

Gender biases and discrimination: a review of health care interpersonal interactions

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June 2007

**Background paper prepared for the Women and Gender Equity
Knowledge Network of the WHO Commission on Social
Determinants of Health**

Background to the Women and Gender Equity Knowledge Network

The Women and Gender Equity Knowledge Network (WGEKN) of the WHO Commission on Social Determinants of Health was set up to draw together the evidence base on health disparities and inequity due to gender, on the specific problems women face in meeting the highest attainable standards of health, and on the policies and actions that can address them.

The work of the WGEKN was led by two organizational hubs – the Indian Institute of Management Bangalore (IIMB) and the Karolinska Institute (KI) in Sweden. The 18 Members and 29 Corresponding Members of the WGEKN represent policy, civil society and academic expertise from a variety of disciplines, such as medicine, biology, sociology, epidemiology, anthropology, economics and political science, which enabled the work to draw on knowledge bases from a variety of research traditions and to identify intersectoral action for health based on experiences from different fields.

Acknowledgments

This paper was reviewed by at least one reviewer from within the Women and Gender Equity Knowledge Network as well as by two external reviewers. Thanks are due to these reviewers for their advice on additional sources of information, different analytical perspectives and assistance in clarifying key messages.

This paper was written for the Women and Gender Equity Knowledge Network established as part of the WHO Commission on the Social Determinants of Health. The work of the network was funded by a grant from the Swedish Ministry for Foreign Affairs through the World Health Organisation, the Swedish National Institute of Public Health and the Foundation of Open Society Institute (Zug). The views presented in this paper are those of the author and do not necessarily represent the decisions, policy or views of IIMB, KI, WHO, Commissioners, the Women and Gender Equity Knowledge Network or the reviewers.

SECTION A: POLICY BRIEF

Gender, either alone or in combination with other determinants of inequity profoundly influence interactions between health care providers and patients. Therefore, it is important to:

1. Mainstream gender consciousness and sensitization into the basic training and continuing education of health care providers;
2. Acknowledge the gender context in which health workers, the majority of whom are women, live and work. By valuing, caring and respecting them, they are more likely to provide client-centred and better quality of care services;
3. Integrate gender into health literacy programmes which intend to raise awareness and empower patient in their interactions with providers;
4. Incorporate gender into clinical audits and other efforts to monitor quality of care; and
5. Ensuring that integration of sexual and reproductive health services does not compromise the patient-provider relationship.

SECTION B: EXECUTIVE SUMMARY

A good interpersonal relationship between a patient and provider - as characterised by mutual respect, openness and a balance in their respective roles in decision-making – is an important marker of quality of care. Unfortunately however, the patient-provider interface has often been described by clients as discriminatory, marginalising, abusive and mirroring the social stratifications of society at large. This holds true for both developed and developing countries. This experience of discrimination and poor quality care is even more marked for poorer, lower class, caste women and men and is also mediated often by other factors including ethnicity, religion and language group etc. While there have been important regional and country efforts to provide more client-centred care, the special role of gender as an underlying social determinant in shaping the interaction between clients and providers while often acknowledged is still poorly understood and only in recent years received attention. In this paper, we recognise that the patient-provider interaction can be studied across a range of services including preventive, promotive, chronic, inpatient and the broad range of sexual and reproductive health services. However, for the purposes of this paper, we will focus on a limited range of conditions and services which will illustrate the important pathways gender impacts on the patient-provider interaction.

In this paper, the question will be addressed in three main parts. In the first part we are interested in mapping the context of how gender shapes provider-client interaction, and the impact of these interactions in 4 areas: 1) differential patterns of care for men and women for the same health problem; 2) differential patterns of care by male and female health workers; 3) the gendered division of labour; and 4) patterns of abuse of patients. The second part of the paper will provide a detailed breakdown of the nature of provider-patient interactions and how gender impacts on these interactions from the perspective of patients and providers. The paper will conclude with reviewing gender-specific policies and programme interventions *within* the health system for improving the interpersonal dimension of health care and hence quality of care. This paper is based on a comprehensive literature review of peer-reviewed studies and the grey literature obtained through a combination of Medline

and web-based searches as well as links provided by colleagues working in the field of gender and health.

In order to explore the assertion of differential patterns of care for men and women for the same health problem, we looked at the experiences in the areas of tuberculosis and depression. In both instances, men and women differed in a number of important ways. Not only did they understand and talk about their illnesses differently, their treatment seeking behaviour also varied. There was also evidence, from a limited number of studies that under-diagnosis of TB in women and depression in men is linked to gender-stereotyping on the part of providers.

Studies investigating gender-based differential patterns of care by providers arise predominantly from the developed countries. The dearth of similar data from developing countries suggests an important gap in documenting the experiencing in a range of middle and low income settings. These studies, which are largely USA-based seem to suggest gender-based differences in communication and services provided. However, none of these studies have directly addressed the issue of how power is altered and shaped by the gender dynamics between the patient and provider. For instance, are patients more passive in their interaction with male providers compared to female providers? Also, how does the interaction of gender with class and ethnicity of the provider influence the interaction? Alternatively, are there instances where it is more important for patients to consult with providers of their own race and ethnicity and gender is of secondary importance?

In highly patriarchal societies, the importance of gender concordance between provider and patient is important because of socio-cultural and/or religious norms and practices which not only demarcate gender roles but also restrict social and physical contact between men and women. In such societies marked by deep gender inequities, gender also impacts providers - particularly those at the front-line - who are predominantly women. In societies, these women experience discrimination within the workplace and the society at large, which spills over into their interaction with their patients.

A consideration of interventions took as its starting point the areas outlined by Women and Gender Equity Knowledge which underscores the importance of recognising that in order redress gender-biases and discrimination in the patient-provider interaction calls for action on multiple levels through the deployment of several strategies. The strategies we considered were in three areas: 1) health systems legislation and policy, 2) integrating gender into health programmes, institutions and 3) integrating gender into health worker training.

We considered firstly policies on the rights of the patient which have attempted to improve the patient-provider interaction, although they do not address gender directly and secondly those which have more explicitly incorporated gender equity, often within a broader context of population and development policies and a quality of care framework. Such policies and actions which seek to empower and strengthen the political agency and autonomy of women can be limited in their reach if they are not supported by appropriate programmatic changes on the ground. For instance, laws intended to reinforce adolescent mothers' rights to care and information can fail if skills are not upgraded and gender sensitisation is not incorporated and facilities are located in areas which adolescent women consider compromise their privacy and anonymity etc. Secondly, we examine the experiences of integrating gender into health programmes, institutions with programme cases of health literacy and women and men centred services. Finally, we argued that integrating gender into health worker training is essential. An improved understanding of how gender shapes the lives of health workers themselves has often been neglected as illustrated by the experience of initiatives such as Health Workers for Change. Finally, we support the view that the male-centric biomedical framework based on male models of pathology and treatment is embedded in the training of health professionals. As illustrated from the case in Kerala, there are efforts in several countries to transform medical education.

In the discussion section we discuss the role of the health system as a core social institution and argue that it should be seen as a space in which to begin to challenge gender norms that negatively impact on the nature of health care providers and patients.

In conclusion the paper argues that it is important to try and raise the sensitisation of health care providers through pre-service and in-service training, along side recognising the gender constraints that health care workers face. It also suggests that empowerment of patients and patient literacy is an important way to improve the power dynamics in the relationships between patients and providers, but that within this movement that has been insufficient attention paid to gender dynamics. Integrating gender into clinical audits and other ways of measuring quality of care is also important. Finally the article concludes that sexual and reproductive health services are particularly impacted by gender bias and discrimination and that particular attention needs to be paid to how these services are provided within the health system.

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SECTION 1: INTRODUCTION

Quality of health services is an important factor in terms of health care access. Access encompasses a range of dimensions spanning availability (e.g. geographic distribution of health facilities etc.), accessibility (transport etc.), affordability (user fees etc.) and acceptability (referring to the social and cultural distance between health care systems and their users) (Hausmann-Muela, Muela Ribera et al. 2003). This aspect of analysis recognises that even if patients do reach health services, and do get to see a health care provider, they will not necessarily be able to access good quality care because of problems with the provider-patient relationship. This dimension of access which signifies an important shift away from narrowly defining quality of services in terms of technical and clinical competence towards a broader definition which acknowledges the importance of the quality of interpersonal communication between providers and patients, as an importance barrier to access. In this paper, we define the patient-provider interaction as one which occurs between a patient and a health service provider. Although we recognise the important role that non-biomedical healers play in meeting the health needs of large sectors of the population, we will not be dealing with interactions between them and patients in this paper.

Across both developed and developing countries, the patient-provider interface has often been described by patients as discriminatory, marginalising, abusive and mirroring the social stratifications of society at large. This together with a lack of privacy and confidentiality, poor communication between providers and patients, failure to communicate medical and health-related information fully including side-effects, a paternalistic approach which fails to give patients information to enable them to make informed consent on the part of the provider we would argue in this paper are all important markers of poor quality and as important as whether the ‘correct drug’ was given, and in cases where the interaction is problematic make it almost impossible to prescribe the ‘correct drug’. This experience of discrimination and poor quality care is even more marked for poorer, lower class/caste women and men and is also mediated often by other ethnicity, religion and language group.

“Clients often experience providers as powerful individuals, who by social background and training are far removed from their own daily

realities and concerns. Clients and providers bring very different expectations to their encounters, and these differences in perspective and power profoundly affect the nature of the interaction.”

Simmons and Elias (1994:4).

While the gender of the patient is important in defining access, we would argue that the *gap* between the provider and patient with respect to gender, class, caste, ethnicity and other social stratifications (i.e. the social distance) might be even more important in shaping the interaction.

While there have been important regional and country efforts to provide more client-centred care, the particular role of gender as an underlying social determinant in shaping the interaction between clients and providers while often acknowledged is still poorly understood and only in recent years received attention. Gender here is understood to refer to the nature and distribution of roles and power between men and women both within and outside the health system. We recognise that as a socially constructed concept gender is inherently dynamic with the meaning of what it is to be a man and a woman varying across cultures and historical moments. There is however in much of the literature we reviewed – and consequently in this review of the literature - some degree of slippage between concepts of gender and sex, as well as relatively a-historical and de-contextualised descriptions of gender roles.

There is a growing literature in health systems research that argues that many of the problems around provider practice in public health systems have been that the health reform and policy implementation agendas in many countries have focused purely on the hardware issues of health systems (i.e. the infrastructure, the technology, the economics) and not focused enough on the ‘software’ of health systems (i.e. the human and social aspects). Many attempts to reform health systems, and to implement policy are based on what Gregory (1999: 65) calls a “economistic reductionism and technocratic structuralism” that fails to take account of the everyday organizational reality of what goes on inside hospitals and of the fact that health care workers are not simply robots who implement policy unthinkingly or are they angels who only have the best interests of the patients at heart but are living thinking reflexive human beings who live in and reflect the social norms of the societies in which they live and

work (Blaauw, Penn-Kekana et al. 2006). People's experiences in using the health system are shaped profoundly by the nature of the relationship with the health care worker and the health care workers attitudes and behaviour is shaped partly by the social context in which she/he lives and works.

In this paper, we recognise that the patient-provider interaction, and the way that gender dynamics influence that interaction can be studied across a range of services including preventive, promotive, chronic, inpatient and the broad range of sexual and reproductive health services. However, for the purposes of this paper, we will focus on a limited range of conditions and services.

The final key limitation of this review is that it is not possible to understand the nature of the patient-provider divorced from the way that health systems in which the interactions are taking place is structured, and the medical science on which the provision of medical care is premised. We suggest that this review be used as a snapshot that needs to be viewed together with other papers written within the Women and Gender Equity Network, the Health Systems Knowledge Network, as well as other networks within the Commission on Social Determinants of Health, to enable the reader to get a full picture of the impact of gender on the nature of patient-provider interactions.

SECTION 2: STRUCTURE OF PAPER

In this paper, the question will be addressed in three main parts. In the first part we are interested in mapping the context of how gender shapes provider-client interaction, and the impact of these interactions in four areas: 1) differential patterns of care for men and women for the same health problem; 2) differential patterns of care by male and female health workers; 3) the gendered division of labour; and 4) patterns of abuse of patients. The second part of the paper will provide a detailed breakdown of the nature of provider-patient interactions and how gender impacts on these interactions from the perspective of patients and providers. The paper will conclude with reviewing gender-specific policies and programme interventions *within* the health system for improving the interpersonal dimension of health and hence quality of care. The paper will not examine those policies and programme

interventions which aim to bring about changes in the wider socio-political context and lie *outside* the health system since those will be addressed in other papers.

SECTION 3: SOURCES FOR THIS REVIEW

Evidence demonstrating impact of gender on patient-provider interactions was relatively hard to come by and synthesis. Apart from some studies documenting different treatment received by men and women most of the studies described are descriptive, or evaluations of relatively small scale interventions. This being partly due to lack of funding of gender studies and interventions that tackle gender issues, but also reflects that gender is a socially constructed concept that is inherently dynamic with meaning varying across cultures and historical moments. It is therefore hard to imagine how a multi-centred randomised control trial of interventions would work. Other challenges in carrying out the review were that work looking at gender and health is cross-disciplinary and wide-ranging, making comprehensive reviews problematic and time-consuming. The fact that the focus of this article was also evidence from low- and middle-income country settings also limited the amount of evidence that we could access.

This paper is based on a comprehensive literature review of peer-reviewed studies and the grey literature. Initial searches for research studies, and reviews and meta-analyses were carried out on Medline Ovid and Pubmed involving combinations of key words (see Appendix 1). The next step was to narrow down the articles to those which addressed specifically the terms of reference for this review. This process was guided by identifying a list of key questions (see Appendix 2). The articles were then furthered expanded with additional searches based on bibliographic information from identified articles. Grey literature was identified through general web searches on Google, Google Scholar and from more focused reviews of relevant websites. The websites reviewed included international agencies and foundations (health, development and family planning) and governmental agencies: Centre for Health and Gender Equity (CHANGE), Guttmacher Institute, EngenderHealth, Centre for Reproductive Rights, Family Health International, The International Planned Parenthood Federation/Western Hemisphere Region IPPF/WHR, Population Council, PAHO (Pan American Health Organization), IDRC, Maximizing Health and Quality,

The Interagency Gender Working Group (IGWG) and WHO. In addition, we also obtained references from colleagues in the WGEKN and more broadly those working in the area of gender and health.

Despite limits and difficulties, we would argue that it is possible to learn from existing experience in order to act. Whereas on a few issues there is clear evidence of the kind conventionally accepted by public health practitioners as ‘rigorous’, i.e. that men and women receive different treatment for similar conditions, on other issues action should be taken based on a combination of values and an assessment of how available evidence can be made useful in different contexts. Importantly, we feel that it is imperative to take action in the face of gender inequity, even where there is only limited evidence on appropriate, specific interventions.

In conclusion, this article agrees with the conclusion the health system knowledge network final report that argued the examples given in the review enables policy makers to carry out what Rose’s (2005) calls ‘policy learning’: looking to the experience of other countries is not to copy but to understand under what circumstances and to what extent policies that are effective elsewhere might work in one’s own context (learning what not to do is also important and lowers the political risk of change). This needs to be done by recognizing that in many cases it may be necessary to adapt interventions to local circumstances and when applying lessons from other settings it is always important to establish monitoring and evaluation processes that allow adjustment in response to the experience of implementation in a particular setting.

Overall we were surprised that although there was a vast literature that stated the gender was an important factor that shaped the quality of care that patients received, very few of the articles looked in detail at the patient-provider interaction and described or theorised the way that gender did impact on this interaction.

SECTION 4: REVIEW OF THE EVIDENCE

4.1 Mapping the Context

4.1.1 Differential patterns of care for men and women for the same health problem

A recent review of the gender-based differences in care for men and women presenting with eczema and psoriasis in an outpatient clinic in Sweden reported that men received more intensive treatment (ultraviolet, prescriptions etc) than the women (Osika, Evengard et al. 2005). This example is yet another in a long line of studies which have attempted to understand why and how gender contributes to differences in care for similar illnesses and conditions. To explore this more fully, in this section we will review evidence for two conditions, namely tuberculosis (TB) and depression which illustrate these differences.

Tuberculosis

TB is commonly described as a ‘disease of poverty’, for preying on the poorest and most vulnerable in society. Although the majority of the world’s poor are women, two-thirds of all notified TB cases are men (WHO 2000). In the past, this discrepancy between men and women was ascribed to sex-based immunological differences and men having more social contacts and in so doing, increasing their risk to contagious diseases. In recent years, the wisdom of this has been questioned. Data from Vietnam and Bangladesh suggest that under-diagnosis and under-notification of female TB cases as well as gender-related differences in access to TB services might be the underlying reason (Dolin 1998, Begum, de Colombani et al. 2001, Thorson, Hoa et al. 2004). For this paper, we restrict our discussion to gender-related differences in diagnosis.

Studies in India (Raikes 1992, Rajeswari, Chandrasekaran et al. 2002, Sudha, Nirupa et al. 2003) and Vietnam (Johansson, Long et al. 2000) have shown that when women accessed care, they often chose traditional healers and private practitioners on account of privacy, anonymity, accessibility and the provision of more patient-centred care. TB is highly stigmatised and has very different social repercussions for men and

women. Women feared being socially ostracised and in some instances even faced the possibility of divorce and in the case of unmarried women experiences difficulties in finding marriage partners. In contrast, men feared more for the economic consequences of the disease (Johansson, Long et al. 1999, Long, Johansson et al. 2001). It is not surprising then that the patient-provider interaction is critical.

(Long, Johansson et al. 1999) found that in Vietnam doctor's delay (time from first contact with medical doctor to diagnosis) was significantly longer for women compared to men. Providers considered women and not factors associated with the health system or themselves to be responsible for delays in diagnosis (See Box 1) (Thorson and Johansson 2004).

Box 1: Doctor's explanation to a longer doctor's delay in diagnosis

Vietnamese women are very shy, they have a character of their own. You know they are afraid when they make contact. They consult me about their health, and after examining them I propose an investigation. After some 5 days they will come back with the result and I ask "what took you so long?" They say that they were very busy taking care of the children and the family. Maybe this is how the TB diagnosis gets delayed. (Male Dr. FG1)

Thorson and Johansson (2004: 40).

Women were described as "shy", "hesitant" with "limited knowledge in health care seeking matters" and often "not following their doctor's prescription mainly because of a need to double-check these with their husband, family and neighbours" and men in comparison were described as "daring and open", "willing to follow directions and prescriptions and, being the primary breadwinners, also to have more access to money and to have a decision-making power of their own, independent of the rest of the family" (Thorson and Johansson 2004: 40). An earlier study by (Johansson and Winkvist 2002) reported that Vietnamese male doctors reported more difficulty in diagnosing female TB patients whilst female doctors did not report any gender-based diagnosing problems. In these instances, although doctors acknowledged gender-based barriers and the role of stigma in delaying care for women, they were gender-blind and failed to take into account differential gender needs in their interactions with patients. Thorson and Johansson (2004) compelling argue that gender equity - which takes into account the differential social and economic impact of TB for men and women- and patient empowerment should guide the patient-provider interaction and reduce the delay in diagnosis. This calls for gender-sensitive patient-provider interaction and for more time "...spent on communication, explanations, information

and other strategies that are thought to empower the patient” (Thorson and Johansson 2004: 44).

Depression

Gender on its own and through interaction with other structural determinants (class, ethnicity, educational levels etc.) has also been acknowledged as an important risk factor for depression and other mental health disorders (WHO 2001). A consistent finding in psychiatric epidemiology is that depression is almost twice as prevalent in women compared to men (WHO 2001, Patel, Araya et al. 2004). Treatment seeking and patient care also show gender-based differences. Women seek out and receive care more often at the primary care level while men predominate in inpatient care (Bertakis, Azari et al. 2000, WHO 2001, Astbury 2002).

Female patients are twice as likely to be diagnosed as depressed compared to their male counterparts (Callahan, Bertakis et al. 1997). Higher diagnosis among women can in part be explained by the finding that with increasing number of health care visits, diagnosis of depression also increases (Cleary, Burns et al. 1990, Bertakis, Helms et al. 2001). Bertakis, Helms et al. (2001: 695) found that “...increased clinic use leads to the physician’s having a greater exposure to the patient’s symptomatology and more opportunity to make the diagnosis of depression correctly”. Since men are generally less likely to seek care at the primary level, this might be an indicator of under-diagnosis of male depression.

Gender-based differences in diagnosis have been investigated in several studies, predominantly in the USA. These studies have argued that these differences might be an outcome of gender-based differences in presentation of complaints to providers. Studies in the USA have found that female patients are more likely to initiate and discuss issues of depression with a provider and providers are more likely to bring up questions regarding depression with female patients (Sleath and Rubin 2002). Colameco, Becker et al (1983) and Bernstein and Kane (1981) in their research found that providers often judge female patients to present more often with psychosomatic problems and at the same time are considered more demanding and emotional. However, female patients with depression are more likely to be correctly diagnosed compared to men (Borowsky, Rubenstein et al. 2000). Is this because depressed men

are more likely to bring up physical rather than emotional complaints, thus making it difficult for the provider to establish the link between the symptoms presented and depression? There is increasing evidence suggesting that poorer treatment seeking and under-utilisation of health services (particularly primary and preventive) among men might be explained by reasons linked to the stereotypes of the male identity of being “strong”, “independent” and “self-reliant”. Unfortunately, these values and norms embodied in such gender stereotypes can lead to comparatively poorer treatment and health outcomes for men, as illustrated in this instance.

While the above examples illustrate the impact of gender alone for care received, it is important to recognise how economic class, caste and other social hierarchies cross-cut gender. That is, while gender-biases are likely to affect all women, the impact can in some instances be more harmful for women lower in the economic class and caste hierarchy. A qualitative assessment of implications of cost recovery for family planning services in Bangladesh found that poor, uneducated women perceived receiving poor quality and discriminatory care because of their social position: “We [poor people] have to buy medicine but they [rich people] get two saline instead of one. If a rich women comes they will take plenty of time to examine her, but I will not get any special favours”(Schuler, Bates et al. 2002: 275). Poor women felt that not only did they receive poor quality care, but that also that wealthier patients received preferential treatment. The experience of these women in the health care system arguably mirrors the values and norms of the society at large.

4.1.2 Differential patterns of care by male and female health workers

Studies investigating gender-based differential patterns of care by providers arise predominantly from the developed countries, suggesting an important gap in the literature in terms of documenting the experiencing in a range of middle and low income settings.

A recent meta-analytic review of 29 publications investigating the effects of physician gender in medical communication in the USA found notable differences (Roter, Hall et al. 2002). Although the review found no gender differences in the biomedical information provided during the consultation, female physicians did engage in

significantly more active partnership behaviours, positive talk, psychosocial counselling, psychosocial question asking, and emotionally focused talk, and spent on average, 2 minutes (10%) longer with clients compared to male physicians. Although earlier studies (Bertakis, Helms et al. 1995) - once again from the USA - explained differences in consultation time between male and female resident physicians in terms of patient gender and health status, a national study of the US National Ambulatory Medical Care Surveys found that female physicians spent more time with their patients compared to male physicians even after adjusting for patient socio-demographics and case mix (Franks and Bertakis 2003). The communication effectiveness of female providers is supported by another study but this time with older patients (Dearborn, Panzer et al. 2006). (Franks and Bertakis 2003) suggest that in addition to patients' gender bias (i.e. that female physicians are more empathetic, nurturing, and responsive) it is also plausible that there are gender-based psychosocial differences in the physician-patient interaction. That is, patients might also have very different expectations depending on whether the physician is a man or women.

While the above studies address the issue of communication style, an increasing number of reviews in the USA assess gender-based differences in treatment and management of patients. A few studies have indicated that female physicians are also more likely to provide more gender-related preventive services (e.g. mammograms, breast examinations etc.) and engage in more general preventive and mental health counselling for patients of both sexes (Hall, Palmer et al. 1990, Lurie, Slater et al. 1993, Bertakis, Franks et al. 2003). This can be an outcome of a range of factors (Bensing, van den Brink-Muinen et al. 1993, Elstad 1994, Franks and Bertakis 2003). There is the possible effect of gender concordance implying that it might be easier for female physician to perform pelvic and breast screening examinations. Also, female physicians might be biased towards female preventive services because of perceptions of their own personal susceptibility to cancer. Finally, patients requiring gender-specific tests for more intimate health problems may choose to see physicians of the same gender and might themselves request the service (Weisman and Teitelbaum 1989, Elstad 1994).

Secondly, none of these studies have directly addressed the issue of how power is altered and shaped by the gender dynamics between the patient and provider. For

instance, are patients more passive in their interaction with male providers compared to female providers? Also, how does the interaction of gender with class and ethnicity of the provider influence the interaction? Alternatively, are there instances where it is more important for patients to consult with providers of their own race and ethnicity and gender is of secondary importance?

4.1.3 The importance of the gender of the provider from the patient perspective

The significance of provider gender has in all probability received more attention in the areas of obstetric-gynaecology than elsewhere. Here again, much of this data emerges from developed countries. Studies carried out in the USA have found that only a minority of women felt strongly about their provider's gender and provider choice was more a function of the provider's attributes including experience, communication style, and technical expertise (Howell, Gardiner et al. 2002, Plunkett, Kohli et al. 2002, Zuckerman, Navizedeh et al. 2002).

However, in highly patriarchal societies, the importance of gender concordance between provider and patient is important because of socio-cultural and/or religious norms and practices which not only demarcate gender roles but also restrict social and physical contact between men and women (Holroyd, Twinn et al. 2004, Rizk, El-Zubeir et al. 2005). A qualitative study carried out in Cuba, Thailand, Saudi Arabia and Argentina, examined the experiences of women seeking antenatal care found that female doctors were more highly preferred by Saudi and Thai women (Nigenda, Langer et al. 2003). For Saudi women, although it is acceptable for male doctors to conduct an examination provided a female nurse is present, the interviewees did not feel happy exposing their bodies to male doctors and more especially felt uncomfortable when the doctor has to do a vaginal examination. Thai women, they also had a strong preference for midwives since they were likely to be themselves mothers and experienced pregnancy, as women and could more easily relate to them on an emotional level. Interestingly, although Cuban women indicated being equally comfortable with male and female doctors, they were warned against male doctors: "...the general practitioner (a woman) told me that in my visit to the specialist (a man) I have to take with me a piece of cloth to cover my body, otherwise the doctor (...) will not take his eyes away from you. The generalist told me that the specialist is

not guilty but I, myself if I provoke his curiosity by not carrying my own piece of cloth” (Nigenda, Langer et al. 2003: 8 of 12).

4.1.4 The gendered division of the health care work force

Globally, lower level front line positions (e.g. nurses) are staffed by predominantly women and more senior positions (e.g. doctors) of influence and power are filled mainly by men (WHO 2006). Hartigan (2001:10) argues that this suggests that “The gendered division of labour within the health system reflects the gender division of labour within society”. Poor salaries, unsatisfactory working conditions (weak and/or absent support and supervision structures) particularly for front line providers often leaves them feeling isolated, disempowered and unappreciated have been documented in numerous studies.

In societies marked by deep gender inequities, these women experience discrimination within the workplace and the society at large. A qualitative study of the experience of the experience of female community-level workers in Pakistan reported hierarchical management and abuse of power, disrespect from male colleagues and sexual harassment, lack of sensitivity to women’s gender-based cultural, hostile community and family attitudes, all of which suggests that health care institutions not only reflect but can maintain harmful and discriminatory societal norms and values (Mumtaz, Salway et al. 2003). The frustrations and discrimination that female workers experienced influenced their interaction with patients:

“When I leave home to come to the Basic Health Unit I need to travel by local transport, and there are men who offer a lift or pass comments. I feel so bad and insulted that when I reach the Basic Health Unit I misbehave with my patients.” (LHV, age 24, 12 years education) (Mumtaz, Salway et al. 2003: 264).

There is a considerable body of literature that we will not be dealt with in this article that deals with the abuse of health care workers, particularly female nurses by senior medical staff, and the general sexual harassment of junior staff. It is unlikely that healthcare workers who are themselves harassed and do not feel safe and if they are not helped and supported are likely to pass on their frustrations. Research also found

that health care workers often have problems of abuse in their own lives independent of their position as nurses.

4.2 Abuse of Patients

Although touched upon in other section of this article, the abuse of patients by health care providers is a critical issue that is receiving increasing attention, and deserves special mention. An underlying implicit assumption in many of the previous sections is that health care providers intend to provide good quality care to patients but a range of factors including gender stereotyping interfere with the quality of these interactions between providers and patients. There is however a literature on the abuse of patients by providers – sexually, physically, verbally and economically – that frames the patient and health provider relationship differently. It argues that the health care provider- patient relationships is “an intimate relationship that can be fraught with issues of power and control...the health provider holds the power of his/her knowledge and of access to the therapy or treatment that the patient requires in order to maintain or regain health” (Ontario Women's Justice Network 2001). In such a relationship all patients, but especially women, and women who are socio-economically disadvantaged in other ways, be it poverty, race, class, age are particularly vulnerable to abuse.

4.2.1 Sexual Abuse of Patients

One of the most severe forms of abuse of the health care provider- patient relationship is that of sexual abuse. Exactly what constitutes sexual abuse in the provider-patient relationship is contested. Most medical professional boards define sexual abuse of patients as any sexual intercourse or other forms of sexual relations, touching of a sexual nature, or behaviour or remarks of a sexual nature with a patient, regardless of whether or not the patient give consent for the relationships arguing that any relationship is “almost always harmful”(Fahy and Fisher 1992,Health Professions Regulatory Advisory Council 2000). There is some debate, particularly in terms of the severity of sanctions, about whether the fact that the relationship is broadly consensual makes a difference with some medical professional groups arguing that forced sexual violation deserves the strongest sanction and others arguing for a policy

of zero tolerance to any sexual relationship between health care providers and patients (Fahy and Fisher 1992, Thomasson 1999, Health Professions Regulatory Advisory Council 2000).

Because of the prohibited nature of the sexual abuse there is little evidence beyond the anecdotal from most of the world on the exact extent to which sexual abuse of patients by providers is a problem.

Anonymous postal surveys carried among doctors in developed countries with a range of different practitioners consistently find around 3- 4% of practitioners admitting to having had sexual contact with patients (Wilbers, Veenstra et al. 1992, Lamont and Woodward 1994). What evidence there is suggests that it is overwhelmingly, but not exclusively, female patients who are getting abused by male doctors. Young gay men also seem to be vulnerable to abuse from older male health care providers. Patients of gynaecologist/obstetricians, psychiatrists and psychotherapists seem to be most at risk of abuse. There is also some information that suggests that sexual abuse of female patients in psychiatric hospitals by male nurses is also a problem.

Studies on doctors' attitudes towards sexual contact between doctors and patients also consistently find that female doctors support stronger sanctions against sexual transgression and sexual violation than the male doctors and stated that female doctors were more likely to be prepared to report colleagues and act as whistle blowers (Wilbers, Veenstra et al. 1992, Lamont and Woodward 1994).

4.2.2 Physical Abuse of Patients

As discussed in the earlier sections on maternal health, there is also literature on physical abuse of patients in health care settings (d'Oliveira, Diniz et al. 2002). In terms of physical abuse of women there is a large literature on the physical abuse of women in labour by health care workers – themselves mainly women - which has been documented around the world (Jewkes, Abrahams et al. 1998, Freedman, Waldman et al. 2005). It is a sad indictment of maternal health services around the world that so much abuse is documented, and appears to go unpunished. It also must go against the campaign to get more women to deliver at facilities when it is widely acknowledged that physical and verbal abuse is common in maternity services.

4.2.3 Verbal Abuse of Patients

As discussed earlier in this paper there is evidence from a range of countries that verbal abuse of patients, particularly when patients are accessing or trying to access reproductive health services – whether it is treatment for sexually transmitted diseases, abortion, family planning services and during deliveries. A study carried out in midwife led units in South Africa found that as well as structural explanations for poor quality of care, health care workers also were judgment of women who it is felt that they should not be having children, for example they are too young, unmarried, already have many children, too old, not married etc.(Jewkes, Abrahams et al. 1998). Race and class differentials between health care midwives and patients was also an important explanatory factor for verbal abuse (Jewkes, Abrahams et al. 1998). All of this despite there is clear evidence that positive support for women during labour fundamentally improves the experience of childbirth for women both in physical and psychological terms, and results in better clinical outcomes (Buttiens, Marchal et al. 2004).

Work in South Africa exploring how sexual assault survivors were treated found that health care workers were often extremely judgmental and rude, and that patients rated the sympathy of health care workers alongside competence as one of the factors that mattered most to them (Christofides, Muirhead et al. 2006). Verbal abuse of women seems often to be linked to factors associated with health care workers presuming that women have transgressed certain gender norms. However the same research that documents such abuse often suggests that it is health care workers own experience of abuse either outside the health facility, or by managers and other staff at the facility that is often an explanation, with health care workers taking their frustrations out of their patients (Kim and Motsei 2002,Christofides, R.K. et al. 2005).

4.2.4 Economic Abuse and Over-medicalisation of Patients

Many women are unable to access services, or elements of services, because of demands for under the counter payments for services and medications that are officially provided free of charge, as well as referrals to health care workers private practices. This is often particularly the case in non-functional health systems where basic needs of health care workers are not met(Parkhurst, Penn-Kekana et al. 2005). Although the literature often does not deal with gender specifically, there is

widespread anecdotal and descriptive data that suggest that because of with women's access to funds, women's poverty then demanding payment, can force women to rely further on men, and sometimes force families into debt, and in other places made services just inaccessible to women, contributing to maternal deaths (George, Iyer et al. 2005).

Related to the economic abuse of patients, is that of over-medicalisation of certain aspects of women's health. The literature suggests that over-medicalisation of women's health, particularly aspects of women's reproductive health, has its roots in a range of different causes. Firstly as a result of profit motives and poor regulation of health care workers where over medicalisation is related to financial incentives for health care workers (d'Oliveira, Diniz et al. 2002, Parkhurst and Rahman 2007). Secondly as a reflection of the power dynamics between patients and providers especially in terms of childbirth where there are studies documenting health care workers inducing labour, or performing c/sections so as their social and work schedules are not interfered with (d'Oliveira, Diniz et al. 2002). Thirdly due to "gender-based stereotypes about women's nature and women's bodies" (Munch 2004). Although at times this stereotyping leads to women's illness being miss-diagnosed as purely psychosomatic, these stereotypes have also resulted in the over-medicalisation of natural event in women's lives such as childbirth and the menopause partly as a result of the classification of these processes as 'disease' (Katz-Rothman 1991). A combination of these factors has commonly led to problems of women being submitted to "excessive or inappropriate medical treatments during childbirth" as well as over medicalisation with no real medical evidence guiding the intervention of women with infertility problems and around menopause (d'Oliveira, Diniz et al. 2002).

4.2.5 Abuse of Health Care Providers By Patients

There is also an increasing literature that documents the abuse of health care workers by patients. For example a study of health care workers in the UK found that 12% of health care workers had experienced physical violence from patients or their relatives in 2006, with 26% reported bullying, harassment, or abuse from patients or patients'

relatives(Healthcare Commission 2006). Nurses working in rural South Africa noted security and fear of attacks from patients as a key factor in shaping their decisions about where to work and not wanted to stay in some rural areas (Penn-Kekana, Blaauw et al. 2004). There is very little work that documents whether there is a gender dimension to this violence and abuse, or documents the levels of violence and abuse in the developing world.

4.3. Impact of Gender on the Provider-Patient Relationship

The previous section reviewed the evidence, in the classical sense, that clearly shows that gender does play a significant role in shaping the relationship between provider and patient, both in terms of the quality of care is given by the provider, and what care the patient receives, with this being mediated by other social stratifications (e.g.. race and class). We would argue that it is not because women are inherently ‘better listeners’ or men the ‘stronger sex’ that this is the case, but it is gender norms which govern much of the behaviour of providers and patients, that vary across time, space and cultural context, that fundamentally impact of the provider-patient relationship. There is a vast, although at times disappointing literature in terms of its analysis and explanatory value that touches on some aspects of the way that gender impacts on the provider-patient interface. What we hope to do in this section is describe some of this literature. Due to the nature of what is being described – i.e. complex changing social phenomenon – the type of evidence that we present in this section of the paper is mainly descriptive. Where possible we have tried to identify common themes across regions or religious groups, we have also in this section due to the need to be selective in the information that we present focused on certain aspects of health care such as maternal health, and treatment for sexually transmitted diseases.

What we also try to illustrate and argue in this section is that we believe that it is important to think about issues around how complying to gender norms impact on provider-patient relationships, but also how transgressing gender norms (especially those gender norms held by health care workers) can lead to a real breakdown in provider-practice and is part of the explanation of why abuse of patients occurs. This appears to be particular the case in reproductive health services, and in the cases of women seeking help after gender based violence (d'Oliveira, Diniz et al. 2002, Kim

and Motsei 2002,Chikanda 2005,Baines 2006). In this section we have drawn particularly from research reports and other grey material.

As touched upon in the previous section more structural and psychosocial explanations have been put forward to explain why men and women health providers provide different care, and why male and female patients receive different care. Those that are given are that men and women perceive and report some symptoms differently; men and women use the health system differently. The way that gender norms impact on interpersonal relations seems to work in two main ways. Firstly norms about behaviour – for example as mentioned in the previous section that male identity is defined around being strong and that to admit feeling depressed would be a sign of weakness. The second way that gender norms can impact provider-patient interpersonal interactions is if the patient is deemed by the provider to have transgressed gender norms and then there is evidence that health care workers can operate in a judgmental manner.

4.3.1 How Gender Influences The Patient Side Of The Interaction?

There is evidence for a number of studies and evaluations that patients may avoid seeking care or care at specific facilities because of the gender of the health care workers. They may not think it acceptable, or their families might not feel it acceptable, to see a health care worker of another sex.

Patients may avoid health care workers also because of the fear that health care workers will be judgmental of the medical condition for which they are seeking help (abortion, contraception, treatment for STI's, infertility, AIDS) feeling that they have transgressed some societal norms to have developed this medical conditions, or need this medical assistance.

Gender dynamics can also fundamentally affect the way that patient communicates with the health care workers. To avoid sanction, or because of beliefs about what it is appropriate to discuss, patients may not discuss certain symptoms which are essential for the health care worker to make a correct diagnosis. This might be around a STI, or around something such as pain where studies have found that there are gendered cultural norms about the acceptability of complaining about pain. Some of these

problems may be exacerbated by being treated by a health care worker of a different sex, but still exist if talking to a health care worker of the same sex.

The gender of the health care worker, and the quality of the interaction with the health care worker, will also affect patients' ability to understand/believe/trust what the provider says and to follow through with the treatment that the provider prescribes. There are for example numerous examples in the literature of patients not taking seriously the prescription of 'nurses' who are predominately female and instead preferring the opinion of the predominantly 'male' doctor; although the reverse is also sometime true. There are also studies that show that patients often feel unable to ask questions of health care workers. This belief that the patient cannot task questions is mediated by a range of social factors including gender. Also issues about levels of literacy/English or official language proficiency among women to tend to be less well educated.

4.3.2 Impact of gender on provider practice.

Gender dynamics impact on whether providers get to see, or are prepared to see certain patients. Most health care in the developing world is provided in a context of scarce resources and overwhelming demand. A number of studies have found that patient's gender impacts whether patients are judged worthy of particular treatments, or attention from certain ranks of health care workers.

Studies have also found that gender dynamics along side race, age, class, etc shapes how provider communicate with patients, how they listen to patients, and the degree to which they believe and interpret what patients say to them. Almost all health care treatment requires that patients take medication, or alter their behaviour in some way. This is particularly true in terms of patients who have been diagnosed with chronic illness. Studies have found that poor communication between providers and patients, as well as providers not understanding the context in which patients live can mean that that medication is not taken properly, or lifestyle changes that need to be made are not. Gender dynamics also influences this relationship.

SECTION 5. INTERVENTIONS FOR REDUCING GENDER BIASES AND DISCRIMINATION IN THE PATIENT-PROVIDER INTERACTION

This section takes as its starting point the six areas for intervention outlined by the Women and Gender Equity Knowledge Network (WHO CSDH). These include: 1) addressing key gender inequities that impinge on the health system from outside; 2) tackling values, norms, practices and behaviour within households and communities; 3) addressing gender specific exposures to health risks; 4) addressing gender specific vulnerabilities in disease and disability; 5) redressing the inequitable social and economic consequences of ill-health; and 6) engendering health systems and health research. This underscores the importance of recognising that redressing gender-biases and discrimination calls for action on multiple levels to address the complexities of the patient-provider interaction. In the following sections we will consider strategies in the following areas: 1) health systems legislation and policy, 2) integrating gender into health programmes and institutions and 3) integrating gender into health care worker training.

5.1 Health Systems Legislation and Policy

Cottingham and Myntti (2002) distinguish between legislation which have a *direct* (i.e. operate within the health care system) and those which have an *indirect* (i.e. operate outside the health care system) impact on women's health and access to quality health care. Indirect legislation and policies are those 1) which affirm and safeguard women's rights (e.g. equal rights) and guarantees their full participation in public, cultural, political and socio-economic life and 2) which empower women and their ability to access health care (e.g. education of girls) (Sen and Batliwala 1996, Cottingham and Myntti 2002, Freedman 2005). Although such legislation and policy changes do not impact directly on the provider-patient interaction, they can potentially empower women to be more assertive in their interactions with providers.

Examples of more direct policies are laws pertaining to the rights of patients, decriminalisation of abortion, ear-marking of funds for youth-friendly health services

etc. In the next section we will consider firstly policies on the rights of the patient which have attempted to improve the patient-provider interaction and which impact gender indirectly and secondly those policies which have more explicitly incorporated gender equity, often within a broader context of population and development policies.

5.1.1 The Paradigm Shift from Provider-Centred to Patient-Centred Care

At a global level, the International Declaration on the Rights of the Patient (World Medical Association 1981) was a watershed in shifting the spotlight onto the patient-provider relationship. The Declaration not only identified a set of patient rights incorporating consent and correlative duties and responsibilities on health professionals, but also signalled an important shift away from a paternalistic model of care to one based on patient autonomy, cognisant of the balance of power between providers and patients. A Cochrane review found that training in patient-centredness for health care providers may improve communication with patients, enable clarification of patients' concerns in consultations and improve satisfaction with care (Lewin, Dick et al. 2005). However, it was not clear whether this training makes a difference to health care use or outcomes.

In late 1980s and early 1990s, international population and family planning organisations, and specifically the work of Judith Bruce and Anrudh Jain from the Population Council drew attention to the provider-patient interaction as an important element of quality of care within the family planning programme delivery context (Bruce and Jain 1991). In 1992, International Planned Parenthood Federation's (IPPF) put forward a Charter on Rights of the Client that considered quality of care from the client's perspective and provided education about rights to information, access to services, choice, safety, privacy and confidentiality, dignity and comfort and continuity of services (Huezo and Briggs 1992). In 1994, the International Conference on Population and Development (ICPD) which not only heralded a major paradigm shift in the population field towards a rights-based and social justice approach but also stressed the importance of implementation of reproductive health programmes from a gender perspective. For family planning, this called for shifts towards voluntary, client-centred services (for both men and women), away from government or

provider-driven targets, within a broad context of sexual and reproductive health services (Sai 1997). The increasing use of the term 'client-centred' as opposed to 'patient-centred' care has gained currency since the former reflects an emphasis on empowerment, patient autonomy, voice, self-determination and participation in decision-making. In this paper, we use the terms inter-changeably.

Since the seminal work of Bruce and Jain, the client-centred approach has taken root and evolved in content and focus. More recently, Murphy and Steele (2000) emphasised the importance of both *process and content* in the interaction. Content refers to the exchange of accurate information and process that creates an atmosphere of trust and allows sharing between the provider and client. [The "S.I.G.N.A.L. Project" in Germany is an important example of a patient-centred intervention to end violence against women \(Hellbernd, Brzank et al. 2005\). It was initiated in 1999 and includes asking patients about abuse, assess danger, inform and refer victims to counselling programs and women's shelters, and document injuries and health problems for use in legal proceedings. Nurses and physicians working in emergency departments have undergone training based on these principles.](#)

This approach has been widely adopted by leading international family planning and reproductive organisations including EngenderHealth's COPE (Client-Oriented, Provider-Efficient services), the Population Council's Client-Centred Approach to Reproductive Health, USAID's Maximizing Access and Quality (MAQ) Initiative and the more recent Decision-Making Tool for Family Planning Clients and Providers developed by WHO and the INFO Project at the Johns Hopkins Bloomberg School of Public Health. These interventions go further in incorporating gender through the inclusion of men in family planning and reproductive health care, couple counselling and providing services specifically for men (Ringheim 2002, Kim, Kols et al. 2003, RamaRao and Mir 2004).

Such policies and actions which seek to empower and strengthen the political agency and autonomy of women can be limited in their reach if they are not supported by appropriate programmatic changes on the ground.

5.2 Integrating Gender into Programmes and Institutions

5.2.1 *Health Literacy*

A situation analysis of family planning and reproductive health services in more than 20 countries indicated that the information exchange between providers and clients is often poor or inadequate, thus compromising the ability of the patient to make an informed decision (Miller, Fisher et al. 1997). Counselling continues to be a one-way encounter in which basic information about the client and information on available methods is incomplete and information on side-effects of different methods is either incomplete or absent. Moreover, patients often do not feel sufficiently empowered to participate actively with providers and demand the necessary and complete information to allow them to make an informed decision. An outcome of this has been an increasing emphasis on patient education and health literacy, with the latter being defined as the ability to obtain, process, and understand basic information and services needed to make appropriate decisions regarding health (National Library of Medicine 2000, Greenberg 2001) which speaks to the right of the patient to make informed choices enabled by an understanding of the full range of options and their consequences.

Box 2 describes the "Smart Patient" coaching intervention in Indonesia which aimed to improve client participation through health literacy in family planning consultations: in Indonesia.

Box 2: Smart patient Coaching in Indonesia

This intervention was carried out by the Johns Hopkins University Centre for Communication Programmes together with Indonesia's National Family Planning Coordinating Board (BKKBN), with support from FRONTIERS. This intervention was motivated by research showing that patients who actively communicate with providers experience better quality of care although evidence from a variety of settings points to relatively poor patient participation. The study was conducted in 64 clinics in two districts of East Java Province, Indonesia between 2002 and 2003. All the providers in the study had received interpersonal communication and counselling training on family planning in the previous 3 years. Within the study clinics, 768 family planning clients (new or continuing) were assigned in equal numbers to either the intervention or control group. Clients in the control group were given a leaflet on HIV/AIDS to read while intervention clients met individually with a client educator who provided individual instruction on 3 basic skills: asking questions, expressing concerns, and seeking clarification. The intervention increased the consultation by approximately 20 minutes. The consultations were audio-taped and analyzed, and both the educators and clients were interviewed. Home visits with clients were made eight months later to measure contraceptive continuation.

Compared with clients in the control group, those who received Smart Patient coaching raised significantly more questions (6.3 vs 4.9) and concerns (6.7 vs 5.4) during the consultations, but they did not seek clarification or volunteer information more often. The intervention narrowed differentials in active communication by client type, age, and assertiveness, but it widened differentials by client education and socioeconomic class. Coaching was associated with more tailored information-giving by providers (24.9 vs. 21.1). However, the intervention did not make a significant impact on contraceptive continuation rates at eight months.

The investigators recommended that there were several specific client and provider behaviours that facilitated better client decision-making and which should be encouraged:

- Client behaviours: clear communication by clients, self-disclosure by clients with regards to doubts and concerns, and the use of pointed questions.
- Provider behaviours: sensitivity to the client's situation and attitudes by inquiring about client's reproductive intentions, breastfeeding status, and prior use of family planning and recognizing and responding to client concerns.

It was also found that provider performance in terms of interpersonal skills was weak suggesting a need for revisions in training content and supervision criteria.

Subsequently, BKKBN expanded the "Smart Patient" intervention by means of a mass media campaign and community mobilisation by local workers. The model has also been revised to include self-learning materials that do not require literacy or the presence of an educator. BKKBN will also provide job aids and training to enable providers to respond accurately to clients' questions.

Source: Kim, Putjuk et al. (2003).

Kim, Putjuk et al.(2003: 20) argue that an important outcome of this intervention was that for clients "...it legitimised their right to speak". However, this was not necessarily equal for all patients: the better educated and higher income clients gained more. Moreover, it was found that clients engaged more actively with providers from the lower socio-economic groups suggesting that client participation increases with a narrowing down of the social distance. This further indicates that the effectiveness of patient education is constrained by underlying structural determinants of poverty, class and gender.

There is evidence that low functional literacy is linked to poorer health outcomes (Brown, Ludwig et al. 2004,Schloman 2004) and the challenge of low literacy levels for health literacy is not limited to developing countries. A recent report by the Institute of Medicine (IOM) entitled Health Literacy: A Prescription to End Confusion, found that almost 50% of all American adults have difficulty understanding and using health information, leading to a higher rate of hospitalization and use of emergency services among patients with limited health literacy (Nielsen-Bohlman, Panzer et al. 2004). Parker and Kreps (2005) in responding to the IOM

findings, propose the introduction of strategic communication training, where health care system providers are taught to evaluate the literacy levels of their patients and develop adaptive and culturally sensitive communication skills and being sensitive to the feelings of embarrassment that patients might be experiencing about having difficulty understanding health messages. (Parker and Kreps 2005) emphasise the use of simple language, non-written materials (e.g. straightforward picture books, videotapes, audiotapes etc.) and surrogate” readers (family members, close friends, neighbours etc.) to help patients understand what they need to do. Kim, Putjuk et al (2003) of the Smart Patient Project also supported the idea that patient education and health literacy can be more effectively enhanced through oral communication methods and low literacy materials.

Recognising that access to education and more specifically literacy is in many parts of the world gendered, health literacy which emphasise reading, writing, speaking, and listening can entrench gender-biases in health care and patient-provider interaction. Therefore, complementary policies which improve access to education and improved literacy especially for girls are critical (Nutbeam and Kickbusch 2000).

5.2.2 Women and Men Centred Services

Judgemental attitudes of providers, lack of privacy and confidentiality, and in some instances denial of care particularly in the context of sexual and reproductive health services has been described earlier as an important barrier to access especially for unmarried women, men and adolescents. This has contributed to the introduction of more gender-and adolescent friendly services which can take a range of forms: youth-only and men-only clinics, women-only services within existing services, out-reach and community based services and different hours of services within existing services.

Women Centred Services

Initiatives towards ‘women centred services’ has taken a variety of forms. One example is the provision of door-to-door services for women whose mobility and hence access to services is constrained. The Lady Health Workers initiative in Pakistan is a response to meeting this need and has been effective in increasing the

uptake of services, improved the adoption of contraceptives and improved community health (Douthwaite and Ward 2005).

Another instance is the integration of health services, which can take the form of multipurpose clinics, multipurpose staff, adding new services that serve a more diverse client population (e.g. expanding family planning services to include men and adolescents), and adding new reproductive health services (e.g. HIV/AIDS) to existing reproductive health services (e.g. MCH) to existing reproductive health services (de Pinho, Murthy et al. 2005). Integration has been motivated for from a patient perspective in terms of time convenience (one-stop-shop) which can potentially enable to access reproductive services and simultaneously access for instance child care services in the same facility. Secondly, integrating STI prevention with reproductive health services instead of separate STI services can also help to ensure privacy and reduce stigma. Although some studies have shown an improvement in the patient-provider relationship (Potter, Mojarro et al. 1987), others have either not examined the question of interpersonal interactions and client satisfaction (WHO 1999), or have found little evidence of such an impact (Dehne, Snow et al. 2000).

The *Kumar Warmi* (Aymara for 'healthy woman') project in Bolivia illustrates how women-centred services through educational processes, shared decision making, and linking with women's groups, can help women overcome negative perceptions of the doctor-client relationship (see Box 3).

Box 3: The *Kumar Warmi* project in rural Bolivia

The *Centro de Informacion y Desarrollo de la Mujer* (CIDEM) is a nonprofit organization that conducts a variety of activities with women, primarily in El Alto, Bolivia. CIDEM initiated a reproductive health project based in the *Kumar Warmi* Clinic. El Alto is characterised by poor infrastructure, lack of basic social services and poor health (including maternal) indicators. In addition to financial barriers which prevented women from seeking professional health care, negative perceptions of the doctor-client relationship were also cited (Schuler, Choque et al. 1994).

The clinic offers integrated services addressing biological, legal, psychological and socio-cultural aspects of women's health, with a complementary focus on traditional medicine. *Kumar Warmi*, which is Aymara for 'healthy woman,' has as its primary objective the provision of education and services that allow women to share in knowledge, responsibility, and decision-making about reproductive health and to participate in the design of health policies and projects. The approach includes an emphasis on continued education and growth, based on respect for differences; an integrated approach to education and service delivery;

and a focus on interpersonal relationships. The project transforms conventional interpersonal relationships so that the doctor is no longer the sole decision-maker and the patient is the passive beneficiary by offering a friendly and supportive environment, in which clients can talk about their daily experiences and in which they can ask for and receive information and personal support from the staff. The relationship is built over a series of encounters where the emphasis is on making health care an ongoing relationship that develops over time. This approach builds trust and confidence in participants enabling them to take a more active role in caring for their own health. The doctor and nurse speak Aymara and they take the time to listen not only to the clients' physical problems, but to "problems of the soul."

The programme views women as participants in the design and delivery of health care services and health care is seen in isolation but as integrated with other social services and regarded as a vehicle for women's empowerment. The programme also employs innovative educational and communication strategies which are non-hierarchical and non-didactic.

Source: Paulson, Gisbert et al.(1996).

Men Centred Services and Male Involvement

Generally, men are poorer users of the health care system than women. Amongst the various barriers to male involvement are poor recognition and sometimes denial of ill-health, poor access (e.g. clinic hours), absence of a male provider and provider bias against male patients (AVSC and Profamilia 1997, Hancock 2004, Smith, Braunack-Mayer et al. 2006). It is increasingly recognised that the skills of health providers are often inadequate for dealing with men. Male stereotypes, perpetuated by providers can create an obstacle to men's involvement (Shepard 2004). As illustrated with studies from Brazil (Manhoso and Hoga 2005) and South Asia (Piet-Pelon, Rob et al. 2000) providers can often fail to provide male patients with accurate information.

The ICDP's Programme of Action called for efforts and organizations to "encourage and enable men to take responsibility for their sexual and reproductive behaviour" and an increasing number of organizations have increased male participation (often referring to counselling, either alone or with their female partner) particularly in reproductive health. The unequal power balance between men and women together with the recognition of men's authority within the family has propelled forward male involvement programmes (Ringheim 2002). The area of family planning has had a number of initiatives involving men, primarily so they will support partners' use of contraceptives, through improved communication; others offer reproductive health services specifically for men and more recently, programmes that attempt to reduce, if not eliminate violence against women through encouraging men to examine detrimental social norms. Box 4 describes an intervention in Peru which trained health workers to sensitise men on gender-based violence.

Box 4: The *ReproSalud* Project, Peru

The *ReproSalud* Project, a USAID funded programme in partnership with a Peruvian feminist organisation *Movimiento Manuela Ramos*, was initiated in 1995 as a reproductive health programme for poor women in Peru (Rogow 2000). The objective was to raise awareness of human rights in the realm of sexual and reproductive health rights. *ReproSalud*, focused on social barriers to women's access to reproductive health services, including limited power to negotiate within sexual relationships, social isolation, domestic violence, lack of cash, and low self-esteem. The project specifically targeted the poorest and hardest-to-reach women (aged 15 to 49) and focused on individual and community empowerment through the use of participatory methods.

The project partnered with 240 women's community-based organizations in eight of Peru's 24 departments and more than 90,000 women and 50,000 men participated in the education and training activities (Rogow 2000). *ReproSalud* and each partner CBO conducted a self-diagnostic workshop, allowing participants to explore their perceptions, attitudes, and experiences regarding sexual and reproductive health, community gender norms, and available health services. *ReproSalud* helped each CBO design and implement a strategy to address the primary reproductive health problem identified in its community, primarily through training a team of health promoters to teach other community members about sexual and reproductive health, emphasizing the selected priority concern (Coe 2001).

When the topic of violence was raised, women demanded that their husbands get involved. *Salud y Genero*, an NGO from Mexico helped with training health workers to sensitise men on issues of violence and more specifically to gender-based violence. Not only was this intervention successful in getting men to understand power and its influence in configuring the relationship between men and women, but men also reported profound personal changes in behaviour that were corroborated by their female partners. An assessment of the project documented dramatic decreases in alcohol consumption, domestic violence and forced sex in the project areas. A project staff member reported "The husbands who have been trained understand better. Before, they brutally forced sex. They hit, especially when they were drunk. Now, no more" (Rogow 2000).

In 2001, *ReproSalud* received a grant to continue working for five more years. Based on ongoing assessment and evaluation, *ReproSalud* will focus on the Andean highlands and on advocacy, linking community-based advocacy groups to form wider networks (Moya 2002).

Sources: Rogow (2000), Coe (2001), Moya (2002).

Male-friendly services are promoted through separate waiting areas, male service providers, separate examination rooms and male only clinics. Profamilia's *Clinica Para El Hombre* in Colombia represents one of the most successful attempts to increase men's access to comprehensive reproductive health services through the introduction of men-only clinics (AVSC and Profamilia 1997). Quality of care and gender-sensitive patient-provider interactions are central to the delivery of services. Staff are trained on personal and cultural beliefs about masculinity, and are encouraged to reflect on their personal attitudes regarding gender and how gender impacts on their interactions with patients.

5.3 Integrating Gender into Health Worker Training

5.3.1. *Gender Sensitisation Training*

The neglect of the perspectives of providers and the complex range of factors which influence their performance and quality of care provided is increasingly recognised as crucial element in the gap between health policy and implementation. While we do recognise the role of other factors (isolation, poor recognition, weak support structures, and conditions of employment) which impact on the way providers interact with patients, mechanisms for addressing these through health human resource policies (supportive supervision, remuneration, productivity measurements etc.) will be addressed in other papers. Here, we are concerned with the potential of gender sensitisation strategies - which encourage providers to examine how gender norms affect their patients' health and health seeking behaviour, how gender stereotypes impact on their interaction with patients and how gender impacts on their own lives within their work and home environment – for improving the patient-provider interaction.

Conventional training on interpersonal communication (IPC) and also within the quality of care framework has often neglected the influence of gender and other social structural determinants on the patient-provider interaction. Health Workers for Change (HWFC) is a departure from conventional models in that it uses a participatory research leaning approach for bringing about improvements in quality of care with emphasis on the need for gender sensitivity in health services (Fonn and Xaba 2001). The intervention, developed by the Women's Health Project in South Africa, was also tested in five other African countries (Uganda, Zambia, Mozambique, Kenya and Senegal) and Argentina (Onyango-Ouma, Laisser et al. 2001) and more recently Pakistan (Shaikh 2006). HWFC has the potential to provide a space for providers to examine how gender and other social issues impact their lives and improve the relationship between providers and patients. Also, it can demonstrate the potential for mainstreaming gender issues into health systems development (Vlassoff and Fonn 2001). More details of this programme are illustrated in Box 5.

Box 5: Health Workers for Change

The Health Workers for Change training intervention (Special edition of Health Policy and Planning vol 16, supplement 1, 2001):

- is a workshop series that provides participants with opportunities for critical reflection on their practices, their patients, the obstacles to providing good quality of care in their facilities and ways of addressing these obstacles;
- gets health care workers to consider the gender roles and norms they themselves and their patients have to operate within
- has been evaluated using a common protocol across seven countries (6 in Africa and 1 in Latin America), generating the conclusion that it had a 'positive impact on the relationship between providers and clients, creating teamwork within a facility, creating a supportive environment for health facility staff to take more initiative and, to some extent, demand more responsiveness from system level' (Onyango-Ouma, Laisser et al. 2001): 30)
- subsequent application of the package in Pakistan also showed that the process was able to generate a renewed commitment to work among participants, with greater willingness to examine their own practices and improve quality of care (Shaikh, Rabbani et al. 2006).
- however, reflecting wider experience, both the multiple country evaluation and the Pakistan study noted that the workshop package is not enough by itself, and that it is also vital to establish an enabling environment that supports the changes initiated at local level - higher level commitment for the programme was identified as a key influence over its potential for positive impacts, as well as an environment of communication and participatory management practices (Vlassoff and Fonn 2001).

Box 6 illustrates the value of examining provider's perceptions and their role in addressing domestic violence

Box 6: An intervention for investigating the potential role of PHC nurses in addressing domestic violence: South Africa

Kim and Motsei (2002) argued that if health workers are to play a role in gender-based violence, it is equally important to understand their own experiences of gender-based violence and how it impacts their lives both professionally and personally. The intervention was conducted among a class of 38 nurses (29 women, 9 men) enrolled in a 12 month residential training programme based in Northern Province, one of the poorest provinces in South Africa. The project had three components.

The first component explored nurses' attitudes and experiences of gender-based violence through focus group discussions (FGDs) and an important finding was differences in the beliefs and attitudes of men and women towards physical, sexual, economic and psychological abuse.

The second component piloted and evaluated a focused educational intervention which incorporated a gender-based violence training module into the nurses' reproductive health curriculum which was informed by the FGDs. The training module was developed in partnership with Agisanang Domestic Abuse Prevention and Training (ADAPT), an NGO. The intervention initially focused on dealing with the attitudes and experiences of the nurses as individuals and included discussion on attitudes and beliefs regarding different forms of abuse (physical, sexual, psychological, and economic), nurses' perceptions of responding to gender-based violence and personal experiences of gender-based violence.

The third component was quantitative and a questionnaire was used to evaluate the following:

1) to compare post-intervention attitudes and beliefs with those expressed during the FGDs; 2) to collect data on the prevalence of gender-based violence among the nurses; and 3) to evaluate the intervention. Amongst the findings were high levels of violence in the nurses' own lives. The evaluation of the gender violence training module found that all 38 nurses "reported that they had found it to be a valuable educational experience and for many, it had marked a turning point in their personal and professional lives. All of the participants reported that they would wish to see such training formally and more widely incorporated into the South African nursing curriculum" (Kim and Motsei 2002: 1249).

Source: Kim and Motsei (2002).

5.3.2. Revisiting the medical curriculum

A cross-sectional survey of physicians (71% - male) practising in Balochistan, Pakistan was carried out, which assessed their knowledge, attitude and practices with respect to specific sexual health problems (Afsar, Sohani et al. 2006). It was found that 32% reported that they were not comfortable talking personal, 44% were uncomfortable talking about frequency of sexual intercourse, and 63% found it uncomfortable to take partners' sexual history. Fifty-five (55%) percent of the respondents were also of the opinion that the present medical curriculum was insufficient to prepare doctors to deal with sexual health problems, particularly those in female patients. This study is an illustration of the implications of a male-centric biomedical framework which underpins the training of medical doctors across the world.

Historically, medicine and medical education has considered the male anatomy as the norm and women were and continue to be under-represented in illustrations of non-reproductive anatomy (Giacomini, Rozee-Koker et al. 1986, Lawrence and Bendixen 1992). This has led to the neglect of the importance of gender, psycho-social and environmental factors in explaining differences in men and women and has arguably contributed to gender-based inequities in medical treatment (kidney disease, depression, tuberculosis etc.)(Gisbers van Wijk, van Vliet et al. 1996, Vlassoff and Garcia Moreno 2002, Reichenbach and Brown 2004). This has ignored the reality that men and women understand, experience and respond differently to diseases and treatment regimes.

Over the past decade, there have been efforts to integrate gender into the medical curriculum in training institutions in a range of developed and developing countries

including the Netherlands (Verdonk, Mans et al. 2005), Sweden (Hamberg 2003), Australia (Monash University 2007), Canada (Gender and Health Collaborative Curriculum Project 2007), the USA (Nicolette and Jacobs 2000)(Nicolette and Jacobs 2000), Philippines (Sobrevega-Chan 2006) and India (Jesani and Madhiwalla 2002,Ramanathan and Khambete 2007).

In 1993 the United States Department of Health and Human Services review of the undergraduate medical curriculum and proposed changes for strengthening the gender focus within the curriculum (US Department of Health Human Services Publication 1995). A decade later, the number of medical schools in the USA with a specific women's health curriculum had increased significantly. However Henrich (2004) argued that progress was slow for reasons including uncertainty about what should be included in the curriculum, a lack of practical guidelines for implementation and institutional resistance to change.

In Europe, similar efforts were initiated to improve the gender content of medical curriculum most notably in the Netherlands and Sweden. In the Netherlands a country-wide initiative to integrate gender into the medical curriculum of the eight medical schools was undertaken in 2002 (Verdonk, Mans et al. 2006). A review in 2006 of the initiative found that the integration was largely successful. Similar steps were taken in Sweden and progress was evaluated across selected medical schools (Norstedt and Davies 2003,Westerstahl, Andersson et al. 2003). Key obstacles included the continued low priority accorded to gender within the medical curriculum and lower levels of support for the initiative among male medical educators.

The Gender Mainstreaming in Medical Education (GME) project which was initiated in India in 2002 is an important initiative which focuses not only on medical schools but also takes a broader view of gender mainstreaming through collaboration with health professionals and NGOs. This project is described in further detail in Box 6.

Box 7: Gender Mainstreaming in Medical Education (GME) project: India

GME is an initiative of Achutha Menon Centre for Health Science Studies (AMCHSS), Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST) with assistance from McArthur Foundation. The project is intended to gender-sensitise medical students by incorporating the gender perspective in textbooks as well as by training a core group of medical educators in gender issues. A national consultation on gender and medical education

was held in Mumbai in early 2002 which identified the strategies and mechanisms for facilitating the process. The project concentrated on six states in India which covered about 43 percent of the medical colleges in India in 2002, namely, Rajasthan, Gujarat, Maharashtra, Karnataka, Goa and Kerala (Jesani and Madhiwalla 2002, Ramanathan and Khambete 2007).

The mechanism was to develop and conduct training programmes, research and advocacy programmes that incorporate a gender, rights and ethics perspective for medical educators and programme implementers. The work of the project included (1) two-weeks intensive training of medical school teachers at national level; (2) 3-4 days training of medical school teachers at province level; (3) undertaking projects on gender and medical education by the teachers thus trained; (4) gender review of Indian text books in 6 disciplines - public health, obstetric and gynaecology, psychiatry, forensic medicine, paediatrics and general surgery (5) and a conference of the Vice Chancellor of Universities, Deans of medical schools, medical policy makers etc for advocacy on the subject.

In late 2006, the project was evaluated by Ramanathan and Khambete with the objectives of reviewing firstly the various training initiatives including curriculum development and training under the project and secondly the participants perceptions and subsequent activities regarding the GME initiative (Ramanathan and Khambete 2007). The overall feedback on the initiative was positive and the attempt to locate gender within the context of the social justice framework was appreciated. Participants expressed the need for a network to support themselves as they attempted to work towards mainstreaming gender concerns within their institutions and in the curriculum. A possible future area of work is the development of training manuals in these areas using different case studies, contexts, and different examples that would be developed collaboratively. Linked to this are strategies for incorporating people from the senior level into this effort through advocacy.

A core group of trainees from the various programmes of the GME have formed an informal network that proposes to plan the way forward in keeping with the aspirations of the larger group of individual medical educators who have received training at the various GME programmes that have been organized (Ramanathan 2007).

Sources: Ramanathan (2007), Ramanathan and Khambete (2007), Jesani and Madhiwalla (2002).

SECTION 6: DISCUSSION

There is clear evidence, across many countries, across many medical conditions, and in terms of diagnosis, treatment as well as patient adherence and patient satisfaction, that gender had a profound impact on provider-practitioner interactions. The impact of gender stereotypes and biases within the provider-practitioner interaction has been shown to be harmful for women as well as men. With men gender norms often making it difficult for them to utilise health care, or express feelings of vulnerability (Bertakis, Helms et al. 2001, Thorson and Johansson 2004). Much of the gender-bias and discrimination that dominate the experiences of the interpersonal interactions between providers and clients can be traced to underlying structural causes (socio-economic, political, cultural) which act out through the more intermediary factors

(e.g. health system biases, exposure and vulnerability and acknowledgement of health needs) and need to be tackled at a wider societal level.

However while acknowledging the need to empower women and girls at the societal level, we also believe that health systems are “core social institutions” (Freedman 2005). How people are treated in these core institutions forms an important part of the experience of what it means to be socially marginalized and disempowered. Provider attitudes and practices that discriminate on the basis of gender, class, ethnicity and caste thereby deepen inequity. This is illustrated by the examples quoted in this article of poor and young women’s experience of verbal and sometimes physical abuse in childbirth; or young women’s experience of verbal abuse and scolding when they try and access contraceptive services; or poor black women in America being made to feel like welfare cheats and therefore constantly changing providers.

Because health facilities are core social institutions we would also argue that there is a responsibility to try and challenge gender norms that are harmful to the health of women, and in some cases men. Although often unspoken in much of the literature there exists a tension between trying to provide ‘culturally accessible’ health services that recognise the gender norms that exist in the society and make it possible for women who are constrained by these norms to seek health care, and to try and challenge these gender norms. This tension is best illustrated by the work of Mumtaz, Salway et al. (2003) in Pakistan. The Pakistan government in recognition of women’s constraints in accessing services trained a cadre of women community health care workers who were meant to meet the needs of women. The problem was that these women themselves were subjected to the very constraints that the women that they were appointed to serve. We would argue that instead of trying to merely reflect the gender norms that exist in society, there is need for the health system to start to challenge them.

Gender sensitisation which challenges workers' gender stereotypes needs to happen alongside re-dressing gender biases that they themselves face in the work environment and the health care system. It would be futile if providers are expected to reorient their practices but at the same time continue to face gender based biases and discrimination from their colleagues and the communities in which they work

(Onyango-Ouma, Laisser et al. 2001). Work such as that done in the HWFC programme shows the powerful impact of interventions which simultaneously explore patient and provider issues (Fonn and Xaba 2001).

As well as working with health care workers, there have also been a number of interventions that show that empowering patients also can have a significant impact on the nature of the patient-provider interaction. A systematic review of the evidence on effectiveness of empowerment to improve health by Wallerstein (2006) found that “women’s empowering interventions, integrated with the economic, educational, and political sectors, have should the greatest impact on women’s quality of life, autonomy and authority and on policy changes, and on improved child and family health”. The study also found that patients’ empowerment strategies had lead to improved health outcomes and quality of life particularly among the chronically ill. There are a number of interventions that have attempted to do this. The limited results show that it is obviously not a simple task, but has to be a worthwhile one. When reviewing all the interventions that had tried to empower women as ‘clients’ it was clear that they were often once off, small scale interventions that were not sufficiently funded, supported, or evaluated. That maybe the explanation for their limited success.

SECTION 7: CONCLUSION

We have illustrated in this paper that gender, either alone or in combination with other determinants of inequity profoundly influence interactions between health care providers and patients. More research has to be done (and probably more work that is being done needs to be published) that explores this issue, and also explores the long term and sustained impact of interventions.

Gender consciousness and sensitisation needs to be incorporated into the basic and continuing training of health care workers. Much of the gender discrimination that appears to take place is almost unconscious, reflecting the norms of the society in which both the health worker and the patient are based. Being made aware of these biases, and how these biases result in colleagues giving different treatment to different patients for no clinical reason may start to make health workers more reflective about their practice. Health workers also need to be made aware of the gender dynamics that

exist which impact on how and when men and women seek care, and how they talk about their symptoms in interactions with health care workers. Using the example from Vietnam quoted earlier, health care workers should be aware of the constraints that women face in terms of seeking care, aware of how organisation of the health care will impact on women, and aware of the social stigma that is attached to the illness for women, and this will enable them to provide better care (Thorson and Johansson 2004). Health workers also need to be educated on issues around sexual abuse of patients, as well as the rights of patients.

Similarly it is important if we are going to try and get health care workers to be more gender sensitive to their patients it is important to acknowledge the gender context in which health workers, the majority of whom are women, live and work. By valuing, caring and respecting them, they are more likely to provide client-centred and better quality of care services;

There is an increasing movement internationally that has looked at empowering patients, through a range of methods including patient' rights changers and health literacy programmes which intend to raise awareness and empower patient in their interactions with providers. We would argue that gender, and the different needs and challenges faced by women and men in such programmes need to be researched and documented in more detail.

In the quality of care literature and in the attempts to improve the quality of care in facilities across the globe the use of clinical audits and other measures of quality of care are increasingly being used. These processes rarely take account of gender. When gender audits are done, these are often once-off events and gender needs to be fundamentally integrated into these processes.

In conclusion, in this paper, we have illustrated that sexual and reproductive health services are particularly impacted by gender bias and discrimination. Gender norms around sex and reproduction are particularly strong, and there is also evidence that being seen to transgress gender norms in terms of sex and reproduction bring on particularly strong sanction from health care workers. We would therefore suggest that health workers working in these services are those which particularly need

training and on going support on issues around gender. These are also services where there seems to be evidence that separate clinics and other services for men and women may be appropriate. In maternal health services more work needs to be done to involve men in services. The special needs of those seeking sexual and reproductive health services and the challenges of providing the services in a supportive, accessible and non-judgemental way that does not compromise the patient-provider relationship need to be taken into consideration when considering integrating these services into mainstream services.

BIBLIOGRAPHY

Afsar, H. A., Sohani, S., Younus, M. and Mohamad, S. (2006) Integration of sexual and reproductive health in the medical curriculum in Pakistan. *J Coll Physicians Surg Pak*, 16(1), 27-30.

Astbury, J. (2002) Mental Health. In Sen, G. G., A. Östlin, P. *Engendering international health- the challenge of equity* (Cambridge: MIT Press, 143-166).

AVSC and Profamilia (1997) Profamilia's clinics for men: A case study. New York: AVSC and Bogota, Colombia: Asociación Profamilia.

Baines, D. (2006) Staying with people who slap us around: Gender, juggling responsibilities and violence in paid (and unpaid) care work. *Gender, Work and Organization*, 13(2), 129-151.

Begum, V., de Colombani, P., Das Gupta, S., Salim, A. H., Hussain, H., Pietroni, M., Rahman, S., Pahan, D. and Borgdorff, M. W. (2001) Tuberculosis and patient gender in Bangladesh: sex differences in diagnosis and treatment outcome. *International Journal of Tuberculosis & Lung Disease*, 5(7), 604-10.

Bensing, J. M., van den Brink-Muinen, A. and de Bakker, D. H. (1993) Gender differences in practice style: a Dutch study of general practitioners. *Med Care*, 31(2), 219-229.

Bernstein, B. and Kane, R. (1981) Physicians' attitudes toward female patients. *Med Care*, 19(6), 600-608.

Bertakis, K. D., Azari, R., Helms, L. J., Callahan, E. J. and Robbins, J. A. (2000) Gender differences in the utilization of health care services. *Journal of Family Practice*, 49(2), 147-52.

Bertakis, K. D., Franks, P. and Azari, R. (2003) Effects of physician gender on patient satisfaction. *Journal of the American Medical Womens Association*, 58(2), 69-75.

Bertakis, K. D., Helms, L. J., Callahan, E. J., Azari, R., Leigh, P. and Robbins, J. A. (2001) Patient gender differences in the diagnosis of depression in primary care. *Journal of Womens Health & Gender-Based Medicine*, 10(7), 689-98.

Bertakis, K. D., Helms, L. J., Callahan, E. J., Azari, R. and Robbins, J. A. (1995) The influence of gender on physician practice style. *Medical Care*, 33(4), 407-16.

Blaauw, D., Penn-Kekana, L., Hongoro, C. and McPake, B. (2006) Neither robots nor angels: the 'dynamic responses' of health care workers and the unintended effects on health systems functioning. Programme, H. S. s. D.

Borowsky, S. J., Rubenstein, L. V., Meredith, L. S., Camp, P., Jackson-Triche, M. and Wells, K. B. (2000) Who Is at Risk of Nondetection of Mental Health Problems in Primary Care? *Journal of General Internal Medicine*, 15(6), 381-388.

- Brown, D. R., Ludwig, R., Buck, G. A., Durham, D., Shumard, T. and Graham, S. S. (2004) Health literacy: universal precautions needed. *Journal of Allied Health*, 33(2), 150-5.
- Bruce, J. and Jain, A. (1991) Improving the Quality of Care through Operations Research. *Prog Clin Biol Res.*, 371259-82.
- Buttiens, H., Marchal, B. and De Brouwere, V. (2004) Skilled attendance at childbirth: let us go beyond the rhetorics. *Trop Med Int Health*, 9(6), 653-4.
- Callahan, E. J., Bertakis, K. D., Azari, R., Helms, L. J. and Robbins, J. (1997) Depression in Primary Care: Patient Factors That Influence Recognition. *Fam Med*, 29(3), 172-6.
- Chikanda, A. (2005) Nurse migration from Zimbabwe: Analysis of recent trends and impacts. *Nurse Inq*, 12(3), 162-74.
- Christofides, N. J., Muirhead, D., Jewkes, R. K., Penn-Kekana, L. and Conco, D. N. (2006) Women's experiences of and preferences for services after rape in South Africa: interview study. *BMJ*, 332(7535), 209-13.
- Christofides, N. J., R.K., J., Webster, N., Penn-Kekana, L., Abrahams, N. and Martin, L. J. (2005) "Other patients are really in need of medical attention"--the quality of health services for rape survivors in South Africa. *Bull World Health Organ*, 83(7), 495-502.
- Cleary, P. D., Burns, B. J. and Nycz, G. R. (1990) The identification of psychiatry illness by primary care physicians: The effect of patient gender. *J Gen Intern Med*, 5355-60.
- Coe, A. (2001) Health, Rights and Realities: An Analysis of the ReproSalud Project in Peru. Takoma Park, MD, Center for Health and Gender Equity.
- Colameco, S., Becker, L. A. and Simpson, M. (1983) Sex bias in the assessment of patient complaints. *J Fam Pract*, 16(6), 1117-1121.
- Cottingham, J. and Myntti, C. (2002) Reproductive Health: Conceptual Mapping and Evidence. In Sen, G., George, A. and Östlin, P. *Engendering Health Equity: A Review of Research and Policy* (Cambridge: MIT Press, 83-109).
- d'Oliveira, A., Diniz, S. G. and Schraiber, L. B. (2002) Violence against women in health-care institutions: an emerging problem. *Lancet*, 359(9318), 1681-1685.
- de Pinho, H., Murthy, R., Moorman, J. and Weller, S. (2005) Integration of Health Services. In Ravindran, T. K. S. and de Pinho, H. *The Right Reforms? Health Sector Reforms and Sexual and Reproductive Health* (Johannesburg: Women's Health Project, School of Public Health, University of the Witwatersrand, South Africa, 215-263).
- Dearborn, J. L., Panzer, V. P., Burlison, J. A., Hornung, F. E., Waite, H. and Into, F. H. (2006) Effect of gender on communication of health information to older adults. *Journal of the American Geriatrics Society*, 54(4), 637-41.

Dehne, K. L., Snow, R. and O'Reilly, K. R. (2000) Integration of prevention and care of sexually transmitted infections with family planning services: what is the evidence for public health benefits? *Bull World Health Organization*, 78(5), 628-39.

Dolin, P. (1998) Tuberculosis epidemiology from a gender perspective. In Diwan, V. K., Thorson, A., Winkvist, A. *Gender and tuberculosis* (Göteborg: Nordic School of Public Health, 29-40).

Douthwaite, M. and Ward, P. (2005) Increasing contraceptive use in rural Pakistan: An evaluation of the Lady Health Worker Programme. *Health Policy And Planning*, 20(2), 117-123.

Elstad, J. I. (1994) Womens priorities regarding physician behavior and their preference for a female physician. *Women Health*, 211-19.

Fahy, T. and Fisher, N. (1992) Sexual contact between doctors and patients. *BMJ*, 304(6841), 1519-1520.

Fonn, S. and Xaba, M. (2001) Health Workers for Change: developing the initiative. *Health Policy And Planning*, 1613-18.

Franks, P. and Bertakis, K. D. (2003) Physician gender, patient gender, and primary care. *Journal of Women's Health*, 12(1), 73-80.

Freedman, L. (2005) Achieving the MDGs: Health systems as core social institutions. *Development*, 48(1), 19-24.

Freedman, L., Waldman, R., Chowdhury, M. and Rosenfield, A. (2005) *Who's got the power? Transforming health systems to improve the lives of women and children*. (London: Earthscan Publications Ltd).

Gender and Health Collaborative Curriculum Project (2007). 2007.

George, A., Iyer, A. and Sen, G. (2005) Gendered health systems biased against maternal survival: Preliminary findings from Koppal, Karnataka, India, INSTITUTE OF DEVELOPMENT STUDIES
Brighton, Sussex BN1 9RE
ENGLAND.

Giacomini, M., Rozee-Koker, P. and Pepitone-Arreola-Rockwell, F. (1986) Gender bias in human anatomy textbook illustrations. *Psychology of Women Quarterly*, 10413-420.

Gisbers van Wijk, C. M. T., van Vliet, K. P. and Kolk, A. M. (1996) Gender perspectives and quality of care: Towards appropriate and adequate health care for women. *Social Science and Medicine*, 43(707-20).

Greenberg, D. (2001) A Critical Look at Health Literacy. *Adult Basic Education*, 11(2), 67-79.

Gregory, R. (1999) Social capital theory and administrative reform: Maintaining ethical probity in public service. *Public Administration Review*, 5963-75.

- Hall, J. A., Palmer, R. H., Orav, E. J., Hargraves, J. L., Wright, E. A. and Louis, T. A. (1990) Performance quality, gender, and professional role. A study of physicians and nonphysicians in 16 ambulatory care practices. *Medical Care*, 28(6), 489-501.
- Hamberg, K. (2003) [Gender perspective relevant in many medical school subjects. Essential to perceive men and women holistically]. *Lakartidningen*, 100(49), 4078-83.
- Hancock, J. (2004) Can mainstream services learn from male only sexual health pilot projects? *Sex Transm Infect.*, 80(6)484-7.
- Hartigan, P. (2001) The importance of gender in defining and improving quality of care: Some conceptual issues. *Health Policy And Planning*, 16(Suppl 1), 7-12.
- Hausmann-Muela, S., Muela Ribera, J. and Nyamongo, I. (2003) Health-seeking behaviour and the health system response. DCPD Working Paper No. 14. Medicine, L. S. o. H. a. T. London, UK.
- Health Professions Regulatory Advisory Council (2000) Final Report to the Minister of Health and Long-Term Care: Effectiveness of Colleges' Complaints and Discipline Procedures for Professional Misconduct of a Sexual Nature.
- Healthcare Commission (2006) National survey of NHS staff 2006.
- Hellbernd, H., Brzank, P., May, A. and Maschewsky-Schneider, U. (2005) [The S.I.G.N.A.L.-Intervention Project to combat violence against women]. *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz*, 48(3), 329-36.
- Henrich, J. (2004) Women's health education initiatives: Why have they stalled? *Academic Medicine*, 79(4), 283-8.
- Holroyd, E., Twinn, S. and Adab, P. (2004) Socio-cultural influences on Chinese women's attendance for cervical screening. *Journal of Advanced Nursing*, 46(1), 42-52.
- Howell, E. A., Gardiner, B. and Concato, J. (2002) Do Women Prefer Female Obstetricians? *Obstetrics & Gynecology*, 991031-1035.
- Huezo, C. M. and Briggs, C. (1992) Medical and Service Guidelines for Family Planning. London, International Planned Parenthood Federation.
- Jesani, A. and Madhiwalla, N. (2002) *Gender and medical education: Report of a national consultation and background material*. (Mumbai: Cehat for AMCHSS).
- Jesani, A. and Madhiwalla, N. (2002) *Gender and medical education: report of national consultation and background material*. (Mumbai: Centre for Enquiry into Health and Allied Themes).
- Jewkes, R., Abrahams, N. and Mvo, Z. (1998) Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science & Medicine*, 47(11), 1781-1795.

- Johansson, E., Long, N. H., Diwan, V. K. and Winkvist, A. (1999) Attitudes to compliance with tuberculosis treatment among women and men in Vietnam. *International Journal of Tuberculosis & Lung Disease*, 3(10), 862-8.
- Johansson, E., Long, N. H., Diwan, V. K. and Winkvist, A. (2000) Gender and tuberculosis control: perspectives on health seeking behaviour among men and women in Vietnam. *Health Policy*, 52(1), 33-51.
- Johansson, E. and Winkvist, A. (2002) Trust and transparency in human encounters in tuberculosis control: lessons learned from Vietnam. *Qualitative Health Research*, 12(4), 473-91.
- Katz-Rothman, B. (1991) *In labour: women and power in the birthplace*. (London: W.W. Norton and Co.).
- Kim, J. and Motsei, M. (2002) "Women enjoy punishment": Attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. *Social Science & Medicine*, 54(8), 1243-1254.
- Kim, Y. M., Kols, A., Putjuk, F., Heerey, M., Rinehart, W., Elwyn, G. and Edwards, A. (2003) Participation by clients and nurse midwives in family planning decision making in Indonesia. *Patient Education and Counseling*, 50(3), 295-302.
- Kim, Y. M., Putjuk, F., Basuki, E. and Kols, A. (2003) Increasing Client Participation in Family Planning Consultations: "Smart Patient" Coaching in Indonesia, Johns Hopkins University Center for Communication Programs.
- Lamont, J. A. and Woodward, C. (1994) Patient-physician sexual involvement: a Canadian survey of obstetrician-gynecologists. *CMAJ*, 150(14), 1433-1439.
- Lawrence, S. C. and Bendixen, K. (1992) His and hers: male and female anatomy in anatomy texts for U.S. medical students, 1890-1989. *Social Science & Medicine*, 35(7), 925-34.
- Lewin, S. A., Dick, J., Pond, P., Zwarenstein, M., Aja, G., van Wyk, B., Bosch-Capblanch, X. and Patrick, M. (2005) Lay health workers in primary and community health care. *Cochrane Database Of Systematic Reviews 2005*, Issue 1 Art No: CD004015. DOI: 10.1002/14651858.CD004015.pub2.
- Long, N. H., Johansson, E., Diwan, V. K. and Winkvist, A. (2001) Fear and social isolation as consequences of tuberculosis in VietNam: a gender analysis. *Health Policy*, 58(1), 69-81.
- Long, N. H., Johansson, E., Lonroth, K., Eriksson, B., Winkvist, A. and Diwan, V. K. (1999) Longer delays in tuberculosis diagnosis among women in Vietnam.[see comment]. *International Journal of Tuberculosis & Lung Disease*, 3(5), 388-93.
- Lurie, N., Slater, J., McGovern, P., Ekstrum, J., Quam, L. and Margolis, K. (1993) Preventive care for women. Does the sex of the physician matter?[see comment]. *New England Journal of Medicine*, 329(7), 478-82.

- Manhoso, F. R. and Hoga, L. A. K. (2005) Men's experiences of vasectomy in the Brazilian Public Health Service. *International Nursing Review*, 52101-108.
- Miller, R., Fisher, A., Miller, K., Ndhlovu, L., Baker, N. M., Askew, I., Sanogo, D. and Tapsoba, P. (1997) *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook*. (New York: Population Council).
- Monash University (2007) Gender and medicine.
- Moya, C. (2002) ReproSalud: Nationwide Community Participation in Peru. Transitions, Clearinghouse Program Associate, International Division, Advocates for Youth.
- Mumtaz, Z., Salway, S., Waseem, M. and Umer, N. (2003) Gender-based barriers to primary health care provision in Pakistan: the experience of female providers. *Health Policy And Planning*, 18(3), 261-269.
- Munch, S. (2004) Gender-Biased Diagnosing of Women's Medical Complaints: Contributions of Feminist Thought, 1970-1995. *Women & Health*, 40(1)101-21.
- Murphy, E. and Steele, C. (2000) Client-Provider Interactions in Family Planning Services: Guidance from Research and Program Experience, Maximizing Access and Quality. 1.
- National Library of Medicine (2000) Current bibliographies in medicine: health literacy. Bethesda, MD, National Library of Medicine.
- Nicolette, J. and Jacobs, M. B. (2000) Integration of women's health into an internal medicine core curriculum for medical students. *Academic Medicine*, 75(11), 1061-5.
- Nielsen-Bohlman, L., Panzer, A. M. and Kindig, D. A. (2004) *Health Literacy: A Prescription to End Confusion*. (Washington, DC: Board on Neuroscience and Behavioral Health, Institute of Medicine).
- Nigenda, G., Langer, A., Kuchaisit, C., Romero, M., Rojas, G., Al-Osimy, M., Villar, J., Garcia, J., Al-Mazrou, Y., Ba'aqueel, H., Carroli, G., Farnot, U., Lumbiganon, P., Belizan, J., Bergsjö, P., Bakketeig, L. and Lindmark, G. (2003) Women's opinions on antenatal care in developing countries: results of a study in Cuba, Thailand, Saudi Arabia and Argentina. *BMC Public Health*, 317.
- Norstedt, M. and Davies, K. (2003) [Medical education seemingly "immune" to discussions on sex and gender. A study indicates that the gender perspective in teaching is limited]. *Lakartidningen*, 100(23), 2056-9.
- Nutbeam, D. and Kickbusch, I. (2000) Advancing health literacy: a global challenge for the 21st century. *Health Promotion International*, 15(3), 183-184.
- Ontario Women's Justice Network (2001) Accountability to the Patient: The Task Force on Sexual Abuse of Patients. Sexual Assault Issues.

- Onyango-Ouma, W., Laisser, R., Mbilima, M., Araoye, M., Pittman, P., Agyepong, I., Zakari, M., Fonn, S., Tanner, M. and Vlassoff, C. (2001) An evaluation of Health Workers for Change in seven settings: a useful management and health system development tool. *Health Policy And Planning*, 1624-32.
- Onyango-Ouma, W., Laisser, R., Mbilima, M., Araoye, M., Pittman, P., Agyepong, I., Zakari, M., Fonn, S., Tanner, M. and Vlassoff, C. (2001) An evaluation of health workers for change in seven settings: a useful management and health system development tool. *Health Policy and Planning*, 16(suppl.1), 24-32.
- Osika, I., Evengard, B., Waernulf, L. and Nyberg, F. (2005) The laundry-basket project--gender differences to the very skin. Different treatment of some common diseases in men and women. *Lakartidningen*, 102(40), 2846-8.
- Parker, R. and Kreps, G. (2005) Library outreach: overcoming health literacy challenges. *J Med Libr Assoc.*, 93(4 Suppl), S81–S85.
- Parkhurst, J. O., Penn-Kekana, L., Blaauw, D., Balabanova, D., Danishevski, K., S.A., R., Onama, V. and Ssengooba, F. (2005) Health systems factors influencing maternal health services: a four-country comparison. *Health Policy*, 73(2), 127-138.
- Parkhurst, J. O. and Rahman, S. A. (2007) Life saving or money wasting? Perceptions of caesarean sections among users of services in rural Bangladesh. *Health Policy*, 80392-401.
- Patel, V., Araya, R. and Bolton, P. (2004) Treating depression in developing countries. *Trop Med Int Health*, 9539–541.
- Paulson, S., Gisbert, M. E. and Quiton, M. (1996) Case Studies of Two Women's Health Projects in Bolivia, Family Health International: Research Triangle Park.
- Penn-Kekana, L., Blaauw, D. and Schneider, H. (2004) 'It makes me want to run away to Saudia Arabia': Management and implementation challenges for public financing reforms from a maternity ward perspective. *Health Policy And Planning*, 19(Suppl 1), i71-i77.
- Piet-Pelon, N., Rob, U. and Khan, M. E. (2000) *Men in Bangladesh, India, and Pakistan: Reproductive Health Issues*. (Dhaka: Karshaf Publishers).
- Plunkett, B. A., Kohli, P. and Milad, M. P. (2002) The importance of physician gender in the selection of an obstetrician or a gynecologist. *American Journal of Obstetrics & Gynecology*, 186(5), 926-928.
- Potter, J. E., Mojarro, O. and Nunez, L. (1987) The influence of health care on contraceptive acceptance in rural Mexico. *Studies in Family Planning*, 18(3), 144-156.
- Raikes, A. (1992) Gender, PHC And The Production Of Health-Care Services - Issues For Womens Roles In Health Development For The Next Decade. *Ids Bulletin-Institute Of Development Studies*, 23(1), 19-28.

Rajeswari, R., Chandrasekaran, V., Suhadev, M., Sivasubramaniam, S., Sudha, G. and Renu, G. (2002) Factors associated with patient and health system delays in the diagnosis of tuberculosis in South India. *International Journal of Tuberculosis & Lung Disease*, 6(9), 789-95.

Ramanathan, M. (2007).

Ramanathan, M. and Khambete, A. (2007) Case study: The Gender Mainstreaming in Medical Education - the Indian Initiative. Trivandrum, India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology.

RamaRao, S. and Mir, A. M. (2004) Transforming relationships. in Pakistani villages. Quality/Calidad/Qualité. New York, Population Council. 15: 20-35.

Reichenbach, L. and Brown, H. (2004) Gender and academic medicine: impacts on the health workforce.[see comment]. *BMJ*, 329(7469), 792-5.

Ringheim, K. (2002) When the Client Is Male: Client-Provider Interaction from a Gender Perspective. *International Family Planning Perspectives*, 28(3), 2002.

Rizk, D. E. E., El-Zubeir, M. A., Al-Dhaheiri, A. M., Al-Mansouri, F. R. and Al-Jenaibi, H. S. (2005) Determinants of women's choice of their obstetrician and gynecologist provider in the UAE. *Acta Obstetrica et Gynecologica Scandinavica*, 84(1), 48-53.

Rogow, D. (2000) Alone You Are Nobody, Together We Float: The Manuela Ramos Movement. Quality/Calidad/Quality series). New York, USA, Population Council.

Rogow, D. (2000) Alone you are nobody, together we float: the Manuela Ramos movement. Quality/Calidad/Qualité. New York, Population Council. 10: 15.

Roter, D. L., Hall, J. A. and Aoki, Y. (2002) Physician Gender Effects in Medical Communication: A Meta-analytic Review. *JAMA*, 288756-764.

Sai, F. T. (1997) The ICPD Programme of Action: pious hope or a workable guide? *Health Transit Rev.*, 7 (Suppl 4), 1-5.

Schloman, B. F. (2004) Health literacy: a key ingredient for managing personal health. *Online Journal of Issues in Nursing*, 9(2), 6.

Schuler, S. R., Bates, L. and Islam, K. (2002) Paying for reproductive health services in Bangladesh: intersections between costs, quality and culture. *Health Policy and Planning*, 17(3), 273-280.

Schuler, S. R., Choque, M. E. and Rance, S. (1994) Misinformation, mistrust, and mistreatment: family planning among Bolivian market women. *Studies in Family Planning*, 25(4), 211-21.

Sen, G. and Batliwala, S. (1996) Empowering women for reproductive rights. In Presser, H. B. and Sen, G. *Women's Empowerment and Demographic Processes: Moving Beyond Cairo* (Oxford: Oxford University Press).

- Shaikh, B., Rabbani, F. and Rahim, M. (2006) Health workers for change: a tool for promoting behaviour change among providers. *Eastern Mediterranean Health Journal*, 12(3/4), 331-339.
- Shaikh, B. T., Rabbani, F. Rahim, M. (2006) Health Workers for Change: a tool for promoting behaviour change among health providers. *Eastern Mediterranean Health Journal*, 12 (3-4), 331-339.
- Shepard, B. L. (2004) Addressing gender issues with men and couples: involving men in sexual and reproductive health services in APROFE, Ecuador. *International Journal of Men's Health*, 3(3), 155-172.
- Simmons, R. and Elias, C. (1994) The Study Of Client-Provider Interactions - A Review Of Methodological Issues. *Studies In Family Planning*, 25(1), 1-17.
- Sleath, B. and Rubin, R. H. (2002) Gender, ethnicity, and physician-patient communication about depression and anxiety in primary care. *Patient Education & Counseling*, 48(3), 243-52.
- Smith, J. A., Braunack-Mayer, A. and Wittert, G. (2006) What do we know about men's help-seeking and health service use? *Medical Journal of Australia*, 184(2), 81-3.
- Sobrevega-Chan, L. (2006) Integration of gender, sexuality and reproductive health issues in nursing and medical curricula. Paper prepared for the Meeting on Integrating Gender into the Curricula for Health Professionals. Geneva, World Health Organization.
- Sudha, G., Nirupa, C., Rajasakthivel, M., Sivasusbramanian, S., Sundaram, V., Bhatt, S., Subramaniam, K., Thiruvalluvan, E., Mathew, R., Renu, G. and Santha, T. (2003) Factors influencing the care-seeking behaviour of chest symptomatics: a community-based study involving rural and urban population in Tamil Nadu, South India. *Tropical Medicine & International Health*, 8(4), 336-41.
- Thomasson, G. O. (1999) Educating physicians to prevent sex-related contact with patients. *JAMA*, 281(5), 419-20.
- Thorson, A., Hoa, N. P., Long, N. H., Allebeck, P. and Diwan, V. K. (2004) Do women with tuberculosis have a lower likelihood of getting diagnosed? Prevalence and case detection of sputum smear positive pulmonary TB, a population-based study from Vietnam. *J Clin Epidemiol*, 57(4), 398-402.
- Thorson, A. and Johansson, E. (2004) Equality or equity in health care access: a qualitative study of doctors' explanations to a longer doctor's delay among female TB patients in Vietnam. *Health Policy*, 68(1)37-46.
- US Department of Health Human Services Publication (1995) Fifth Report: Women and Medicine. Council on Graduate Medical Education. Rockville, Maryland.
- Verdonk, P., Mans, L. J. L. and Lagro-Janssen, A. L. M. (2005) Integrating gender into a basic medical curriculum. *Medical Education*, 39(11), 1118-1125.

Verdonk, P., Mans, L. J. L. and Lagro-Janssen, T. L. M. (2006) How Is Gender Integrated in the Curricula of Dutch Medical Schools? A Quick-Scan on Gender Issues as an Instrument for Change. *Gender and Education*, 18(4), 399-412.

Vlassoff, C. and Fonn, S. (2001) Health Workers for Change as a health systems management and development tool. *Health Policy And Planning*, 16(4), 1647-52.

Vlassoff, C. and Fonn, S. (2001) Health workers for change as a health systems management and development tool. *Health Policy and Planning*, 16(suppl.1), 47-52.

Vlassoff, C. and Garcia Moreno, C. (2002) Placing gender at the centre of health programming: challenges and limitations. *Soc Sci Med*, 54(11), 1713-23.

Wallerstein, N. (2006) What is the evidence on effectiveness of empowerment to improve health? Health Evidence Network report. Copenhagen, WHO Regional Office for Europe.

Weisman, C. S. and Teitelbaum, M. A. (1989) Women and health care communication. *Patient Educ Couns*, 13(12), 13183-199.

Westerstahl, A., Andersson, M. and Soderstrom, M. (2003) Gender in medical curricula: Course organizer views of a gender-issues perspective in medicine in Sweden. *Women & Health*, 37(4), 35-47.

WHO (1999) *Integrating STI management into family planning services: What are the benefits?* (Geneva: WHO).

WHO (2000) *Global tuberculosis control: WHO report 2000*. WHO. Geneva, World Health Organization.

WHO (2001) *The World Health Report 2001. Mental health: new understanding. new hope*. (Geneva: World Health Organization).

WHO (2006) *Working together for health: The World Health Report 2006*. (Geneva: World Health Organization).

Wilbers, D., Veenstra, G., Van de Wiel, H. B. M. and Weijmar Schultz, W. C. M. (1992) Sexual contact in the doctor-patient relationship in the Netherlands. *BMJ*, 304(6853), 1531-1534.

World Medical Association (1981) *Declaration of Lisbon: The Rights of a Patient*.

Zuckerman, M., Navizedeh, N., Feldman, J., McCalla, S. and Minkoff, H. (2002) Determinants of Women's Choice of Obstetrician/Gynecologist. *Journal of Women's Health and Gender-Based Medicine*, 11(2), 175-180.