What Works?

Integrating Gender into Government Health Programmes in Africa, South Asia, and Southeast Asia

CASE STUDY SUMMARY REPORT:

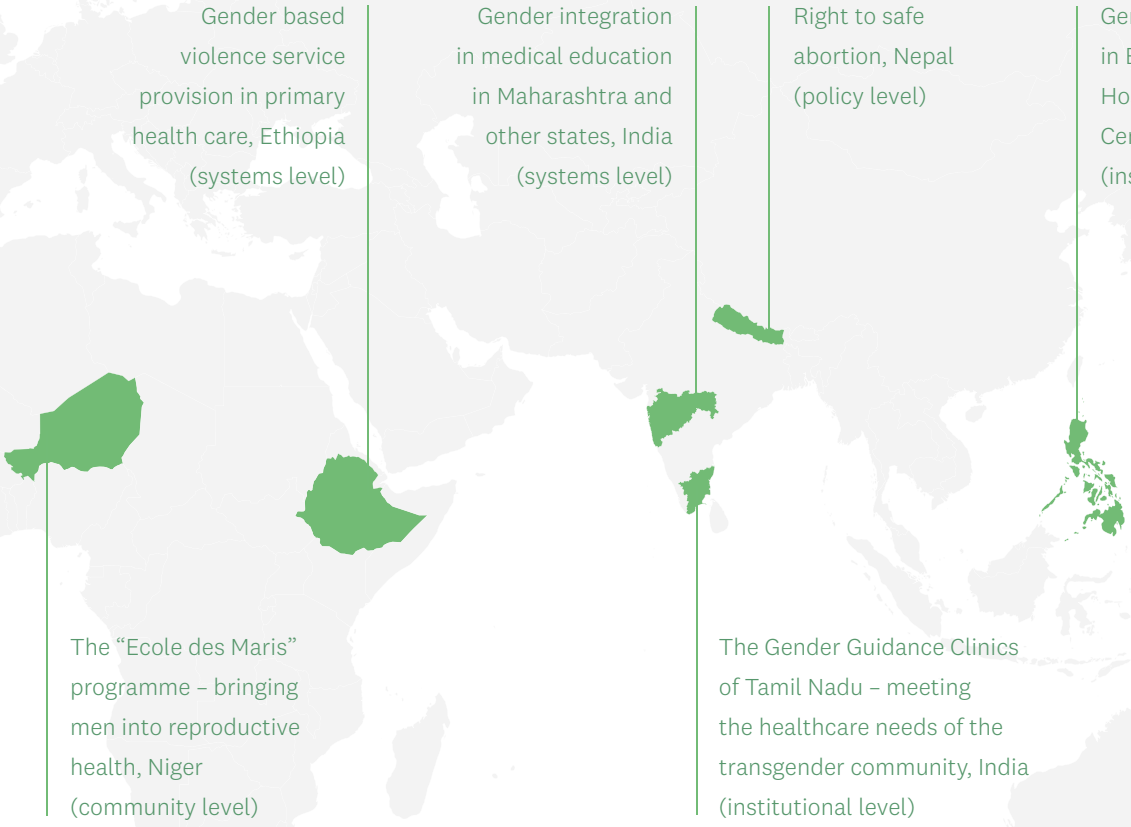
Gender integration in Baguio General Hospital and Medical Center (Philippines)

UNU IIGH
University of the Western Cape School of Public Health
PUBLIC HEALTH FOUNDATION of INDIA
Gender & Health Hub

Regional promising practice project overview

Strengthening health systems in order to improve health and gender-equality outcomes requires robust country leadership and governance. Widespread commitments have been made to integrate gender into health, yet substantial gaps remain in intent, level of investment, and implementation. There is a pressing need for more contextualised, practice-based evidence of the pathways along which gender integration can be institutionalised and sustainably resourced in government health programmes.

The United Nations University International Institute for Global Health (UNU-IIGH), in partnership with the School of Public Health at the University of Western Cape in South Africa, and the Public Health Foundation of India through the Ramalingaswami Centre on Equity and Social Determinants of Health in India, co-led a collaboration to document and analyse six diverse and promising practices of gender integration in government health programmes. The resultant case study series consists of six stand-alone summaries with key findings spanning policy, systems, institutional, and community levels. Detailed case study reports are forthcoming.



Gender integration in Baguio General Hospital and Medical Center (BGHMC)

This case focuses on how gender integration was embedded within the practices and administration of a tertiary hospital in the Philippines. The programme was selected as a promising practice because BGHMC stands out as an example of the advancements that can be made in tertiary care to address gender inequalities and improve cultural competence.

The case study was led by Jennifer Curry Josef, working alongside Arlene B. Galvez, with support from Zaida Orth and Johanna Riha. Based on in-depth analyses of interviews and published materials, it examines the contextual factors that gave rise to the institutionalisation of gender integration in BGHMC, the enabling factors and challenges encountered, outcomes achieved, and lessons learned, including those that might be transferable to other contexts (see Figure 1).

1. Background

The need for gender integration and cultural competence in tertiary care

Equitable health systems are crucial for delivering effective and efficient healthcare, and aligning with the Sustainable Development Goals to provide universal health coverage and ensure that no one is left behind. Tertiary hospitals play a critical role in the public healthcare system by providing specialised care, fostering medical research and education, and serving as pivotal referral centres for complex medical cases. However, persistent gender inequalities, which are rooted in harmful gender norms and biases, are often widespread across the health system – including tertiary hospitals – ultimately impacting the wellbeing of both healthcare providers and clients. These axes of discrimination often run along different intersecting social dimensions, including class, race, and indigeneity, affecting who has access to quality healthcare, how they are treated within the healthcare system, and the decision-making power they have over their health and wellbeing. To serve the needs of diverse populations and not reinforce harmful stereotypes and norms, it is imperative that the healthcare system, including tertiary hospitals, take measures towards improving gender integration and cultural competence.

In the Philippines, the Department of Health has reported that indigenous groups, which account for approximately 13 percent of the Filipino population, are among the most disadvantaged and marginalised, and considerably vulnerable to health inequities (DOH, NCIP, and DILG 2013). These disparities are further compounded along gendered lines, with indigenous women and LGBTQ+ groups experiencing additional discrimination and stigmatisation. The principles of health equity and inclusiveness are implemented in the Philippines through the universal healthcare strategy of the Department of Health, with the aim that all Filipinos, not just those financially and socially advantaged, have access to health services, especially in remote parts of the country.

BGHMC is the biggest tertiary hospital in northern Philippines in terms of the number of patients, staff, and facilities in the region, with a current capacity of

1,200 beds and over 15 different medical departments. The hospital caters to a large migrant community, the LGBTQ+ community, and indigenous ethnolinguistic groups, who continue to practice some aspects of their indigenous culture to varying degrees. Most patients at BGHMC are from lower-income socio-economic groups in the Cordillera administrative region, and the contiguous provinces of La Union and Pangasinan. The hospital, which is the lone apex hospital in northern Philippines, is undergoing a major expansion, including a multi-specialty centre (heart, brain, kidney, and lung) and a trauma centre, with the long-term goal of building capacity to transplant organs, so that patients do not have to go to Metro Manila for such services. In order to provide more gender-responsive and culturally sensitive healthcare, since 2016, BGHMC has been actively mainstreaming gender in the hospital's programmes and services through the gender and development (GAD) focal point system (GFPS).

The GAD focal point system in BGHMC

The GFPS is the main mechanism for gender mainstreaming in all government institutions and agencies in the Philippines from the national level down to the smallest political unit in villages. Implementation of the GFPS is mandated by law in all government agencies – line agencies, government-owned and controlled corporations, state colleges and universities, public hospitals, etc. This includes development and submission of GAD plans and budgets and achieving a minimum budget allocation of 5 per cent. However, few government institutions meet the 5 per cent budget allocation rule, and rarely is the GFPS institutionalised. BGHMC stands out as an example whereby the GFPS has been institutionalised across the hospital, improving the provision of more gender-responsive and culturally sensitive healthcare.

BGHMC has had a GFPS since 2016 as "an interacting and interdependent group of people tasked to catalyse and accelerate gender mainstreaming. It is also an enabling mechanism established to ensure and advocate for, guide, coordinate and monitor the development, implementation, monitoring, review, and update of their GAD plans and GAD-related programmes, activities, and projects" (Gaerlan 2021). The BGHMC maintains a GFPS in all departments and units of the hospital.

BGHMC has a GFPS composed of 42 members. The medical centre's chief is the chairperson of the GFPS and appoints the vice-chairperson of the GFPS, who, in turn, heads the Technical Working Group (TWG). The TWG is composed of eight members from the following medical departments and units: (1) obstetrics and gynaecology; (2) public health; (3) budget office; (4) human resource management; (5) planning unit; (6) nursing services; (7) engineering and facilities management; and (8) women and children protection unit. These units are the most relevant units to ensure efficient implementation of GAD plans and budgets.

The GFPS has a management committee composed of eight members from the following units: (1) nursing service; (2) hospital operations and patient support services; (3) finance and management office; (4) allied health professional services; (5) BGHMC employees' organisation; (6) professional education training and research office; (7) quality assurance office; and (8) public health.

2. What has been achieved?

BGHMC has maintained a GFPS in all departments, and regularly undertakes gender analysis, gender planning and budgeting, and evaluation of GAD plans, which are mandated by law. While other government institutes find it difficult to meet the minimum 5 per cent budget requirement, in 2022, BGHMC assigned around 19–20 per cent of its budget to GAD (Josef 2023a; BGHMC 2022).

Based on a patient satisfaction survey, BGHMC appears to enjoy high ratings and has the reputation of providing affordable gender-responsive care, and being sensitive to elderly persons and persons with a disability. Based on interviews and reviews of documents, across a range of departments, the GFPS has led to a number of achievements, including:

- **The provision of gender-sensitive and gender-responsive healthcare**. Examples include:
    - Provision of comprehensive health services to victims/survivors of abuse, spanning a range of services, including interviews, physical examination, specimen collection and diagnostic procedures, debriefing and counselling, and referral to other departments as required. This also includes providing medico-legal certificates and testifying in courts.
    - Improvements in sensitive and non-judgmental post-abortion care.
    - Dedicated schedules, areas and personnel for teenage parents in paediatrics, obstetrics and gynaecology.
    - Spousal consent no longer required for women to receive contraceptive drugs, devices, and procedures, including bilateral tubal ligation.
    - Psychosocial support for female caregivers of admitted patients who are prone to stress.
- **Community-based training on gender-based violence.** The Women and Children Protection Unit (WCPU), with support from the GAD TWG, has gone beyond their mandate to conduct training of officials at village level on gender-based violence. The GAD TWG consider this one of the notable accomplishments of the WCPU, and believe it should be replicated in other hospitals and regions.
- **Promoting gender equity among staff** through:
    - Proactive encouragement and recruitment of male medical residents in psychiatry, given 80 per cent of staff in the department are female.
    - Proactive encouragement and recruitment of female medical residents in the surgical department, given the large gender disparity, with successful recruitment of two new female residents and fellows in surgery.
    - During the COVID-19 pandemic, the Family and Community Medicine Department was able to prioritise the medical needs of hospital employees. This included rolling out medical tests, such as pap smears and mammograms to masculine-presenting lesbians, with some tests diagnosing masculine-presenting lesbian employees with diseases related to their reproductive health.
    - Regular training about sexual harassment in the workplace.
- **Training on how to set up GFPSs in other healthcare settings.** In recent years, the BGHMC TWG has trained management and staff of other hospitals on how to set up a GFPS (the most recent was conducted in early 2023 for the St. Louis Medical Center).

3. What contextual factors facilitated the establishment of the gender focal point system in BGHMC?

A range of national and organisational factors provided a broader enabling context, which facilitated initiation and scale-up of the GFPS in BGHMC.

National level

Strong and dynamic women's and people's movements and civil society organisations

- The Philippines has a long history of a very strong and dynamic women and people's movement and civil society. These have been instrumental in policy reforms, lobbying for national laws and policies, as well as local and village-level ordinances. The observed progressive stance on gender and development is partly due to the advocacy work of key feminist personalities and gender champions. Moreover, for decades many activists and feminist leaders have joined the executive and legislative branches of government, helping reform institutions, and draft and enact "women's laws."

- The various women's coalitions had a pool of writers who drafted women's laws and mobilised strong lobby groups to push for the enactment of the laws. The passage of several women's laws in the Philippine Congress were preceded by at least a decade of struggle in order to get the laws passed.

Bold legal and policy frameworks on GAD and health

- Landmark women's laws, or gender-equality laws, paved the way for GAD programmes including those in the health sector. Salient legislation includes:

    - Women in Development and Nation-Building Act of 1992 (Republic Act No. 7192), which aimed to promote the integration of women as full and equal partners with men in development and nation-building.

- The GAD budget policy was introduced through the General Appropriations Act, 1995, to support programmes and projects focused on gender advocacy, and commitment to women's empowerment (Delgado, 2017).

- The Anti-Violence Against Women and Their Children Act of 2004, which formed part of the basis for establishing the women and children protection units in hospitals, and the women and children's desk in police precincts.

- The Magna Carta of Women (Republic Act No. 9710), 2009, which is a comprehensive women's human rights law that seeks to eliminate discrimination against women by recognising, protecting, fulfilling and promoting the rights of Filipino women, especially those from marginalised sectors. It defined GAD as an essential mechanism for gender mainstreaming, along with GAD planning and budgeting to ensure implementation of the law.

- The Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act No. 10354).

- The Philippine HIV and AIDS Policy Act of 2018 (Republic Act No. 11166).

- The Universal Health Care Act of 2018 (Republic Act No. 11223).

Mandatory implementation of annual GAD plans and budgets and GAD accomplishment reports in all government institutions and agencies

- **GAD plans and budgets** are one of the prerequisites for approval of each government agency's annual budget. Approval of institutional budgets (e.g. hospitals and schools) is contingent on the approval of GAD plans and budgets by respective government departments. This has been instrumental in making government agencies comply with implementing GAD plans and budgets (Josef 2023b).

- **Philippine commission on women (PCW).** This is the national agency in charge of monitoring GAD plans and budgets in all government agencies and units, as well as the GFPS. Given its limited budget and personnel, central offices of different government agencies, including the Department of Health, are responsible for supervising, evaluating and monitoring annual GAD plans, budgets, and accomplishment reports. In 2014, the PCW rolled out a gender mainstreaming monitoring system for submitting annual GAD plans, budgets, and accomplishment reports.

Key actors – gender champions and key political personalities

- **Political culture in the Philippines is still heavily personality-oriented.** The passage of a bill still depends on the sponsorship of popular politicians. Unfortunately, many female politicians are not necessarily pro-women. As elites, their interests and actions are mainly consistent with their class interests. There are only a handful of genuine gender champions in the Philippine Congress, such as the late Philippine Senator Leticia Ramos-Shahani, who was the sister of former Philippine President, Fidel V. Ramos. She was a GAD champion and ally to women's groups.[1]

- **Feminist leaders advocated for sexual and reproductive rights.** Several women's health NGOs and consortiums conducted research and lobbied for the passage of progressive health laws. WomanHealth Philippines Inc. is a nationwide organisation of feminists and women's health advocates. Two of their long time national officers, Maria Ana Ronquillo-Nemenzo[2] and Mercedes Lactao-Fabros,[3] as well as Sylvia Estrada-Claudio and Junice Demetrio Melgar of the Likhaan Center for Women's Health Inc., have been at the forefront of policy advocacy and the movement for sexual and reproductive health and rights nationally and globally.

Opposition from strong conservative religious groups

- **The full implementation of gender-equality laws is hampered by persistent, conservative patriarchal systems** in Philippine society. The hold and power of the Roman Catholic Church hierarchy, and organisations of Muslim Filipinos on Philippine politics (politicians and electorate) have been, and remain, fetters to enactment and implementation of "women laws" that aim to help foster gender equality. This is evident in how the conservative

1 Leticia Ramos Shahani was a former UN Assistant Secretary General for Social and Humanitarian Affairs (1981–1986). She is credited with preparing the first draft of the United Nations Convention of the Elimination of All Forms of Violence Against Women (UN CEDAW), which was eventually adopted by the United Nations in 1979. The Philippines ratified the Convention in 1981.
2 Maria Ana Ronquillo-Nemenzo is a feminist working on women's sexual and reproductive health rights. She served as Vice-Chairperson for the Basic Sector of the National Anti-poverty Commission in 1999 and Commissioner for the Women Sector until March 2008. She is a pioneer in reproductive health rights advocacy and activism, and health policy expert on legislative concerns (WeDpro 2015).
3 Mercedes Lactao-Fabros was among the pioneering leaders of WomanHealth Philippines, Inc. She headed a team of feminist researchers for the IRRRAG seven-country research on reproductive health and rights. The research output was transformed into the chapter "From Sanas to Dapat – Negotiating entitlement in reproductive decision making in the Philippines", which analyses Filipino women's concept of sexual and reproductive rights from the aspirational ("*sana*") to rights ("*dapat*") in the book, *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures* (1998, pp. 217–255).

sectors have used all means to block the passage of the Responsible Parenthood and Reproductive Health Act of 2012 (RA 10354) in Congress, where its constitutionality was questioned by conservative groups in the Supreme Court.

Institutional level (BGHMC)

- **Strong "culture of compliance" and commitment to ethics of care and institutional mission of patient-centred service.** There is an apparent strong culture of compliance among government workers. For BGHMC, this culture of compliance can be attributed to a sense of fulfilment in "doing the job right" and the hospital's culture of providing patient-centred services. This is also linked to some of the criteria for tenure and promotion (e.g. individual performance and commitment ratings of the Civil Service Commission).

- Another driver of this culture is the **feedback received via patient satisfaction surveys**, which are a prerequisite for certification by the International Organization for Standardization (ISO), an independent body that sets standards for ensuring the quality, safety, and efficiency of products and services.

- **Doctors and staff are invested when patients are not total strangers.** Many patients at BGHMC are *kailyan* or town-mates, kin, distant relatives, or acquaintances (unlike in other mega-cities where the majority of patients are total strangers). Social networks, social capital, and cultural sensitivity become very important. There is also the concept of *inayan* (*Kankana-ey* ethnolinguistic group), which is loosely translated as an indigenous belief and practice of taboo and avoidance of losing face in the community. This is manifested in the practice of doing right by others so as not to have a negative reputation in the community.

- **Experience of implementing GAD in the obstetrics and gynaecology department.** The BGHMC, as a government hospital, needs to comply with all GAD laws and policies. The BGHMC started implementing GAD plans and budgets in 2014. Initially, implementation of the GFPS was not to address a need but rather to comply with the gender-equity laws. Initially, only one hospital department, obstetrics and gynaecology, was consistent in submitting GAD plans and budgets. The chairperson of the GFPS during this period was from the same department.

4. What catalysed the expansion of GFPSs across all hospital departments?

Certain catalytic moments, whereby a change in the internal or external context opened a window of opportunity, which was seized by specific actors, included the following:

- **Appointment of a gender champion as chairperson of the GFPS TWG.** The current chairperson of the GFPS TWG was appointed by the medical centre's chief in December 2016. The new chairperson strongly advocated for an institutionalised approach to GFPS. She recruited and convinced a licensed nurse within the hospital to be vice-chairperson of the GFPS TWG and subsequently assumed the position of health promotions officer.

- **The new chairperson took a very hands-on approach** to institutionalising GFPS through recommending people to be appointed to the GFPS TWG from various medical departments and other units.
- **Support for the GFPS from the highest levels within the hospital.** The medical centre chief has supported the chairperson in institutionalising the GFPS. This has been a critical factor in ensuring that all departments come on board.

5. What actions allowed changes to be sustained over time?

Expansion of the GFPS and GFPS TWG

- The highly personal nature of Philippine culture has been an important factor in recruiting members of the GFPS. The chairperson personally approaches potential recruits to the GFPS whom she feels could contribute to GAD work. She then recommends these medical consultants and staff members to be appointed by the medical centre chief.
- GAD committee appointees are usually recruited for the following reasons: (1) their potential to make a positive contribution to GAD work; (2) their interest in GAD work; (3) new hires who cannot refuse additional work; and (4) staff who have time available.
- The GFPS currently has 42 members, which represent all medical departments and units across the medical centre. The medical centre chief chairs the GFPS, along with a management committee composed of five core members and six guest members.4
- The GFPS is directly supervised by the GFPS TWG, which is composed of eight members and has a chairperson and vice chair. They are assisted by a GAD ward assistant.
- Aside from the TWG, there are 20 GAD point persons with representation across all hospital departments.5

Staff commitment and training on gender plans and budgets

- The GFPS TWG took 2 years to achieve a high level of compliance across hospital departments with respect to submitting GAD plans and budgets. TWG members remained committed to GAD mainstreaming.
- Initially, the process was challenging because staff were trained in medical and allied services (i.e. bedside, nursing, and medical care), not planning and budgeting. It took 3 months to learn the rudiments of GAD planning and budgeting.

4 The five core members represent the following departments or offices: (1) medical service; (2) hospital operations and patient support services; (3) nursing; (4) allied health professional service; and (5) finance. The guest members include the following: (1) quality assurance officer; (2) professional education and training office; (3) public health unit; (4) the hospital employees' association; (5) legal office; and (6) planning unit.
5 The 20 GAD point persons are from: (1) md-anaesthesiology; (2) cancer centre; (3) dental; (4) emergency room; (5) family and community medicine; (6) family planning; (7) HIV-AIDS core team; (8) internal medicine; (9) medical social work; (10) obstetrics and gynaecology; (11) otorhinolaryngology head and neck surgery; (12) human resource management; (13) neurology; (14) nursing services; (15) nutrition and dietetics; (16) pathology; (17) paediatrics [2 representatives]; (18) psychiatry; (19) radiology; and (20) surgery.

- In 2016, the GFPS TWG conducted in-house training for staff. Trainers were either from PCW in Manila or BGHMC staff/consultants. Training covered: (a) gender sensitivity; (b) GFPS; (c) GAD planning and budgeting; and (d) training the trainer. These intensive sessions were critical to the consistent and systematic submission of annual planning and budgeting.
- Training sessions were consistently maintained, even during the COVID-19 pandemic using an online mode of delivery.

6. What were the missed opportunities and challenges?

While the GFPS in BGHMC has shown promising interim outcomes related to gender-responsive and culturally sensitive services, and implementation has been sustained across all hospital departments, a number of challenges remain, including the need to:

- **Build more systematic recruitment processes for GFPS.** There is a need to cultivate the next generation of GFPS members. However, there is no systematic recruitment process for GAD staff and advocates.
- **Foster greater appreciation and remuneration of GAD work.** Across government institutions, GAD work is often additional to the existing workloads of staff who are already overworked. Appropriate valuation of GAD work should be institutionalised through creating dedicated positions. This has been a longstanding issue within the central offices, the Department of Budget and Management, and the Office of the President. Despite efforts between 2017 and 2019 to push for at least one GAD position in all government offices, there has been no positive development. The issue was sidelined during the COVID-19 pandemic. However, the proposal needs to be revived and lobbied at various levels of government. Meanwhile, other incentives for members of GFPS should be explored and institutionalised, such as individual performance ratings, performance-based bonuses, and other means of acknowledging staff accomplishments.
- **Improve data collection of gender and other identities on patient information forms.** There is an urgent need to revise the patient information form to improve data collection and analysis, including sex assigned at birth, gender identity, sexual identity, religion, ethnolinguistic group, and other relevant variables that impact the services patients require. Culture and religion are important factors in determining the health intervention, as well as the acceptance or rejection of proposed medical interventions – for example, the openness of medical doctors to indigenous birthing positions (with scientific bases). For transgender patients, especially those who are victims of physical or psychological abuse or violence, data on sexual identity is important. This could be simultaneously pursued at both the medical centre, and the central office of the Department of Health. The assistance of gender-sensitive and progressive politicians, government officials and advocacy groups should be enlisted to push for this simple, yet impactful, reform.
- **Maximise local resources and collaboration in relation to GAD training.** Strategies and mechanisms should be implemented to develop and strengthen interagency structures and mechanisms, such as the regional GAD committee. Local experts and the PCW mechanism of accreditation and referral of trainers should be tapped for the various GAD training needs of GFPSs in the region.

- **Integrate GAD into the curricula of medical and allied health professions.** The Commission on Higher Education and the Association of Medical Schools should be lobbied to integrate GAD into medical curricula and into the medical education of allied health professionals. This would help improve GFPS implementation across more medical establishments, with graduates already sensitised to the importance of GAD and related processes.

- **Increase the number of LGBTQ+ services.** There has been a steady increase in the practice of do-it-yourself or non-prescribed cross-sex hormone therapy. This indicates a growing demand for the provision of professional medical services related to transitioning, including the need for a referral system of patients to psychiatrists and endocrinologists willing to provide these services. However, the Philippines remains very conservative on issues of sexuality, especially gender-affirming interventions such as hormone therapy and surgery. These are highly controversial themes for the Roman Catholic Church, as well as fundamentalist Christian and Islamic groups. The Philippines should study and learn from the experiences of countries that have successfully implemented gender clinics for LGBTQ+ communities, taking into consideration the unique context of the Philippines.

7. Conclusions

The BGHMC case demonstrates how a very favourable legal and policy framework related to gender equality and development has been conducive to implementing gender integration in health programmes. The mandatory implementation of gender planning and budgeting in all government units resulted in the institutionalisation of gender mainstreaming, mainly through the GFPS. BGHMC's commitment to implementing the GFPS stands as an exemplar in spite of various challenges.

The hospital has implemented a GFPS in all departments, and these regularly undertake gender analyses, gender planning and budgeting, and evaluation of GAD plans, in addition to quarterly meetings. Whereas other government agencies have failed to meet the minimum 5 per cent GAD budget requirement, this hospital committed 19–20 per cent of the budget to GAD in 2022. The GFPS TWG has been fundamental in institutionalising change through in-depth and repeated training sessions. From a lone gender champion who started gender-mainstreaming efforts in 2014, there are now many gender champions thanks to the GAD training. Training deepened the hospital staff's understanding of gender issues in the hospital setting, resulting in strong commitment to its integration into a number of programmes and services. Perhaps this raising of gender-consciousness can start not just through hospital staff training, but earlier by including gender integration in the curriculum of medical schools and other allied health courses.

There is still a need for a more systematic selection and recruitment process for selecting GAD focal point persons at BGHMC. A proper evaluation of the importance of GAD work needs to be matched by proper remuneration and incentives for the already overburdened staff doing additional GAD work.

Overall, the relative success of the BGHMC in implementing the GFPS can be viewed as a result of certain socio-cultural, economic, and other institutional contexts, support from key officials, and the dedication of the GAD secretariat and members of the TWG and GFPS. The experiences documented here are worthy of adopting in other settings.

8. References

BGHMC (Baguio General Hospital and Medical Center) (2022). "Gender and development (GAD) report FY 2022". https://bghmc.doh.gov.ph/wp-content/uploads/2023/05/2022-ACCOMPLISHMENT-REPORT.pdf.

Delgado, M.K.V. (2017). "Gender-responsive planning and budgeting at the national level: The Philippine experience". Presentation. https://www.unescap.org/sites/default/files/2.%20The%20Philippines.pdf.

DOH (Department of Health), NCIP (National Commission on Indigenous Peoples), & DILG (Department of Interior and Local Government) (2013). "Joint memorandum circular No. 2013-01". http://ncipcar.ph/images/pdfs/DOH-NCIP-DILG-JMC-2013-01-s-2013.pdf.

Gaerlan, M.V.A. (2021). "PCW memorandum circular No. 2011-01". https://gad.denr.gov.ph/index.php/resources/gad-policies/memorandum-circulars/3395-pcw-memorandum-circular-no-2011-01#:~:text=1.2.,Gender%20Equality%20and%20Women's%20Empowerment.

Josef, J.C. (Unpublished). "GAD focal point system (GFPS) as promising mechanism in integrating gender in government health programs: The case of the Baguio General Hospital and Medical Center."

Josef, J. (2023a). Interview with Lorraine Ramos.

Josef, J. (2023b). Interview with Lorraine Ramos and Kleifanie Ferrer.

Suggested citation: JC Josef, AB Galvez, Z Orth, J Riha (2023). Gender integration in Baguio General Hospital and Medical Center (Philippines). Case study summary report. Part of the Regional Promising Practices Consortia. What Works? Integrating gender into Government Health programmes in Africa, South Asia, and Southeast Asia. United Nations University International Institute for Global Health. Kuala Lumpur, Malaysia.

DOI: https://doi.org/10.37941/RR/2023/6

Layout and design: The Creativity Club

Copy-editor: David Cann

Figure 1: Key catalysts, contextual enablers and sustaining mechanisms for gender integration in Baguio General Hospital and Medical Center (Philippines)