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FOR THE PROMOTION OF GLOBAL DIALOGUE AND DEMOCRACY / MIFTAH

Gender-Based Analysis of Public Health Sector Services:

A Beneficiary-Based Study

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"Institutionalization of a National Gender- Responsive Budget" Program

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Foreword

The Council of Ministers decision last June, to adopt a gender-responsive budget constituted a culmination of the lobbying efforts of the Palestinian Initiative for the Promotion of Global Dialogue and Democracy- MIFTAH. This decision may constitute a quality shift in the governmental approach towards issues of equality and social justice, and is in line with the process of development and community progress adopted by the government.

This gender-perspective analysis of public health sector in the Palestinian Territories complements the efforts exerted through MIFTAH program "Institutionalization of a Gender-Responsive Budget", launched in 2004.

The study aims at highlighting the existing gender gaps in the health sector policies and program development, resource allocation, activities and service delivery in the health sector in the Palestinian Territories. The most notable gap is the limited representation of women in administrative and oversight positions at various units within the Ministry of Health, which influences the outputs of strategic and sectoral planning, and has a major impact on efforts to achieve justice and equity in access to health services.

We express our appreciation to all the efforts exerted to complete this study as desired, particularly the Ministry of Health, which facilitated and provided the necessary information and data for completing this study that includes findings and recommendations addressed to policy and decision-makers in our Palestinian official institutions.

Lily Feidi
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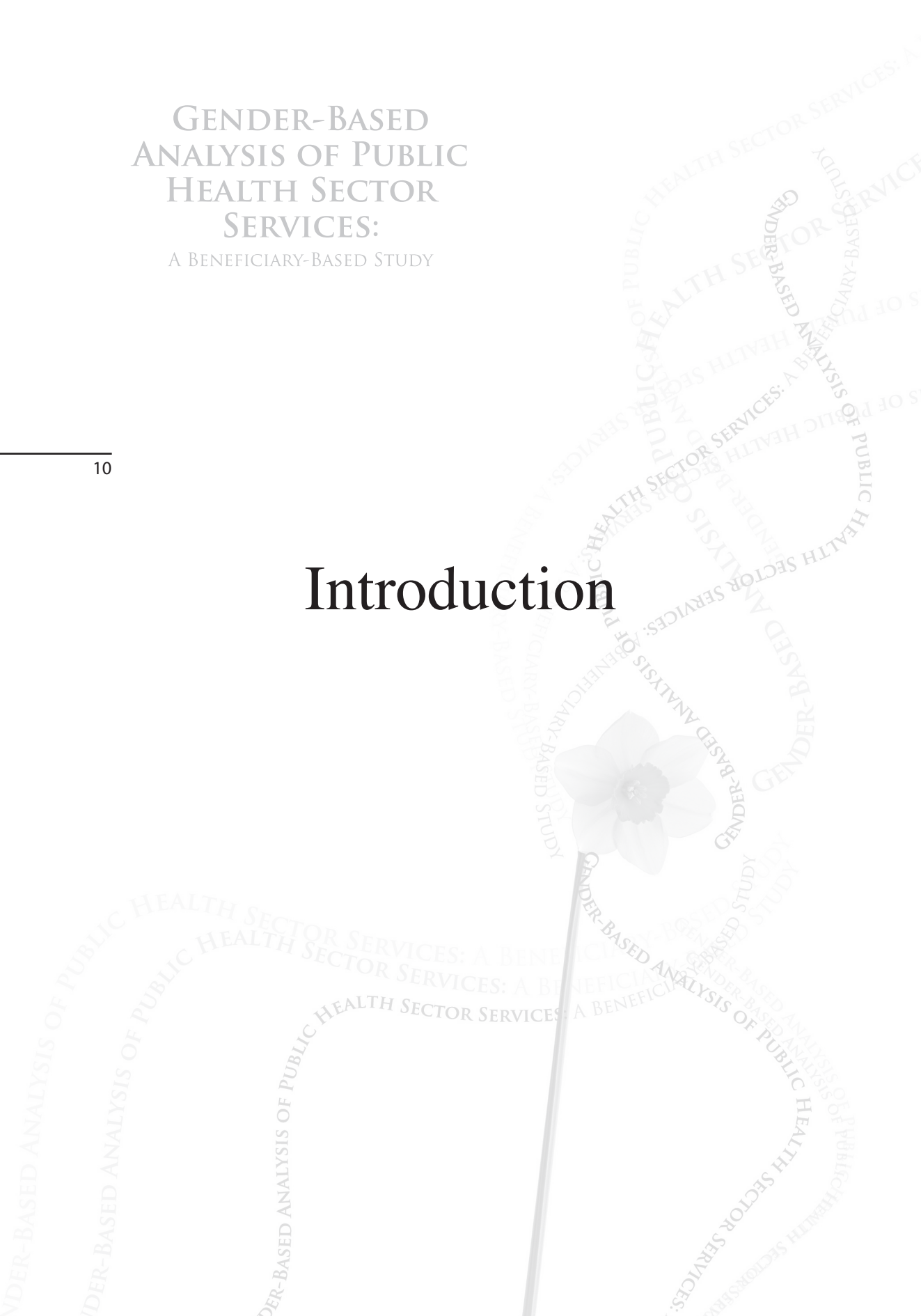
Executive Summary

This study aims at conducting a gender-perspective diagnosis and analysis of the reality of the public health sector in the Palestinian Territories. The study complements previous efforts exerted to adopt more balanced and more gender-responsive public policies. More importantly, the study is in line with the public policy approved by the Council of Ministers on 22 June 2009, to adopt a gender-responsive budget and designate the Ministry of Women Affairs to follow up on the commitment of ministries to women's issues and finalize the setting up of gender units in all Palestinian ministries. To achieve the goals of the study, secondary data available at the Ministry of Health (MOH) and the Palestinian Central Bureau of Statistics (PCBS) were reviewed, in addition to other secondary sources such as studies and reports. Moreover, a questionnaire was designed as a tool for primary data collection. A random sample of beneficiaries of the services provided by MOH at the three levels; primary, secondary and tertiary health services were selected. The study uses a descriptive-analytical methodology in processing and analyzing the findings of the field survey.

The findings of the study highlighted the most important gaps between men and women in the field of health and access to different health services. In the area of human resource distribution in the health sector, the findings revealed a continuous limited representation of women in administrative and oversight positions at various MOH units, and at the different levels of health services, which may adversely affect the opportunities of developing more balanced policies towards gender health issues and needs. On the other hand, the findings revealed that despite the improvement in life expectancy, the gender gap in life expectancy has diminished during the past five years, and maternal mortality rate is high compared to other countries with similar income. Furthermore, the rate of women who suffer from diseases, especially chronic, is higher than that of men, which may suggest that women receive lower levels of proper health care. The findings of the statistical analysis clearly indicate a higher need for health services among women. Although they expressed a higher level of satisfaction with the provided services, they still face many difficulties in accessing health facilities, in addition to their belief that not all needed medical services are available in the government health facilities.

Despite the recent progress during the last years in the size and type of MOH health services, and the significant increase in the number of maternity and childhood centers, the number of beds allocated to women in secondary and tertiary care facilities, and the women health programs, it is yet to be confirmed whether gender has been taken into account upon developing targets, allocating resources, identifying different health activities and results of different health programs. Thus, providers of health services, particularly MOH, the backbone of the health sector in Palestine, should exert further efforts to achieve gender justice and equity in the health sector and in access to health services.

Introduction



Gender differences are among the most important reasons behind inequality in access to health services and consequently equality in health care opportunities (WHO 2002). A growing international and local interest in gender issues and health has been observed in recent years. At the international level, the World Health Organization (WHO) adopted in 2006 a draft strategy for gender mainstreaming in all the work of the organization as well as in its programs and policies (WHO, 2006). WHO has urged member states to:

1. Include "gender" in the work of the joint strategic and operational planning, including the country cooperation strategies.
2. Develop national strategies to address gender issues in health policies, programs and research.
3. Collect and analyze gender disaggregated data and use the results to guide the development of policies and programs.
4. Progress towards gender equality in the health sector to ensure that the contribution of women and men in paid or unpaid health care is equal, is taken into account in health policies and planning.

Despite the increased international attention to gender issues and health, findings of some recent studies (Chen et al., 2004) indicate that the rate of women's access to health care, services, information and resources needed to protect their health and achieve their full potential is less than that of men in many countries (WHO, 2006, World Bank, 2005). Moreover, existing and gender-related habits affect men's health differently from women, through making them play roles that promote risk-taking behaviors that lead them to neglect their health (Pampel et al, 2009). Furthermore, gender interacts with other social, economic and cultural inequalities, which leads to inequality in health, or inequality in the capacity to benefit from different health services by different social groups on one hand, and by women and men on the other hand (WHO-Europe, 2007).

Various studies agree that ensuring equal access for men and women to opportunities of realizing their full health potential requires the health sector to recognize differences between the two groups in terms of sexual and gender characteristics (Gorman et al., 2002). Both women and men, due to the social differences (gender) and biological differences (sexual attributes) face different health risks, and receive different responses from health systems; they are also different in terms of seeking to enjoy health, a fact that requires designing programs and developing health policies that take into account the total existing differences, not only on the basis of sexual characteristics, but also those resulting from gender differences.

This study comes in the context of the continuous efforts towards achieving public budgets and policies that are more balanced and responsive to gender issues and needs. Locally MIFTAH initiated such efforts since 2004, focusing on conducting studies, research, workshops and training courses aimed to promote gender concepts among specialists and decision-makers in governmental and non-governmental organizations, as well as assessing public policies and programs in vital sectors such as education, labor and health. MIFTAH seeks to complement these efforts to pursue gender issues in the sector of basic social services. This study aims at assisting decision-makers and institutions concerned with gender-responsive budgets to identify gender gaps in basic health services, identify mechanisms to reduce these gaps and improve justice and efficiency in the performance of this sector, which is one of the most important sectors directly linked to human capital.

1.2 Goals

Ensuring the provision of comprehensive and integrated health care and services to the people in a fair and accessible manner, and without discrimination on the basis of gender or any other factors, such as economic capacity or others, is one of the most important objectives of the health system of any country (WHO, 2006). Maintaining the health of the individual and the society from epidemics and various diseases, and achieving the principles of 'justice in health horizontally and vertically", ensuring easy access to health services in their three levels: primary, secondary and tertiary is one of the major challenges that continue to face health systems in developing countries (World Bank, 2005). No doubt that the limited financial and human resources as well as the limited technical capabilities available to the health system play a key role in impeding the full realization of the above-mentioned principles. However, it is important to conduct periodic reviews and evaluation of the extent of realization of the principle of justice in the provision of health services, identify areas of appropriate and necessary interventions and enable decision makers to work on bridging the gaps.

In this context, the most difficult question within the Palestinian health sector is how we can improve the general health conditions of different social groups with the limited resources available to the health system. Another issue is the sources of gaps and differences in the health conditions of these social groups, most notably those related to or arising from gender needs. Perhaps what distinguishes this study is mostly its focus on this dimension/perspective upon reviewing the health conditions in the Occupied Palestinian Territories (OPT) and the services delivered by the Palestinian health sector. Hence, this study generally aims at conducting a gender-perspective diagnosis and analysis of the health services delivered to the Palestinian public through the public health sector, to identify the level of gender-responsiveness in those services.

The major goals of this study are:

- Diagnose and identify the existing health gaps between females and males in terms of prevailing patterns of diseases and causes of death.
- Review and analyze public health policies, programs and services targeting females and assess their gender- responsiveness in particular.
- Identify potential gender gaps in access to health services, through quantitative and qualitative analysis of gender programs, projects and services in terms of the extent to which these services reach the target groups, through the review of MOH plans and documents, including a review of MOH allocation of expenditures to programs and services and their consideration of gender issues.
- Study MOH administrative and organizational structure and the distribution of males and females on executive and oversight structures, to determine the level of gender balance in the distribution of roles and functions.
- Identify the points of views of the beneficiaries of the services of the public health sector regarding their satisfaction with health conditions, access to services and the level of satisfaction with the quality of provided services.
- Quantitative and qualitative analysis of gender programs, projects and services, regarding the extent to which these services reach the target groups, through reviewing MOH plans and documents, including a gender-perspective analysis of MOH allocation of expenditures on programs and services.

1.3 Significance

There are several studies of the Palestinian health sector, and evaluations and reviews of public health conditions in the Palestinian Territories (Mataria et al, 2009, Abu Zaineh et al, 2009; Giacaman and Khatib, 2009). However, this study is distinctly conducted within the framework of ongoing efforts led by MIFTAH to develop gender-responsive public policies and budgets, through focusing on the study and evaluation of programs and services of the most gender-sensitive sectors, including education and public health sectors. This study acquires further relevance as it is in line with the public policy. On 22 June 2009, the Council of Ministers decided to adopt a gender-responsive budget, and to designate the Ministry of Women's Affairs to follow up on the commitment of ministries to women's issues and finalize setting up gender units in all ministries (Al-Quds Newspaper, No 14316, 22\6\2009). The importance of this study stems from being the first after the cabinet decision to provide a gender-perspective diagnosis and analysis of the public health conditions. This study complements other MIFTAH research efforts on gender-sensitive budgets.

We hope that the findings of this study constitute a resource for concerned officials, civil institutions and individuals, in their pursuit to incorporate gender issues in the core principles of development policies and programs of successive Palestinian governments, especially with respect to program budgets and allocations. The findings and recommendations of this study may influence the efforts that aim to advance administrative and financial reform, and to re-draft MOH budget and make it more gender balanced and responsive.

1.4 Methodology

Different gender-perspective studies of the health sector performance suggest various measurement and analysis tools, through which it is possible to identify gaps that cause inequality in access to health services between males and females in a society. This is a list of the most important analytical tools (WHO, 2002; Elsong, 1997) some of which will be used in the study:

- Gender-aware policy appraisal: This method is based on a review of various policies and programs through examining their level of attention to gender issues. It is based on questioning the assumption that these policies are gender-neutral. The key question is: To what extent are these policies likely to reduce or increase gender inequality?
- Gender-aware medium term health policy framework.
- Gender-disaggregated beneficiary assessments: This method is based on directly asking the current and potential beneficiaries about the responsiveness of government programs and policies to their needs and priorities.
- Gender-public expenditure analysis: This method compares public expenditures of programs in terms of the distribution of expenditures between males and females, and is usually based on household surveys.
- Gender-aware budget statements analysis: This method is based on the analysis of the extent of commitment of the public sector, coordination among various ministries and departments to develop a gender-responsive budget.
- Gender-sensitive impact analyses: It depends on the quantitative and qualitative analysis of the programs, projects and services in terms of their reach out to the target groups, through reviewing MOH plans and documents, including a gender-perspective of expenditure allocations on programs and services.

- To achieve the goals of this study, and because of lack of access to detailed data on public expenditures and the general budget, the research methodology includes the following steps:
- An analytical review of the reality of the Palestinian health sector, through the presentation and review of MOH/ Health Information Center and PCBS official data on the one hand, and review of previous analytical studies of the general problems and challenges in the Palestinian health sector.
- Study the organizational structures of various technical and executive levels of government services in the health sector, review MOH budget as a framework and frame of reference, and link it with MOH organizational structure in terms of female/male distribution on different functions, and analyze MOH 2008-2010 plan.
- Conduct a field survey of a random sample of beneficiaries of MOH services and programs. A questionnaire was designed and a random sample of MOH beneficiaries was selected. Details of the survey methodology, including the sample selection criteria and specifications appear in Section 4.1 of the study.
- Conduct interviews with workers in the public health sector, to identify and discuss their point of view towards a range of issues related to gender needs from the point of view of health service providers.

1.5 Questions/hypotheses of the study

This study seeks to answer a set of hypotheses/questions on possible inequality between the sexes in health. The main hypotheses/questions are:

- Men are healthier than women.
- Patterns of common diseases among men are different from those among women.
- Obstacles that impede men's access to health services are different from those encountered by women.
- Men are more capable of accessing health services than women.
- Health services that men need are more available than those that women need.
- The rate of women's access to health information to protect their health is less than that of men.

1.6 Plan of the study

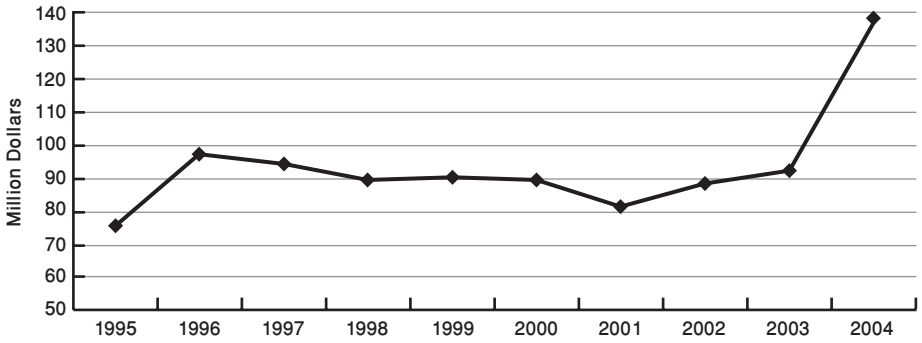
In addition to this chapter, the study comprises four main chapters. The second chapter reviews the reality and problems of the Palestinian health sector. The third chapter reviews the results of the gender-perspective evaluation of different MOH programs, while the fourth chapter analyzes the findings of the field survey of the beneficiaries of health services and providers. The study concludes with main conclusions and recommendations.

An overview of the reality of the Palestinian health system

The health sector is one of the most important social sectors in Palestine. The latest estimates indicate that the total expenditures on health services (including the direct household spending) in Palestine amount to 13% of the gross domestic product; per capita GDP is around US$ 122(World Bank, 2007). This rate is very high compared to the rates of expenditure on health in some neighboring countries, such as Egypt(5.3%), Syria(4.2%) and Israel (7.8%) (WHO, 2008).

Such high rates of spending on health are partially attributed to the significant increase in PNA expenditures on health during the last decade. Data from the Ministry of Finance revealed an increase in MOH allocations up to US$140,157m in 2005 (10.6%), compared to US$100m in 2003 (9.5%) (Ministry of Finance, 2006). This increase is attributed to the increase of employment in the public sector. The high salaries PNA payroll, and expenditures on service contracts with non-governmental organizations and treatment transfers abroad, led to the decrease in the financial resources available for medicines, medical supplies, operations and maintenance, amid an almost complete absence of financing of capital expenditures (World Bank, 2007).

Figure 1: The evolution of public current expenditures on Palestinian health care 1994 – 2004



Source: E-bulletin of the Palestinian Ministry of Finance.

Despite the significant increase in the number of hospitals and primary care centers and the increase of the numbers of beds and doctors, the health sector in the Palestinian Territories continues to suffer from several problems the supervising authorities failed to overcome, despite the multiplicity of those authorities (Mataria et al., 2008). MOH oversees the health sector, while the health service delivery system is divided between MOH, UNRWA, and NGOs active in the health sector, in addition to the private sector. Those parties try to provide basic health services to Palestinian citizens. However, because of the lack of financial resources, the population increase, and many problems stemming from the Palestinian reality, the health sector is incapable of overcoming several problems and meeting the needs of citizens (Giacaman and Khatib, 2009).

2.1 The health service delivery system

As in other health systems, health care provision in Palestine has a pyramidal structure, where the base constitutes primary and public health care services (first tier), while tertiary health services lie at the top of the pyramid, and secondary services in the middle. Primary health care services constitute the first point of

contact between women and men, on one hand, and the health system on the other hand. Services of this level include several programs classified into three main programs:

1. Preventive medicine program, including programs for monitoring and combating communicable, chronic and sexually transmitted diseases.
2. Community health program, including maternity and childhood programs, pregnancy risk, breast and cervix tests and family planning.
3. Environmental health program, including food and water control, pest control and others.

Secondary services include specialized health care, such as cardiology and internal medicine. Tertiary services include highly specialized services, such as neurology, intensive care and surgery. It is worth noting that health care providers in the secondary and tertiary levels usually receive patients referred from the first level of primary health and community health.

The structure of the Palestinian health system has been significantly affected by the volatile political situation in which the Palestinian people live in the West Bank and Gaza Strip, and which often led to several difficulties, most notably the lack of financial and human resources and organizational fragmentation and dispersion (Roetrs, 2005). Some attribute this dispersion and the extremely complicated structure of the Palestinian health system to the multiplicity of health providers and the poor coordination among them (Mataria et al, 2008). In fact, four different parties deliver health services at all levels; these are the government represented by the Ministry of Health, a group of non-profit community-based organizations, the private sector, and UNRWA.

2.2 The public sector: Ministry of Health

The Palestinian Ministry of Health (MOH), which began its work in 1994, is one of the most important Palestinian ministries. It has played a pioneering role in many functions. The major MOH functions include: Regulation, planning and oversight over health care services, in coordination with all health care providers, educational institutions and other relevant organizations. MOH activates and stimulates community-based health education programs through the management and dissemination of health information, the development of human resources, and ensuring that the allocations of expenditures to health care services are commensurate with the needs of the population (MOH, 2008).

MOH is the backbone of the health sector in the Palestinian Territories. MOH is the leader in the provision of primary health services; it oversees 416 primary health care centers out of 654 centers, (63.6%) of the total primary health centers in the West Bank and Gaza Strip (PHIC, 2009). On the other hand, MOH operates 24 out of 78 hospitals, i.e. 30% of all hospitals in the West Bank and the Gaza Strip and 58.3% of the total number of beds. MOH allocates 387 hospital beds for obstetrics and gynecology, i.e. 13.5% of total MOH hospital beds, of which 179 beds are in the West Bank and the rest in Gaza Strip. MOH allocates 561 hospital beds for children (19.6% of total beds), of which the largest rate (% 12.6) is in Gaza Strip (PHIC, 2009).

There has been a significant increase in MOH services during the past few years; MOH facilities received around 46.1% of the total number of patient visits in 2005 (PCBS, 2006) and 47% in 2006 (World Bank, 2008). This increase in the

size of MOH services is attributed to the increase in the number of Palestinian households covered by the public health insurance, and the deteriorating economic conditions, which led to an increase in the number of Palestinians who cannot afford the costs at other health care providers, particularly the private sector. This significant increase in the scale of MOH services coincided with a severe financial crisis the health sector faced after Israel had stopped transferring tax revenues it collects on behalf of PNA, and the severe decrease in foreign aid, which impede MOH ability to cover operational expenses and led to the deterioration in the quality of services provided to the public (Abu Zaineh et al, 2008).

Table 1: Indicators of distribution of health service facilities according to the service provider and region

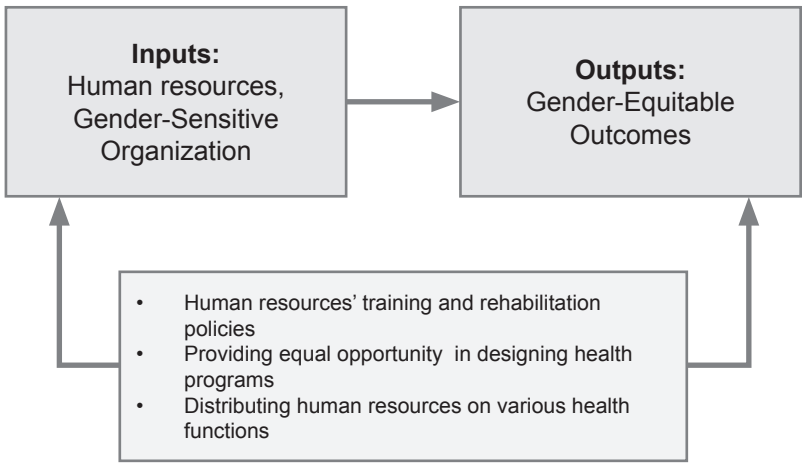
	Ministry of Health		Non-profit NGOs		Private sector		UNRWA		Total
	West Bank	Gaza Strip	West Bank	Gaza Strip	West Bank	Gaza Strip	West Bank	Gaza Strip	
Primary health care centers*	360	56	130	55	Unavailable	Unavailable	35	18	654
Secondary and tertiary care centers**	14	10	20	10	21	2	1	0	78
Total number of beds	1316	1499	1196	485	432	34	63	0	5025
Beds for women and childbirth ***	6.3%	7.3%	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable
Market share (according to number of visits) ****	46.1%		12.8%		21.4%		19.7%		100%
Average use (of the total patients)	47.0%		11.7%		16.7%		24.6%		100%

Source :
* Ministry of Health. Health Status in Palestine, 2008 Annual report, Palestine, October 2008
** Ministry of Health. Health Status in Palestine, 200* Annual report, Palestine, October 2008
*** PCBS. Health Care Providers and Beneficiaries Survey-2005, Main Findings, June 2006
**** World Bank, BCRD. The Role and Performance of Palestinian NGOs in Health, Education & Agriculture, December 2006

2.3 Gender balance in the human resources working in the public health sector

Gender balance in qualifying, employing and distributing human resources to various administrative, supervisory and technical functions in the health sector is one of the most important factors that help develop and deliver health services that are balanced quantitatively and qualitatively, and are responsive to various health needs of both women and men (Chen et al, 200). Some previous studies indicate the close link between the level of outputs (level of health for both sexes), and adopting a gender-perspective in all internal procedures and policies, especially those related to employment and training, and providing equal opportunity in designing and implementing various activities and projects.

Figure 2: Theoretical framework for the gender-perspective analysis of the relationship between the organization's inputs and outputs



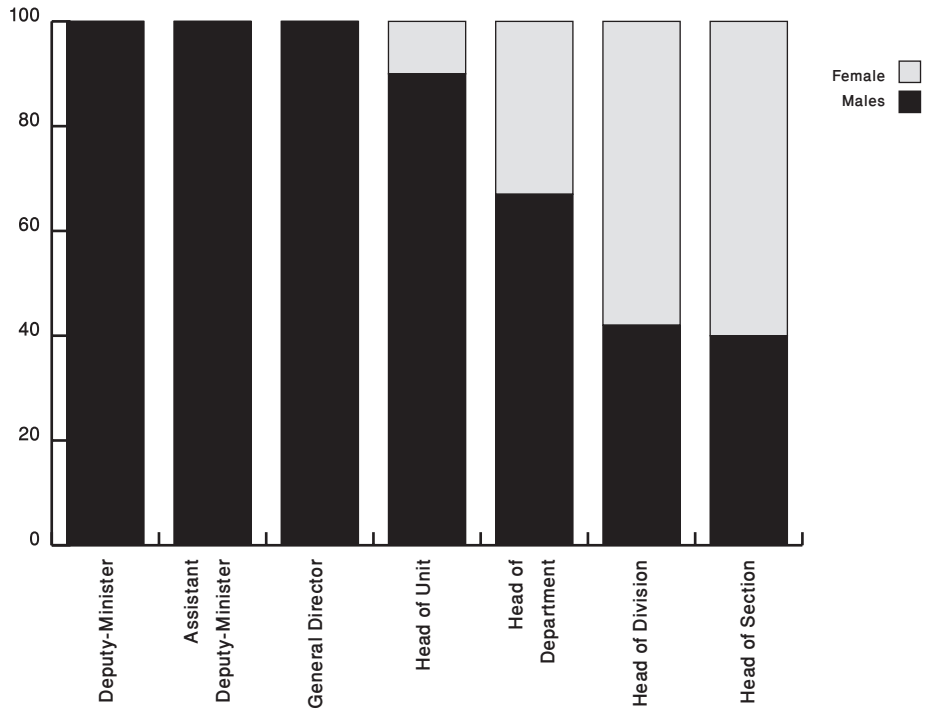
This section reviews the gender balance in the conditions of employment and human resource distribution in the health sector, based on official MOH and PCBS data.

The government health sector is the largest employer of the workforce in the health sector, where the number of MOH employees reached around 13,057 in 2006 (MOH, 2008), constituting around 41% of the total number of workers in the health sector, according to PCBS data (PCBS, 2006). Table 2 indicates the number and distribution rates of males and females in administrative and oversight positions according to the latest MOH approved organizational structure. Table 2 and Figure 3 indicate that the distribution of administrative and oversight positions in MOH units is significantly tilted in favor of men. This is particularly evident in senior administrative positions (deputy-minister, assistant deputy-minister and general directors), whereby women representation is limited, constituting 23% only of the total number of these positions, all concentrated in the position of general directors in West Bank governorates. Women representation increases significantly in lower administrative and supervisory positions, such as heads divisions or sections, by 58% and 60% respectively. Despite the importance of these positions in the follow-up and the implementation of administrative decisions, the continuing lack of representation of women in senior positions may adversely affect the opportunities for developing policies and taking decisions on health issues and needs in a more gender balanced manner.

Table 2: Gender distribution of administrative and oversight positions in MOH units

Job Title	Northern governorates				Southern governorates				Total			
	Males		Females		Males		Females		Males		Females	
Deputy Minister	1	100%	0	0%	1	100%	0	0%	2	100%	0	0%
Assistant Deputy-Minister	1	100%	0	0%	1	100%	0	0%	1	100%	0	0%
Director-General	11	73%	4	27%	3	100%	0	0%	14	100%	4	0%
Head of unit	9	90%	1	10%	1	100%	0	0%	10	90%	1	10%
Director of department	46	58%	33	42%	38	83%	8	17%	84	67%	41	33%
Head of division	35	34%	69	66%	30	61%	19	39%	65	42%	88	58%
Head of section	17	26%	49	74%	22	69%	10	31%	39	40%	59	60%
Total \ percentage of the Ministry	**118**	**43%**	**156**	**57%**	**94**	**72%**	**37**	**28%**	**221**	**53%**	**193**	**47%**

Figure 3: Gender distribution of administrative and oversight positions in MOH units



Regarding the distribution of administrative and oversight positions in health facilities (hospitals and health directorates), tables 3 and 4 indicate that the rates of women representation in senior administrative positions is still very low,

with only 4% of women holding the position of hospital director, while this rate increases to 12% in the position of health director. It is also noted that the rates of women representation remarkably increase in lower technical and supervisory jobs, amounting to 37% and 46% for positions such as hospital head of the division and head of the section respectively, and to 65% for positions such as director of nursing affairs at the health directorate.

Table 3: Gender distribution of administrative and oversight positions in MOH hospitals

Job Title	Northern governorates				Southern governorates				Total			
	Males		Females		Males		Females		Males		Females	
Hospital Director	11	92%	1	8%	12	100%	0	0%	23	96%	1	4%
Director of Medical Affairs	11	92%	1	8%	9	100%	0	0%	20	96%	1	4%
Director of Medical Support Affairs	6	67%	3	33%	8	80%	2	20%	14	74%	5	%26
Administrative and Financial Director	11	92%	1	8%	9	100%	0	0%	20	96%	1	4%
Director of Nursing Affairs	2	17%	10	87%	11	92%	1	8%	13	54%	11	46%
Head of Division	123	50%	123	50%	112	89%	14	11%	235	63%	137	37%
Head of Section	76	47%	86	53%	53	69%	24	31%	129	54%	110	46%
Total\ percentage of hospital	**240**	**52%**	**225**	**48%**	**214**	**84%**	**41**	**16%**	**454**	**63%**	**266**	**37%**

The data in Tables 3 and 4 also reveal a considerable disparity in the gender distribution of positions in the health sector between the West Bank and the Gaza Strip. In fact, the overall rate of women working in hospitals and health directorates in the West Bank governorates is higher than the overall rate of women working in these facilities in Gaza Strip, amounting to 48% and 49% in hospitals and health directorates respectively in the West Bank, in comparison with 16% and 23% in hospitals and health directorates respectively in Gaza Strip.

Figure 4: Gender distribution of administrative and oversight positions in MOH hospitals

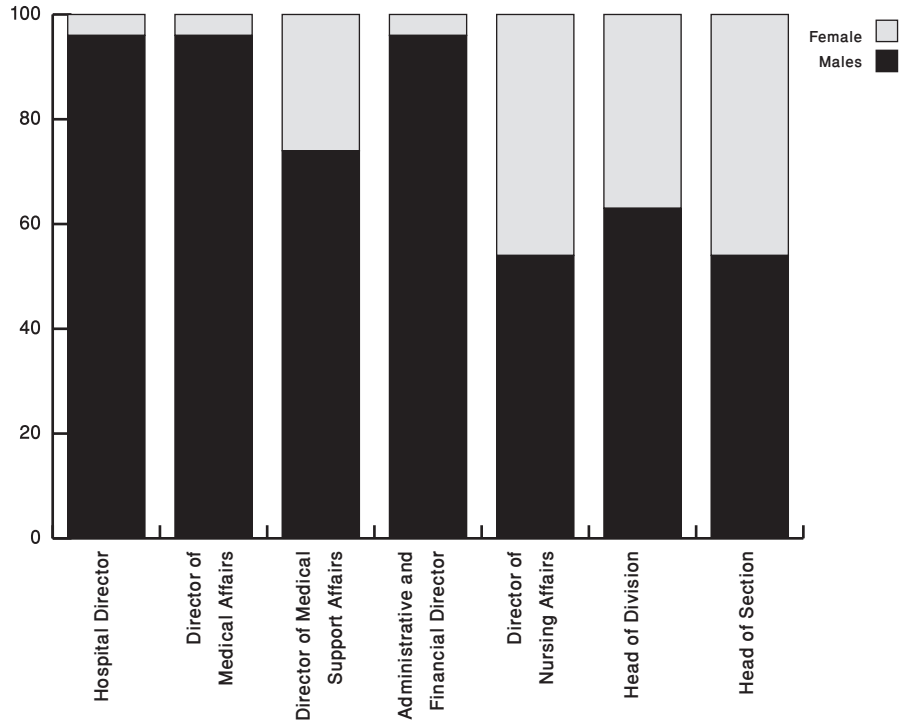
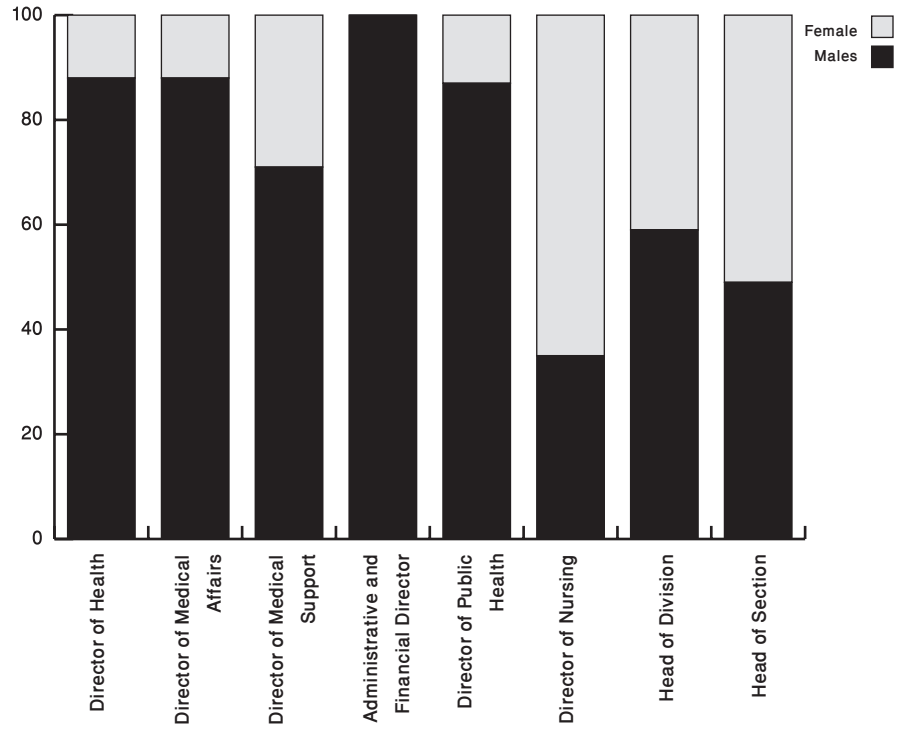


Table 4: Gender distribution of positions at MOH directorates

Job Title	Northern governorates				Southern governorates				Total			
	Males		Females		Males		Females		Males		Females	
Director of Health	11	100%	0	0%	3	60%	2	40%	14	88%	2	12%
Director of Medical Affairs	10	83%	2	17%	5	100%	0	0%	15	88%	2	12%
Director of Medical Support	5	56%	4	44%	5	100%	0	0%	10	71%	4	29%
Administrative and Financial Director	12	100%	0	0%	5	100%	0	0%	17	100%	0	0%
Director of Public Health	8	80%	2	20%	5	100%	0	0%	13	87%	2	13%
Director of Nursing	1	8%	11	92%	5	100%	0	0%	6	35%	11	65%
Head of Division	110	53%	96	47%	44	79%	12	21%	154	59%	108	41%
Head of Section	111	44%	144	56%	56	70%	24	30%	167	49%	168	51%
Total\ percentage of the Ministry	268	51%	259	49%	128	77%	38	23%	396	57%	297	43%

Figure 5: Gender distribution of positions at MOH directorates



Although MOH developed in 2001 a strategic plan for human resource development in the health sector, the review of the components of this plan indicated that it lacked a key variable in human resource development, namely gender. It addressed all issues pertaining to human resource development and organization using variables such as specialization and geographic distribution, with no reference to any strategies that may balance male and female employment and achieve equality in various administrative, supervisory and technical functions in the health sector. This also applies to the section on human resource development in the National Strategic Plan (Mid-Term Development Plan 2008-2010), whose recommendations and development projects for the years 2008 - 2010 were void of any reference to the need to develop mechanisms that achieve gender balance in the development of sufficient and adequate human resources in the health sector.

2.4 Preliminary gender-perspective analysis of public health indicators

Periodic reviews of basic health indicators constitute the starting point to measure and evaluate the performance of health systems in general, and the impact of various health programs in particular. Such a review enables the initial identification of the most important gender differences and gaps in public health indicators. Despite the significant progress in MOH, with the establishment of the Palestinian Health Information Center which produces basic health indicators, much of these indicators and data still lack the data that identifies gender differences, and disaggregated data on health services received by females and males separately. This section reviews the most important health indicators,

focusing on gender related issues and maternity and childhood health, based on official information gathered from MOH, PCBS in addition to the reports of some international organizations operating in the Palestinian Territories.

Life expectancy rates at birth have increased for both genders between the years 2003 and 2008. The life expectancy for Palestinian women is 75 years. Despite such progress in the life expectancy for women, it is still lower than women life expectancy in neighboring countries such as Jordan, Lebanon and Israel, where women life expectancy is 81, 83 and 85 respectively. At another level, Table 5 reveals that the gap in the life expectancy of both sexes has decreased between 2003 and 2008, and is lower than the expected gap between the two sexes, since women have a biological advantage over men concerning life expectancy at birth. Studies (WHO, 2002) indicate that when adequate and healthy conditions are provided, women generally live 5 more years than men. Hence, when the life expectancy gap between men and women decreases, or when the life expectancy for women is equivalent to the life expectancy of men, this may be an indication that women receive less adequate health care or nutrition than men (World Bank, 2005).

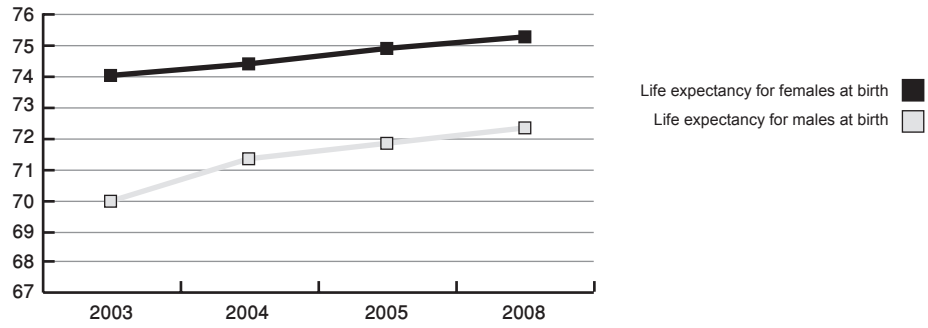
Table 5: Life Expectancy at Birth in Palestine according to gender

Year	Life expectancy for males at birth	Life expectancy for females at birth	The gap between the life expectancy at birth for males and females
2003	70,0	74,0	4
2004	71,1	74,3	3,2
2005	71,5	74,7	3,2
2008	71,9	75,0	3,1

Source: United Nations Development Program WPP 2009

The increase in life expectancy in general, and for women in particular, usually results in the decrease in the number of infant and maternal mortality, which in turn reflects improved health care for pregnant women and an increase in the rate of delivery under medical workers supervision. Regarding births and deaths, the data of PCBS demographic health survey in 2005 revealed that mortality rates had decreased in the Palestinian Territories because of improved health care services and increased attention to health conditions in general, which had a positive impact on infant mortality rates, which decreased 27.7 deaths for each 1000 live births in 1990-1994, to 24.2 deaths for each 1000 live births in 1999-2003. This led to an increase in life expectancy at birth to 71.5 years for males and 74.7 years for women.

Figure 6: Life expectancy at birth in Palestine according to gender



Despite this fact, registered death rates for maternal mortality in the Palestinian Territories is higher than other countries with similar income. Maternal mortality rate increased in 2008 at the national level to around 19.6 deaths for every 100000 births (Palestinian Health Information Center) compared to the number of 12.7 deaths for every 100000 births in 2003, constituting 22.3% of all women at fertility age (15-49) years old) (Palestinian Health Information Center). It is worth noting that 43.8% of all Palestinian women are within the fertility age (15-49), while data indicates that 95.2% of all births take place in hospitals, and that MOH hospitals receive 47.7% of these cases. This indicates that most Palestinian women choose to deliver at hospitals, in general, and MOH hospitals in particular, since public health insurance covers delivery expenses.

It is worth noting that the 2008 Palestinian Health Information Center Report had indicated that the rate of maternal mortality was lower than anticipated, acknowledging the extreme importance of further efforts to identify the real rate, as an important indicator in measuring and evaluating reproductive services and programs. Hence, a national committee was established to follow up on registrations and notifications of maternal mortality in the West Bank and Gaza Strip. Despite this important step to collect and prepare more accurate data, it is not an alternative to incorporating the goal of decreasing maternal mortality rates in the national health plan. The current plan (2008-2010 National Strategic Health Plan) is void of a specific goal pertaining to this matter, although reducing the maternal mortality rate is one of the major Millennium Development Goals (MDGs).

At another level, the overall average fertility rates in the Palestinian Territories (the actual number of children that would be born alive to the woman during her childbearing life identified at a specific age) is still one of the highest rates in the world, because of the continuous phenomenon of early marriages of young girls, the desire to reproduce and the prevailing customs and traditions in the Palestinian society. Nevertheless, the overall fertility rates significantly declined during the past two decades, as recent data revealed that the overall female fertility rate has reached 4.6 infants per female at the national level (5.4 in Gaza and 4.2 in the West Bank) (PCBS, 2006). The decrease is partially attributed to the increase in education levels of women, as the female to male ratio in the years 2003-2004 reached 97.7% in primary education, 106.7% in secondary education and 98.0% in higher education (Ministry of Education and Higher Education, 2005).

No doubt that the reason for the decline in fertility rates is also the increased interest in family planning programs, which is the focus of many health service providers in general, and MOH in particular. Such attention was evident in the increase in 2008 of the number of primary health care centers that provide family planning services to 115 centers in different governorates, of which 97 centers are in the West Bank and 18 centers in Gaza. The total number of female visitors to family planning centers in the northern governorates during the first quarter of year 2009 amounted to around 8824 (Health Information Center, 2009). The total number of visits of beneficiaries of these family planning programs during 2008 was around 111403 visits. The number of new women beneficiaries of the family planning services in 2008 was 26593 women; during the same year, pills were the most common contraceptive (4944 woman), compared to 2793 women who used IUDs (Palestinian Health Conditions 2008,2009).

Despite the significant increase in the numbers of visitors of family planning centers, and the spread of various birth control methods, it is worth noting that the prevailing birth rates usually reflect men's choices, for social, economic and cultural considerations, and are not dependent only on the availability of family planning methods to women, which explains the coexistence of high fertility rates and the spread of contraceptives in many third world countries. Some studies (Prichet, 1994) indicate that around 90% of the differences in fertility rates in Mediterranean and North African countries result from the differences in desired fertility rates (demand factors), and not from the availability of contraceptives. Hence, if we wish to understand the impact of family planning as an important indicator in evaluating the level of responsiveness to genders needs, it is important to identify the age group that uses contraceptives, the used contraceptive methods (since some methods adversely affect women's health) and the context that motivates their use.

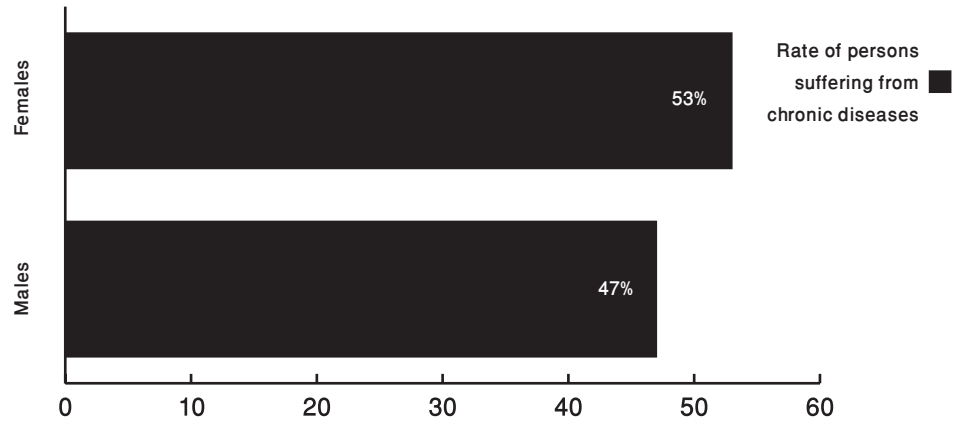
At another level, the analysis of the first health expenditures survey in the Palestinian Territories, conducted by PCBS in 2004, revealed that the rate of women who suffer from chronic diseases is generally higher than that of men (See Table 6 and Figure 7). It is also noted that the findings of this survey, which included a representative sample of the West Bank and Gaza Strip population (and not only the beneficiaries of health services), revealed that the rates of women who suffer from two or three chronic diseases (61% suffer from 2 chronic diseases and 93% suffer from three chronic diseases) are higher than the rates of men who suffer from two or three chronic diseases (39% and 82.8% respectively). While the rate of women who receive regular treatment for chronic diseases is higher than men (for example, 95% of women who suffer from two chronic diseases receive treatment compared to 84% of men), the rate is in the favor of men who suffer from three chronic diseases, as 93% of those men receive treatment in comparison with 83% of women only.

Table 6: Gender distribution of morbidity patterns in the Palestinian Territories

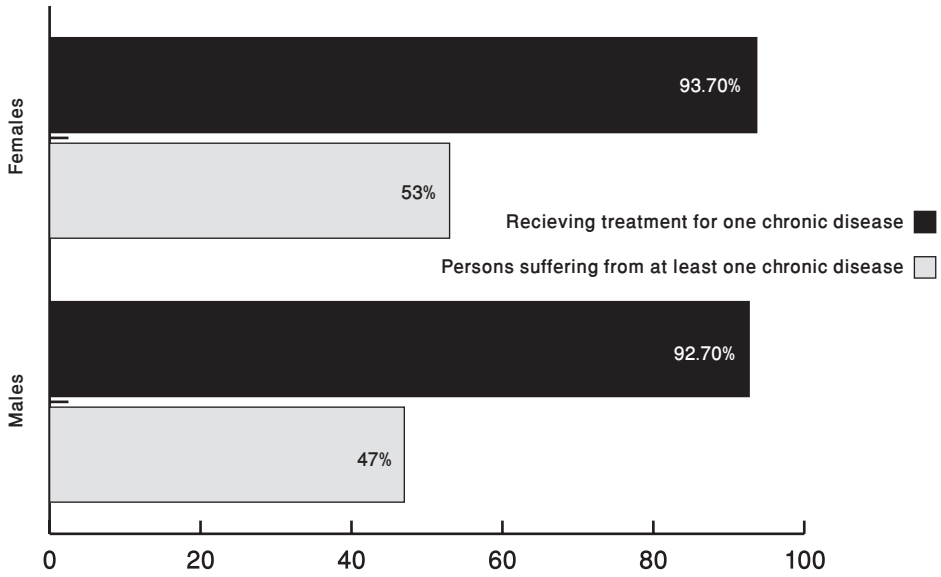
Sex	Number	People who suffer from chronic diseases	People who suffer from at least one chronic disease		People who suffer from two chronic diseases		People who suffer from three chronic diseases		Chronic disease patients under five years old	Chronic disease patients over fifty years old	Patients who suffer from the most common chronic diseases	
		Number (percent)	Number	Receiving treatment (percent)	Number	Receiving treatment (percent)	Number	Receiving treatment (percent)	Number (Percent of Patients)	Number (Percent of Patients)	Diabetes	Hypertension
Males	12894	1162 (47%)	1157 (47%)	1073 (92,7%)	270 (39%)	226 (84%)	69	64 (92,7%)	58 (5%)	498 (42,3%)	234 (45%)	148 (32%)
Females	12286	1309 (53%)	1302 (53%)	1221 (93,7%)	416 (61%)	396 (95%)	134	111 (82,8%)	48 (4%)	750 (57,3%)	285 (55%)	308 (67%)
Total	**25180**	**2471 (100%)**	**2459 (100%)**	**2294 (93,3%)**	**686**	**622 (91%)**	**203**	**175 (86,2%)**	**106 (4,2%)**	**1248 (50,5%)**	**519 (100%)**	**456 (100%)**

Source: PCBS, 2004

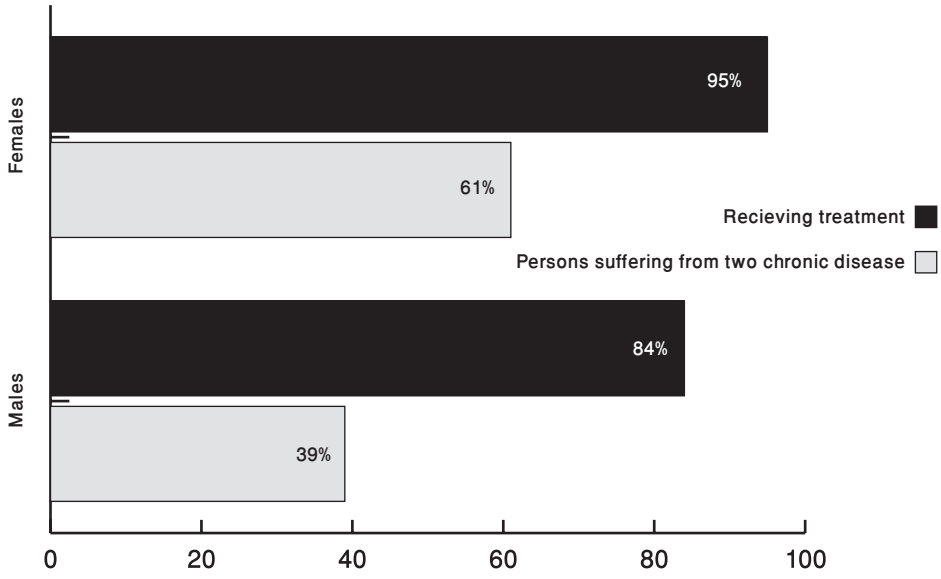
Figure 7: Relative gender distribution of persons suffering from chronic diseases



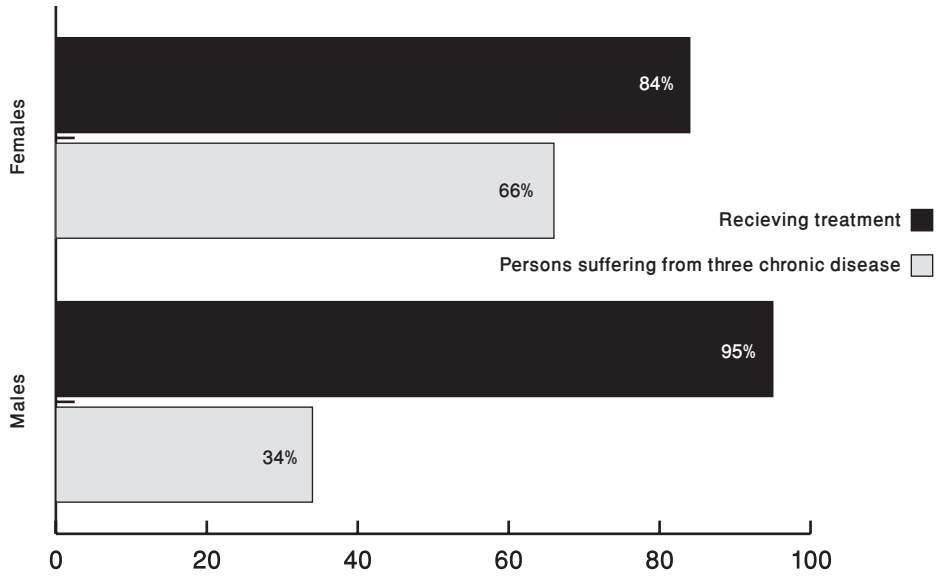
Relative gender distribution of persons who suffer from one chronic disease and the rate of treatment recipients



Relative gender distribution of persons suffering from two chronic diseases and the rate of treatment recipients



Relative gender distribution of persons suffering from three chronic diseases and the rate of treatment recipients



A gender-perspective assessment of the health conditions and the health sector services from the beneficiaries' point of view

This chapter provides a gender perspective presentation and analysis of the findings of a field survey of the beneficiaries' point of view towards governmental health services. It consists of five main sections: The first section consists of the survey methodology; the second presents general attributes of the survey sample; the third section comprises indicators of self assessment of health conditions and common morbidity patterns; the fourth section discusses access to health facilities; and the fifth section discusses the beneficiaries evaluation of health services at primary, secondary and tertiary health facilities.

3.1 Survey methodology

The MOH database was used the purposes of designing and selecting the sample of health service recipients. The sample included the fourth level primary health care centers, which are comprehensive health centers that deliver preventive and first aid services, in addition to specialized maternity and child care and psychological counseling. It also included health facilities that provide secondary and tertiary health services, consisting of the public hospitals in all the West Bank governorates. In the cases where there were no fourth level health care centers, as in Tubas (Tammoon) and Southern Hebron (Al-Thahiriya), third level health care centers were selected. These centers provide all the services provided by the fourth level centers, except for some specialized services, such as psychological counseling and x-ray imaging.

The survey sample consisted of 404 female and male beneficiaries of the three levels of health care services, selected in the following method:

1. A sample of beneficiaries of primary health care services was distributed proportionately with the population in each governorate and the number of beneficiaries at the peak time of the survey day and in a systematic random method.
2. The sample of beneficiaries of secondary and tertiary health care services was selected, in coordination with the administrations of hospitals, to identify the number of in-patients in different sections. The sample was distributed in a systematic random method proportionate to the number of patients in each section.

3.2 General background indicators on survey sample

Table (6) sums up the most important socio-economic attributes of the survey sample. The relative distribution of patients at primary health care according to gender indicates that women visit health care centers more often than men (56% women and 44% men) at all three levels: Primary, secondary and tertiary. This clearly reflects the larger health needs for women compared to men. The rate of respondents in 23-50 age group constitute around 49% of the total sample, while 28% were over 50 years old and 17% were in the 5-22 age group. The rest (6%) were less than 5 years old. These findings were not anticipated, as they indicate that health care needs are higher among the youth than among the children and the elderly.

On the other hand, the average number of household members among the respondents was 6.3, while 73% of the respondents said that their average monthly income was less than 2000 NIS, 62% of it from salaries and wages. This clearly reveals that most patients at public health facilities are from the limited income groups and are wage recipients who are covered by the public health insurance.

Attributes of respondents from the beneficiaries of secondary and tertiary health services were not much different from attributes of the respondents from primary health care beneficiaries. 56% of beneficiaries were females, while 44% were males. Around 44% of respondents were from 23-50 age group, 9% were over 50, 16% were from 5-22 age group and 11% were under five years old. The average number of household members among the respondents was 7.0, and 73% of the respondents said that their average monthly household income was less than 2000 NIS a month, mostly (49%) from salaries and wages, while the incomes of 17% were from family enterprises.

Table 7: General background indicators of the survey sample in primary, secondary and tertiary health care centers

		Primary Health Centers	Secondary & Tertiary Health Centers
Sex	Male	43.6%	44%
	Female	56.4%	56%
Age	Under 5	6%	11%
	5-22	17%	16%
	23-50	49%	44%
	Over 50	28%	29%
Monthly Income	Less than 1000 NIS	33.3%	30%
	1000-1999	39.2%	43%
	2000-2999	16.1%	15.5%
	3000-3999	7.8%	5.0%
	More than 4000	2.9%	2.0%
Social Status	Single	20%	16.5%
	Married	60.3%	66%
	Divorced	2%	1.5%
	Widowed	10.2%	4%
Level of Education	Primary or less	32.9%	36%
	Intermediate School	25.5%	24.5%
	Secondary School	19%	15%
	Bachelors or Diploma	16.2%	13%
	Masters or above	1%	1.5%
Relation to labor force during last month	Full-time or part-time worker	27%	19%
	Unemployed	8.3%	11%
	Housewife/house caretaker	0%	35.3%
	Full-time student	11.3%	9.5%
	Incapacitated	6.4%	10%
	Neither working nor seeking to work	9.8%	5.5%
Average number of household members		6.3	7.0

3.3 Health conditions and morbidity patterns

This section identifies and examines the gender differences in morbidity patterns and health needs, which is an essential step to the study and diagnosis of the social groups most susceptible to disease an to types of diseases. This diagnosis also helps to identify response patterns among men and women to the diseases they suffer from. It is worth noting that a comprehensive diagnosis of these patterns and health determinants of both women and men in a certain society usually requires a comprehensive survey that is not restricted to the beneficiaries of health services, but also includes persons who needed health services but could not get it. However, the findings of the survey of the beneficiaries of health services may provide preliminary gender-perspective indicators about the determinants and the attributes of beneficiaries of health services.

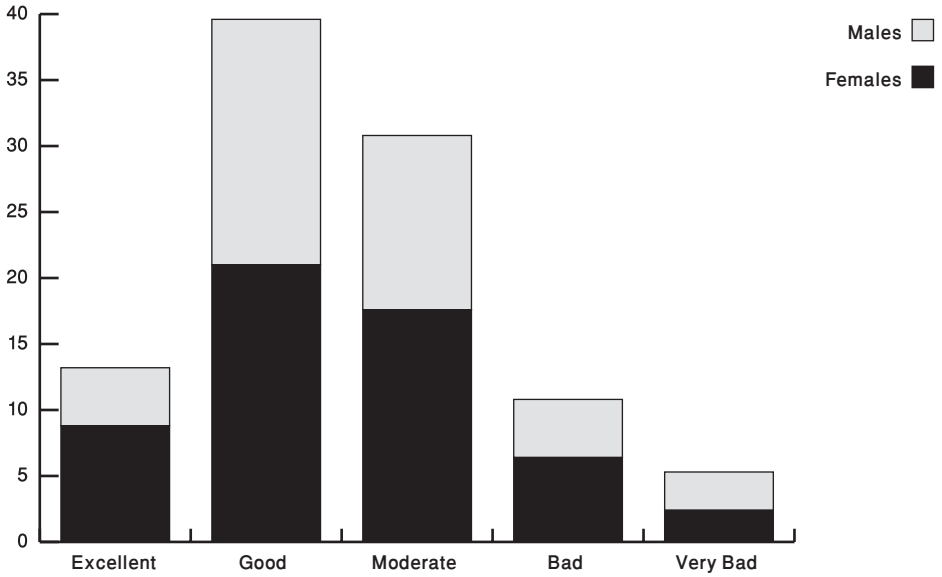
Table (8) summarizes the beneficiaries' assessment of their health status. The table reveals significant variations in the assessment of the health conditions between men and women. While 8.8% of women receiving primary health care services and 7.5% of women receiving secondary and tertiary health care services described their health conditions as excellent, the rate for men who received the same services was 5% only. These findings differ significantly among those who described their health conditions as moderate to very bad, as 25% of women who received primary health care described their health conditions as moderate to very bad, in comparison with 20% only among men. Similarly, the rate of women receiving secondary and tertiary health care and who described their health status as moderate to very bad was higher than the rate of men recipients of the same service (30% for women and 26.4% for men).

Table 8: Health conditions of beneficiaries according to level of care and gender

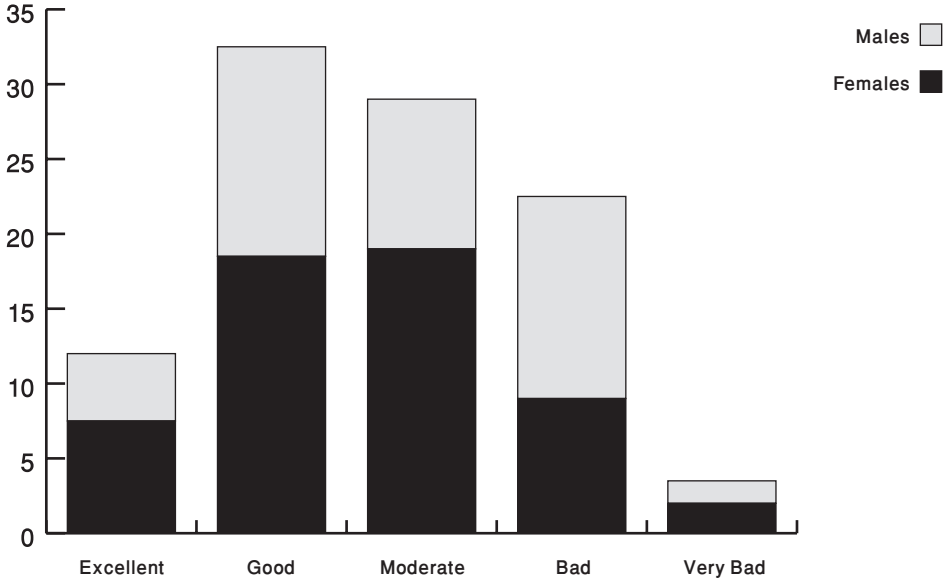
Health Condition	Primary Care		Secondary and Tertiary Care	
	Males	Females	Males	Females
Excellent	4.4%	8.8%	4.5%	7.5%
Good	18.6%	21%	14%	18.5%
Moderate	13.2%	17.6%	10%	19%
Bad	4.4%	6.4%	13.5%	9%
Very Bad	2.9%	2.4%	1.5%	2%

Figure 8: Health conditions of beneficiaries of health services according to gender

Health conditions of beneficiaries of primary health services according to gender



Health conditions of beneficiaries of secondary and tertiary health services according to gender



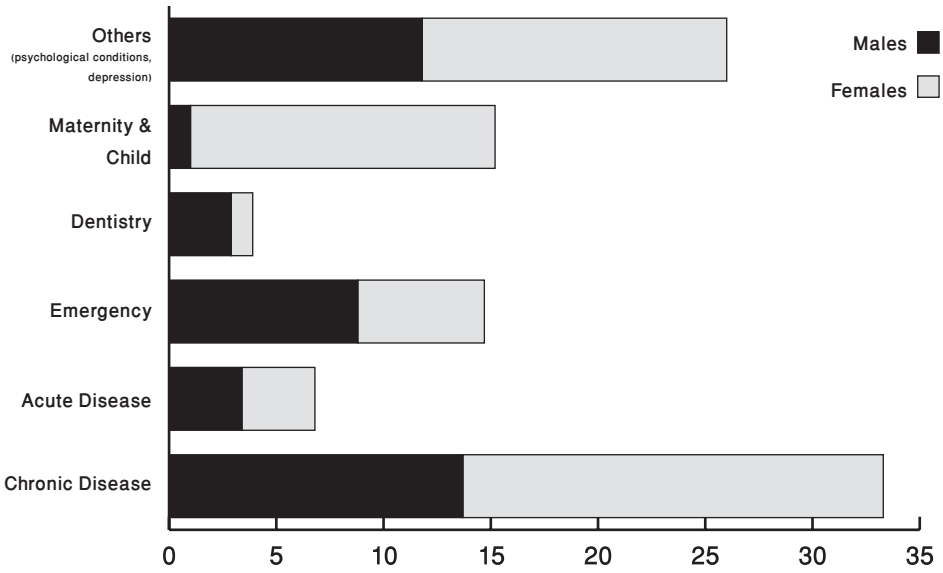
Of course, several psychological, cultural, social and economic factors play a major role in the process of health self-assessment and in determining the extent to which a person seeks the necessary health care. However, the above-mentioned findings generally reveal the importance of gender in identifying differences in the assessment of the health conditions of beneficiaries. While these findings generally demonstrate a higher need for health care among women, they further indicate that women who receive health care services actually feel the deterioration in their health conditions, and their consequent need for receiving health care. It is also worth pointing out the social/cultural factor that is directly linked to gender differences (the different social roles and responsibilities allocated to men and women and the resulting differences in cultural and behavioral attitudes). Previous studies (WHO, 2000) mention that this factor plays a major role in preventing women from accurately describing their health conditions and how they feel, especially in developing countries, stereotypical roles continue to prevail (Kuga et al, 1996). Indeed, there is evidence that indicates that women do not quickly disclose their health conditions, and wait longer than men to receive health care for a disease they suffer from. This is partially attributed to women's unwillingness to obstruct housework and their prior knowledge of the intolerance of their social circles towards their health conditions (Paltiel, 1993).

This diagnosis leads to a question about the morbidity patterns and the nature of the health needs for both men and women. Table (8) shows the relative distribution of morbidity patterns and the types of health problems faced by both men and women. The findings show that the rate of women who suffer from chronic diseases is higher than men (19.6% of women and 13.7% for men). This rate is similar in acute diseases (3.4% for men and women). On the other hand, the rate of men is higher than women in emergencies (8.8% for men and 5.9% for women) and dentistry (2.9% for men and 1% for women) . Finally, while it is not surprising that the need for maternity and childhood care was concentrated among women (14.2%), the findings revealed a higher rate of women (14.2%) in comparison to men (11.8%) with respect to other diseases, such as psychological conditions and depression.

Table 9: Relative gender distribution of morbidity patterns and health problems

Health Problem Type	Males	Females	Total
Chronic Disease	13.7%	19.6%	33.3%
Acute Disease	3.4%	3.4%	6.8%
Emergency	8.8%	5.9%	14.7%
Dentistry	2.9%	1%	3.9%
Maternity & Child	1%	14.2%	15.2%
Others (psychological conditions, depression)	11.8%	14.2%	26%

Figure 9: Relative gender distribution of morbidity patterns and health problems



These findings are in line with the health expenditure survey (PCBS 2004), not only asserting the concentration of women health needs, but also revealing discrepancies in those needs, called the gender gap in morbidity. The gender gap in morbidity is widest in chronic diseases (including diabetes and cardiovascular diseases, including hypertension and strokes, and cancer and lung diseases). These life-threatening medical conditions are the main causes of adult deaths around the world generally and in Palestine particularly. As indicated in MOH 2008 report, diabetes, cancer and cardiovascular diseases, including high blood pressure and strokes, constitute more than 50% of the causes of adult deaths. Given the current status of health services and the increase in poverty rates, there is an urgent need for special attention to disabilities resulting from chronic disease, especially among women who suffers from those diseases the most.

It is hard to attribute the imbalance in the spread of diseases, particularly chronic diseases among women to mere biological and physiological factors (except for diseases that are directly related to the different biological composition). Several previous studies (Gorman & Ghazal, 2006) pointed out several variables directly related to the difference in roles and responsibilities and to resource allocation among men and women in society, and their direct relation to determining morbidity patterns and means of prevention. For example, a study in Zimbabwe (Vlassoff& Bonilla, 1994) proved that women are more susceptible to parasitic diseases, such as Schistosomiasis (which causes liver fibrosis and increases the risk of cancer), since women are more in contact with water resources as they wash the dishes and do the laundry. On the other hand, several studies emphasized the decisive role of the distribution of the economic resources and access to information in making women less capable of protecting themselves from diseases than men. For example, women are less capable of using income to buy preventive means of combating diseases or to buy the necessary medical services (Tanner &Vlassoff, 1998).

3.4 Access to health services

Ensuring access to health care that is adequate to health needs constitutes the foundation of a strong and fair health system based on principles of justice and social solidarity, regardless of whether these services were equal or different to each sex. A gender-perspective evaluation of access to health care raises several questions or criteria through which such an important dimension of health services may be evaluated. In this context, this section responds to some of these questions, most notably:

- What are the obstacles that women and men face as they seek to obtain the required health care? Are these obstacles different for women than men?
- Is health information available to both sexes equally?
- Are the specificities of women taken into consideration upon getting the required health care?
- To what extent does the health care system recognize the obstacles that impede access to health care for both women and men? How does it seek to overcome these obstacles?

Figure 10: Theoretical framework for the analysis of the relationship between gender and access to health care

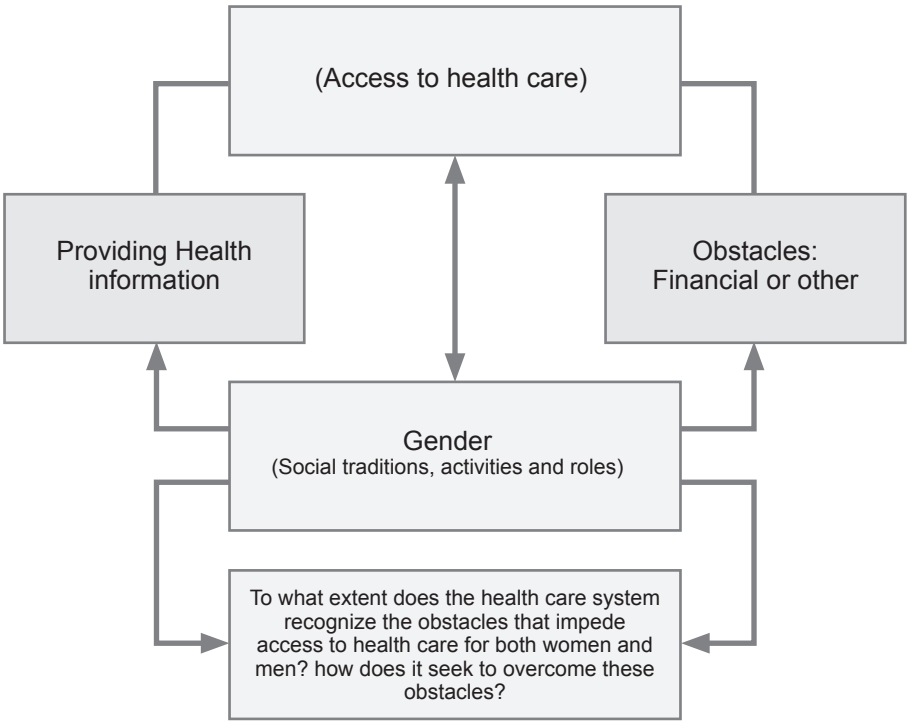
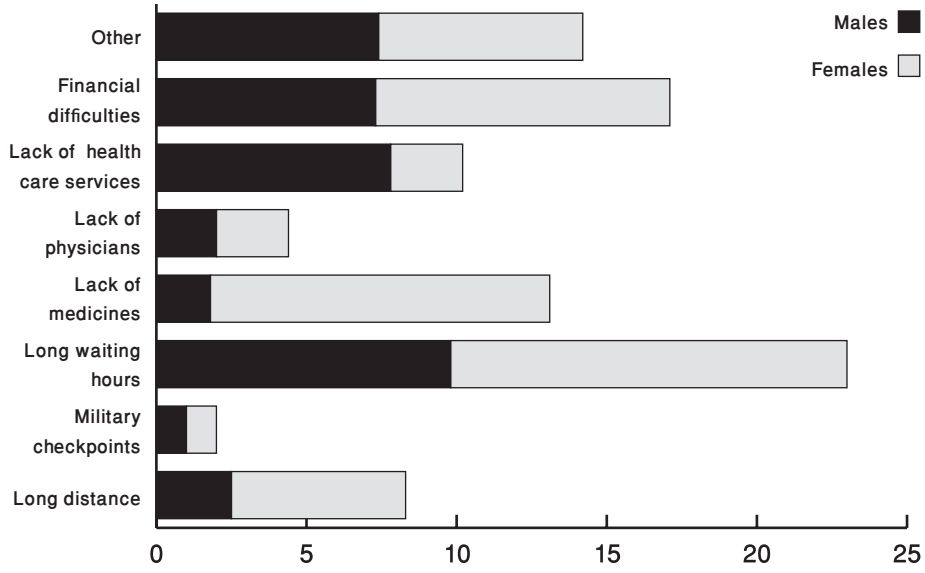


Figure 11 and Table 10 present the main obstacles that women and men face in their pursuit to obtain health care at the three levels (primary, secondary, and tertiary). In primary health care, long waiting hours, lack of medicines, financial difficulties, the long distance between health services and places of residence and the unavailability of the needed health services, constituted the main obstacles to primary health care that women particularly face. 13.2 % of women (compared

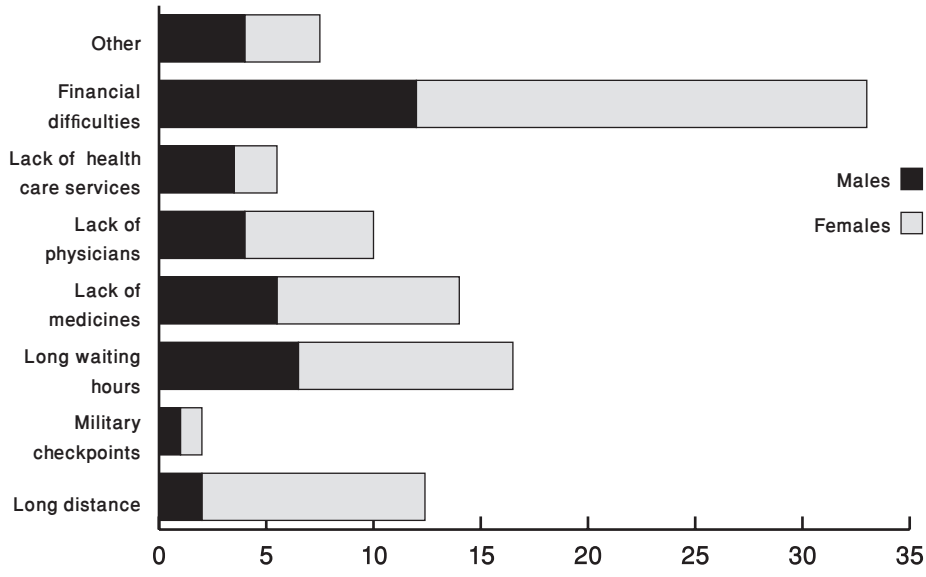
to 9.8% of men) pointed out the long waiting hours, 11.3% of women (compared to 1.8% of men) mentioned lack of medicines, and 9.8% of women (compared to 7.3% of men) mentioned financial difficulties. 5.8% of women (compared to 2.5% of men) considered distance from residence as the major obstacle.

The rates are not much different from rates in the other two levels of health care (secondary and tertiary), where 10% of women (compared to 6.5% of men) indicated long waiting hours, 8.5% of women (compared to 5.5% of men) mentioned lack of medicines and 10.4% of women (compared to 2% of men) mentioned distance from residence. Financial difficulties constitute a major obstacle to most women (21% of women compared to 12% of men). 6% of women and 4% of men considered the lack of physicians a major obstacle.

Figure 11: Obstacles to access primary health services



Obstacles to access secondary and tertiary health services according to gender



Regarding the time needed to access health care, the findings indicated that men are faster and easier to get the primary health care than women; 48.5% of men (compared to 29.9% of women) reach primary health services within less than two hours, while less than 1% of men reach their health services the next day, compared to 2.7% of women who have to wait till the next day to get health services. Regarding the time needed to reach secondary and the tertiary health care, the findings indicated that the time is longer for women than for men, as 30.5% of women (compared to 40% of men) reach such services in less than two hours, while the rates were higher for women who needed two, three or longer hours to reach those services in comparison with men. This also applies to getting services during the next day, which constituted 2.7% of women, compared to only 1% of men.

Table 10: Gender perspective evaluation of access to different health services

Obstacles impeding access to health care		Primary care			Secondary and tertiary care		
		Female	Male	Total	Female	Male	Total
Distance from place of residence		5.8%	2.5%	8.3%	10.4%	2%	8.4%
Military checkpoints or the Apartheid Wall		1%	1%	1%	1%	1%	2%
Long waiting hours		13.2%	9.8%	23%	10%	6.5%	18.5%
Shortage in medicines		11.3%	1.8%	13.1%	8.5%	5.5%	14%
Unavailable physicians		2.4%	2%	4.4%	6%	4%	10%
Unavailable required health services		2.4%	7.8%	10.2%	2%	3.5%	5.5%
Financial difficulties		9.8%	7.3%	17.1%	21%	12%	26%
Other		6.8%	7.4%	14.2%	3.5%	4%	7.5%
Time needed to access the closest center to receive adequate health care	Less than 1 hour	29.9%	48.5%	78.4%	30.5%	40%	70.5%
	From 1 -2 hours	9.8%	6.4%	16.2%	7.5%	5%	12.5%
	More than 3 hours	1%	0.5%	1.5%	5%	1%	6%
	Arrived one day earlier and was served today	2.7%	0.8%	3.4%	2.7%	1%	3%

Table 11 and Figure 12 present the respondents' evaluation of the extent to which they receive their needs of health services. The findings indicate that the rate of women who did not receive health services that are responsive to their needs is higher than the rate of men. Only 20% and 30% of women expressed their satisfaction with receiving the primary and secondary and tertiary health care they had requested, in comparison with 35.8% and 37% respectively of men.

The rate of respondents who said that they duly received adequate primary health care was higher among men (35%) than women (20%), while 37% of men and 30.5% of women gave the same response for secondary and the tertiary health care. On the other hand, the rate of women respondents who said they received the primary health care that responded only partially to their needs was higher (45.8%), in comparison with 26% of men, and 39% of women compared to 25.5% of men for the secondary and the tertiary health care. This also applies to periods

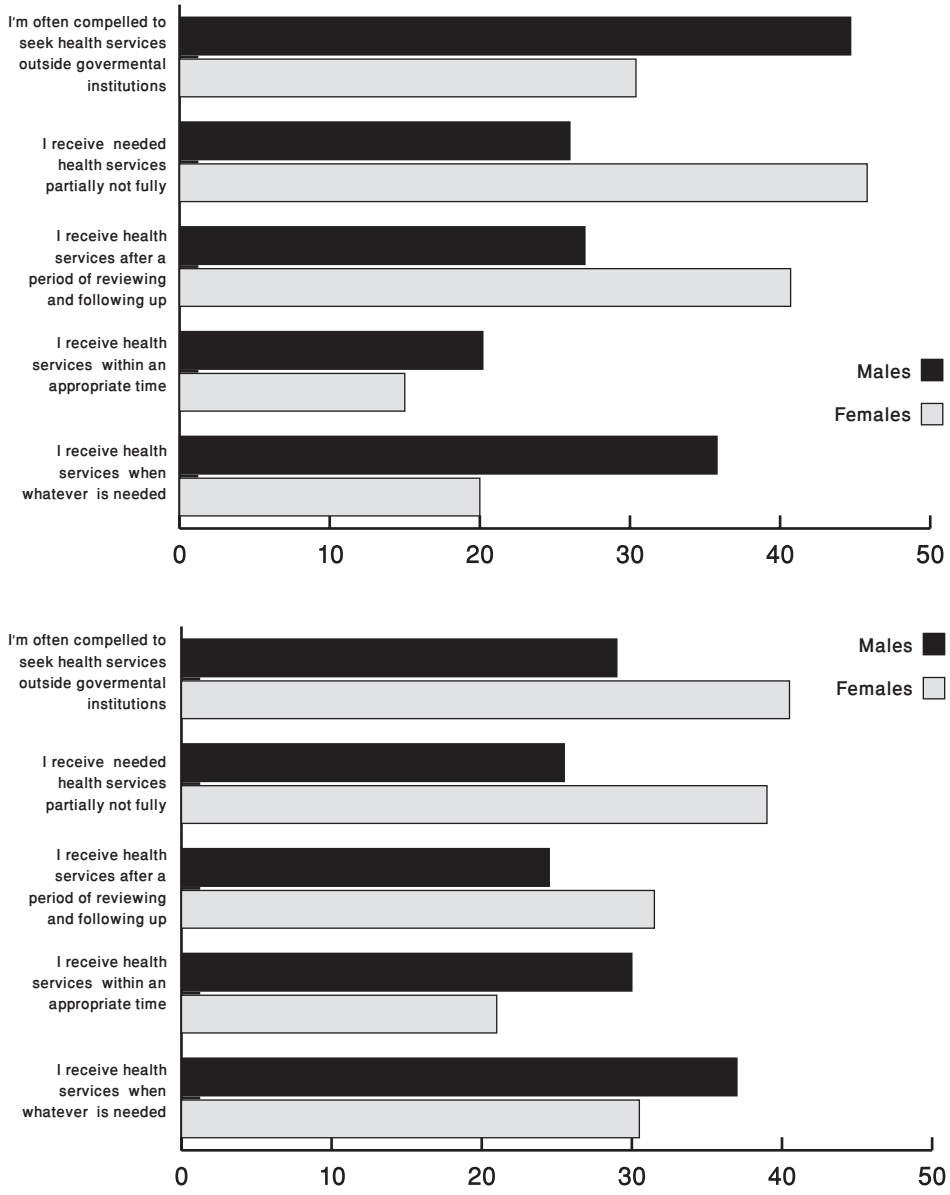
of follow up and reviews, whereby the rates of women who said they received the necessary service but after a long period of reviews and follow ups was higher than the rate of men. Table 11 indicates that 44.7% of men seek primary health services outside the public health facilities, compared to 30.4% of women, while 40.5% of women seek secondary and the tertiary health care outside the public health facilities, compared to 29% of men.

This may be an indication either of the unavailability of the health service required by women in secondary and tertiary public health facilities, or of an increase in the rate of referrals of women from MOH to non-governmental and private facilities. Verifying which option is more accurate requires identifying the rates of MOH referrals to non-governmental facilities according to gender and health conditions. Since the above findings indicate that the rate of women who said they received only part, and not all of their required health service is higher than men, this may explain at least partially, the increased rate of women who seek health care outside the public health facilities.

Table 11: Assessment of public perceptions about access to the required health services

	Primary Care		Secondary and Tertiary Care	
	Males	**Females**	**Males**	**Females**
I receive health care no matter what the need is	35.8%	20%	37%	30.5%
I receive health care in suitable time	20.2%	15%	30%	21%
I receive health care but after a long period of follow ups and reviews	27%	40.7%	24.5%	31.5%
I receive only part, and not all of my required health service	26%	45.8%	25.5%	39%
I often have to seek health care outside public health services	44.7%	30.4%	29%	40.5%

Figure 12: Assessment of access to health care



3.5 Satisfaction with health services

Gender equality in access to health services is vital. However, to complement a gender-perspective assessment of health services, it is necessary to assess the level of satisfaction. In that context, this section presents the findings of the assessment of satisfaction with health services according several criteria, as illustrated in Table (12).

In general, it is the level of satisfaction among women is higher than among men for all the criteria used in the assessment of health service at all levels (primary,

secondary, and tertiary). Privacy upon giving medical advice or discussing health conditions is an exception, as most women (56%) expressed their dissatisfaction with the level of privacy upon receiving medical advice compared with only 8% of men.

However, women's relative satisfaction with the public health services significantly decreases compared to men, upon the use of another set of criteria to measure satisfaction. These criteria are usually used to explore the beneficiaries' satisfaction through identifying their general perceptions and opinions towards issues related to health service delivery system (see Table 13 and Figure 13). The majority of women (51%) agree that medical referrals abroad need connections (favoritism), compared to (5.4%) only of men. Most women (50.3%) believe that the medical staff usually treats men better than women, which leads women to disagree with preferring public health services over private health services (43% of women and 13% of men). While 25% of men agree that pubic health services are available to everyone, only 6% of women agree. Similarly, while 52% of men agree on the ability to complain when facing a problem or being dissatisfied with the service, only (5%) of women agree.

Table 12: Assessment of satisfaction with health services according to gender

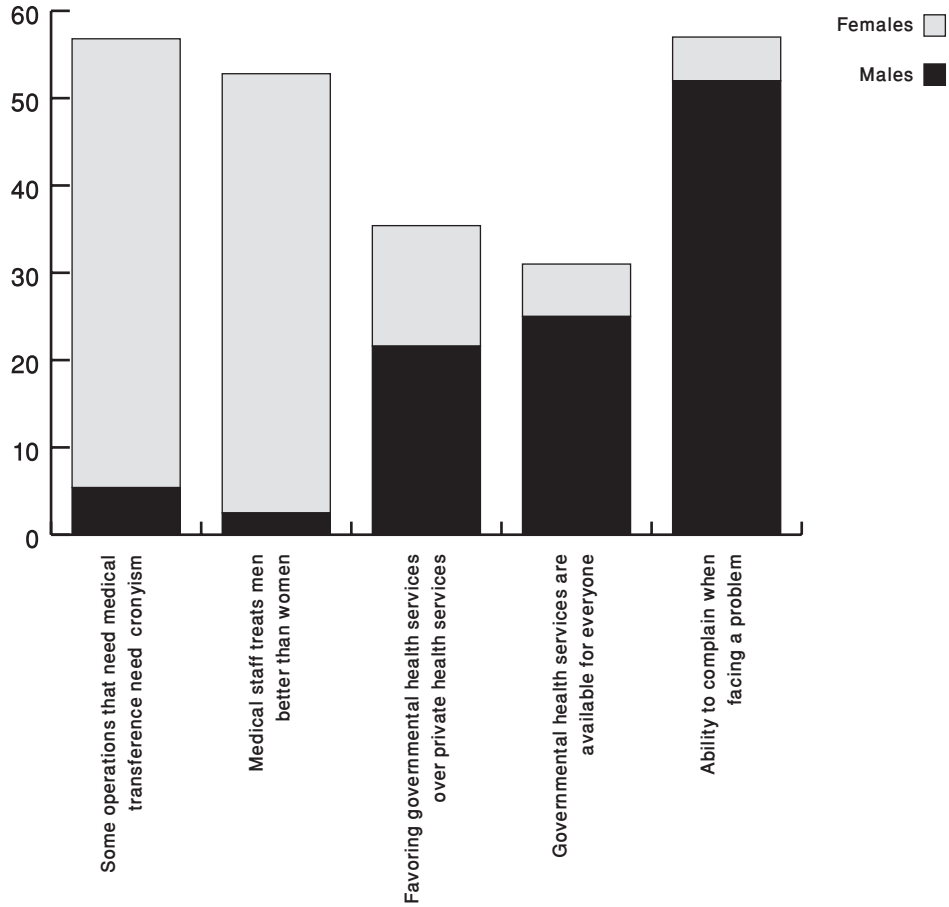
		Male		Female	
		Primary care	Secondary and tertiary	Primary care	Secondary and tertiary
Working hours	Satisfied	34.3%	-	46%	-
	Somewhat satisfied	8.3%	-	7%	-
	Dissatisfied	1%	-	2.5%	-
Order	Satisfied	27.5%	-	38.3%	-
	Somewhat satisfied	10.8%	-	11.8%	-
	Dissatisfied	5.4%	-	6.4%	-
Hygiene	Satisfied	24.5%	26%	36.3%	26%
	Somewhat satisfied	12.3%	8.8%	13.3%	14.2%
	Dissatisfied	6.9%	8.3%	6.9%	14.7%
Convenience of patients' waiting rooms	Satisfied	22.5%	12.7%	28.4%	20.6%
	Somewhat satisfied	9.8%	12.3%	12.7%	%13.2
	Dissatisfied	11.3%	18.1%	15.2%	21%
Availability of medicines	Satisfied	15.7%	17.6%	20%	27.9%
	Somewhat satisfied	16.7%	14.2%	20.5%	18.1%
	Dissatisfied	3.1%	11.3%	14.7%	8.8%
Availability of specialized doctors	Satisfied	22%	19.1%	29.4%	30.8%
	Somewhat satisfied	8.8%	14.7%	15.7%	14.7%
	Dissatisfied	12.7%	9.3%	11.3%	8.8%

Availability of equipment	Satisfied	17.6%	-	26.5%	-
	Somewhat satisfied	15.2%	-	22%	-
	Dissatisfied	10.3%	-	7.4%	-
Availability of laboratories and laboratory examinations	Satisfied	23%	26%	36.8%	33.3%
	Somewhat satisfied	18.1%	13.7%	15.2%	14.7%
	Dissatisfied	2.5%	3.4%	4.4%	6.4%
The efficiency of the provided service and its responsiveness to therapeutic needs	Satisfied	22.5%	23%	32.3%	28.9%
	Somewhat satisfied	15.7%	15.7%	19.6%	19.6%
	Dissatisfied	5.4%	4.4%	4.4%	6.3%
Treatment of medical staff	Satisfied	28.9%	27.9%	43.6%	33.8%
	Somewhat satisfied	10.8%	8.8%	9.8%	16.1%
	Dissatisfied	3.9%	8.8%	3%	4.9%
Treatment of nursing staff	Satisfied	30.9%	27.9%	42.4%	34.3%
	Somewhat satisfied	7.8%	10.3%	10.3%	14.2%
	Dissatisfied	4.9%	4.9%	3.9%	6.4%
Treatment of administrative employees	Satisfied	29.9%	29.9%	42.2%	31.4%
	Somewhat satisfied	11.8%	9.8%	10.3%	19.6%
	Dissatisfied	1.9%	3.4%	3.9%	3.9%
Availability of necessary medical information	Satisfied	22.5%	18.6%	27.9%	20%
	Somewhat satisfied	9.3%	11.3%	7.8%	12.7%
	Dissatisfied	11.3%	13.2%	20.5%	21%
Level of privacy in discussions	Satisfied	-	18.6%	-	20.6%
	Somewhat satisfied	-	8.8%	-	15.7%
	Dissatisfied	-	15.7.%	-	18.1%

Table 13: Assessment of the beneficiaries' general perceptions towards health service delivery

		Male	Female
Some operations that need referrals require favoritism	Agree	5.4%	51.4%
	Somewhat agree	7.4%	10.3%
	Disagree	11.8%	15.2%
Medical staff treats men better than women	Agree	2.5%	50.3%
	Somewhat agree	9.3%	8.3%
	Disagree	31.9%	42.2%
Prefer pubic health services to private health services	Agree	21.6%	13.8%
	Somewhat agree	9.8%	11.8%
	Disagree	13%	43%
Public health services are available to everyone	Agree	25%	6%
	Somewhat agree	15.7%	22.5%
	Disagree	8.3%	8.8%
Ability to complain when facing a problem	Agree	52%	5%
	Somewhat agree	2.9%	11.3%
	Disagree	9.8%	16.7%

Figure 13: Assessment of the beneficiaries' general perceptions towards health service delivery



Conclusions and recommendations

This study aimed at providing a gender-perspective diagnosis and analysis of the public health sector in the Palestinian Territories. In its analysis of the health system and the reality of public health, the study relied on official data provided by MOH and PCBS, in addition to reviews of previous studies and reports. On the other hand, opinions of representative samples of female and male beneficiaries of MOH primary, secondary, and tertiary services were surveyed. The findings of the survey identified the most important gaps between men and women in health and access to health services, as it clarified the concentration of health needs among women; despite revealing a higher level of satisfaction with delivered services, women continue to face multiple difficulties in access to health facilities, believe that public health facilities do not have all the medical services they need, and believe that favoritism in medical referrals outside the pubic health sector continues to exist.

Despite the progress in the scale and type of public health services during the past few years, such as the notable increase in maternity and childhood centers, the number of beds for women at the secondary and tertiary health facilities, and health programs dedicated to women health, it is not yet clear that "the attributes of both sexes" are taken into consideration upon the identification of aims and activities, allocation of resources, and in the outcomes of various health programs. All health service providers, particularly MOH, as the backbone of the health sector in Palestine, must exert additional efforts to achieve the goals of gender justice and equity in health delivery and access to health services.

Recommendations

- **Develop MOH capacity in gender based analysis and planning**, to ensure that all levels of MOH operations include analyses of gender roles and gender attributes in health and adequate planning.
- **Gender mainstreaming of the operations and programs of Ministry of Health and all service providers,** since engendering a results-based management, planning and budgeting and monitoring and evaluation, shall effectively promote equal opportunity between sexes.
- **Raise awareness of workers in health institutions towards gender concepts and their role in shaping different health patterns.** This is a necessary condition to identify obstacles that impede achieving gender justice in health, since workers in the health professions should have a fundamental understanding of the subject, and develop their capacities to analyze gender and health conditions.
- Adopt a gender-perspective **within the goals of human resource development,** increase women representation in senior administrative positions, and identify mechanisms to ensure gender balance in all administrative and oversight positions.
- **Invest in strengthening health care systems,** including access to reproductive health to ensure long term and sustainable improvement in mother, infant, and child health; combat diseases; incorporate social protection and social security network programs in the broader national and social policies and the national developmental strategies, and build statistical capacities in designing, implementing and monitoring health policies and programs.

- **Promote gender disaggregated data,** adopt gender indicators to identify programs and conduct program assessments using these indicators, focusing on setting up a structure for monitoring the implementation of plans to achieve identified goals.
- **Encourage quantitative and qualitative researches** to analyze the compound impact of social and cultural factors on health and alleviate any gender-bias in health information and research. Moreover, conduct further research to examine the aspects and causes for the health disparities between both sexes, especially in chronic diseases and in the determinants of health care use.

References

- World Bank, 2007, Public Expenditures Review: From Crisis to larger financial Autonomy.
- World Bank, 2005, Gender and Development in the Middle East and North Africa.
- United Nations Development Program, Gender Initiative and Citizenship, http://gender.pogar.org
- United Nations Development Program, Human Development Report, 2008
- Palestinian Ministry of Health, Palestinian Health Information Center, 2009, The Health Status in Palestine 2008.
- Palestinian Ministry of Health, Palestinian Health Information Center, 2009, The Health Statistical Report, First Quarter 2009.
- Palestinian Ministry of Health, The Health National Strategic Plan: Mid-Term Development Plan (2008-2010).
- The Palestinian Initiative for the Promotion of Global Dialogue and Democracy-MIFTAH , 2008, towards a Gender-Responsive Budget , Sectoral studies.
- Palestinian Central Bureau of Statistics, 2004, Preliminary Findings of the Health Expenditures Survey.
- Palestinian Central Bureau of Statistics, 2006, The Health Demographic Survey.
- Palestinian Central Bureau of Statistics, 2005, Survey of Health Service Providers and Beneficiaries.
- Mark Roberts, 2005, A Review of the Health Sector. Abu Zaineh, M., Mataria A., et al, (2009). Equity in health care finance in Palestine: the triple effects revealed, Journal of Health Economics.
- Elsong, D. (1997). Tools for gender integration into macroeconomic policy. Gender and Development, 2, Summer, p 13.
- Mataria, A., Khatib, R., Donaldson, C., Bossert, T., Hunter, D., Alsayed, F. and Moatti, J.-P. Agenda for a health care system in the occupied Palestinian territory. The Lancet 2009.
- Chen, L., Evans, T., Anand, S. , et al. (2004), Human resources for health: overcoming the crisis. The Lancet, Volume 364, Issue 9449, 2004.
- Giacaman, R., and Khatib, R., (2009). Promoting health for Palestinians. Lancet, Volume 373, Issue 9666, Page 801, 7 March 2009.
- Guidelines for the Analysis of Gender & Health, Liverpool School of Tropical Medicine, 2008.
- Gender Inequality and Health Sector Reform, Policy Briefings for Health Sector Reform, Liverpool School of Tropical Medicine, 2000.
- WHO (2008). Monitoring the Health Sector in the occupied Palestinian territory, series reports.
- WHO (2002), Gender Analysis in Health: A Review of Selected Tools. Geneva, Department of Gender and Women's Health, World Health Organization.
- WHO (2000) Gender Working Group, Gender Policy for WHO. Geneva, World Health Organization.

- Kuga Thas A, Surgey D, Abdullah R., (1996) Women-centred and Gender-sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific: Health Resource Kit. Kuala Lumpur, Asian-Pacific Resource and Research Centre for Women (arrow).
- Gorman, K., Ghazal J., (2006) Gender disparities in adult health: An examination of three measures of morbidity. Journal of health and social behavior, 2006, vol. 47, no2, pp. 95-110.
- Tolhurst, R., de Koning, K., Price, J. J., Kemp, S. Theobald and Squire, S.B., (2002). The Challenge of Infectious Disease: Time to Take Gender into Account. Journal of Health Management, 2002, Vol.4, 135.
- Vlassoff, C. (1994). Gender inequalities in health in the third world: Unchartered ground. Social Science and Medicine, 39(9): 1249-59.
- Vlassoff, C. and E. Bonilla (1994). Gender-related differences in the impact of tropical diseases on women: What do we know? Journal of Biosocial Science, 26, 37-53.
- Tanner, M., Vlassoff, C. (1998). Treatment Seeking Behaviour for Malaria: A Typology based on Endemnicity and Gender, Social Science and Medicine Vol.46, Nos 4-5. pp. 523-532.
- Paltiel, F., (1993) Women's mental health: a global perspective in Koblinksy, M., Timyan, J., and Gay, J. (eds.) 1993. The Health of Women: A Global Perspective Westview Press.
- Pampel, Fred C., Patrick M. Krueger, Justin T. Denney (2009). Socioeconomic Disparities in Health Behaviors, Annual Review of Sociology. Volume 36, Aug 2009.
- Pritchet, L. (1994) . Desired Fertility and the Impact of Population Policies. Population and Development Review 20 (1):1-55.
- Schofield, Toni (2009). Gender and health inequalities: what are they and what can we do about them? Australian Journal of Social Issues September 22, 2008.