

GENDER AUDIT

Ministry of Health



Republic of the Fiji Islands

GENDER AUDIT

MINISTRY OF HEALTH



Ministry for Women, Social Welfare & Poverty Alleviation,
Republic of the Fiji Islands
P.O. Box 14068 Suva, Fiji Islands

Funded by the Asian Development Bank,
Manila, Philippines

November 2003

This report is the result of a technical assistance project (TA No. 3360-FIJ) from the Asian Development Bank, carried out by a team of consultants from Agriteam Canada Consulting Ltd.

USP Library Cataloguing-in-Publication Data

Gender audit. Ministry of Health - Suva, Fiji : Ministry for Women, Social Welfare & Poverty Alleviation, 2003.

p. : ill. ; 21 cm.

ISBN 982-9007-08-1

1. Women in development - Fiji 2. Women - Government policy - Fiji 3. Sex role - Government policy - Fiji 5. Fiji. Ministry of Health I. Fiji. Ministry for Women, Social Welfare & Poverty Alleviation II. Fiji. Ministry for Women, Social Welfare & Poverty Alleviation

HQ1240.5.F5G464 2003

305.231099611

Copies of this Publication may be obtained from

Ministry for Women, Social Welfare & Poverty Alleviation,
P.O. Box 14068 Suva, Fiji Islands
Telephone: (679) 3312 199
Fax: (679) 3303 829
E-mail: women@govnet.gov.fj
Web site: <http://women.fiji.gov.fj>

and

Asian Development Bank
P.O. Box 789 0980 Manila, Philippines
Fax: (632) 636 2648
E-mail: adbpub@adb.org
Web sites: <http://www.adb.org/publications>
<http://www.adb.org/gender>

Foreword

.....

In 1998, the Ministry for Women, Social Welfare & Poverty Alleviation launched the Women's Plan of Action (1999–2008). The five main areas of focus are mainstreaming women and gender concerns, women and the law, microenterprise development, shared decision making, and violence against women and children.

These are considered the priorities that the Fiji Islands must address if we are to improve the status of women in our country.

Government's commitment to gender equality is further reinforced in its endorsement of the Millennium Development Goals, the overarching objectives of which are aimed at eradicating absolute poverty and hunger by 2015. The third of the eight goals clearly states that promoting gender equality and empowering women are critical if governments are to achieve sustainable development and eliminate the root causes of poverty. There is growing and compelling evidence that women not only bear the brunt of poverty but also that their empowerment is critically important for eliminating poverty.

In stating our commitment to gender equity, we recognize that this must be accompanied by practical, realistic, and achievable strategies. One such strategy is the focus on gender mainstreaming as articulated in the Beijing Platform for Action:

...Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programs, so that before decisions are made, an analysis is made of the effects on women and men, respectively.

The Ministry for Women supports this strategy and has established a Task Force on Gender Mainstreaming that is chaired by the Ministry of Finance and National Planning. The Task Force is mandated to implement gender mainstreaming and to support and strengthen gender responsiveness in all government processes.

This gender audit is an outcome of an Asian Development Bank-funded technical assistance (TA No. 3360-FIJ) for the Women's Plan of Action, carried out during November 2001–January 2003 and designed to support the gender mainstreaming strategy. The project assisted the Ministry and the Task Force on Gender Mainstreaming to begin to assess and analyze systematically national and sectoral policies/programs for their responsiveness to gender, based on the Women's Plan of Action. The approach was piloted in two ministries with the expectation of replicability in other government organizations. This report provides a gender audit of the Ministry of Health. A companion report covers the Ministry of Agriculture, Sugar and Land Settlement.

Mr. Rishi Ram

Permanent Secretary

Ministry for Women, Social Welfare & Poverty Alleviation

Contents

FOREWORD	iii
ABBREVIATIONS	vi
EXECUTIVE SUMMARY	vii
INTRODUCTION	1
Background	1
Rationale and Objectives	2
Methodology	4
OVERVIEW OF GENDER ISSUES AND ELEMENTS OF THE ANALYTICAL FRAMEWORK	7
Social and Gender-related Determinants of Health	7
Links Between Health Outcomes and Gender Equality	10
Summary	20
GENDER AUDIT OF THE MINISTRY OF HEALTH	21
Organizational Analysis	25
Analysis of the Policy Development Process	32
ANALYSIS OF KEY RESULT AREAS IN THE MINISTRY OF HEALTH	37
CASE STUDY: ANALYSIS OF THE HIV/AIDS POLICY, USING THE GENDER ASSESSMENT PATHWAY (GAP) TOOL	49
STRATEGIC PLAN FOR INSTITUTIONALIZING GENDER MAINSTREAMING IN THE MINISTRY OF HEALTH	57
BIBLIOGRAPHY	67
APPENDIXES	
Appendix 1: Ministry of Health Core Team Members	71
Appendix 2: Members of the Agriteam Canada Consulting Team	72

Abbreviations

.....

ADB	Asian Development Bank
GAP	gender assessment pathway
GDP	gross domestic product
GFP	Gender Focal Point
GTF	Gender Task Force
HSR	health sector reform
KRA	key result area
MoH	Ministry of Health
MoW	Ministry for Women, Social Welfare & Poverty Alleviation
NACA	National Advisory Committee on AIDS
SIDA	Swedish International Development Agency
SPIGM	Strategic Plan for Institutionalizing Gender Mainstreaming
STI	sexually transmitted infection
UNDP	United Nations Development Programme
WPA	Women's Plan of Action

Executive Summary

.....

The goal of the gender audit was to contribute to strengthening government processes by providing an assessment of any differential impact on males and females because of policies, programs, organizational structures, and processes within the Ministry of Health (MoH) and to identify where strategic initiatives could be implemented to build commitment to and strengthen capacities for gender mainstreaming. The audit was a pilot activity, intended to be replicated in other ministries, and the process assisted the Ministry for Women, Social Welfare & Poverty Alleviation to develop appropriate support and guidance for further gender mainstreaming within the Government.

The study team assessed the presence and level of various factors that facilitate gender mainstreaming, such as political will and leadership, an appropriate policy framework to support a gender mainstreaming approach, and staff with the knowledge and skills to carry out a gender analysis and gender-responsive planning and implementation.

In collaboration with a Core Team drawn from staff of the ministry, the study team conducted surveys/interviews with ministry staff; reviewed relevant documents; verified initial findings through follow-up interviews, focus-group sessions, and field visits; selected one policy area as a case study in order to assess the design and implementation of a policy from center to field level; and developed recommendations for entry points for gender mainstreaming and provided suggested strategies for incorporating gender mainstreaming into key result areas.

The findings of the draft gender audit were presented to senior members of the ministry to ensure that the findings were clearly understood and accepted. The written and verbal responses from the ministry were incorporated into the final gender audit.

The gender audit for the MoH assessed gender issues in Fiji's health sector compared to the situation internationally in two main areas: the social and gender-related determinants of health and the links between health outcomes and gender equality. The audit findings indicate that the MoH needs to develop a greater understanding of the non-medical factors that influence health outcomes. For example, many factors influence an individual's capacity to access opportunities and resources within the communities. Thus, it is important to take a broad-based approach to achieving health outcomes, including carrying out a gender analysis to contribute to understanding different health risks faced by women and men and to better predict health outcomes.

The MoH has now adopted an approach to achieving health outcomes that acknowledges people's lifestyles and that the conditions in which they live and work strongly influences their health. There is now recognition that social determinants of health have gender aspects. The audits examined the differences in patterns of health and illness in women and men in a number of areas, including biological/epidemiological differences

and gender-based differences in health outcomes and the provision and consumption of health services. A number of areas of health care were analyzed that illuminated how biological and gender-based differences between women and men influence health risks and health-related outcomes in Fiji.

The study team carried out an assessment of the presence of the enabling factors or preconditions for gender mainstreaming at MoH. Formal acknowledgement and commitment to gender equality have been made by the minister and permanent secretary. However, senior leaders within MoH still need training and sensitizing to provide direction to include a gender mainstreaming perspective for corporate planning exercises at central and divisional levels.

Priorities for a gender equality plan for MoH were identified in the 2002 Corporate Plan. Based on progress in 2002, follow through with the next steps is less certain. The structure for gender mainstreaming is in place in the Government through the Women's Plan of Action, but the Inter-Ministerial Committee and Gender Focal Point identified as critical to implementing gender mainstreaming are not active. There is extensive recognition of the importance of gender as a variable in health outcomes within MoH. The study team recommended that more systematic training is needed to bridge the gap between awareness, the existing tools, and progress in bringing gender concerns into planning and program implementation.

The organizational analysis of MoH showed that the mission and vision statements provide a strong rationale to build an analysis of gender-based differences in the development and delivery of policies and programs. These statements are backed up by a series of value statements about how MoH will fulfil its mandate. The guiding statements promote gender mainstreaming and conform with national policy statements from the Government, such as the Women's Plan of Action, and the United Nations Convention on the Elimination of all Forms of Discrimination Against Women.

Major changes to the organizational structure, such as bringing authority and responsibility for decision making closer to the point of service delivery, are being put in place with the implementation of the Fiji Health Management Reform project funded by the Australian Agency for International Development. The development of separate program unit plans and activity scheduling has changed significantly, not only within the MoH but also as part of a shift to a strategic management framework required by the National Planning Office. These organizational changes provide an opportunity to demonstrate how gender analysis and gender mainstreaming can strengthen the adoption of the new focus on health outcomes, rather than on the previous more traditional approach to disease control. To ensure that these opportunities are taken up, the gender audit recommended that the role and function of the Gender Focal Point be reviewed. The individual taking on this responsibility should be encouraged to participate more fully in interministerial committee meetings and to assume leadership within the MoH to carry out gender mainstreaming more systematically, which may require more consistent capacity building to ensure this person has the required information and analytical skills to demonstrate the importance of gender mainstreaming.

The current staffing at MoH indicates a gendered division of labor, with the overall proportion of women at 77%, while men hold the highest proportion of the most senior positions (56%) and those that require the greatest amount of training (61%). The MoH has already conducted a senior executive leadership program targeting the development of senior managers, and female nurses made up a significant proportion of those selected to participate in the program. Front line management development programs are being conducted in each of the new divisions, and nurses are well represented amongst the candidates undertaking these courses. A priority concern for MoH is the high turnover rate and high number of vacant positions, particularly for nurses.

As the approach of the MoH shifts from curative care to take into account efficiencies to be gained from changing health-seeking behavior and promoting preventative care, the knowledge that community-based health care workers bring to policy and planning in MoH is of critical importance. It was evident to the study team that nurses at the community level have a good knowledge of gender-based differences, because they observe more closely the links between symptoms presented and causal factors as they visit homes, and have the opportunity to discuss a broad scope of the patient's life. Mechanisms are now being put in place to facilitate a better flow of information from the community level up to those making decisions concerning programming and policies. The gender audit recommended that community-based staff be included in management committees at the subdivisional levels to work more closely on program planning with officers from other ministries, for example women's interest officers from the Ministry for Women, Social Welfare & Poverty Alleviation. Increasing the number of women sitting on governing boards, such as hospital boards, will increase understanding of women's needs, both as health care providers and as consumers of health services.

New procedures for the development of policies and the planning cycle have recently been put in place in MoH. Under the newly decentralized structure, the divisional levels will be responsible for developing activity plans for operational objectives and will track progress against key result areas (KRAs). The study team noted that while these changes will take some time to be operational as planning skills are strengthened and information flows adjusted, this is an opportune time to introduce planning approaches that incorporate gender variables more systematically. The study team recommended that the Core Team and Gender Focal Point at MoH encourage the incorporation of specific gender concerns as the 2003 plans are finalized at central and divisional levels.

There is now a strong statement of commitment to gender mainstreaming in the draft MoH Strategic Plan, 2003–2005. However, this commitment is yet to be translated into KRAs or draft corporate or division plans for 2003. The study team reviewed and analyzed the ten KRAs in the current draft strategic plan and provided a set of guidelines outlining where gender concerns are relevant, so that these issues are raised and gender-sensitive indicators identified to assist in assessing progress. Where appropriate, recommendations for entry points and examples of gender mainstreaming strategies were provided for objectives under each KRA.

Introduction

.....

Background

The Fiji Islands are in the heart of the Pacific Ocean and cover about 1.3 million square kilometers. There are two major islands—Viti Levu and Vanua Levu. The population of the Fiji Islands in 2000 was estimated at 854,800, of which approximately 49.8% were Fijian, 45.2% were Indo-Fijian, and 5% belonged to other ethnic groups. More than 60% of the population live in the rural areas.

The policy framework of the Government is the Strategic Development Plan 2002–2005,¹ which was presented for public consultation at an Economic Summit in September 2002 and subsequently approved by Parliament. The underlying theme of the plan is “Rebuilding Confidence for Stability and Growth.” The plan will guide the Government in its development of policies and programs over the next three years. The main policy areas covered under the Plan are ensuring macroeconomic recovery and competitive markets, engaging the global economy, an efficient and effective public sector, education and health, affirmative action for the disadvantaged (explicitly including women as a marginalized group), good governance, and partnership with civil society.

The economy grew slowly in 2001 following the coup in 2000, and the Government is adopting a more interventionist approach to economic management to address the long-standing problems of weak employment growth and poverty, low levels of private investment, and restructuring of the sugar industry.² The gross domestic product (GDP) increased by an estimated 1.5% in 2001, largely reflecting the partial recovery of the tourism sector. The labor market remained sluggish in 2001 because of the slow economic growth. During May 2000 to the end of 2001, an estimated 9,000 workers were laid off, of whom 2,700 (30%) were garment workers. Skills shortages became more evident in both the public and private sectors, as qualified and skilled citizens emigrated.

Public health care is provided free of charge (excluding oral health) through a range of hospitals, primary health care centers, and nursing stations. The coverage of service is impressive given the challenges presented by the proportion of rural population living in small communities located in remote islands and mountainous regions of the larger islands. Consistent with international trends, the population of the Fiji Islands is ageing, and suffering increasingly from noncommunicable diseases associated with lifestyle changes rather than communicable diseases. Changes are also taking place regarding the health-seeking behavior of the population, indicated by increases in bed occupancy rates and lengths of stay in hospitals in 2000,³ while at the same time there is significant attrition

¹ Government of the Fiji Islands 2001.

² ADB 2002.

³ MoH 2002b, p. 4.

of both medical and nursing staff. These challenges are being addressed by the Ministry of Health (MoH), while at the same time there is pressure to reduce spending and increase efficiency of service delivery across the whole public service.

During the Fourth United Nations Conference on Women held in Beijing in 1995, the Government made commitments in 5 areas to advance and achieve the goals set out for women into the new millennium: (i) mainstreaming of women and gender concerns in planning processes and all policy areas, (ii) review of laws affecting women, (iii) micro-enterprise development, (iv) gender balance among decision makers, and (v) eliminating violence against women and children.

Following the Beijing Conference, the Ministry of Women and Culture (MoWC; now called Ministry for Women, Social Welfare & Poverty Alleviation, or MoW) developed and formulated the Women's Plan of Action (WPA), incorporating these 5 areas of commitment. The then Prime Minister Rabuka launched the WPA in 1998 and an inter-ministerial committee comprising deputy permanent secretaries was set up to oversee the plan. A Task Force on Gender Mainstreaming, chaired by the permanent secretary of National Planning, was established to provide guidance and direction. The systematic implementation of the WPA requires (i) assisting the MoWC to realign and strengthen its capacity to advise and coordinate the implementation of the WPA, and (ii) gender capacity building in the sectoral ministries that have the primary responsibility for implementing the WPA. Translating the document into concrete programs and actions requires institutional strengthening of the sectoral ministries to carry out gender-responsive planning and programming.

Rationale and Objectives

As identified above, the first key objective of the Government's WPA (1999–2008) is "mainstreaming women's and gender concerns in the planning process and all policy areas."⁴ The WPA goes on to identify 3 major components in the mainstreaming process:

- using the structure and management of government machinery to allow concerns of women and of gender to be taken care of in mainstream policies, programmes and projects;
- consultations with and input from women....; and
- public advocacy and monitoring.

In order to use the structure and management of government machinery, it is important to develop and strengthen government processes to be gender responsive, and the WPA specifically identifies gender audits as a direction for action. This is identified as "...sectoral studies of policies, programmes, projects, legislation, etc. for

⁴ Ministry of Women and Culture 1998, Volume 2, p. 6.

gender responsiveness.”⁵ There have been no previous attempts to mainstream gender concerns systematically into the work of the MoH.

The gender audits will contribute to strengthening government processes by indicating the status quo and where strategic initiatives can be taken up to build commitment to and strengthen capacities for gender mainstreaming. The output will also assist MoW to develop appropriate supports and guidance for gender mainstreaming within the government machinery. It should be noted, however, that a gender audit alone cannot sustain effective gender mainstreaming within a ministry. Consultation with women and public advocacy are parallel strategies for sustaining gender mainstreaming.

According to the Organisation for Economic Co-operation and Development’s Development Assistance Committee on Aid Evaluation, an audit is an independent, objective assurance activity designed to add value to and improve an organization’s operations. Management audits can be used to assess whether an organization’s mandate is actually followed in reality, why tasks are performed, how well they are performed, and to what effect. In this context, a gender audit might be conducted to assess the conditions that a particular organization has created to realize gender mainstreaming, what is actually being done to achieve gender mainstreaming goals, and the perception of achievement of those involved in gender mainstreaming.

These types of audits are looking at past performance based on pre-established benchmarks provided in policies or action plans, and identifying opportunities to improve performance.⁶ Other elements have been included in some gender audits, drawing from social audit methodologies. The two major purposes of audit processes as identified by social audit methodologies in general are “a) to assess accountability of agency work in relation to values, vision and policy and b) to improve agency performance.”⁷ These social audit approaches recognize the important role that attitudes of individual staff members play in taking up leadership and changing decision-making patterns in order to bring gender equality concerns into the mainstream of an organization’s operations. In this study, certain aspects of these social audit methodologies have been adopted.

The objectives of the gender audit for MoH are

- to review and assess the organization’s potential for incorporating differential impact on males and females of MoH’s policies in key result areas (KRAs) and hence into programs as delivered in the Fiji Islands; and
- to identify entry points for increasing gender responsiveness of the MoH, including potential links to and/or support from the MoW, Task Force on Gender Mainstreaming, other central agencies, etc.

⁵ Ministry of Women and Culture 1998, Volume 1, p. 8.

⁶ SNV 2000, p. 4.

⁷ Hunt 2000, p. 25.

Methodology

Analytical Framework

In assessing the differential impact on males and females of the policies and programs of the MoH, the analysis

- distinguishes between gender inequality aspects of health outcomes and health care services (the role of gender and gender relations in the creation of health risks or disadvantages within the health care system, for example, in access to or provision of services) and women's specific health needs (based on differences in epidemiological profiles between sexes and hence the types of services required by them) and applies these findings to KRAs of MoH operations. Responding to these differences will improve health outcomes and efficiency in delivery of the MoH mandate; and
- reviews the level of organizational and attitudinal enabling factors for gender mainstreaming within the MoH. Based on experience, key preconditions or enabling factors for gender mainstreaming were identified and verified through workshops with the MoH and other stakeholders in order to identify where and how these factors could be strengthened within the specific organizational structures of different government line ministries.

Application of the Framework

A Core Team⁸ for gender mainstreaming from the MoH was selected to participate in all technical assistance activities, including the gender audit. In collaboration with the Core Team from the MoH, the study team

- (i) conducted survey/interviews regarding enabling factors for gender mainstreaming to assess staff perceptions and organizational structures;
- (ii) carried out a review/audit of documents and other material available;
- (iii) verified findings from (i) and (ii) above through follow-up interviews, focus-group sessions with Core Team members, and field visits;
- (iv) used the HIV/AIDS policy and strategic plan as a case study in order to assess implementation of policy. This provided the context for looking at the potential to strengthen the enabling environment for gender mainstreaming; and

⁸ The list of Core Team members is given in Appendix 1; and the study team members (Agriteam Canada Consulting team) are listed in Appendix 2.

- (v) developed recommendations for the MoH and MoW, Task Force on Gender Mainstreaming, and other relevant central agencies, of entry points for future actions to strengthen gender mainstreaming and gender responsiveness within the MoH (the gender mainstreaming institutionalization strategy), and provided examples and suggestions of gender equality issues relevant to MoH KRAs.

Structure of the Report

The report first presents an analysis of gender issues associated with determinants of health outcomes; reviews the organizational structure and different MoH KRAs to provide an overview of how the ministry operates; develops recommendations for each area that a) identify entry points where pre-conditions/enabling conditions can be strengthened for gender mainstreaming, and b) suggest how operations can become more gender responsive.

A case study is presented illustrating in more detail how gender mainstreaming can be strengthened through the identification of entry points and the development of a gender action plan.

Overview of Gender Issues and Elements of the Analytical Framework

.....

Social and Gender-related Determinants of Health

There have been numerous changes in attitudes toward (and the organization and financing of) health systems over the past 40 years.⁹ There has been a greater recognition by experts of the role of good health in economic development, as illustrated by the use of health measures as indicators of overall development (e.g., life expectancy in the Human Development Index (HDI) of the United Nations Development Programme (UNDP) and the need for health systems to meet new challenges, such as the spread of HIV/AIDS, and shifts in patterns of disease away from infectious (e.g., polio, malaria) to lifestyle diseases (e.g., diabetes and alcohol or tobacco addiction).

There has also been a significant shift in perceptions of the goal of those government agencies responsible for the delivery of health services away from disease control toward prevention and maintenance of good health, or healthy communities. However, developing strategies to achieve good health involves many more factors beyond government-delivered health inputs and services, such as the identification and addressing of environmental and social factors (including gender inequalities) that either contribute to or detract from health objectives. It also requires an understanding of what communities and individuals define as good health, and how their criteria might be maintained, involving a broad range of factors beyond those resolved through the application of good medical science.

At the same time, there has been increasing pressure on governments to control spending on health care. Greater financial control has increased attention on the efficiency of health services provided—hence, analysis of the quality and appropriateness of the supply of services against the actual demand. The introduction of cost-recovery mechanisms to offset cuts applied to the financing of health services has led to debates concerning how alternative pricing systems can affect access to, and use of, services among different population groups. In turn, this has encouraged greater understanding of different factors, beyond simple, cost-effective health-seeking behavior—again requiring social analysis of differences among members of communities and households.

Cost reduction and greater efficiency have also resulted from increasing the burden of responsibility to individuals and households for achieving health outcomes through public-health measures (e.g., community involvement in environmental health issues, improving workplace health and safety standards), and changing health-seeking behavior (e.g., dietary changes, preventive care). However, many of these changes affect women as

⁹ The following sections draw on material from several publications, including Oxaal and Cook 1998; Lopez-Acuna 2000; and Standing 1997.

primary health-care providers within the family. Their burden of work and responsibility for rehabilitation after hospital care, for example, may be intensified, without necessarily increasing their access to appropriate resources, such as cash, information, or skills.

During this period of financial constraint, many governments, including that of the Fiji Islands, have identified the need to implement health sector reforms (HSR) affecting the organizational structures and mandates of ministries and other government agencies involved in health-service delivery. Debates continue in all countries, both developed and developing, concerning the merits of alternative mixes of responsibility for the delivery and financing of health services and, hence, the overall capacity of a Ministry of Health to deliver affordable health services equitably to all its population. Emerging from these debates is an acknowledgement that good health is a basic right of all individuals. As stated in the draft Strategic Plan for the MoH in the Fiji Islands for 2003–2005:

*The Ministry of Health acknowledges that it is the right of every citizen of the Republic of Fiji, irrespective of race, sex, colour, creed or socio-economic status, to have access to a national health system that provides a high quality of health services. The principle function of which is to promote and maintain the health and well being of the citizens of Fiji to the maximum extent possible within available resources.*¹⁰

The draft Strategic Plan also notes that people's lifestyles and the physical conditions in which they live and work strongly influence their health; it provides a list of examples of social determinants of health, illustrating the importance that the MoH now places on taking a broader-based approach to providing preventive and curative services in order to achieve its overall mandate. The draft states:

All of the ... social determinants are experienced differently for men and women, and these gender-based differences need to be recognised as the Ministry of Health seeks to increase the health status of the population.

*A comprehensive approach to addressing social determinants of good health for men and women requires the mainstreaming of gender concerns into the corporate plan of the Ministry of Health. Mainstreaming these concerns will ensure that the basic right of every citizen, irrespective of sex, to have access to a national health system that provides a high quality of care appropriate to their needs will be respected.*¹¹

The MoH also recognizes that health outcomes—its measure of achievement (broader than the evaluation of activities alone)—are not only the responsibility of hospitals and the medical and/or curative model of care, but “will come from a health system-wide approach” depending upon this broader definition of good health outcomes that also involves all members of the community.

¹⁰ MoH 2002b, p. 2.

¹¹ *Ibid.*

These shifts in focus adopted by the MoH require a good understanding of the non-medical factors that influence health outcomes. A comprehensive approach to achieving improved health outcomes will need an organizational structure and technical capacities that take into account gender-based differences in social determinants, among other variables, such as race, age, and economic status.

While the term *gender* is now used in many contexts, its relevance to determining health outcomes is not always clear. Many factors influence the way individuals interact with others in society and determine an individual's capacity to access opportunities and resources within his or her family and community. There are two basic types of factors associated with being male and female: those that are fixed, i.e., biologically determined, and those that are constantly changing between generations, cultures, and ethnic groups, i.e., socially determined; the latter factors are termed *gender-based differences*. In other words, being a man or woman or growing up as a boy or a girl is influenced not only by biological differences but also by social attitudes and stereotyping about what is appropriate for a girl or a boy to do within the family, how to earn an income, and how to behave.

Relations between women and men—whether in the family, the workplace, or the public sphere—also reflect gender stereotypes and expectations of behavior appropriate to women and men. The expectation that women are caregivers to children and elderly members of the household, for example, requires that women have access to health services for these dependents, even in the absence of financial resources or easily available time to do so. Men tend to be more involved in public spheres of decision making, including decisions about health policies, even though women are the primary users of health services.

Much work carried out to address gender-based differences focuses on women, because they are generally disadvantaged in relation to social and economic resources and decision making.¹² Most health research in the past was based on male experiences as the norm, and there has been a need to redress some of the imbalances in data and analysis concerning women's health, which to some degree has been achieved. However, taking a gender perspective rather than a women's health perspective can provide as much information on the needs and behavior of men as of women. As identified in the MoH vision statement,¹³ it is important to take a broad-based approach to achieving health outcomes, including disaggregating the experiences and expectations of the population by those factors that most significantly affect health outcomes: sex, economic status, age, race/ethnicity, and the physical environment. A gender analysis contributes to understanding different health risks faced by both women and men and to predicting health outcomes.

¹² SIDA 1997. This report explores how taking a gender perspective can help to understand men's situation as well as that of women.

¹³ MoH 2002.

Links Between Health Outcomes and Gender Equality

Patterns of health and illness in women and men show marked differences. For example, women tend to live longer, even though women in most communities report more illness and distress than men.¹⁴ Health outcomes are influenced by a very broad range of determinants and, as discussed above, include a persistent pattern of inequality based on gender differences that fall into two main categories:

- (i) *Biological/epidemiological differences between women and men.* Many health risks that influence health outcomes are linked to biological determinants, for example, the incidence of depression correlated with hormonal menstrual changes, hormonal life changes, and hormonal abnormalities among women.¹⁵ Differences in reproductive systems lead to significantly different health outcomes; e.g., death rates from prostate cancer among men are now as high in some countries as those for women from breast cancer. While these biological differences might not appear initially to fall within the definition of gender concerns, the delivery and consumption of appropriate health services to address health issues based on biological differences are influenced by attitudes and organizational structures that have highly gendered characteristics. For example, for many generations, women's responses to hormonal changes during the reproductive cycle were considered to be due to psychological "weakness" rather than biologically based. Hence, medical research and programs were misdirected and failed to address the causes of many health concerns for women.
- (ii) *Gender-based differences in health outcomes and provision and consumption of health services.* Gender relations and socially defined differences in roles, responsibilities, and, hence, behavior within households and communities influence health risks, vulnerability, and health-seeking behavior. Some factors are:
 - *Financial and opportunity costs.* Women as primary caregivers may not be able to access sufficient cash from family resources to pay for transport to seek medical care for a family member. Women also have significant opportunity costs in seeking health care, for example, they may need to find care for other children while attending a clinic. These constraints may result in delays or failure to access appropriate professional care and, hence, influence health outcomes.
 - *Different types of work.* The different work carried out by women and men determines differences in exposure to certain health risks; e.g., those caring for cattle have greater exposure to leptospirosis. Many men are involved in occupations with high injury risks (e.g., fishing), while women are increasingly used as unskilled labor in factories that have limited concern for health and

¹⁴ WHO 1998, p. 5.

¹⁵ Davidson et al. 1997, p. 2.

safety issues. A woman of child-bearing age also risks exposing herself (or her fetus) to harmful toxins or injury during work in hazardous conditions.

- *Social behavior.* Such behavior as smoking and alcohol abuse is more associated with men than with women, resulting in, for example, significantly higher rates of lung cancer among men (55% of men and 22% of women in the Fiji Islands smoke).¹⁶ Generally, physical risk taking is associated with young males in all societies and hence, young men run a much greater risk than young women of dying from vehicle accidents (often associated with alcohol abuse) and violence.¹⁷

There are differences in the definitions of good health outcomes for women and men, as well as different priorities for care. For example, some studies have demonstrated that women's definitions of health encompass more lifestyle, psychological, and social factors and less emphasis on absence of disease.

Gender-based differences within the family and health-providing organizations also influence the provision of health services. There is a strong division of labor in the delivery of voluntary health care in the home— women are primarily responsible for caring for all sick family members. Among professional health providers, women tend to be nurses and hold lower status positions within decision-making bodies, whereas men tend to have more training and become doctors. These differences influence not only the way that health care is provided, but also the manner in which both women and men seek professional care. Public-health campaigns, for example, have addressed the need to target male and female clients differently, and other types of health programs are beginning to follow suite.

A brief analysis of several areas of health care illustrates how biological and gender-based differences between men and women, and gender relations influence health risks and health-related outcomes.

Incidence and Treatment of Noncommunicable Diseases

Addressing the increasing incidence of noncommunicable diseases, such as diabetes, hypertension, and heart disease, is of growing concern to the MoH. The incidence of diabetes and obesity is related to changes in diet and, because responsibility for purchasing food lies primarily with women in the Fiji Islands, public health campaigns are attempting to dissuade women from buying highly processed, high fat, and high carbohydrate foods that exacerbate diabetic or obese conditions. Heart disease and hypertension may also be linked to changes in diet, but also to more sedentary life styles for both women and men. Different messages are required to change such behavior among different ethnic groups with different food preferences.

¹⁶ UNDP 1999, p. 63.

¹⁷ WHO 1998, p. 6.

Addressing patterns of behavior, therefore, requires different approaches, both in preventive and curative programs. A recent study carried out by the Pan American Health Organisation¹⁸ in Peru and Argentina found different attitudes of women and men patients and health professionals toward diabetes type II and hypertension conditions. The study demonstrated significant gender-based differences that have similarities with experiences recounted during the present audit. For example, women tend not to comply with medically prescribed diets, because they see taking care of themselves as selfish, particularly in economically difficult situations where special diets mean additional food expenditures; in addition, they believe they have no control over their health situation. Men do not comply because they doubt the doctor's recommendations and/or they feel better.

Patterns of social behavior also present different risks for women and men. Alcohol abuse among men not only results in illness for the individual but is also linked to high levels of traffic and other accidents, domestic violence, suicides, and violent crime.¹⁹ Studies that track progress on health outcomes associated with noncommunicable diseases have to take into account a broad range of risk factors and determinants. Some public health campaigns have taken these gender differences into account, but other program areas need adjusting to respond more flexibly to these kinds of social determinants.

Incidence and Treatment of Communicable Diseases

Exposure to health risks that lead to communicable diseases is affected by many factors, most of which have a gender dimension. For example, the incidence of dengue is associated with environmental factors, including prevalence in areas where the vector might breed, such as standing water. Women, who remain closer to their houses in rural settings, might be more exposed to these sites. Access to bed nets might be influenced by gender differences in decisions regarding household expenditure.

The delivery of curative care for communicable diseases is also influenced by gender differences. Men tend to wait until symptoms are more critical before seeking medical care and, hence, expose themselves to greater risk, whereas women might attend clinics but be unable to purchase certain items (such as bed nets) required to address risks. The opportunity costs for women to seek care for themselves and other household members are also influenced by their multiple roles, and they may require, for example, clinics to be open at times when husbands are available to look after other children.

Public health campaigns could also encourage men to support women more in their health-caring responsibilities. Chronic illness and adult disability within a household are identified as a significant cause of poverty in the Fiji Islands.²⁰ Women in such households may be unable to leave the home to work, because they must care for the sick or disabled. Women may require additional support from the health care system, for example, training in

¹⁸ Cited in WHO 1998, Chapter 5.

¹⁹ WHO 1998.

²⁰ UNDP 1999, p. 63.

health care techniques. The International Red Cross HIV/AIDS palliative care programs currently being implemented in the Fiji Islands do extend support to families, and this could be used as a model for other areas of long-term care in the home.

Reproductive Health/Maternal Mortality (Family Health)

Differences in reproductive health outcomes are primarily associated with biological differences. Women's capacity to conceive and bear children means that they are much more likely than men to seek reproductive health services, both preventive and curative. Men do have specific reproductive health needs, such as those associated with prostate or testicular cancer, or the symptoms of sexually transmitted infections (STIs), that require specific prevention and curative services.

Many reproductive health outcomes, however, are also determined by gender-based differences. Difficulties during pregnancy or delivery might be the result of vulnerabilities women face, such as the inability to access enough cash to cover transport to a clinic. A woman may feel that when food is scarce, her children should receive good food before herself. Maternal mortality rates have improved in the Fiji Islands, comparing favorably with other countries in the region and globally. However, despite these gains in some areas of reproductive health, there are surprisingly high rates of cancer of reproductive organs amongst women in the Fiji Islands. This is thought to be related to a poor understanding of the importance of screening²² and other aspects of health-seeking behavior among Fijian and Indo-Fijian women.

Adequate provision of services to meet women's full reproductive health needs is a basic right. Reproductive health services require considerable resources. From a raw assessment of budget allocated, it may appear that more resources are available for women's needs than those of men. However, the health outcome of reducing maternal mortality, or improvements in other reproductive health indicators, may require that more than 50% of all resources for reproductive health target women.

Men do have an important role in reproductive health, however, and too much focus on delivering services to women may undervalue the importance of challenging certain gendered attitudes toward family planning or transmission of STIs. Traditionally, men in Fijian and Indo-Fijian society have not been involved in birthing or prenatal care, but some informants in the present audit pointed out the importance of involving men early to influence future reproductive decisions regarding child spacing, use of contraceptives, and sharing more in overall child care.

There is evidence that women prefer to be attended by women health professionals during certain prenatal and birthing procedures, and similarly that men prefer to discuss reproductive health concerns with male health professionals. The MoH has responded to

²¹ UNDP 1997, p. 54–55.

²² UNDP 1999, p. 62.

these needs for women at maternal and child health and reproductive health clinics. More attention to men's needs might be appropriate to strengthen male reproductive health outcomes.

Sexually Transmitted Infections/HIV/AIDS

The incidence of STIs, especially HIV/AIDS, is of sufficient concern to the MoH and the Government to have called for a multisectoral policy and action plan, based on broad consultation and involvement of many different stakeholders in 2002. This approach recognizes the complexity of these communicable diseases and the unique way that gender and other sociocultural issues overlap with the biological risk factors and influence prevention and care programming. The spread of HIV/AIDS in the Fiji Islands, although increasing, has been contained to date, but there is great potential for it to take on epidemic proportions and to have a significant impact on the economic and social fabric of the island community.

The risk of contracting STIs is indisputably associated with gender relations. Having multiple sexual partners is relatively common among Fijian men, particularly those who are mobile, such as seafarers and military personnel. Only 16% of all cases of syphilis in 2001 were among Indo-Fijians, compared to 77% for Fijians.²³ Men tend to control the frequency of sexual relations with their spouses, and a woman may find it difficult to insist on the use of condoms, even if she is concerned that her partner may have been exposed to disease from other sexual partners. In some relationships, these inequalities are reinforced by men through the threat of violence and the use of violence itself.

Biologically, women are two to four times more likely to be infected by HIV and other STIs than men,²⁴ because of the larger surface area exposed to their partner's sexual secretions during intercourse, which may also remain in the vagina for hours after intercourse. Therefore, women are inherently more at risk of contracting HIV and other STIs than men. Lesions and other complications from STIs for women also increase the entry points for HIV. Because of women's physiology, symptoms of STIs remain unnoticed for longer periods. Women who are HIV-positive present a high risk for passing the virus on to their baby during delivery.

Because of the expectation that women will provide care to sick household members, the burden of care for those with AIDS falls primarily upon women, who may themselves become infected through sexual or other contact with blood and secretions if they are not aware of the risks. Programs for providing care to people living with AIDS, such as the one currently offered by the International Red Cross in the Fiji Islands, should not only be targeting professional health-care providers, but also women caregivers and other family members in their homes.

²³ Statistics provided by MoH, Statistics Unit.

²⁴ WHO 1998, p. 10; and Population Council 2002, p. 8.

Screening for HIV/AIDS is an important part of the effort of the MoH to address the impact of this disease in the Fiji Islands, but the strategy presents many challenges associated with gender and social stigmas. The social stigma is still great; programs are being planned to change attitudes to assist people living with AIDS and to build awareness of preventive measures. This stigma is manifested differently toward women than toward men, based on attitudes regarding sexual behavior. A woman may have been infected as a result of her spouse's behavior, but will be assumed to have behaved immorally as well. Consequently, all programs need to be backed up with adequate and gender-sensitive supports for those who test positive (for example in prenatal screening), and assist in the follow-up with sexual partners, family, and others in the community. Confidentiality is key, and guidelines reinforced by legislation are now being considered by MoH under the draft strategic plan.

All facets of the prevention and care for STIs are influenced by gender-based differences for all age groups. Much has been learned in other countries that will assist the Fiji Islands in making its programs more effective; it is important that all stakeholders be aware of the gender factors involved, and not ignore the implications of these differences in all components of their work. The development of a broad-based approach through the National Advisory Council on AIDS (NACA) provides an opportunity for the MoH and MoW to take leadership on ensuring that gender is mainstreamed as the policy is put in place and implemented.

Mental Health/Depression

Women are more likely than men to report symptoms of mental distress.²⁵ Some explanations have linked hormonal causes to symptoms of anxiety or emotional instability. However, more plausible links have been made to the levels of stress faced by women with multiple roles and responsibilities, and their low status within their families or communities. This may be particularly the case among Indo-Fijian women, as demonstrated in a study of suicide levels in the Fiji Islands cited in the UNDP Pacific Human Development Report.²⁶

Men, on the other hand, experience higher rates of schizophrenia and serious psychoses globally.²⁷ Suicide in the Fiji Islands is identified by the MoH Strategic Plan for 2003–2005 as a major problem. The rate "is considered one of the highest in the world,"²⁸ and is linked to socioeconomic factors that should include gender variables. Those at greatest risk are 15–29-year olds. Young men are most likely to commit suicide, although among Indo-Fijians the rates are the same among males and females.²⁹ The pressure of rapid change in social expectations (e.g., obtaining high school grades) of young Fijian males is cited as a major cause of suicide and is an example of a gender-based difference.

²⁵ WHO 1998, p. 8.

²⁶ UNDP 1999, p. 65.

²⁷ WHO 1998, p. 8.

²⁸ MoH 2002b, p. 6.

²⁹ UNDP 1999, p. 65.

Violence in the Home and Community

As identified by the World Health Organization, "intentional and non-intentional injuries are major causes of morbidity and mortality for both women and men at all ages and across all societies."³⁰ In the Fiji Islands in 2000, this became the second leading cause of mortality behind circulatory disease.³¹ Intentional injuries are most common among men and are often linked to "masculine" behavior, risk-taking, and the abuse of drugs and alcohol. But women are also affected by male violence in several ways, either as direct victims of their spouse or others known to them, as caregivers for male family members who have sustained injuries, or as the sole responsible adult for the family if the spouse is disabled or dies from violent causes.

The physical health consequences of violence for women might include injury, STIs, or unwanted pregnancy from rape or sexual assault, alcohol or drug abuse, and irritable bowel syndrome. Mental health consequences are as severe, yet less well understood. They include post-traumatic stress disorder, depression, anxiety, and sexual dysfunction. All these conditions have a broad impact on families because they limit women's ability to fulfill their responsibilities as family caregivers and income earners.

The cost of violence against women in the Fiji Islands was estimated by the Governor of the Reserve Bank, Savenaca Narube at a seminar on the economic costs of violence against women in the Fiji Islands on 25 November 2002, to be around \$300 million annually, equivalent to 7% of Fiji's GDP. Mr. Narube based his statistics on a New Zealand case study that measured the cost of family violence. Based on those crude estimates, he concluded that 36,000 women in the Fiji Islands annually experienced violence and "this totals to \$97 million as the direct cost borne by the victims and their family". The Government spends approximately \$200 million on welfare, law enforcement, and health care for the victims.³² In some studies, many women identify a home without violence as an important criterion for good health.

Health professionals are frequently the first to encounter victims of this form of violence, but the capacity of health professionals to address these issues alone is limited, and overall changes in social attitudes will be required to make a significant difference in the incidence of violence against women. Protocols already exist for responses by health workers when they suspect child sexual abuse, and similar protocols need to be developed for domestic gender-based violence. The MoH is participating in an inter-ministerial Task Force on Violence Against Women, where a broad range of issues is being considered for government action and where the role that MoH can play in addressing this serious issue in partnership with other government and nongovernment actors can be developed.

³⁰ WHO 1998, p. 14.

³¹ MoH 2002b, Appendix 4.

³² Anon 2002a.

Occupational and Environmental Health

The gender division of labor leads to exposure to different health risks. Men are more likely than women to suffer death or disability as a result of occupational hazards. Men tend to be employed in the most dangerous industrial sectors, such as operating heavy machinery on ships, farms, and in factories. The division of labor between women and men in subsistence agriculture in the Fiji Islands varies among Fijian and Indo-Fijian communities and regions. For example, there are risks of leptospirosis among women tending to cattle. Weeding and other repetitive activities requiring bending and carrying heavy weights (usually carried out by women) can result in arthritis and other chronic conditions, which are often identified by community health workers as the most commonly reported health problems for women in more remote, rural areas of the Fiji Islands.³³

Women in the Fiji Islands, however, are now taking up more paid work outside the home and are working in many sectors with low health and safety standards, such as the garment sector. In some countries where cheap female labor is used in the industrial-scale production of goods, such as manufacturing chemicals, hormone-dressed seeds, or attaching lead weights to fishing nets, the incidence of occupational injury among women has sharply increased. Many products are particularly hazardous for a woman during her reproductive years and have far-reaching implications for the health of her children as well as herself.

These shifts in patterns of employment for women and the trend by some manufacturers to lower labor costs by ignoring health and safety regulations should be taken into account in occupational and environmental health programming. For example, the present audit team was informed in Levuka that female factory workers at the Pacific American Fish Co. cannery make up the majority of admissions to the health clinic; health and safety concerns need to be raised with the cannery owners.

A primary focus of environmental health programming in the past has been improving water and sanitation conditions. Care has been taken to involve women in planning and implementing these programs, and this approach to community participation can be extended to all areas of health programming.

Care of Older Persons

Despite recent reversals of previous progress in the Fiji Islands in raising life expectancy,³⁴ longevity will increase over the long term and the resources and skills required to address care for the elderly will need to change. One significant characteristic of older populations is that they are increasingly female. Reductions in maternal fertility and mortality because of economic, social, and scientific improvements have sharply demonstrated

³³ From interviews during the present study.

³⁴ Government of the Fiji Islands 2001, p. 121.

women's inherent biological advantage over men. While women may live longer, experience in countries with greater life expectancy, such as Canada,³⁵ has demonstrated that their quality of life is limited by chronic illness during later years. This has significant impact on health costs and the need for skills and resources to address the increased incidence of diseases (such as arthritis); different ways that services have to be delivered to the elderly as mobility becomes limited; and the increased demand for drugs. The need for more rehabilitation programs to address the needs of the elderly. However, a gender dimension needs to be added to ensure that these programs are appropriate for the needs of women as well as men.

Older women are also expected to provide care to other household members, especially as younger women are taking up employment outside the home. Many women look after their grandchildren and, because they live longer, may at the same time be required to care for chronically ill spouses. These challenges can often result in stress and depression for older women as new responsibilities are added while their energies and health are deteriorating.

Care Giving from the Community

Health outcomes are also influenced by the capacity of caregivers in the home, primarily women, to take up where the public system stops, such as after a patient leaves hospital, or for non-acute care in the home (colds, influenza, and such chronic conditions as arthritis). The network of volunteer health workers established by the MoH, working out of village nursing stations, provides basic support to women caring for family members at home. In the evaluation report by the Australian Agency for International Development (AusAID) of the Fiji Kadavu Rural Health Project, it was noted that where volunteer health workers and village health committees, organized through local structures with support from Soqosoqo Vakamarama (Fijian Women's Society), "...were functioning well, women were represented in equal or greater numbers than men"³⁶ on the committees. These village health committees provide opportunities for women as caregivers and consumers of health services to have input into the planning and delivery of services. The AusAID report also notes, however, that only in rare cases are women chairing these committees.

The extent to which women's voluntary labor in caring for the sick within the family contributes to achieving overall health outcomes is not necessarily taken into account as services are adjusted to respond to new spending constraints. Under many HSRs in developed countries, increased burden has been placed on home-based care, often without adequate community support being put in place, and in some areas of health care, outcomes have deteriorated.

³⁵ Interview with Professor Michel Kerisit, specialist in Gerontology and Women's Health, from the School of Social Work, University of Ottawa, Canada.

³⁶ Aus Health International 2000, p. 20.

In the Fiji Islands, where traditional family structures are still strong, women can draw on community support when they are required to care for sick family members, but as families become more urbanized, these traditional supports may deteriorate. New challenges are also coming to the Fiji Islands, for example, palliative care for people living with AIDS. Improving the skills of home-based caregivers before critical care is required, so that chronically sick or rehabilitating patients may remain in their homes longer, is an important factor when considering not only the quality of their lives but also for limiting the costs of long-term care. It is also important that women are consulted as family caregivers as concerns over the increasing use of hospital care in the Fiji Islands are addressed. A contributing factor to increased hospitalization³⁷ might be a result of more women being unable to continue to provide care within the family because they are working outside the home.

Health Research

Women's health experts have identified many types of gender biases in medical research. Methods frequently took men as the biological norm, partly to avoid complications presented by hormonal changes experienced by women. But biologically-based differences were not integrated into the health policies or programs resulting from research findings. Medical research has also tended to cover topics of greatest concern to male decision makers within the scientific community and ignored areas of concern to women or community-based health workers. This situation is changing in developed countries. Gender biases in medical research have been identified and are mostly avoided or corrected. Further, determinants of health outcomes that reach beyond scientific factors are also now being taken into account; this has necessarily brought gender-based differences more into the scope of study.

Nevertheless, some areas of health-care delivery of particular significance to women are still not well explored through research. For example, the impact of different cost-recovery mechanisms on disaggregated populations has been addressed in a limited manner. Such issues are of vital importance, because HSRs are underway in countries where financial constraints may demand quick decision making without extensive exploration of gendered impact of changes in policies and programs.

Because women participate less often than men in decision making at the highest levels in political and government organizations, research findings challenging and changing gender imbalances tend to be ignored in favor of more traditional solutions. The ongoing efforts to increase the representation of women in health decision-making bodies, such as the decentralization process now underway in the Fiji Islands, have the potential to influence decisions regarding health research and how the findings are used in policy and program development.

Much new research information is available in many areas of women's health, gender variables in health care provision, health-seeking behavior, and overall risks and vulnerability

³⁷ MoH 2002b, p. 4.

that can be applied to the Fiji Islands. If a gender task force is established within the MoH, it could be given the responsibility to collect and make readily available current information in all relevant areas of health programming in the Fiji Islands. The possibility of setting up a research center for women's health at the University of the South Pacific or establishing networks with existing centers where such research is carried out should be considered to ensure that the MoH can access all relevant information required to mainstream gender concerns in all policies and programs.

Summary

It is important that gender-based differences are taken into account when developing policies and programs to improve health outcomes.

- A gender analysis can predict certain impact of policies and programs, and assist in identifying priorities for action.
- Gender-sensitive indicators are required that reflect different rates of progress toward result areas with gendered elements.
- It is also important to understand where such analysis is most appropriate in the cycle of planning and implementation of policies and programs, and to provide guidance on types of issues that might need to be taken into account.
- A gender mainstreaming approach also requires different tools and skills, and leadership in taking up these issues as traditional analytical practices are challenged.

A gender audit should take into account all of these factors in analyzing the organizational structure and existing policies and programs to promote a practical approach to gender mainstreaming.

Gender Audit of the Ministry of Health

Integrating a gender mainstreaming approach into the MoH requires a series of actions to be taken, and for certain skills and knowledge to be in place, before progress can be made. A series of enabling factors that facilitate gender mainstreaming has been identified based on experiences of gender mainstreaming in other governments.³⁸ These factors are

- political will and leadership;
- appropriate policy framework that provides strong rationale to take up a gender mainstreaming approach;
- structure and mechanisms within an organization;
- human and financial resources;
- sex-disaggregated data;
- knowledge and presence of supporting tools;
- adequate motivation; and
- demand from civil society and other stakeholders.

The study team carried out an assessment of the presence of these preconditions or enabling factors in several government agencies, including the MoH, based on the findings of a survey and interviews with individual staff members as a first step in the gender audit. The table on page 22 presents, in brief, the findings from the survey and analysis.

As identified in the table, several opportunities exist to strengthen many of the enabling factors for gender mainstreaming, particularly as the MoH is undergoing significant organizational reform. The following sections provide a more detailed analysis of where strategic entry points exist. First there is an assessment of the organizational mission and structures and how this provides opportunities and constraints to strengthening gender mainstreaming. The corporate plan now identifies KRAs to cover comprehensively all aspects of how the MoH develops and delivers its programming, and strategic entry points for gender mainstreaming will also be recommended for each of the relevant KRAs.

³⁸ Government of Indonesia 1999; and CIDA/Agriteam Canada 2000.

MoH Survey Findings

Enabling Factors for Gender Mainstreaming	Yes	No	Part	Comments
<p>Political Will and Leadership: Formal acknowledgement and commitment from Ministry decision makers/leaders that gender equality is a critical starting point for the implementation of gender mainstreaming.</p>	√		√	<p>Yes and partial because minister and permanent secretary (leadership) have approved, but political will is still partial because senior leaders are not necessarily aware. They still need training and sensitizing to provide direction for strategic steps, with corporate planning exercises at central and divisional levels, and to assist in the articulation of why and how gender mainstreaming will improve effectiveness and efficiency of MoH, and will fulfill the equality mandate of the Ministry.</p>
<p>Policy Framework: A specific gender equality policy, plan, or statement within the organization.</p>			√	<p>Priorities were identified in 2002 Corporate Plan and demonstrated in development of draft HIV/AIDS policy. However, follow through with next steps based on progress of 2002 priorities is less certain.</p> <p>The Core Team found it challenging to bring gender issues into discussions for the 2003–2005 Strategic Plan; a specific statement was added to the draft, and it is hoped that priorities and indicators will be included in the 2003 Corporate Plan at central and divisional levels.</p>
<p>Government Structures and Mechanisms: The structures and mechanisms/operating guidelines of the Ministry, such as planning, priority setting, resource allocation, implementation, monitoring, and evaluation. These are consistent with the goals of gender mainstreaming and contribute to the incorporation of gender perspectives within Ministry processes. National women's machineries are recognized as advocates and expected to provide leadership in gender mainstreaming, gender analysis, coordination, and monitoring.</p>		√		<p>Structure is available as set out by the MoW, but there has been a lack of active participation of the MoH Gender Focal Point in inter-ministerial activities, or to take leadership in key corporate planning process for the 2003–2005 Strategic Plan. The Core Team was expected to provide support on gender issues. Divisional-level decision makers will play an important role in corporate planning and setting goals at levels close to health-care users; structures and mechanisms need to be put in place to support gender mainstreaming at these levels.</p> <p>Mechanisms are more clearly identified in the draft HIV/AIDS policy with NACA and representation from stakeholders including women's organizations.</p> <p>Links at the local level to MoW staff are not used fully to provide additional support in gender mainstreaming.</p>

(continued next page)

MoH Survey Findings (cont'd.)

Enabling Factors for Gender Mainstreaming	Yes	No	Part	Comments
<p>Human and Financial Resources: Resources allocated to support the structures (Inter-Ministerial Committee, Gender Focal Point, etc.) and practices required for mainstreaming activities; i.e., to engage in gender analysis and gender-responsive planning and implementation.</p>		√		<p>Structure is in place, but the Inter-Ministerial Committee and Gender Focal Point are not active. Hence, specific resources are not allocated to achieve significant progress on gender mainstreaming.</p> <p>Human resources are not in place, i.e., persons with adequate training and skills to carry out gender analysis and implement recommendations at divisional levels, where new patterns of decision making will start once HSRs are finalized.</p> <p>Knowledge of gender-based differences is strong at the community level among nurses and health volunteers. However, they are not aware of how to use this information and structures are not in place through which it could flow to decision makers.</p> <p>Resources can be more effectively applied if gender-based differences are taken into account, e.g., by installation of appropriate infrastructure for women patients in hospitals, or stopping inappropriate preventive health messages being created for women.</p>
<p>Sex-disaggregated Data: Data that document differences in circumstances and opportunities between women and men to provide the basis for policy and program development and evaluation.</p>	√			<p>Yes, MoH has an existing health management information system that is being strengthened. There is a good opportunity to bring gender analysis into the new procedures and analytical requirements in this unit. Monthly reports contain extensive, sex-disaggregated data that are consolidated at the central level. Training is required to demonstrate how these data can be used to provide strong gender analysis of trends in all aspects of the health information system.</p> <p>There is no systematic collation and analysis of qualitative information that already exists at the district and community levels regarding gender aspects of key social determinants of health outcomes.</p>
<p>Knowledge and Presence of Supporting Tools: The tools and materials to conduct gender analysis and the skills to use these tools</p>			√	<p>Yes, there is extensive recognition of the importance of gender as a variable in health outcomes; however, more systematic training and other support are needed to bridge the gap between awareness, the</p>

(continued next page)

MoH Survey Findings (cont'd.)

Enabling Factors for Gender Mainstreaming	Yes	No	Part	Comments
effectively to develop gender mainstreaming strategies.				<p>existing tools, and progress on bringing gender concerns into planning and program implementation.</p> <p>Health care providers at the community level intuitively identify and build into their work gender-based variables regarding health-seeking behavior and health risks; however, they are unaware of tools that are available to build this information into planning and program delivery.</p>
<p>Adequate Motivation: Ministry employees, both male and female, given opportunities, encouragement, and incentives to develop new skills and take on new responsibilities for mainstreaming gender within government sectors.</p>			√	<p>As identified above, there is a great deal of awareness of the importance and implications of gender-based differences in such areas as health risks, particularly among the nursing staff at the community level. However, encouragement and opportunities to take these issues up during decision-making procedures are absent.</p> <p>There are also incentive gaps (e.g., travel allowances) between nursing staff and medical officers, implying that not enough importance is given to the skills and information of women caregivers in planning and programming.</p>
<p>Demand from Civil Society: Individuals and groups within a society who play a role in motivating government to fulfill its commitment to gender mainstreaming; appropriate consultation with client groups, both male and female.</p>	√			<p>Reforms are currently underway that revise the structure of Health Boards and other mechanisms through which stakeholders provide inputs into MoH policies and programs. Currently, there are very few women on these governing boards, but increased efforts can be made to ensure women's voices are heard at these strategic levels.</p> <p>The draft HIV/AIDS Policy is being guided through the NACA, which includes representation from activists and stakeholders representing women's organizations, and is taking leadership of gender concerns. This model could be applied in other areas of concern to MoH. Data available from patient satisfaction surveys can be used to contribute to gender analysis; there are currently few complaints, but direct questions concerning differences in access to health services for women and men could be added.</p>

While it is important that specific gender issues are identified in each of the KRAs and indicators that take into account different impact of policies and programs on men and women, it is also necessary that internal organizational structures are changed and strengthened to guide and monitor the overall progress of gender mainstreaming within the MoH. The MoH Core Team members together with the study team developed an institutionalization strategy to build on the findings of the gender audit. The detailed plan, Strategic Plan for Institutionalizing Gender Mainstreaming (SPIGM) in the Ministry of Health (p. 57), includes specific objectives, performance indicators, strategic steps, risks and mitigation strategies to overcome these risks, and a timeframe as well as identifying who is responsible for completing each step.

Organizational Analysis

Mission and Vision of the MoH

The MoH Draft Strategic Plan for 2003–2005 contains the following Mission and Vision statements:

Mission: to provide quality health services for the people of the Fiji Islands.

Vision: an integrated and decentralized health system to foster good health and well-being.

These statements are backed up by a series of value statements concerning the approach of the MoH to fulfilling its mandate:

Customer focused: being genuinely concerned that our customers receive quality health care, respecting the dignity of all people.

Equity: striving for an equitable health system and being fair in all our dealings; irrespective of ethnicity, religion, political affiliation, disability, gender, and age.

Quality: pursuing high quality outcomes in all facets of our activities.

Integrity: committing ourselves to the highest ethical standards in all that we do.

These guiding statements provide strong rationale to build an analysis of gender-based differences in the development and delivery of policies and programs in MoH. A series of social determinants affecting health outcomes is also outlined. A later draft of the Strategic Plan also includes the following statements:

All of the ... social determinants are experienced differently for men and women, and these gender-based differences need to be recognised as the Ministry of Health seeks to increase the health status of the population.

*A comprehensive approach to addressing social determinants of good health for men and women requires the mainstreaming of gender concerns into the corporate plan of the Ministry of Health. Mainstreaming these concerns will ensure that the basic right of every citizen, irrespective of sex, to have access to a national health system that provides a high quality of care appropriate to their needs will be respected.*³⁹

The statements promoting gender mainstreaming conform with national policy statements from the Government; for example the WPA and international commitments, such as the United Nations Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). While these statements are important, a broader approach has to be put into practice throughout each KRA for corporate plans to enable mainstreaming to take place and enhance the health services delivered to women and men at the community level.

The key reasons for incorporating a gender mainstreaming approach that can be used by staff to argue for the inclusion of gender analysis into their work planning include:

- *Customer-focused approach.* Women make up 50% of the population, and are the largest group of users of health care services—both in the role as mothers (reproductive health) and as primary health providers within the home. Their specific needs have to be understood if a customer-focused approach is to be realized.
- *Equity.* Striving for equity means respecting women's right to health, as they define those rights.
- *Quality.* Males and females require different approaches to health-care service delivery, and these differences have to be understood to ensure the highest quality of service for all users.
- *Efficiency.* Financial resources have been wasted when services or preventive programs are not delivered appropriately to males and females, e.g., for women, the use of inappropriate infrastructure, clinics held at inconvenient times, and lack of understanding of social determinants specific to women.
- *Health outcomes.* These may be defined differently for males and females and, if poorly understood, may never be achieved.

Major changes to the organizational structure of the MoH are being put in place with the implementation of the Fiji Health Management Reform Project 1999–2004, funded by AusAID. As stated in the 2003–2005 draft Strategic Plan, the core management principle underlying the HSR is to bring authority and responsibility for decision making closer to the point of service delivery. This will be achieved through decentralizing the

³⁹ MoH 2002b, p. 2.

ministry's management operations; staff training and development activities to improve management capacity to carry out these changes (while also strengthening specific aspects of the ministry's management systems, such as information systems and legislative framework); and improving planning, policy development, and implementation capacities.

These changes have brought significant challenges to the staff of the MoH at all levels as lines of responsibility and accountability have changed with the re-delegation of certain decision-making powers. At the same time, the development of separate program-unit plans and activity scheduling has meant significant changes not only within the MoH, but also under the government-wide shift to a strategic management framework, as required by the National Planning Office.

The MoH has identified KRAs to guide the new program units. Each program unit in the Central Office will focus on national-level activities, including health policy and planning, standards setting, monitoring, and review. Authority and responsibility for operational management of health-care delivery are delegated to the divisional level. The secondary objective of these structural changes is to reduce the current demands on medical officers to take all management responsibility for the delivery of all health-care systems, and allow them to focus more on public health or acute care. Other nonmedical professionals will be responsible for management and administrative functions.

All these organizational changes provide an opportunity to demonstrate how gender analysis and gender mainstreaming can strengthen the adoption of the new focus on health outcomes and various determinants of health risks, rather than on the previous, more traditional approach to disease control. The changes, however, also mean that many staff are finding it difficult to meet their own work demands while having to take on additional tasks associated with new planning procedures and information collection.

The Gender Focal Point for the MoH was identified under guidelines established by Cabinet Memorandum of 1998 and further elaborated in the WPA. However, there is uneven political will at ministerial and senior management levels to encourage and systematize gender mainstreaming. MoH staff need more time and resources to ensure that a broad-based analysis for policies and programs is carried out that incorporates not only gender but other social variables. These resources need to be committed and additional incentives provided to encourage all staff to test out new approaches. Members of the Core Team now have the skills, knowledge, and enthusiasm to lead the process of gender mainstreaming, but, as identified to the study team, they also require clear demonstration of support from the Gender Focal Point and permanent secretary to validate their work.

Recommendations

- (i) Prepare a gender mainstreaming brief with clear messages on the benefits of incorporating gender mainstreaming into the policies and programs of MoH (included in Issue 2 in the SPIGM).

- (ii) Increase awareness of the importance and potential for increased effectiveness from gender mainstreaming by encouraging senior management participation in activities, such as capacity-building workshops and future activities planned by the MoW (included in Issue 5 in the SPIGM). The gender audit is providing guidance on the way in which gender analysis can assist in more effective delivery of the MoH mandate, but if senior management demonstrate that they require this approach to be incorporated into the daily work of staff by raising gender-related questions at meetings and tracking progress of key indicators, levels of gender mainstreaming will increase.
- (iii) The Gender Focal Point is encouraged to participate fully in interministerial gender mainstreaming activities and to assume leadership within the MoH to put in place the necessary mechanisms to carry out gender mainstreaming more systematically (included in Issue 1 in the SPIGM). This may require more consistent capacity building of Gender Focal Points to ensure they have both the information and analytical skills to demonstrate the importance of this approach to implementing the MoH mandate.
- (iv) The permanent secretary should provide adequate support and commitment to the Gender Task Force at Central Office to ensure that responsibilities are carried out. This can be done by including task force requirements in members' job descriptions, and by providing adequate time for them to attend gender training and meetings (included in Issue 1 in the SPIGM).
- (v) A budget needs to be put in place to implement the SPIGM to allow adequate resources for other recommendations in the gender audit. The resources required are not extensive and if unavailable from within the regular MoH budget, funds should be sought from other sources (e.g., donor agencies) to cover these costs until resources can be secured through government channels. Continued leadership from the permanent secretary will be required to ensure the necessary resources are put in place.

Staffing

The current staffing of the MoH demonstrates a gendered division of labor common to this professional area across the world. Table 1 demonstrates how, overall, the proportion of women is higher than that of men within the MoH, but the highest proportion of the most senior positions and those that require the greatest amount of training, are held by men.

It is important that women are fully represented at decision-making levels within the MoH. As primary users of health care services and as a significant proportion of health care professionals, their extensive experience and specific needs must be reflected in opportunities to shape priorities and program choices. It should not be assumed, however, that increasing the number of women at decision-making levels would encourage gender mainstreaming. It is the responsibility of all staff to incorporate these concerns into their work.

Table 1: Composition of Ministry of Health Staff, by Sex

Level	Men	% of total	Women	% of total	Total
Full Staff	565	22.7	1,915	77.3	2,480
Medical Cadre	219	61.0	140	39.0	359
Nursing Cadre (2002 data)	89	5.5	1,516	94.5	1,605
Senior Executive Service	15	55.5	12	44.5	27
Administrative/Support	0	0	51	100	51

Source: Civil List for 2000, except for nursing cadre data

At the senior executive level, the gender balance is impressive compared to that in some other government ministries. Several women with nursing backgrounds have become managers of hospitals and are responsible for nursing training, etc. The MoH has made a commitment to maintain this excellent gender balance, drawing from its large pool of highly experienced female staff, when some of these positions become assigned to professional managers following the Fiji Health Management Reform Project's implementation.

The MoH has already conducted a senior executive leadership program, targeting the development of senior managers. Female nurses have made up a significant proportion of those selected to participate in this program. Front-line management development programs are also being conducted in each of the new Divisions and nurses are also well represented among those undertaking the courses.

Education levels also affect the potential for promotion. It is difficult to promote female staff if they do not have basic education levels required for a more senior position. Table 2 indicates that the higher levels of qualification are held by male staff, primarily doctors, while the lower qualification levels are held predominantly by female staff. The MoH is addressing this issue by offering nurses a conversion program to upgrade their diploma training to that of a bachelor or nursing degree. A joint initiative with the James Cook University in Queensland, Australia provides training in the Fiji Islands, recognizing the need for minimum disruption to family and work life that is generally associated with off-shore training.

Table 2: Qualification Levels of MoH Staff, by Sex

Qualification	Male	Female
Doctoral	–	–
Masters	32	14
Bachelor	138	97
Diploma	209	1122
Certificate	137	701

Source: Civil List, 2000.

There is a high turnover rate and high number of vacant positions, particularly for nurses.⁴⁰ This situation is a priority concern for the MoH and there are several initiatives to encourage nurses to remain in the Fiji Islands, and to upgrade the skills of nursing attendants, as well as to provide opportunities for advancement into management positions as outlined above. The HSRs also recognize that the old centralized structure contributed to low morale among nurses as well as other staff. The new structure with three geographic Divisions of Health will provide greater incentives for nursing staff to participate in the planning and management of service delivery.

Several other factors, identified during interviews with MoH staff by the study team, contribute to a lack of professional staff (doctors and nurses) to fill establishment posts in hospitals, health centers, and nursing stations. These factors may not be addressed through the current HSRs. Some of these are:

- *Inappropriate/inadequate incentive programs for doctors and nurses, particularly in remote areas.* Nurses and other categories of staff generally taken up by women receive fewer incentives than do medical officers to seek out rural postings. It was reported to the study team that community-level nurses receive significantly lower living allowances for rural postings, and no travel allowances when they have to go to distant areas of their districts. Other professionals, such as rehabilitation specialists, receive travel allowances when carrying out duties in remote areas. MoH is undertaking a program with the Department of Public Works to upgrade many residences for medical officers and nurses to address some of the staffing problems (for example on Naviti Island).
- *Excess stress and responsibility placed on nurses without corresponding compensation.* To cope with the shortage of trained medical officers, MoH has begun training experienced nurses as nurse practitioners who are then entrusted with many of the duties normally performed by doctors. However, there is a large salary differential between trained nurse practitioners and medical officers with less experience—in favor of the medical officer. Many nurses work under difficult conditions when there is no medical officer resident, particularly in remote communities. The nurses may seek advice by radio telephone in emergency situations, but there are frequent breakdowns of equipment, and the nurses feel that the responsibility for acute care under these conditions is onerous and beyond their capacities, increasing their stress and sense of isolation.
- *Emigration of professional staff.* Emigration appears to have affected male-staffed positions more because it is easier for doctors and other highly trained professional than for nursing staff to find jobs outside the country. Family ties also limit the mobility of women more than that of men. Despite this, nurses are migrating and are the target of recruitment campaigns of other countries, offering employment packages that the MoH is currently unable to match.

⁴⁰ MoH 2002, p. 4.

- *Physical insecurity for single nurses living in remote areas.* Several senior nurses reported incidents of harassment or sexual assault against younger nurses, with little recourse possible from the communities, which do not generally offer support or improved living conditions to help nurses feel safer. Frequently, single nurses have to live in a section of the clinic and as a result are often expected to provide services during their off-hours.

The present organizational culture within the MoH may also promote greater respect for the expertise of doctors than that of nurses. However, as the MoH shifts to a broader approach in seeking positive health outcomes, the knowledge that community-based health care workers can bring to policy and planning within MoH is of critical importance. It was evident to the study team that the nurses, particularly those based at the community level as well as volunteer nursing assistants, have a good knowledge of gender-based differences because they observe closely the links between symptoms presented and causal factors when they visit homes, and have the opportunity to discuss in detail the broader scope of the patient's life. Mechanisms are only now being put in place under the MoH's organizational reform to enable a better flow of information from the community level up to those making decisions concerning programming and policies. Inviting those with greatest experience in these issues to participate directly in decision making and, hence, increase respect for this knowledge, may also increase the respect for nurses within the MoH, and provide additional incentive to remain in this profession.

Recommendations

- (i) Efforts to reduce staff turnover might be improved if decision makers at senior levels seek out information and experience held by nurses at the community level. This type of information about trends and health outcomes is vital if the shift in approaches to health care envisaged in the MoH Strategic Plan for 2003–2005 is to be realized. Mechanisms might be considered that bring community-based staff to management committees at subdivisional levels to work on program planning with officers from other ministries, e.g., MoW Women's Information Officers.
- (ii) Other factors that affect female more than male staff need to be addressed to improve the working conditions of nurses and other health workers, e.g., physical safety in remote areas, living conditions, and work load. This may require specific campaigns at the community level to increase the respect for and understanding of the needs of female community health workers.
- (iii) Increasing the number of women sitting on governing bodies of various MoH institutions, e.g., hospitals, will also increase understanding of women's needs both as health care providers and as consumers of health services. Women's organizations, such as *Soqosoqo Vakamarama* (Fijian Women's Society), can participate in encouraging women to take their experiences from village health committees to levels closer to policy and program decision making.

Analysis of the Policy Development Process

New procedures for the development of policies and the planning cycle have recently been put in place across all ministries and agencies of the Government. The MoH follows these procedures:

Step One: macro-level policies. These are developed by the Ministry of National Planning in consultation with the Prime Minister's Office. The national policies (e.g., the national Strategic Development Plan) provide the framework for the development of each ministry's strategic plan.

Step Two: strategic plans. These are usually of 3 years' duration, although there are exceptions. The MoH has been finalizing a strategic plan for January 2003–December 2005. This plan provides an overview of the mission, vision, and strategic direction for the ministry and presents the KRAs for the plan period using a results-based model for planning and implementation set out by the Public Service Commission.

Step Three: sectoral corporate plans. These are annual plans developed by each ministry, responding to the KRAs contained in the strategic plan; the plans provide details of activities and processes that will be undertaken to achieve key results. Corporate plans contain objectives, strategies to achieve these objectives (activities), centers of responsibility, and key performance indicators.

Under the newly decentralized structure of the MoH, the divisional levels will be responsible for developing activity-level plans for operational objectives and will track progress against KRAs. Corporate plans are a relatively new concept, as are the formats in which they must be presented. The first corporate plan for the MoH was put in place for 2002.

In conjunction with corporate planning, a new accountability system that will be monitored by the Public Service Commission is being put in place. The Commission is developing performance agreements for the permanent secretaries of each sector ministry. These agreements are intended to hold permanent secretaries accountable for the achievement of the objectives/key results in their corporate plans and for the management of public funds to arrive at those results.

The study team also noted from interviews and discussions with the Core Team members that planning remains a centralized process with little input from divisional-level or community-based staff. Provisions to bring planning closer to health care users are being put in place with the MoH reforms. These changes will take some time to become operational, because planning skills have to be strengthened and information flows adjusted. Thus, this is an opportune time to introduce planning approaches that incorporate gender variables systematically.

Consultations with stakeholders outside MoH are limited and women's groups are not often specifically invited for their input into the planning process. The development

of the HIV/AIDS national policy demonstrated that it is possible to consult more widely, especially across different ministries. While it is not practical to carry out extensive consultations for each policy area, mechanisms could be strengthened to ensure that the voices of women contribute to the decision-making process. This is most easily accomplished through consultations with women's advocacy groups. However, in the health sector, particularly in rural areas, these groups are not well formed. It is, therefore, important that MoH staff be encouraged to seek out opportunities at the village level to understand the needs of users and then bring this information into the central planning process. Community-based health workers are already well informed of how social determinants, including gender, influence health outcomes and this information is a vital resource in the planning process.

While there is a strong statement of commitment to gender mainstreaming in the draft MoH Strategic Plan 2003–2005, this is yet to be translated into KRAs and draft corporate/division plans for 2003. Performance related to gender mainstreaming may not be monitored or evaluated, as the current plans stand. It is hoped that the Core Team and the Gender Focal Point will encourage the incorporation of specific gender concerns as the 2003 plans are finalized at central and divisional levels. The SPIGM in MoH, developed under the present ADB technical assistance, provides concrete steps that can be followed and anticipated outputs incorporated into the appropriate KRA. Progress also needs to be tracked to ensure that, unlike the unfulfilled commitments made in the 2002 Corporate Plan, these outputs are achieved. This illustrates the importance of a multipronged approach to ensuring that practical steps are actually taken and progress monitored.

Recommendations

- (i) The senior management has committed, through incorporation in the SPIGM in MoH, to take a phased approach to gender mainstreaming in the corporate plan and business plans of the MoH. During the current planning cycle, 3 priority program areas will be selected by the Core Team where specific efforts will be focused by undertaking small research initiatives to explore in detail gender concerns, and to incorporate specific indicators that will be tracked in this first phase and during the review of the 2003–2005 strategic plan. Findings from these 3 pilot areas will be used to illustrate how gender variables can be incorporated in planning analysis and can be used in in-service training on corporate planning at central and divisional levels. Guidance is provided in the sections below of how gender can be incorporated, and the types of questions and strategies that could be considered. (See Issue 3 in the SPIGM.)
- (ii) Strengthen the capacity of those responsible for monitoring the progress of each KRA to include gender considerations even if, at this early stage of incorporating a gender mainstreaming approach, adequate data are not being collected or analyzed. Asking questions concerning progress will

remind divisional directors and others responsible for corporate planning that these issues must be taken into consideration.

- (iii) Specific training and awareness-raising activities should be planned and undertaken in preparation for the next corporate planning cycle, to increase the capacity of all those involved to mainstream gender concerns. This training should include the identification of gender concerns, development of suggestions for appropriate activities at the divisional level to ensure these concerns are taken into account as programs are developed, and inclusion of suitable indicators that will encourage follow up and monitoring of progress. As this training is being developed, the findings from the pilot areas can be incorporated. The purpose of this gender training is to build greater depth of understanding for those at the Central Office, and to increase the capacities of those responsible for planning at the divisional level. (See Issues 5 and 7 in the SPIGM.)
- (iv) Mechanisms need to be put in place for broad consultations with women's health care users and organizations representing women's concerns, such as those working on domestic violence, women with HIV/AIDS, and law reforms, in the corporate planning process. (See Issue 4 in the SPIGM.)
- (v) Information on and trends in health outcomes can also be sought more actively from community nurses and other health care workers, so that their knowledge and expertise concerning gender variables are used effectively. Formal participation in planning meetings at the divisional levels could be supplemented with mechanisms for direct consultation at the community level involving all types of health care workers. (See Issue 7 in the SPIGM.) If accountability for changing approaches to health care provision is to be effective, it has to be matched with opportunities to provide inputs into planning how those changes will be made. This applies throughout the planning system. Improving consultation at the health service delivery point will also increase the respect for the information provided at this level.
- (vi) Revisions to reporting mechanisms on health information management currently underway should include the collection and analysis of qualitative as well as quantitative data concerning gender as a variable among other social determinants. Skills of staff responsible for analysis of these primary data need to be strengthened to ensure that gender variables are not lost when data are reaggregated for presentation at the Central Office. (See Issues 6 and 7 in the SPIGM.)
- (vii) Small-scale action/participatory research on the importance of gender variables in areas of priority to the MoH can be used as a capacity-building opportunity for health workers at the community level for reporting on trends in these factors and to encourage community responsibility for health outcomes. This research

could also provide opportunities to engage other stakeholders, e.g., in social welfare and agriculture, whose support will be necessary as the MoH shifts to a broader approach to achieving health outcomes. The findings can also be used to increase awareness of the importance of these issues with associated line ministries (e.g., agriculture, MoW) as well as central agencies involved in tracking indicators of progress.

- (viii) Baseline studies using existing sex-disaggregated data should be carried out to describe and identify gender-based differences in how men and women access and benefit from the health system. Linking this activity to the pilot areas would provide a demonstration of the benefits and process of using gender as a variable, and could then be supplemented with additional studies as priority health issues emerge. (See Issue 6 in the SPIGM.)

Analysis of Key Result Areas in the Ministry of Health

.....

Following is a set of guidelines outlining where gender concerns are relevant in the KRAs, to help ensure that these issues are raised and indicators identified in assessing progress. The wording used in this report for each KRA is taken from the draft Corporate Plan available to the study team in late November 2002. Exact wording may change as the Plan is finalized, but the content of most areas will not change.

KRA: Public Health and Health Promotion

Promotion and protection of good health of all the people in the Fiji Islands through a strengthened public health and health promotion approach/system.

Intersection of Gender Issues

Public health promotion is seeking to address health risks and vulnerabilities, and therefore needs to look at factors influencing these risks and vulnerabilities:

- *Gendered differences within the household and the workplace.* Who is doing what kind of work, e.g., exposure to leptospirosis for those handling livestock; number of hours of work outside and within the home leading to poor resistance to infections, etc.; lifestyle differences leading to noncommunicable disease (such as tobacco and alcohol abuse among men); location of activities, e.g., dengue fever exposure of women who spend more time in the garden where mosquitoes are prevalent. Some health risks are determined by gender and race difference, e.g., the higher incidence of anemia among Indo-Fijian women and diabetes among Fijian women is associated with race-specific nutrition habits. Some preventive programs already assess gender differences and incorporate different approaches to address the differences identified, but this is not consistent. A useful example would be nutrition programs that encourage women to purchase different foods to reduce the incidence of diabetes or obesity, acknowledging that women are primarily responsible for the purchase and preparation of foods within the household, irrespective of race.
- *Biological differences between women and men.* Reproductive health issues, symptoms of heart disease.

Changing health-seeking behavior is a strategy to lead to improved public health. There are differences between men and women in health-seeking behavior, e.g., men wait until conditions are acute before seeking professional care; opportunity cost for women is often high because they are busy with domestic and outside work or caring for other sick family members; men may fail to attend reproductive health clinics or take responsibility for contraception. Different campaigns are required to address these differences.

Good health and well-being are defined differently by women and men. Decisions concerning priorities for public health and health promotion need to take these into account, e.g., women may include freedom from violence as a key component of a healthy home, whereas men will not.

Recommendations for Entry Points – Public Health and Health Promotion

Objective	Examples of Gender Mainstreaming Strategies
<i>Public Health Policy.</i> To strengthen policy and legislation for public health priority action areas. All existing policies and legislation are under review in the 2003 planning period.	Gender variables and the potential differential effect of policies on women and men should be taken into account in reviewing policies, etc. (Linked to Issue 2 of the SPIGM).
<i>Public Health Service Delivery.</i> To develop standardized service inventories for all levels of health care.	Gender is a key variable in standardized service inventories at the community level (e.g., different approaches to delivery of reproductive health care services for women and men; ensuring women's access to pediatric care at times and places most convenient to them as primary care givers for children). Information regarding gender-based differences known by community health workers can be incorporated into this activity.
<i>Family Health.</i> To strengthen/develop and review reproductive health and other family health programs.	Gender and gender relations are key variables in all aspects of reproductive health and family health issues. The gender audit used the HIV/AIDS policy as a case study that includes several recommendations that could be taken into account in the current planned activities. The Core Team is also aware of these issues and their inputs can be incorporated to bring a gender perspective into this area of programming. There is also much information available on gender variables that are important considerations when developing relevant materials (e.g., messages to encourage men to be more responsible for contraception require different messages from those for women).
<i>Oral Health.</i> To facilitate the improved oral health status of all people of the Fiji Islands.	Gender variables influence health-seeking behavior (e.g., opportunity costs, relative priority given to oral health). An understanding of these variables would improve effectiveness of program delivery.
<i>Nutrition.</i> To facilitate and promote the achievement of a good nutritional health status of all people of the Fiji Islands.	Gender, among other factors, is an important variable in changing behavior and can contribute to effective programming in this area. These gender variables are already clearly understood such areas as food purchasing and preparation by women, but a more consistent inclusion of gender analysis during program planning would demonstrate

(continued next page)

Recommendations for Entry Points – Public Health and Health Promotion (cont’d.)

Objective	Examples of Gender Mainstreaming Strategies
	its importance for changing many nutrition-related health outcomes. For example, different approaches are required for men and women to encourage improved dietary habits; teenage girls and boys have different anxieties about diet, often fed by media images.
<i>Healthier Lifestyle.</i> To promote a healthier lifestyle through increased levels of physical activity and healthier food choices.	Targeting of public health education programs will require an understanding of gender-based differences in responses to campaign messages (e.g., physical activity choices vary widely between women and men; food choices differ between those preparing food and those consuming it).
<i>Environmental Health.</i> To facilitate the protection of the environment that will be supportive to health.	Community development and participation components (e.g., water and sanitation, household issues, and certain workplaces) may need to encourage women’s participation specifically and ensure that gender-based differences are identified in program content and delivery.
<i>Health Promotion.</i> To facilitate the protection and promotion of good health, e.g., weight control, cholesterol levels.	Gender variables in approaches to good health promotion need to be understood to ensure that campaigns are effective. Promotion campaigns for weight control are a good example of how women and men require different messages—women need to be encouraged to take care of their own health needs as a priority for the whole family, and for men to take responsibility for requesting food that will resolve their weight gain problems.
<i>Mental Health.</i> To facilitate improved mental health services for all people of the Fiji Islands.	Participation of women as well as men is needed in assessing clinical and public health needs, e.g., identifying gender variables in vulnerability to incidents, such as suicide (that also vary by race and age). The cause in young men may be pressure to achieve in school or the work place, whereas among women, it may be related to domestic violence or pressure from domestic responsibilities and poverty. Hence, there is a need for different awareness messages for women and men in different age or race categories. There is a strong reliance on family (women) care givers for those suffering from mental illness. The needs of these care givers, who may have multiple responsibilities within the family, have to be taken into account.
<i>Public Health Laboratory.</i> To enhance the vector-borne disease outreach programs and strengthen the capacity of public health laboratory diagnostic and surveillance services and capabilities.	Gender variables are associated with health risks and vulnerability to vector-borne diseases; for example, links to different household responsibilities for women and men that expose them to various risks. These variables have to be incorporated into control programs for the latter to be most effective.

(continued next page)

Recommendations for Entry Points – Public Health and Health Promotion (cont'd.)

Objective	Examples of Gender Mainstreaming Strategies
	Services at public health laboratories have to be delivered in a gender-sensitive manner; for example, information regarding test results such as sexually transmitted disease might have different significance for women than men and have to be delivered in a sensitive manner, respecting individual privacy rights.
<i>TB/Leprosy.</i> To facilitate the eradication, monitoring, and surveillance of TB and leprosy.	Identify gender-based differences in health risks and vulnerability associated with each disease. Programs may need to be sensitive to different needs of women and men as patients and caregivers, and in awareness/preventive campaigns.
<i>Care of Older Persons.</i> To promote healthy ageing and provide a supportive environment for older persons.	In the review of aged care services, gender variables must be incorporated to address the specific needs of women and men; e.g., how would women and men prefer to have programs delivered? The differences might be associated with time of day or location.
<i>Rehabilitation Medicine.</i> To prevent further disabilities and handicaps and to promote independence and community integration of persons with disabilities.	Rehabilitation entails different services to respond to biological and gender-based needs of women and men. Campaigns for the integration of persons with disabilities into the work place or society as a whole should take gender variables into account; e.g., respecting different aspirations of women (as mothers or choice of career) and men (as fathers or choice of career) within society.

KRA: Health Protection through Curative Services

Protection and maintenance of health of the population by providing effective, efficient, and quality clinical, diagnostic, and rehabilitative services at all levels of the health-care system.

Intersection of Gender Issues

- Both men and women may prefer some types of services to be delivered by same-sex health professionals, e.g., contraceptive advice. For some ethnic groups, it is impossible for a male doctor to attend a female patient, or there must be a second female in the room.
- There are differences in perceptions of standards and approaches to curative services between women and men; e.g., women want to be “listened to” by their doctors, whereas men want to have their problem solved and prefer “high-tech” solutions; women prefer “telephone” shower heads in maternity health centers rather than fixed shower heads—male architects and planners may not identify these different needs.

Recommendations for Entry Points – Health Protection through Curative Services

Objective	Examples of Gender Mainstreaming Strategies
To provide quality clinical services.	The types and range of clinical services should take into account gender variables of health-seeking behavior, e.g., services where women or men prefer attendance of same sex-health professionals.
To ensure the provision of drugs and consumables in an efficient manner.	Drug requirements should consider gender-based variables as well as biological differences; e.g., women and men have different attitudes about how drugs are administered.
To ensure the provision of appropriate equipment and instruments.	Ensure that differences in requirements for women and men are taken into account; use the gender task force to track and assess differences.
To strengthen diagnostic and support services.	Ensure that differences in requirements for women and men are taken into account; use the gender task force to track and assess differences.

KRA: Reorganizing/Restructuring/Reforms of Health System

Strengthening and empowerment of decentralized integrated health services to deliver seamless and borderless health care that is efficient, effective, and of high quality.

Intersection of Gender Issues

Gender implications in the following areas need to be included in health sector reforms.

- *Decentralization.* Being close to health service consumers offers opportunities to understand gender-based differences in health-seeking behavior and the factors that influence health risks.
- *Efficient and equitable resource management.* Equity in access does not necessarily mean that different needs of women and men are taken into account; e.g., because of women's reproductive health needs, women require more services, and which may need to be delivered in a different form or time than those for men and, hence, cost more. Male health needs may also require special attention in certain places.
- *Professional management.* It is important that non-health professionals managing resource allocations also understand the different health needs of women and men and of the gender-based differences in health risks and health-seeking behavior.
- *Community participation.* As the MoH establishes new mechanisms, it is important to increase community participation so that women's voices are heard as major stakeholders. Women are already participating in Village Health Committees, but need additional encouragement to participate in provincial or hospital governance.

The MoH might consider placing a minimum percentage of women representatives on hospital boards or other committees and seek candidates by recommendation from local women's committees, such as *Soqosoqo Vakamarama*. If women are encouraged to chair village health committees, they can improve their decision-making skills in such areas as health program and resource planning. As decision making on health planning and resource management is decentralized, existing male members of health committees at all levels also need to be alerted to the importance of ensuring representation of all stakeholders, including women, in these activities. Gender awareness training is already being extended to members of some of these decision-making bodies by MoW, and MoH could assist by sharing costs or incorporating gender equality concerns into briefings for new health committee members.

Recommendations for Entry Points – Reorganizing/Restructuring/Reforms of Health System

Objective	Examples of Gender Mainstreaming Strategies
To continue to strengthen the health management structure to support integrated health services.	Management will be more effective if it takes into account gender variables in the health risks and health-seeking behavior of populations. Different skills will be required if gender and other social determinants are to be taken into account in planning and programming, as well as mechanisms that encourage the flow of information regarding program impact from the community level up.
Development and implementation of divisional development plans.	Gender training should be provided to incorporate gender variables into planning workshops, etc., i.e., gender mainstreaming is an integral part of the shared vision and reform initiatives for the MoH.

KRA: Human Resource Management and Workforce Development

Management and development of health workforce to enhance the delivery of quality health services.

Intersection of Gender Issues

- *Employment equity.* The Government has established an Employment Equity policy; it is important, as organizational changes take place within the MoH, to ensure that this policy is applied. About 77% of all MoH staff are women (Table 1); however, these women are predominantly in lower and less qualified positions (Table 2).
 - Will new incentive and professional development programs provide opportunities to women to advance into more senior positions—particularly to decision-making levels—and, hence, reflect the needs of the population as a whole?

- Achievement of decentralization and community participation objectives of HSRs place greater responsibilities and demands on community-based health workers, predominantly women. Will their achievements be compensated and recognized accordingly?
 - Will the reorganization of the MoH be sensitive to the particular needs of women as they are reassigned, e.g., in terms of housing, seniority, and security for community health workers living and working in isolated conditions? Will new standards of discipline and working conditions take into account specific challenges faced by women?
 - Will performance appraisals of all professional staff include sensitivity to gender issues, e.g., differences in health-seeking behavior of women and men and other issues raised above?
- *Gender sensitization.* Some indicators for these objectives for 2002 have not been achieved, but new activities have not been incorporated into the draft Corporate Plan for 2003. Recommendations from the gender audit and the SPIGM can be included in the Gender Mainstreaming Action Plan. Specific targets can be put in place and monitored by senior management to encourage implementation of this plan.

Recommendations for Entry Points – Human Resource Management and Workforce Development

Objective	Examples of Gender Mainstreaming Strategies
<i>Planning.</i> To analyze and manage workforce needs.	Some position descriptions may need to be changed to provide accountability for gender mainstreaming into the organizational structure of the MoH.
<i>Recruitment and Selection.</i> To recruit, select, and deploy appropriate staff to meet the needs of the Ministry of Health.	Position descriptions will need to be changed to ensure that decision makers are responsible for taking gender variables into account and appropriate training is carried out to monitor these tasks.
<i>Education and Training.</i> To produce appropriately skilled health workforce.	Gender and other training on the importance of social determinants in policy and program development and delivery need to be integrated into regular training and professional development provided for MoH staff. A survey of selection criteria for in-service training opportunities is needed to ensure that they are not gender biased.
<i>General.</i> Create a conducive environment that enhances staff commitment to organizational goals.	Key areas of concern to female staff, particularly nurses, need to be taken into account to maintain commitment to working in remote and difficult circumstances, e.g., housing and physical security for nurses and incentives for volunteer health workers. Commitment to a gender-sensitive workplace needs to be reinforced through action, e.g., by making physical security for nurses in remote areas a priority concern.

KRA: Standards and Quality

Promote continuous improvement in quality and standards by implementing health “best practices” that are customer focused.

Stress is now placed on customer-focused approaches to health service delivery. Standards and quality definitions/indicators must incorporate the basic differences between men and women as customers of these services in terms of

- perceptions of health and well-being and their consequences (e.g., men perceive ill health as a limiting capacity to earn income; women view illness as limiting their capacity to care for the family and earn income); and
- the most appropriate way for services to be delivered (e.g., time of day, different mix of professional and nonprofessional services, or use of traditional approaches).

These differences need to be taken into account when monitoring the effect of changes in standards and quality definitions/indicators, and adjustments made accordingly.

Recommendations for Entry Points – Standards and Quality

Objective	Examples of Gender Mainstreaming Strategies
<i>General.</i> Continue to develop and implement health management standards for the Fiji Islands.	Customer-focused approaches to health service delivery require that different perceptions of health and well-being of women and men, and the most appropriate way for services to be delivered be taken into account. The efficiency and quality of services also has to be assessed from a gender perspective to ensure that these different needs and approaches are taken into account.
<i>Clinical.</i> Upgrade clinical health standards and quality health services.	As above.

KRA: Financial Management

Adopt best practice in financial management at all levels.

Intersection of Gender Issues

Gender mainstreaming not applicable.

KRA: Health Information Management and Decision Support System

Systematic collection and analysis of data to provide information to support policy, planning, and decision making at all levels.

Intersection of Gender Issues

- Ensure that all data collected are disaggregated by sex under each subcategory.
- Increase understanding of ways that sex-disaggregated data can be analyzed to assess various social policy outcomes, such as equity in health outcomes and effectiveness/quality of services; e.g., incidence of contagious disease as related to different health risks for women and men. Also, analysis of epidemiological data disaggregated by sex can provide information about issues influenced by sex or by social/gender-based factors, and this information can be fed back into the development of public health policies, programs, and campaign messages.
- It is important that health information systems reach below the household level for all types of relevant information. Different members of a household have different health requirements, expectations, and health-seeking behavior. All survey, research, and other data collection methods need to include information from all members of households. For example, as the Fiji Islands' population ages, the demand for some health services by older household members will increase and others will decrease—postmenopausal health needs of women, such as osteoporosis, will increase while the demand for maternal health care will decrease.

Recommendations for Entry Points – Health Information Management and Decision Support System

Objective	Examples of Gender Mainstreaming Strategies
To continue to develop a patient information system.	Ensure that those carrying out analyses have the capacity to incorporate gender as a key social variable. Ensure that sex-disaggregated data collected at service delivery points are not re-aggregated for trend analysis. Different indicators might have to be incorporated to ensure that differences in health-seeking behavior between men and women are taken into account.
To strengthen and enhance information technology and data analysis capabilities.	Ensure that those carrying out analyses have the capacity to incorporate gender as a key social variable.
To develop policies and systems to ensure the timely and effective availability of information for decision making.	Ensure that those carrying out analyses have the capacity to incorporate gender as a key social variable. Ensure that sex-disaggregated data collected at service delivery points are not re-aggregated for trend analysis.

KRA: Health Care Financing

Explore alternative sustainable methods of funding to improve and support health care delivery.

Intersection of Gender Issues

- Ensure that the cost-recovery system does not result in an increased burden on women as caregivers within their families or householders. Volunteer contributions of labor from women who lack of resources to pay for health services may mean that these women have to carry out more care giving in the home—because poverty rates are high among families headed by a disabled member who requires additional care from female household members.
- Women's opportunity costs are greater in seeking health services. Therefore, threshold levels for absorbing user fees may be lower for women than for men; e.g., there are additional costs to transport children if they have to go with a woman to the doctor, or additional child care costs while the mother is attending a clinic.
- Key health areas for women should not be compromised by imposition of user fees, e.g., reproductive health checks and immunization programs for children.
- Patterns of expenditure on health services and decision making regarding who has priority within the family for resources required to pay health care fees, must be analyzed within the household, i.e., all individuals within a family. Women place lowest priority on their own health care spending, increasing their health risks because they either delay or fail to seek care, especially when there are other sick or handicapped family members.

Recommendations for Entry Points – Health Care Financing

Objective	Examples of Gender Mainstreaming Strategies
To identify possible sources and modes of funding to foster greater financial independence.	It is vital that the impact on women and men of all possible sources and modes of cost-recovery funding is carried out. Gender variables, such as opportunity costs for accessing health services, must be taken into account to ensure that responsibility for health care does not overburden the family— and, therefore, women. Such “downloading” has resulted in the deterioration of health outcomes, not only for women themselves, in certain areas.

(continued next page)

Recommendations for Entry Points – Health Care Financing (cont'd.)

Objective	Examples of Gender Mainstreaming Strategies
To raise public awareness about the concept of health-care financing systems.	Ensure that in developing public awareness messages, stakeholders are involved, especially women's advocacy groups, which can provide assistance in understanding the needs of women regarding changes in services and financing systems.
Enabling legislation.	Gender variables regarding the impact of legislation need to be taken into account as options are assessed.

KRA: Effective Partnerships and Communication

Development and maintenance of effective relationships with all stakeholders to enhance customer satisfaction.

Intersection of Gender Issues

- Differences in client groups' needs have to be reflected in communication mechanisms and topics.
- Messages contained in communication campaigns need to respond to or address social factors affecting health as well as biological factors; e.g., existing posters for a vasectomy promotes "caring" men, i.e., encourages a change in gender roles.

Recommendations for Entry Points – Effective Partnerships and Communication

Objective	Examples of Gender Mainstreaming Strategies
To establish and formalize partnership arrangements with stakeholders.	Women as key stakeholders and providers of health care in the home need to have strong and informed representation in all forms of partnership (local, district, divisional, etc.). Increased participation by women will also improve their ownership of efforts to change health-seeking behavior and for communities to take greater responsibility for health outcomes. Affirmative action measures could be taken to encourage more women to participate in decision-making bodies, e.g., by seeking suitable candidates from women's NGOs, offering information to village health committees on how to apply for such positions, and assisting newly elected/appointed women to improve their skills.
To promote active, meaningful, and regular participation of stakeholders.	As above.
To strengthen internal communication.	Internal communication tools can be used to demonstrate MoH's commitment to gender mainstreaming.

KRA: Health Facilities

Plan, develop, and maintain appropriate physical infrastructure to enable health services to be delivered.

Recommendations for Entry Points – Health Facilities

Objective	Examples of Gender Mainstreaming Strategies
Determine national priorities for the development of new buildings and the maintenance of current structures.	Ensure that the needs of women staff (nurses, etc.) and the different requirements of women as patients are incorporated into priorities, e.g., by providing additional security measures in unmarried female nurses quarters; and in maternity wards, accommodate the specific needs of women during postnatal stay in hospital (such as correct shower heads). Monitor ongoing maintenance and the development of new structures to ensure that these needs are taken into account.
Develop an asset management system that encompasses all types of assets.	Gender mainstreaming not applicable.

Case Study: Analysis of the HIV/AIDS Policy, Using the Gender Assessment Pathway (GAP) Tool

.....

The gender assessment pathway (GAP) is a 5-step process that takes policymakers and planners through a series of questions regarding gender-responsive policymaking, implementation, and monitoring and evaluation. It enables mainstream policymakers to identify gender gaps in their policies, assess why these gaps exist, and help find ways to address these gaps. GAP is both a gender-analysis tool and an approach to gender mainstreaming. It is a learning-by-doing tool to assist planners in government ministries to conduct gender-based policy analysis.

On the following pages, the GAP tool developed for the Fiji Islands is shown, followed by a description of the steps involved in the GAP process, as reviewed with stakeholders and adapted to meet the government approach to mainstreaming.

Results of the Case Study: the Fiji Islands National HIV/AIDS Policy and Action Plan. Suggested Revisions to Reflect GAP Analysis and Gender Mainstreaming

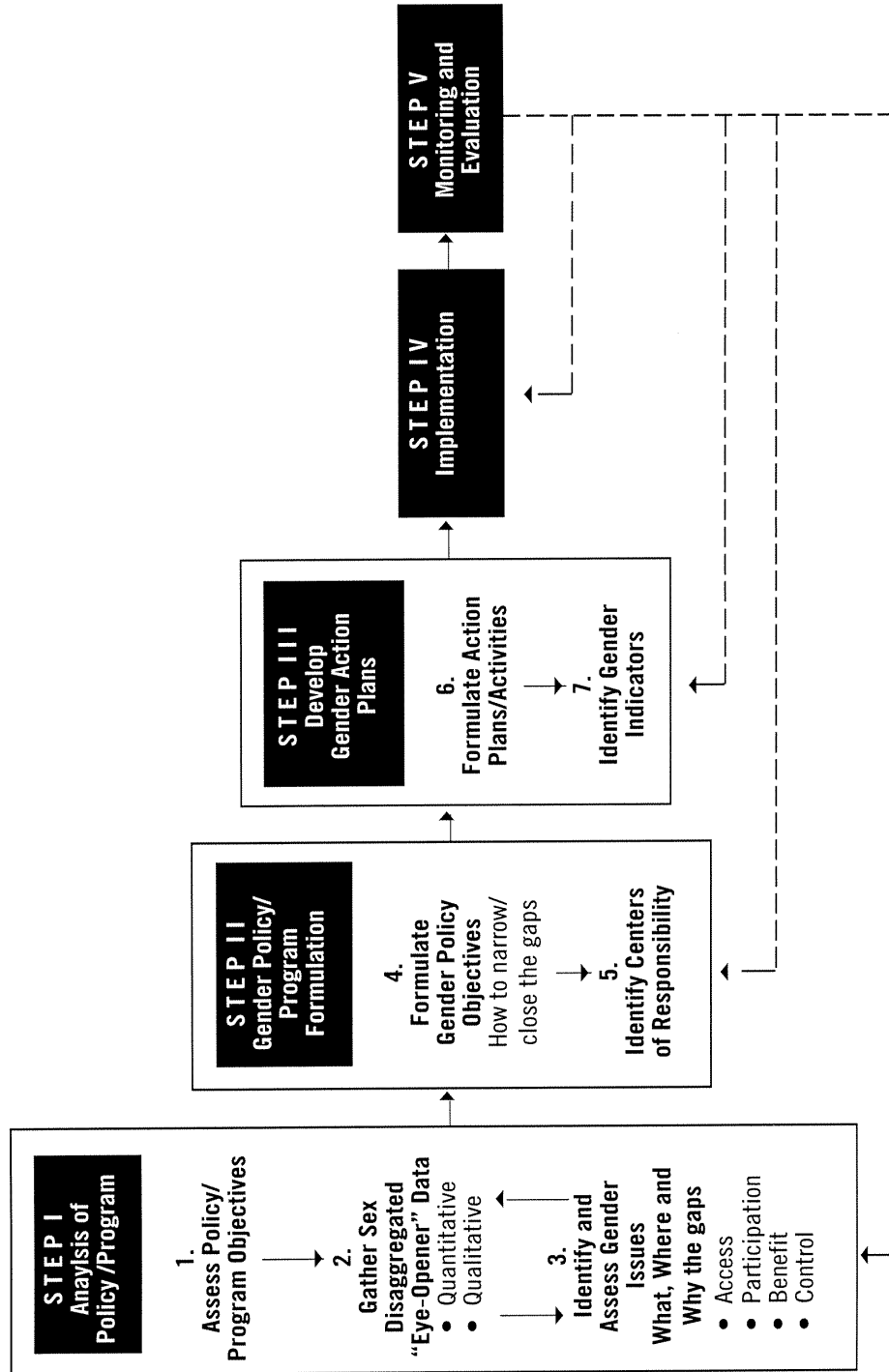
Current Policy Objective

To provide a framework for leadership and coordination of the national multisectoral response to the HIV/AIDS epidemic. This includes formulation by all sectors of appropriate interventions that will be effective in preventing transmission of HIV/AIDS and other sexually transmitted infections, protecting and supporting vulnerable groups, and mitigating the social and economic impact of HIV/AIDS.

Gender-sensitive Policy Objective

To provide leadership and coordination of the national multisectoral gender-sensitive response to the HIV/AIDS epidemic. A comparison of current and gender-sensitive programs and activities is given in the Table beginning on page 52.

Gender Assessment Pathway (GAP)



Description of Steps in the GAP Process

1. Step I: Analysis of Policy/Program

There are three subsections of analysis in this step. This is a general policy analysis process that includes the specific collection of data disaggregated by sex, which enables policymakers and planners to identify gaps.

a. Assess Current Policy/Program Objectives

Government policy is rarely gender neutral. It is important to understand what government has already agreed to do to improve the status of women and to assess whether commitments are reflected in existing policy objectives.

b. Collect Sex-disaggregated Data

Sex-disaggregated data reveal how policies affect men and women and why differences exist. They reveal how women and men participate in and benefit from societal resources, often in different ways and at different rates.

c. Identify and Assess Gender Issues

In most cases, the data reveal gender gaps in existing policies. The data assist in identifying the larger issues and problems as to why there are gender gaps between women and men and how government policies and programs may have contributed to this imbalance.

2. Step II: Gender Policy/Program Formulation

a. Formulate Gender Policy/Program Objectives

This step identifies policy and program objectives to reduce or eliminate gender gaps to ensure that women and men participate fully in and benefit from development processes. This step involves rewriting the policy/program objectives while taking into account the identified gender issues and ways of reducing the gender gap.

b. Identify Centers of Responsibility

3. Step III: Develop Gender Action Plans

a. Formulate Action Plans/Activities

In this step action plans in the form of gender-responsive policy/programs are formulated to close or eliminate gender gaps according to the gender policy objectives identified in Step II.

b. Identify Gender Indicators

Articulating specific gender indicators allows policymakers and planners to monitor how well the policy or program is addressing the gender gaps. (In the present study, a workshop was conducted, during which the Core Team developed gender indicators with the assistance of a study team member who is an expert in gender-sensitive indicators.)

4. Step IV: Implementation

How policies and programs are implemented can have an important bearing on the outcome of projects or legislation designed to eliminate or reduce gender gaps.

5. Step V: Monitoring and Evaluation

It is important to include a monitoring and evaluation plan when designing gender-sensitive policies and programs so that remedial steps can be taken if it becomes apparent that gender gaps continue to exist during policy and program implementation.

Comparison of Current and Gender-sensitive Programs/Activities

Current Program Objectives	Gender-sensitive Program Objectives/Result Areas	Gender-sensitive Activities	Gender Indicators
<p>To create and sustain increased awareness of HIV/AIDS through targeted advocacy, information, education, and communication for behavior change at all levels by all sectors. This hinges on effective community involvement and empowerment to develop appropriate approaches in the prevention of HIV infection, and in care and support to those infected and affected by the epidemic, including widows and orphans.</p>	<p>To create and sustain increased awareness of HIV/AIDS for behavior change at all levels by all sectors including males and females in vulnerable groups, such as commercial sex workers, prisoners, partners of mobile groups, adolescents, and military personnel.</p>	<p>To conduct a knowledge, attitude, practices (KAP) survey and follow-up with sentinel surveillance, with representation from specific vulnerable groups.</p> <p>To train health promotion staff and community health workers on gender-related aspects of HIV/AIDS.</p> <p>To involve and empower gender-balanced stakeholder groups to participate in developing appropriate approaches in the prevention of HIV infection, and in care and support to those infected and affected by the epidemic.</p> <p>To provide training for health care workers on safe blood practices.</p> <p>Through targeted advocacy, information, education, and communication, to strive for behavior change at all levels of society.</p> <p>To encourage effective community involvement and empowerment to develop appropriate approaches in the prevention of HIV infection, and in care and support to those infected and affected by the epidemic, including widows and orphans.</p>	<ul style="list-style-type: none"> • Percentage increase of awareness of high risk behavior/modes of transmission and preventative measures in vulnerable groups. • Number of brochures distributed. • Number of men and women collecting condoms. • Decrease in incidence of STIs. • Level of confidence to be able to share information on HIV/AIDS. • Number of programs and workshops, disaggregating attendees by male and female. • Number of condoms distributed through networks of vulnerable groups. • Number of requests for follow-up programs conducted following train-the-trainers workshops.

(continued next page)

Comparison of Current and Gender-sensitive Programs/Activities (cont'd.)

Current Program Objectives	Gender-sensitive Program Objectives/Result Areas	Gender-sensitive Activities	Gender Indicators
<p>To prevent further transmission of HIV/AIDS through making blood and blood products safe, promoting safer sex practices through faithfulness to partners, abstinence, nonpenetrative sex, and condom use according to informed individual's decision.</p> <p>The key issue of moving from abstinence or condom use to another strategy depends on testing in between early and effective treatment of STIs in health facilities, with special emphasis on high-risk behavior groups and early diagnosis of HIV infection through voluntary counseling and testing.</p>	<p>To prevent further transmission of HIV/AIDS.</p> <p>To reduce the incidence of transmission of HIV/AIDS.</p>	<p>To make blood and blood products safe.</p> <p>To promote safe sex practices through faithfulness to partners, abstinence, nonpenetrative sex practices, and condom use according to informed decisions.</p> <p>To ensure that those receiving blood are involved in training on international standards.</p>	<ul style="list-style-type: none"> • 10% increase in number of men/women taking voluntary testing among specific vulnerable groups. • Percentage of blood products that are safe, meeting international standards. • Percentage of men and women diagnosed with HIV/AIDS (however, doctors do not write AIDS on death certificate because of the stigma).
<p>To promote early diagnosis of HIV infection through voluntary testing with pre- and post-test counseling.</p> <p>The main aim is to reassure and encourage the 85–90% of the population who are HIV negative to take definitive steps not to become infected, and those who are HIV positive to receive the necessary support in counseling and care, prolong their lives, and not to infect others.</p>	<p>To promote early diagnosis of HIV infection with pre/post test counseling and encourage men to be tested.</p>		<ul style="list-style-type: none"> • 10% increase in number of men/women taking voluntary testing among vulnerable groups.

(continued next page)

Comparison of Current and Gender-sensitive Programs/Activities (cont'd.)

Current Program Objectives	Gender-sensitive Program Objectives/Result Areas	Gender-sensitive Activities	Gender Indicators
To provide counseling and social support service for people with AIDS and their families.	Establish a counseling network and support service for people with AIDS and their families.	<p>To train peer educators and health care workers on gender-sensitive counseling techniques.</p> <p>To include and develop gender-sensitive counseling curricula at appropriate institutions.</p> <p>To establish and strengthen support especially for those caring for people with AIDS.</p> <p>To conduct awareness workshops to establish a network, ensuring that vulnerable groups—especially care providers of people with AIDS—are represented.</p> <p>To set up a hotline for networking and support.</p> <p>To conduct advocacy campaigns using champions.</p>	<ul style="list-style-type: none"> • Number of participants by sex of vulnerable groups who attend workshop. • Satisfaction survey of the people with AIDS of the support provided by the network. • Increased number of contacts through the hotline service. • Increased number of men, women, girls, and boys accessing the service. • Increased number of people who come in for screening and counseling (noting that when an awareness campaign is conducted, there is increased reporting or increase in the number of people seeking tests and counseling).
To strengthen the role of all the sectors—public, private, NGOs, faith groups, people with AIDS, community-based organizations, and other specific groups—to ensure that all stakeholders are actively involved in HIV/AIDS work and to provide a framework for coordination and collaboration.	To strengthen the role of all the sectors—public, private, NGOs, women's organizations, faith groups, people with AIDS, community-based organizations, and other specific groups—to ensure that all stakeholders are actively involved in HIV/AIDS work and to provide a framework for coordination and collaboration.	<p>To conduct a gender-sensitization workshop for NACA.</p> <p>To undertake a needs assessment of community stakeholders of the collaborative role of NACA.</p>	<ul style="list-style-type: none"> • Effective outreach of programs in the community. • Effective collaborative partnerships among stakeholders developed at community level. • Increased number of meetings held collaboratively with all sectors of the community. • Increased number of people attending the meetings.

(continued next page)

Comparison of Current and Gender-sensitive Programs/Activities (cont'd.)

Current Program Objectives	Gender-sensitive Program Objectives/Result Areas	Gender-sensitive Activities	Gender Indicators
<p>To participate in HIV/AIDS research, nationally and internationally, and to establish a system to disseminate scientific information resulting from this research while upholding ethics that govern intervention in HIV/AIDS.</p>	<p>To participate in gender-sensitive HIV/AIDS research.</p>	<p>To conduct research on the gender differences in voluntary testing at health centers and in health-seeking behavior. To identify research needs and ensure that gender aspects are identified. To conduct sentinel surveillance, ensuring that gender relations are taken into account.</p>	<ul style="list-style-type: none"> • Number of research papers produced that cover gender aspects of HIV/AIDS. • Decision makers having quality information that they use. • Better quality decisions based on gender-sensitive research findings. • Number of men and women surveyed. • Number of male and female respondents.
<p>To create a legal framework by enacting a law on HIV/AIDS with a view to establishing multisectoral response to HIV/AIDS, to address legal and ethical issues in HIV/AIDS, and to revise the legal situation of families affected by HIV/AIDS in order to give them access to family property after the death of their parent(s).</p>	<p>To create a legal framework by enacting a law on HIV/AIDS with a view to establishing a gender-sensitive multisectoral response to HIV/AIDS and to address legal and ethical issues in HIV/AIDS, and to revise the legal situation of families affected by HIV/AIDS in order to give them access to family property after the death of their parent(s).</p>		

Strategic Plan for Institutionalizing Gender Mainstreaming in the Ministry of Health



Introduction

The development of strategic plans for institutionalizing gender in the ministries of agriculture and health has grown out of capacity-building activities throughout the ADB technical assistance. The Plans also consolidate the findings of the gender audits and provide a framework for the implementation of recommendations over the short-term. The ability of Core Team members to identify issues that impinge upon gender mainstreaming within their ministries and to recommend strategies to address these is indicative of gains in knowledge and skills that have occurred.

Early in November 2002, members of the core and support teams attended a 2-day workshop, facilitated by the technical assistance organizational specialist, to (i) identify constraints to and opportunities for gender mainstreaming within their ministries and (ii) develop strategies to overcome these. After determining the key issues that affect the inclusion of gender responsiveness in their ministries, the teams developed relatively short-term strategies aimed at creating a more enabling environment for mainstreaming. The resulting plans follow formats familiar to government and set out clear objectives, rationales, strategies, and steps to increase gender responsiveness in policies and programs. The plans also identify performance indicators and identify risks and mitigation strategies.

Members of the core teams and senior management from each ministry then met the following week to review the plans and agree on centers of responsibility and achievable timeframes in which to carry out the activities. A final meeting with senior management, including heads of departments, was held on 26 November 2002, to further validate the plans and reach an understanding that the plans will become an integral part of the work of each Ministry.

In each plan, the teams have identified the following areas that require systematic strengthening: staff capacity at all levels and the deepening of knowledge and skills; internal organizational structures for gender mainstreaming; political and senior bureaucratic will and commitment. These are seen as key to ensure that gender mainstreaming moves "off the paper and into reality." Participants from each ministry identified strategies to garner support from senior management; extend the responsibility for gender mainstreaming from the focal point to core teams; expand training opportunities and integrate gender within on-going in-service training programs of their ministries.

Senior officials stated that the Ministry of Health is committed to the principles of gender mainstreaming and believes the new management structure will support the

process. The approval of senior officials lends authority to the plan, as does the support of the MoW for the strategic directions the MoH has undertaken to achieve gender mainstreaming objectives.

The following plan is the direct result of the work of the MoH Core Team and demonstrates their understanding of steps that must be taken within their sectors to move gender mainstreaming forward. Seven strategies are to be implemented:

- Strategy #1: Appoint a team to oversee the institutionalization of gender mainstreaming in MoH.
- Strategy #2: Increase political will to institutionalize mainstreaming at ministerial and senior management level.
- Strategy #3: Include gender mainstreaming objectives in corporate, business, and division plans.
- Strategy #4: Incorporate a gender perspective in all health policies and legislation.
- Strategy #5: Increase staff skills to carry out gender analysis.
- Strategy #6: Undertake sex-disaggregated baseline studies.
- Strategy #7: Develop mechanisms to incorporate gender-based variables in the planning process.

Issue #1: There is a need to appoint a team to oversee the institutionalization of gender mainstreaming in MoH.

Rationale: There is general agreement that the Gender Focal Point system, as it is currently constituted, is not effective in part because of competing priorities and an absence of effective support networks. There is therefore a need to broaden the responsibility for gender mainstreaming within the Ministry for Health to assist in ensuring that policies and programs are systematically reviewed for gender-responsiveness. During this technical assistance, a core team from the ministry has developed considerable skills and knowledge about gender issues in health and strategies to incorporate a gender mainstreaming approach. The formal appointment of these individuals to a Gender Task Force (GTF) will capture their commitment and facilitate the implementation of this plan. The agreement to establish the Gender Task Force and the appointment of individuals needs to be accompanied by clear reporting and monitoring frameworks.

Strategy #1: Appoint a team to oversee the institutionalization of gender mainstreaming in MoH.

Objective: To establish a GTF at the Central Office, accountable for implementing the Strategic Plan for Institutionalizing Gender Mainstreaming in the MoH and providing support to the Gender Focal Point (GFP).

Performance Indicator(s)

- Action taken by the permanent secretary in response to recommendations for institutionalizing gender mainstreaming.
- Extent to which GTF appointments meet criteria.
- Extent to which modifications in position descriptions of members of the GTF recognize time requirements.

Risks and Mitigation Strategies

- *Risk:* The establishment of a GTF and maintaining the momentum of committed gender-aware staff may be compromised as a result of the pressures facing health staff in implementing the organizational change associated with the Fiji Health Management Reform Project (FHMRP).
- *Mitigation Strategies:* Include gender objectives in position descriptions for members of the GTF; provide time and resources for staff to fulfil these objectives; and ensure that the MoW presents a cabinet paper regarding the findings of this gender audit and the whole technical assistance to reinforce support for gender mainstreaming from the ministerial level.

Steps to Achieve Objectives

Planning Officer/Gender Coordinator will report to the GFP on the results of the "Strategic Planning for Institutionalizing Gender Mainstreaming" workshop and brief this person on the draft strategic plan for MoH. The GFP will convey this information to the permanent secretary.

It is critical to have the permanent secretary officially appoint members of the GTF, so that gender mainstreaming is formally incorporated into their work and monitored through position descriptions.

Suggested criteria for selection of Task Force members include:

- Commitment to and interest in gender mainstreaming.
- Skills and knowledge of gender mainstreaming.
- Drawn from a cross-section of the Ministry.
- Includes both men and women.
- Position of principal or above.
- The GFP (deputy permanent secretary) will chair the Task Force.

Central Office will develop terms of reference in accordance with established committee structures.

A member of the MoH GTF will be co-opted to sit on the Gender Mainstreaming Task Force.

Issue #2: Uneven political will at ministerial and senior management levels to institutionalize gender mainstreaming in MoH.

Rationale: In order for the ministry to deliver targeted services to men and women and therefore accomplish its mission more effectively, the minister and senior managers need to be aware of the benefits of incorporating a gender mainstreaming perspective into policies, plans and programs. Political will is a well-known determinant in the success of gender mainstreaming, and it is therefore key to obtain support and commitment from the minister and senior bureaucrats to validate the work of staff and ensure that the requisite resources are available. The steps outlined below are short-term and need to be followed up by the appointment of the GTF referred to in Issue #1.

Strategy #2: Increase political will to institutionalize mainstreaming at ministerial and senior management levels.

Objective: To increase awareness of gender issues/gender mainstreaming at ministerial and senior management levels.

Performance Indicator(s) Not applicable

Risks and Mitigation Strategies

- *Risk:* Inability of Planning Officer/Gender Coordinator and Core Team members to prepare a brief within the time period.
- *Mitigation Strategy:* Core Team members and the MoW to provide support.

Steps to Achieve Objectives

Prepare a brief on gender mainstreaming for the GFP who will in turn provide a briefing for the permanent secretary and minister.

Invite and encourage the minister, permanent secretary, and GFP of MoH to view the ADB technical assistance results.

Issue #3: Strong gender-responsive language is present in the strategic plan (2003–2005), and commitment has been made to extend gender mainstreaming into the corporate, business or divisional plans of the MoH by way of a phased approach.

Rationale: There is a strong statement of commitment to gender mainstreaming in the strategic plan (2003–2005), but the process of incorporating gender concerns into all Key Result Areas (KRAs) is a large task. A phased approach to gender mainstreaming within all KRAs has been adopted by the MoH by identifying three priority program areas that will be used as pilots for the current planning cycle. Gender sensitive objectives, activities,

and indicators will be fully incorporated into these pilot areas, based on a more detailed analysis. Monitoring of these indicators will be undertaken systematically and the findings used for capacity building for gender-sensitive corporate planning in the next planning cycle – Phase 2. These pilot areas will also demonstrate alignment with national policies and the Strategic Development Plan for the Fiji Islands (2003–2005). The latter includes specific requirements for the inclusion of gender.

It should be noted that the corporate plan for 2002 did include gender mainstreaming objectives and indicators but no actions were taken in the current year to achieve these. This illustrates the critical importance of active follow-up to assure that planned activities are undertaken and that specific responsibility is assigned for meeting targets.

Strategy #3: Include gender mainstreaming objectives in corporate business and division plans.

Objective: To fully incorporate a gender perspective into the 2003 corporate, business, and division plans of at least three pilot program areas to achieve the general gender mainstreaming objectives outlined in the strategic plan (2003–2005).

Performance Indicator(s)

- Extent to which gender perspectives and objectives are incorporated into at least three pilot program, corporate, and division plans for 2003.
- Gender-sensitive indicators used to monitor overall progress of Phase 1 programs, and 2003 corporate and division plans.

Risks and Mitigation Strategies

- *Risks:* GFP and Planning Unit may not see gender as a priority (risk level: medium); GTF may not be established and thus not able to support the Planning Unit (risk level: low); MoH staff from Northern and Western Divisions have not been involved in the Core Team and may not have the knowledge and skills to incorporate a gender perspective into their division plans (risk level: low).
- *Mitigation Strategies:* Ensure the support of the permanent secretary for this undertaking; ensure Planning Unit is aware of government requirement to include gender in plans; plan to meet with the permanent secretary prior to the review and garner support for the appointment of the GTF. Even if the GTF is not formally appointed prior to review, Core Team members can work with Planning Unit to incorporate mainstreaming approaches into plans; and ensure that overall training plans for Northern and Western Division staff include gender awareness training and that key staff members are trained in gender analysis using the GAP tool.

Steps to Achieve Objectives

Core Team (proposed Gender Task Force) to meet and agree on pilot program areas e.g., healthy lifestyles, for Phase 1 of gender mainstreaming approach in the MoH and submit for approval to the permanent secretary and GFP.

Review and recommend revisions to the plans for the programs selected for Phase 1 in order to incorporate gender into each. Review other corporate and business plans more generally to incorporate gender concerns where possible.

Issue #4: Not all health policies and legislation incorporate a gender perspective.

Rationale: All health policies and legislation will undergo a review by the legal unit at the MoH as part of the corporate plan for 2003. The review will take place in 2003 with specific timelines set for the completion of individual policy reviews, including the priority areas within them. This presents an immediate opportunity to include gender responsiveness in the review parameters. If this is done, the ministry will be in a position to analyze i) the differential impacts of its policies for vulnerable groups; ii) issues of access to services by male and female clients; iii) any differences in health seeking behaviors between women and men. Conducting a gender analysis of policies as part of the review will point out any gender gaps and will provide policymakers with gender-based analyses to address these. The pilot program areas selected for more focused gender mainstreaming during the current corporate planning cycle can be used to illustrate where and how this process can be applied. This will enable the ministry to more effectively focus its services and ultimately impact positively on health outcomes.

The gender audit of the MoH provides a tool to assist the policy review process as it identifies links between gender and KRAs. It also represents a baseline against which the ministry will be able to measure future progress toward gender-responsiveness in health policies.

Strategy #4: Incorporate a gender perspective in all health policies and legislation.

Objective: To ensure that a gender perspective is systematically incorporated into all current health policies and legislation.

Performance Indicator(s)

- Extent to which the policy review process incorporates gender as a key variable in health policy and planning processes.
- Number of health policies and legislation that contain explicit gender-sensitive language.

Risks and Mitigation Strategies

- *Risk:* Lack of middle management commitment to carry out a gender analysis as part of the legal review (risk level: medium).
- *Mitigation Strategies:* Permanent secretary's support will be sought; Reform of position descriptions for entire public service is to include gender in position descriptions; MoH will develop a gender policy statement, part of its commitment to gender-mainstreaming.

Steps to Achieve Objectives

1. It is critical to have the permanent secretary officially appoint members of the GTF, so that gender mainstreaming is formally incorporated into their work and monitored through position descriptions.
2. Consult the Legal Officer to review the findings of this project and MoH responsibility within the context of government's overall commitment to gender mainstreaming, particularly for legislation associated with the Phase 1 pilot program areas
3. Obtain agreement from senior management to include gender as one of the review parameters.
4. Establish a schedule for carrying out a gender analysis of policy legislation in accordance with the established policy review schedule, focusing during the current year on the Phase 1 pilot program areas.
5. Review policies from a gender perspective and recommend modifications to ensure they incorporate gender responsiveness.
6. Report to the GTF and the GFP with findings and recommendations.

Issue #5: MoH staff lack the skills to carry out gender analysis and thus incorporate a gender perspective in their policies and programs.

Rationale: The gender audit reveals specific ways in which gender is a key variable in understanding health risks/vulnerability and the health-seeking behavior of both women and men. By ensuring that MoH staff make use of existing sex-disaggregated data (for example, identify trends based on an understanding of gender) and incorporate a gender perspective in their work, the ministry will better meet the needs of both male and female clients and provide better-targeted service delivery, resulting in improved health outcomes. The findings from the focused gender mainstreaming exercise of Phase 1 program areas can be used as capacity building tools for skill building at all levels within the MoH.

Strategy #5: Increase staff skills to carry out gender analysis.

Objective: To strengthen the capacity and skills of MoH staff to analyse sex-disaggregated data to incorporate a gender perspective in their policies and programs.

Performance Indicator(s)

- Number of in-service training programs that integrate gender in the syllabus.
- Ability of trained personnel to apply a gender variable in policy development and program planning.
- Percentage of newly recruited staff who have undergone gender awareness training.

Risks and Mitigation Strategies

Risk: Training officers/statistical unit staff may not see gender training as a priority (risk level: low).

Mitigation Strategies: The directive for this training will be issued with the Central Office, thus giving it authority and importance; position descriptions will include clear gender objectives and responsibilities.

Steps to Achieve Objectives

1. To integrate gender analysis training into existing in-service training programs:
 - Convince senior management that this is an important initiative and link the argument to corporate/division plans and objectives, and KRAs.
 - Select ongoing training programs with relevance to the Phase 1 pilot program areas and use these to demonstrate how incorporating a gender variable can improve programming and contribute to improved health outcomes.
 - Make recommendations for modifications in training programs to the National Executive Committee (NEC) for approval.
 - Planning Officer/Gender Coordinator will liaise with the Central Office training division to arrange necessary budgets.
2. To train technical officers in gender analysis, provide training in each division using the " Gender Assessment Pathway: A Practical Guide to Gender Mainstreaming" and a learning-by-doing approach:
 - Develop a practical, hands-on training program to assist technical staff to carry out a gender analysis of programs and policies on a unit-by-unit basis.
 - Provide training-of-trainer programs and include training officers in them.
 - Train staff in the statistical unit at HQ to use sex-disaggregated data to identify gender-based factors in health trends.

3. To provide training in gender-awareness during Induction/Orientation programs: Provide training officers in each division with appropriate gender-awareness training and support materials.

Issue #6: Baseline studies (using existing sex-disaggregated data) are needed to illustrate whether there are gender-based differences that influence how men and women access and benefit from Fiji's health system.

Rationale: The provision of sex-disaggregated baseline information will provide and clarify evidence of differential health outcomes or issues of access to health services for women and men in the Fiji Islands. This evidence will assist decision-makers to allocate resources more equitably and efficiently to achieve improved health outcomes for women and men, boys, and girls in the Fiji Islands.

Strategy #6: Undertake sex-disaggregated baseline studies.

Objective: To conduct a sample baseline cost/benefit analysis in Phase 1 pilot program areas to ascertain any differential health outcomes for men and women.

Performance Indicator(s)

Extent to which baseline findings influence planning processes and service delivery.

Risks and Mitigation Strategies

Risk: Chairperson of research committee may be uninterested in undertaking this research and may not understand the need for sex-disaggregated baseline data (risk level: low).

Mitigation Strategy: Ensure the rationale for the need for sex-disaggregated baseline data is clear and backed by examples.

Steps to Achieve Objectives

1. Core Team (proposed GTF) will liaise with the chairperson of the research committee at the Central Office to develop a proposal to undertake this research.
 - Submit proposal.
 - Select team to conduct the two baseline studies.
 - Oversee the studies.
 - Submit findings to the permanent secretary, GFP.

Issue #7: There is a need for mechanisms to ensure that information from the community level concerning gender-based variables that influence health outcomes is incorporated into the planning process.

Rationale: The ministry is committed to moving toward more decentralized delivery of health services. This requires that communities and health professionals closer to the client base have a say in planning processes and that their knowledge is valued and respected by planners. At the community level, and especially among community health workers, there is already extensive sex-disaggregated data and awareness of gender-based differences that influence health outcomes for women and men.

Strategy #7: Develop mechanisms to incorporate gender-based variables in the planning process.

Objective: To improve health planning processes by ensuring that community-based information and knowledge about gender-based variables of health outcomes are acknowledged and reflected in ministry plans.

Performance Indicator(s)

Extent to which gender-sensitive community information is utilized in corporate planning processes and incorporated into programs.

Risks and Mitigation Strategies

Risk: Planners may resist incorporating gender-sensitive community-level information.

Mitigation Strategy: Ensure that community-level information is provided in formats that conform with corporate planning requirements.

Steps to Achieve Objectives

1. Ensure that health workers and clients from the community level contribute to the shared vision and teamwork approach within new health divisions.
2. Incorporate specific mechanisms to ensure that information collected at the community level is fed upward and gender-based information is valued and used by planners and decision makers.
3. Provide training at district and divisional levels in gender-sensitive health trend analysis and incorporate gender in basic planning parameters.

Bibliography

- Anon. 2002a. Violence Against women Costs \$300m Yearly. *Daily Post, Fiji*, 26 November.
- Anon. 2002b. For 80 Cents More. Special Report Health Care in Poor Countries. *The Economist*, 17 August 2002. p. 20–22.
- Asian Development Bank (ADB). 1999. *Country Assistance Plan (2000–2002). Republic of the Fiji Islands*. Manila: ADB. December.
- . 2002. *Fiji Islands Outlook 2002*. Manila: ADB.
- Aus Health International. 2000. *Developing Integrated Rural Health Care Systems: An Evaluation of Fiji Kadavu Rural Health Project*. Sydney: Aus Health International.
- . 2001a. *Change Management Strategy*. Fiji Health Management Reform Project. Sydney: Aus Health International.
- . 2001b. *Proposed Organisation Structure – Ministry of Health*. Fiji Health Management Reform Project. Sydney: Aus Health International.
- Budlender, Debbie, and Rhonda Sharp, with Kerrie Allen. 1998. *How to do a Gender-sensitive Budget Analysis: Contemporary Research and Practice*. London: Commonwealth Secretariat; and Canberra: Australian Agency for International Development.
- Campbell, J., G. Bruhm, and S. Lilley. 1998. *Caregivers' Support Needs: Insights from the Experiences of Women. Providing Care in rural Nova Scotia*. Halifax: Maritime Centre for Excellence in Women's Health.
- Canadian International Development Agency (CIDA)/Agriteam Canada. 2000. *Accelerating Change: Resources for Gender Mainstreaming*. Hull: CIDA.
- Commonwealth Secretariat. 2000. *Learning by Sharing: Commonwealth Plan of Action on Gender and Development*. London: Commonwealth Secretariat.
- . 1999. *Gender Mainstreaming in the Public Service: A Reference Manual for Governments and Other Stakeholders*. London: Commonwealth Secretariat.
- Corner, Lorraine. 1996. *Women, Men and Economics: The Gender-differentiated Impact of Macroeconomics, with Special Reference to Asia and the Pacific*. New York: United Nations Development Fund for Women.
- Davidson, K. et al. 1997. *Considering Gender as a Modifiable Health Determinant*. Paper Presented at the Fifth National Health Promotion Research Conference, Dalhousie University, Halifax, Nova Scotia, 4-5 July 1997.
- Department for International Development (DFID), Gender and Health Group. 1999. *Guidelines for the Analysis of Gender and Health*. London: DFID.
- Elson, Diane. 1999. *Gender Budget Initiative – Background Papers*. London: Commonwealth Secretariat.
- Government of the Fiji Islands. 2001. *National Strategic Development Plan, 2002-2005*. Suva.
- Government of Indonesia. 1999. *Gender Analysis Pathway*. Jakarta.
- Hunt, J. 2000. *Report on Institutionalising Gender Equality Commitments in Development Organisations and Programs*. Canberra: Winston Churchill Memorial Trust of Australia. Unpublished document.

- Lopez-Acuna, D. 2000. *The Nature of Health Sector Reform in the Americas and its Significance for Pan-American Health Organization's (PAHO) Technical Cooperation*. Paper Prepared for the Annual PAHO Meeting, October 2000. Washington, D.C.
- Macdonald, H, et al. 1998. *Gender and Organisational Change: Bridging the Gap Between Policy and Practice*. The Hague: Royal Tropical Institute.
- Maritime Centre for Excellence in Women's Health. 2001. *Women's Definitions and Priorities of Health*. Moving Toward Women's Health. No. 20. Halifax.
- Ministry of Finance. 2001. *Corporate Plan*. Suva.
- Ministry of Health (MoH). 1998. *Gender Management Systems in the Health Sector*. Workshop Background Paper. Nadi, Fiji Islands, 19–23 October 1998. London: Commonwealth Secretariat and Commonwealth Medical Association.
- . 2000. *Strategic Plan, 2000-2001*. Suva.
- . 2001a. *Briefing Notes for the Honourable Minister for Health*. Government of the Fiji Islands. Suva.
- . 2001b. *Corporate Plan 2002*. Suva.
- . 2001c. *Draft Fiji National HIV/AIDS Policy*. Suva.
- . 2002a. *Decentralisation of Functions and Accountabilities, Central Office and Divisional Health Service*. Report presented at workshop on May 1, 2002. Suva.
- . 2002b. *Draft Strategic Plan, January 2003–December 2005*. Suva.
- . 2002c. *Policy Development Guidelines (Draft 31/1/02)*. Suva.
- . 2002d. Various statistics produced by the Statistics Unit. Suva.
- Ministry of Women and Culture. 1998. *Women's Plan of Action 1999-2010*. Vol. 1 and 2. Suva.
- Na I Soqosoqo Vakamarama I Taukei. 2002. *Submission to the Economic Summit, 12 to 13 September, 2002*. Suva, Unpublished paper prepared for public consultations with Government of Fiji Islands.
- National Council of Women *Profile, Fiji*. Undated. Suva. Unpublished paper.
- Northern Province. 2000. *Gender Audit Process*. Available from Office of the Premier website.
- Oxaal, Z., with S. Cook. 1998. *Health and Poverty Gender Analysis*. Briefing prepared for SIDA. Bridge Report No. 49. Institute of Development Studies. Brighton: University of Sussex.
- Population Council. 2002. *What factors affect the Prevalence of HIV in sub-Saharan Africa?* Population Briefs. New York: Population Council.
- Pridmore, Saxby. 1993. *Mental Health Services for Fiji and the Solomon Islands*. Hobart: University of Tasmania.
- Schalkwyck, J, B. Woroniuk, and H. Thomas. 1997. *Handbook for Mainstreaming: A gender Perspective in the Health Sector*. Stockholm: Swedish International Development Agency.
- Secretariat of the Pacific Community. 1999. *Fiji Islands Population Profile (Based on 1996 Census): A Guide for Planners and Policy Makers*. Noumea.
- Sen, Gita. 2000. *Gender Mainstreaming in Finance: A Reference Manual for Governments and Other Stakeholders*. London: Commonwealth Secretariat.
- SNV (Netherlands Development Cooperation). 2000. *Manual for the Participatory Gender Audit*. The Hague: SNV.

- Standing, H. 1997. Gender and Equity in Health Sector Reform Programmes: a Review. *Health and Policy Planning* 12(1): 1–18.
- Taylor, Vivienne. 1999. *Gender Mainstreaming in Development Planning: A Reference Manual for Governments and Other Stakeholders*. London: Commonwealth Secretariat.
- United Nations Development Programme (UNDP). 1999. *Pacific Human Development Report*. New York: UNDP.
- UNDP/Government of Fiji. 1997. *Fiji Poverty Report*. New York and Suva.
- United Nations Development Fund for Women (UNIFEM). 2001. *Strengthening Economic Governance: Applied Gender Analysis to Government Budgets: Concept Paper*. New York: UNIFEM.
- UNIFEM/AusAid/UNDP. 1995. *Development Partnerships – Gender Advocacy for Community Workers in Pacific Island Countries. Training Manual*. New York and Canberra.
- World Health Organization (WHO). 1998. *Gender and Health*. Technical Paper. Available: www.who.int/reproductive-health/publications

Appendix 1

Ministry of Health Core Team Members

.....

Ms. Penina Cirikiyasawa, A/PAS
P.O. Box 2223, Government Buildings, Suva
Phone: 212479 Fax: 306163
E-mail: pcirikiyasawa@health.gov.fj

Ms. Nisha Khan, A/CDN
P.O. Box 2223, Government Buildings, Suva
Phone: 306177 Fax: 306163
E-mail: nkhan@health.gov.fj

Dr. Etika Mesulama, Assistant Director, Dental Services
P.O. Box 2223, Government Buildings, Suva
Phone: 306177 Fax: 306163
E-mail: emesulama@health.gov.fj

Mr. Simione Radakua, DHI C/E
P.O. Box 30, Suva
Phone: 306235 Fax: 315568

Ms. Losalini Tavaga, CHA CWMH
P.O. Box 115, Government Buildings, Suva
Phone: 215481 Fax: 303232
E-mail: ltavaga@health.gov.fj

Ms. Mereani Tukana, DHS
P.O. Box 30, Suva
Phone: 314988 Fax: 315568
E-mail: mtukana@hotmail.com

Ms. Losana Ugavule, SAS
P.O. Box 2223, Government Buildings, Suva
Phone: 221422 Fax: 306163

Appendix 2

Members of the Agriteam Canada Consulting Team

.....

1. Leonore Rogers
2. Gayle Turner
3. Helen Thomas
4. Lynda Nicholls
5. Linda Miranda
6. Tony Beck
7. Gina Houg Lee
8. Arrieta Matalomani Moceica
9. Emele Sima Duituturaga