue ethics, care ethics and postmodern ethics—three major perspectives in feminist bioethics (Tong, 1997) *Virtue ethicists suggest that, since good persons typically make wise judgments, it is imperative that physicians and other healthcare professionals cultivate character traits such as honesty, courage, and justice. Care ethicists build on some of the insights of virtue ethics, affirming that good persons are not only honest, courageous, and just but also caring. In particular, what makes physicians and other healthcare practitioners caring is their desire to treat patients as unique individuals rather than as "diseases," "conditions," or "problems." Finally, postmodern ethicists take attention to detail and difference to their full length. In suggesting, for example, that health and disease have plural meanings and that there is no way to assess whether life is better than death, postmodern ethicists threaten the traditional notion that medicine is an art and science that must always be used to restore health or to preserve life"* (Tong, 1997: 3).

On the other hand, gender-sensitive healthcare focuses on the power differential between women and men in terms of access to, participation in and control over their defining their health needs, and the services that are suited to their specific needs based on their sexual differences. A gender-sensitive perspective in health also integrates a life cycle approach. This approach ensures that the health of women and men throughout the different stages of their lives are given appropriate and timely attention. The issues of access, participation, and control are principles in the gender and development framework that has been adopted in the present official mandate on gender mainstreaming. Right to genuine development is a guaranteed human right. Weave this around with the right to health, another internationally-guaranteed human right, and we have grasped the foundation of what a gender-sensitive and ethical healthcare system should be. The cliché 'health is wealth' is an apt way to summarize the links between health and development.

A policy approach to gender-sensitive and ethical healthcare, therefore, must proceed from combining a gender-sensitive approach to development and human rights perspective. The triad of choice-control-connections must be woven into the principles of access, control and participation, enhanced by ongoing *conscientization* that brings into the arena of advocacy a recognition of the power relations between women and men on the one hand, and patients and healthcare professionals on the other hand.

Choice, **control,** and **connections** are three key words that summarize the main concerns of feminist bioethics, on the one hand, and **equity**, **equality,** and **empowerment** are the goals of development, on the other hand.

A More Comprehensive Perspective

The existing official framework that guides the official agencies in providing healthcare is premised on the World Health Organization's definition of health, to wit:

Within the framework of WHO's definition of health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions, and system at all stages of life. Reproductive health therefore implies that people are able to have a responsible, satisfying, and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the rights of men and women to be informed of and to have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice, and the rights of access to appropriate health services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (WHO, 1994a)

The definition, I would like to think, is premised on an understanding of both historical and contextual parameters that bear upon the issues of completeness of physical, mental and social well-being. One cannot talk of reproductive health without examining the state of women's health. In fact, many women's groups and NGOs affirm that the broader perspective that women's health affords us is to make a distinct link with the developmental circumstances that women and men

find themselves in. Health is a development agenda, and the state of the economy which also reveals itself in the socio-political and cultural spheres of human life, is a key element in the promotion of a gender-sensitive and ethical health care system.

SIBOL, a local women's alliance, had forwarded a definition of women's health which states thus as: ...[encompassing] various concerns, which include among other things reproductive health and rights, sexuality, and violence against women. The human rights framework imbued with a women-centered, gender-sensitive perspective utilizing a life-cycle approach and examined in the context of the interplay of socio-cultural, political and economic institutions is essential towards achieving unities even as we acknowledge our diversities in terms of gender, class, ethnicity or race, age, sexual orientation, and social status. Sustainable development, which takes into account ecological and environmental issues, and social justice are two fundamental goals of the struggle towards strategic women's empowerment, both in the private and public spheres of their lives.

The State of the Public Health System

Health services to Filipinos are provided at various levels, from the *barangay* or village level up to the municipal and provincial levels. Unfortunately, a number of these community-based or *barangay* clinics are poorly resourced, not just in terms of facilities and medicine, but of health professionals. Low remuneration, overseas migration of health professionals, low priority for health and an endemic corruption in the management of public funds remain some of the more basic reasons for the inadequacy of the public health system. Public health clinics and hospitals remain to be the more accessible venues for most poor Filipinos, as privately-owned medical facilities are expensive and oftentimes based in urban areas.

In recent years the issue of privatization of public health facilities has hounded the health sector, alongside privatization of other public services and utilities, including the educational system. Critics of privatization have forwarded the view that the greed for profit by some sections of the private sector and multinational companies coupled with government inefficiency and corruption, plus the push from the World Bank (WB) and International Monetary Fund (IMF), two big-

gest global institutions that impact on and guide development plans in the country, have put at greater risk the general well-being of Filipinos. Commercialization of the health system has upped the cost of medicines beyond the reach of ordinary Filipinos.

The Health Sector Reform Agenda Philippines 1999-2004, forwarded the vision that it shall serve as the "health catalyst that will bring the country toward the realization of a shared vision of health for all Filipinos," and looks at five major reforms that the health sector needs to address: 1) provision of fiscal autonomy to government hospitals; 2) securing funding for priority health programs; 3) promoting the development of local health systems and ensuring its effective performance; 4) strengthening the capacities of health regulatory agencies; and, 5) expansion of the coverage of the National Health Insurance Program (NHIP).

The year-end report of the DOH for the year 2000 painted a positive gain for the health sector, among which are the upgrading of both national and local hospitals, the drafting of the National Government Hospital System Reform Act of 2000 that establishes a system for providing fiscal autonomy, training of pharmacists, the establishment of Collaborating Centers nationwide which cover such concerns as mental health, population health and nutrition, concept of a healthy city, laboratory center for tuberculosis, patient education in diabetes and for schistosomiasis, and patient education in tertiary hospital. The foreign-assisted Women's Health and Safe Motherhood Project (WHMSP) which aims to improve the health, nutrition and family status of women, continues to support the development of local health systems by "upgrading and renovating health facilities in selected parts of the country." Other programs include competency-based curricula for Primary Healthcare for physicians and self-instructional materials and radio scripts for the Distance Education pilot projects.

The same report stated that the aim of health regulation is to ensure that the people have access to affordable, adequate, and high-quality healthcare. The DOH report also said that close to half of the total Philippine population has been covered by the Philippine Health Insurance Corporation pursuant to the mandate of universal coverage.

Two major policy documents were developed and published: the Health Sector Agenda Philippines 1999-2004 and the National Objectives for

Health 1999-2004. In a report, the Department of Health (DOH) stated that the health status of Filipinos has significantly improved in the last fifty years. (DOH Health Sector Reform Agenda, 2000) Life expectancy, mortality and morbidity rates have generally improved. In 1993, poorer populations were reported to be increasing their access to public health services.

Despite the best efforts of the government, the health situation of the Filipinos in general has improved minimally. In a country where millions live below the poverty line, health has not been a priority area. A review by the National Commission on the Role of Filipino Women (NCRFW) of data compiled from various sources, asserts that women's health situation continues to be an area of continuing concern. Nutrition, maternal, childbearing /reproductive and other health concerns indicate that much remains to be done in terms of addressing women's generally poor state of health. Seeking healthcare particularly of reproductive nature among women is generally a low priority.

In an ICPD+ 5 country report (The Commission on Population, 1999), gaps were identified in the assessment of reproductive health area of the DOH. A National RH Advisory Committee was established composed of at least three major services, namely, the Family Planning, Maternal and Child Health, HIV/AIDS, Non-Communicable Diseases, and Nutrition. These services were involved in the implementation of three major projects: the Integrated Family Planning and Maternal Health Project, Strengthening the Management and Field Implementation of the FP/RH Project, and The Women's Health and Safe Motherhood Project. The review revealed the following: 1) fragmentation of services due to vertical program implementation; 2) inefficiencies in resource utilization due to highly centralized approaches, and, 3) lack of an overriding philosophical framework rooted in the gender differences between men and women. More importantly, the review took cognizance of the fact that reproductive health interventions isolated it from other "mainstream" or "core" public health services on disease control and environmental health. The report also noted the need to integrate the gender perspective in all public health interventions.

I have chosen to focus on a few agenda items in terms of re-examination of policy options for enhancing gender-sensitive and ethical health care systems, for lack of time, and in cognizance of the following issues as central concerns for the thematic concern of this gathering.

Maternal Mortality / Medicalization of Reproduction

Despite the reported relative improvement in the overall health situation of the Filipinos, maternal mortality, on the other hand, showed very slow improvement. In 1993, maternal mortality rate stood at 200 deaths per 100,000 live births. In 1995, the leading causes of maternal mortality were complications related to pregnancy occurring in the course of labor, delivery and puerperium, hypertension complicating pregnancy, childbirth and puerperium, postpartum hemorrhage, pregnancy with abortive outcome, and hemorrhages related to pregnancy. In 1998, there were 172 deaths per 100,000 live births.

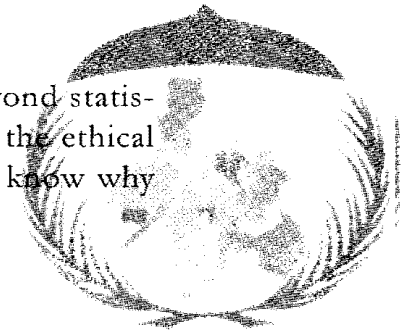
Maternal mortality in 1995 was highest in Muslim-dominated populations — Sultan Kudarat, Maguindanao, Tawi-Tawi, Aurora and Sulu, which are also considered the poorest areas in the country (DOH Social Reform Agenda, 2000).

The maternal and child care program of the DOH is focused on child-bearing married women, with an emphasis on the ideology of motherhood. While this is a much-needed program, women's health covers a much wider range of issues and implicates women who are not necessarily child-bearing but are prone to reproductive health problems. We need to move beyond a heterosexual, motherhood-oriented ideology that presently permeates the overall design of the key public health programs.

The medicalization of reproduction is one of the policy areas which need our attention. This medicalization alienates women from their own bodies, their own knowledge, their own capacities, and from reproduction itself. Men are often perceived as outside reproduction, and many men act this out which further perpetuates gender-inequality and women's subordination in particular.

ABORTION

Abortion is a reality that cannot be denied or hidden. Beyond statistics, the issue of abortion has to be seen in the context of the ethical considerations of choice, control and connections. We all know why



abortion is resorted to, either out of poverty situation or of personal circumstances—particularly of women who bear children out of wedlock or because of sexual liaisons that could not be sustained. Our understanding of abortion has to be linked with the principles of women's autonomy over their bodies, the need for women to be able to decide freely on their reproductive capacities, and the connections of women to other women and their social reality.

As a bioethicist pointed out, "...in our society, it is important to make certain that women's reproductive 'choices' are truly autonomous. The fact that a woman decides to have an abortion does not mean she has freely chosen to do so—not if social and personal support systems for single mothers are lacking; the fact that a woman enters an in-vitro fertilization (IVF) program does not mean she has freely chosen to do so—not if she has been made to feel that a woman who cannot have a child is not really a woman; the fact that a woman agrees to be a commercial surrogate mother does not mean she has freely chosen to do so—not if she is relatively poor and needs extra money to support herself or her own children. The point here is that bioethicists need to attend to persons' gender (as well as race, ethnicity, class and so forth) in order to distinguish between true autonomy and coercion masquerading as choice" (Tong, 1997: 3-4). In much the same way, those who choose to sustain a pregnancy does not negate the possibility of fear of social isolation or religious sanctions as a reason for such a decision. Poor women with many children who continue to bear children—because of contraceptive failure or lack of it, spousal violence when sex is refused, forced sex, or a combination of these and other personal factors—cannot be blamed for the seemingly irrational decision to keep on having pregnancies in the face of glaring inadequate economic constraints.

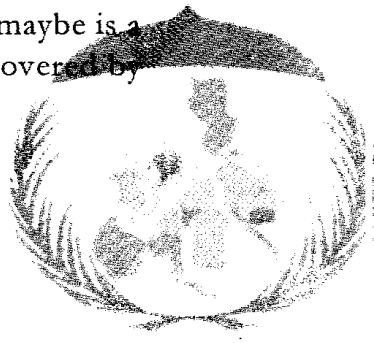
The claim of some of us that abortion is murder should be juxtaposed with the concern with women's ability to judge and make choices about their reproductive capacities or incapacities. From an ethically gendered perspective, the latter should be weighed with greater clarity and with a keen understanding of women's situation and the macro realities that pregnancy and childbearing bring along. Therefore, health policies should reflect the nexus between ethics and gender, with a prime consideration for those who bear the greater responsibility for and consequences of reproduction—the women—more than anything or anyone else.

So when religious or moral judgment—which in recent times found articulation in some legislative proposals to punish severely the abortees and the health professionals or other persons who assist or directly perform abortion procedures—is handed down against women who practice abortion as a means of contraception or simple termination of unwanted pregnancy, we have condemned the women to eternal damnation *and* continued disempowerment.

Social Hygiene Clinics (SHCs)

The SHCs, like it or not, equals stigmatization of women who oftentimes are considered "bad" women—the prostituted women. The SHCs have served to be the operational structure for controlling sexually transmitted diseases of women who are considered by society as the scum of womenhood. These clinics are in reality making our women "clean", i.e., free of diseases, so that they can protect their clients. It is true that when the women go to these clinics, they are told if they are infected with STDs or not, but in a continuum of analysis, the health authorities are merely ensuring that once they are out in the streets or in nightclubs and brothels, they are stamped "ready for use." The health cards are not just medical grades, they are literally a way through which the women are controlled. Women do not choose to be sick or infected, but the pervasive lack of control over their clients and the sexual activity per se, make them ill. They get infected because of the nature of their sexual activity, which in turn, is a given in the system of prostitution. The clients are not tested, nor is there any health program that ensures that men are "clean," too.

Women's groups who directly work with women in prostitution (and some NGOs with men in prostitution), have gathered enough experience and evidence that the disease-control approach that is embedded in the ideology of social hygiene clinics, is not the way to protect women. More than anything, SHCs stigmatize them. During the presence of the US military bases in Angeles, Pampanga, women who are found infected are advertised through photos in the bulletin board—as a warning to the US personnel not to "use" the women. This maybe is a thing of the past, but it shows that "bad" women are not covered by the WHO definition of health.



One may argue that they are a population of women who are not the "normal" or "ordinary". An ethical approach to healthcare delivery does not distinguish women who have sex for a fee and women who have sex because they have husbands or sexual partners who do not pay them for the sex. The continued existence of SHCs in their present setup continue to play on the unequal relations between women and men, perpetuate the divide between "bad" and "good" women, and promote prostitution. It safeguards men's health using women as the method for the control of sexually transmitted diseases. For as long as men demand sexual services of women bound to their poverty and marginal status, SHCs will continue to be a disempowering structure for those trapped in prostitution.

Sexuality is at the core of the issue that I had just presented. And our notion and practice of sexuality is an ethical concern, perhaps one of the most intimate and subjective. We certainly cannot impose policies on sexuality, but we can demand that our sexual rights be an arena for protection and promotion by the State.

Undoubtedly, some significant policies and actions have been mainstreamed by the Department of Health, such as nutrition programs, self-care and detection of common disorders, use of herbal medicine, programs on the elderly, among others, which target women and children primarily (NCRFW 1997:13). Targeting women and children is only a part of current attempts to enhance gender-sensitive and ethical healthcare systems. Making them full partners in crafting policies and developing health programs is a key element in addressing the gender disparities and inequalities that beset this society.

Wanted: Gender-Sensitive Ethical Healthcare Framework

We need to evolve a framework on gendered and ethical healthcare that looks at reproduction beyond fertility and pregnancy. Reproduction is a 24-hour, 7-day, 12-month event in our lives—from waking up to going to sleep, and having sex or making love.

The cornerstone of a gender-sensitive and ethical healthcare system consists of the marriage of the perspective of health as a human right and a development issue, and should be translated into policies that

not only bring quality of care but a quality that goes beyond caring and into justice. This would include genuine participation of women and men in policy development, through participation at various levels of decision making.

Moreover, this concept of justice belongs beyond healthcare, but takes cognizance of global developments that impact on our healthcare systems, such as the issue of globalization, the new international division of labor and gender division of labor, migration, rise of megacities, homogenization of cultures, rise in pandemic such as AIDS, bio-diversity and food security, and social movements and civil societies. Studies have shown that GO-NGO collaboration remains crucial in the delivery of health services and improving the lives of communities particularly women (e.g., ICOMP, 1999). In all these, health lies precarious, especially women's health. Production and reproduction are not divided spheres but rather two faces of human lives. Policies must consider these global and national trends in crafting health policies, more as a pro-active intervention on behalf of the poorest of the poor, the women.

Finally, I agree that ethics is in a flux. What is ethical today may be differently viewed tomorrow. But for as long as our ethical considerations are rooted in our understanding of gender relations, and go beyond the clinics and hospitals into our homes and lives, then we can be assured that the policies we evolve are genuinely just and forward-looking.

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Setting Standards for Gender-Sensitive and Ethical Healthcare

Susan Pineda-Mercado

It would be an understatement to say that the process of setting standards for gender-sensitive and ethical healthcare is a challenge.

Delving into the issues of gender in healthcare within the broader context of ethical discourse requires not only much thought and reflection on gender-sensitivity as a relevant paradigm for analyzing health care services, but the process requires engaging various seemingly unrelated disciplines and systems (medicine, law, sociology, anthropology, the justicial system, the law enforcement establishment, local governments) to a deeper understanding and appreciation of how gender issues emerge against a complex background of rapidly changing technology in healthcare not to mention an environment of political, social, institutional, professional and individual values and value systems that often compete with each other. This is further compounded by an explosion in information and communication technology that allows us to quickly point out the divergence and clashes in opinions and beliefs of groups and individuals even when societies may not have the mechanisms or the institutional structures to resolve these.

Undeniably therefore, any responsible discussion on standard-setting for gender-sensitivity and ethical healthcare must include determining acceptable mechanisms for resolving ethical conflicts and uncertainties in a society that is itself torn by political and social change.

Suffice it to say, that this topic truly exists in the grey zone where an interface between the health and social sciences, both in theory and its applications is not only important but is perhaps the crux of the matter.

What types of ethical issues do we speak of and how do these converge with the need for gender-sensitive healthcare systems?

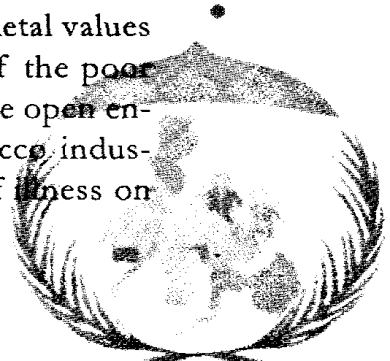
The Report of the Task Force of the Society for Health and Human Values (SHHV) and the Society for Bioethics Consultation of the US [1] cite some of the ethical dimensions of complex clinical cases that are perhaps relevant to this discussion. These ethical issues could involve:

- beginning of life decisions (abortion, the use of reproductive technologies, fetal genetic testing)
- end of life decisions (withholding or withdrawing treatment, euthanasia, assisted suicide)

- organ donation and transplantation
- genetic testing
- spread of sexually transmitted diseases

Ethical conflicts and issues then arise in relation to various players in the healthcare delivery system, and not just between patient and provider: (and at this point I would like to try to relate some of these issues to those that may have a specific implications for gender-sensitivity)

- patient-provider relationship, patient or provider rights, autonomy, informed consent, confidentiality and confidence (e.g. trivializing of women's complaints related to pre-menstrual syndrome, refusal of health professionals to perform female sterilization because a patient is too young, or has too "few children", the overuse of labor induction, caesarian sections, mastectomies, hysterectomies, psychotropic drugs)
- family/surrogate and patient-provider relationships - proxy decision-making, best interest, advance directives (e.g. the need for consent of the husband in cases of female sterilization, refusal of physicians to provide contraceptives to unmarried women, failure to recognize lesbian/ gay relationships)
- provider-provider relationships, physician-nurse relationships, inter-or intra-service disputes, communication problems (e.g. sexual harassment of nurses or female physicians in the operating room, discrimination and resentment against women in administrative positions in hospitals or public healthcares systems, unethical "PR" activities of drug companies)
- institution-provider or institutional-patient, family, and/or surrogate relationships - futility, resource allocation, DNR, discharge and out placement (e.g. refusal of hospitals to provide family planning services, lack of protocols for domestic violence assessment or the lack of evidence gathering kits for sexual assault and rape cases)
- relationship between various communities and any of the above - the intersection of a particular community's values and institutional missions, patient-provider relationship, societal values (e.g. the propensity to solve the health problems of the poor through medical missions, charity and "freebies"; the open endorsement by the head of government of the tobacco industry when all evidence points to the heavy burden of illness on passive smokers who are women and children)



And yet despite these seemingly critical issues, perhaps the most compelling of all these ethical issues is that which has to do with our inability as a nation and as a society to ensure health as a basic human right. In our current setting it is the lack of equity in health for women especially the poor i.e. access to quality healthcare services —health promotion, prevention, treatment to rehabilitation, lack of access to social health insurance. When we look at the evidence pointing to deaths related to childbearing and pregnancy, the inability of the system to protect women from sexually transmitted diseases, the lack of programs to address the problem of hypertension and cardiovascular disease among women which is the leading cause of death, the lack of an organized response for depression and mental illness, our concerns need to be placed in perspective. Perhaps the key issue is not gender-sensitivity or ethical care but the fundamental lack of access to any form of medical or health care for a significant number of women in our society.

On the other hand, going into a discussion on standards in healthcare per se —brings us to the underdeveloped field of health regulation in the Philippines. This requires that we also tease out certain issues that arise in relation to standards and regulations in health in general, as there is much more to this than setting policies and broad directions. Much of the work in standards and regulations in healthcare in our setting now and in the future, must evolve around the issue of health human resource development: both human competencies and structural capacities of the healthcare delivery system to deal with ***where we want to go*** (assuming that we can arrive at a consensus within the health sector and among other relevant sectors) vis-à-vis how prepared we are for change or ***how we must prepare ourselves to get to where we want to go*** considering that there are other equally compelling issues in the area of health standards and regulations that again compete for the time and attention of those involved in health systems development.

So where do we start?

Starting where we can share common values

I think a good starting point for both the health science and the social science sectors would be to identify common ground where an opportunity to **generate and confront the evidence** will illustrate how the

lack of gender-sensitive care contributes to the negation of specific values that are widely acceptable. This would establish the need then, for change or improvements through standard setting that we will get to in a short while.

For example, let us take the case of domestic violence and the need for systems-wide protocols and standards at all levels of the healthcare system to address this problem.

Recent yet unpublished data coming from the National Institutes of Health on Baseline Data for the National Objectives for Health, report close to 50% incidence rates of abuse and violence in the home. As far as a few years back, in the absence of a national survey to prove this was otherwise, we would have said that this is not a problem of public health magnitude and does not necessitate system-wide interventions or standard-setting. But now as the picture becomes sharper we realize that we are sitting on a social volcano that the health sector has been completely unprepared for. While there are still many who shake their heads and say, this is not a problem of the health sector, a re-articulation of how domestic violence in fact violates the right of the individual to health vis-à-vis freedom from physical and emotional harm is necessary to establish why systems-wide interventions are necessary. If health is a human right, how can we tolerate a norm that allows almost institutional infliction of injury and emotional trauma within the basic unit of society?

So first and foremost in our process for standard-setting would be to prioritize areas in which we can establish the evidence and prove that gender-sensitivity could make a difference in improving healthcare for a greater number of people.

Developing Core Competencies

The second step probably would be to determine what "core competencies" are needed to deal with situations that we want to address in a gender-sensitive manner and to identify entry points within the health care delivery system where changes must occur.

While this may sound simple, it may in fact be the most difficult step in the process for standard-setting, as this process entails a deep understanding of the healthcare delivery system with all its permutations.

national, regional and local, public and private, promotion-prevention-treatment-rehabilitation, formal and informal sectors, health center-based, hospital based, home-based, community-based, those covered by health insurance and those who are not, and so on and so forth.

Given the complexity of the healthcare system, empirical evidence must be the basis for deciding on how and where interventions are to take place.

Let us take for another example the detection of breast cancer in women. A couple of years back, I had a patient who came to me with a painful bone lesion at the level of the right knee. She had been to three major medical centers over a period of a few years, where she had been given all kinds of painkillers and advice on arthritis and yet the pain would not go away. After taking a history, I thought I would do a complete physical exam instead of going straight ahead to the knee. I must say the temptation to focus on that knee was great. But since we were running a women's clinic we had made it part of our the routine to do a breast exam on ALL PATIENTS, regardless of what the chief complaint was. Lo and behold there was a large dimpling mass on the left breast, which was unmistakably breast cancer. It turned out that the bone lesion was in fact a metastasis from the breast mass.

So the question is, if we are to set standards for breast cancer detection through a clinical breast exam, where should we build that capacity? With the cancer specialists? With the general practitioners? With the midwives? With the medical students? With the women themselves? Who will teach women to do self-breast examination? Where do they go if they palpate a mass? To a surgeon? To the OB? To the oncologist?

These are practical issues that must be addressed. It is not enough to say that the policy is that all women should undergo a clinical breast exam. It doesn't work that way with a click of a finger. There must be a strategic intervention point where a critical mass for change can be faster and more easily realizable.

This reminds me of Dr. Cora Ngelangel's proposed alternative 'visualization' method for screening for cervical cancer using acetic acid. In the Philippines, cervical cancer is the second most important cancer in women, second only to breast cancer. The incidence has remained

unchecked from 1980-1995. Close to 2/3 of all cases of cervical cancer are detected in the advanced stage where it is too late to save the patient.

For years, we in the public health sector have been pounding our heads against the wall trying to find a way to improve compliance to PAP smears which is THE acceptable standard for screening and early detection of cervical cancer. Routine PAP smears have significantly decreased morbidity and mortality from cervical cancer as a public health concern in most of the developed world. On the surface, it seems simple. Women go to a clinic, a swab is taken, it is sent to the laboratory and the results are read. If they are positive the patient should be treated; if they are negative then all is well. So is this merely a problem of getting ' lazy' childbearing women to have a regular PAP smear taken?

On closer examination we find that this is not the case. What this entire process does not tell us is that this relatively simple procedure should be supported by a complex health infrastructure of physicians, pathologists, laboratories, cyto-technicians and the like; conditions which do not exist in an overwhelming number of clinics and health centers which would be the only access point for healthcare for a great majority of women who are most prone to cervical carcinoma. To compound the situation even where there are professionals who can read the slides, the chances of accurate readings are not that high. Apart from that the time elapsed between taking the smear and obtaining the results is so long that it is not unusual for a patient to have a smear taken and to forget about coming back to find out what the results were. This does not include the problem of finding an adequate way of financing surgery or treatment if the results are positive.

Dr. Ngelangel has proposed utilizing a different method for screening which is simpler, using direct visualization of the cervix and a simple staining method using acetic acid or vinegar. The evidence shows that both sensitivity and specificity issues would be appropriately addressed by this alternative screening method. And at this point it seems there is a need to convince decision-makers to shift from the conventional PAP smear to this new, more appropriate alternative that will not need such a complex support system for it to work.

So now the question is how and where do we build the capacity to

train healthworkers to undertake this new method. Which button do we press to get to where we want to go?

Core competencies in gender-sensitivity and ethical healthcare practice need to be defined and strategically determined. This also involves policy development but more importantly it requires translating policy into resources, and resources into programs. And this requires political will.

The key to operationalization here is building human competencies among health care providers.

Certification, Accreditation, or Voluntary Compliance?

Once we have agreed on priority issues, once we have set the standards and determined appropriate intervention levels and have solved the problem of finding resources for standard-setting, the next question is that of quality assurance. In any discussion on quality assurance and standard-setting we cannot escape from a discussion on the existing models that are available to us namely: formal certification of groups or individuals, accreditation of formal programs and voluntary compliance. Although, in most instances a mixture of these three approaches emerge, it is useful for us to take a closer look at each of these:

Certification refers to documentation that an individual or a group has the capacity (knowledge, attitudes, skills) to meet certain practice standards. This is usually determined through standardized testing. The implication or course is that non-certification should result in sanctions — bar from practice. This poses new problems in a system where there are deficiencies in health human resources or where more competent practitioners tend to stay in more affluent communities; this could in fact widen equity and access to healthcare in already underserved areas. Apart from this certification requires another layer of bureaucracy — the one that will ensure that standards are known, they are properly executed and that the ability to execute these standards are properly documented. As you can imagine this will come with its attendant administrative costs and difficulties.

Accreditation of educational programs on the other hand involves en-

suring that adequate knowledge, attitudes and skills are acquired through changes in the curriculum whether these are conducted through pre-service or basic health science education training or through continuing education programs. In this model, the program itself is accredited and standards based on compliance with program requirements. Very much like the certification model, accreditation of educational programs involves the creation of new infrastructure again with its attendant administrative difficulties as it entails the organization of an accrediting body. There are cross-over issues i.e. would there be incentives offered to those who participate in an accredited program over those who do not? How do organizations or institutions update themselves through an accreditation program?

Voluntary Guidelines refer to compliance with standards based on the willingness of the institution, organization or individual to do so. This implies that the institution, organization or individual would do so due to intrinsic rewards and would imply sensitivity to quality improvement and assurance as a premise, and not as a prize. In other words, in utilizing voluntary guidelines these would be undertaken based on their own merit as so determined by the implementers.

Which of these three or what mixture of these three would be most appropriate in our setting? This needs to be discussed and further studied. Off-hand, there are many opportunities for utilizing any of these approaches. The question then becomes one of efficiency. Which of these three would bring us to where we want to go in the quickest time with the least financial requirements?

In the Philippines, there is a tendency for us to want to "require" people to do things. Hence perhaps a cultural bias for certification and accreditation. Sometimes we tend to think that voluntary guidelines means that these are mere suggestions.

Experience has shown however that there is great value in voluntary guidelines if these are mixed with incentives that are not necessarily financial in nature but endow practitioners with prestige or social recognition.

In the case of the DOH Sentrong Sigla program health centers were "certified" for basic standards (using both process and outcome indicators) and "rewarded" for performance with a seal for quality and

cash incentives. In the case of PHILHEALTH, institutions and individuals are "accredited", although Dr. Romualdez wanted accreditation for services instead of accreditation of institutions. This would entail the development of both clinical practice guidelines and public health practice guidelines that would set the standards for care and could be the basis for accreditation or certification. Failure to comply would result in non-reimbursement through the health insurance system.

The experiences in these areas could be reviewed in relation to gender-sensitivity and ethical health care practices.

The Market as Driving Force

In conclusion, the one aspect of the discussion that we have left untouched is the role of client or the beneficiary in the development of these standards and in ensuring that these are maintained.

Much of what we have discussed have to do with the response of the health sector, when in fact a large driving force for change is the market itself.

Hence part of the strategy for setting standards should be consulting various publics in the deliberations and discussions on what it is that people want in concrete terms such as services.

In our setting there are larger political issues and concern which surround the problems of gender-sensitive and ethical healthcare, the most pressing being the progressive breakdown and weakening of social and democratic institutions. In its worst form it manifests as the widely perceived inability of the State to enforce law and order which results in the emergence of other power blocks that would want to determine our behavior and thinking. What is good or bad, right or wrong based on moral considerations (the Roman Catholic Church) or to coerce through the power of the gun/force (police/military), or the power to dominate and mould public opinion (media).

How do these affect our work on gender or ethics?

These will have serious implications on our attempts to develop more gender-sensitive and ethical healthcare systems.

Our society is beginning to sidestep rationality, scientific thinking and logical process and has substituted this for beliefs, religious dogma, prejudice and bias, reactionism and sensationalism. These are now becoming the key tools in decision-making processes.

The modus operandi is to rule by fear and sensationalism instead of reason and evidence.

Public opinion has overtaken due process, process of law as a means for delivering justice.

Magical thinking has overtaken scientific method as a means of establishing fact.

In this type of a society, is there still room for evidence, science or true philosophical discourse, which are the bases for much of what I have discussed here today?

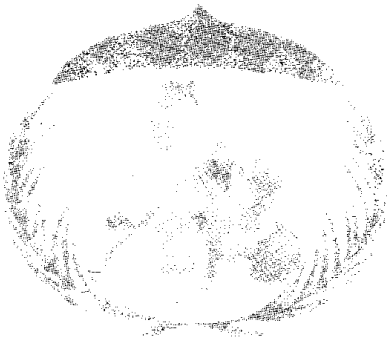
Are we left with a system where decisions will be made by the tallest tale, the scariest scenario and the biggest street mobilization?

Will these methods bring us to where we want to go?

I am afraid not.

So we ask ourselves the larger question: what is the role of the scientific community in a society where we see the disintegration of social and political institutions?

This is perhaps the greater challenge we face as social scientists and as health professionals as we address the issue of gender-sensitive and ethical healthcare.



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