

Pharmacists supporting women and responsible use of medicines

Empowering informal
caregivers

2018



International
Pharmaceutical
Federation

Colophon

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Foreword

By the Executive Director and Co-founder of Women in Global Health

My congratulations to the International Pharmaceutical Federation (FIP) on launching this impressive report, *“Empowering informal caregivers”*, outlining the support pharmacists can give to women as informal caregivers in promoting and delivering better health. The major contribution made by women to global health is often overlooked and undervalued so I applaud FIP’s vision in recognising and researching this critical area.

Access to quality health care is a human right fundamental to well-being, life chances and life itself. That right is currently denied to millions, particularly in low- and middle-income countries (LMICs). Significant progress has been made in global health in the past 30 years. More children survive into childhood, more mothers survive childbirth, we are close to eradicating diseases such as polio and people are living longer. But rising inequality, changing demographics (ageing populations in high-income countries and young populations in low-income countries), the increase in non-communicable diseases, possible pandemics and emerging threats like antimicrobial resistance (AMR) all require a radical rethink of global health systems and approaches. And that radical rethink requires harnessing the expertise and commitment of all potential change agents in health prevention, promotion and delivery, with a central role for pharmacists and women as informal caregivers.

Globally, women make up 70% of the healthcare workforce, yet occupy less than 25% of the most influential leadership positions. Women contribute around USD \$3 trillion to global health care, but nearly half of this (2.35% of global GDP) is unpaid and unrecognised. Their contribution to health systems is monumental, yet the majority of their work is either underpaid, unpaid or unrecognised. This creates an inequitable health system that impacts negatively on the health of us all.

In 2016 the world’s governments committed to achieving the Sustainable Development Goals (SDGs), the most visionary being the commitment to achieving universal health coverage (UHC) by 2030. This ambitious target will be the global gamechanger that brings quality, affordable health care, prevention and promotion to all, leaving no-one behind. UHC delivery will rest on the paid and unpaid work of women, and critically also on the role of pharmacists supporting those women with delivery of safe medicines and services, enabling women to prevent ill health and promote health literacy and care for their families and communities. In many contexts, a pharmacist will be the first and only health professional an informal caregiver may consult so the role of pharmacists on the front line of global health is critical. Listening to the needs of female caregivers will be essential to building a bond of trust. This report helpfully highlights the contribution to society of women as informal caregivers, and aids all our understanding.

I trust that the analysis and case studies in this report will inspire pharmacists in FIP’s 140 national organisations to support female informal caregivers and bring the world closer to health for all.

Dr Roopa Dhatt

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This report would not be possible without the input and cooperation of FIP member organisations and the inspirational leadership of FIP President Carmen Peña.

Background

In 2016, the world transitioned from a focus on the United Nations Millennium Development Goals (MDGs) to a renewed focus on international equity through the cross-sectional application of 17 Sustainable Development Goals (SDGs).^{1,2} The SDGs seek to change the course of the 21st century, addressing key challenges such as gender inequality and need for empowerment of women and girls. Achieving gender equality and women's empowerment is a stand-alone goal — Goal 5 — of the SDGs. It is also part of all the other goals, with many targets specifically recognising women's equality and empowerment as both the objective and as part of the solution.³ Goal 5 recognises that in the labour market, women worldwide make 77 cents for every dollar earned by men.⁴ At the same time, they carry out three times as much unpaid household and care work as men — from cooking and cleaning, to fetching water and firewood, or taking care of children and the elderly.⁵ Women are the non-professional caregivers closest to healthcare professionals and, more often than not, are the ones who visit pharmacies and assume responsibilities for health in the household. Understanding how pharmacists can support women in their roles as informal caregivers can facilitate achieving the ambitious goal of gender equality and sustainable development by 2030.

The International Pharmaceutical Federation (FIP) is the global federation of national associations of pharmacists and pharmaceutical scientists, representing the voices of more than four million experts in the development, manufacturing and use of medicines.

FIP's first woman President, Dr Carmen Peña, in her opening speech at the 2015 FIP Congress in Düsseldorf, Germany, declared an emphasis on people as one of the three main pillars for FIP work. The 2016 World Pharmacists Day theme was "Caring for you" and it was taken up by the pharmacists' profession with pride across the globe. With a focus specifically on women, in 2016 the FIP Bureau established the Working Group on Women and Responsible Use of Medicines to gather evidence on how pharmacists have the potential to contribute as agents of women's empowerment through supporting and promoting their education and providing them with the information they need to ensure medicines are used responsibly.

The working group identified the focus of this work to be the pharmacists' role in supporting women as informal caregivers. It worked to gather evidence of the roles women play in contributing to good health and disease prevention when providing informal care to their family members. The overall aim of this work is to bring about positive change in this area.

To achieve its objectives, the working group performed an analysis of existing data by reviewing the available literature on the role of women in health care, and the role of pharmacists in supporting women's empowerment as informal caregivers. The working group further undertook a survey among FIP member organisations on existing interventions by pharmacists. Based on the literature review and the survey, the working group prepared this reference document. The working group has mostly worked electronically, with one meeting at the FIP congress in Seoul in September 2017.

This document can further serve as a basis for an FIP statement of policy.

How pharmacists provide reproductive health care directly to women is beyond the scope of this document. For more information on this topic, refer to the FIP Reference Paper: "The effective utilization of pharmacists in improving maternal, newborn and child health (MNCH)".⁶

Executive summary

Women are the non-professional caregivers closest to healthcare professionals and are often the ones who visit pharmacies and assume responsibilities for health in the household. In general, women tend to seek treatment and visit doctors or pharmacies (and pharmacists) more frequently than men do. It is often the woman who encourages family members to visit a healthcare professional and who makes sure they take medicines and understand the treatment.⁷ In the USA, about 75% of family caregivers are women, and approximately 25% are spouses.⁸ With an ageing population, women are increasingly volunteering to care for their elderly family members. Worldwide, nearly 70% to 80% of the impaired elderly are cared for at home by their family members. Varying estimates across different countries indicate that 57% to 81% of all caregivers of the elderly are women. In most cases, female caregivers are wives or adult daughters of the elderly person.⁹

Pharmacists should support women in these emerging roles, because medicines are like a double-edged sword — of great benefit if used correctly, but capable of causing harm if used incorrectly. The overuse, underuse or misuse of medicines results in wastage of scarce resources and widespread health hazards. By intervening with compassion and providing information, resources and support, pharmacists may positively affect care recipients and their caregivers.

In this reference document, attention is paid to the fact that women as informal caregivers considerably lighten the load of the healthcare labour force, often playing a crucial and underappreciated role in providing healthcare to families and communities. The evidence reveals that health systems rely on women's contributions as important caregivers, but they do not adequately support women in this endeavour. There is strong evidence on the negative impact of caregiving on women, if they are unsupported. This presents an opportunity for pharmacists to become more actively involved. Examples of successful pharmacy-led initiatives are included in this document.

Our review of the literature reveals that pharmacists, as the most accessible healthcare professionals, are in an ideal position to:

- Empower women in their role as informal caregivers
- Communicate to women the need to be informed
- Support women's health literacy, to enable them to influence others

This document also provides an overview of gender-based policies and a brief overview of current initiatives in this area (Annex 1). Data on women's health and well-being show a clear need for policies to go beyond reproductive and maternal health, encompassing a broader perspective of women and their roles in their own health care and in relation to those they care for (Annex 2). Women's contribution to health care is summarised in Annex 3. The document also provides guidance for pharmacists on supporting health literacy (Annex 4) and empowerment of women (Annex 5).

The working group further undertook a survey among FIP member organisations on existing interventions by pharmacists and the results are available in Annex 6.

With the publication of this reference document, FIP has shown true global leadership, and we urge other professional, non-profit or industry partners to come on board and be active in this area. This document aims to provide a platform for discussion with various partners on this important topic.

1 Women as caregivers

1.1 Care for children

As mothers, women are the primary caretakers of their children’s needs, including their health. Figure 1 shows that nearly four in 10 adult women (38%) have dependent children (under age 18) at home. In addition to their regular childrearing responsibilities, more than one in 10 mothers (12%) are also caregivers for a chronically sick or disabled family member.⁷

A survey performed across 31 developing countries revealed that only 4% of women in these countries use childcare services, while almost 40% care for their children themselves.¹⁰ Such arrangements limit women to less formal and lower-paid jobs and may expose their children to health and safety hazards.

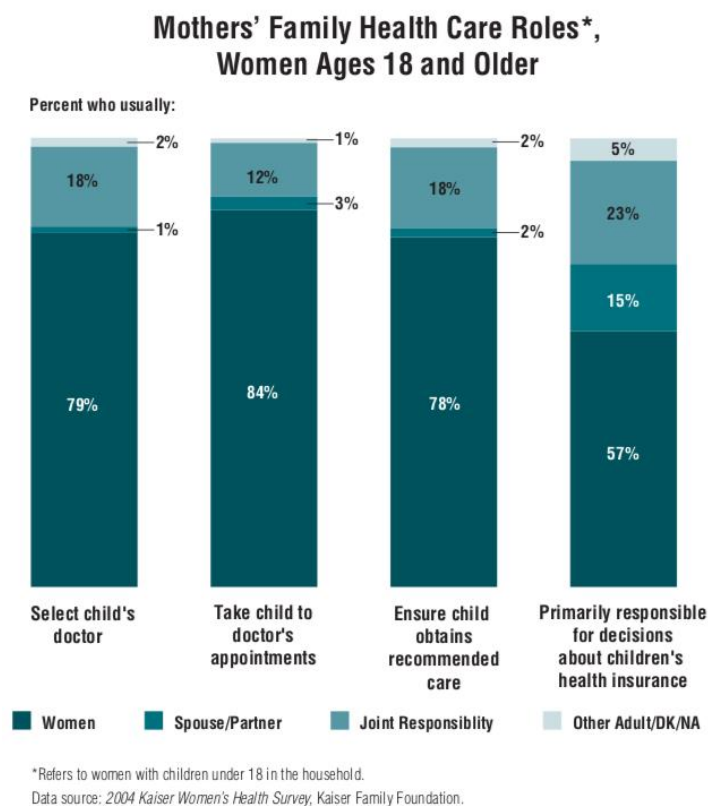


Figure 1. Women’s role in health care for their children⁷

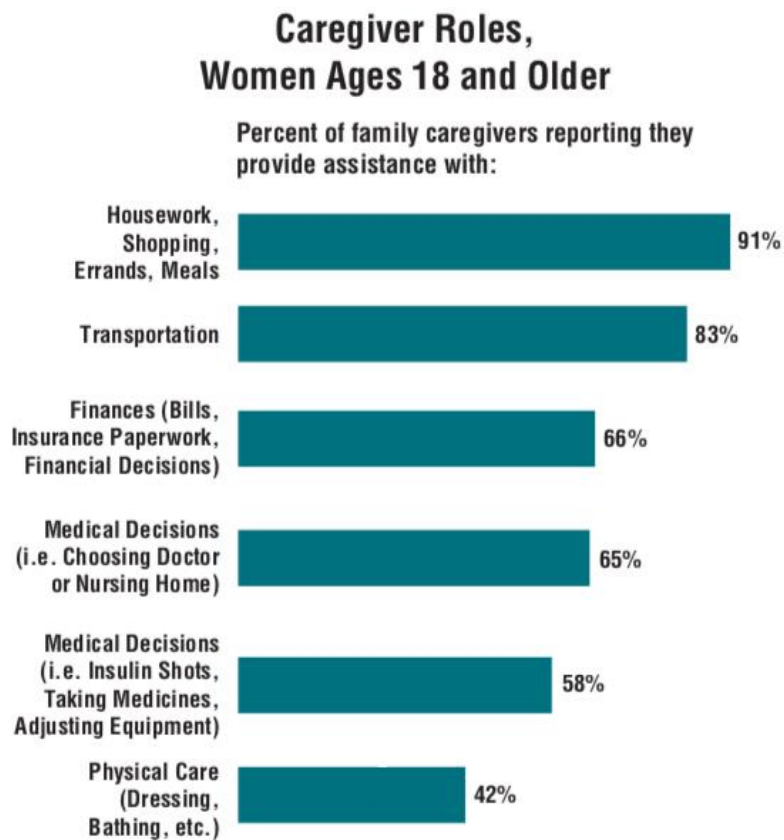
1.2 Care for family members

Health systems rely heavily on unpaid and informal work that disproportionately falls to women. Data from the USA show that women are the major providers (66%) of long-term care. US women spend 50% more time in caregiving roles than men.¹¹ A study of six African countries showed that 81% of informal caregivers are women.¹²

Twelve percent of women care for a family member who is chronically ill, disabled or elderly, compared with 8% of men.⁷ Nearly half of these women are caring for a parent or parent-in-law (47%), a spouse (18%), a child (12%) or other relatives (2%).

A sizable share of caregivers spend the equivalent time of a full-time job caring for their sick family members. The weekly time involved in caregiving ranges from less than five hours per week (18%) to more than 40 hours (29%). Low-income caregivers spend more time in caregiving for their family members than women with incomes of at least twice the income defined as poverty, who have more resources to pay for professional care. Forty-four percent of low-income caregivers assist for 40 hours or more compared with 17% of caregivers with family incomes at least twice the income defined as poverty. Family caregivers are not generally paid for their time, and for those who do it on a full-time basis, their ability to earn income through outside work is compromised, which may be particularly hard on low-income women.⁷

Caregivers provide assistance across a wide range of daily activities (see Figure 2). Two-thirds of caregivers participate in medical decisions for their relatives. Six in 10 provide medically related care, such as help with medicines, injections and equipment. Many informal caregivers do not receive formal training in these tasks and must learn how to perform them to keep up with their relatives' health needs.⁷



Data source: 2004 Kaiser Women's Health Survey, Kaiser Family Foundation.

Figure 2. Women's caregiver roles⁷

A recent study conducted among 2,400 family carers of persons with dementia in the Netherlands has shown that 10% feel the burden of care to be "heavy" and 36% feel it to be "quite heavy".¹³ It is known that the percentages of older immigrants with one or more chronic conditions who are receiving family care are 60% for those originally from Morocco, 30% for Turkish immigrants and 23% for Surinamese. These percentages are much higher than those for elderly native Dutch people with chronic dementia conditions, of whom only 10% receive family care.

1.3 Impact of caregiving on women

Caregiving in its primary sense is connected to a positive experience. Many family caregivers report positive experiences from caregiving, including a sense of giving back to someone who has previously cared for them, the satisfaction of knowing that their loved ones are getting excellent care, as well as a sense of personal growth and increased meaning and purpose in their own lives. Some caregivers feel that they are passing on a tradition of care and that by modelling caregiving, their children will more likely care for them if necessary.¹⁴

Many caregivers also report that they find benefits in their role and activities. This is seen as a positive form of coping with stressful circumstances and situations, through positive reappraisals, spiritual beliefs or other adaptive coping mechanisms in the face of stress.¹⁴

Some women caregivers reported a caregiver “gain”, with more purpose in life than their non-caregiving women peers did. Some women feel beneficial effects, including more autonomy, more personal growth and more self-acceptance when caring for friends.¹⁵

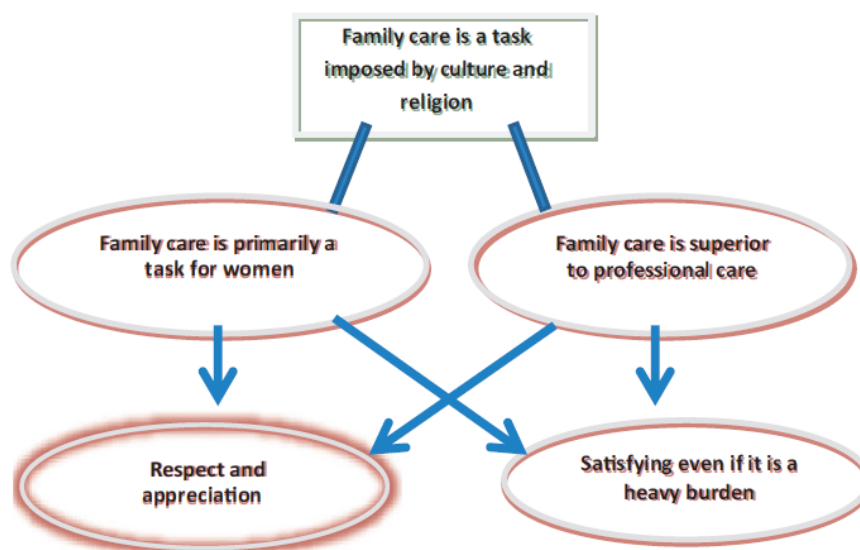


Figure 3. Family care for immigrants with dementia. Perceptions of carers with Turkish, Moroccan and Surinamese Creole backgrounds regarding care for a close relative with dementia.¹³

According to Figure 3, family care is perceived to be superior to professional care, and it is primarily a task for women in countries such as Turkey, Morocco or Surinam. Female family members who are taking care of their relatives have respect and appreciation, and the unique way they care for their relatives could be satisfying, even if it is a heavy burden. If adequately supported, family caregivers can succeed in meeting patients’ needs and caregiving can become a rewarding experience.

However, many cases are not this ideal. There is plenty evidence showing that caregiving can have negative health effects on caregivers. It can take physical, emotional and financial tolls on women, especially if they remain unsupported. Health systems currently rely heavily on women as informal caregivers, but they do not provide adequate support for them.

1.3.1 Caregiving and negative impact on physical health

The impact of providing care can lead to long-term care needs for the caregiver. A national survey from the United States shows that caregiving can lead women to neglect their own health needs:¹⁶

- 21% of female carers accessed mammogram examinations less often
- As many as two out of three older women do not take advantage of preventive health services due to lack of information and high out-of-pocket costs
- 25% of women caregivers had health problems because of their caregiving activities
- Women who spend nine or more hours a week caring for an ill or disabled spouse double their risk of coronary heart disease.

Other health effects seen were elevated blood pressure and increased risk of developing hypertension, lower perceived health status, poorer immune function, slower wound healing and an increased risk of mortality found that more than one-third of caregivers provide intense and continuing care to others while suffering from poor health themselves. This issue has been prevalent since 1999 when a study indicated that, compared with non-caregivers, women caregivers were twice as likely not to fill a prescription for themselves because of the cost (26% vs. 13%).¹⁷ Elderly women caring for a loved one with dementia may be particularly susceptible to the negative health effects of caregiving because they receive significantly less help from family members for their own disabilities. For example, in 2015, over one-third of primary carers (37.8%) in Australia had a disability or additional health needs themselves.¹⁸

Due to the physical and emotional tolls of caregiving and risk factors for disease, women caregivers are less likely to have their own health needs met. One study found that women providing care to an ill or disabled spouse were more likely to report a personal history of hypertension, diabetes and hypercholesterolaemia.¹⁴ These same caregivers were also slightly more likely to smoke and to consume more saturated fat. Additionally, compared with non-caregiving women:¹⁹

- 25% of caregivers (vs. 17%) rated their own health as fair or poor
- 54% (vs. 41%) had one or more chronic health conditions
- 16% (vs. 8%) were twice as likely in the past year to not seek needed medical care
- 25% (vs. 16%) had difficulty accessing medical care

A case study conducted at the Pennsylvania State University in the US using purposive sampling identified the following issues for older spousal caregivers:²⁰

- Balancing multiple morbidities
- Feeling overwhelmed and exhausted
- Dealing with personal health issues
- Co-ordinating care

1.3.2 Caregiving and negative impact on mental health

Higher levels of depression, anxiety, and other mental health challenges are common among women who care for an older relative or friend. Studies found that men respond to caregiving responsibilities in a fundamentally different way. Women tend to stay home to provide time-consuming care to ill or disabled friends or family members, whereas men respond to a loved one's needs for support by delaying retirement to alleviate the financial burden associated with long-term care.

The impact of women's intensive caregiving can be substantial; 51% of women caregivers exhibited depressive symptoms vs. 38% of non-caregivers.¹⁵ One four-year study found that middle-aged and older women who provided care for an ill or disabled spouse were almost six times as likely to suffer depressive or anxious symptoms compared with those who had no caregiving responsibilities.²¹ It is not only care for a spouse that can affect mental health, however. The same study found that women who cared for ill parents were twice as likely to suffer from depressive or anxious symptoms as non-caregivers.

One in five female caregivers aged 18 to 39 years said that stress was nearly always present in their lives: nearly twice as many as those who were not caregivers and for male caregivers. The negative impact on carers' relationships and social networks due to their reduced ability to participate in activities outside their caring role can lead to carers experiencing social isolation, which in turn can affect their psychological wellbeing. Studies have demonstrated that women are more vulnerable than men to the effects of reduced social support.²²

A World Mental Health survey conducted by the World Health Organization in 20 countries showed that among the 26.9–42.5% caregivers in high, upper-middle, and low/lower-middle income countries reporting serious health

conditions caused by caregiving, 35.7–42.5% reported burden.¹⁶ Of those caregivers, 25.2–29.0% were struggling with a lack of private time and 13.5–19.4% with a lack of money, while 24.4–30.6% felt distress and 6.4–21.7% felt embarrassment. Objective burdens (time, financial) and subjective burdens (distress, embarrassment) in low/lower-middle income countries were two- to three-fold higher than in higher-income countries, with the financial burden averaging 14.3% of median family income in high, 17.7% in upper-middle, and 39.8% in low/lower-middle income countries. Higher burden was reported by women than men. Mental illness caused by caregiving was reported more often by spouses and children than by parents or siblings.²³

A particularly strong factor in determining the mental health impact of providing care is the amount of care per week that a woman provides. One study²¹ found a marked increase in risk among women who provided 36 or more hours per week of care to a spouse. There is likely a threshold of time involvement, beyond which the likelihood of mental health consequences rapidly rises.²¹

The incidence of symptoms or experiences are not limited to depression. Various studies have identified other common hallmarks of women’s caregiving experience:

- Higher level of hostility and a greater decline in happiness for a family member
- Greater increases in symptoms of depression, less “personal mastery” and less self-acceptance
- High caregiving-related stress¹⁵

A study about verbal and physical abuse experienced by caregivers conducted in the US found that 51% of the sample reported some form of abuse in the 12 months prior to assessment.²⁴ Caregivers who reported some form of abuse reported significantly greater distress and burden than caregivers who did not report any abuse. These data indicate that clinicians should attend to incidents of verbal and physical abuse that may occur between caregivers and care-recipients.¹⁵

1.3.3 Financial impact of caregiving

As women’s educational attainment and workforce participation increases, caregiving could pose even greater financial challenges for many women workers, mostly due to lost wages from reduced work hours, time out of the workforce, family leave or early retirement.¹⁵

However, there is a related, and more fundamental, reason why caregiving work remains so persistently undervalued. Women, especially those from migrant and minority communities, often carry out the most unpaid care work. In many ways, these women are subsidising public care at the cost of their employment, time and welfare. Yet their labour frequently is dismissed as just “women’s work”. Until only recently, this sort of discrimination was also rooted in the way organisations gathered — or, rather, did not gather — data on unpaid care work and household activities: data often glossed over the weighty contributions women make in the household and only reinforced gender stereotypes about unpaid care work. This kind of discrimination often leaves this work underpaid and underrated, and prevents the women who perform it from achieving full economic empowerment.²⁵

Furthermore, caregiving is expensive. Whether it is paying for prescription medicines, installing wheelchair ramps or purchasing consumable supplies, caregiving has a significant economic impact on a family. Women who are family caregivers are 2.5 times more likely than non-caregivers to live in poverty and five times more likely to receive supplemental security income. Furthermore, a 2011 worldwide study by MetLife found that 23% of non-working and 20% of working female caregivers were providing financial assistance to parents that they are caring for.¹⁵

The costs of providing care are high, but the demands on caregivers’ time are also substantial. Estimates indicate that 20% of all female workers in the United States are family caregivers. Nevertheless, women do not abandon their caregiving responsibilities because of employment. Instead, they cope to the best of their abilities with the combined pressures of caring for a loved one, their need for income, reliance on often inadequate public programmes and fewer employment-related benefits. Unmarried women caregivers may have even fewer options for balancing work and caregiving.¹⁵

These caregivers often have multiple roles and responsibilities and often face economic and health challenges of their own. Many are low-income and have chronic health problems. Caregivers vary across the age spectrum: 41% are aged 18 to 44, 42% are 45 to 64, and 16% are 65 and older. Four in 10 caregivers have children under the age of 18 and nearly

six in 10 are employed outside the home (56%). A significant portion (40%) are in families with household incomes lower than two times the income defined as poverty, compared with 29% of non-caregivers.⁷

A national study in the United States on women and caregiving highlighted the conflicting demands of work and care of the elderly.²⁶ The study found that:¹⁵

- 33% of working women decreased work hours
- 29% passed up a job promotion, training or assignment
- 22% took a leave of absence
- 20% switched from full-time to part-time employment
- 16% quit their jobs
- 13% retired early

Other research paints a similar picture. For example:

- The negative impact on a caregivers' retirement fund is approximately USD 40,000 more for women than for men.
- More intense caregiver responsibilities tend to have a greater impact on the odds of retiring. Women who assist several family members or friends have 50% higher odds of retiring than non-caregiving women.
- Caregiving reduces paid work hours for middle-aged women by about 41%.
- In total, the cost impact of caregiving on individual female caregivers in terms of lost wages and social security benefits equals USD 324,044.¹⁵

Caregiving places a further strain on the precarious nature of many women's retirement income, because time out of the workforce does not only have short-term financial consequences. For most women, fewer contributions to pensions, social security and other retirement savings platforms are the result of reduced hours on the job or fewer years in the workforce. Women caregivers in the United States are significantly less likely to receive a pension and, when they do, the pension is about half the amount that men receive. They are also likely to spend an average of 12 years out of the workforce raising children and caring for older relatives or friends.

To complicate the picture, researchers have found that women who reduced their work hours while caregiving did not increase their work hours once caregiving had stopped. Additionally, caregivers who return to full-time employment after caregiving are more likely to earn lower wages, have a "benefit-poor" job and receive reduced retirement benefits.¹⁵

Women's contribution to health care has been estimated to account for nearly 5% of global gross domestic product, but almost half of this is unpaid and unrecognised. A study of volunteer caregivers in six African countries found that 81% of informal caregivers were women, with only 7% of the caregivers receiving a stipend.¹²

On a positive note, some countries such as Costa Rica, Turkey and the United Kingdom, among others, have introduced regulations that remunerate informal care work and provide employment-related protections.¹²

Costa Rica, like many countries in Latin America, is characterised by having a social structure where women play an essential role in family care, in addition to their other tasks. According to a "Survey on the use of time" conducted in 2011, Costa Rican women spend approximately 70 hours per week working, of which 37 hours correspond to unpaid work. The authors included informal care in this category, with an estimated 15 hours per week. They also found that time invested would be higher with increasing levels of dependence of the person being cared for. Also, this behaviour bore no relation to the level of schooling of the women.²⁷

In the case of older adults, it is recognised that most of their caregivers are women, mainly daughters residing in their parents' home. In this case, 79% of the interviewees spent more than 24 hours a week on care.²⁸

1.4 Empowerment in economic decisions

There are gender differences in people's experience of ill health and their access to health services. For example, women are typically the providers of health care, whereas men are more frequently involved in making financial decisions around health care and transporting sick relatives to clinics and hospitals.²⁹

When women are not pregnant, some husbands and families may see women's health problems as a potential interference with the maintenance of the household. Husbands and members of the extended family may view women's general health problems as further reducing the household's limited financial resources, especially if the cost of treatment is high. Women themselves are sometimes raised with the cultural norm that their health problems (and other aspects of their lives) are less important, and thus may minimise them.³⁰ These views are culture-dependent and are not the norm across all populations.

In many developing countries, women are not empowered to make recommendations for themselves about when to seek medical attention or when to pay for prescription medicines. In many situations, these decisions are made by the husband or parents-in-law.

In many cultures, productive activities and reproductive activities (meaning having children) are valued differently. Generally, earning an income brings greater autonomy, decision-making power and respect in society. Given the greater involvement of men in the paid labour force and their higher earnings, even when domestic and other activities of women are costed, they generally enjoy more autonomy and higher social status. The gender differences in economic status and purchasing power affect the health-seeking behaviour and health outcomes of men and women.³¹

In fact, having children and caring for family members is also productive and beneficial for society/economics. For example, gender-aware economics includes unpaid caring work in the home in the concept of productive labour and informal paid work, such as home-based income-generating activities and work in non-profit or non-governmental organisations.³¹

Research on gender and the economic determinants of health and illness is relatively scarce. Taking an example of mental health, some studies have been carried out in several countries that demonstrate a clear relationship between economic factors and mental health by gender. Strategies that address structural determinants, for example to promote women's education, may reduce the burden of common mental disorders in women.³²

Poor health is a major constraint on those attempting to climb the economic ladder and can render programmes to tackle poverty ineffective. Therefore, the general poverty reduction efforts aimed at women should incorporate health care. Expanding healthcare programmes is among the most pressing measures. For example, some countries may benefit greatly by integrating professional responses to violence against women into health programmes or training health workers to recognise signs of violence.²⁷ Additionally, promoting respect for women among health professionals and providing training to informal carers may have benefit.

Finally, educating adult men on the benefits of gender equality has made a large impact in some countries; showing men that they can be agents of change and that all members of society benefiting from gender equality is a vital step toward transforming gender relations and improving health. In Nicaragua, for example, workshops for men on gender equality and masculinity have resulted in reduced intimate partner violence, increased participation by men in domestic duties, including caring, and increased shared decision-making by couples.³³

2 Pharmacists supporting women

Women are the non-professional caregivers closest to healthcare professionals and, more often than not, are the ones who visit pharmacies and assume responsibilities for health in the household. In general, women tend to seek treatment and go to doctors' offices or to pharmacies more frequently than men do. It is often the woman who encourages family members to visit healthcare professionals and who makes sure they take medicines and understand their treatment. With an ageing population, women are increasingly volunteering or being asked to care for their elderly family members. Pharmacists can support women in these increasingly common roles. By intervening with compassion and providing information, resources and support, pharmacists may positively affect care recipients and their caregivers.

Pharmacists are often ranked as the most trusted healthcare professionals. The pharmacist's relationship with women caregivers is key to the value women place on the pharmacy as a community resource. Linked to this fact, women are more proactive in addressing their health issues and many have become involved in other community initiatives.³⁴ A cross-sectional survey conducted on adults aged 35 and older in community pharmacies in the UK, found that women were more likely to have obtained medicines and asked for advice (76%) than men. There was a slight variation with age ranging from 67% of 35–44-year-olds to 75% of 65–74-year-olds. Poor self-rated health was the key factor in obtaining medicines, for both prescription and over-the-counter medicines. Those with poorer health are more likely to visit pharmacies each month. This provides an opportunity for public health initiatives to be delivered in pharmacies.³⁵

2.1 Pharmacists' prevention of communicable diseases

Pharmacists are qualified to monitor and review treatments of patients, identify medication errors and provide healthcare teams with therapeutic recommendations. Many countries allow clinical pharmacists to prescribe medicines in some capacity (e.g. the US, UK, Canada and New Zealand).³⁶ Additionally, pharmacists promote good health and medicines usage habits into their communities by delivering public health campaigns and offering pharmaceutical consultations for patients in need. Pharmacists are well positioned to provide vaccinations as a useful tool to prevent disease. Provision of pharmacy-based vaccinations would increase accessibility as well as national capacity for response to pandemic risks without compromising service quality.³⁷ Advising on medication, prescribing medicines and administering vaccinations allow pharmacists to play a key role in preventing communicable diseases, particularly in women.

Through a process of triage, pharmacists evaluate whether or not they can offer a solution via treatment of minor ailment symptoms.³⁷ If pharmacists are unable to resolve a problem themselves, they refer patients to other healthcare professionals.

Example from the United Kingdom

To facilitate the screening and the treatment of chlamydia infections, especially among young adults, the National Pharmacy Association (NPA) initiated a "Chlamydia test and treat" service in 2008. It was offered after azithromycin was officially launched as an over-the-counter pharmacy-only medicine. Between five and 10 tests a day were received by GLG Laboratories, an NPA partner in this service. Pharmacists can supply tablets to individuals who are confirmed as having a positive Nucleic Acid Amplification Technique (NAAT) chlamydia test result and to their sexual partners without them having to take a test. Approximately 70% of NPA members are now qualified to provide this service. The service is free for 16–24-year-olds.³⁷

Furthermore, the Royal Pharmaceutical Society launched a campaign called "Ask about medicines week". More than 100,000 copies of its "Ask about sexual health" leaflet were distributed to community pharmacies and primary care organisations in 2005 as part of the campaign. The aim was to drive home the message that community pharmacists are ideally placed to provide expert help and advice on all aspects of sexual health. This leaflet was designed to encourage people to visit local pharmacies for sexual health advice.³⁷

Example from Belgium

In 2009, Belgian pharmacists assisted in campaigns aligned with the national or regional vaccination programmes, particularly aimed at chronically ill patients, pregnant women and healthcare personnel. The results of these initiatives were encouraging: between 2006 and 2009 there was an increase in influenza vaccination rates for the general population from 14.8% to 17.3%.³⁸

Example from the USA

The human papillomavirus (HPV) is a sexually transmitted infection that causes many cervical and vaginal cancers.³⁹ Vaccination to adolescent and teenage girls can prevent infection with the most common types of HPV. Specifically, promoting pharmacy-driven vaccination programmes can help improve HPV vaccination rates among young girls. The US is an example of a country that commonly allows pharmacists to administer HPV vaccines. As of January 2016, most states (40/51) grant pharmacists the authority to administer HPV vaccines, establish third-party vaccination authorisation requirements, stipulate age restrictions and uphold practice requirements, including training and reporting.

Example from Ireland

Pharmacists have been delivering influenza vaccinations since 2011, when close to 1,400 pharmacists were trained to do so. Subsequently in 2013, the Irish Pharmacy Union led an activity where pharmacists delivered seasonal influenza vaccinations to eligible patients. The service was available free-of-charge to those at-risk such as elderly people, pregnant women and people with chronic illnesses. As a result, 23% of the patients who received an immunisation from their pharmacist had never received an influenza vaccine before, 81% of these patients were high-priority (or groups of patients considered at risk), and 90% of all patients who received an immunisation were in this “at-risk” group. Statistical data revealed that community pharmacies contributed to reducing the number of influenza cases in Ireland and consequently reduced care costs.³⁷

Example from Argentina

Every year, the Argentinian government guarantees free access to influenza vaccines across the country to young children up to two years old, pregnant women, people over 65 and those with risk factors. Pharmacists have the important role in this campaign of verifying patients’ immunisation status and reminding them when their next vaccination is due; they also identify and advise high-risk patient groups and administer the vaccines. In 2015, more than 5,000 pharmacies, distributed across the national territory, administered 480,000 vaccines free of charge. No prescription was required for the pharmacy-based administration of both influenza and pneumococcal vaccines to people aged over 65. The campaign has been running successfully for 19 years and in pharmacies since 2010 with patients providing positive feedback about the services provided.³⁸

More examples of successful infection prevention services and immunisation services can be found in FIP’s report on the impact of pharmacy on immunisation³⁸ and the FIP reference document on “Fighting antimicrobial resistance”.³⁷

2.2 Pharmacists’ health promotion activities and prevention of non-communicable diseases

Pharmacists’ unique position in healthcare systems makes them the most accessible healthcare professional. This puts the pharmacist in an ideal position to support the health of women and their family members. As healthcare costs rise

and healthcare workers worldwide become more burdened, it is important to recognise how pharmacists with their unique skills and knowledge may contribute to the goal of better health for all (Annex 3).

Pharmacists' organisations, both national and international, develop health and well-being promotion strategies, screening and early detection strategies, and educational campaigns targeting a specific topic or audience. Pharmacists and their organisations promote, to governments and other stakeholders, the need to take effective action to improve policy, practice, science and education in relation to attainment of good health and illness prevention. There is a wide range of expertise among these organisations worldwide that can be mobilised for the purpose of health promotion.⁴⁰

In the joint FIP/WHO guidelines on good pharmacy practice, one of the four key roles of pharmacists is focused on health promotion ("Role 4: Contribute to improve effectiveness of the health-care system and public health"). In terms of this role, pharmacists have direct responsibility and accountability for:

- Function B: "Engag[ing] in preventive care activities and services" with the following explanation: "Pharmacists should engage in preventive care activities that promote public health and prevent disease, i.e. in areas such as smoking cessation, infectious and sexually transmitted diseases" and "Pharmacists should provide point-of-care testing, where applicable, and other health screening activities for patients at higher risk of disease"
- Function C: "Advocat[ing] and support[ing] national policies that promote improved health outcomes" with the following explanation: "Pharmacists should contribute to public and professional groups to promote, evaluate and improve health in the community"

As part of the fulfilment of these roles expected by society, pharmacists develop and implement programmes for health promotion and prevention of disorders.

The non-communicable diseases (NCDs) are mainly cardiovascular diseases, cancer, chronic respiratory diseases and diabetes.⁴¹ NCDs largely occur due to risk factors such as tobacco use, harmful use of alcohol, unhealthy diet, lack of exercise and unhealthy environmental factors. A large proportion of deaths from NCDs, especially in those who have yet to reach old age, are avoidable with cheap, cost effective and, in some cases, cost-saving interventions.⁴¹ Given that women visit pharmacies more often, every pharmacy visit offers an opportunity to promote such interventions to women.³⁵ FIP is currently preparing a document for publication in 2019 with a detailed overview of pharmacists' interventions to prevent NCDs.

A significant NCD risk factor is tobacco use. The burden of tobacco use on the health of people and on healthcare systems is evident in countries all around the world. About 250 million women in the world are daily smokers. About 22% of women in developed countries and 9% of women in developing countries smoke tobacco. In addition, many women in south Asia chew tobacco.⁴² Pharmacists can offer smoking or tobacco cessation services that help women to quit. It is proven that smokers receiving help from a healthcare professional are more likely to quit than those who try to quit on their own. In 2015, FIP published a guide for pharmacists to support them in establishing tobacco cessation services.³⁴ The FIP document "Establishing tobacco-free communities: A practical guide for pharmacists" provides useful tips for pharmacists, also tailored for different audiences, e.g. pregnant women. Pharmacists should be utilised to their full potential as active and recognised resources for tobacco cessation.²⁰

Pharmacists have an invaluable role in the development and implementation of programmes for mental health promotion and prevention of mental disorders. At a local level, pharmacists' integration of social and mental care in the community supports equitable access to affordable, quality and comprehensive health services. Pharmacists can facilitate the integration of mental health considerations into all areas of the healthcare system.⁴³

Substance use disorder is another area where pharmacists can play a key role within health promotion. The American Society of Health-System Pharmacists states that "pharmacists have the unique knowledge, skills, and responsibilities for assuming an important role in substance abuse prevention, education and assistance. Pharmacists, as healthcare providers, should be actively involved in reducing the negative effects that substance abuse has on society, health systems and the pharmacy profession."⁴⁴ Substances include but are not limited to alcohol, tobacco, marijuana, cocaine, heroin, methamphetamine and opioids.

Furthermore, pharmacists can help women to take control of their reproductive health. Pharmacists can help women develop a reproductive life plan.⁴⁵ A reproductive life plan consists of personal goals or intentions about having or not

having children.⁴⁶ Pharmacists can help meet the need for better access to reproductive health resources through counselling, and providing education and services, including contraception and sexually transmitted infection management. In the US, some states, including California, Oregon, Washington and New Jersey, allow pharmacists to prescribe hormonal contraception such as the oral tablet and transdermal patch without a physician's prescription.⁴⁷

During and after pregnancy, pharmacists can provide women with essential education on contraindicated medicines, recommended prenatal vitamins and infant feeding options, such as breastfeeding and formula feeding. See the FIP reference paper "The effective utilization of pharmacists in improving maternal, newborn and child health (MNCH)" for more information.⁶

Example from the UK

Around 2000, in certain areas of Northern Ireland, a higher proportion of people experiencing high levels of violence also reported having poor health (13%) compared with those living in areas of low violence (4%). A study was conducted in Toome, a rural village located 20 miles from Belfast, which had problems relating to access to public services, transport and a high incidence of suicide.³⁴ Financial support came from the Building the Community-Pharmacy Partnership in 2001. This GBP 1 million government project aimed to use local pharmacies to combat the causes of ill health in Northern Ireland.⁴⁸ A local pharmacist, thanks to a close relationship with the women in the town, who regarded the pharmacy as a community resource, noticed that many young mothers were being prescribed antidepressants. The pharmacist recognised that lack of accessible transport, childcare and family support, as well as vulnerability and isolation, were affecting these women's health.³⁴ Therefore, in 2000, she established a weekly discussion group for local women at the Toome pharmacy. Sessions were held within the health centre she shared with the local general practitioner.⁴⁸ Beginning with a small group of eight women for six weeks, after seven years the project had grown to an annual programme of health-related events³⁴ and each week, around 50 local women met up to discuss subjects including herbal medicines, stress management, reflexology and spirituality.⁴⁸

Example from Spain

The General Council of Pharmaceutical Official Associations of Spain launched a health campaign called PLENUFAR in 1992.⁴⁹ The first edition, called PLENUFAR 1, was addressed to mothers in relation to their role as housewives in assuring the nutritional status and dietary habits of their children. The objective of the campaign was to achieve better nutritional training in a reduced number of sessions and to offer women knowledge that they could apply immediately and practically. The campaign involved 3,000 pharmacists who advised 60,000 families, amounting to some 240,000 individuals. Among the results recorded was an increase in the consumption of vegetables, salads, fruits and fish and a decrease in the consumption of sausages, cakes, eggs, chocolate and alcoholic beverages. PLENUFAR 4 addressed women who were pregnant or nursing and found deficiencies in vitamins (folic acid/vitamin B12) and a prevalence of smoking and alcohol.⁵⁰ PLENUFAR 5 addressed menopausal and post-menopausal women and how their experiences influenced quality of diet and life. Overall, hundreds of thousands of people benefited from these campaigns via many forms of media, including live events, webpages, scientific papers and journals.

2.3 Pharmacists empowering women through health literacy

Given the large number of medicines on the market and their multiple indications and intricate administration instructions, it is no surprise that patients can be left confused. For example, asthma sufferers with poor health literacy

skills have a decreased understanding of how to manage their disease, which results in more exacerbations and more admissions to hospital.⁵¹ This also applies to people with diabetes mellitus, chronic obstructive pulmonary disease, heart failure and many other conditions:⁵² individuals with low literacy levels are more likely to misinterpret medication instructions, but even those with adequate literacy skills have a one-in-three chance of misinterpreting them.⁵³

Pharmacists, as the most accessible healthcare professionals, can work to empower women in their role as informal caregivers, to communicate to women the necessity to be educated and to support their health literacy (Annex 4). Empowering people to increase control over their health needs to go hand in hand with providing adequate support to them in terms of access to quality information and expertise on specific matters. Nowadays, information is accessible from many different sources but its validity and comprehensibility can be questionable. Healthcare professionals are the most reliable and trusted source of information and pharmacists are often ranked as the most trusted among them. Many pharmacists' associations have developed comprehensive programmes directed at the general population or specific groups (e.g. children, elderly, migrants) to improve their health literacy and their understanding of their rights and duties in healthcare settings, as these facilitate health literacy and through it the patient's and caregiver's empowerment skills (Annex 5).

In Spain, the National Women's Health Report stated that low health literacy affects women more than men and is also a larger predictor of poor health status than other socio-demographic determinants.⁴⁹ This creates major healthcare problems for women. This report recommended various simple methods to combat the issue. One was to write patient education materials at lower reading levels and to use a variety of pictures to support the text in these materials. It is also important to teach healthcare professionals how to best communicate complex information and to recheck with patients that they have understood the information correctly by having them repeat back what they have learnt.

Moreover, the literacy level of mothers has a direct impact on a child's growth and cognitive development. As a mother's time in formal education increases, the incidence of illness decreases in children — there is better immunisation status, better nutrition and better performance in cognitive tests. It is important to distinguish that health literacy, health knowledge and education (school, university) may be related, but they are different concepts. Education can influence health literacy, but advanced education does not always correlate with high health literacy. In addition, health knowledge impacts health literacy but it is not the same. Mothers with some education are more active in implementing health practices, have greater access to information and a greater voice in family health decisions.⁵⁴

A study from 2014 in Australia focused on increasing the health literacy of women.⁴² It found that women with lower levels of education, elderly women, women from lower socioeconomic groups, indigenous Australians, and women who were culturally and linguistically diverse, were more likely to have lower health literacy. A total of 109 women who were within these groups were provided with educational sessions that included reproductive health, general health and well-being, preventive health and emotional health. A limitation to this study was that its success was only measured based on a three-question satisfaction survey given to the participants. However, all participants evaluated the programme positively.⁵⁵ Similar efforts have been undertaken in other countries (e.g. Spain, Germany, and France) and the number is growing. The desire, ability and availability of pharmacists to support people in well-being, self-care and health literacy is also growing.⁵⁷

Effective interventions by healthcare professionals help people to make good decisions about their health, adopt healthy habits, avoid risks and quit harmful products. The adequate remuneration of healthcare professionals is essential to ensure the preventive measures result in cost savings for the healthcare system.

In some countries, including South Korea, caregivers for the elderly are most often daughters and daughters-in-law, who may already have children to look after. Availability of pharmacists' help to those family caregivers can be improved through group meetings. Group meetings and education have proven successful in rural areas, e.g. in Southern Africa. Caregivers in rural areas do not necessarily have access to media and internet search engines. Even if accessible, the information available on the internet is not always credible. Pharmacists, especially public sector pharmacists, who may be more accessible, can use this group meeting strategy so that medicines information can be discussed and understood by groups of caregivers.⁵⁸

Example from Japan

The Japan Pharmaceutical Association collaborated with the Council for the Proper Use of Medications to create a series of lectures by pharmacists on the correct use of medicines, targeting pupils in elementary schools and students in high schools. The project was supported by a grant from the Ministry of Health. The educational material took into consideration the age and grade levels of the students.⁵⁶ Pharmacists in Japan also regularly organise the “Medicines and health week” to contribute to the maintenance and improvement of public health and health care by spreading accurate knowledge on medicines and by promoting greater understanding of the role of pharmacists.

2.4 Pharmacists encouraging responsible use of medicines through women

The use of medicines in society can not only decrease mortality and increase quality of life, but also decrease overall healthcare costs. However, The World Health Organization has found that numerous studies have shown that only 50% of patients in developed countries are correctly taking their medicines, and that this number is assumed to be even lower in undeveloped countries.⁵⁹ These studies reveal that there is a significant need for improvement in patient education, and there is much to be gained from an increase in the responsible use of medicines, in particular with improved adherence.

A study in 2012 by the IMS Institute for Healthcare Informatics estimated that USD 500 billion, or 8% of the total amount of healthcare expenditure, can be saved through the optimal usage of medicines. This study considered non-adherence to medication, suboptimal generic use, medication errors, antibiotic misuse, mismanaged polypharmacy, and untimely medicine use when estimating the percentage of total healthcare expenditures for each country. Non-adherence proved to be the largest contributor and is believed to contribute to over half of the total avoidable health costs in the world. One of the main recommendations from this study was to strengthen the role of pharmacists in interventions with patients regarding adherence to medication.⁶⁰

The goal of “responsible use of medicines” is that the components of the healthcare system are aligned to ensure patients receive the correct medicine at the appropriate time, take the medicines correctly, and experience a benefit from them.⁶¹ If patients are educated on the importance of the responsible use of medicines, this can greatly positively affect their quality of life, morbidity and mortality, and the total cost of health care.⁶¹

Figure 4 shows how women care for the health and well-being of the family and guard the use of medicines. It also highlights the role that pharmacists can have in developing interventions tailored for women.

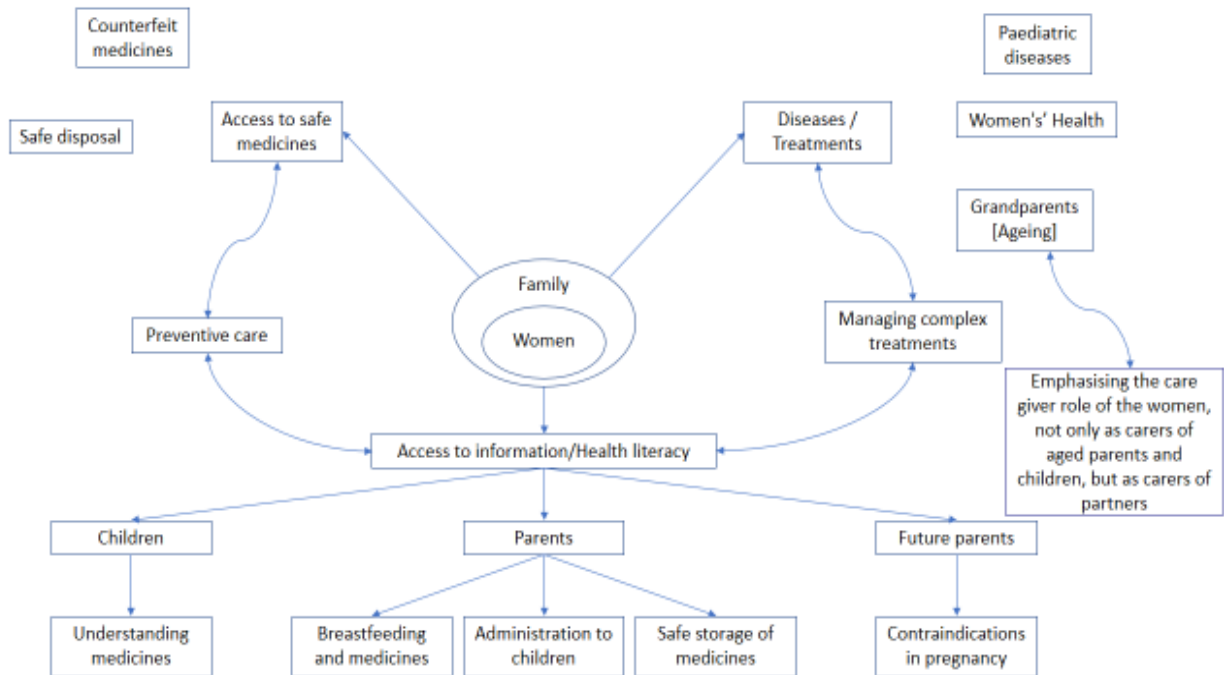


Figure 4. Pharmacists can help women better provide family care by increasing access to health-related information and safe medicines.

Women often assume the responsibility for the health of the whole family. They search for information about:

- Their children’s medication: making sure the parents have the right understanding of their children’s medicines. Pharmacists can help them by simplifying the information.
- Parenthood: the correct use of medicines while breastfeeding; the administration of the medicines to their children; how to store the medicines safely. Pharmacists can help in all cases, encouraging women to breastfeed where appropriate, adjusting the medicine’s taste, dosage or formulation to suit the child and giving the proper information and advice.
- Pre-pregnancy support: pharmacists can explain contraindications to medicines in pregnancy, offer medication review during pregnancy and lactation, and recommend prenatal vitamins.
- Menopause and how it affects women’s bodies: pharmacists can help women to understand their or their female family members’ hormonal changes, to differentiate normal or abnormal symptoms and to help manage this important stage in women’s lives as smoothly as possible. Women commonly experience menopausal symptoms such as hot flushes, mood swings, sleep disturbances, painful joints, among others.⁶² Pharmacists are in a unique position to identify strategies to help women manage their symptoms through medication or lifestyle changes. This can be achieved through counselling, patient education, and providing resources on hormone replacement therapy. Compounding pharmacists can even make bioidentical hormones for patient-specific needs.⁶³

With adequate health literacy and information, and when supported by a pharmacist, women can utilise the advice on good care for their families and facilitate the responsible and safe use of medicines. Additionally, they will be able to manage complex treatments, and make sure the right medicine is taken for a certain disease (e.g. in the elderly). Pharmacists can empower women to effectively and appropriately prepare, obtain, store, secure, distribute, dispense, administer and dispose of medical products where appropriate as part of preventive health and treatments, for themselves and those in their care, and therefore, ensure effective disease and medication management.

In addition, pharmacists can encourage women to be aware of their own health and raise knowledge about the importance of ill-health prevention, which could have a positive effect on the quality of their lives.

Community and hospital pharmacies are the most approachable healthcare facilities for patients and informal caregivers, so they are a critical part of health system infrastructure. Pharmacy remuneration models aim to ensure the safe and responsible use of medicines. From a health systems perspective, these models need to be cost-effective. For pharmacies, they must also be easily understood in order to enable sustainable access to medicines and delivery of comprehensive pharmacy services, including important public health services.

The viability of the pharmacy profession is an issue for the broader health sector and society as a whole. Today pharmacists have a key role to play in delivering cost-effective solutions for payers and better health outcomes for people. This is particularly true for patients with multiple illnesses and those with chronic diseases who are taking several medicines.

Pharmacy remuneration models must be founded on a social contract between pharmacies and society. Therefore, there is a move towards a mixture of remuneration components, such as remuneration of medicines supply and dispensing activities, incentivising efficiency and quality and implementing professional fees for pharmaceutical services focused on patient needs. These models need to value what pharmacies already bring to patients' use of medicines, public health, health systems and the economy, as well as embrace extended roles and collaborative practices within primary care and hospital care.⁶⁴

Ineffective use of medical devices is a common cause of non-adherence to therapy and can also cause device-related injuries and, in the worst cases, deaths. Education on the effective use of medical devices is thus crucial. Pharmacists should ensure that women caregivers are properly trained on the use of medical devices such as glucometers.⁵⁸

Women caregivers may struggle with a lack of skills in the administration of parenteral medicines. While training might be briefly provided by clinicians or nurses, it is important for pharmacists, as custodians of medicines, to ensure that the correct practices are followed. The caregiver should be empowered through the provision of appropriate training and ensuring that the skill is well-practised.⁵⁸

Example from the Philippines

In the Philippines, a community-based pharmacy programme has been developed that serves as a good example of how pharmacists can collaborate with young mothers. Pharmacists have started to bring mothers to a wellness activity each month for three months, then quarterly thereafter. The activity includes a seminar for mothers on the rational and responsible use of medicines and other topics relevant to mothers as the caregivers of the family. This activity includes compiling patient profiles for family members taking chronic medicines to determine the wellness and health programme for the residents of the community. The pharmacists are in the best position to do this, because they are readily accessible to the mothers not only as operators of a community pharmacy but also as residents of the community. The pharmacists engaged in this programme are organised into a group: the Philippine Society of Family Pharmacists.⁵⁸

Example from Costa Rica

Ensuring responsible use of medicines in Costa Rica by informal women caregivers has been found challenging in vulnerable populations (e.g. people taking a number of medicines). Acknowledging this, the Costa Rican Social Security Fund has formalised a protocol with pharmacists to involve them in the education of patients, family members, or caregivers in a personalised manner.⁶⁵ Likewise, the University of Costa Rica has promoted the responsible use of medicines through a project centred on community features and accessibility.

2.5 Empowerment of women as informal caregivers

Empowerment is a complex process rather than a linear sequence of inputs and outcomes.⁶⁶

Women as caregivers are affected by various social ideologies such as patriarchy, feminisation of household work and care, and societal expectations. It is important to understand that women do not necessarily choose to be caregivers, but rather sometimes assume this duty by virtue of their gender and the environment in which they live. Their mental well-being should also be provided for, while their exposure to various infections from those whom they care for should also be monitored. Empowerment of women to be better carers will not only improve the quality of life for patients, but in cultures where boys are preferred over girls, it may also help increase appreciation of women as daughters, daughters-in-law or in other roles.⁵⁸

A pharmacist can assist a female caregiver in building confidence in the work she does, such as in the areas highlighted in Figure 4 (p19). In some cultures, patriarchal practices can sometimes prevent female caregivers from exercising care confidently.⁵⁸ A woman should understand the importance of the medicines she is giving, and therefore needs to be more assertive.

Example from South Africa

In rural South Africa, women who are carers often lack confidence. Therefore, when a parent or parent-in-law refuses to take a medicine for whatever reason, the woman may not be assertive because she assumes the position of being a child or daughter-in-law rather than a caregiver.⁵⁸

Pharmacists can empower women caregivers to manage complex treatment and identify adverse reactions caused by medicines, e.g. jaundice.⁵⁸

Pharmacists can also empower women caregivers to avoid drug-drug and drug-food interactions. Empowering caregivers to avoid these interactions and to maintain safe complex treatments is essential for effective provision of care.⁵⁸

2.6 Pharmacist's role in supporting women in crisis

Disasters have had an impact on the lives of women all around the world. Disasters can be natural, man-made or political. They include floods, wildfires and terrorist attacks, and can happen anywhere at any time. Women in crisis are unable to depend on their normal familiar coping mechanisms. In disasters, they are commonly seen as victims and their role in facing the aftermath is much neglected. After a major crisis, women are more prone to depression and other mental disturbances and this is due to the trauma, stress and added burden of duty. They experience strong emotions, tensions and anxiety. Thus, pharmacists can provide medicines and basic psychological support to affected women.

The lack of medicines and basic supplies adversely affects maternal and infant health during crises. The main trauma arises when a crisis situation results in increased mortality among their children, for example, due to illnesses such as acute respiratory infections, measles, diarrheal diseases and severe malnutrition. The knowledge and expertise of pharmacists in relief efforts is invaluable in helping women and their families in an extreme crisis in accordance with health care guidelines. Pharmacists can aid in infection prevention and control, immunisation and treatment of diseases such as diarrhoea, measles, acute respiratory infections, pneumonia and malnutrition. Pharmacists' training makes them uniquely positioned to educate the public.

As the most accessible healthcare provider, the pharmacist plays an especially vital role when a disaster disrupts a community's healthcare system. Several articles have described pharmacists' experiences and the lessons learned in both planning and responding to crisis situations. Also, pharmacy associations have recognised the responsibilities and

duties of pharmacists to prepare for and respond to disasters and to participate in the full range of issues related to pharmaceuticals.⁶⁷

Women are often vulnerable yet resilient under circumstances outside their own control. However, they are still the ones who seek health care and oversee the medicinal needs of their families. Most importantly, pharmacists have a unique opportunity to help the desperate and most deserving people while providing pharmaceutical care. Pharmacists can contribute to ensure that women in crisis have timely accessibility to medicinal supply in fulfilling their current practice responsibilities as well as expanded roles of first responder, triage, immunisation, and first aid administration.

In a crisis, a pharmacist considers the current state of the women's living environment, prioritising for example access to balanced nutrition and longer-term care. Issues such as increased risk of adverse effects, a partial ability to maintain continuity of care, reduced access to proper nutrition and patients' decreased ability to appropriately store their medicines all provide a variety of challenges for pharmacists and the affected women during a crisis.

It is known that in crisis situations, the burden of diseases is mainly malnutrition and infections, which create a lot of concern and stress for women. Pharmacists providing the relief effort would be able to provide quick treatment consultation about digestive problems such as diarrhoea due to a temporary lack of meals or change in diet, minor infections and other health-related issues. In addition, pharmacists' knowledge of drug therapy management could be critical in preventing health crises in post-disaster situations.

Example from South Africa

In the North West province of South Africa, violent political protests began in March 2018. This resulted in ongoing major disruption of the supply of medicines. The lives, health and well-being of the communities were compromised. The South African Association of Hospital and Institutional Pharmacists, which is a sector of the Pharmaceutical Society of South Africa, has recognised the urgent need to develop a national disaster management plan for the delivery of medicines and medical supplies in emergencies.

3 Conclusions

One of the 21st century's key challenges and priorities outlined in the Sustainable Development Goals is the empowerment of women and girls. Throughout history, women have been the primary caretakers of children and elders in every country of the world. With the projected ageing of society and the increased need for long-term care, women's informal caregiving will become more important than ever for spouses, parents, parents-in-law, friends and neighbours.

Health systems largely rely on women's role as informal caregivers but do not adequately support them in this endeavour. Because of the multifaceted role that family and informal caregivers play, they need a range of support services to improve their caregiving skills and remain in their caregiving role. Women caregivers also have their own health needs, which need to be addressed in order for them to remain healthy. Moreover, caregiving can have several negative effects on women's health and these should also be considered.

Women are the non-professional caregivers that are closest to healthcare professionals and, more often than not, are the ones who visit pharmacies and assume responsibilities for health in the household. In general, women tend to seek treatment and go to doctors' offices or pharmacies more frequently than men do. It is often women who encourage family members to visit a healthcare professional and who make sure family members take medicines and understand treatment. Women play many roles while caregiving, including being hands-on health providers, care managers and medicines administration supervisors. Pharmacists, as the most accessible health care professionals, are in an ideal position to work to empower women in their role as informal caregivers, to communicate to women the necessity to be informed and to support their health literacy. If adequately supported, women family caregivers can succeed in positively influencing others and meeting patient needs, allowing caregiving to be a rewarding experience.

Pharmacists have been running many successful and meaningful projects targeting health promotion and ill-health prevention strategies for both communicable and non-communicable diseases. Pharmacists are in an ideal position to empower women in their roles as informal caregivers, help them achieve responsible use of medicines and provide them with professional support.

This reference document serves as guidance for pharmacists and their organisations to explore initiatives and services that empower women. This may be achieved through supporting and promoting women's education and by providing them with the information they need to ensure medicines are used responsibly. Pharmacists can become more actively involved through new pharmacist-led initiatives. This document may also be used to inspire dialogue with a broad range of stakeholders, in order to bring about positive change in this area.

4 Annex 1 — Women in global policies

4.1 Background

There is a tendency to attribute all male-female differences to biology. For a long time, the consequence has been that maternal health programmes have been seen as an adequate response to addressing differences in health between sexes. The need for examining gender issues in all health problems as well as in delivery of healthcare services remains somewhat unrecognised.

Although the disadvantages experienced by women in sectors like education, employment or political participation are evident from available data, the case of health is more complex. Many policymakers and programme managers remain unconvinced of any gender-based inequalities in health, and of the need for a gender-based approach.

Other dimensions of gender inequality in health, such as in morbidity, access to health care and in social and economic consequences of ill health, have seldom been examined.

Still today, health sectors in many countries are informed by a biomedical approach to health and disease under the leadership of health professionals who may not see the relevance of understanding the social dimensions and determinants of health. Healthcare providers tend to see themselves as technical persons who solve a problem presented to them and may believe themselves to be free from any gender (or other social) biases. A gender-based approach, in their view, may represent a diversion of valuable time and resources away from the far more important task of “saving lives”.⁶⁸ There is a need to support healthcare professionals in understanding the importance of healthcare services tailored to women’s needs.

4.2 Evolution of international policies

Integrating gender considerations in health needs to build on experiences with developing and implementing women’s health policies and programmes in different parts of the world.

Organised efforts by feminist movements across the globe in the 1970s demanded changes in legislation, policies, programmes and services affecting women’s health.

Grassroots activism to promote women’s control over their fertility and sexuality, to demystify medical knowledge and to advocate for women-centred policies and programmes was widespread in many developing countries. All these contributed to the emergence of an international women’s health movement in the early 1980s, providing further impetus to women’s health advocacy. One outcome of advocacy was the development of women’s health policies in some countries. Brazil was the first country to create a comprehensive women’s policy, in 1983. The Australian National Women’s Policy was formulated in 1988, and the Colombian “Health for women, women for health” policy was created in 1992. Efforts were also made in South Africa in 1994 to develop a women’s health policy agenda.

In all instances, the policies have gone beyond sexual and reproductive health concerns to address violence against women, occupational health and mental health. They have also drawn attention to health needs of women and girls of all age groups. The policy process, initiated by the women’s health movement, involved a wide cross-section of stakeholders such as health providers, trade unions, social workers and government departments.⁶⁸

4.3 The WHO and gender applied policies

In 2002, the World Health Organization adopted its first gender policy in health with the aim of contributing to better health for both men and women through health research, policies and programmes which give due attention to gender considerations and promote equity and equality between women and men. Further, it aimed to promote equity and equality between women and men throughout the life course and, at the least, ensure that interventions do not promote or perpetuate inequitable gender roles and relations. More simply, it aimed “to identify where gender differences exist and provide balance when needed”.

More recently, the WHO also adopted the Global Strategy for Women’s, Children’s, and Adolescents’ Health goal for 2016–2030, which is to improve the health and well-being of women and children and to end preventable diseases among them. This programme has various initiatives that vary by disease area. These include sexual and reproductive health services, nutrition, disease management, breast and cervical cancer screening and management, violence response and prevention for women, and pre-pregnancy risk detection and management.⁶⁹

In November 2017, the WHO established the Gender Equity Hub, co-chaired by the WHO and Women in Global Health.⁷⁰ It comprises over 30 members, including FIP. The hub was established following the fourth Global Human Resources for Health Forum. It brings together key stakeholders to advance gender-transformative change in the health workforce and promote gender equality and rights, which is one of the core recommendations carried forward under the Working for Health programme. The hub is in the process of finalising a working paper on gender equity in the health and social workforce.

The Partnership for Maternal, Newborn and Child Health has ambitious goals for 2030. It wants to decrease maternal, newborn, and childhood mortality rates, achieve universal access to sexual and reproductive health and reproductive rights, and improve family planning with modern contraceptives. It hopes to achieve these goals by prioritising by need, creating partnerships, and accelerating and focusing on the actions and financing of these initiatives.⁶⁹

Through Health 2020, the WHO European health policy framework, the European region integrates an equity element into its work, reinforcing the principles of non-discrimination, equality and participation, to ensure that every woman and child has the opportunity to fulfil their ambitions and is not held back by their gender.⁷¹

4.4 UN Women

In 2010, the United Nations General Assembly created a specialised agency called UN Women — United Nations Entity for Gender Equality and the Empowerment of Women. UN Women strives to address the structural causes of gender inequality, such as violence against women, unpaid care work, limited control over assets and property, and unequal participation in private and public decision-making.

UN Women, among other issues, works towards the:

- Elimination of discrimination against women and girls
- Empowerment of women
- Achievement of equality between women and men as partners and beneficiaries of development, human rights, humanitarian action, peace and security

UN Women published a series of policy briefing documents that synthesised research findings, analyses and policy recommendations on key policy areas around gender equality and women’s rights that require urgent policy attention, and proposed a set of suitable measures to address them.⁷¹

These documents can be used as resources for gender equality advocates, civil society and other policy actors working to achieve gender equality and women’s rights:

- Policy brief no. 2: Gender equality, child development and job creation: How to reap the “triple dividend” from early childhood education and care services¹⁰
Policy brief number 2 outlines that facilitating women’s labour force participation, enhancing children’s capabilities and creating jobs in the paid care economy have huge economic and social pay-offs for families, individuals and societies. One of the examples for a policy change is to make investments in early childhood education and care services.
- Policy brief no. 5: Redistributing unpaid care and sustaining quality care services: A prerequisite for gender equality⁷³
Policy brief number 5 aims to bridge the gap between the emerging consensus on the importance of care and the not-so-clear policy options for supporting care without reinforcing it as an exclusively female domain. It proposes

action on how to reduce the drudgery of unpaid care and domestic work, as well as redistributing it more equally between women and men, and between families and broader society.

4.5 Sustainable Development Goals

In 2015, the United Nations set ambitious Sustainable Development Goals (SDGs). These goals seek to realise the human rights of all and to achieve gender equality and the empowerment of women and girls. They are integrated and indivisible and balance the three dimensions of sustainable development: economic, social and environmental. There are 17 SDGs with 169 targets, to be met by 2030.⁷³

With the adoption of the 2030 Agenda for Sustainable Development and the SDGs, governments have made clear the indivisible nature of economic, social and environmental development and reaffirmed human rights, gender equality and women's empowerment as being crucial to progress on all goals and targets. This means that reaching the targets of SDG3 on health and well-being will be enabled by progress under other SDGs, particularly SDG5 on gender equality and SDG10 on reducing inequalities within and between countries.

From all 17 SDGs, there are three SDGs⁷⁵ that particularly affect women:

SDG3: Ensure healthy lives and promote well-being for all at all ages

SDG3 aims to: reduce global maternal mortality; end preventable deaths of newborns and children under five years of age; end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and fight hepatitis, water-borne diseases and other communicable diseases; reduce premature mortality from non-communicable diseases; strengthen the prevention and treatment of substance abuse; halve the number of global deaths and injuries from road traffic accidents (by 2020); ensure universal access to sexual and reproductive healthcare services; achieve universal health coverage; reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination — all by 2030.

SDG5: Achieve gender equality and empower all women and girls

SDG5 aims to: end all forms of discrimination against all women and girls; eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation; eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation; recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate; ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life; ensure universal access to sexual and reproductive health and reproductive rights as agreed.

SDG8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

SDG8 aims to: sustain per capita economic growth in accordance with national circumstances; achieve higher levels of economic productivity through diversification, technological upgrading and innovation; promote development-oriented policies that support productive activities, decent job creation, entrepreneurship, creativity and innovation, and encourage the formalisation and growth of micro-, small- and medium-sized enterprises; improve global resource efficiency in consumption and production and endeavour to decouple economic growth from environmental degradation; achieve full and productive employment and decent work for all women and men; by 2020, substantially reduce the proportion of youth not in employment, education or training; take measures to eradicate forced labour, end modern slavery and human trafficking and secure the prohibition and elimination of the worst forms of child labour, by 2025; protect labour rights and promote safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment; devise and implement policies to promote sustainable tourism that creates jobs and promotes local culture and products.

4.6 Other organisations' work

Most organisations that have initiatives targeting women are pertaining to reproductive health and children. One of these initiatives is Women Deliver, which is a global programme that focuses on maternal, reproductive and sexual health, and the rights of women. Women Deliver also collaborates with the WHO in the advocacy for the Global Strategy for Women's, Children's and Adolescent's Health and the Partnership for Maternal, New-born and Child Health.⁷⁶

UNESCO aims to promote the right to education and the empowerment women and girls. It advocates for women's education through partnerships such as the Global Partnership for Girls' and Women's Education "Better life, better future", which focuses on increasing literacy and secondary education.⁷⁷

The UN Commission on Life Saving Commodities has developed key steps and recommendations about life-saving commodities for women and children. These include medicines, medical devices, and health supplies that, if more widely accessed and used, could significantly reduce preventable deaths among women and children. The commission has several recommendations on this topic. It plans to increase the availability of life-saving medicines, medical devices, and health supplies. It hopes to give incentives to increase production, distribution and appropriate promotion of these life-saving commodities.⁷⁸

Women in Global Health is an organisation built on a global movement that brings together all genders and backgrounds to achieve gender equality in global health leadership.⁷⁹ It creates a platform for discussions and collaborative space for leadership, facilitates specific education and training, garners support and commitment from the global community, and demands change for gender transformative leadership. Its vision is that everyone has the right to attain equal levels of participation in leadership and decision-making, regardless of gender.

The Centers for Disease Control and Prevention in the US have good online resources for women with health-related questions. They also have various women's health online programmes for specific health issues. These include cancer, bleeding disorders, heart disease, HIV/AIDS, infertility, sexually transmitted infections, reproductive health, and early detection programmes for breast and cervical cancer. A limitation of these programmes is that women have to go online and actively search for information pertaining to these health issues. Furthermore, there is no person for them to talk to and ask questions.⁸⁰

URIDU is a non-profit, non-partisan organisation that empowers rural women in developing and emerging countries. It has programmed solar powered MP3 players with various health information and hopes to empower women to increase their health literacy with the use of these MP3 players.⁸¹

FIP understands the value of other organisations having programmes addressing women's health concerns. This being said, there are still many gaps to be filled regarding women's health care in particular, and community health care in general. This is a major concern, but it offers an opportunity for FIP, pharmacy organisations and individual pharmacists to have a substantial impact.

5 Annex 2 — Women’s health

There are biological differences between women and men in health needs and experiences. Women outlive men in most countries and, for many health conditions, male mortality exceeds female mortality.⁶⁸ Life expectancy of women across Europe, for instance, differs by up to 15 years, with certain groups of women continuing to be more exposed and vulnerable to ill health, and having lower well-being.⁷¹

A common scenario is where an older woman discovers that there are few healthcare or financial resources to meet her own needs for assistance. For example:¹⁵

- Women who were 65 in the year 2014 can expect to live another 24 years to age 89
- In 2005, almost half (48%) of women age 75+ were living alone, compared with less than one quarter (22%) of men
- In 2005, one in nine older women aged 75+ and one in five aged 85+ needed assistance with daily activities

Women have long-term healthcare or economic needs during their lifetime.

5.1 Communicable diseases

The communicable diseases include sexually transmitted infections (STIs) such as HIV/AIDS, hepatitis (B, C, E), female genital schistosomiasis, malaria, tuberculosis and group B streptococcus. They pose an especially formidable threat to women, claiming more than 15 million lives around the globe each year. For many infectious diseases, women are at higher risk and have a more severe course of illness than men for many reasons, including biologic differences, social inequities and restrictive cultural norms.⁸²

Malaria causes serious illness in pregnant women and children under five years of age. In 2016, the number of total worldwide reported cases of malaria reached 216 million, causing 445,000 deaths. The WHO African Region contains the vast majority of malaria cases and deaths.⁸³

UNICEF is working with the WHO, the World Bank, the UN Global Fund for AIDS, Tuberculosis and Malaria, and other Roll Back Malaria partners to support malaria-endemic countries to ensure increased use of insecticide-treated nets, access to effective antimalarial drugs and treatment, and prevention and control of malaria epidemics. Between 2014 and 2016, 582 million insecticide-treated nets were delivered globally as a primary prevention against malaria.⁸³ Most of the nets were distributed to pregnant women, through antenatal clinics, and to children under five years of age during routine childhood immunisation and measles vaccination campaigns.⁸⁴ The UN Global Fund to Fight AIDS, Tuberculosis and Malaria mobilises and invests nearly USD 4 billion a year to support programmes run by local experts in countries and communities most in need.⁸⁵ However, much work still needs to be done to prevent the ill health of women due to infectious diseases.

Women account for 38 million cases of adult HIV infection worldwide:⁷³

- In Sub-Saharan Africa, the region most affected by HIV, women are 30% more likely than men to be HIV-infected
- 35% of new HIV infections in the United States resulted from heterosexual contact; among these, almost two thirds (64%) occurred in women
- Around 12 million infants are orphaned by HIV-related deaths

At the end of 2014, 7.3 million people were receiving antiretroviral therapy through the Global Fund.⁸⁶ With continued efforts in recent decades from global leaders, such as the WHO, the HIV/AIDS epidemic has greatly improved. The current goal of the WHO is called the “90-90-90 target”.⁸⁷ By 2020, this initiative strives for 90% of people living with HIV knowing their HIV status, 90% of people diagnosed with HIV receiving antiretroviral therapy, and 90% of people living with HIV and receiving treatment achieving viral load suppression. These targets coincide with the global goal to reduce incidence of HIV/AIDS by 75% by 2020.

STIs pose a threat to women, since they often go undiagnosed due to cultural reasons. Chlamydia infections, for example, if untreated, can cause severe damage to women's fertility. STIs are the causes of more than 50% of preventable infertility in the United States.

In certain geographical regions, the tropical parasitic disease schistosomiasis affects more than 200 million people in 74 countries. Women are at greater risk for the disease because of their increased exposure to contaminated water through domestic work.⁸² Female genital schistosomiasis, often wrongly diagnosed as an STI, can cause tumours, ulcers and infertility, and may increase the risk for STIs.

Communicable diseases pose a threat to women because they are generally at higher risk and have a more severe course of illness than men. There are initiatives that help women to overcome social inequities and restrictive cultural norms and improve access to early diagnosis and treatment. However, special attention is needed to address biologic differences and provide care tailored to women's needs.

5.2 Non-communicable diseases

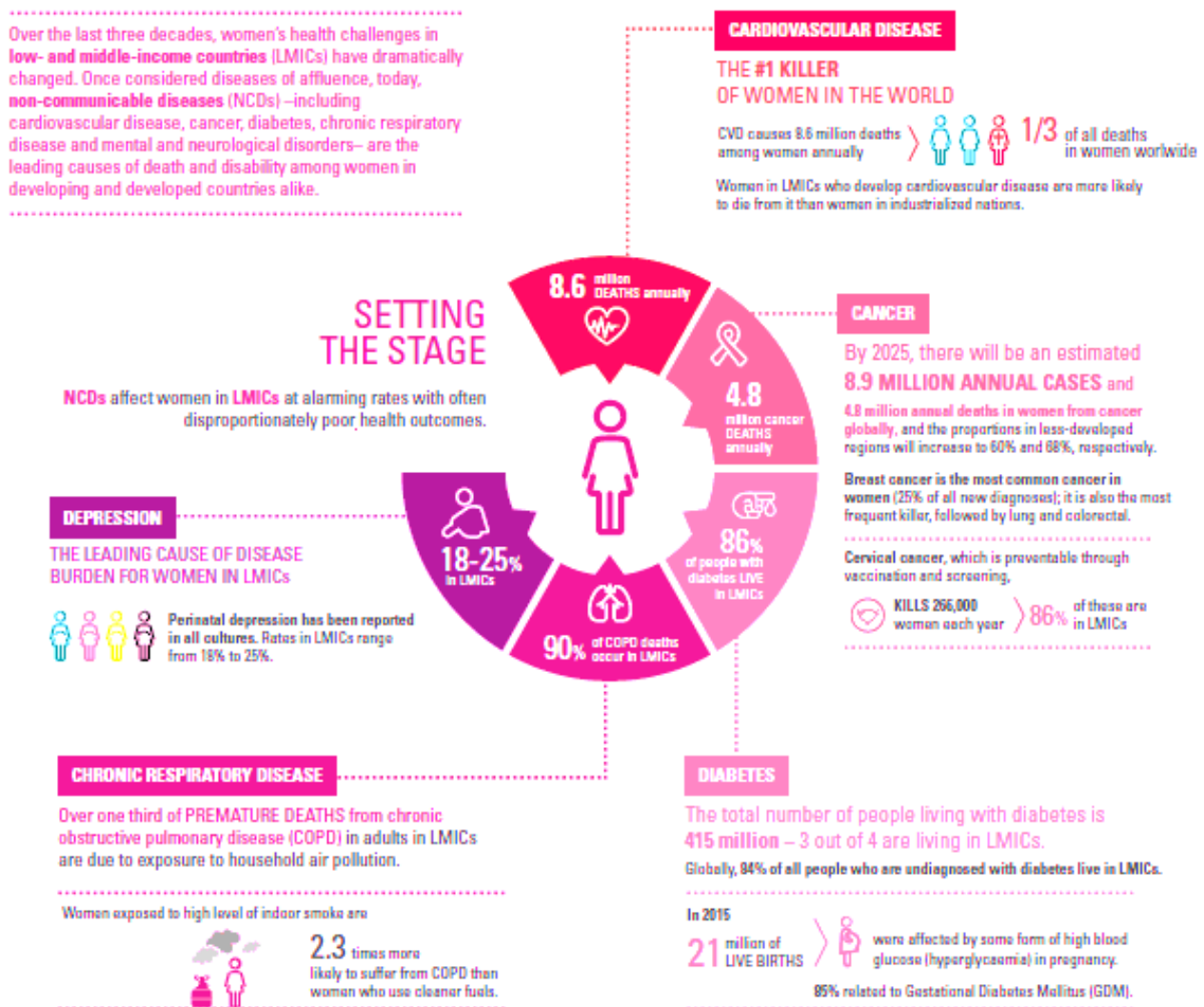


Figure 5. A call to action: Women and non-communicable diseases.⁸⁸

The non-communicable diseases (NCDs) are mainly cardiovascular diseases, cancer, chronic respiratory diseases and diabetes.⁴¹ Two thirds of all deaths in women relate to NCDs annually. Age-specific NCD death rates in women lag behind the rates in men by about 10 years. Women live longer, on average between six and eight years, and that causes the absolute number of NCD deaths in women (16.2 million) to be similar to that of men (18.4 million). Sixteen million

people die prematurely each year from NCDs, of whom 82% are in low- and middle-income countries, and the rates are much higher in these countries than in high-income countries.⁸⁹

NCDs largely occur due to risk factors, such as tobacco, harmful use of alcohol, unhealthy diet, lack of exercise and unhealthy environmental factors.⁴¹

Dietary risk factors have broadly similar effects for both women and men. With the exception of high body mass index and high fasting plasma glucose, most of the leading risk factors for NCDs have declined, especially in high-income countries. Obesity levels are a concern for women; almost everywhere, women are more obese than men. There are also significant differences in the way both symptomatic and asymptomatic women are treated compared with men. For example, gender, but not age, race, or social class of a patient significantly influenced doctors' diagnostic and management activities in a study that controlled for these variables simultaneously. Women were asked fewer questions, received fewer examinations, and had fewer diagnostic tests ordered for coronary heart disease. These differences are a reflection of the strong gender bias against equitable prevention and treatment of women.⁴¹

Cardiovascular disease

Cardiovascular diseases continue to comprise a major part of the overall NCD burden for women.⁸⁸ There are 8.6 million deaths annually, it is the number one killer of women in the world and it causes one third of all deaths in women worldwide.⁸⁸ Risk factors for heart disease and stroke, the two leading causes of death among women, are similar for men and women. Factors such as age and family history play a role, but the majority of CVD deaths are due to modifiable risk factors such as tobacco use, diets high in fat, salt, and sugar, high blood pressure, high cholesterol, obesity and diabetes.⁴¹

Cancer

By 2025, there will be estimated 8.9 million cases and 4.8 million deaths annually in women from cancer globally, an increase by 60% and 68%, respectively. Breast cancer is the most common cancer in women (25% of all new diagnoses). It is also the most frequent killer, followed by lung and colorectal cancers. Cervical cancer, which is preventable through vaccination and screening, kills 266,000 women each year with 86% of deaths occurring in low- and middle-income countries.⁸⁸

Diabetes

The total number of people living with diabetes is 415 million, with three-quarters living in low- and middle-income countries. In 2015, 21 million live births were affected by some form of high blood glucose in pregnancy, with 85% being related to gestational diabetes mellitus.⁸⁸

Chronic respiratory disease

Over one third of premature deaths from chronic obstructive pulmonary disease (COPD) in adults in low- and middle-income countries are due to exposure to household air pollution. Women exposed to high levels of indoor smoke are 2.3 times more likely to suffer from COPD than women who use cleaner fuels.⁸⁸

Depression

Depression is the leading cause of disease burden for women in low- and middle-income countries. Perinatal depression has been reported in all cultures. Rates in low- and middle-income countries range from 18% to 25%.⁸⁸

To address the effects of NCDs, governments have recently agreed upon a global goal to reduce avoidable NCD mortality by 25% by 2025.⁴¹ Despite the overall increasing number of NCD deaths in women due to increasing population size and ageing, the age-specific death rates, especially for cardiovascular diseases, are declining, and in some countries surprisingly quickly. In many countries, the decline began before governments or non-governmental organisations mounted awareness and prevention campaigns.

More recently, treatments, especially drugs to manage high levels of blood pressure and cholesterol, have also played an important part in continuing the decline in death rates from NCDs, which now include lung cancer (especially in men, but not yet in women), as well as stomach cancer, and breast and cervical cancers, which are specific women's diseases. The challenge now is to apply globally the interventions that have been so beneficial to women in high-income countries.⁴¹

NCDs constitute a hazard to women's health, because women are generally at higher risk of suffering from these diseases and have a more severe course of illness than men. There are initiatives that aim to help women overcome social inequities and restrictive cultural norms, improving access to early diagnosis and treatment.

Nevertheless, special attention must be given to coping with biological differences and provide care prioritising women's needs.

5.3 Mental health

Mental health disorders predominate in women. They affect approximately a third of people in the community and constitute a serious public health problem in the world.⁹⁰ According to the Australian Institute of Health and Welfare, nearly a half of Australian women have experienced a mental health problem (43% or 3.4 million).⁹¹ Depression is almost always reported to be twice as common in women than in men across diverse societies and social contexts.⁹² Data from the WHO European Region show that rates of mental ill health are increasing across all ages. High levels of depression and anxiety among adolescent girls in Europe is of particular concern.⁷¹

5.4 Gender-based violence

Well-being is gaining in importance as a concept and measure not only of good health, but also of general societal progress. Gender-based violence against women remains not only a violation of women's rights, but also a serious public health problem in all countries.⁷¹ Worldwide, an estimated one in three women will experience physical or sexual abuse in her lifetime. Victims of violence can suffer sexual and reproductive health consequences, including forced and unwanted pregnancies, unsafe abortions, traumatic fistula, sexually transmitted infections including HIV, and even death.⁹³ Gender inequalities, discrimination and gender stereotypes are important underlying factors influencing behaviour and practices that affect women's health across their life-course.

5.5 Conclusions

There are biological differences between women and men in health needs. Women's health is threatened more often from communicable and non-communicable diseases. Additionally, their mental health is 40% more likely⁹⁴ to be disturbed than men's. Considering the biological differences between women and men, special focus should be given to women's needs and help them overcome social inequities and restrictive cultural norms.

On a positive note, progress is being made in relation to gender equality and other social, economic and environmental determinants of women's health and well-being. It is important that health systems adapt to address women's health issues beyond reproduction and maternal health.

6 Annex 3 — Women in health care

Women's contributions to health care and the healthcare labour force deserve particular attention. Women play a crucial and underappreciated part in providing health care to families and communities. They are important drivers of the wealth, as well as the health, of nations. In one recent analysis, the financial value of women's contributions to the health system (in 2010) was estimated to be 2.4% of global Gross Domestic Product for unpaid work and 2.5% of GDP for paid work — the equivalent of USD 3.1 trillion. Valued, counted, enabled and empowered women's economic, social, political and environmental inputs are crucial for inclusive economic growth and sustainable development. Demographic and epidemiological transitions will further drive demand for health and social care, which are major sources of employment for women.

Yet women are currently severely disadvantaged in work. In most countries, the number of women in the workforce (paid and unpaid work) is substantially larger than the number of men. The Human Development Report 2015 estimates that women contribute to 52% of global work. Yet labour force participation (paid work) for women is far less than for men (50% versus 77%). Women's participation in the labour force is shaped by cultural and social traditions. These traditions often seriously limit the part women can and should play in the health economy.

The health sector could play a far larger part in expanding and financing decent work opportunities for women. Across a sample of 123 countries, for example, women make up 67% of health and social sector employment compared with 41% of total employment.⁹⁵

Gender biases create systemic inefficiencies in health systems by limiting the productivity, distribution, motivation and retention of female health workers.¹²

Even in developed countries, there is still a great need for healthcare programmes and initiatives targeted at women. For example, a meta-synthesis analysis done in Canada in 2014 showed that although Canada has universal healthcare coverage, there are still many concerns with access disparities associated with gender.⁷⁷ Women may encounter gender-based challenges to accessing health care in addition to susceptibility to illness and vulnerability to suboptimal care. Women's access to health care is shaped by four major forces: contextual conditions, constraints, barriers, and deterrents to health care.

7 Annex 4 — Pharmacists supporting health literacy of women

Health literacy is the set of cognitive and social skills that determines the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. It is a critical empowerment strategy to increase people’s control over their health, their ability to seek out information and their ability to take responsibility. Individuals need to be viewed, not as health consumers, as if health services were the source of health, but rather as health creators.”⁶⁶

Pharmacists should be aware of health literacy to help reduce medication error and morbidity/mortality rates, build trust in patients and help them become more active in their medication management.

Pharmacists can use several tools. The United States Agency of Healthcare Research and Quality provides a variety of freely available tools on its [website](#). A [literacy toolkit for the pharmacy and its staff](#) analyses staff’s understanding of health literacy and familiarity with their facility’s literature (e.g., posters, advertisements, brochures). Tools for the rapid estimate of adult literacy in medicine are freely available (in English) with health literacy assessments for patients to understand what type of information they need.

Pharmacists can start the discussion with the patients and encourage them to ask three simple questions:

1. “What is my main problem?”
2. “What do I need to do?”
3. “Why is this important for me to do?”⁹⁶

It is recommended to avoid negative language (see Figure 6).

Word types to avoid	Definition	Example word	Alternative word
Medical words	Used to describe health	Condition	How you feel
		Dysfunction	Problem
Concept words	Used to describe an idea	Avoid	Do not use
		Wellness	Good health
Category words	Used to describe a group	Adverse	Bad
		High-intensity exercise	Use a specific example
Value judgment words	Require an example to convey their meaning	Adequate	Enough
		Significantly	Enough to make a difference

Figure 6. Words to avoid at patient consultations⁹⁷

The use of pictograms is highly recommended to increase the health literacy of patients. FIP has developed several pictograms for better patient understanding. Below is an example — see Figure 7:

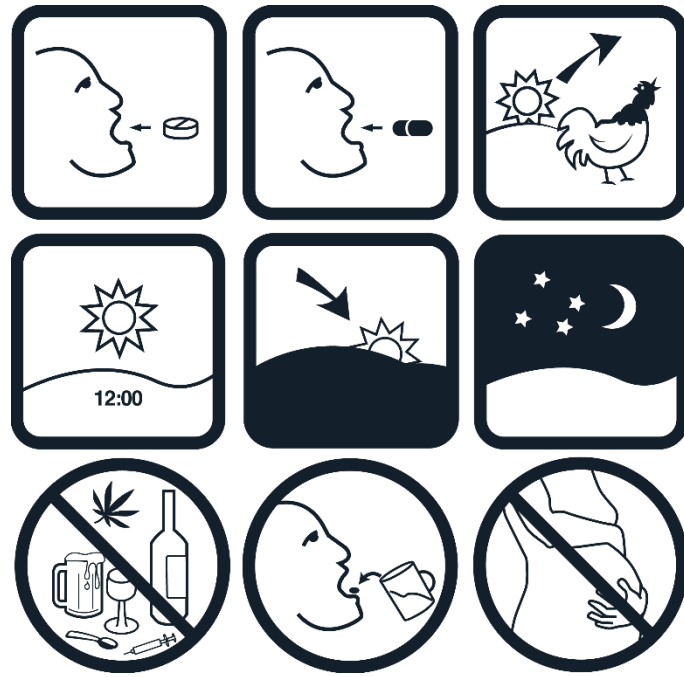


Figure 7. Example of a pictogram on how to take medicines (FIP Pictogram Project)

8 Annex 5 — Ways to achieve empowerment

Empowerment can be achieved through the management of health concerns, in particular, through effectively adapting to the new situation with health problems, being in control of the situation and thus reducing stress to minimum.

Encourage patients to take an active part in participatory care by interacting effectively with health personnel and participating in medical decision-making. In fact, increased familiarity with different sources of health information contributed to personal development, higher self-confidence, better physical and mental abilities and increased participation in social activities.

Increase self-protection of the patient by giving advice on lifestyle modification and the promotion of preventive behaviours, supporting patients in self-care and helping them improve their adherence to treatment.⁹⁸

Furthermore, empowerment can contribute to:

1. Addressing gender biases
2. Recognising and valuing women's unpaid and informal work
3. Building the evidence base on women in the health workforce
4. Recognising and reforming gender-unequal laws.

Recheck with patients that they understand the information correctly by having them repeat back what they have learned. Prepare patient education materials at lower reading levels, use a variety of pictures or search for more tools (see Annex 4 for health literacy tools). Teach your colleagues and other healthcare professionals how to communicate complex information.

9 Annex 6 — FIP survey and case studies of pioneering initiatives

In 2017, FIP developed a survey that aimed to determine what kind of initiatives are currently implemented by member organisations to increase the responsible use of medicines in women. Survey participants were asked nine “yes/no” questions on whether they had specific programmes. If a participant responded “yes”, they were asked to describe the type of programme.

Survey results were received from 15 respondents (out of 139), from 14 countries, namely, Vietnam, Iceland, Belgium, Italy, Portugal, USA (2), Tanzania, Kenya, India, China Taiwan, Mauritius, Sierra Leone, Ghana and Sweden.

- Two responses (13%) came from low-income countries
- Six responses (40%) came from middle-income countries
- Seven responses (47%) came from high-income countries

The survey showed that there are a limited number of initiatives specifically targeting women.

Table 1. Survey responses (total responses n=15)

Question	Yes	No	Percentage
Current programme(s) focusing on the role of/empowering women in supporting responsible medicine use in elderly patients?	3	12	20%
Current programme(s) focusing on the role of/empowering women in supporting responsible medicine use in children?	3	12	20%
Current programme(s) focusing on empowering women to manage their medicines cabinet and first-aid kit?	2	13	13%
Current programme(s) focusing on informing and educating women about having their children vaccinated?	0	15	0%
Current programme(s) addressing public health issues specifically through women?	3	12	20%
Current programme(s) which empower women financially, specifically to buy their medicines?	0	15	0%
Current programme(s) which empower women through medicines use literacy?	2	13	13%
Current programme(s) which are centred on empowering women to manage their household health?	2	13	13%

Question	Yes	No	Percentage
Do you know any pharmacy, pharmacists and/or pharmacy students' organisations that develop programmes that specifically target women as per the objectives of this FIP work?	2	13	13%

Two countries declared that they have programmes specifically promoting to women the responsible use of medicines:

- Ghana has a programme that targets women of the Anglican Diocese of Accra and educates them on safely choosing and using medicines, what to do if they do not experience the outcome that is expected, and what to do if the medicine is suspected to be counterfeit.
- Tanzania had an initiative to raise awareness on the rational use of medicines in 2015, during National Pharmacy Week. Pharmacists set up tents in high traffic areas and targeted women who were caretakers of the family. They addressed key points about the rational use of medicines.

The other countries that reported “yes” in the survey have programmes that do not strictly target women and the responsible use of medicines but are targeted at the whole population.

Example from Philippines

The Community-based Pharmacy Programme (CBPP) in the Philippines is an innovative way of providing community pharmacy services to clients. The objectives of this project are:⁵⁸

- To promote rational and responsible use of medicines
- To ensure that the residents in a community have access to only quality and legitimate medicines and services
- To improve the image of pharmacists and promote their value in the health system
- To develop an effective pharmacist-entrepreneur with focus on community service

The mechanics of operating the CBPP happens in three phases:⁵⁸

1. Pre-activation — a pharmacist is identified and apprised of the project, signage is placed in his or her residence, and coordination with the Programme leaders is done
2. Activation — 50 mothers are invited for an explanation of the project and a seminar on responsible use of medicines in general, the pharmacist is introduced to the community, medical services are also made available and a team of doctors, pharmacists and nurses is present
3. Post-activation — follow up on outcomes of the project based on identified deliverables

Conclusions

The FIP survey has been able to identify a limited number of programmes and activities run at national levels targeting women’s empowerment for responsible use of medicines. As a result, there is a limited number of examples the FIP project can rely on to develop a specific approach.

Moreover, the survey highlights that the scope of women and responsible use of medicines is an unexplored territory that might be worth exploring.

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