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BIAS FREE

A Case Study of the

Application of The *BIAS FREE* Framework

for the Elimination of Gender Bias in the Process of Transforming the Women's Hospital in San José, Costa Rica: Documentation of the experience

Research Report

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Organización Panamericana de la Salud
Oficina Regional de la Organización Mundial de la Salud

SEGURO SOCIAL

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Acronyms

AMASPSI	Asociación de Mujeres Aserríseñas y de San Juan de Dios Promocionando la Salud Integral
AMES	Asociación de Mujeres
AMPROSIA	Asociación de Mujeres para la Promoción de la Salud Integral de Acosta
ASIMDE	Asociación Salud Integral de las Mujeres Desamparadeñas
ATAP	Assistant of Primary Attention
BIAS FREE	Building an Integrative Analytical System for Recognizing and Eliminating InEquities
CCSS	Costa Rican Social Security System
CEDARE	Centro Docente Asistencial de Referencia
CENDEISSS	Centro de Desarrollo Estratégico e Información en Salud y Seguridad Social
CIDA	Canadian International Development Agency
CLAP	Latin American Centre for Perinatology and Human Rights
CTISS	Interinstitutional Health Sector Technical Commission
EBAIS	Primary Health-Care Teams
GBA	Gender-based Analysis
GDP	Gross Domestic Product
INAMU	National Women's Institute
INS	Instituto Nacional de Seguros
MS	Ministry of Health
NGO	Nongovernmental Organization
OPS	Organización Panamericana de la Salud
PAHO	Pan American Health Organization
TCC	Technical Cooperation Treaty between Canada and Costa Rica
UNFPA	United Nations Population Fund
UNICES	Unidad de Cuidados Especiales
UNINOB	Unidad de Observación
WHB	Women's Health Bureau

Executive summary

In 1998, a small team set about to put human rights and women at the centre of a planned transformation of a maternity hospital in Costa Rica to a fully-functioning women's hospital. Like others before them interested in implementing a people-centred approach, those leading the change process knew «what» they wanted to do, but for two years were at a standstill as they did not know «how» to do it.

In 2001, a workshop introducing them to the BIAS FREE Framework was the key to unblocking the process; it gave them the «how» they had been missing.

This case study is presented as a model so that others may benefit from the experience in Costa Rica. While a rights-based, people-centred approach to health is recognized by the World Health Organization as a best practice in efforts to attain the highest possible level of health, implementation of this approach has been problematic.

> Underpinned by a rights-based approach, the [People at the Centre of Care Initiative (PCI)] seeks to promote people-centred health care as a means of contributing to the attainment by all peoples of the highest possible level of health as the realization of a basic human right...Despite its long history and increasing popularity, people-centred health care has not been satisfactorily and collectively enunciated at the health system level, to encapsulate the needs, wants and expectations of individuals, families and communities, and how health practitioners, health administrators, and bureaucrats could respond.
>
> *People at the Centre of Care Initiative, WHO. Geneva.*
> *www.wpro.who.int/sites/pci/home.htm and www.wpro.who.int/sites/pci/health_care.htm*

This case study of the transformation of the Hospital de las Mujeres Dr. Adolfo Carit Eva in San José, Costa Rica documents an exciting success story in the implementation of a human rights and people-centred approach to health care. It demonstrates how a consistent, carefully planned and strategic application of the BIAS FREE Framework by a dedicated and skilled leadership team was the key to this success.

The BIAS FREE Framework shaped the strategic planning process and was applied to every aspect of the hospital, transforming everything from the hospital's vision

and mission, to the management structure, community outreach, training, staffing and physical infrastructure.

The case study presents the immense benefits that resulted to patients, the community, hospital staff and the health-care system – results so convincing that the Ministry of Health has plans to implement the model in every other hospital in the country.

I Introduction

Introducing a gender focus in the provision of health services entails challenging and complex processes of change. In Costa Rica, a variety of work has been carried out with this aim. But the experience at the Women's Hospital was unique. A transformation of the hospital that put women at the centre and ensured their rights was the result of the joint efforts of many partners, following the development and implementation of a number of proposals and methodologies. The documentation of this experience has been undertaken to present the lessons learned with respect to successes and challenges along the way.

By the end of the 1990s, the Women's Hospital Dr Adolfo Carit Eva, previously Instituto Materno Infantil, was deeply involved in the process of modernizing the country's health-care institutions, and became an appropriate site for implementing a new model of integrated care that would eliminate gender bias.

Implementing the new model of care at the Women's Hospital and its assigned Health Areas, was a complex process which brought together different initiatives and multiple influences. To fully appreciate the achievements attained and the challenges overcome one must understand the processes undertaken by the different parties involved. While it is difficult to attribute all achievements to a single initiative, this document aims to highlight the contribution made by the gender-based analysis (GBA) methodology, in particular the *BIAS FREE* Framework[1], developed by Mary Anne Burke and Margrit Eichler[2], to this transformation and to gender equity.

The *BIAS FREE* Framework is an instrument designed to identify and eliminate biases resulting from social hierarchies in the conduct of health research. The authors, Mary Anne Burke and Margrit Eichler presented an earlier, gender-only version of their Framework to the health personnel participating in the transformation of the Women's Hospital and discussed its application in the realm of health services

1 *BIAS FREE* is an acronym for Building an Integrative Analytical System For Recognizing and Eliminating InEquities.

2 Burke MA, Eichler M. The *BIAS FREE* Framework: A practical tool for identifying and eliminating social biases in health research. Geneva, Global Forum for Health Research, 2006. www.globalforumhealth.org.

during a workshop in 2001. The GBA framework was applied by the workshop participants, not only to gender, but also to race and disability. It was this experience that propelled Burke and Eichler to broaden the focus of their tool to address all social hierarchies and rename it the *BIAS FREE* Framework. Throughout this report, the Eichler-Burke Framework is referred to by its revised name, the *BIAS FREE* Framework. Evidence related to the usefulness of this type of instrument is very valuable for future experiences in Costa Rica and abroad.

This report describes the conditions that favoured the transformation of the Women's Hospital, how the initiative started and what partnerships were created in the process. After the background section, the report discusses the strategies that supported the change process at the Hospital. Specific changes are identified in relation to the GBA framework, and the impact of these changes on the health and lives of women.

The assessment of the transformation process at the Women's Hospital and of the application of the *BIAS FREE* Framework are based on a review of documents, interviews with key informants, observations of important events and the processes involved in health-care services (see Annexes). The report also describes the degree of inclusion of a gender focus and progress related to women's empowerment and gender equality.

The report concludes with a summary of the lessons learned throughout the experience of transforming the Women's Hospital and assigned Health Areas, and a schedule of the events as they unfolded.

The research for this report, financed by the Global Forum for Health Research, was undertaken by Jessica MacDonald Quiceno with the guidance and support of Mary Anne Burke and Margrit Eichler, who kindly provided requested information and reviewed the document.

The support of Zully Moreno, MBA and Dr Luis Ledesma was also critical for the research study and for the drafting of this report. As leaders of the process to transform the Women's Hospital, they were important guides during the research. Questions about the transformation process were addressed to them. The results of the research were enriched by their contributions. Moreover, they were responsible for putting the findings of this research into practice and applying them both in the Hospital and outside its premises to establish alternative health care for women. An equally important contribution to this report was made by Ana Rojas, MSc, a former official at the Instituto Nacional de las Mujeres [National Women's Institute] (INAMU), who was responsible for leading the design of the Model of Integrated Health Care for Women, together with the Technical Commission of the Women's Hospital, and for closely following its implementation from 1999 to 2003.

We hope that this report will be a useful reference for future processes of transformation within the Costa Rican health system and the health systems of other countries.

II Background

a.1 Characteristics of the country and its health system

Costa Rica is a country located in Central America. Its territory is 51 100 km2. It borders Nicaragua to the north, Panama to the south-east, the Caribbean Sea to the east and the Pacific Ocean to the west.

The country has a population of 4 189 300 inhabitants, of which 49.1% are women and 50.9% men. Fifty-nine per cent of the population lives in urban areas and 41% in rural areas. Population growth between 1984 and 2000 was 2.8% annually, and according to estimates for 2015, an annual decrease of 1.8% in the growth rate is expected. The structure of the population shows a progressive trend towards aging, due to a decrease in mortality and fertility. The present global fertility rate is an average of two children per woman. Life expectancy at birth is 79.1 years; 76.9 for men and 81.4 for women. The country invests 6.7% of its gross domestic product (GDP) in health.

The Ministry of Health, the Social Security System (Caja Costarricense de Seguro Social - CCSS), the Water and Sewage System (Instituto Costarricense de Acueductos y Alcantarillados - AyA), the Insurance System (Instituto Nacional de Seguros - INS), universities and municipalities comprise the Costa Rican Health System.

In the 1990s, the country began a process of health reform to modernize the Ministry of Health and the Social Security System with the aim of improving equity, efficiency, quality, sustainability, participation and control over the health systems and services. The reform process focused on four elements: health direction by the Ministry of Health; improvements to the model of care in which the CCSS is the health-care provider; finance adjustments and modernizing the structures, work systems and administrative procedures in both institutions. The financing structure of the CCSS is based on the fees paid by workers, employers and the state.

Improvements to the CCSS health-care model included strengthening the primary health-care system and the establishment of three differentiated levels of care. At the level of primary care, the country is divided into Health Areas, which generally correspond to the distribution of the cantons. Health Areas are usually divided into health sectors, to which a primary care basic team (EBAIS) is assigned. Each team is composed of a general physician, nurse, assistant nurse and assistant of

primary attention (ATAP) who serve an average of 5000 people. These teams are supported by the Interdisciplinary Team of the Health Areas. Secondary health care includes Major Clinics and Hospitals in outlying regions, with specialized health-care personnel who have a higher level of training for resolving health problems and who receive referrals from the primary care centres. Tertiary care hospitals are the third level of care. They are staffed by more specialized personnel and provide more complex care. These three levels of care comprise the Model of Integrated Health Care for Women, improve access to health services and focus on actions that promote health and prevent illness.

a.2 Profile of Women's Hospital

The Women's Hospital was created in 1914, under the name of Maternidad Carit, and was intended to provide health care for low-income women. Later on it was renamed Instituto Materno Infantil Carit Eva and specialized in gynaecology, obstetrics and neonatology of low and medium complexity. From the beginning, the Hospital played an important role in the education of health personnel, both doctors and nurses, in the area of obstetrics. This led the National Council for Continuous Education in Maternal Child Health (Consejo Nacional de Educación Permanente en Materno Infantil), of the CCSS to be renamed as the Centro Docente Asistencial de Referencia (CEDARE).

In 1999, this institute changed its name to Women's Hospital Dr Adolfo Carit Eva and increased the complexity of the services it provided. Its assigned population of women who are at least 15 years old represents about 250 000 persons, while the population served represents 71.4% of the total female population in the surrounding areas. Part of this population comes from medium- and low-income households and lives in marginal urban areas, particularly the Southern Communities of the province of San José. Eighty-one percent of care administered is to women aged 20-44.

The hospital has 104 beds. In 2005, 11 641 women received care, of which 60% was obstetric care. There were 6360 births. Gynaecology represented 17% of services provided, neonatology 13% and surgery 10%.

The Hospital has 425 employees, of which 67% are women and 33% are men. Although the majority of employees are female, the director and deputy director of the hospital, as well as the chief physician, are men.

As part of the health services network, the Women's Hospital receives patient referrals from the Dr Carlos Durán and Marcial Fallas Clinics, both of which are major clinics providing secondary health care and serving an urban population with some marginalized populations. The Women's Hospital also provides services to the Health Areas of Desamparados, Aserrí, Acosta and Corralillo, which provide primary health care. According to the last census (year 2000) the canton of Desamparados had an urban population of 88%, while Aserrí's was 60.4% and Acosta's 22.1%.

a.3 Political context favoured a proposal for change

During the Rodríguez Echeverría government's administration (1998-2002), several factors combined to produce a favourable context in which to propose changes

in the Women's Hospital. For one, progress had been made, with the approval of the Law for Decentralizing Hospitals and Clinics (Law #7852)[3], in decentralizing care from the CCSS as required by the Health Reform. This law provided health units with the autonomy to define and evaluate the services they offer and made it possible to involve communities in decision-making about administrative and financial issues. That administration gave particular relevance to social participation in the social policies advanced by the government[4].

Furthermore, during the Rodríguez Echeverría administration, resolving the problem of inequity among men and women was set as a priority. By approval of the Legislative Assembly, in April 1998, the Centre for the Development of Women and Family, which was part of the Ministry of Culture, was elevated to a National Women's Institute (INAMU, Law #7801), an autonomous and decentralized institution. Not only was the political-administrative status of the former centre raised, but its roles and responsibilities expanded. The INAMU was created as the governing body for national policies related to gender equality and equity. A Management Area for Public Policies related to Equity was established within INAMU, in which health policies are an important component. In addition, the position of Minister for the Status of Women (Ministra de la Condición de la Mujer) was created, with responsibility for INAMU. These changes elevated issues related to women and gender to the highest level of decision-making, the Government Council.

During the same administration, the Vice-Minister of Health committed to fostering the well-being of women, and the Executive President of the CCSS showed his interest in the process of change at the Women's Hospital. Thus, the hospital had support from the highest levels of the health system to allocate resources and make institutional decisions concerning technical matters.

The events leading to the change from Instituto Materno Infantil to a Women's Hospital provided an opportunity to merge political and technical interests into a new proposal for health-care services for women, as we will see in the next sections.

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3 This law allows public hospitals and other health units to have more autonomy with respect to their budget, administration and human resources. In this way, the health units have become empowered, as they used to be constrained by centralized planning of budgets and resources. Approval of the law coincided with the creation of Management Commitments, an administrative tool through which the Administrative Management of the CCSS agrees on an offer of health services for each health unit during a given period. The application of this instrument requires the allocation of financial resources to the institution in compliance with the offer of services. At the same time, the law creates Health Boards, composed of representatives of the users of the services and employers, to provide citizen oversight of the financial and administrative decisions taken by the health unit. The Boards are also responsible for the promotion of citizen participation.

4 During this government administration, several social programmes were developed, including "Triángulo de Solidaridad", which sought to create alliances among communities, companies and public institutions at the local level. Different methodologies were proposed to empower the communities and their participation in making decisions about policies and the distribution of resources at the local level.

III Transformation process

This section describes the stages in which the Women's Hospital was transformed.

b.1 First phase: Construction of a political support platform

This phase produced the political conditions to make the desired changes. The convergence of interests and needs from different officials, both technical and political, was crucial. The creation of strategic alliances was also necessary to position a gender focus as the driving force for the transformation of the Women's Hospital.

b.1.1 Proposal to convert the Instituto Materno Infantil into a Women's Hospital

The Instituto Materno Infantil Dr Adolfo Carit Eva had remained, over several decades, unchanged in terms of its infrastructure and resources (both material and human), in spite of growing demand for services and new health-care requirements. Since the end of the 1980s, several attempts were made to obtain support from the authorities of the CCSS for better resources and facilities to respond to these needs. In the 1990s, several assessments were conducted and a recommendation was made for providing human and material resources to improve the physical plant and create a Medical Centre for Complex Care with care, teaching and research services. This proposal was developed and promoted by a group of physicians from the institution, who were interested in enhancing specialized services from a biomedical risk approach that would be suitable for the acquisition of highly complex technology. However, the desired changes never became a reality because of lack of support from the Hospital authorities.

Assessments of organizational culture indicated that the institution had excellent human resources who demonstrated high levels of commitment to their work, but who were demoralized because of the lack of progress in spite of diverse attempts to produce change. Also, the hospital was threatened with closure as it had not made the adjustments to the model of care set out by the CCSS, as a Specialized Hospital with the capacity to function as a tertiary care facility.

During the Rodríguez Echeverría administration (1998-2002), the Executive President of the CCSS, the highest level decision-maker within the institution, considered improving the performance of the Instituto Materno Infantil Dr Adolfo Carit Eva. As

a result, an adjacent parcel of land was purchased to expand the physical facilities in a way that its architectural design would facilitate the delivery of the service. As part of this initiative to transform the Instituto Materno Infantil into a national specialized hospital, a proposal was made to change its name to Dr Adolfo Carit Eva Women's Hospital.

The change in the name permitted the Hospital and CCSS authorities to approach the Minister of Women's Affairs and the INAMU. The INAMU responded with a proposal to develop a project to strengthen the institutional capacities of the health centre, based on a gender perspective. In line with this new focus, the opportunity was taken to define a Model of Integrated Health Care for Women that would provide guidelines for provision of health services for women for the whole country. The project would be applied in the hospital as a pilot project.

b.1.2 Formalization of agreements and mechanisms for decision-making and change management

An agreement for interinstitutional cooperation was signed, among the Ministry of Health, INAMU and the CCSS to develop and implement the Model of Integrated Health Care for Women. It established the coordinated development of four lines of work, including adjustments to the Health Care Model at the Women's Hospital.

This agreement created two interinstitutional commissions that would be responsible for promoting the Model. The commissions were composed of representatives from the three institutions who had high political and technical status and experience in gender and health. The first of these, the Interinstitutional Commission of High Political Level was composed of the Executive President of the CCSS, the Minister for the Status of Women, the Vice-Minister of Health and a medical advisor to the CCSS Executive Chair. This commission was charged with setting guidelines and policies for making decisions and supporting the project of transformation. Indeed, the commission greatly supported the project and channeled financial and human resources to support the change process.

The second commission created was the Interinstitutional Health Sector Commission (CTISS). Its function was to prepare the proposal and to implement the new model of care at the technical-operational level. The commission was composed of representatives from the Hospital and the central level of the CCSS (Technical Direction of Health Services – CCSS, Management of Modernization, Women's Office, Management of Institutional Planning and Management of Organizational Development), and supported by a representative from INAMU. Several CTISS appointees had expertise in gender, such as the representatives from INAMU and the Women's Health Chief from the Technical Management of Health Services – CCSS. The other members were new to the subject. Representing the Women's Hospital on the CTISS was the Chief of the Social Work Service, an obstetrics nurse, and a gynaecologist-obstetrician, who were assigned full time to implement the Model of Integrated Health Care for Women in the Hospital.

A woman, who was the Hospital's Chief of Social Work, and also trained in business management and health services, was appointed to head this commission. This was the first time in the history of the Hospital that a woman was assigned this kind of responsibility, breaking the tradition of male and medical leadership in the Hospital's administration.

b.2 Second phase: Formulation of the change proposal

In this second phase advances were made in the planning of the proposal, as well as in developing strategic alliances for its implementation.

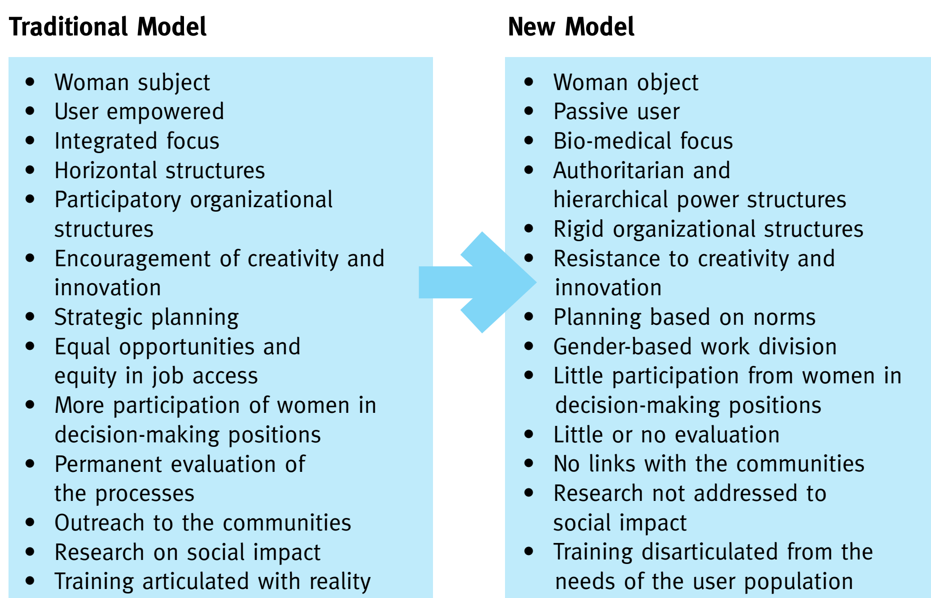
b.2.1 Development of the Model of Integrated Health Care for Women

The proposal for the Model of Integrated Health Care for Women was made by the Interinstitutional Technical Commission (CTISS) in February 2000 and was published as a document in July 2001. The Model sought to change the power relations between men and women, between the health personnel and the users of the service, and between the health centres and the communities. The proposal therefore combined a gender focus with a focus on rights and with integrated health care.

Two key obstacles were identified: one was the traditional and hegemonic paradigm for health care; and the other, the patriarchal culture within health institutions. In the first case, the challenge was to transform a health-care service based on a model of care that was fragmented and vertical, shaped by a bio-medical view of health, and centred on physicians to the detriment of other disciplines, into a model of integrated care. In the second case, the goal was to modify the social relations, marked by inequality and inequity, among men and women in the institution, by creating new practices, discourse, habits and values that would be more egalitarian.

The proposal for a Model of Integrated Health Care for Women defined a vision, mission, objectives, strategies and implementing phases. The implementation of the Model in the Hospital, as a pilot project, involved a variety of social actors in a collective construction.

Fig. 1 Synthesizes the type of transformation proposed by the Model of Integrated Health Care for Women



Source: MS, INAMU, CCSS, Dr Adolfo Carit Eva Women's Hospital. En Modelo de Atención Integral de la Salud de las Mujeres: una propuesta para su construcción. July, 2001

The strategic plan, part of the proposal, was a key tool to guide the process of change and the development of the organization. To implement the new model, changes had to be made in the organizational culture of the Hospital, moving towards flat management structures, health care based on interdisciplinary team work, and interinstitutional and intersectoral collaboration. This reorganization also sought to create a working environment where equity and equality in relationships would be the norm, based on respect for human rights.

b.2.2 Introduction to strategic planning to lead change

For the first time in the history of the Instituto Materno Infantil Dr Adolfo Carit Eva and the new Women's Hospital, the need to develop a planning process that would involve the participation of different social actors and from a strategic perspective, was considered. Initially, the new model was presented and discussed in a public forum attended not only by hospital officials but also by women from the communities, representatives of nongovernmental organizations (NGOs) and officials from international organizations who could be potential partners in implementing the model. This was followed by a workshop on strategic planning, attended by representatives of public institutions, including heads of departments and other officials from the Hospital, representatives of NGOs and the central level of the CCSS and INAMU, and women from the communities. The Pan American Health Organization (PAHO) supported the activity by financing the workshop and providing an expert in strategic planning.

Consensus was obtained on the following vision and mission of the Women's Hospital:

Vision
To become a complex care hospital of national and international prestige, a leader in integrated, interdisciplinary and interinstitutional health care for women, their families and newborns, and with a gender perspective.

Mission
To provide integrated care to women, newborns and their families, through the inclusion of a gender approach, social participation, education, promotion, rehabilitation, research, community empowerment and access to decision-making, as a leader in women's health care and in the development of a Model of Integrated Health Care for Women.

The following **values** would be upheld:
- Respect of women's human rights
- Empathy and affinity without sexism
- Equity and equality
- Social commitment
- Solidarity
- Loyalty
- Honesty
- Quality
- Dignity
- Non-discriminatory or sexist language
- Autonomy

The following areas of work were defined:

1. Train and raise awareness concerning gender equity and equality among health-care personnel.
2. Open the Hospital and reach beyond its walls by forming service networks among levels of care and strategic alliances with other sectors and social actors, and by building a strong relationship with the communities and a commitment to their empowerment in health-related areas.
3. Empower the women of the communities to actively exercise their health-related rights.
4. Adapt programmes providing care to women so that they incorporate an integrated and participatory approach, a gender focus, and interdisciplinary working teams.
5. Develop an open and friendly organizational culture that has a strategic and participatory management approach.

This first strategic plan gave direction as to needed actions and favoured the negotiation of international cooperation links. This exercise was to be repeated every four years and new strategic plans developed. But, unlike the first plan, the others did not continue the strategy of having participation from different social actors in the planning process.

b.2.3 International cooperation

The efforts to build a Women's Hospital were supported by several international partners. PAHO offered technical and financial support from its different work units, including the Woman's Programme, Health and Development and the Unit of Systems Development and Health Services.

As mentioned above, PAHO supported the strategic planning process and also facilitated collaboration between the Women's Hospital and the Latin American Centre for Perinatology and Human Development (CLAP/OPS) on a programme of excellence in maternal health. It also gave technical and financial support to a community project on health for middle-aged women in one of the Health Areas assigned to the Women's Hospital.

In addition, cooperation links were established with health authorities of Costa Rica and the Federal Government of Canada, together with other agencies such as Health Canada, the British Columbia Centre of Excellence for Women's Health, British Columbia Women's Hospital, Health Sciences Centre of the Toronto Women's College Hospital – a WHO Collaboration Centre for Women's Health – and the IWK Grace Hospital in Halifax. A Technical Cooperation Agreement between Canada and Costa Rica (TCC) was established to promote the exchange of experiences between the two countries. Through this treaty, visits and training opportunities were arranged for health personnel and INAMU officials, representatives of the Women's Hospital and central offices of CCSS, as well as representatives from NGOs, to institutions in Canada. Training activities that would be provided by Canadian experts on the topic of gender and health were also defined.

The Canadian International Development Agency (CIDA) supported the creation of a new model through a project called "Social Participation and Strengthening Networks for the Model of Integrated Health Care for Women", which had as one of its goals to establish a group of well-informed, empowered women who had the personal and collective capacity to promote the model among their communities.

This particular project was financed by the Gender Equality Fund of the Canadian Cooperation Programme of the Canadian International Development Agency (CIDA).

b.3 Third phase: Gender-related sensitization and training process

Raising awareness and training with respect to gender equality and equity was defined as one area of work within the pilot project to implement the Model of Integrated Health Care for Women in the Women's Hospital and its assigned Health Areas.

In this phase and in the next, raising awareness, redefining the programmes and projects of the Hospital, and strengthening the changes related to the work and organization of the health-care process happened simultaneously.

b.3.1 Gender-related training

The Canadian experience in health policies related to gender equality, the implementation of specific health programmes for women that involve community participation, and the development of gender sensitive research are considered important sources of knowledge for enriching the Costa Rican experience. Therefore, the agreement between the countries (TCC) included training provided by the Canadian experts to the personnel of the Hospital and Health Areas, who would then be able to:

- Incorporate a gender approach in health policies, in evaluations and in the Model of Integrated Health Care for Women, at the three levels of health care.
- Develop gender-sensitive methodologies to evaluate the Hospital programmes.
- Implement gender-sensitive research methodologies to strengthen decision-making based on evidence.

In 2000-2001 the training sessions began. In total, the following five workshops were given by the Canadian experts:

1. A preliminary activity called "Model of Integrated Health Care and Community Services for Women" facilitated the exchange and comparison of experiences related to health care for women, in Costa Rica and in Canada.
2. Workshop on "Gender-based Analysis Methodology", taught by the Canadian experts, Mary Anne Burke and Margrit Eichler.
3. Technical advisory workshop to identify key sources of information that would foster gender-sensitive best practices in women's health care, taught by Judith Hockney.
4. Research workshop called "Action: Gender-sensitive Focus in Health Research", led by Loraine Greaves and Ann Pederson.
5. Training for changing the organizational culture of the Women's Hospital, taught by Patricia Campbell from Women's College Hospital.

The people who participated in these workshops were selected according to the goals of each workshop. As these activities were aimed at promoting horizontal relations between participants, representatives from different levels of care and different sectors were invited, thus breaking with established hierarchies.

The officials from remote Health Areas were surprised to participate for the first time on an equal basis with directors, both men and women, of the Hospital and Major Clinics and to get to know the people who made decisions, from a more equal and human position. The women from the communities also found it a new experience to sit down with health-care personnel who previously they perceived as inaccessible, and to see them as equals. For the health personnel, to listen to the women and work with them in the discussion groups was an enriching experience, both at a personal and professional level. This was a new experience for all, which helped to break down barriers and recognize diversity and the possibility of working together.

The methodology workshop "Gender-based Analysis" offered by Margrit Eichler and Mary Anne Burke was a doorway to the process for raising awareness. It was designed to open up the topic of potential gender bias in health care. The workshop would also produce a group that would replicate the process and adapt it to their local realities. The detailed process is explained below.

b.3.1.1 Gender-based Analysis workshop

When this workshop was planned, three target groups were identified: providers of health-care services at health-care levels I, II and III; female community leaders with experience in assessments and health-related project formulation; and NGOs with ample experience in health work with women.

The workshop, which employed a participatory methodology, took place in February 2001. The facilitators of the workshop explored, together with participants, their experiences related to gender bias at work and in everyday life. The types of problems reflected in these experiences were discussed. Participants' level of knowledge about key concepts related to gender equity and equality were also assessed. Then, work was done on the concept of gender bias and on gender-based analysis.

This exploration identified several biases in health-care services, such as the invisibility of women's needs and their origin in their role as mothers and family caretakers. It was important for the participants to recognize that women have particular needs and interests and that within their family circle they face inequitable power relations and subordination to their partners or husbands.

The Canadian experts presented a framework known as the *BIAS FREE* Framework that classifies problems in three categories (Maintaining an existing hierarchy, Failing to examine differences, and Using double standards[5]) and evaluates possible solutions to overcome these gender bias problems. The identification of problems and their solutions was explored through role-play situations. The workshop provided many examples; the facilitators encouraged participants to share their experiences.

The workshop process permitted the participants to take ownership of the gender-based analysis methodology as they applied the Framework to analyse documents for gender bias. Action plans designed to apply what was learned to the process of change at the Hospital were a product of the workshop. The participants committed to applying the *BIAS FREE* Framework systematically to situations at the Hospital and in its Health Areas.

5 See Annex

For example, members of the health-care team in the Acosta Health Area, which is the most remote area served by the Hospital, wondered why so few Pap tests were taken in their Area. By listening to the women of the communities, they learned that the women were reluctant to have a vaginal smear taken because they did not feel comfortable with the male medical personnel. This information led to new strategies and a female physician was assigned to the community. Both were well accepted, increased the number of tests taken and improved the early detection of cases of cervical cancer.

A second example concerns the personnel from the Aserrí Health Area who analysed their work with women affected by domestic violence. The *BIAS FREE* Framework helped them to detect unnoticed biases and as a consequence better empower women.

Twenty-seven people attended the Burke-Eichler workshop. Most of them said that it was a new experience that helped them reflect upon their lives and health practices from a new perspective. Some of their testimonies are:

> *"I learned to recognize that I am worthy, that I am somebody and did not come to the world to be walked over. This helped me to put more effort ... to be willing to study. Prior to this, I was not thinking of studying ..., I did not believe I could improve. This workshop helped me to be more sensitive to my girls (collaborators) and users".*
>
> *(interview with administrative official from the Hospital. At the time of the workshop, she was experiencing domestic violence. After participating in the sensitization process, she went back to school and got a promotion in her job)*

> *"It was a very new concept [gender], to see women from a different point of view, it was very enriching ... it provides a new basis for the care of women. In spite of being a woman, sometimes we can perceive women from a male perspective (machista). Some women say, during a medical examination, that they don't get a surgery or do not take the cytology because their husbands do not allow it. This training helps us to open the path for them and tell them that things are different, that they are independent beings who do not depend on their husbands.*
>
> *(interview with female physician who works in a Health Area)*

> *"We were invited, and I did not know what to expect ... we were told that it was about gender sensitization; I did not know what use to give to that. It was very nice; I liked it much because it started by taking a look at oneself inside. How am I? How was I before this? How am I after the workshop? Maybe one is very machista and one starts to look at things in a different way, to get level with women ... Not to see women as objects, but as equal to men; not to look down on them. At home, maybe I was like that, very machista, and I changed. As a man, I did not share my experiences with my family, what concerned me, or if I was ill. But after the workshop, I started to be more expressive, to talk when I feel bad, when something bothers me; before, it was only gestures, I did not speak. As an experience, I liked it a lot".*
>
> *(interview with nurse from Health Area)*

The *BIAS FREE* Framework became a valuable tool in guiding the process of adopting the new model of care. This is illustrated in the following words from the coordinator of the Interinstitutional Technical Commission of the Health Sector:

> *"Although the change process began in 1999, we, as the team responsible for the implementation of this process in the Hospital, were stuck; we knew what to do but not how to do it. This workshop was the key to understanding how to advance in that direction. To identify the hierarchies and see that they had to be flattened, helped me understand how the gender focus is applied".*

For the group that led the process of change at the Hospital, the *BIAS FREE* Framework had the virtue of being a simple tool that helped them identify gender biases in the provision of health services that could and should be modified within the new integrated health-care model. This tool also made it easier to conceive ways of modifying those situations.

The Canadian experts provided a manual[6] developed in Canada for training using their gender-based analysis methodology. This manual was reviewed and adapted to the local reality. Initially, a national consultant was hired to do this job; however, the product was not satisfactory, and a new working team, composed of gender and health experts from the Ministry of Health and the National Institute of Women, completed a final version[7], which was validated with the Replicating Group (see below) in 2004.

The document is a pedagogical tool divided into modules designed to change concepts, attitudes and actions of the personnel responsible for providing health care. This document sets guidelines for training health-care personnel in the analysis of policies, programmes and projects from a gender perspective, and for planning the provision of health services based on gender equity.

b.3.1.2 Replication of the GBA workshop in the Hospital and Health Areas

Even though the Gender-based Analysis training manual was not available immediately after the workshop, the *BIAS FREE* Framework provided by the Canadians, as well as the workshop experience, served as the model for the replication workshops to be held at the Hospital and in its assigned Health Areas. To that aim, the people who attended the original workshop became the Replicating Group responsible for reproducing the workshop in their workplaces and communities. The purpose of the replication workshops was to apply the gender-based analysis systematically to facilitate the design of programmes and projects related to health services which promote gender equity.

This experience was very new for the group, as their members had never worked in a horizontal way with the leaders of the communities. This was also an opportunity for health units to coordinate their efforts, instead of working in isolation as usual. As a group, they reviewed the material and designed the workshops. In the words of one of the members of the Replicating Group:

> *"I have very good memories of the training with the Canadians. The process led me to reflection, to share with others. The group developed*

6 Health Canada. Moving Toward Equality: Improving the Health of Canada's People, Recognizing and Eliminating Gender Bias in Health, Health Canada, Unpublished. Ottawa, Women's Health Bureau.

> *well; there was a lot of friendship. We met together for planning and designing the workshops; we supported each other in the execution of the workshops; we made the material and did the evaluation together".*
>
> *(interview with a social worker at a Major Clinic)*

The workshops were offered in the Women's Hospital, Area 3 of Desamparados and the Clínica Marcial Fallas, Clínica Dr Carlos Durán, Aserrí Health Area and Acosta Health Area, and were addressed to health-care personnel and community leaders.

The workshops maintained the non-hierarchical relationships and gender equality the Replicating Group had achieved. The workshops were organized and facilitated mainly by women, the majority of them, social workers and nurses. The experience produced challenges in this respect, but with the support of CTISS, the group developed cohesion as agents of change.

The facilitators of the replicating workshops reported good reception from the participants who expressed interest in follow-ups. The goal of sensitization was achieved. In general, the results were more positive with young or new personnel; older personnel preferred to maintain their established patterns and the previous model of care. However, these persons were a minority.

After the workshops, the gender focus was introduced in a more systematic way in the training provided by health services on topics such as intra-family violence or sexual and reproductive issues. In the latter case, the aim was to support women's decisions to use or not use sterilization as a means of pregnancy prevention. This is one example of where health-care personnel were sensitized about and learned how to better respect the rights of women to make decisions about their own bodies and lives. Many other examples took place across the health services.

b.4 Fourth phase: Development of strategies for social participation

Another important element of the proposal for a Model of Integrated Health Care for Women is social participation. At the Women's Hospital two novel processes were promoted in the delivery of health services within CCSS. One was to empower women leaders in the communities to express women's needs and interests related to health; and the other was to develop a network for social participation promoted by the Health Board of the Women's Hospital. These processes enabled the construction of a sound base of citizens who were active in supporting and defending the new model.

This strategy was consistent with the sensitization processes discussed during the workshops with the Canadians. The application of the *BIAS FREE* Framework enabled the Lead Group at the Hospital and the health personnel to identify asymmetries in their relationship with the users of the services and to be more

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[7] Rojas Marielos, Balmaceda Grettel, Rojas Ana. Análisis Basado en Género: una herramienta metodológica para la planificación en salud [Gender-based Analysis: A Heuristic Methodology for Health Planning]. Costa Rica, Ministerio de Salud, INAMU, CCSS, OPS and UNFPA, 2004.

open to listening to their voices and to respect their rights. This resulted partly from the successful inclusion of women from the community, under conditions of equality with the health personnel, in the workshops offered by the Canadians. These women later became part of the processes to empower women leaders in the communities, as explained below.

b.4.1 Empowerment of female community leaders

From the year 2000, strategies were sought that would facilitate the inclusion of women from the communities as well as other social actors in the implementation of the new model. This would ensure that the needs and interests of women were met and create opportunities for citizens to participate in the processes of formulation, implementation and evaluation of health policies and programmes with a gender focus. Thus, the process recognized the need to enable women to become protagonists in the construction of their own health and of the definition of a new model of care tailored to their needs.

This strategy was an initiative and an interest of the National Women's Institute (INAMU) and the leading team of the Women's Hospital. The initiative led to the proposal and implementation of the first social participation project called "Proyecto Puente de Fortalecimiento de Redes para el Modelo de Atención Integral de la Salud de las Mujeres" [Building Bridges to Strengthen the Network Management in the Model of Integrated Health Care for Women]. This project helped to establish a link between the Hospital and the women in their communities and organized civil society. The project was financed by the Embassy of Canada, through the Canadian International Development Agency (CIDA) and later on, the CCSS financed the second phase of the project.

The project aimed at forming a group of informed and empowered women with personal and collective skills to promote the new model in their cantons. The project was under the coordination of a Costa Rican consultant, expert in gender, health and local management, Msc Margarita Aragón, and was implemented in three cantons: Desamparados, Aserrí and Acosta.

The following steps or phases were followed:

1. Initial assessment and establishment of a leaders' group

During this phase, the new model and the work proposal were presented to different social actors in the three cantons. Women's organizations and institutions in each locality were identified to work on an equal basis through a coordinated interinstitutional and intersectoral approach and mechanisms to facilitate the operationalization of women's rights to health.

Although the concepts of health and illness presented by the new model exceeded the narrow way in which health services had been defined, time constraints and feasibility led the team to focus their efforts on the health services of the CCSS. During this phase, support was obtained from institutions and key officials who would become links with the projects that were identified. In addition, women who were leaders in their communities were identified and informed about the new model and invited to participate in the project.

2. Training of women leaders and formulation of their health-related demands

During this phase, four workshops[8] were carried out with women leaders from the communities, exploring concepts of health, their bodies and their lives, as well as experiences related to health services. These workshops empowered the women by encouraging them to take ownership of their bodies, by recognizing their rights and by offering new ways of thinking about women's leadership. The last workshop resulted in three proposals for Integrated Women's Health Agendas, designed by the women of the cantons themselves. These agendas covered the demands of the women for improvement in the quality of health services, and their needs as leaders. With respect to the latter, women expressed the need for constructing a new type of leadership where the institutions would establish relations of respect and recognize the historical exercise of women's leadership in their communities and their social value.

For the women, it was a novel experience that they remember as empowering. In their own words:

> *"This experience helped us in many ways: friendship, exchange of ideas, a feeling of safety, we learned to assign value to ourselves as women, to defend ourselves and maintain peace at home, enjoying freedom and self-esteem by being respected and by respecting we learned to exercise our rights, we learned to negotiate. (Agenda in Women's Integrated Health, Desamparados canton)*

> *"We also learned that women have many needs and that our health is closely related to the quality of our lives (...) The training helped us recognize the value of respecting and loving ourselves, which will contribute to becoming better persons and to develop better as leaders, without entailing exhaustion or sacrifice". (Women's Integrated Health Agenda, Aserrí canton)*

> *"We have grown as people, as women, we have learned that our job as leaders is a responsibility, but that it should not be ever a heavy load or sacrifice. It is important to set limits to our work, that we recognize what we really want to do, that we commit to what brings us satisfaction, fulfills us and does not affect us in a negative way. It is possible to exercise a type of leadership that would nourish us and not exhaust us". (Women's Integrated Health Agenda, Acosta canton)*

3. Establishing action plans and women's associations within the cantons

During this phase, a fifth workshop was carried out with the women: "Building our Action Plan" in each canton. As part of the action plans, they decided to present their health agendas and validate them with other women from the different districts of each canton. In total, 28 surveys were made with the participation of 840 women from the three cantons. These activities were successful in strengthening

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8 The workshops were: "Apropiándonos de nuestro cuerpo" [Taking ownership of our bodies], "Nuestras vidas, nuestra salud" [Our lives, our health], "Nuestro liderazgo en salud" [Our leadership in health] and "Construyendo nuestra agenda en salud"[Constructing our health agenda].

the women, and giving them experience in how to organize themselves. Through them, they were able to legitimize their positions as health leaders and review their agendas with a broader level of representation of the needs and interests of the women from the cantons. The surveys were also used to encourage other women to become leaders and to foster the creation of associations that would provide legal support for the actions of the leaders. Three associations were created to promote the health of women in the cantons: Asociación Salud Integral de las Mujeres Desamparadeñas (ASIMDE), Asociación de Mujeres Aserríseñas y de San Juan de Dios Promocionando la Salud Integral (AMASPSI), and Asociación de Mujeres para la Promoción de la Salud Integral de Acosta (AMPROSIA).

4. Negotiation of Health Agendas

During this phase, a process was carried out to prepare the health personnel in each Area and legitimize the efforts and actions the women were making to express their concerns and needs. The agendas were later submitted by the leaders to the Technical Councils[9] of each Area, and the demands made by the women were negotiated with health authorities within this first level of care. The training the Canadians gave to the health personnel had already paved the way for a good reception. In fact, the directors of the Health Areas had participated in the application of the *BIAS FREE* Framework and were already convinced of the value of changing the relationship with the women users of the services. An open attitude and willingness to listen to the women was present. Each Health Area defined strategies and mechanisms for the women to follow up on the agreements established, and the health units would report on the application of the recommendations in the operation of the health centre. Some women even became members of the Technical Councils of the Health Area.

The project achieved great success and important changes in health services for women have been driven by it. The leaders were indeed empowered, and this effected changes in their lives that continue to this day. They became aware of situations that affected their lives, and were empowered to make vital decisions that would change those circumstances. They took on a critical position regarding their everyday reality and moved away from the traditional vision of their role as women. They developed organizational and communication skills. For many of them, the experience was exceptional and gave them confidence in themselves and in speaking publically. They also modified their participation as volunteers, and became more autonomous and effective as leaders.

Now, there are three health-related women's associations with a legitimate place in their communities to promote activities that will improve the health of women in the cantons. The Association of Women from Aserrí has been designated a place within the Ministry of Health to develop their activities, to support women who are experiencing intra-family violence, and to be active members of the network for care related to intra-family violence. They also participate in municipal committees for promoting the well-being of the population. The president of the association has worked closely with the social worker from the Ministry of Health and is in charge of a waste recycling project. The Association of Women from Desamparados does grassroots work with the EBAIS and participates in national and international organizations for promoting health. The Association of Acosta develops activities addressed to women of the canton and works closely with health services. The three associations have representatives on the Health Boards of the Health Areas and, therefore, play a key role in citizen oversight of health-related decisions.

Another important outcome is the impact that the participation of the community leaders had on obtaining financing and support from the Legislative Assembly for the construction of the new hospital. The women collected signatures to support the Women's Hospital's process of transformation. Besides paying a visit to the legislators, the women leaders attended activities where the authorities of the CCSS were making decisions regarding the social participation promoted in the institution. At those meetings, they provided critiques from the perspective of the communities and demanded commitment from institutional authorities to establish more respectful relations and improve conditions for true community participation in health matters.

The activism of the women leaders also led to the development of research activities related to the problem of intra-family violence in their communities. This research was linked to the international day of non-violence against women and to an event organized for that purpose. They designed the poster convening the event, and the result was a very succesful experience in organizing.

b.4.2 The Health Board makes bridges to the communities

As stated at the beginning of this document, the Health Boards are organizational structures created within health centres to establish citizen oversight. The Health Board of the Women's Hospital has become an important body in the participation of the citizenry, with respect to gender issues.

This Health Board has played a key role in detecting and dealing with problems related to equity in the provision of health services at the Hospital. For example, access problems affecting special groups, such as women in prisons who are transferred to the Hospital or women from far away areas who have difficulties in registering at the Hospital very early in the morning for ambulatory surgery. These situations have led the Health Boards to include surveys in their work plan that will determine whether or not the services the Hospital provides are really serving the women.

This progress, over the years since the Board was established, was achieved thanks to the inclusion of several retired nurses who know the institution well and who have considerable experience in advocating for the rights of women.

Although the members of the Health Board did not participate in the GBA workshop facilitated by the Canadians, one member of the first Health Board was a representative of INAMU in the CTISS. The Hospital assigned an obstetrics nurse, trained in gender issues, to serve as a link and to facilitate coordination with the Hospital. The Board also maintained, and still maintains, a close relationship with the coordinator of the CTISS and the Head of Ambulatory Visits (Consulta Externa). This assisted in the inclusion of the gender focus in the work of the Health Board. In addition, the CTISS Coordinator helped to create conditions in the Hospital that gave recognition to the Board and established alternative ways of relating that would eliminate hierarchies as the *BIAS FREE* Framework proposed. Unlike other health units of the CCSS, the Hospital gave a legitimate place to social participation, through the Association of Women in Health and the Health Board of the Hospital, and was open to constructing new joint work.

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9 The Technical Councils in the Health Areas are organizations composed of a Director of the Area and representatives from different services. These Councils plan, provide follow-up and evaluate the services provided. Thus, they make fundamental decisions

An INAMU representative to the CTISS described the process as follows:

> *"The strategy designed by the CTISS was that the Health Board would be taken into account as an autonomous group, capable of monitoring the resources of the Hospital, and the treatment given to the users. This had different moments. At the beginning there was more intervention from the Hospital representatives; the Health Board was considered a useful body, at the service of the Hospital but not of the women, who were in reality its reason for being. This slowly changed. The Board won territory until becoming what it is now. The distribution of the budget became an important point of discussion, and also letting the Board of Directors know how their slow decisions were lagging behind the needs, such as approving the budget".*

The Health Board, little by little, found new opportunities to act. For example, the network management model and the presence of representatives of the Board on the Operation Management body of that network, created links with other Health Boards from the other units involved in care levels I and II, and with other social organizations related to integrated health care for women, as will be described in Section b.5.3.

Later on, the Health Board of the Women's Hospital, in the context of implementing the Model of Network Management, designed a new project entitled, "Building Bridges to Strengthen the Network Management". In 2003, there was recognition of the need to join efforts with the boards of the other Health Areas where the women who use the services of the Hospital live. Exchange meetings took place and contacts were made with the three Associations of Women, from Desamparados, Aserrí and Acosta.

In 2006, a joint assessment of the needs for education on health with a gender focus was made. Different workshops for strengthening the networks of Health Boards and Associations of Women were planned. The workshops were implemented with the support of other public organizations, such as INAMU and international organizations such as the United Nations Population Fund (UNFPA) and the Costa Rican Institute against Cancer. The last workshop, on sexual and reproductive rights, had a large attendance and was facilitated by a representative from the Costa Rican Demographic Association, an NGO dedicated to the topic, and an official from UNFPA.

At present, the social participation process promoted by the Women's Hospital is considered a model that the CCSS authorities would like reproduced in the rest of the country,

b.5 Fifth phase: Process of change in the way of working, including health practices and management

As indicated before, the sensitization and training processes that resulted from the Gender-based Analysis workshop and the application of the *BIAS FREE* Framework favoured important transformations in the way of understanding health programmes and practices. These changes range from the conceptualization of health problems to changes in dealing with them, organizing services, and even changes in the hospital building itself.

b.5.1 Review of programmes

The Interinstitutional Technical Commission (CTISS) selected three aspects of women's health which were considered strategic: teenage pregnancy, cervical and breast cancer, and health needs of middle-age women. A proposal was made to design programmes that would follow the guidelines of the new model of integrated care. The advice from the Canadians, together with the application of the *BIAS FREE* Framework, proved very useful in designing programmes with a new approach that would address social hierarchies, failure to examine differences and double standards.

Three interdisciplinary teams, coordinated by social workers and nurse officials, were established to direct these programmes. Although interdisciplinary collaboration was not new in the institution, the application of the *BIAS FREE* Framework made visible and helped to dispel disciplinary hierarchies. Indeed, the new approach favoured team coordination by non-medical disciplines such that collaboration is no longer one led by male physicians or driven from an exclusively biomedical perspective. The teams were composed of nurses, doctors, social workers, technical personnel from the health registry and administrative personnel. The programme for Integrated Care for Adolescent Women is still coordinated by a social worker; the programme for Health Care for Middle-Aged Women is coordinated by a nurse; and the programme for caring for cervical-uterine and breast cancer - Programa de Atención de la Salud Cervico-Uterina y de Mama - was coordinated for several years by a social worker and is now coordinated by a physician who is a specialist in palliative care.

The application of the *BIAS FREE* Framework also underscored the importance of taking into account the perspective of women and their health-related needs. Each programme developed activities to consult with the users of the services, through focus groups in which the women expressed their needs and desired changes in the care they receive at the Hospital[10]. These qualitative assessments or surveys, together with the Health Agendas made by the women in the communities, were critical in designing and executing new modalities of care based on the needs that the women themselves identified. In addition, the coverage of the programmes increased in other geographic areas.

Each interdisciplinary team developed or reviewed their respective programme, taking into consideration the concerns expressed by the women, and defined actions according to the new model. The advice from the Canadian experts on gender and women's health, as well as the support received from gender and women's health experts from the CCSS, INAMU, the University of Costa Rica and NGOs were essential for redesigning these programmes. At the same time, in the Hospital, institutional capacities were generated to guide, monitor, control and evaluate the work process, from the administrative-technical perspective, to result in a positive impact on human resources, continuous improvement of service quality and administrative efficiency.

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[10] Based on reports from the programmes, the women identified the need to have more privacy during visits with the doctor. They reported their discomfort with the presence of many students during diagnosis and treatment, and also requested to be better-informed in that regard. They stated the need for better infrastructure, decreased waiting time, both for medical care and for lab results, and continuity of treatment with the same specialist, and respect for their own decisions. They also mentioned their interest in sharing experiences with other users who may have similar health situations.

Among the changes implemented by the three programmes, one of the most important was the creation of new opportunities for exchange, reflection, support and empowerment of women based on a gender perspective. One example of this with respect to group education activities was the addition of pre-natal classes for teenage mothers in which their partner, mother and other family members are invited to support the adolescent throughout their pregnancy.

Another example comes from the "Encuentros de Saberes" activities in which the health personnel meet with middle-aged women to share knowledge with them and listen to their experiences and concerns. The programme also offers a support group for women, where the discussion hinges on gender-based analysis of everyday life and supports personal growth and mutual empowerment. The women discuss traditional gender roles, their feelings of malaise are validated, and awareness is raised about situations where their husbands exercise control and treat them as if they were a child, as all of these may lead to depression and other health problems. Here are some of the comments from women attending the support group:

> *"I used to be depressed, I started to give myself my rights and to go on; the group helped me identify my fears. One needs to go somewhere, seek support".*
>
> *"Since I've come here, there are things that other women say, and I ponder about it. I am fearful, and here, they have helped me to vent. I have changed in small things; I think that they may be right".*
>
> *"Just being here for me is a change. I cannot go out if my husband does not allow it. I told him: these meetings, I will not miss. 'Well', he said, 'if you feel they do you good, then go'".*

As the women exchange experiences and strategies they become empowered and begin to recover autonomy.

Similarly, the Cervical-uterine and Breast Health Programme (Programa de Salud Cervico-uterino y de Mama) established a support group for women with cancer or who have had cancer and their family members. This programme led to the development of an association of women survivors of cancer, who, on a volunteer basis, support women with cancer in the hospital or in the communities.

Again, these activities include a gender focus and concern for the rights of women, in some cases as subject matter and educational content, and in other cases, as a transversal axis that cuts across the activities. Social workers are able to include a gender focus in their work with ease, while a focus on rights is generalized among the rest of the personnel who participate in these activities. It was observed that special emphasis was given to questioning traditional gender roles, promoting the right to information, health-related decision-making, and a life free of violence.

b.5.2 Changes in hospital practices

b.5.2.1 Transforming obstetric practices based on medical evidence

The transformation of medical practices in the Hospital is vital within the New Model of Integrated Health Care for Women. A challenge to be addressed, however,

was the resistance on the part of physicians to include a gender focus in their activities. While this focus was indeed a concern for social workers and nurses, for others the proposal was too theoretical or abstract, so they barely participated in sensitization activities. For this reason, a strategy was adopted that aimed at provoking change in medical practice based on scientific evidence. Since the head of the Obstetric Service was a physician with ample research experience, it was decided this would be a good place to start.

PAHO was an important ally in the process, since it enabled the contact between the Women's Hospital and the Centro Latinoamericano de Perinatología y Desarrollo Humano [Latin American Centre for Perinatology and Human Development] (CLAP), an institution specialized in research and advisory services in perinatal care in the region. The Hospital showed its interest in participating in the award programme for quality in maternal care, "Programa de distinciones especiales a maternidades con alta calidad de atención", promoted by CLAP/PAHO. To achieve this award, changes in obstetric practice based on medical progress, among other things, were considered.

According to information gathered by CLAP, many routine obstetric practices in the region were based on custom and not science. An assessment made at the Women's Hospital found that two thirds of the hospital's obstetric practices were not based on science.

Among the changes that the proposal sought to implement were elimination of routine episiotomies, promoting natural childbirth without interference from the medical or nursing personnel if not needed, allowing women to have a more active role in the birthing process, and improved satisfaction with the care received. Also, there was a recommendation to allow continuous support during labour from people close to the women, and to respect women's preferences with respect to birthing positions as there is evidence that both contribute to making the delivery experience more positive for the women. The Hospital of Dublin was presented as a model for these changes.

CLAP's proposal was compatible with the requirements of the new Model of Integrated Health Care for Women, since it empowered women and their families. It also respected women's rights to an integrated approach to their health needs, favoured informed decision-making on the part of the women, and humane treatment.

Training activities were required to implement these changes. A workshop entitled, "Workshop to Analyse and Reflect on Obstetrical Practices that are in the Best Interests of Mother and Child" (Taller de Reflexión y Análisis de Prácticas Obstétricas Beneficiosas para la Madre y su Hijo(a)) was developed. It was attended mainly by nurses, but also by obstetric physicians, administrative personnel and cleaning staff. The workshop dealt with the practices of continuous support during delivery, choice of birthing positions, education of users and supporters during the delivery process, sexual and reproductive rights, humane treatment during the birthing process and bioethics. The training included group exercises to identify factors that would facilitate or limit the implementation of the new obstetric practices and to think of solutions or improvements that could be applied in the hospital.

The project also offered scholarships for obstetric physicians and nurses to be trained at the CLAP facilities in Uruguay. Medical personnel attended a workshop

for the development of perinatal clinical guidelines and also a course on perinatal medicine. The Costa Rican delegation was composed of four obstetric physicians.

After returning, those who had benefited from a CLAP scholarship, offered workshops and education sessions on evidence-based medicine in obstetric practice, in which they shared the knowledge they had acquired with other physicians and nurses from the Obstetric and Gynaecology Services of the Hospital.

Participation in the programme on quality maternal care, "Programa de distinciones especiales a maternidades con alta calidad de atención", did not proceed due to lack of funding from CLAP. However this initiative led to the creation of a committee to be responsible for the project, composed of obstetric physicians and nurses, and coordinated by an obstetric nurse. The effective collaboration among physicians and nurses, as well as leadership of the process by a nurse, would not have been possible without the previous sensitization on gender at the Hospital as well as the support and training offered by the Canadian experts.

The proposal required not only motivation but also conviction about the importance of translating gender equality into practices that, in effect, would improve the quality of the care. The Head of Service and an important group of physicians and nurses committed themselves to eliminating certain practices and adopting others that would improve the health of the women, their babies and their families.

These changes and changes in the infrastructure of the Obstetric Service were made at the same time. The delivery room was redesigned, setting up cubicles that would give more privacy to women during obstetrical examinations. Also a small waiting room was created, and a garden was planted so that the women could have the company of family members and respect given to their birthing position choices, in a nice and supportive environment. These changes broke the image of a closed and hostile hospital environment.

Also, some routine practices disliked by women, and for which there was no scientific evidence to support their use, such as the administration of enemas and shaving of the pubic area, were eliminated. The performance of episiotomies decreased significantly. According to statistical data, in 1998, 43% of women underwent an episiotomy; in 2002 the percentage decreased to 15%, and in 2007 the percentage was 17%. According to the Head of Service, there is a different attitude in the women, who are not uncomfortable after delivery, are more satisfied with their care, and recover more quickly. In 2000 cesarean sections represented 23% of deliveries and in 2001 the rate dropped to 16%. Cesarean sections have remained under 20% of deliveries. Also, support from family members during delivery happened in 30% of deliveries at the beginning of the year 2000, and in 2001 the figure increased dramatically to 90% of the women.

These changes met with resistance from the programme to reduce infections in hospitals at the level of the CCSS, and were rejected at the beginning. The presence of family members in the delivery room was considered a health risk and against the infection control standards of the institution. However, as the changes began to take place, with documented results that refuted these arguments, and showed favourable outcomes, these changes became institutionalized. Also, the myth that delivery needs to take place in a surgery room was replaced with an understanding that birth is a natural process that is monitored by health personnel.

In addition, the Obstetric Service has introduced new services over the last several years. Among them, out-patient induction of delivery in cases of overdue pregnancy in which hypertension is not a risk factor. In the past, these women were hospitalized to have the delivery induced, which meant an average stay in the hospital of three days, time in which the women were anxious about being away from home and concerned about the care of their other children. The new practice entails monitoring the induction during the morning, and allowing the women to go back home in the afternoon, to return the next day for the delivery to take place.

For the Hospital, this change in practice has also meant a reduction in hospitalization costs, decreasing by one and a half days women's stay in hospital. The women are informed about the programme, and are given the choice to participate in it or not. In most of the cases, they choose to participate. Of the 290 women who elected to participate in the programme (which was implemented in February 2006), only three abandoned it and sought attention at another hospital. The preference of some women to be hospitalized for induction was also respected.

Informative talks about potential risk signs and how to care for themselves and their babies have also been implemented in the delivery rooms, facilitated by nurses.

Changes in the attitude of the health personnel have been key to the successful implementation of the new practices. Success of the programme is reliant on the health personnels' capacity to motivate and convince the women about the benefits of these obstetric practices. This requires skills to inform and support the women and their families about the positive impacts these practices have on delivery.

No doubt, all these changes were influenced by multiple factors, among them the reflection triggered by the *BIAS FREE* Framework, which revealed that some obstetric practices and the layout of the physical space responded more to the criteria and comfort of the health personnel than to the needs and rights of the users of the service.

Successful implementation of the changes in practice should not be attributed solely to the initiatives of CLAP and to the new Model of Integrated Health Care for Women. Another important factor was that a group of obstetric nurses had informed themselves and were convinced of the need to humanize delivery practices at the hospital. In addition, a movement by women in favour of more humanized delivery, supported by several NGOs, created pressure in the media that helped to promote the implementation of changes in obstetric services of CCSS hospitals. This movement was not only national, but international, and evidence-based medicine was an important tool for achieving the objectives pursued by these groups.

In summary, significant changes in the obstetric services took place at the Women's Hospital as a result of different initiatives and efforts that converged. Among these was the application of the *BIAS FREE* Framework.

b.5.2.2 Improvement in the quality of gynaecology and neonatal hospital services

In addition to obstetrics, two other hospital services also underwent changes. The gynaecology service was already sensitive to improving the quality of care

and some gynaecologists agreed with the idea of offering more personalized care. An initiative promoted by the head of service was to respect women's privacy by eliminating the practice of recording patients' clinical history in the common rooms, in front of other people. A cubicle was set up were the women could provide the required information with more privacy and confidentiality.

Another measure was to ensure the informed consent of the women before surgery and guaranteeing the same surgeon who performed the surgery would inform them fully about the procedure and would provide post-surgical follow-up. Also, some information sessions were provided as pre-surgery preparation. These sessions were conducted by the nurses and were aimed at informing the women and giving them the opportunity to express their fears and doubts. As a result they went into surgery feeling calmer.

Specific physical space for women seeking or undergoing an abortion was provided. This space is separate from the Obstetric Service so that the process of mourning and the specific needs of these women are respected.

A number of the nursing personnel embraced the idea of change at the Hospital and supported specific changes that would provide better care for the women. The secretary of Gynaecology Service became a key player in the coordination of services, improving the efficiency of the care provided. She proposed coordinating with other hospital services, including pharmacy, follow-up appointments, lab and ultrasound exams, as well as with other health units outside the hospital, so that when the women left the hospital their post-natal care was arranged. This is a good example of team work and effective coordination, especially as it managed to establish practices that ended fragmentation of services and discontinuity of care. Putting women at the centre in resolving their health problems raised levels of satisfaction among users of the Gynaecology Service, and indeed resulted in the highest ratings on the Human-warmth Index recorded among all Hospital services, over several years.

Neonatology has also included a gender focus in its breastfeeding programme and programme for care of premature babies and their families. When it was Instituto Materno Infantil, the hospital was awarded the status of a "Baby-friendly Hospital", and was also a pioneer in the country of the Mother Kangaroo Programme. This programme focused on the well-being of the baby, and the mother was expected to respond to the baby's needs particularly in relation to breastfeeding. In incorporating the change to a gender focus, many practices that promoted traditional gender roles that jeopardized a mother's health were revealed. Making the mother exclusively responsible for the care of the baby or blaming her when she was not responding to the baby's needs, even at the neglect of her own health and needs was one of the practices reviewed. Now, the participation of the father and other family members in the care of premature babies is recommended. The mother is not forced to breast feed the baby, nor is she judged negatively if she chooses not to. Health personnel provide education that promotes child-rearing practices that encompass other members of the family.

The neonatology service now has a Breastfeeding Clinic that promotes mother-to-mother support to women encountering difficulties with breastfeeding. Also an interdisciplinary team has developed a programme of education and mutual support among family members of premature babies to empower them and to train them in the care of babies, from an approach of shared responsibility. A project to

be implemented in the short term is to provide follow up in the home. Two nurses specialized in neonatology investigated the overload experienced by mothers with premature babies and how health personnel can support them by promoting a family network that would break traditional gender roles and facilitate equity.

Finally, the Breastfeeding Committee is coordinated by a social worker, not a paediatrician, as is the custom in other hospitals.

Not all the personnel from other hospitals attended the GBA workshop, nor were they familiar with the *BIAS FREE* Framework, but those who did attend and knew the Framework become good promoters and receptors of the proposed changes. Once again, synergy is evident in the factors favouring change.

b.5.3 Hospital outreach to Health Areas through network management

As mentioned above, the proposal to transform the Women's Hospital required the creation of conditions for reaching out beyond its walls. This would allow more interaction among the three levels of care, based on new management concepts favouring prompt and efficient attention to women's health.

By the year 2002, several activities had taken place to establish close connection among the three levels of care; among them sensitization and training processes about the new model of care with a gender focus, in which personnel from the three levels participated. Advances were made towards the creation of an organizational form that allowed for coordination of efforts among the three levels of care. Initially, the idea was to develop these sensitization and training processes led by the interdisciplinary teams of the three programmes of integrated care of the Hospital, jointly with the women leaders of the communities in the three health areas.

For this purpose, a workshop was developed on "Strengthening Work in Network-based Management for an Integrated Approach to Women's Health". The workshop proposed an alternate form of management, based on a more horizontal management form and the building of solidarity and trust among the participants. This proposal was consistent with the *BIAS FREE* Framework, calling for the need to eliminate hierarchies that interfere with equality and equity in relationships between levels of care and with women of the community so that all could work together in the transformation of the hospital. This allowed the idea of a common set of shared objectives among the different social actors to take hold and for joint work towards this purpose. The Workshop included participants from each of the three hospital programmes, and the "Replicating Group" from the three health areas, including the women leaders from the communities. This new network-based management style was consistent with the guidelines of the new model of integrated care, and was a vital contribution in guiding the joint work to transform the hospital.

To implement this new network-based management model, changes in the organizational structure of the Hospital were required. A strategic change was the creation of the head of out-patient visits (Jefatura de Consulta Externa), who jointly coordinated the process of change to a network-based management with the coordinator from the CTISS. They relied on the principles for transformation proposed by the *BIAS FREE* Framework and guidelines by Mario Rovere[11] on

[11] Rovere Mario. Redes: hacia la construcción de redes en salud [Networks: construction of health networks]. Argentina, Secretaría de Salud Pública Municipalidad de Rosario, 1998.

constructing management networks without hierarchies, in which decisions are made by all members. They formed strategic alliances with the Management of Female Physicians and Management of Modernization of the CCSS to support the work among the three levels of care.

The Head of Ambulatory Visits, with the approval of the authorities of the institution, approached the different Health Areas and elicited support from the directors of the Major Clinics and Health Areas, by communicating the advantages of this strategy for organizing health-care services in a more efficient way. An important factor in this decision was that of the Directors of the Major Clinics and Health Areas, four out of five were female physicians.

The first action agreed to by the Directors and Head of Out-Patient Visits was to identify critical obstacles in the provision of care among the levels. Through a participatory planning process, the Directors of the Major Clinics and Health Areas brought forward evidence of a lack of coordination among the three levels, and a disconnect between the actions of the hospital in relation to local realities.

Several problems were identified: inadequate decision-making capacity at each level of care; lack of effective communication channels among the levels of care; no evaluation of compliance with institutional care norms and risk management; lack of flexibility and timely coordination in resolving health problems, including an absence of citizen participation. The result was an institutional labyrinth of contradictions and thousands of obstacles that women found very frustrating to navigate as they attempted to resolve their health problems.

This assessment showed the need to jointly plan and implement actions. Using the network management model, several management bodies were created. The first was an Overall Management body responsible for overall coordination of the transformation. It included the highest level of decision-makers, including several directors of the Hospital, Major Clinics and Health Areas. The second was an Operational Management body that included the head of Hospital Out-patient Visits; the Coordinator of what had been the CTISS; delegates named by the directors of Major Clinics and Health Areas; and representatives from the Hospital's Health Board. They immediately set up an operations arm involving the coordinators of women's health-care programmes and projects and the Replicating Group and are seeking to add representatives from women's organizations.

The initial strategy of independently implementing the three programmes of integrated care among the levels, with each programme conducted by a different interdisciplinary team at the Hospital, had to be reviewed and adjusted in light of this new form of operational coordination. Decisions within Operations Management are made mainly by medical personnel as the directors of Clinics and Health Areas delegate responsibility to them. An action plan was made, listing strategies to be developed within the model of network management and ways of implementing them. This action plan identified five areas of work: education and training of the internal and external social actors; coordination among the levels and network activities; interdisciplinary team work and programmes of integrated care; social participation and strengthening referral and referral processes among levels. The model of network management was shaped by the principles of the gender-based analysis and the guidelines for the new Model of Integrated Health Care for Women.

One of the strategies promoted by this process was the exchange of knowledge and feedback among the levels, to improve capacity to resolve health problems and technical competence among personnel. To that end, training activities were planned jointly so that they would respond to the real needs and patterns identified in the assessment. The Hospital took leadership for the processes of training and transference of specialized knowledge to Levels I and II to improve the timely detection of health problems and make referrals based on better technical evidence. This required many training workshops and fellowships within the hospital services.

Although the model of network management is based on the Model of Integrated Health Care for Women, most decisions are still made based on medical criteria and training is focused on physicians. Efforts are being made to sensitize medical personnel about team work, gender issues and human rights, and to include instructors from other disciplines in the training workshops. Another effort to break medical hegemony in decision-making regarding the health of women, as can be seen by the application of the *BIAS FREE* Framework, is the inclusion of representatives from the Health Board of the Women's Hospital on the Operation Management team, and to introduce citizen participation.

For the Hospital, network management has meant approaching local networks and understanding their needs; for the Clinics and Health Areas it has been an opportunity to learn about the Hospital's operation, increase their access to the hospital's more complex services and improve their own diagnostic and referral capacities. For the Hospital and the Health Areas, it is an experience that facilitates mutual learning and exchange of experiences, training of human resources and establishment of programmes among levels, all focused on the real needs of women.

In the words of a member of the Operation Management of the network:

> *"Before the training given by the Canadians, there was no relationship with the Hospital. Since then, a connection that has become very close has formed and been maintained, and in fact, it is the best network that we (Health Area) have. We can coordinate well, the attention is timely. In any problem, I can call Zully or Doctor Ledesma and they resolve it; there is trust".*
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> *(interview with Medical Director from Health Area)*

The same person compares this network with another network which is hierarchical, where the hospital defines and assigns tasks to the Health Areas; there is no planning based on local reality. This testimony shows a qualitative difference where the gender focus is prevalent; there is more recognition of the importance of empowering women and including them in the Health Boards, and in decision-making processes. This further evidences the value of the *BIAS FREE* Framework in supporting processes of change that go beyond superficial change, to substantial change in power relationships.

Positive results from the new model of network management have already been observed. Plans and programmes for working in partnership and with shared goals have been designed. As the coordinators of the Operation Management stated and other members confirmed:

- Capacity to resolve problems at the different levels has increased.
- Cooperative actions among levels have been established, such as the

provision and exchange of diagnostic equipment and other tools required to improve the work and to make timely diagnoses.

- Waiting times have decreased. In 2002 the waiting time for a colposcopy was more than 6 months. In 2005 it was reduced to a month and a half. Waiting times for appointments for menopause-related concerns decreased from 9 months in 2002 to 3 months in 2005.
- The epidemiological profile of the women gathered from information from hospital out-patient visits is used to set priorities for joint actions among the levels of care.
- The referral process has been restructured and its quality improved to facilitate women's access to timely care. In the past, the women had to take a referral slip to the Hospital and request an appointment. Now, the referrals are sent by messenger and the appointments are booked for the women. This has improved the communication and flow of information between levels, improving the referral system among the three levels of care.
- Social participation projects have been set up within the networks in which the communities have actively developed health programmes such as early detection of cervical-uterine cancer through Pap tests.

This experience has served as a national model, and at the same time has helped to set criteria for management commitments in other health services networks and has become a model for network management throughout the country.

b.5.4 Transforming the structure of the organization, administration and human resources policies

The Canadian experts were successful in highlighting the importance of making changes in the organization's culture as well as structural changes from a gender perspective. The *BIAS FREE* Framework served to identify hierarchies in organizational structure and propose required changes. However, both the changes in the organization and administrative structure have been slow and challenging. The new model has sought to create flat structures that will enable more horizontal cooperation among disciplines and within disciplines. Resistance to these types of changes has been strong. However, the strategic planning and alliances with the Direction of Organization Development of the CCSS have resulted in a proposal pending approval that would break the medical hegemony and the hierarchical organizational structure that has characterized the Hospital. Under this new proposal, the programmes of integrated care will be given preferential treatment, with the allocation of specific resources. These resources will help to minimize the difficulties encountered in coordination between disciplines and services.

Changes in the management of the Hospital throughout the years of transformation have been noteworthy. Before implementing the new Model, the Hospital management style was closed. Decisions were made by the Director and Assistant Director of the hospital; there were no clear channels of communication with the rest of the hospital; nor was it possible to make any real substantive changes within the hospital. External pressure and the internal initiatives led to an open-door management policy, which is more communicative and participatory. The strategic planning succeeded in breaking away from old centralizing practices, and delegated the performance of key functions to teams that were capable of more agile, efficient and effective administrative responses. Advisory groups were created to support management decision-making processes, and led to more participatory practices and better performance of management. This is evident in the score the

Hospital has obtained on the Management Commitments signed with the CCSS Administrative Direction. In 1999 they received a score of 56; by 2006 this score was 96. It is only possible to achieve this score with the cooperation of all involved in the proposed goals. The administration of the Hospital has also understood and supported initiatives for social participation, giving the hospital its unique characteristic as an institution.

The hospital also stands out with respect to its administrative management. In 2002, the Executive President of the CCSS requested that quality indicators be developed with a gender focus and included in the Management Commitments to be signed between the Services Purchasing Unit of the Administration of the CCSS and the Women's Hospital and the assigned Health Areas for the year 2003. This was an opportunity to define the commitment from the administration to implement the Model of Integrated Health Care for Women within the hospital and health areas, and the CTISS took on the challenge. The intent was that the indicators would be formulated jointly by different experts on gender. However, the indicators were developed by the coordinator of the Interinstitutional Technical Commission and the representative from INAMU on that commission. Until then, few of these had been included as part of the management commitments. The greatest achievement, as said above, was the establishment of a network model of management, but as other people interviewed confirm, the management tools are not gender-focused and women's health is still limited to reproductive health and its care.

In addition, the Department of Human Resources of the Women's Hospital has not applied any affirmative action policy in favour of more female personnel, since it is also following institutional and trade union guidelines that are difficult to change at a local level. The only progress has been the application of criteria of equality among genders, but equity has not been achieved nor has compliance with the preferences expressed by users in different diagnostic assessments, in particular their explicit statements that they prefer to be served by female personnel. However, in orientation and training of new personnel emphasis is given to the Model of Integrated Health Care for Women and the gender focus. A trend has also been observed among heads of services to hire female medical professionals. In 1999, all physicians were men; right now the Gynaecology Service has three female gynaecologists out of the ten. The Obstetric Service has four female doctors, and the number of female residents is also higher than before.

Finally, the establishment of a Comptroller Office of Health Services in the Hospital has become the key channel for complaints from the women and a provider of legal support. This office has advocated for the rights of women and their families.

b. 6 Plans for the future

The Hospital has gained a valuable experience that it is now seeking to strengthen within its new Strategic Plan for ensuring the sustainability of the Model of Integrated Health Care for Women. The idea is that the hospital will become a centre of excellence in the field of integrated health care for women within the CCSS. As established in working documents, the Women's Hospital, in its role as a specialized hospital, of national coverage, seeks to become a centre of excellence in regard to sexual and reproductive health in the country, as well as "public policy-maker, leader in health care and creator of specific health-care models, norms and protocols to treat women's health in an integrated manner".

To that aim, the Women's Hospital is carrying out a process to increase the level of complex care they can offer so that they can better address the health-related needs of women and their babies who historically have had to be sent to other national hospitals that have more resources and specialized technology. For example, women would be sent to more specialized hospitals for obstetric, gynaecologic and neonatal intensive care services. These services will now be among the services provided in the Hospital's new building, which is under construction. The Hospital is also getting experience in caring for HIV/AIDS patients, beyond the simple screening historically done by the institution, and is offering integrated care to women who have this condition. Such care is based on performance standards of international quality, a gender and rights focus, and an interdisciplinary and interinstitutional approach.

The new organizational structure that the Hospital is proposing aims at breaking with the traditional hierarchical structure that considered medical care substantial services and the work performed by other disciplines as support services. The proposal would give more status and resources to programmes of integrated health care. This will result in transcending a structure of services based on disciplines to one based on programmes of care to which a budget and human resources are assigned. As the coordination of services with Health Areas is also sought, the programmes would be conceived as integrated ones involving all three levels of care.

This proposal is novel for the CCSS and if it becomes a reality, it would be the first hospital to set aside the traditional hospital structure to adapt an organizational structure in line with the integrated health-care model. For these changes, the Hospital is seeking strategic alliances with the Management of Organizational Development of the CCSS.

The Women's Hospital is a demonstration model of how the Model of Integrated Health Care for Women might be applied to the other hospitals of the country. In fact, the National Development Plan of 1998-2002 proposed that it be implemented in seven other hospitals of the CCSS. While such a task exceeds the Hospital's responsibilities and requires the approval and interest of the institution to disseminate and generalize the Model, representatives from the women's hospital have participated in discussion and analysis forums at the national level, in which they have shared their experience and supported the development of standards for women-centred health care and health policies.

As a demonstration model, the Women's Hospital has shown the importance of supporting the process of transformation with valuable, practical and simple tools, such as the *BIAS FREE* Framework. The Framework has proven to be an important support for identifying problems and possible solutions to inequities in health services, and at the same time, for guiding the required changes. Similarly, other strategies that had a favourable impact in the implementation of the new model of care could also be replicated.

Finally, the new Hospital building will have better infrastructure for health care. Among the improvements is the inclusion of patient education and training programmes while women are waiting for their appointments in the Out-Patient Care Services. These programmes will increase women's level of knowledge about their health issues and help them to make more informed decisions.

IV Advances in gender equity in the hospital and beyond its walls

Inequities in health services are expressed in a variety of ways such as in gender relations, the interactions of patients and health personnel, and between disciplines, directors/collaborators, levels of health care, and urban and rural areas. There is a diverse combination of these various categories and the experience of inequity increases incrementally for people, with each non-dominant group in which they are located. With respect to the Women's Hospital and its assigned areas, the dominant groups are men, doctors, specialists in tertiary care, and residents of the metropolitan area, while the non-dominant groups are professionals from non-medical disciplines, female patients, primary care physicians and residents of rural areas.

The application of the *BIAS FREE* Framework helped to identify the diverse ways in which inequities are expressed, in the Hospital and beyond its walls. This experience also gave feedback on use of the instrument in a complex reality such as in the context of health services. The most complex step was to move from the identification of inequities to transforming them. This section will summarize the progress towards equity reached at the Hospital, according to the categories established by the *BIAS FREE* Framework.

Eliminating hierarchies in a hospital characterized by a rigid and vertical structure is a difficult task. Therefore, the achievements related to equity must be understood in the context of conflicting interests, where some individuals seek to preserve existing power relations and others wish to transform them. The hierarchies are normalized in the daily routine and become legitimized through habit. Multiple mechanisms are at work to create a hierarchy among and within disciplines, among the different levels of care and in relation to the users of the service. Becoming aware of the hierarchies and being able to identify them is a first step and modifying them is a difficult and continuous task. The achievements are a combination of coinciding interests, favourable conditions, processes of consciousness-raising, and group and individual struggles to reach equality and equity.

Within the Hospital, gender inequity was found especially between disciplines and between users and suppliers, as characterized by the relationship between doctors and nurses and between health personnel and female patients. The transformation process has resulted in important changes in these power relationships, although there is still much more to be done. Several strategies and situations account for the changes achieved.

In the case of the relationship between doctors and nurses, the gender sensitization and training, together with the application of the *BIAS FREE* Framework, led many nurses to review their subordinate attitudes and practices. In the words of one nurse:

> *"In the hospitals, doctors are kings and the nurses have been viewed as servants, their employees. Important changes have occurred, but there is much more to be done. One must defend her place. There is more respect from the doctors to the nurses, but not as much as there should be (...). The doctors used to ask the nurses to help them put on their gloves, to go with them during the visits to hand them the papers, even to clean their shoes. I am positive that I am not here to serve the doctor, but the user"*
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> *(interview with obstetric nurse)*

Also, some nurses have made additional contributions to the provision of health services, through the acquisition of further knowledge – in particular, specialized knowledge acquired through Masters degrees. The Neonatology Service, for example, has been improved by the graduate projects of several nurses who designed valuable programmes that were implemented with the approval of the medical chief. Nursing took on leadership to improve the quality of services, and its contribution is recognized.

On the other hand, promotion of work by interdisciplinary teams allowed them to move away from a purely medical approach to health problems. Through the creation of programmes led by interdisciplinary teams, teamwork has been fostered. It also helped to strengthen other disciplines that had not been as privileged within the health system as the medical discipline. This created opportunities for new views and discourses concerning women's health. The coordination of the teams has been mainly assigned to female personnel, from non-medical disciplines. This brought about an important change that was met with some resistance on the part of the physicians, but with time, this has decreased. Traditional gender roles have also been modified through simple but symbolic practices. Taking minutes for instance, was traditionally assigned to women, regardless of their profession. In the interdisciplinary teams this task is rotated, and physicians have learned to take minutes and make legible notes.

New opportunities for interdisciplinary discussion were created such as: the discussion sessions with all Hospital personnel for planning and consultation about new services and changes to the physical infrastructure, which were in the process of being implemented with the construction of the new facility. While some space was opened for joint analysis and decision-making, with time this has closed and the medical personnel have reverted to making decisions for all.

Some disciplines, such as social work, were more successful at introducing the gender focus in their daily activities, particularly in the content of the trainings and methodologies addressed to women. These efforts have been strengthened and sustained for many years.

In addition, the proposal for network-based management has succeeded in becoming a working modality among the levels of care, based on horizontal relations respect and mutual support. Thus, there has been progress in overcoming the hierarchical relationships between health care Levels III, II and I, in which

officials from level three have traditionally considered themselves to be above those in the second and first levels of care. The hierarchy was built on the type of medical specialization and the resources at their disposal. The hierarchy played out in the disregard of or indifference to referrals made by general physicians from the Health Areas (Level I), to the Marcial Fallas Clinic (Level II) or the Women's Hospital (Level III), by the physicians and specialists in Levels II and III and in the lack of communication among levels. The new network management structure has improved women's access to timely health care at the hospital, and resulted in appropriate follow-up and better quality health care.

Decision-making by medical doctors, however, is still the norm because positions of authority within the health institutions providing care are usually staffed by physicians. The decisions made receive little feedback; and what feedback is received is at the operational level only. Nevertheless, there are some indications of movement away from this traditional system, such as the presence of the Head of Social Work and representatives from the Women's Health Council on the Operation Management Committee, which should lead to changes in the near future.

With regard to the relationship between health personnel and the women, there is evidence that signals the introduction of important changes. These changes are associated with processes of empowerment of the women as well as advances made by the health personnel in establishing more horizontal relationships. There has also been support for processes to facilitate women's personal development through informational and educational activities that have helped women to take charge of decisions about their health. In addition, this has led to the development of a supportive environment and community actions that encourage women and their families to participate in their own health care.

The traditional paradigm in health care, based on a hierarchy that values doctors' knowledge above all else, the invisibility of the interests and needs of women, and the denial of their rights, was to a certain degree shaken and modified by the process. The health personnel yielded power to the women, by establishing more horizontal relations. An acceptance of and respect for the perceptions and needs of the women is now evident.

The changes have also reached some of the educational activities organized by the Hospital, in terms of both the content and the methodology applied. There is a transition from the teaching model where the professionals decide the content and lead the process, to a more horizontal one, based on the interests and needs of the women in defining the material to learn. The experiences of the women themselves serve as a starting point, and they are encouraged to share their life experiences and opinions, validating in this way their knowledge and their awareness of their rights as persons. The professionals act only as facilitators of a group learning process and do not attempt to impose their knowledge.

In addition, women's groups have been created for women to support each other, such as the groups created for middle-aged women that serve for educational purposes and especially for peer support. The women's experiences are used to raise awareness about gender issues and how they affect their health. The women are able to identify symptoms of depression and physical ailments associated with their status as women, and propose their own strategies for change. The women's groups provide mutual support and lead to the recognition of similarities of experience and possibilities for changes not previously identified.

At the same time, important changes are also evident in overcoming health-care practices that pathologize, objectify and blame women. This is the case particularly among social workers who have recognized the need for a whole transformation in their care for women and their problems and to think through their treatment plans. The objective is not a diagnosis or label about the women, but rather understanding their problems within the context of their lives. Women are now seen and treated as subjects with the ability to make decisions about their lives, and success has been reached in not blaming women, particularly those in situations of violence or poverty.

Another important success is the qualitative change that underpinned the transformation of the Menopause Clinic that reflected the medical view that pathologized this phase in a woman's life, to a Programme for Integrated Care for Middle-aged Women that aims to understand more fully the physical, psychological and social changes experienced by women during this phase of their lives.

Similarly, the present trend in the Obstetric Service is to advocate for a more natural delivery, without medication. This is all done within an environment of respect for women's decisions about their own bodies and health. One of the most important changes has been the elimination of obstetric practices that took control over women's bodies and forced women to submit to the decisions of the health personnel during labour and delivery. The elimination of unnecessary procedures and the respect for the women's choice of labour position are among the most important advances.

One can now observe a greater sensitivity towards the practical needs of women. Health-care services make efforts to identify the needs of women, such as nursery school and lodging for women with young children who must travel from remote areas to access care. There still exist some gaps between intention and action. For example, the Sexual and Reproductive Health Counselling Services are well aware of the impact gender has on decisions over birth control, including high risks of coercion and pressure to please a partner. However, there is still much to do in regard to men's share of responsibility in women's health. The Women's Hospital has focused on fostering the well-being of women, but their well-being also requires the recognition that men have a responsibility in sexual and reproductive health, as well as in the upbringing of their children. This is reflected in the Sexual and Reproductive Health Counselling Clinics where few men participate and few birth-control methods target men. This means that all the responsibility for birth control still falls upon women.

The services provided have also been adapted to respond to the needs of women. In the past, the women had to approach different departments to obtain certain services, which might have been offered in one place. For instance, a woman who had had a hysterectomy would be released by Gynaecology, but would have to wait in a queue to make a follow-up appointment, then another to obtain her medicines and yet another for lab tests. These services are now integrated and more efficient. The secretary in Gynaecology coordinates with the other services so that by the time the woman leaves the hospital she will have her follow-up appointment booked, her medicines and lab tests ordered, and visits to other health centres arranged for her, if required.

The efforts made by the Hospital to provide outreach to local care levels have created another context in which to offer health care to women. For example, the

nurses who care for neonates have made a particular effort to provide follow-up care to premature babies in their homes. This experience, by itself, improved quality of care and opened an important channel to support the family.

As for the future, the Hospital has established a new organizational structure that will enable it to build on all these efforts in a coherent manner and in connection with the Health Areas. Furthermore, the experiences developed by the women community leaders have also enabled new health practices, and the women have attained and maintained an important position in health services and decision-making.

Thus, the Hospital has progressed in empowering women through:

1. Enabling women to take decisions for their health, through educational and informational activities.
2. The creation of supportive environments, including rooms in the hospital where families can be together for support, women's support groups, sessions where the knowledge the women already have is validated and survivors share their healing process, as in the case of women with cancer.
3. Community action in the training of grassroots leaders and the organization of Women's Associations that participate actively in improving the quality of health services and decision-making.
4. The policies of the Hospital and Health Areas that favour the collective actions of Women's Associations and transfer power to women for developing programmes for the health and well-being of the canton.

All these achievements must be sustained and improved through time. To do so will require continuous building, maintaining and strengthening of efforts into the future.

V Conclusions

The Women's Hospital and its assigned areas have indeed gone through a process of transformation. The qualitative changes observed are associated largely with the introduction of the gender focus, which has been assimilated as part of the improvements in quality of care from an integrated approach to women's health.

The training provided by the Canadian experts was key to that transformation. The *BIAS FREE* Framework was a very useful tool for making visible the hierarchies that permeate the health services, and to question them, from a gender and human rights perspective. This analysis tool was valuable for those who took leadership of the process and who had no previous knowledge of gender-based analysis. It was a simple and practical tool for formulating changes. This was the case, in particular, with the CTISS coordinator, who was able to understand through its use, how to generate strategies that would reduce the gap between dominant and non-dominant groups, and to promote initiatives in that direction.

Most of those who participated in the Gender-based Analysis workshop, given by Burke and Eichler, had little experience in the topic of gender equity. In terms of sensitization, there were good results, both with respect to the content and the methodology used. The workshop itself modeled the non-hierarchical relationships and mutual respect that the Framework seeks to instill. Although the design of the replication process did not manage to establish a systematic application of the *BIAS FREE* Framework by all the various people involved, the replication workshops did assist in the planning of activities in each Health Area. Nevertheless, many changes consistent with a gender-based analysis are evident, as described in previous sections of this document.

The changes implemented in health services were mainly promoted by mid-level management and in some cases they came from the bottom up, and not necessarily within the hospital. Many of the changes had been considered by officials at the Hospital before they became part of the sensitization and training process. However, the environment for innovation, generated in 2001-2002, catalyzed the acceptance of new ideas focused on the needs of women. Many of the people interviewed did not attach as much relevance to the gender focus as they did to the improvement in the quality of care and the humanization of the services. It is interesting that both are components of the gender focus, however, there was resistance to name and recognize them as such.

At the beginning, the gender focus produced resistance particularly from the medical personnel, the Director and Deputy-Director, and the Administration of the Hospital; all of whom were men. There was no previous experience in women's leadership such as occurred in the process of developing and implementing the Model of Integrated Health Care for Women. The following words of astonishment of a person interviewed for this report illustrate this:

> *"A bunch of women came!"*
>
> *(interview with medical chief of a Hospital Service)*

With these words the interviewed person described the visit to the hospital by the Minister for the Status of the Women, the representatives from INAMU and the CCSS, the Canadian Deputy Minister of Health and other experts.

This situation led to a decision to use other concepts that had greater acceptance, and a focus on rights did just that. Respect for women's right to make their own decisions, their right to privacy, and to be part of all decisions and actions related to their own health, as well as the continuous improvement of quality of service were better accepted, and the consequent results were many. This research found concrete evidence of hospital practices that do respect several rights of women: the right to decide, the right to information and the right to privacy.

This acceptance later made way for an embracement of a gender focus. To a certain degree, a new language has been introduced in the organizational culture of the Hospital, and is now used by male and female personnel. There is a certain peer pressure to use non-sexist language and censorship if sexist language is used. As the same doctor quoted above stated:

> *"... it has been imprinted in the way of thinking of the physicians... the gender focus has indeed permeated the Hospital"*
>
> *(physician interviewee)*

Introducing the Model of Integrated Health Care for Women was not an easy task, and for many, it remained a complex, unread document imposed by outsiders. The training given by the Canadian experts led to increased support for the Model's implementation. The workshop helped to expose the centres of resistance and led to the development of strategies to overcome the obstacles that had been blocking the process up until then. From the seven-year process a great deal of experience was gained and many lessons learned. These lessons are presented below.

The process of implementation of the new Model of Integrated Health Care for Women was itself a dynamic process in which forces both for and against it were at play, and through which advances and backward movements were made along the way. As such, the lessons learned include:

1. A structured guide outlining the phases that will be developed throughout the process of implementation of the Model is necessary. Long periods of uncertainty and the absence of a practical guide for the implementation of the Model generated a great deal of frustration and disappointment inside the Hospital.

2. To implement the Model, it is essential to define beforehand the minimum prerequisites needed to unite the health unit selected for development.

A prior assessment of the health facility's condition and factors that are obstacles or advantages will help in identifying resources, understanding organizational climate and determining the willingness of the health centre to carry out the required changes.

3. After such an assessment, a phase focused on motivating and raising awareness with respect to gender issues should be carried out to create a committed and supportive environment with a shared language among the personnel of the Health Area or Centre. It is essential to highlight the benefits that implementing the new model may bring.

4. Gender-related training should be accompanied by strategic planning designed to link the content of the training to the processes and services to be changed. The *BIAS FREE* Framework is a heuristic tool that facilitates the identification of problems of inequity and corrective measures towards which actions in the strategic plan can be oriented.

5. Based on the experience of the Women's Hospital, the original plan to create a specific plan and a budget for the Model separate from that of the hospital budget was an error. The new model should be implemented across the health unit. The organizational and administrative structures in place should also be reviewed to bring them in line with the new model. The application of the *BIAS FREE* Framework helped to bring these issues to light and resulted in a better allocation of the institution's budget based on a more equitable vision of institutional transparency and accountability. Then, social participation could become a valuable strategy in reducing the hierarchy between service providers and the population served.

6. Clear guidelines at the technical and managerial level should be established to incorporate a gender approach in the operation of the health unit. It is essential to go beyond the conceptual proposal to define clear plans of action. It is also important that the leaders of change have the leadership capacity to drive the process. Again, the *BIAS FREE* Framework would contribute to the success of this exercise and help to clarify the specific changes to be executed.

7. A commitment by the Hospital Management, in writing, is critical in conducting and implementing the changes. Credibility of the process of transformation should be promoted from the highest level of management. It is not enough to delegate this function to lower-level officials who lack authority over the rest of the personnel. Only management can make demands and follow up on required changes throughout the system, as well as support decisions parallel to the process.

1. Introducing the gender focus into a traditional hospital environment is expected to produce resistance, but experience shows that this can be overcome. Changes produce uncertainty, because the safety of what is known is temporarily lost. For example, the medical personnel found it very difficult to receive criticisms and questioning from other disciplines and from the women of the communities. Sometimes, that was not tolerated. However, with time to assimilate these changes, a real change in attitude eventually occurred and more horizontal power relations were established. The *BIAS FREE* Framework helped identify existing hierarchies in the relations between

the health personnel in general and the users of the service. This led to the definition of corrective measures with the purpose of empowering women through: further social participation, informed decision-making about their own health, participation in the design of projects, and the creation of new services and projects. All of these have contributed to continuous improvement in the quality of health services, through more accessible services, new technologies that are better suited to women's needs, reduced waiting times, more respect for patient privacy, and other adjustments in accordance with the Law for Disability and other related guidelines.

2. Support from INAMU, the Ministry of Health, and the CCSS management is essential to guarantee that required changes in the health unit were made. It is also necessary that those external agencies and institutional authorities have a system for monitoring progress in implementing the Model. To this end, the levels of competence within and outside the institution must be clearly known, to guarantee the sustainability of the transformations.

3. To introduce a focus on gender equality in health care successfully, it is essential to go beyond abstract concepts, because this causes confusion and their rejection. The concepts must be supported with concrete experiences that show how to put the concepts into practice and the benefits that can be obtained. Particularly, in the case of professionals in medicine and nursing, concrete operational proposals are needed. The *BIAS FREE* Framework becomes a simple and practical tool to identify inequities and to reflect upon new scenarios for change.

4. Presenting experiences from other countries can provide models to be replicated. That was the case with the Dublin Hospital, which became a model for the changes in Obstetric Services. Similarly, the Canadian experience shared through training workshops and visits to Canadian Centres and Hospitals[12] served as models for seeing new ways to provide health care to women.

1. Scientific evidence to support proposed changes is critical for persuading medical personnel. Research which is able to show evidence of and explain gender biases and their impact on the health of both men and women is necessary. Once again, the *BIAS FREE* Framework should be a tool available to all research processes, to guarantee the elimination of gender bias.

2. The starting point for the transformation process should be the needs perceived by the people, and from there, the focus on gender equality may be introduced. It is not advisable to impose it as an external and obligatory proposition as this would reproduce the authoritarian approach and lead to resistance that would be difficult to overcome. The methodology used during the Gender-based Analysis workshop is a good example of how to construct changes in the context of current health services, and how to make visible the needs of groups that traditionally have been invisible, such as those of women.

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[12] Sunnybrook and Women's College Health Sciences of the Women Health Bureau (WHB), Centres of Excellence for Womens Health Program (WHB), British Columbia Women's Hospital and Health Centre, IWK Grace Hospital, Halifax and Sunnybrook and Women's College Health Sciences.

3. It is important to keep in mind that the incorporation of a focus on gender equality and rights in health practices is a slow and continuous process. The changes required time to be assimilated and for everyone involved to become convinced of the positive effects obtained by applying them.

4. The contribution of women from the communities is essential for the qualitative improvement of health care services. This contribution is substantially greater if processes to empower women are established, based on a focus on gender equality, and which provide opportunities to share these contributions with the health personnel.

5. It is necessary to develop processes to support and strengthen the women leaders in the communities that are independent of the health- care services, so that these leaders are able to fully represent the interests of women.

In conclusion, while the *BIAS FREE* Framework is a heuristic tool created by acedmics to serve as a guideline for designing research protocols that are free from biases, the Costa Rican experience shows that its application goes beyond the scope of research and academia. The reality of health services is more complex and permits less controls than the environment for which the tool was designed and used originally. Changes are made not only through analysis, but they also require a strategic planning of the transformation process, with leadership that has the capacity to negotiate, create and learn through the process. Health-care practices are part of complex cultural processes, and transformation is more than an academic exercise; it is a political and practical exercise, since inequity is a matter of control of resources and therefore, a matter of power.

Thus, the experience at the Women's Hospital has been useful in providing feedback on the use of the *BIAS FREE* Framework. And perhaps, the Framework has also opened a new field of research with respect to understanding and systematizing the processes that lead to viable changes that will help achieve bias-free health services and greater gender equality and equity for the building of more just societies.

Recommendations

The implementation of the Model of Integrated Health Care for Women in all services of the CCSS is still in progress. The experience of the Women's Hospital to date has demonstrated the viability of the Model and that it can guide the operation of the institution. However, administrative and institutional conditions are required for the sustainability of the Model and continuity in efforts to guarantee gender equity in health care. This commitment should be made by the central management of the institution according to their competencies.

It is also necessary to make explicit gender equity policies in health services and to create clear tools for evaluation and accreditation of health establishments from a gender equality focus. This should be the responsibility of the Ministry of Health, with the support of INAMU, and would involve the creation of indicators to guide the performance of health establishments and the institutionalization of the Model.

The achievements made by the Women's Hospital and its assigned areas may only be maintained if efforts continue to promote gender equality as a principle of health care and to strengthen community work with women leaders.

The process of gender sensitization should be continuous and permeate teaching, education, and training and the sensitizing of human resources within and outside the hospital. The *BIAS FREE* Framework is a key tool for evaluating these processes, and the ongoing evaluation of the performance of health services and required community actions.

Schedule of events

1998 Law No 7852 for decentralizing hospitals and clinics of the social security system was approved. It created Management Commitments and Health Council as administrative tools and community bodies that would favour decentralization.

1999 The Board of Directors of the social security system - CCSS (Session 7352, 29/7/1999) agreed to expand the scope of responsibility of the Instituto Materno Infantil Dr Adolfo Carit Eva and to change its name to Dr Adolfo Carit Eva Women's Hospital. The focus of this transformation was the development of a model of integrated health care for women with a focus on gender equality and broad social participation.

1999 On 14 August, the Agreement for Interinstitutional Cooperation between the Ministry of Health, the Costa Rican Social Security System and the National Women's Institute was signed.

1999 In the week of 19-25 September, a Costa Rican delegation went to Toronto, Canada. The delegation was composed of health officials and representatives from INAMU, the director of the Women's Hospital and a representative of a women's NGO. During this visit, a Letter of Understanding was signed between Sunnybrook and Women's College Hospital Health Sciences Centre to strengthen institutional capacities of the Women's Hospital in Costa Rica, through technical cooperation, field visits from Canadian professionals to Costa Rica and vice versa to exchange experiences on the implementation of the health-care model. They also made arrangements for an exchange of materials, including: technologies and methodologies for diagnosis and treatment; equipment; research; education and training; information systems; and methodologies to involve officials, women and communities in women's health-care programming.

1999 Between 29 September and 1 October, the First Lady of Costa Rica attended the IX Conference of The First Ladies of the Americas, in Ottawa, Canada. The First Lady, together with the Health Vice-Minister, who was also in Canada, established a framework for cooperation with the Canadian Federal Government. Health Canada and the Canadian International Development Agency (CIDA) established a Bridge Project to guarantee the

participation and real inclusion of women in the process of transformation of the Women's Hospital.

1999 In September, the Interinstitutional Technical Commission was formed and given responsibility for drafting a theoretical and methodological proposal for a Model of Integrated Health Care for Women that would strengthen the institutional capacities of the Hospital for implementing integrated health-care services for women, based on a gender perspective. The High Political Level Interinstitutional Commission, at that time, was composed of the CCSS Executive President, the Health Vice-Minister, and the Minister for the Status of Women. This commission's functions included establishing policy guidelines, assignment of resources and guaranteeing that the change process be efficiently implemented.

2000 On 21 February, Executive Order #28484 was issued, creating the High-Level Political Commission and the Interinstitutional Technical Commission of the Health Sector to lead the process of introducing a gender perspective in the operation of State institutions, including those pertaining to health.

2000 On 29 February, the document "Modelo de Atención Integral de la Salud de las Mujeres: una propuesta para su construcción" [Model of Integrated Health Care for Women: a proposal for its development], prepared by a sub-group of the Interinstitutional Technical Commission, was submitted to the High-Level Political Commission, and the proposed Model was approved.

2000 The 13-15 March workshop, "Taller de Planificación Estratégica para el desarrollo del Hospital de las Mujeres» was conducted by Dr Elena Batista Valentín, a PAHO/WHO consultant, on the Model of Integrated Health Care for Women.

2000 The event, "Modelo de Atención Integral y Servicios Comunitarios para las Mujeres", took place 20-24 March at the Colegio de Médicos y Cirujanos. Participants included a delegation of women experts in gender and health, from the government of Canada, the Women's Health Bureau (WHB), Centres of Excellence for Women's Health Program, British Columbia Women's Hospital and Health Centre, IWK Grace Hospital in Halifax and Sunnybrook and Women's College Hospital Health Sciences. The goal of this meeting was to identify lines of technical cooperation between Costa Rica and the Canadian Federal Government, and a Treaty for Technical Cooperation (TCC) between both countries was signed.

2000 In May, a validation workshop called "Plan Estratégico para el desarrollo del Hospital de las Mujeres" was held and a decision was taken to include in the Operation Plan for 2001 some of the activities that would start the process of change. The activities were included in the Operation Plan in June and July, and the budget was allocated for 2001.

2000 On 26 July, the Minister for the Status of Women, Vice-Minister of Health, CCSS Executive President, and the Director of the Women's Hospital signed a letter of commitment to guarantee the implementation of the Model of Integrated Health Care for Women, through a demonstration project, at the Hospital. This letter specifies that health-care services for women would be transformed into an integrated health-care service with gender sensitivity,

over a four-year period. Among other agreements, the Hospital committed to developing a strategic management plan and to creating opportunities for women to participate in the process of constructing health. The CCSS committed to building a new facility for the Hospital. The same day, a Letter of Intent was signed, summarizing the most relevant agreements of the previous letter, signed by the same people, and adding as honourable witness, the First Lady of the Republic.

2000 In August, the Canadian International Development Agency (CIDA) approved the project called: "Participación Social y Fortalecimiento de Redes para el Modelo de Atención Integral de la Salud de las Mujeres", which was carried out in June-December 2001.

2000 In October, a document for cooperation between Costa Rica and Canada was approved and the Women's College Hospital of Toronto, Canada, was designated as coordinating counterpart responsible for carrying out the required trainings for the development of the Model. In November, a coordinating meeting with Canadian representatives took place, in which decisions were made about the type of workshops, methodologies, profiles of participants and conditions required for starting the trainings.

2001 The coordinator of the CTISS and the Director of Management of Organization Planning of the CCSS took a training fellowship at the Centre for Research in Women s Health at IWK Grace Hospital in Halifax, Nova Scotia.

2001 In February, the workshop on Gender-based Analysis was given by the Canadian experts, Mary Anne Burke and Margrit Eichler.

2001 A decision was made to review existing programmes and to create three new health-care programmes in which the new model would be implemented. The programmes were: the Programme of Integrated Attention to Adolescent Women; Programme of Integrated Attention to Middle-aged Women and Programme for Integrated Attention for Women's Cervical-Uterine and Breast Health. Three interdisciplinary teams were established to undertake this work.

2001 On 14-15 June, the Director of Centro Latinoamericano de Perinatología y Desarrollo Humano (CLAP) visited the country to announce the programme of awards for quality in maternity care, Programa de Distinciones Especiales a Maternidades con Alta Calidad de Atención (CLAP/OPS/OMS) and to enroll the Women's Hospital in it. In August, two CLAP consultants provided training to the Hospital personnel on evidence-based medicine.

2001 In July, the document, "Modelo de Atención Integral de la salud de las Mujeres: una propuesta para su construcción", was published. The document was prepared by the CTISS, with financial support from the Centro de Desarrollo Estratégico e Información en Salud y Seguridad Social (CENDEISSS) and PAHO, and with the approval of the Minister of Women's Affairs and the Executive President of INAMU, the First Lady of the Republic, the Health Vice-Minister and the Executive President of the CCSS.

2001 In July, work meetings were carried out to review the three programmes of the Women's Hospital with interdisciplinary teams from the three integrated

health-care programmes, and a technical advisory team composed of experts in gender and health from different agencies, institutions and nongovernmental organizations.

2001 On 30-31 July, the workshop "Reflexiones en torno al proceso de construcción del modelo de atención integral de las mujeres" was held for members of the Replicating Group who would be responsible for replicating the Gender-based Analysis workshops at the Women's Hospital and in the Health Areas. Soledad Díaz, a national consultant, facilitated the event.

2001 In September, the project "Proyecto de Participación Social y Fortalecimiento de redes para el Modelo de Atención Integral de la Salud de las Mujeres en Desamparados, Aserrí and Acosta" began. It was conducted by the national consultant Licda Margarita Aragón.

2001 On 15-19 October, Canadian experts (Heather Maclean and Judith Hockney) visited the country to consult on the development of programmes, and give their recommendations. On 22-25 October, Judith Hockney offered the workshop "Taller de Asesoría Técnica" to identify key sources of information that would promote gender-sensitive best practices for health care for women. The workshop for health personnel and community women leaders was carried out at the Colegio de Médicos y Cirujanos of Costa Rica.

2001 On 19-21 November, Canadians experts (Dr Lorainne Greaves and MSc Ann Pederson) offered the workshop «Taller de Investigación-Acción: un enfoque género sensitivo para la investigación en salud».

2001 On 10-13 December, a Canadian expert (Patricia Campbell from Women s College Hospital) offered two training workshops for "Change in the Organizational Structure of the Women's Hospital", which covered strategies for change with hospital personnel.

2002 The document *"Análisis Basado en Género: una guía metodológica para personal de salud"*, prepared by Soledad Díaz and Isabel Gamboa, was presented, as a guideline for the process of replicating the workshop in the Women's Hospital and associated Health Areas.

2002 In February and March, consultations were carried out with women in the communities to validate the Health Agendas proposed by the women leaders in Desamparados, Aserrí and Acosta. In Aserrí, ten consultation activities were carried out with 380 women. In Acosta, eleven consultations took place with 220 women, and in Desamparados eight consultations were conducted with 240 women.

2002 On 12-13 March, the workshop "Taller de Fortalecimiento de la gestión de la salud en red para la atención integral de las mujeres", was offered to interdisciplinary teams from the three integrated health-care programmes, the Replicating Group of the Gender-based Analysis workshop, and leaders of the communities. This workshop was facilitated by MSc Jessica MacDonald, a consultant hired by INAMU.

2002 On 9-10 April, the workshop "Taller de reflexión y análisis de prácticas obstétricas beneficiosas para la madre y su hijo(a)" was offered at the

Colegio de Médicos y Cirujanos de Costa Rica. Twenty-five people from the hospital participated: 14 from nursing, 6 obstetric physicians, including the chief of the section, 3 from the cleaning staff, and 2 from administration.

2002 In April, a proposal was made for management indicators with a gender focus to be included in the management commitments that the authorities of the hospital must sign with the Services Purchasing Unit of the Administrative Management of the CCSS for the year 2003.

2002 On 28 May, International Women's Health Day, a symposium was organized on the programme for excellence in maternity care "Programa de Distinciones Especiales a Maternidades con Alta Calidad de Atención". This was a public activity with presentations from PAHO, the Women's Health Section of the CCSS, women's association of AMES and Women's Hospital. It was attended by representatives from public and private universities, women from the communities, volunteers and INAMU representatives.

2002 On 2-14 June, the workshop "Taller de Medicina Basada en la Evidencia en la práctica obstétrica" was offered at Colegio de Médicos y Cirujanos de Costa Rica. Sixteen officials from the Women's Hospital participated: 9 obstetric physicians, 1 gynaecologist and 6 obstetrics nurses.

2004 The document, "Análisis basado en Género: una herramienta metodológica para la planificación en salud", prepared by MSc Marielos Rojas, MSc Grettel Balmaceda and MSc Ana Rojas was published.

Annexes

People interviewed

Women's Hospital

1. MBA Zully Moreno, Chief of social work service, was coordinator of the Technical Commission of the Interinstitutional Health Sector for the implementation of the Model of Integrated Health Care for Women, and is currently coordinator of the network of services for the health-care model, member of the Medical Service Advisory Team, member of the Adolescence Integrated Health-care programme and of the Health Care for Women Carriers of HIV/AIDS Team.

2. Licda Lidia Campos, a social worker, was coordinator and is now a member of the Cervical, Uterine and Breast Integrated Health-care Programme, coordinator of the Technical Support and Personnel Selection Committee of the Women's Hospital.

3. Licda Fanny Torres, a social worker, member of the interdisciplinary team of the Middle-aged Women Programme and coordinator of the Commission for breastfeeding.

4. Licda Ericka Obando, a social worker and member of the Integrated Interdisciplinary Adolescence Pregnancy Health-care Programme of the Palliative Care, Pain Control and Intrafamily Violence Clinic.

5. Msc Ligia Cerdas, a social worker, was official of the Women's Hospital and member of the Replicating Group. She no longer works at the Women's Hospital.

6. Dr Jorge Ramírez Beirute, Director of the Women's Hospital until September of 2007.

7. MSc María del Carmen Fernández, Assistant Director of Nursing and past member of the Interinstitutional Technical Health Committee.

8. Dr Luis Ledesma, former Chief of Emergency and Out-patient Care and member of the Interinstitutional Health Committee. General Director of the

Women's Hospital as of September 2007 and Coordinator of the Network Management Model.

9. Dr Gerardo Montiel Barrios, Chief of Gynaecology Service.

10. Licda Nidia Miranda, general nurse at the Gynaecology Hospitalization Service.

11. Sra Maricela Paniagua, secretary of the Gynaecology Hospitalization Service.

12. Dr José Francisco Cascante, Chief of the Obstetrics Service.

13. Dr Calderón Torres, Chief of the Obstetrics Service Clinic.

14. Dr Oscar Carazo, medical assistant of Obstetrics and member of the interdisciplinary Integrated Intrafamily Violence Team.

15. Licda Sisinia Chacón, obstetric nurse and former member of the Interinstitutional Health Sector Technical Committee.

16. Licda Blanca Boza, obstetric nurse and in charge of UNICES, facilitator from the Women's Hospital Health Council.

17. Licda Flor Herrera, obstetric nurse and member of the interdisciplinary team of the Integrated Adolescent Women's Health-care Programme.

18. Dr Mauricio Amador, Chief of Neonatology.

19. Dr Juan Carlos Molina, Assistant Chief of Neonatology.

20. MSc Eraida Palacios, nurse specializing in early stimulation and neonatology, coordinator of Integrated Health-care for Middle-aged Women.

21. MSc Silvia Rivera, perinatal nurse with Neonatology Service.

22. MSc Maureen Murillo, perinatal nurse with Neonatology Service.

23. Licda Xinia Vargas, Service Comptroller.

24. Lic Jenny Marenco, Hospital Statistics, was Chief of archives and appointments.

25. Licda Maureen Rodríguez, psychology.

26. Licda Ana Cecilia Ramírez, Chief of Human Resources.

27. Lic Mario Lobo, Human Resources, co-established the Replicating Group.

Health Areas and Clinics

28. MSc Nuria Valverde, Chief of Social Work at the Dr Carlos Duran Clinic, co-established Replicating Group GBA.

29. Dra Ana Isela Navarrete, medical coordinator of the Desamparados 3 Health Area, co-established Replicating Group GBA.

30. Dr Javier Céspedes, Director of Aserrí Health Area, co-established Replicating Group GBA.

31. Licda Mayela Fonseca, nurse at the Aserrí Health Area, co-established Replicating Group GBA.

32. Dra Zianny López, Director of the Acosta Health Area.

33. Lic Berny Rodríguez, Chief of Infirmary of the Acosta Health Area.

INAMU

34. MSc Ana Rojas, sociologist and ex-board member of INAMU, was part of the CTISS.

35. MSc Margarita Aragón, board member of INAMU, was in charge of empowering women leaders of the community project.

Civil society

36. Licda Eulalia Cole Porter, President of the Women's Hospital Health Board.

37. Licda Haydee Gómez, Vice-President of the Women's Hospital Health Board.

38. Sra Xinia Madrigal Céspedes, secretary of the Women's Hospital Health Board.

39. Sra María Elena Valerio, 1st Voting Member of the Women's Hospital Health Council.

40. Licda Noelia de León Carvajal, 3rd Voting Member of the Women's Hospital Health Council.

41. Licda Zaray Vargas, 4th Voting Member of the Women's Hospital Health Council and ex-Director of Nursing, Instituto Materno Infantil Dr Adolfo Carit Eva.

42. Soledad Díaz, consultant in charge of preparing the draft Gender-based Analysis Guide for Costa Rica and validating it with the Replicating Group.

Women leaders of the communities

43. Mirna Hernández, President of the Guidos Community Development Association, member of the Popular Committees on Health and member of the Asociación Salud Integral de las Mujeres Desamparadeñas (ASIMDE).

44. Dominga Cortés, member of the Guidos Health Committees and member of the Asociación Salud Integral de las Mujeres Desamparadeñas (ASIMDE).

45. Rosa Valverde, President of the Aserrí Women's Association, San Juan de Dios Promocionando la Salud Integral (AMASPSI) and member of the Health Board of the Aserrí Health Area.

46. Norma Mora, President of the Acosta Women's Association of Integrated Health Promotion.

47. Marlene Hernández, Volunteers Association Supporting Women with Cancer.

Observation

1. Sexual and Reproductive Health Consulting Sessions at the Women's Hospital
2. Middle-aged Women's Support Group at the Women's Hospital
3. "Encuentro de Saberes de Mujeres en la Mediana Edad" at the Women's Hospital
4. Course for psychophysical preparedness for childbirth, addressed to adolescents and their families, at the Women's Hospital
5. Workshop "Construyendo puentes para fortalecer el trabajo en red" with Health Boards, Women's Associations from Desamparados, Aserrí and Acosta
6. International Women's Health Day, speech about cancer and women, given by the Costa Rican Cancer Institute
7. Sensitization course for social workers provided by the Cancer Interdisciplinary Group
8. Delivery Room
9. UNICES, Special Care Unit, Obstetrical Service
10. UNINOB, Observation Unit, Obstetrical Service
11. Obstetric Room
12. Out-patient Services
13. Neonatology Service
14. Breastfeeding Clinic, Mother Support
15. Gynaecology Service
16. Tour in hospital and Health Areas
17. Intersectoral meeting on attention to intra-family violence at the Ministry of Health, Aserrí
18. Social work services

Documents reviewed

1. Anthology and Memories of workshops offered by Canadian experts.

2. Aragón, Margarita. *Informes de avance y finales del Proyecto Participación social y fortalecimiento de redes para el modelo de atención integral de las salud de las mujeres [Information on the progress and outcomes of the Social Participation Project and Strengthening of the Networks for the model of women's integral health care], 2001-2002.*

3. Burke MA and Eichler M. (2006) *The BIAS FREE Framework: A practical tool for identifying and eliminating social biases in health research.* Geneva, Global Forum for Health Research, 2006.

4. Díaz, Soledad e Isabel Gamboa (2002) *Análisis basado en Género: una guía metodológica para personal de salud [Gender-based Analysis: A methodological guide for health personnel].* San Jose, Costa Rica, February 2002.

5. Dr Adolfo Carit Eva Women's Hospital. *Strategic Plan 2007-2010,* June 2007.

6. Ledesma, Luis Guillermo (2006) *Análisis de los efectos de la aplicación del Modelo de Gestión en Red en la Consulta Externa y las áreas de atracción del Hospital de las Mujeres. [Analysis of the effects of the application of the Model of Network Management in Out-patient Service and the areas of attraction of the Hospital of the Women]. [thesis].* Instituto Centroamericano de Administración Pública (INCAP) [Central American Institute of Public Administration], Costa Rica, 2006.

7. Mac Donald, Jessica. *Memoria del taller: Fortalecimiento del trabajo de gestión de la salud en red para la atención integral de las mujeres [Workshop proceedings: Strengthening network management for integrated health care for women].* San José, Costa Rica, INAMU and Women's Hospital, 2002.

8. Mac Donald, Jessica. (2004) *Balance de la implementación de tres programas de atención en salud dirigidos a mujeres adolescentes y adultas: Memoria del proceso y análisis de las lecciones aprendidas. [Balance of the implementation of three programmes of adolescent and women's health: proceedings of the process and analysis of lessons learned].* San José, Costa Rica, INAMU, OPS, CCSS and MS, 2004.

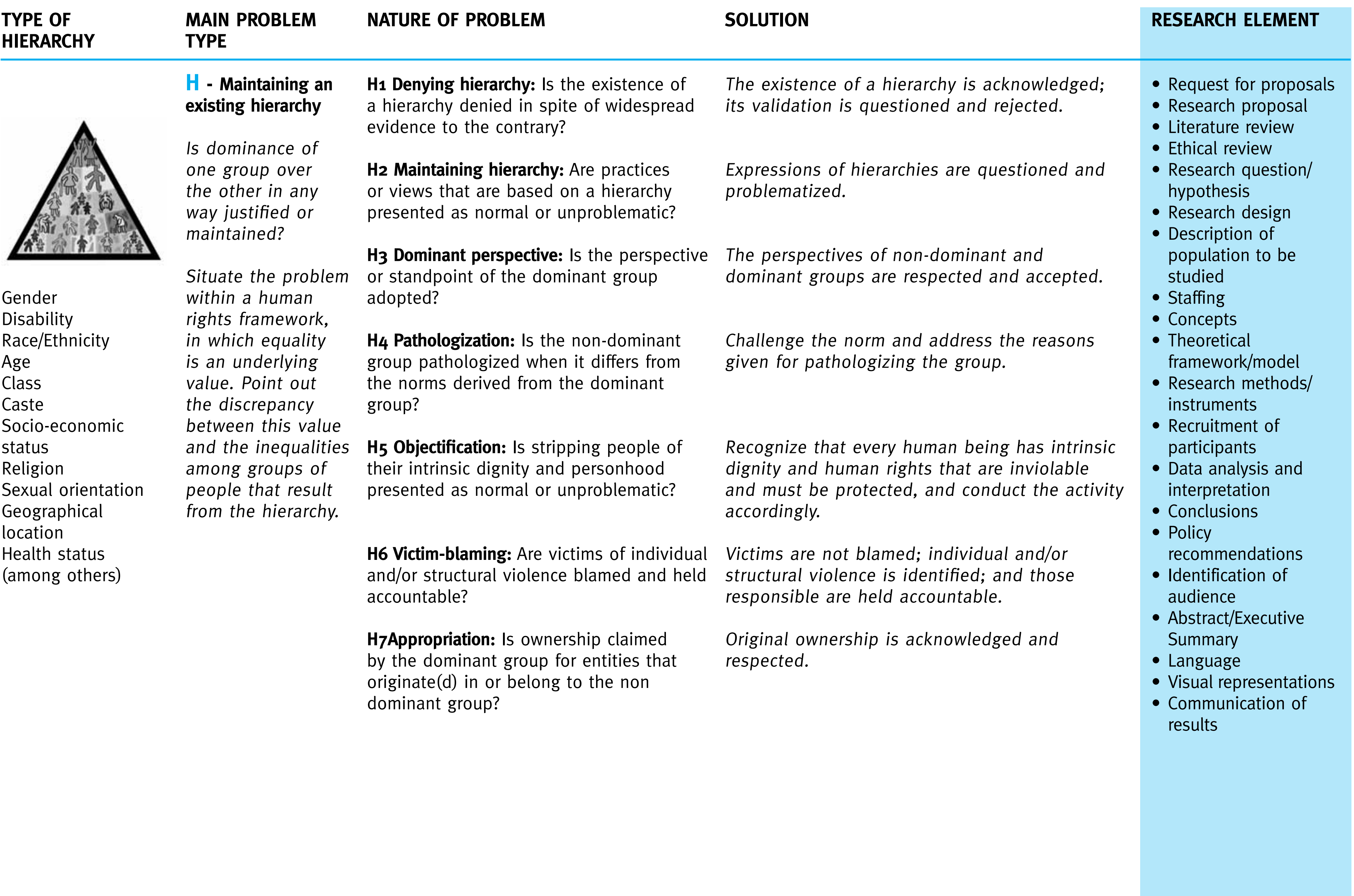
9. MS/INAMU/CCSS/Hospital de las Mujeres Dr Adolfo Carit Eva. *Modelo de Atención Integral de las Salud de las Mujeres: una propuesta para su construcción [Model for Integrated Health Care for Women].* San José, Costa Rica, 2001.

10. MS/INAMU/CCSS/ Hospital de las Mujeres. *Resumen cronológico de las principales acciones relacionadas con el Desarrollo del modelo de junio de 1999 a octubre del 2000. Modelo de Atención Integral de la salud de las mujeres: una experiencia demostrativa en el Hospital de las Mujeres Dr Adolfo Carit Eva [Chronological summary of the main actions related to the Development of the June 1999 to October 2000 model. Model for Integrated Health Care for Women: a demonstration project in Dr Adolfo Carit Eva Women's Hospital].* 2000.

11. MS/INAMU/CCSS/Hospital de las Mujeres. *Plan estratégico para el desarrollo del Hospital de las Mujeres Dr. Adolfo Carit Eva [Strategic Plan for the Development of Dr Adolfo Carit Eva Women's Hospital].* San José, Costa Rica, 2000.

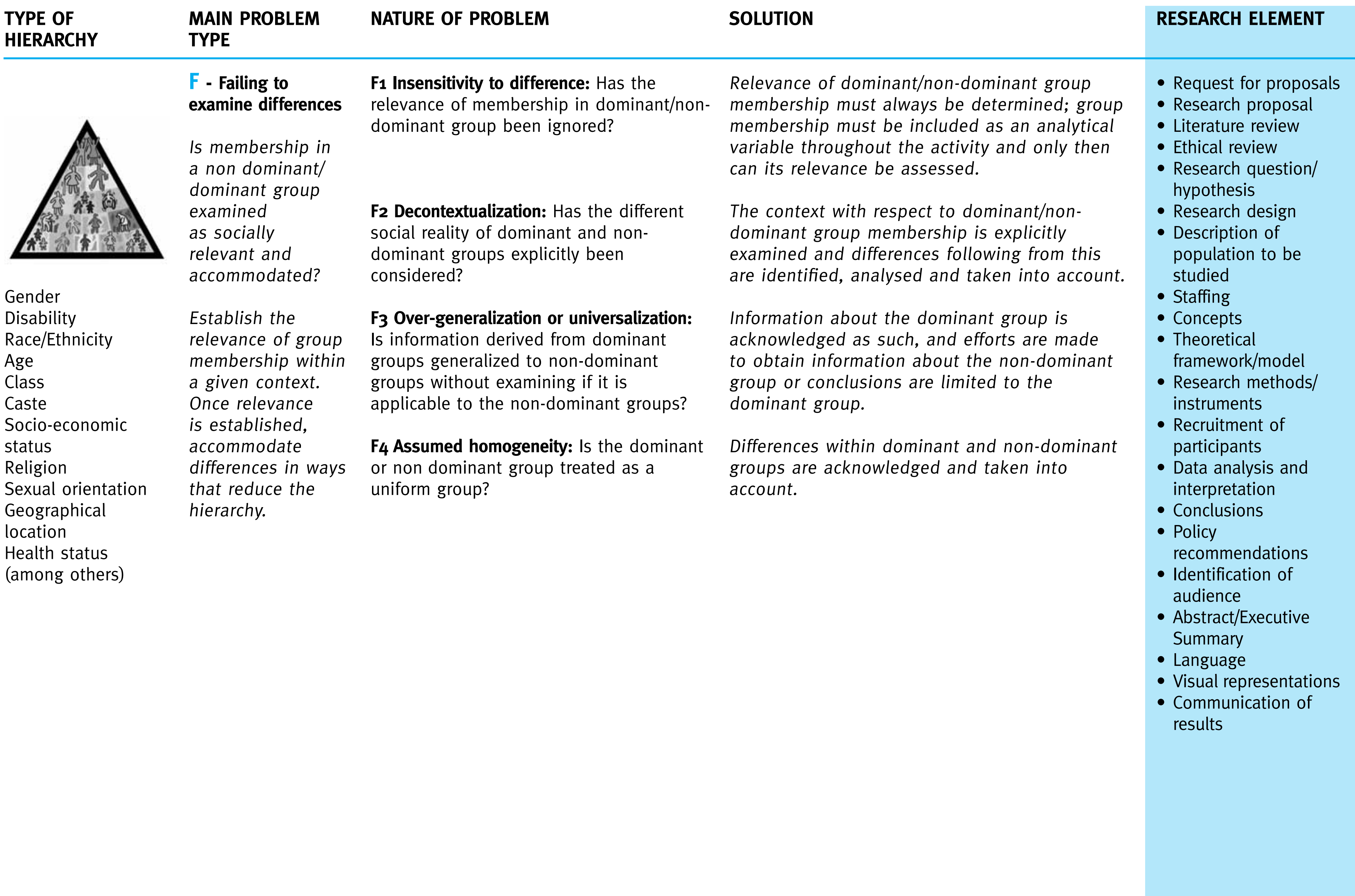
12. Work documents, reports, budgets and statistical information on the Hospital and Health Areas.

BIAS FREE Framework

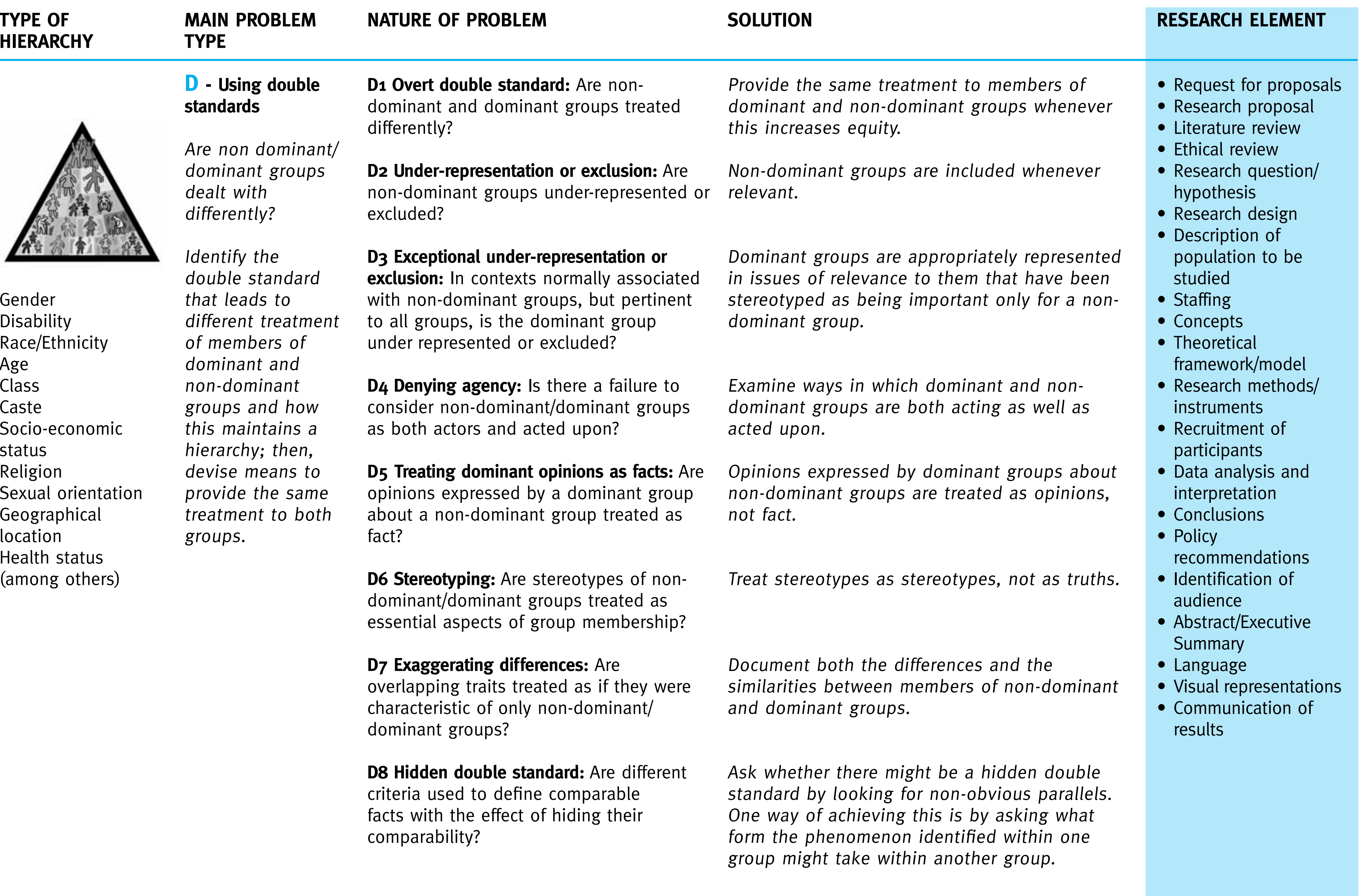


TYPE OF HIERARCHY	MAIN PROBLEM TYPE	NATURE OF PROBLEM	SOLUTION	RESEARCH ELEMENT
Gender Disability Race/Ethnicity Age Class Caste Socio-economic status Religion Sexual orientation Geographical location Health status (among others)	**H - Maintaining an existing hierarchy** *Is dominance of one group over the other in any way justified or maintained?* *Situate the problem within a human rights framework, in which equality is an underlying value. Point out the discrepancy between this value and the inequalities among groups of people that result from the hierarchy.*	**H1 Denying hierarchy:** Is the existence of a hierarchy denied in spite of widespread evidence to the contrary?	*The existence of a hierarchy is acknowledged; its validation is questioned and rejected.*	• Request for proposals • Research proposal • Literature review • Ethical review • Research question/ hypothesis • Research design • Description of population to be studied • Staffing • Concepts • Theoretical framework/model • Research methods/ instruments • Recruitment of participants • Data analysis and interpretation • Conclusions • Policy recommendations • Identification of audience • Abstract/Executive Summary • Language • Visual representations • Communication of results
		H2 Maintaining hierarchy: Are practices or views that are based on a hierarchy presented as normal or unproblematic?	*Expressions of hierarchies are questioned and problematized.*	
		H3 Dominant perspective: Is the perspective or standpoint of the dominant group adopted?	*The perspectives of non-dominant and dominant groups are respected and accepted.*	
		H4 Pathologization: Is the non-dominant group pathologized when it differs from the norms derived from the dominant group?	*Challenge the norm and address the reasons given for pathologizing the group.*	
		H5 Objectification: Is stripping people of their intrinsic dignity and personhood presented as normal or unproblematic?	*Recognize that every human being has intrinsic dignity and human rights that are inviolable and must be protected, and conduct the activity accordingly.*	
		H6 Victim-blaming: Are victims of individual and/or structural violence blamed and held accountable?	*Victims are not blamed; individual and/or structural violence is identified; and those responsible are held accountable.*	
		H7Appropriation: Is ownership claimed by the dominant group for entities that originate(d) in or belong to the non dominant group?	*Original ownership is acknowledged and respected.*	

BIAS FREE Framework

TYPE OF HIERARCHY	MAIN PROBLEM TYPE	NATURE OF PROBLEM	SOLUTION	RESEARCH ELEMENT
 Gender Disability Race/Ethnicity Age Class Caste Socio-economic status Religion Sexual orientation Geographical location Health status (among others)	**F - Failing to examine differences** *Is membership in a non dominant/ dominant group examined as socially relevant and accommodated?* *Establish the relevance of group membership within a given context. Once relevance is established, accommodate differences in ways that reduce the hierarchy.*	**F1 Insensitivity to difference:** Has the relevance of membership in dominant/non-dominant group been ignored?	*Relevance of dominant/non-dominant group membership must always be determined; group membership must be included as an analytical variable throughout the activity and only then can its relevance be assessed.*	• Request for proposals • Research proposal • Literature review • Ethical review • Research question/ hypothesis • Research design • Description of population to be studied • Staffing • Concepts • Theoretical framework/model • Research methods/ instruments • Recruitment of participants • Data analysis and interpretation • Conclusions • Policy recommendations • Identification of audience • Abstract/Executive Summary • Language • Visual representations • Communication of results
		F2 Decontextualization: Has the different social reality of dominant and non-dominant groups explicitly been considered?	*The context with respect to dominant/non-dominant group membership is explicitly examined and differences following from this are identified, analysed and taken into account.*	
		F3 Over-generalization or universalization: Is information derived from dominant groups generalized to non-dominant groups without examining if it is applicable to the non-dominant groups?	*Information about the dominant group is acknowledged as such, and efforts are made to obtain information about the non-dominant group or conclusions are limited to the dominant group.*	
		F4 Assumed homogeneity: Is the dominant or non dominant group treated as a uniform group?	*Differences within dominant and non-dominant groups are acknowledged and taken into account.*	

BIAS FREE Framework



TYPE OF HIERARCHY	MAIN PROBLEM TYPE	NATURE OF PROBLEM	SOLUTION	RESEARCH ELEMENT
Gender Disability Race/Ethnicity Age Class Caste Socio-economic status Religion Sexual orientation Geographical location Health status (among others)	**D - Using double standards** *Are non dominant/ dominant groups dealt with differently?* *Identify the double standard that leads to different treatment of members of dominant and non-dominant groups and how this maintains a hierarchy; then, devise means to provide the same treatment to both groups.*	**D1 Overt double standard:** Are non-dominant and dominant groups treated differently?	*Provide the same treatment to members of dominant and non-dominant groups whenever this increases equity.*	• Request for proposals • Research proposal • Literature review • Ethical review • Research question/ hypothesis • Research design • Description of population to be studied • Staffing • Concepts • Theoretical framework/model • Research methods/ instruments • Recruitment of participants • Data analysis and interpretation • Conclusions • Policy recommendations • Identification of audience • Abstract/Executive Summary • Language • Visual representations • Communication of results
		D2 Under-representation or exclusion: Are non-dominant groups under-represented or excluded?	*Non-dominant groups are included whenever relevant.*	
		D3 Exceptional under-representation or exclusion: In contexts normally associated with non-dominant groups, but pertinent to all groups, is the dominant group under represented or excluded?	*Dominant groups are appropriately represented in issues of relevance to them that have been stereotyped as being important only for a non-dominant group.*	
		D4 Denying agency: Is there a failure to consider non-dominant/dominant groups as both actors and acted upon?	*Examine ways in which dominant and non-dominant groups are both acting as well as acted upon.*	
		D5 Treating dominant opinions as facts: Are opinions expressed by a dominant group about a non-dominant group treated as fact?	*Opinions expressed by dominant groups about non-dominant groups are treated as opinions, not fact.*	
		D6 Stereotyping: Are stereotypes of non-dominant/dominant groups treated as essential aspects of group membership?	*Treat stereotypes as stereotypes, not as truths.*	
		D7 Exaggerating differences: Are overlapping traits treated as if they were characteristic of only non-dominant/ dominant groups?	*Document both the differences and the similarities between members of non-dominant and dominant groups.*	
		D8 Hidden double standard: Are different criteria used to define comparable facts with the effect of hiding their comparability?	*Ask whether there might be a hidden double standard by looking for non-obvious parallels. One way of achieving this is by asking what form the phenomenon identified within one group might take within another group.*	

Application of The *BIAS FREE* Framework