



GENDER & HEALTH PLAN 2018-2020

SAHRAWI MINISTRY OF PUBLIC HEALTH

Gender & Health Plan

2018 - 2020



SAHRAWI REFUGEE CAMPS

July 2018

TECHNICAL DATA SHEET:

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ACRONYMS

PHC	Primary Health Care
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
RTH	Right to Health
ICPD	International Conference on Population and Development
SRC	Sahrawi Refugee Camps
SRR	Sexual and Reproductive Rights
GID	Gender in Development
STIs	Sexually Transmitted Infections
MPH	Sahrawi Ministry of Public Health
SDO	Sustainable Development Objectives
SO	Specific Objective
NGO	Non-Governmental Organization
NGOD	Non-Governmental Organizations for Development
UNO	United Nations Organization
WHO	World Health Organization
PAHO	Pan American Health Organization
CSO	Civil Society Organizations
SHP	Strategic Health Plan
NCDP	National Chronic Diseases Program
NRHP	National Reproductive Health Program
SICHP	Sahrawi Integral Children's Health Program
SADR	Sahrawi Arab Democratic Republic
GR	Gender Review
HIS	Health Information System
SRH	Sexual and Reproductive Health
AU	African Union
SARIOYU	Saguia al-Hamra and Rio de Oro Youth Union
SWNU	Sahrawi Women National Union

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PRESENTATION

Institutionalization of gender equality can be understood as the process by which institutions integrate the gender approach through specific procedures and processes, incorporating it into existing routines and norms, making it an important part of institutional practices, the organizational structure, and the definition of the organization's objectives and methodologies. Institutionalizing gender therefore implies translating the political will towards equality between men and women, not only in formal commitments and agreements, but also in strategic planning, organizational culture, budget, organizational structure and working procedures, information and communication systems, or monitoring and evaluation systems¹.

In the health area it is not an end in itself, but a process that helps to better direct health policies towards the needs of citizens based on the principle of equality; a process that promotes a fairer and more efficient distribution of resources in the development of the right to health (RH), and which involves all actors and agents involved in health policy and committed to its protection and guarantee.

The **Gender and Health Plan (2018-2020)** of the Sahrawi Ministry of Public Health (MPH) aims to help incorporate the gender perspective into the Sahrawi health policy, consistently with Line 3. *Incorporating the gender perspective in health*, under Strategic Health Plan 2016-2020 (henceforth SHP 2016-2020). The Gender and Health Plan has been created based on the Gender and Health Strategic Lines Framework Document, produced in the first phase of the Plan preparation process. The Framework Document offered an initial diagnosis and helped all the agents involved to reach a consensus about a first context approach, as well as the priority areas of work on which the Gender and Health Plan (2018-2020) measures have been designed.

The first chapter of the Plan presents the regulatory, theoretical and instrumental framework that justifies and guides the diagnostic approach contained in the second chapter. This framework and the main diagnostic conclusions guide the Plan objectives set out in chapter three and shape the map on which the proposals for action presented in chapter four are drawn up. The fifth chapter contains a technical data sheet for each of the measures and actions identified, with a six-month schedule included in chapter six. Finally, chapter seven describes the Plan monitoring system and the indicator scoreboard.

The process entails an enormous technical and strategic challenge that requires the creation of participatory planning spaces in which a shared vision and commitment to the process is progressively built. With these principles of action, the outcome will undoubtedly be a better development of the RTH for the entire Sahrawi population, based on equality, efficiency, innovation and quality criteria.

¹ Rico, N. (2001). The project Institutionalization of the gender approach in ECLAC and sectoral ministries. In N. Rico and L. Bravo (coop). Santiago, Chile: ECLAC. Available at: http://repositorio.cepal.org/bitstream/handle/11362/6485/S01121081_en.pdf?sequence=1.

1. THEORETICAL, REGULATORY AND INSTRUMENTAL FRAMEWORK

The decisive incorporation of the gender perspective into the Sahrawi health policy included in the SHP 2016-2020 means the consolidation of the sustained effort that the MPH has been making to direct health policy towards the health needs of its population, improving equality and the quality of the Ministry's performance. This line of work helps to align the Ministry of Public Health's responsibility regarding the respect for and protection and guarantee of the RTH of the Sahrawi refugee population with the international and regional regulatory frameworks for gender equality promotion. Similarly, experience shows that inequality between men and women is a vulnerability factor and a key determinant in the health of populations; and that the achievement of adequate health standards requires the incorporation of the gender perspective into all phases of health policy and at all health planning, management and decision-making levels.

The MPH Gender and Health Plan is based on this regulatory, theoretical and instrumental framework that justifies and guides the diagnostic approach, the priority lines of action and the specific measures included in the following sections of the document.

1.1. Gender & Health

Men and women have the same right to health and although they face many similar health problems, they have **different epidemiological profiles** depending on factors and determinants affecting their health, both biological and those related to the characteristics of their organization and social interaction. Therefore, the protection and promotion of the RTH requires that health policies recognize that men and women have different needs, obstacles and opportunities².

Men and women are biologically different and therefore have different health risks depending on **biological factors** -genetic, hereditary, physiological, etc.- that condition their respective epidemiological profiles. In addition, the health of men and women is conditioned by risks derived from **cultural and social factors** associated with the roles and stereotypes that each society assigns them, by the different capacity of access to health services and resources, or by the unequal capacity to make decisions about their own health. Gaps in access to education, nutrition, employment or income also condition the differentiated opportunities for men and women to enjoy good health³.

² Amo, M. (2008). Guide to facilitate the incorporation of a gender perspective into health plans. Regional Government of Andalusia. Regional Ministry of Health.

³ WHO (2009). Women and health: today's data, tomorrow's agenda [online]. Available at: http://www.who.int/gender/women_health_report/en/

WHO (2010). Gender, women and primary health care renewal. A discussion paper [online]. Available at: <http://apps.who.int/iris/handle/10665/44430>

PAHO (2007). Gender inequity in health: unequal, unjust and inefficient. Why it exists and how we can change it. Network of Knowledge in Women and Gender Equity [online]. Available at: http://www.paho.org/hq/index.php?option=com_content&view=article&id=1503%3A2009-la-inequidad-genero-salud-desigual-injusta-ineficaz-ineficiente&catid=3344%3Agender&Itemid=40517&lang=en

The **gender and health perspective** shows how gender inequalities are an obstacle to the development of the RTH based on the principle of equality and non-discrimination, and offers very relevant information when it comes to directing and planning health policy. Thus, for example⁴, *availability*, in terms of the number of resources, goods and services available for the fulfilment of the right to health, is closely related to the definition of priorities and budgetary allocation, which are decision-making spaces where women tend to be less represented. *Accessibility* is linked to non-discrimination in the provision and the geographical, cultural or economic scope and, in this sense, women tend to have fewer mobility resources, less access to economic resources or greater pressure from cultural norms. The *quality* of services, both technical and human, relates to meeting the expectations of those who provide the services, as well as those who receive them. Quality is increased by paying attention to the differentiated needs of men and women and by opting for caring and for confidentiality criteria that favour women's access and satisfaction. *Acceptability* in relation to the cultural values of rights holders requires a review of these values from a gender perspective and according to the life cycle.

In addition, it should be pointed out that **participation** is a fundamental RTH principle that requires a specific effort by all the agents involved (both from the Ministry of Public Health itself and from the rest of the holders of responsibilities such as international agencies and NGOs) to promote higher participation by women at all levels, both in decision-making on their own health and in their capacity to influence the social determinants of health.

The gender and health perspective therefore helps to identify possible breaches in the implementation of the RTH between men and women and, as a **political commitment**, calls for the promotion of specific measures to transform these inequalities. The gender perspective on health also implies an unquestionable **technical challenge** for health systems in the strengthening of their capacities to reduce the health risks specific to men and women, and to identify their respective opportunities to enjoy good health. This health policy challenge also involves transforming the gender awareness and sensitivity of health professionals and strengthening their knowledge in the handling of health gender determinants that affect women, not only as consumers, but also as essential health care⁵ providers.

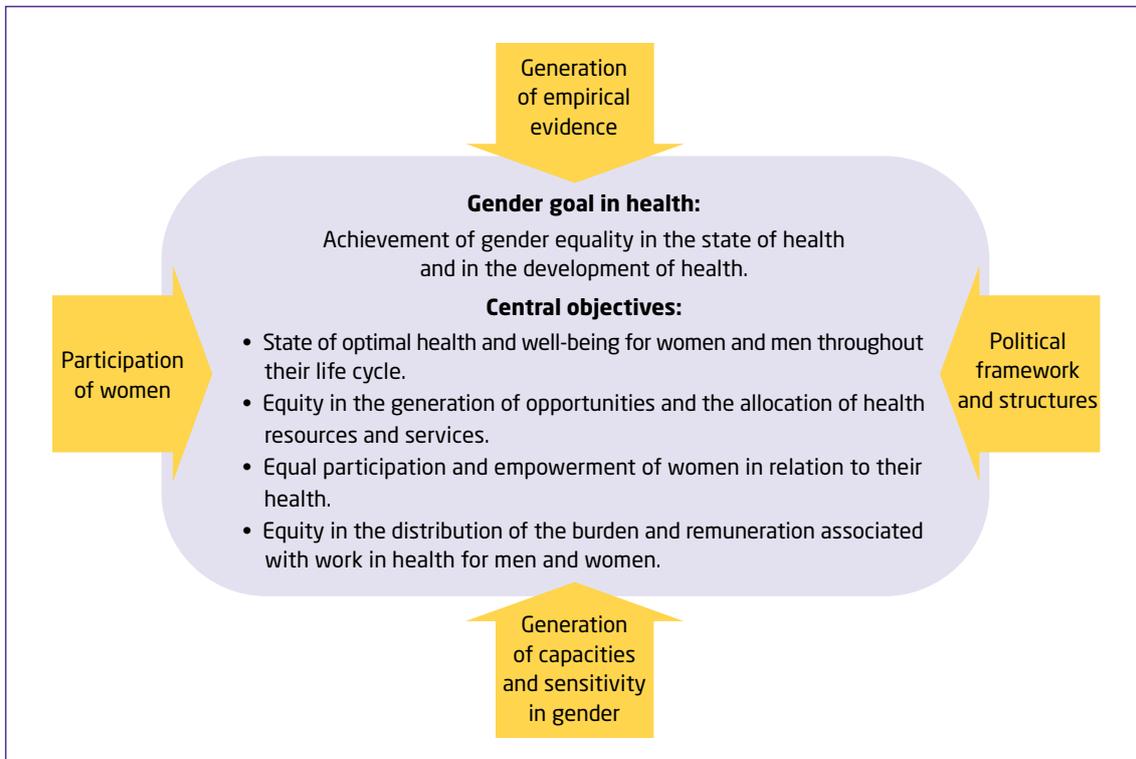
In all contexts, the **analysis of responsibilities and the distribution of power** in the sector is a key element from a gender and health perspective, because although most health workers are women (with and without remuneration), they have less power to influence health policy and decision making, as they concentrate at the base levels of the sector's workforce. Women are also the **main care providers** in the family environment due to their assigned social role and the health policy has to take into account this circumstance, which often leads to work overload, time poverty, difficulties in reconciling professional and

⁴ Prepared by the author, on the basis of ISI (2010). *Guide for the inclusion of the human rights-based approach in cooperation interventions for development*. Madrid: IUDC.

⁵ PAHO (2007).

personal life, as well as emotional and physical exhaustion with a significant psychological impact. In cultural terms, women also tend to be the main health promotion and prevention generators, without the social value of this work being visible and recognised. Health policy must take these circumstances into consideration and, from a perspective of social and public co-responsibility, improve the conditions in which prevention and health promotion work is carried out, strengthening the **community approach** to this type of interventions, policies and initiatives essential for the development of health at primary health care (PHC)⁶ level.

Graph 1. Strategic areas for the institutionalization of gender in health



Source: Prepared by the author based on adaptation from PAHO, 2010 (p.6).

⁶ The various world conferences on health promotion, held within the WHO framework, and their corresponding declarative and operational documents, have highlighted the role of women as community health workers, and specific recommendations for gender perspective inclusion have been made. Recommendations include: the Ottawa Charter for Health Promotion (1986), Adelaide Recommendations on Public Health Policies (1988), Sundsvall Declaration on Appropriate Environments for Health (1991), Jakarta Declaration on Health Promotion in the 21st Century (1997), Mexico Ministerial Declaration on Health Promotion: From Ideas to Action (2000), the Bangkok Charter for Health Promotion in a Globalized World (2005) or the Declaration of the 9th Global Conference on Health Promotion (Shanghai, 2016). http://www.who.int/healthpromotion/Milestones_Health_Promotion_05022010.pdf?ua=1 and <http://www.who.int/healthpromotion/conferences/9gchp/es/>

The inclusion of the gender perspective in health policy therefore requires the development of the following essential capabilities⁷:

- Identifying the **state of health** (prevailing diseases and intensity by gender) and the **health determinants** for men and women throughout their life cycle (differentiated biological, social and cultural risk and protection factors).
- Identifying the **obstacles to access** health services and resources (including transport, access to information, decision-making capacity, availability of economic resources and time).
- Identifying the **response and differentiated impact** of health policies and programs and their extent to change gender views (whether a change in inequalities, in the balance of power or in gender beliefs and stereotypes is attained).
- Recognizing women's contribution to health provision, and addressing the responsibilities and distribution of decision-making power and remuneration for **work in the health sector** (in the formal and informal systems).
- Increasing the **capabilities** and improving the **conditions** of women, adolescents and girls for their enjoyment of good health and strengthening their **control** and decision-making over their health.
- Generating **epidemiological data** differentiated by gender and age and promoting **studies and research** that take into account women's health and illness processes and results.
- **Development of gender sensitization and** gender and health **capabilities** for all health and management personnel.

These basic capabilities are common to all contexts and establish the essential guidelines for the design of the roadmap to include the gender perspective in health policies.

1.2. Regulatory framework

The inclusion of the gender perspective in public policies and development policies is widely supported by international regulatory frameworks, in which equality between men and women is considered a core objective in the promotion of spaces for coexistence focused on the well-being of people, on the promotion of social cohesion and on the fulfilment of human rights under the principle of equality and non-discrimination. The main regulatory instruments supporting the commitment to gender equality include the 1979 **Convention on the Elimination of All Forms of Discrimination against Women** (CEDAW) and the **Fourth World Conference on Women** (Beijing, 1995), which made a decisive contribution to promoting the **Gender and Development Approach** (GAD approach) as the most effective way to achieve equality.

⁷ Prepared by the author based on WHO (2009, 2010) *Ibidem* and PAHO (2010). *Gender equality in health: Greater equality and efficiency in achieving health for all* [online]. Available at: <http://www.paho.org/hq/dmdocuments/2010/gender-equality-in-health-sp.pdf>

The GAD approach emphasizes the structural causes of inequalities and of the violation of rights, and inspires the creation of **comprehensive and transforming policies** that promote changes in the distribution of resources, opportunities for participation and decision-making, changes in institutional norms and practices, and also in the awareness of women and men and in cultural values and stereotypes that can lead to discrimination and exclusion⁸.

In 2015, the international community adopted the **2030 Agenda for Sustainable Development** (2015), a universal agenda for all countries, in which this commitment to equality is strengthened by mainstreaming the gender approach in the 17 Sustainable Development Goals (SDG), among which a specific one is also formulated, aimed at “Achieving gender equality and empowering all women and girls” (SDG 5). **SDG 5** includes a goal on “Ensuring universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Action Program of the International Conference on Population and Development, the Beijing Platform for Action and the outcome documents of its review conferences”. For its part, **SDG 3**, aimed at “Ensuring a healthy life and promoting well-being at all ages” also includes targets aimed at reducing maternal mortality, promoting universal health coverage and, in particular, a target for universal access to comprehensive sexual and reproductive health (SRH) services.

The gender perspective and the promotion of women’s right to health are also reflected in **General Comment No. 14** (2000), on the right to the highest attainable standard of health, by the Committee on Economic, Social and Cultural Rights. In the area of sexual and reproductive rights (SRHR), mention should be made of the **International Conference on Population and Development** (ICPD, Cairo, 1994), which goes beyond the term mother-and-child health, and definitively assumes the rights-based approach and the importance of SRHR as part of human rights. The ICPD and the ICPD+20 review emphasize the need to make further progress in achieving equality and to promote higher women’s empowerment in the area of health, as well as men’s involvement in reproductive responsibilities.

For its part, the commitment of the **African Union (AU)** to gender equality is reflected in various declarations and documents, such as Article 4 of its Foundational Memorandum, the *Protocol on Women’s Rights in Africa* and the *Solemn Declaration on Gender Equality in Africa* (2004). In January 2010, the Assembly of the African Union adopted the *Women’s Decade (2010-2020)*, the objectives of which are linked to the Beijing Platform for Action and the ICPD agenda, among other regional commitments. With regards to SRHR, mention should be made of the *Maputo Plan of Action on Health and Sexual and Reproductive Rights* for the implementation of the *Continental Policy on Health and Sexual and Reproductive Rights* (2006), the *Plan of Action against Trafficking of Human Beings, particularly Women and Children* (2006), the *African Health Strategy* (2007-2015) or the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA).

⁸ For more information on the gender transforming approach see *Gender at Work Framework* and UN Women (2015). *Gender Equality and Human Rights. Discussion Paper* [on line]. Available at: <http://www.unwomen.org/en/digital-library/publications/2015/7/dps-gender-equality-and-human-rights>

Attaining gender equality is also contained in **Goal 17** related to “Full gender equality in all spheres of life”, included in **Agenda 2063**, which sets out regional development priorities for the coming years. The gender perspective is also integrated and mainstreamed in the other objectives and goals set by the Agenda in the areas of employment, political participation and governability, education, health, etc⁹.

The **SADR Constitution** (1999) includes an article¹⁰ aimed to consolidate the equality of “all citizens” and another article¹¹ focusing on women’s promotion, although specific equality policies aimed at the development of this principle have not been generated. In recent years, higher attention has been paid to the gender agenda, encouraged by the active policy of the National Union of Sahrawi Women (NUSW) in order for women to hold decision-making positions, which is embodied in the *Quotas Act of 2013*, which calls for at least 30%¹² women.

1.3. Gender & Health Plan

The systematic integration of the gender perspective into health policy requires political, technical and human resources and necessarily implies a process of change also within the actual institution responsible for its design and provision. In this process to institutionalize the gender perspective, two complementary and simultaneous strategic lines of action can be identified¹³:

- “Inwards”: the systematic inclusion of the gender perspective within the MPH itself, taking into account aspects related to the political framework, structures and processes, human resources and budget management, etc.
- “Outwards”: the systematic inclusion of the gender perspective in health care policies and actions generated by health programs.

Consistency between the two levels is essential for the successful institutionalization of gender and for the achievement of the objectives of guaranteeing the RTH for the entire population under the principle of equality, and of producing changes in the visions and patterns of organization and relationship that may have an effect on women’s health and on their participation in the social, economic, political and cultural life of the Sahrawi Refugee Population Camps (SRCs).

⁹ AU (2015). *Agenda 2063. The Africa we want* [on line]. Available at: https://au.int/sites/default/files/pages/3657-file-agenda2063_popular_version_en.pdf, AU (2016). *African gender scorecard* [on line]. Available at:

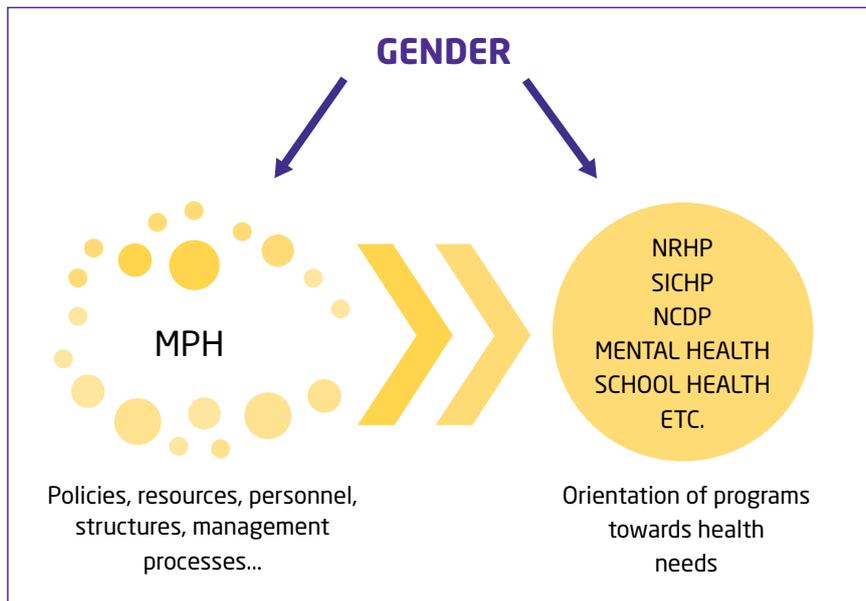
https://au.int/sites/default/files/documents/31260-doc-2015_auc_african_gender_scorecard_en.pdf

¹⁰ Article 25 of the 1999 SADR Constitution adopted at the 10th National Congress of the Polisario Front: “All citizens are equal before the law, both for protection and for sanction”.

¹¹ Article 41: “The State shall pursue the promotion of women and their political, social and cultural participation in the construction of society and the development of the country”.

¹² Currently, women represent 34% of Parliament, 48% of the presidencies of *dairas*, 17% of the diplomatic staff abroad and 50% of the governors and there is also a woman in the Consultative Council of the SADR Government Delegation. (interview with Fatma Al Mehdi, president of the NUSW).

¹³ Adapted from López, I. (2007). *The gender approach in social intervention*. Madrid: Red Cross. Page 39.

Graph 2. Gender consistency between the MPH internal and external levels

Source: prepared by the author.

Despite this need for consistency between the two levels, organizations and institutions have tended to prioritise gender work outwards, adopting gender-sensitive methodologies and planning tools for the design, implementation, monitoring and evaluation of health interventions and policies. Evidence, however, has shown that work within the organization is a *sine qua non* condition, since it implies the development of the essential capabilities indicated above, for the implementation and consolidation of the gender and health perspective.

This is why the Gender and Health Plan (2018-2020) emphasizes these “inwards” measures as a strategic priority area in the process for gender perspective institutionalization. Both the diagnostic approach and the proposals for progress focus on identifying the main institutional, organizational and technical weaknesses and, derived from these, the main **priority lines of action** within the Ministry of Public Health itself.

This orientation of the Plan aligns with the priorities set by SHP 2016-2020 in the formulation of Line 3. *Incorporating the gender perspective in health*, and of specific objectives (SO) and gender goals in other Lines. It should be noted that the current SHP represents a decisive commitment¹⁴ as it incorporates the gender perspective in health by including this Line 3 among the 6 strategic Lines covering the main areas of intervention, which “must set the criteria to measure the relevance and adequacy of activities, the internal and functional organization of health services, and even of projects and programs developed from the Ministry of Public Health and with other actors”¹⁵.

¹⁴ The SHP (2011-2015) included social and gender equality as one of its inspiring management and action principles; however, no specific measures were established to channel this principle.

¹⁵ MSP (2015), *Strategic Health Plan 2016-2020*, page 29.

These 6 Lines are based on four values that foster the gender perspective: understanding health as a human right for everyone, without regard to race, sex (...); free, universal and equitable access to preventive health services and according to each individual's needs (...); efficient management; and community participation¹⁶.

Table 1. SHP (2016-2020) strategic lines and gender SOs

STRATEGIC LINES		GENDER-SPECIFIC SOs
Line 1.	Improving the management and performance of health personnel.	SO. 5 To implement a policy that improves working conditions and family and work reconciliation, making it easier for women to hold decision-making positions (Goal 4).
Line 2.	Increasing the coverage and improving the quality of basic services (preventive and assistance).	
Line 3.	Mainstreaming the gender perspective in health.	SO. 12 To increase access to resources and benefits for health care workers and users. SO. 13 To increase women's participation in decision-making about their health and at the health policy level. SO. 14 To achieve institutionalization of gender in legislation, political and declarative documents and in operational management. SO. 15 To improve the training in health and gender of the MPH staff and the different centres.
Line 4.	Improving information transparency and accountability.	SO. 17 To develop health communication and promotion plans to increase the acceptability of services and programs among men and women, in coordination with CSOs and NGOs (Goal 18).
Line 5.	Strengthening inter-sector collaboration, and with other agencies and organizations, and civil society participation.	SO. 21 To encourage the coordination and signing of agreements with civil society organizations for their participation in health (Goal 22 specifies reaching agreements with women's organizations).
Line 6.	Achieving political and humanitarian commitment for sustainable financing of the health sector.	

Source: Prepared by the author on the basis of SHP (2016-2020).

¹⁶ *Idem.*

The gender and health perspective implies understanding that **no policy and initiative is gender-neutral** and that, therefore, a policy or initiative has effects on the relations between men and women that, if not taken into account when planning, can affect adversely the advancement in imbalances. It is for this reason that all the Lines, SOs and the actions to be carried out have a gender reading, which is expected to be addressed in subsequent revisions and editions of the Gender and Health Plan, upon the current one coming to an end in 2020.

Table 2. Line 3 2020 targets. Mainstreaming the gender perspective in health

M. 11	Design and monitoring of a Gender and Health Plan of Action
M. 12	Universal coverage in all the daïras of the SRH services (pregnancy monitoring, delivery care, postpartum monitoring, family planning, health promotion, abortion prevention and treatment).
M. 13	Active participation of civil society women's groups and organizations in health analysis and decision-making.
M. 14	All declarative and operational documents refer separately to the needs of both sexes and to interventions aimed at meeting those needs.
M. 15	Inclusion of gender training in Staff Training Plans.

Source: SHP (2016-2020)

The **Gender and Health Plan** design process is consistent with Goal 11 of the SHP and, as mentioned above, the first edition focuses on identifying priority lines of action for the systematic "inwards" inclusion of the gender perspective in the Ministry of Public Health itself. These priority lines may also guide the work in other strategic lines and provide content input for a large part of the goals formulated.

However, from a comprehensive and integral point of view and as referred to in the theoretical framework, there are strategic areas that transcend Line 3 and which are common to all Lines and programs: the generation of empirical evidence through disaggregated data, specific studies and gender indicators, the development of capabilities and gender sensitivity, the participation of women at all levels and under equitable conditions, as well as the promotion of a monitoring, evaluation and accountability culture in relation to the objective of equality. For this reason, the Gender and Health Plan (2018-2020) also includes lines of progress in these areas.

2. DIAGNOSTIC APPROACH

The preparation of a Gender and Health Plan must necessarily start from a situation analysis as adjusted as possible, that is, from a participatory and shared diagnosis that reveals the differences and inequalities between women and men and their causes, and possible measures to correct the imbalances. To this end, it is necessary to identify needs, problems, points of interest and opportunities for improvement in gender equality in two directions: within the institution itself and towards the services and public policy actions carried out from the institution. The result of this analysis must necessarily be the definition of a list of priorities and objectives, and the application of action strategies, analysing the possible contingencies that may arise¹⁷.

2.1. Methodology

For the preparation of this Gender and Health Plan, progress was initially made in the drafting of a Strategic Lines Framework Document that included a first diagnostic approach that could offer data and significant information in two main lines. Firstly, on the degree of gender institutionalisation¹⁸ of the MPH, that is, on the integration of gender equality into the organization's daily practices and routines. Secondly, on the equality situation in the actual structure of the personnel responsible for management and the medical and health personnel, that is, their distribution by gender in the various groups and levels of responsibility, the incentive scheme, participation in the decision-making spaces, etc.

The diagnosis and the Framework Document were developed in different phases: a first think tank phase in which an approach was made to the available information on the context, the updated data on the health situation in the SRCs, the current planning and programs, and so on. Among other things, the results of the *Survey on health services users' satisfaction in the SRCs* (carried out in December 2017), the data provided by the health information system (HIS), as well as the documents of the *XVI Round Table* held in Rabuni in November 2017 and of the *Health Update Platform* were reviewed. Finally, the field work agenda was drawn up, where the key information providers for this study within the MPH were identified, at the political, technical and management levels. The agenda also included the identification of other agents - such as the NUSW, NOVA or the SARIOYU - who also play a role in guaranteeing the RTH of the Sahrawi population and, in particular, of Sahrawi refugee women.

The **second phase consisted in fieldwork development**, for which two female researchers¹⁹ were transferred to the SRCs for seven days. The experience gathered by the research team due

¹⁷ Spanish Federation of Municipalities and Provinces-FEMP (s.d.). *Guide to develop local plans for equality between men and women*. [on line]. Available at: <http://femp.femp.es/files/566-182-archivo/Guia%20elaboracion%20Planes%20Locales%20Igualdad.pdf>

¹⁸ Rico, N. (2000). *Gender approach institutionalization process in the substantive work of ECLAC*. [on line]. Available at: <https://www.cepal.org/publicaciones/xml/8/4318/ddr1e.pdf>

¹⁹ Consultants Alicia del Olmo and Marta Pajarín provided technical advice for the preparation of the Framework Document during the months of March and April 2018, within the framework of the Médicos del Mundo project "Access to health for the entire population, through a comprehensive strengthening of primary health care in the Sahrawi Camps in Algeria", financed by AECID.

to its involvement in past work conducted by Médicos del Mundo in the SRCs, the use of tools and methodologies and familiarity with the context, facilitated identifying the key actors faster and approaching the problem's situation in a relatively short period of time.

From the beginning, a participatory approach was chosen since for an organizational transformation process to be successful it is necessary to start from the information and consensus of the main responsible people who must feel involved in it. In addition, the use of participatory techniques with a gender perspective contributes to gender awareness and the empowerment of women and men, as well as to accumulating knowledge in this field²⁰.

A total of 8 individual and 4 group interviews were conducted, bringing together a total of 18 people. Subsequently, the information obtained through these interviews was analysed and some preliminary conclusions were shared in the final identification and design work meeting with the Ministry of Public Health, the main objective of which was to bring to light the information gathered during the work week and the joint analysis and shared identification of proposals for improvement in collaboration with the Ministry's staff. This meeting was attended by a total of 13 people, most of whom had been interviewed on previous days. The meeting was thus attended by people responsible for different ministerial departments (Cooperation, Healthcare and Personnel Directorates; Heads of dispensaries), medical and health personnel (nursing school teachers and midwives) and representatives of organizations such as the NUSW or the SARIOYU.

In a **third phase**, the information gathered was analysed in depth and the other MPH documentary sources were studied as relevant for obtaining work proposals for integrating the gender perspective into Sahrawi health policy.

Finally, during the month of May, the **phase for dissemination**, among the MPH staff, of the Strategic Guidelines Framework Document was implemented and a presentation was made to all the management staff. The comments and contributions made in these spaces guided the adjustment of the Document content with a view to the **phase for design and formulation** of the measures contemplated in the Health and Gender Plan (2018-2020).

2.2. Main diagnostic conclusions

Institutionalizing gender is the process by which practices aimed at equality become regular and continuous, are established by regulations and have a significant importance in the structure of organisations and in the definition of the objectives and methods adopted by an institution²¹. This process should not be construed as the addition of practices and activities to existing structures, but rather as a process of internal questioning, of change and innovation.

²⁰ Sojo, D.; Sierra, B. y López, I. (2002). *Health and Gender. Practical guide for cooperation professionals*. Madrid: Médicos del Mundo.

²¹ Rico, N. (2000).

As mentioned above, the purpose of this diagnostic approach is to determine the extent of gender institutionalization in the MPH, that is, the extent to which the institution itself integrates the gender perspective into its planning, management, provision of services, etc., and the situation of medical-healthcare and management personnel from the perspective of equality between women and men.

In order to incorporate the gender perspective globally and across an organisation, it is necessary to plan actions and strategies for change and the state of the gender equality situation needs to be studied at three main levels²²: the political framework, the structural level and the organisation's culture.

2.2.1. Political framework

The political framework refers to all the "substantial" content of the institution, i.e. the vision, mission, legal texts, strategic planning documents, and in general, its objectives, as well as the concept of policy that it promotes.

The existence of **political will** within an institution in relation to the need to advance in gender equality is fundamental to the success of an institutionalization experience. The current Sahrawi context is favourable in this respect, since the MPH expresses a clear commitment to join in the task of incorporating the equality approach into Sahrawi politics, centred on incorporating women into participatory and decision-making positions. In this respect, it can be affirmed that for some years²³ there has been a certain proactive environment from some institutions to integrate and give voice to women. This apparent open attitude, which can even be seen as a driving force behind women's participation in the political life of the SADR on the part of the institutions, coexists with certain manifestations about women's role in society and which restrict them to their reproductive role. Nevertheless, the Sahrawi authorities are making efforts to attract women to positions of greater responsibility and visibility.

In the health area, the MPH is openly positive towards an increase in women's presence in it, something that can have positive effects on policy planning in terms of decision-making and empowerment, following the path started by programs such as the National Reproductive Health Program (NRHP) within the Ministry.

At the same time, it can be seen that some of the main MPH strategic and planning documents already contain a gender perspective in their proposals. In fact, **SHP 2016-2020** represents a turning point in the health policy's commitment to advance gender equality, since it reflects "*the express commitment stated by the MPH to incorporate the gender perspective into health policy*"²⁴. In addition, although with some room for improvement, and as described in the previous section, some gender elements have been included in other Lines, as well as gender objectives in the aforementioned Plan, which are worth highlighting.

²² Sojo, D.; Sierra, B. y López. I. (2002).

²³ Pajarín, M. y del Olmo, A. (2015). *The right to health of the Sahrawi refugee population from a gender perspective*. Médicos del Mundo internal document.

²⁴ Ministry of Public Health (2015). *Strategic Health Plan (SHP) 2016-2020*.

Therefore a positive trend is observed in the last decade since in 2008²⁵ there was little visibility of a differentiated analysis of men's and women's health problems, beyond those that had to do with women's reproductive role. In fact, the two previous strategic health plans, SHP 2006-2010 and SHP 2011-2015, did not take any significant steps in relation to gender equality. This "window of opportunity" provided by SHP 2016-2020 is reinforced by the existence of international legal frameworks on health and gender as referred to in the section relating to the regulatory framework included in this document.

Although this improvement is observed in health policy **strategic planning** at the global level, this fact does not seem to extend to the planning documents of most of the Ministry of Health programs (programs, guides, internal documents, etc.). The Ministry currently has a total of seven programs in specific health areas, in addition to several cross-cutting programs:

Table 3. Sahrawi Ministry of Public Health Programs

Specific areas	Of a cross-cutting nature
National Reproductive Health Program (NRHP)	Awareness-raising and education
Sahrawi Integral Children's Health Program (SICHP)	Surveillance and epidemiology
National Chronic Diseases Program (NCDP)	
Mental Health Program	
School Health Program	
Celiac Disease Program	
Vaccine	

Source: Prepared by the author on the basis of information from the XVI Round Table.

According to the information gathered in this diagnostic approach, only the NHRP contains relevant aspects from a gender perspective, partly due to the joint effort made between the MPH and Médicos del Mundo for more than a decade. This program is undoubtedly an example of a successful experience in terms of **linking the gender perspective with improving the quality of health programs**. In fact, specific results²⁶ can be identified in the advancement of gender equality and Sahrawi women's empowerment, which have to do with their access to resources and benefits, with the increase in their participation in decision-making on their health and at the health policy level, and with a progressive gender institutionalization in the MPH²⁷.

²⁵ In 2008, as part of the work of Médicos del Mundo in the SRCs, the diagnosis *Gender and sexual and reproductive health in the Sahrawi refugee camp* was made, the results of which set out the guidelines for the organisation's work strategy in this health area. Subsequently, in 2015, this diagnosis was updated, and specifically, the situation of the health determinants in the SRCs, i.e., the factors that affect the set of activities, rights, obligations and opportunities of women and men, and their consequences for the health of the population.

²⁶ OECD (2009). *Management focused on results on gender equality in partner countries* [on line]. Available at: <http://www.oecd.org/dac/gender-development/43430647.pdf>

²⁷ Pajarín, M. and del Olmo, A. (2015).

The NRHP has helped to promote and strengthen the exercise of Sahrawi women's Right to Health and Sexual and Reproductive Rights. The trend followed in recent years suggests that there has been a solid increase in the use of the NRHP services and that these improvements have had a clear impact on Sahrawi women's health and on the reduction of maternal mortality.

The promotion of equitable access to quality SRH services at the PHC level is a priority line of work in guaranteeing the RTH of the Sahrawi refugee population from a gender perspective. In this respect, a sustained and progressive effort has been made to improve the population's access to SRH resources and services that transcend the mother-child approach, through the implementation and consolidation of the NRHP, in an attempt to simultaneously address all the essential components of safe motherhood and new-born care (prenatal care, delivery care, new-born care, mother-child nutrition, etc.), in addition to progressively including other SRH elements such as postpartum care, pregnancy spacing, contraceptive practices, STI awareness and prevention, etc., as well as greater consolidation of children's health through the development of the Sahrawi Integral Children's Health Program (SICHP).

Improving the fulfilment of such a relevant health need for Sahrawi women was achieved by trying to incorporate gender-sensitive measures such as promoting higher quality care and caring, improving their privacy and confidentiality and increasing their knowledge of reproductive health through institutionalised information activities during perinatal check-ups.

Another outstanding result from a gender perspective has been the visibility and recognition of the role played by women in maintaining the health of their community. The improvement in the economic and motivational conditions under which midwives carry out their work results in an increase in the quality of care. For this reason, the efforts made to improve their mobility and working conditions through measures related to remuneration, institutional consolidation (improvement to their working conditions), strengthening of knowledge and skills, and social and professional recognition were so important.

In addition, one of the most relevant results of the activities developed was the consolidation of the NRHP team, with a woman in its leadership, and the creation of an organizational structure for coordination at the national and regional levels which has taken control of the NRHP and can monitor the program, with regular spaces for information exchange and participatory management.

Over the years, considerable progress has been made in promoting informed and participatory health management thanks to the availability of increasingly reliable health information (through the development of the registration system and conducting studies and reports) and the creation of institutionalised spaces for communication, exchange and coordination between medical and health personnel and MPH senior officials.

Working together with women's organizations and strengthening them is a measure for women's empowerment, as a key strategy for achieving gender equality. The NUSW has been a strategic partner in improving access to reproductive health information and awareness.

However, there are few sector-based planning documents in the MPH and those that exist show that gender equality is hardly included in their objectives, actions and indicators. It can be stated that not enough institutional capabilities have been developed to work with a strategic and operational planning framework, with a timing (especially annual) definition of objectives, priorities and indicators helping towards monitoring and accountability. This weakness is an obstacle to gender institutionalisation, which requires processes guided and participated in by the personnel responsible for planning and management. At the same time, integrating the gender line may represent an opportunity to improve all Ministry's strategic and operational planning documentation.

In this respect, the program²⁸ documents do not include the cross-cutting gender line, despite the fact that the SHP mandate clearly refers to the obligation to include the gender line in planning, in its SO 14 "To achieve the institutionalisation of gender in legislation, political and declarative documents, and in operational management".

2.2.2. Structure

This level refers first to internal structures, that is, the distribution of women and men in different positions in the organisation and the responsibilities and tasks assigned to them, as well as recognition in economic terms, for access to resources and decision-making given to them. It is essential to study gender differences in the health system organization because inequalities in health personnel contribute to maintaining inequalities in the provision of services²⁹.

Secondly, it focuses on the analysis of institutional procedures, daily routines and activities in the different phases of the institution's activity, in decision-making processes, etc.

2.2.2.1. Analysis of the Ministry of Public Health personnel

The process of integrating gender into public policies requires an **analysis of the position occupied by women and men** in the definition, implementation and management of actions. The knowledge of the percentage of both sexes in the institution, and above all their presence according to levels of responsibility and decision, provides important conclusions on equal opportunities in the public sector and, in general, on the results of the measures to promote the balanced participation of women and men in all areas³⁰. In addition to aspects such as gender

²⁸ Within the framework of this work the following documents were revised: National Reproductive Health Program Guide (NRHP), Sahrawi Integral Children's Health Program Guide (SICHP), Clinical therapeutic manual for primary care, and the Health Promotion Guide.

²⁹ Sojo, D. y López, I. (2002). *Health and Gender. Practical guide for cooperation professionals*. Madrid: Médicos del Mundo.

³⁰ Regional Government of Andalusia (2010). *Gender impact assessment report of the Autonomous Community of Andalusia Budget for 2011*.

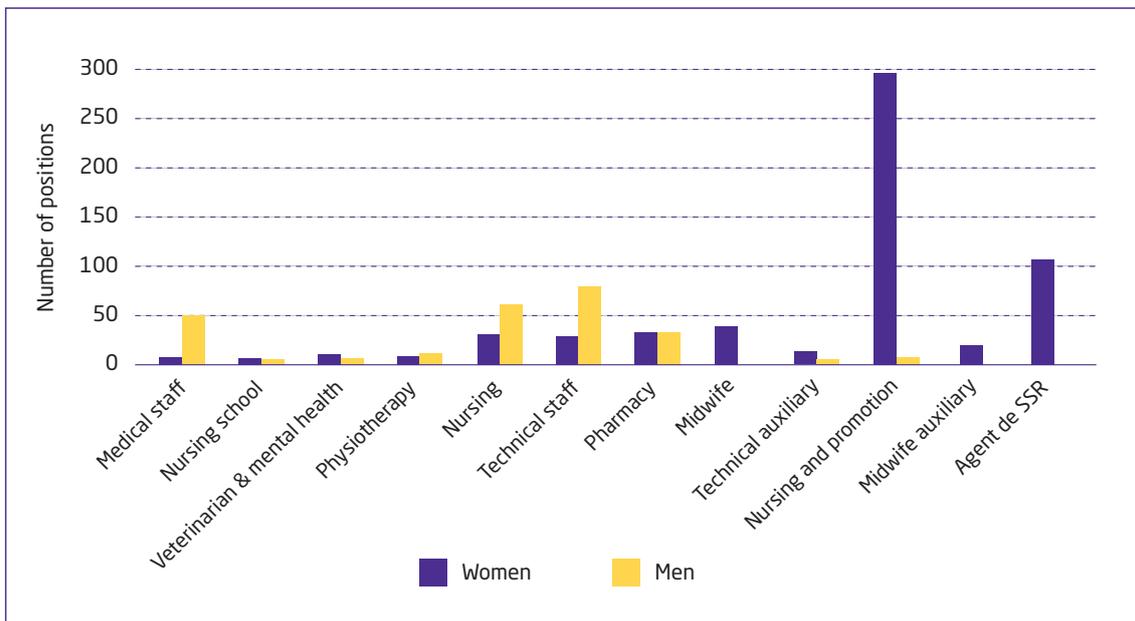
composition in each group and position of responsibility, the arrangement of remuneration, incentives and bonuses measures should be analysed, as well as the enjoyment of paid and unpaid leaves.

In the Sahrawi health sector, as in other contexts, the composition of personnel by gender is rather unequal depending on the different levels and areas of responsibility. In March 2018, the Ministry of Public Health had a total of **1,328 staff**³¹, of whom 59.8% were women and 40.2% were men.

According to the information provided by the MPH Training and Civil Service Directorate, the personnel employed by the MPH are made up of four differentiated groups. The first group, **medical and health personnel**, brings together all the professional categories in the sector: general and specialised medical personnel, veterinarians, mental health, nurses, midwives, different technical bodies (nutrition, vaccination, ophthalmology, stomatology, etc.), pharmacists, personnel responsible for health promotion and SRH community agents, etc.

Graph 3. Medical and health personnel disaggregated by gender (MPH, 2018)

(Categories in English from left to right: Medical staff, Nursing School, Veterinarians and Mental Health, Physiotherapy, Nursing, Technical staff, Pharmacy, Midwife, Technical auxiliary personnel, Nursing and promotion auxiliary personnel, Midwife auxiliary personnel, SRH community agent.)



Source: Prepared by the author on the basis of data provided by the Directorate-General for Training and Personnel.

Note: data from March 2018. Inclusive language on professional categories is not found in the original tables.

³¹ Data provided by the Training and Civil Service Directorate, MPH.

This group, made up of 851 individuals, is formed by 70% women and 30% men. Women are mainly found in the categories of midwife (97.4%), technical auxiliary staff (75%), nursing and promotion assistants (98.3%), midwife assistants (100%) and SRH community agents (100%). The medical profession positions are mainly held by men (89.5%), as well as nursing (67.4%) and technical personnel (74.5%). The most balanced categories in terms of gender are pharmacy (50% men and 50% women), physiotherapy (58.8% men) and Nursing School staff (55.5% women).

Management staff totals 181 individuals, of whom 45.3% are women and 54.7% are men. This group brings together the persons responsible for the management of health policies and services at central level (general secretariat, central directorate, head of central department, hospital management and central services secretariat), regional level (regional directorate, regional hospital management, regional services secretariat) and local level (local management and local services secretariat).

Graph 4. Management personnel disaggregated by gender (MPH, 2018)



Source: Prepared by the author on the basis of data provided by the Directorate General for Training and Personnel.

Note: data from March 2018.

Women occupy only 9.8% of the total management staff, that is, central, regional and hospital management positions and central department heads. Male presence concentrates in the most senior positions particularly at the central level, where men hold 88.9% of the management positions in the Ministry or 82.1% of the central department head positions. At the regional level, management positions are 100% represented by men, as are the management positions of the five existing hospitals in the SRCs. At this level, the presence of men and women is slightly more balanced in the regional department head positions, with 11 women and 14 men. Finally, women are in the majority in positions at the local level: they represent 70% of local managers (or heads of dispensaries) and 100% of local service secretaries.

The third group is made up of **service personnel**, which groups together vital jobs for the maintenance of infrastructures and services such as cleaning, cooking, driving, surveillance, auxiliary services and other tasks. This group is composed of 68.5% men and 31.5% women. Men work mainly as drivers, guards and in auxiliary services, where they hold 100% of the jobs.

Finally, the **social assistance** group, made up of 52% women and 48% men, includes persons (or their widows or widowers) who were formerly in the service of the Ministry and who now receive a small remuneration by way of economic recognition.

2.2.2.2. Personnel-related challenges of the Sahrawi health system from a gender perspective

The Sahrawi health system personnel are committed to the health of the SRC population and face numerous difficulties in carrying out their work. The availability of trained medical and health personnel is one of the greatest challenges for Sahrawi health today. The situation of prolonged refuge, the dependence on external funding, the lack of a professional career and the lack of professional and salary motivation **lead to medical and health personnel dissatisfaction and even abandonment** of their work.

It should be remembered that professionals are volunteers who receive an incentive for their services, an incentive which is subject to many instabilities (such as delayed payment) and which nowadays is at risk due to the reduction in the volume of international aid and the difficulty for funding agencies to place payment thereof among their priorities. The estimation of the amount of these incentives for the different categories, as well as the evaluation of work performance, is the subject of internal controversy among personnel, as will be seen below in relation to their gender analysis.

Added to all this is the appearance of a phenomenon in the SRCs which, although not new, has worsened in recent years: the development of **private medicine** which is affecting the fragile balance of the Sahrawi public health system. In the last ten years, there has been a rapid increase in medical consultation and diagnostic testing surgeries which attract the scarce existing medical and health personnel in the face of an opportunity for higher remuneration. According to the interviewees, in the absence of incentives that sufficiently recognize the work performed by medical and health personnel in the public health system, many professionals are responding to offers from organizations or individuals in charge of private health initiatives.

Part of the personnel shows a general lack of motivation that increases the risk of professionals fleeing both in the SRCs, from the public to the private system, and abroad, whether Algeria, Spain or other surrounding countries. The motivation and retention of professionals at all health care levels is becoming increasingly complicated since, as described above, the conditions created by the prolonged refuge situation hinder the functioning of the Sahrawi institutions and health system.

If this situation is analysed from a gender perspective, trends are identified which, in the context of a general weakness, affect women more strongly.

a) Sahrawi health system gender pyramid

As explained in the previous section, women account for slightly more than half of the posts in the health system (59.8%). This figure rises to 70% when dealing with medical and health personnel, in which women represent a total of 584 compared to 251 men. The most feminised professional categories are midwives (38 women and 1 man), nursing and promotion assistants (296 women and 5 men), midwife assistants (18 women) and SRH community agents (106 women).

Women occupy most of the positions at **the local level**, which is of vital importance for the maintenance of health in the SRCs because it is there that prevention and primary care work is developed and, therefore, women have closer access and a greater capacity to influence the population.

At the same time, women are underrepresented in the power and decision-making structures that define priorities and allocate resources for health policy at the various levels of care at central and regional levels. Only 1 of the 9 central directorates of the Ministry of Health is occupied by a woman in March 2018, while 5 central department heads out of a total of 28 posts and 3 central service secretariats out of a total of 11 are female. The management positions of the 5 hospitals are also occupied by men.

There is a “gender pyramid” phenomenon in which **women prevail at the base of the health system but are underrepresented at the top, at the political decision-making, planning and resources distribution levels.**

As mentioned above, in recent years the Ministry of Health (and more specifically its head, the Minister) is interested in more women in positions of responsibility in the central and regional directorates of the health system, which is very positive for the promotion of specific actions in this respect, but requires clear support for specific measures.

b) Insufficient consolidated vision on the role of women as political leaders in society

The Sahrawi health system has very capable, interested and committed women, who are still highly recognized for their role in the health care of the Sahrawi population. However, despite this social and professional recognition, they are not sufficiently represented in relevant health policy and management positions, an aspect that WHO considers fundamental for equitable health policies.

However, despite this recognition, there is a certain tendency, according to the testimonies collected, to blame women for their lack of availability and commitment to occupy higher ranking positions, when the fact is that they normally work a triple shift (job, household and community), which leaves them without being able to control their time, a resource which is much more flexible for men. The sexual separation of labour is never questioned in the SRCs, that is, the distribution of tasks and responsibilities assigned by gender in each society. In this context, women are mainly responsible for family care and household activities, as well as for community tasks, in addition to their professional work in the health field.

WHO diagnoses a similar situation in many contexts around the world and states that “women, who constitute the backbone of the health system, are rarely represented in executive or management positions; rather, they tend to concentrate on jobs with low salaries and exposed to higher occupational health risks. Their role as informal health care providers at home or in the community is often unsupported, unrecognised and unpaid³²”. The paradox is that women, as formal and informal providers, contribute the most to improving the health of the population, but their health needs are less represented and they occupy fewer decision-making positions.

In the current conditions, Sahrawi health professionals show a significant **overload of tasks and responsibilities**, mainly due to the shortage of dedicated personnel and the multiplicity of programs that have been implemented in recent years, which fall on the same people at the base of the health system and the implementation and supervision of which is becoming increasingly complex.

This overload is due to their role in society, in which, as has been pointed out, they have a great responsibility in maintaining life in the SRCs, both in the private and community spheres. Women health professionals express significant difficulties in **reconciling personal and family life**, which, according to testimonies, is the main although not the only reason why many women health professionals are reluctant to occupy positions of greater responsibility or to assume more tasks. They cite other reasons for not doing so, such as **difficulties to travel** to the Ministry’s facilities in Rabouni and the limited availability of transport, the existence of **too masculine environments** in which women are in a minority, and the difficulty of participating and negotiating with those responsible. In these professional spaces there are a series of routines created and managed by men in which women find it difficult to fit in comfortably, which discourages them from frequenting them.

c) Incentive policy and performance monitoring

As mentioned above, the health system personnel receive financial compensation for carrying out their work. It is called “incentive” or more recently “service cost”, a recognition that although not very high is necessary for personnel to perform in a satisfactory way.

In recent years, and due to various factors related to funding, the health incentive system has entered a critical period, resulting in delays in payment and, more recently, difficulties that put its sustainability at risk. In addition, there is a shortage of efficient **performance control mechanisms** to ensure that the functions assigned to each job are carried out, which creates unease among staff. In recent years a great effort has been made to rationalize the remuneration system. At present, monthly performance is assessed on the basis of base wages, seniority calculation and performance assessment, calculated as the ratio of actual attendance over compulsory attendance.

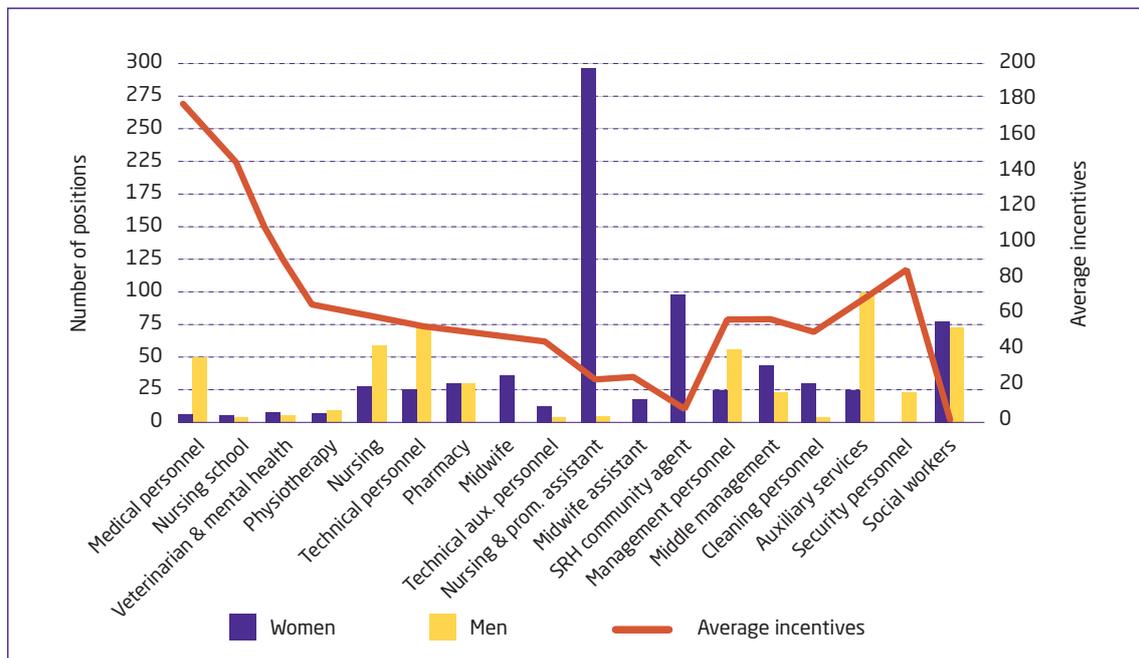
³² WHO (2009).

Although, as has been pointed out, women health professionals are highly valued in the SRCs, in reality the system only **recognizes in part the nature of the work** performed by some women professionals. As a result, work performance is assessed based exclusively on attendance, which creates controversy in the group in general. On occasion on-duty shifts, night shifts or childbirths are not taken into account, or the journeys made by women professionals to visit convalescent patients or dependent people.

As regards the incentive amount, incentives range from a maximum of 176 Euros/month received by a doctor to a minimum amount of 9 Euros received by a SRH female community agent, through the 58 Euros received by a nurse, the 47 Euros received by a midwife or the 24 Euros received by a nursing assistant. Special mention should be made of people who receive social aid of around 6 euros per month for services rendered when they or their widowers were active.

Graph 5. Distribution of incentives by professional category and gender (MPH, 2018)

(Categories in English from left to right: Medical personnel, Nursing School, Veterinarians and Mental Health, Physiotherapy, Nursing, Technical personnel, Pharmacy, Midwife, Technical auxiliary personnel, Nursing and promotion assistant, Midwife assistant, SRH community agent, Management personnel, Middle management, Cleaning personnel, Auxiliary services, Security personnel, Social workers)



Source: Prepared by the author on the basis of data provided by the Directorate General for Training and Personnel, and the documentation presented at the XVI Round Table.

Note: Data from March 2018. Inclusive language on professional categories is not found on the original tables.

As shown in the graph above, which represents the distribution of incentives by professional group, the mostly male categories receive relatively higher incentives than the more feminized categories. This phenomenon is clearly seen in the categories of medical personnel, nurses,

technical personnel, management personnel, auxiliary services and security. The categories where the average incentive is lower are those where the highest number of women concentrates: nursing and promotion assistants, midwife assistants and SRH agents, and on which, as mentioned above, an important part of the health care in the SRCs is supported.

Given the expected downwards revision of incentives, there is a real risk that this reduction will affect female professionals more acutely, which may increase their overall demotivation. Therefore, the search for **other ways and forms of incentives** for female personnel is a crucial aspect not only for women professionals themselves, but also for the health system's survival in the camps.

d) Other relevant weaknesses in working conditions from a gender perspective

On the other hand, continuous training and **professional retraining** in health are absolutely essential for personnel to keep their skills updated, as well as their techniques and tools knowledge and management to adapt to new social and health realities.

Women professionals from the various health care groups express important needs in this respect since they consider that retraining and exchanging knowledge and experience with personnel from other contexts are essential for them to develop their work in a more updated and also more motivated way. All the more so when, due to the shortage of medical personnel, health personnel are forced to face many responsibilities that should normally fall on doctors. This need is not only expressed by women professionals but also by women health promoters who, within the framework of the program developed by the MPH in collaboration with the NUSW, demand an update on the contents of their health awareness and promotion activities, as well as on techniques and methodologies for community sensitization and awareness.

In addition, the difficulties expressed by female personnel in relation to the performance of their work are also related to practical aspects. Among them, access to the use and control of the **transport** resource, of strategic importance in the SRCs, is very limited for female professionals, which makes it difficult to monitor certain health programs that have seen their resources cut down in recent years.

Similarly, female health professionals indicate the need to improve **health facilities and infrastructure**, in relation to the facilities reserved for personnel rest, which either do not exist or are not maintained in good conditions, mainly in relation to equipment.

Finally, there are clear deficiencies in the availability and management of **health material and medicines**, particularly in hospitals, which makes it very difficult for women professionals to perform their work.

All of this has **negative consequences** for the work of female health professionals in the SRCs. Women occupy most of the positions at the base of the health system with a huge overload of tasks and responsibilities, and significant difficulties to reconcile personal, family and working life. At the same time, their presence is hardly found in the health system power

and management structures, which marginalizes them from the main decision-making spaces in Sahrawi health policy.

As a result, there is a general lack of motivation which, although it is not exclusive to women, leads to their not joining the health profession (in the case of recent graduates) or their abandoning the health profession and withdrawing to the domestic sphere, or even devoting themselves to other productive activities that generate a higher economic profit and make it easier to reconcile personal, family and working life; while, paradoxically, those that remain due to the lack of personnel are forced to assume higher responsibilities than those associated with their position.

In other words, at the same time as there is a loss of human capital in relation to trained women in whom the health system has invested resources and time, there is an overload of tasks and responsibilities on the women who remain in the system. According to this diagnostic approach, this lack of motivation is also reflected in the difficulty to have women enrolling in the health training system and, specifically, in the Nursing School.

2.2.2.3. Information-gathering, monitoring and recording tools

Knowing the evolution of the health-disease *continuum* through reliable indicators is fundamental in order to be able to understand the evolution of health and make decisions accordingly. For this, it is necessary to have an integrated information system that allows planning, managing, evaluating and, therefore, providing management with a tactical and strategic decision-making instrument for short- and middle-term³³ decision-making.

Undoubtedly, one of the most important advances in the Sahrawi health system in recent years has been the development, from 2012, of a mechanism for collecting and managing information the population's health through the health information system (HIS). In 2014, this system, developed by the Health Care Statistics Department, began to be implemented in national and regional hospitals, as well as in dispensaries.

In March 2018, and according to the information provided by the aforementioned Statistics Department, the HIS has a total of 86 indicators, of which 36 are updated on an annual basis. There is a weekly epidemiological control system managed through the regional admission office in each hospital, which is the unit responsible for collecting and sending data to the Ministry. Once received, the quality of the data is controlled and, in some cases, the reports are returned for correction.

One of the outstanding aspects of this tool is that it has been designed from the outset taking into account the **transversal disaggregation by gender**. It is essential to have a solid database of reliable health data that shows the differences determined by gender in this

³³ Canela-Solera, J. et al. (2010). Health Information Systems and Health Indicators: An Integrating Perspective in Clinical Medicine, 134.

area, establishes outcome indicators, and considers gender as a cross-cutting issue alongside other sources of health inequality, such as poverty, age, ethnicity, and socioeconomic status in a specific context.

However, further progress is required in the development of the HIS so as to obtain disaggregated data for all indicators since at the time this report was prepared the weekly reports did not contain disaggregated data for chronic patients (people suffering from hypertension, a disability, etc.).

It is necessary to continue **improving health information from a gender perspective**, on women and men, since this information is essential for the planning and management of programs³⁴ and for monitoring health changes in the population. It is also necessary to continue improving the capacities of personnel to interpret data and information from a gender perspective and, at a more advanced stage, to design gender indicators that can be incorporated into the HIS since, in addition to data disaggregated by gender, it is essential to have indicators that can capture gender gaps and more complex evolutionary trends in terms of existing imbalances between women and men, including complex indices and multivariate analysis.

2.2.3. Organization's culture

In general, this aspect refers to the beliefs and values system of the people who determine the conventions and unwritten rules of an organization. The gender relations that occur in society are reproduced, to a greater or lesser extent, in institutions and organizations, manifesting the existing imbalances, stereotypes and prejudices.

Through the testimonies collected, we have observed that the MPH personnel have not assimilated and integrated the value of gender equality as central and strategic in its organizational culture, despite the progress described in the previous sections. In any case, a certain **advance can be observed in the approach to the concept of equality** with respect to previous years in which, and surely due to ignorance of the term, any use of it in the public health policies definition, planning and management processes was rejected. Proof of this progress is the entire process generated around SHP 2016-2020 and the preparation of this Gender and Health Plan.

On the other hand, certain **preconceived ideas persist regarding the roles** played by women and men in society, which have to do with the concept of women's potential leadership in public institutions, as is the case with the MPH. There is no debate on the causes of women's greater difficulties to hold positions of greater responsibility, which, as mentioned above, have to do, among other things, with their overload of responsibilities in the private and public spheres, but it is blamed on a kind of "indolence" that is typically feminine as regards the performance of a position of responsibility.

³⁴ WHO (2009).

Upholding dynamics of this type towards women can create a **certain atmosphere of pressure and incomprehension** towards them that may lead to higher marginalization and lack of motivation. Creating an environment conducive to women joining the organization is fundamental to the success of the measures implemented. It is not only a question of formal actions (such as measures to reconcile personal and working life) from the management, but also the transmission of values of respect, understanding and collaboration between all members of staff.

In addition, the MPH occupational health policy does not have a gender perspective, and no measures have been formally developed for the prevention of and action against sexual harassment, nor have psychosocial risks been contemplated (*mobbing, burnout syndrome*) in risk evaluation and prevention, usual in positions held by women. Gender institutionalization aims to influence the organizational culture, beliefs, attitudes and explicit and implicit values of the organization's members in relation to gender equality, as well as to forms of relationship between the ones and the others. In many contexts, the existence of protocols against harassment at work and/or on the basis of gender prevents and acts in this type of situation.

In this respect, the MPH has no adequate mechanisms for the **public management of care or a clear reconciliation policy** which can be used by women and men in the service of the institution, although there are measures to make it easier for women to take maternity leave and leaves to take care of their children.

It is therefore appropriate to translate the explicit commitment of the MPH to gender equality at this time into a more solid application of the principle of equality in labour relations as well as in the awareness of all personnel, including personnel in decision-making positions and middle management.

Finally, in order to increase personnel awareness on the importance of having an equal gender vision in health, and supplementary to awareness-raising, **training represents the other fundamental line** of an organization's cultural change process. The work carried out by organizations supporting the MPH, such as Médicos del Mundo, in this matter over the years, in terms of awareness and training aimed in particular at medical and health personnel, should continue to expand and deepen, providing basic training on gender equality, but also training related to human resources management and focusing on specific health areas.

3. GENDER AND HEALTH PLAN OBJECTIVES

The MPH has among its values the understanding of health as a human right from the principle of equality and non-discrimination on the basis of sex. To implement the RTH from the principle of equality and to achieve gender equality in the state and development of the Sahrawi population's health, the MPH assumes the relevance of the gender perspective in health. The MPH considers that the principle of equality between women and men represents a strategic value and an element that helps towards the efficiency, quality and modernization of health policy management and the institution's organizational culture.

3.1. General Objective

The Gender and Health Plan (2018-2020) aims to achieve equal opportunities and non-discrimination in the recognition, guarantee and provision of the RTH of the Sahrawi refugee population, and to help to include the gender perspective in the Sahrawi health policy, in accordance with Line 3. *Incorporating the gender perspective in health, SHP 2016-2020.*

3.2. Specific Objectives

As Specific Objectives, the Gender and Health Plan (2018-2020) proposes the following:

- To foster women's participation and ensure equality in the representation of management positions, coordination and participation in coordination bodies, groups or platforms.
- To further the inclusion of the gender perspective in health as an organizational principle of the MPH and to favour the access of women professionals to the spaces, resources, transport and available health material required for the performance of their duties.
- To advance in the development of capacities and gender sensitivity in all MPH personnel.
- To further the knowledge of the differentiated health needs of Sahrawi women and men.

4. PRIORITY LINES OF ACTION

The main diagnostic conclusions show the strengths and opportunities for gender and health institutionalization in the MPH, and also mark the institutional, organizational and technical weakness areas that require specific “inwards” measures in the MPH, as well as measures for the systematic integration of the gender perspective in the assistance and preventive actions of health programs.

The Gender and Health Plan (2018-2020) emphasizes the importance of creating a political and strategic framework, organizational structures, management processes and, in short, an organizational culture in the MPH, which are consistent with the objective of achieving gender equality in the development of the RTH. This internal consistency is essential for health policy planning and provision from a gender and health perspective.

The priority lines of action respond to the four strategic areas essential for institutionalizing the gender perspective in health: i) political framework and structures; ii) capacity and gender sensitivity development; iii) women’s participation in health decision-making; and iv) empirical evidence generation.

The development of measures and proposals is articulated for each of the specific objectives set out in the Gender and Health Plan.

4.1. Women’s participation

- Facilitating and improving the **reconciliation of personal, family and working life** of MPH women professionals.
- Favouring **women’s participation** and ensuring equality in the representation of management, coordination positions and in participation bodies, groups or platforms, as well as in the distribution of tasks and functions.
- Improving the **managerial skills and abilities** of women in management positions through specific training.
- Strengthening the collaboration and participation of **women’s organizations** and civil society in the analysis, decision-making and development of prevention and health promotion actions.
- Creation of an **Advisory Committee** on Gender and Health, made up of female health professionals from all levels of health and the NUSW, to participate in the key moments of the MPH strategic planning of all health programs and all measures concerning its personnel.

4.2. Equality as an organizational principle

- Strengthening **coordination between programs** and the organization of competencies, roles, and responsibilities of women professionals at the base of the health system.
- Systematic incorporation of the **gender perspective into all strategic and operational planning documents**.

- Guaranteeing a **remuneration system** that recognizes and values the work done by female health professionals, especially at the community level.
- Favouring the **access of the health system women professionals to the resources**, spaces, transport, medicines and health material available and required for the performance of their functions.
- Guaranteeing equal access for men and women to training, internal and external, attending to the needs to reconcile work and family life.

4.3. Development of capacities and gender sensitivity

- Improving **health and gender training** for the MPH personnel and the different health centres (SO. 15).
- Strengthening the **recognition of health and care work** by Sahrawi women, both in the community and in the family.

4.4. Knowledge generation

- Strengthening capacities to **understand the differentiated health needs** of Sahrawi men and women, identifying the state of health (prevailing diseases and intensity by gender), the health determinants for men and women throughout their life cycle (differentiated biological, social and cultural risk and protection factors) and the obstacles to access health information, services and resources. This priority line of action may integrate the following activities:
- **Communicating, disseminating and disclosing** this information in health coordination spaces among the various agents that make up the health system in SRC, such as the Round Table or the Health Update Platform, as well as in the Scientific Health day Sessions.

5. ACTIONS DATA SHEETS

5.1. Women´s participation

Action 1.1. Policy to reconcile work, family and personal life	
Schedule	2018 (second semester)
<p>Objective and description of the action:</p> <p>To include labour flexibility measures systematically, through a clear and defined reconciliation policy in the MPH.</p> <p>Measures aimed at overcoming the difficulties of reconciling professional, family, community and personal life constitute a priority line of progress for more women to take management positions in the MPH. This priority is reflected in SO. 5 <i>To implement a policy to improve working conditions and family reconciliation, which makes it easier for women to take decision-making positions</i>, and in Goal 4, which establishes 30% presence of women in decision-making positions (department/program management and coordination, and regional and hospital management). At present, the proportion is 9.8% in department/program management and coordination positions, and in regional and hospital management.</p> <p>The reconciliation policy must provide guidelines about working days and methods in relation to attendance or meeting schedules, and address essential working conditions such as access to transport or the existence, care and maintenance of work spaces in the MPH. It is also essential in order to create a favourable and understanding environment in the MPH.</p>	
Indicator and monitoring and evaluation mechanism.	<ul style="list-style-type: none"> • 1 MPH reconciliation policy designed in a participatory manner with specific and defined measures. <p>The increase in the number of women in management positions will be assessed on an annual basis.</p>
Target group.	All the female professionals of the MPH.
Responsible Personnel.	General Secretariat of the MPH, General Directorate for Personnel, Directorate for Prevention, Advisory Committee.
Means planned for carrying out the action.	Transport and spaces for meetings, technical support from Médicos del Mundo.

Action 1.2. Establishment of a Gender and Health Advisory Committee	
Schedule	2018 (second semester)
<p>Objective and description of the action:</p> <p>Creation of a Gender and Health Advisory Committee made up of women health professionals from all health care levels and the NUSW, to participate in the key moments of strategic planning of the MPH for all health programs and all measures concerning its personnel.</p> <p>Creating this Advisory Committee may be a transitional measure until a balanced presence of women in decision-making positions is achieved, with the objective of ensuring their participation in key planning moments. It would not be a Committee working on an on-going basis and with regular meetings (that would be a work overload for the women making it up), but a group of representative women professionals, who can guide and provide information in the decision-making process from their reality standpoint.</p>	

Indicator and monitoring and evaluation mechanism.	<ul style="list-style-type: none"> Advisory Committee formed and consulted in at least 4 decision-making processes per year. <p>The dynamics of the Committee's work, its capacity for action and relevance will be evaluated on an annual basis.</p>
Target Group.	Women professionals identified by the MPH to be part of the Committee.
Responsible Personnel.	Minister, General Secretariat, Personnel Management, professional members of the Advisory Committee.
Means planned for carrying out the action.	Transport and spaces for meetings, technical support from Médicos del Mundo.

Action 1.3. Training in managerial skills and abilities

Schedule	2019 (first semester) and 2020
Objective and description of the action:	
To improve the managerial skills and abilities of women in management positions and of those interested in promotion, through specific training included in the MPH Annual Training Plan.	
Indicator and monitoring and evaluation mechanism.	<ul style="list-style-type: none"> 1 Training action in administration and managerial skills, aimed at MPH women professionals. <p>The content of this training will be evaluated on an annual basis, according to the needs identified by the professionals.</p>
Target Group.	All female MPH professionals who are in coordinating positions or who wish to be promoted.
Responsible Personnel.	Directorate-General for Training and Personnel, Advisory Committee.
Means planned for carrying out the action.	Transport and spaces for training, technical support from Médicos del Mundo and other cooperation agents.

Action 1.4. Participation of women's organizations and civil society

Schedule	2019 (first semester)
Objective and description of the action:	
To strengthen the collaboration and participation of women's organizations and civil society in the analysis, decision-making and development of prevention and health promotion actions.	

<p>In relation to the NUSw, in addition to participating in the Advisory Committee, progress will be made on the updating of coordination and collaboration in specific promotional and awareness-raising activities aimed at women's health. With organizations such as SARIOYU, SARIOSU and NOVA, a horizontal and institutionalized dialogue will be promoted in order to advance in sensitization with a gender perspective, particularly among the young population.</p>	
Indicator and monitoring and evaluation mechanism.	<ul style="list-style-type: none"> Update of the collaboration agreement between the MPH and the NUSw.
Target Group.	Health promotion agents.
Responsible Personnel.	National Health Promotion Program (NHPP) Coordination, NUSw.
Means planned for carrying out the action.	Transport and spaces for meetings, technical support from Médicos del Mundo.

5.2 Equality as an organizational principle

Action 2.1. Coordination between programs and organization of competences	
Schedule	2019 (second semester) and 2020
<p>Objective and description of the action:</p> <p>To strengthen coordination between programs and the organization of the competencies, roles and responsibilities of women professionals at the base of the health system.</p> <p>Sahrawi women health professionals bear a significant overload of tasks and responsibilities increased by the multiplicity of programs that have been implemented in recent years. These programs (NRHP, NCDP, SICHP) are managed by the same people at the base of the health system and their implementation and supervision is becoming increasingly complex. Progress in health policy management or in the homogenization of care procedures (SHP Lines 1 and 2) will help to improve the conditions in which Sahrawi women professionals do their work. The design of these advances must contemplate specific efforts to guarantee the participation of women professionals at the base of the system in this design process, since they are less represented in decision-making and policy planning positions.</p>	
Indicator and monitoring and evaluation mechanism.	<ul style="list-style-type: none"> System for work instruction, career and performance assessment, designed from a gender perspective.
Target Group.	All MPH personnel.
Responsible Personnel.	MPH General Secretariat, General Directorate for Personnel, Directorate for Prevention, Advisory Committee and Program Coordination bodies.
Means planned for carrying out the action.	Transport and spaces for meetings, technical support from cooperation agents.

Action 2.2. Gender perspective in all MPH documents	
Schedule	2019 NRHP and as from 2020 the other programs
<p>Objective and description of the action:</p> <p>Systematic integration of the gender perspective into all strategic and operational planning documents.</p> <p>Institutionalizing gender requires guided, predictable and monitored processes. This is why the institutionalization of the gender and health perspective is strengthened as the institution's planning capacity improves. Currently, the MPH has few strategic, sector-based and operational planning documents, and the existing ones contain little gender equality included in their objectives, actions and indicators. Improvements in institutional capacities for strategic and operational planning, with a timing definition (particularly annual) for objectives, priorities and indicators (SHP Lines 1, 2, 4 and 5) will contribute to the achievement of Line 3 and, specifically, of SO.14 <i>To achieve the institutionalization of gender in terms of legislation, political and declarative documents and operational management</i>, which is a necessary first step to make progress in gender institutionalization at other levels.</p> <p>It is expected that in 2019 progress will be made in reformulating the NRHP from a gender perspective, and from 2020 in the other programs, consistently with SHP's Goal.14 <i>All declarative and operational documents refer to the separate needs of both sexes and to interventions aimed at meeting such needs</i>.</p>	
Indicator and monitoring and evaluation mechanism.	<ul style="list-style-type: none"> The NRHP is reformulated including the principle of equality.
Target Group.	All MPH personnel.
Responsible Personnel.	MPH General Secretariat, Prevention Directorate, Advisory Committee and Program Coordination bodies.
Means planned for carrying out the action.	Transport and spaces for meetings, technical support from Médicos del Mundo.

Action 2.3. Equality in the remuneration system	
Schedule	2018 (second half-year period)
<p>Objective and description of the action:</p> <p>Adaptation of the performance assessment system in relation to the nature of the work performed by women professionals in the health system.</p> <p>In recent years, the MPH has made progress in reforming its human resources policy, in particular by managing the remuneration system and linking it to the quality of its personnel's performance. This effort, however, should integrate better the work reality of women professionals in the health system, whose work at the PHC level cannot centre exclusively on physical presence. Night work or night births, travelling to follow-up convalescent patients, pregnant women or dependent persons are not sufficiently recognized. This line of work is aligned with the priorities set out in Line 1. <i>Improving health personnel's management and performance</i>.</p> <p>Finally, in relation to the remuneration system and in anticipation of future restructuring and adjustments as may derive from the situation of instability to which the system is subject, it is necessary to bear in mind that the work of PHC, on which most women professionals concentrate, is essential for the development of the Sahrawi population's right to health and it should not be the level where adjustments are concentrated.</p>	

Indicator and monitoring and evaluation mechanism.	<ul style="list-style-type: none"> • Performance assessment system with a gender approach (taking into account night shifts, home visits and travelling).
Target Group.	All MPH personnel.
Responsible Personnel.	MPH General Secretariat, Personnel Directorate, Prevention Directorate, Advisory Committee.
Means planned for carrying out the action.	Transport and spaces for meetings.

Action 2.4. Women professionals' access to resources and benefits

Schedule	2019 and 2020
<p>Objective and description of the action:</p> <p>To facilitate the access of women professionals in the health system to the resources, spaces, transport, medicines and health-related material available, as necessary for the performance of their functions.</p> <p>Women professionals in the health system are very capable, interested and committed to their work and to the health of the Sahrawi population. Their lack of motivation goes beyond economic remuneration, and women professionals express the need for other motivational measures linked to the basic conditions in which they do their job. These supplementary motivation measures relate to SO.12 <i>To increase access to resources and benefits for women workers and users of health services</i>, and they are also associated with SHP Lines 1 and 2. The following measures can be prioritised:</p> <p>2.4.1. Adaptation of spaces for women professionals to do their tasks, particularly the fitting out, provision and maintenance of rest areas in dispensaries and hospitals. This health infrastructure improving measure is essential to improve the conditions in which they do their work and must therefore be a priority in the design and adaptation activities.</p> <p>2.4.2. Improving the use and control of transport for follow-up activities included in the different programs and for the operability of activities and spaces for coordination and communication among professionals. As mentioned above, all transport personnel is male and this imbalance sometimes has a negative impact on the management of the availability of this strategic resource in SRCs, for women professionals.</p> <p>2.4.3. Making progress in the management of centres, drugs and medical supplies. Improved availability and management of resources, and of centres (particularly regional hospitals), based on efficiency and transparency criteria, contribute decisively to facilitating working conditions at the daïras, where most health professions are concentrated.</p>	
Indicator and monitoring and evaluation mechanism.	<ul style="list-style-type: none"> • The 5 regional hospitals and at least 80% of the dispensaries have rest areas for professional women, adapted to their needs and properly maintained. • The NHRP has its own transport on a permanent basis.

	<ul style="list-style-type: none"> • Vehicle Use Plan designed in a participative way and adapted to the needs identified by women professionals at all levels. • A management supervision system regarding resources, medicines and spaces in health centres, designed and operational.
Target Group.	All MPH personnel.
Responsible Personnel.	MPH General Secretariat, Prevention Directorate, Personnel Directorate, Advisory Committee, Regional Directorates and Program Coordination.
Means planned for carrying out the action.	Annual Training Plan, Transport and meeting spaces, technical support from Médicos del Mundo.

Action 2.5. Equal access to training

Schedule	2019 (second half-year period) and 2020
<p>Objective and description of the action:</p> <p>To guarantee equal access for men and women to training, both internal and external, taking into account the need to reconcile work and family life.</p> <p>To develop training and retraining plans and activities for women professionals, with training being easily accessible in terms of location and timetables. Continuous training is also a motivating factor in order for women professionals to be able to face the responsibilities they assume at PHC level. This training must be adapted to the reality of the work they do, focus on its practical and daily applicability and adjust to women professionals' time and mobility needs.</p>	
Indicator and monitoring and evaluation mechanism.	<ul style="list-style-type: none"> • The MPH Annual Training Plan takes into account the training needs expressed by women and provides for on-the-job training.
Target Group.	All MPH personnel.
Responsible Personnel.	Directorate for Training and Personnel, Advisory Committee.
Means planned for carrying out the action.	Transport and spaces for work meetings and training.

5.3. Development of capacities and gender sensitivity

Action 3.1. Training in gender and health at the MPH

Schedule	2019 and 2020
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<p>Objective and description of the action:</p> <p>To improve the health and gender skills of the MPH and the various health centres personnel (SO. 15).</p> <p>Training in gender and health is a fundamental line in the development of essential capacities to include the gender perspective and in the consolidation of an equal vision for all the MPH management, technical, medical, and health personnel. The design of a systematic training program included in the Personnel Training Plans should provide basic training on gender equality, related to human resources management, and focused on specific health areas adapted to the context. In the middle term, a Health and Gender Guide can be developed in the SRCs, as a training tool specially designed in a participatory manner for the MPH needs.</p>	
<p>Indicator and monitoring and evaluation mechanism.</p>	<ul style="list-style-type: none"> At least 2 training actions in health and gender for all the MPH medical, health and technical personnel, included in the Personnel Training Plans (Goal.15 SHP).
Target Group.	All MPH personnel.
Responsible Personnel.	Directorate for Training and Personnel.
Means planned for carrying out the action.	Transport and spaces for training, technical support from Médicos del Mundo.

Action 3.2. Recognition of women professionals' work	
Schedule	2018 and 2019
<p>Objective and description of the action:</p> <p>To reinforce recognition of health and care work as carried out by Sahrawi women, both at community and family level.</p> <p>Institutionalizing gender and health implies creating awareness, attitudes and values among all the MPH personnel and, in short, an organizational culture that takes into account and is sensitive to the overload of responsibilities and tasks faced by its women professionals, as well as their difficulties in reconciling professional, family and community life. The lack of understanding of this reality can lead to a certain atmosphere of pressure towards them, which may lead to higher marginalization and lack of motivation. The creation of a favourable environment for women to join the organization is fundamental for the success of the measures put in place. It is not only a question of formal actions (such as measures to reconcile personal and working life) from management, but also the transmission of values of respect, understanding and collaboration among all staff members.</p>	
<p>Indicator and monitoring and evaluation mechanism.</p>	<ul style="list-style-type: none"> At least two recognition and awareness campaigns on co-responsibility, promoted by the MPH.
Target Group.	All MPH personnel.

Responsible Personnel.	General Secretariat, Prevention Directorate, Personnel Directorate, Advisory Committee.
Means planned for carrying out the action.	Transport and spaces for meetings and technical support from Médicos del Mundo.

5.4. Generation of knowledge in health and gender

Action 4.1. Generation of health knowledge from a gender perspective	
Schedule	2019 and 2020
<p>Objective and description of the action:</p> <p>To strengthen the MPH capacities to understand the differentiated health needs of Sahrawi men and women, to identify the state of health (prevailing diseases and intensity by gender), the health determinants for men and women throughout their life cycle (differentiated biological, social and cultural risk and protection factors) and the obstacles to access health information, services and resources. This priority line of action may integrate the following activities:</p> <p>4.1.1. Furthering the production of data disaggregated by gender and age on all health indicators and their reflection in regular reporting.</p> <p>4.1.2. Carrying out health diagnoses and studies from a gender perspective, including consulting the population in a differentiated manner, through balanced consultation groups and specific gender indicators, as well as the production of qualitative health-related knowledge.</p> <p>In the future, and for subsequent Gender and Health Plan revisions, measures should be taken to improve health data and information interpretation from a gender perspective and, at a later stage, to generate gender-specific indicators that can be incorporated into the HIS.</p>	
Indicator and monitoring and evaluation mechanism.	<ul style="list-style-type: none"> • Weekly and monthly HIS reports disaggregate all indicators by gender. • At least one diagnosis of women's health needs.
Target Group.	All MPH personnel, particularly HIS.
Responsible Personnel.	General Secretariat, Prevention Directorate, HIS, Advisory Committee.
Means planned for carrying out the action.	Personnel, transport, meeting spaces and technical support from cooperation agents.

Action 4.2. Communication and dissemination of gender and health information	
Schedule	2018 - 2020.
<p>Objective and description of the action:</p> <p>Communicate, disclose and disseminate this information in health coordination spaces among the various agents that make up the health system in SRC, such as the Round Table or the Health Update Platform, as well as in the Scientific Health Daily Sessions.</p>	

Indicator and monitoring and evaluation mechanism.	<ul style="list-style-type: none"> • Data presented at the Round Table are disaggregated by gender. <p>At least one study on health and gender is presented at the Scientific Daily Sessions every year.</p>
Target Group.	All MPH personnel.
Responsible Personnel.	General Secretariat, Prevention Directorate, Personnel Directorate, Cooperation Directorate, Program Coordination, Advisory Committee.
Means planned for carrying out the action.	Personnel, transport, spaces for meetings and technical support from Médicos del Mundo and other cooperation agents.

6. SCHEDULE

The Gender and Health Plan is valid until 2020, so a six-month scheduling of the 17 identified measures should be as follows:

MEASURE	2018	2019		2020	
	2 nd HY	1 st HY	2 nd HY	1 st HY	2 nd HY
1.1. Policy for reconciliation of work, family and personal life.	●				
1.2. Creation of an Advisory Committee on gender and health.	●				
1.3. Women's managerial and management skills and abilities training.		●		●	
1.4. Participation of women's organizations and civil society.		●			
2.1. Program coordination and organization of competencies.			●	●	
2.2. Gender perspective in all planning documents.			●	●	●
2.3. Equality in the remuneration system.	●				
2.4. Women professionals' access to resources and benefits.	●				
2.4.1. Adaptation of spaces for women professionals to do their tasks.	●		●		●
2.4.2. Improving the use and control of transport.		●		●	
2.4.3. Advancing in the management of centres, medicines and health supplies.		●		●	
2.5. Equal access to training.			●		●
3.1. Training in gender and health for the MPH.		●		●	
3.2. Recognition of the MPH women professionals' work.	●		●		
4.1.1. Production of data disaggregated by gender and age in all health indicators.		●		●	
4.1.2. Carrying out health diagnoses and studies from a gender perspective.			●		
4.2. Communicating, disclosing and disseminating gender and health information.	●		●		●

7. MONITORING AND EVALUATION SYSTEM

Setting up a monitoring and evaluation system for SOs and targets as proposed in SHP 2016-2020 is crucial for the constant improvement and adaptation of SOs and targets to the complex and changing reality of the SRCs. Supplying this information on the progress related to the proposed objectives also contributes in a decisive manner to facilitating the involvement of citizens in health policy and to developing the task of accountability which corresponds to the Ministry of Public Health as the highest authority in the protection and guarantee of the RTH.

This system must take into consideration the indicators formulated for Line 3, but also the gender dimension and impact of the other Lines, SOs and goals. That is why a future line of work in the successive updates of the MPH Gender and Health Plan should be creating indicators from a gender perspective for each of the SHP 2016-2020 SOs and goals.

The following table of indicators is proposed for monitoring the identified priority lines of action.

Table 4. Scoreboard of monitoring indicators - 2018-2020 period

ACTIONS	PROPOSED INDICATOR
1. WOMEN'S PARTICIPATION	
1.1. Policy for the reconciliation of work, family and personal life.	• 1 Reconciliation policy for the MPH designed in a participatory manner with specific and detailed measures.
1.2. Creation of an Advisory Committee on Gender and Health.	• Advisory Committee formed and consulted in at least 4 decision-making processes per year.
1.3. Training in managerial and management capacities and skills for in women.	• 1 training action in managerial and management skills for the MPH women professionals (gender review -GR ³⁵ - Goal. 2).
1.4. Participation of women's organizations and civil society.	• Updated collaboration agreement between the Ministry of Public Health and the NUSW.
2. EQUALITY AS AN ORGANIZATIONAL PRINCIPLE	
2.1. Program coordination and organization of the competencies, roles and responsibilities of women professionals at the base of the health system.	• Job training, career and performance assessment system designed from a gender perspective (GR Goal.3 SHP).
2.2. Gender perspective in all strategic and operational planning documents.	• The NRHP is reformulated incorporating the principle of equality.
2.3. Equality in the remuneration system.	• Gender-focused performance assessment system (taking into account night shifts, visits, travelling, etc.) (GR Goal.3 SHP).

³⁵ GR refers to the review of the SHP 2016-2020 goals, from the gender perspective.

2.4. Professionals' access to resources and benefits.	<ul style="list-style-type: none"> • Design of a Motivation Plan aimed at women health professionals.
2.4.1. Adaptation of spaces for women professionals' to do their work, particularly the fitting out, provision and maintenance of rest areas in dispensaries and hospitals.	<ul style="list-style-type: none"> • The 5 regional hospitals and the national hospital and at least 80% of the dispensaries have rest areas for women professionals, adapted to their needs and with adequate maintenance.
2.4.2. Improving the use and control of transport for follow-up activities included in the various programs and for the operability of activities and spaces for coordination and communication among professionals.	<ul style="list-style-type: none"> • The NRHP has its own transport on a permanent basis. • Plan designed in a participatory manner for the use of vehicles adapted to the needs identified by women professionals at all levels.
2.4.3. Advancing in the management of centres, medicines and health supplies.	<ul style="list-style-type: none"> • A supervision system for the management of resources and spaces in the health centres, designed and operational.
2.5. Equal access to training.	<ul style="list-style-type: none"> • The MPH Annual Training Plan takes into account the training needs expressed by women and includes on-the-job training (GR Goal.2 SHP).
3. DEVELOPMENT OF CAPACITIES AND GENDER SENSITIVITY	
3.1. Training in gender and health at the MPH.	<ul style="list-style-type: none"> • At least 2 training actions in health and gender for all the MPH medical, health and technical personnel, included in the Personnel Training Plans (Goal.15 SHP).
3.2. Recognition of the MPH women professionals' work.	<ul style="list-style-type: none"> • At least two recognition and awareness campaigns on co-responsibility, promoted by the MPH.
4. GENERATION OF KNOWLEDGE IN HEALTH AND GENDER	
4.1.1. Production of data disaggregated by gender and age in all health indicators	<ul style="list-style-type: none"> • Weekly and monthly HIS reports disaggregate all indicators by gender.
4.1.2. Carrying out health diagnoses and studies from a gender perspective, including consultation of the population in a differentiated manner.	<ul style="list-style-type: none"> • At least 1 diagnosis of women's health needs.
4.2. Communicating, disseminating and disclosing information on gender and health.	<ul style="list-style-type: none"> • Data presented at the Round Table are disaggregated by gender. • At least one study on health and gender is presented every year at the Scientific Health Daily Sessions.

Monitoring the progress made in the objectives proposed in the MPH Gender and Health Plan will be implemented every six months by the **Gender and Health Plan Joint Commission**, which is formed by:

- General Secretariat.
- Prevention Directorate.
- Personnel Directorate.
- Cooperation Directorate.
- The women professionals that make up the Gender and Health Advisory Committee.

At the second and final meeting held each year, fulfilment of the objectives and implementation of the measures as proposed in the Plan will be assessed, and the actions planned for the following year will be scheduled.

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