

Adopting a gender lens in health systems policy:

A guide for policy makers

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Introduction

Policy makers are interested in knowing what practical steps to take to move towards a more gender-equitable and transformative health system. This is a guide that will help them bring a gender lens to their policy deliberations on health systems and through this approach it will support them in meeting overarching health targets such as those related to Universal Health Coverage.

Gender is often misinterpreted as being only about women and girls and excluding others; or just being relevant to certain health areas such as sexual and reproductive health and rights.

Actually, gender is everyone's business.

We should take account of the needs and rights of all people in our health systems policy and planning. But, too often, some groups of people are not factored into our decision making because gender biases, norms, and power relations mean that their needs and rights are not identified, recognised or prioritised.

The World Health Organization identified six health systems building blocks: health service delivery, governance, medical products and technology, health systems financing, human resources and health information systems. These are often referred to as the hardware of health systems. Health systems software is harder to see but it is critical: it cements and informs the success of work on the building blocks and includes relationships, values, trust, and power. Both the hardware and software of the health system are affected by gender. Gender norms, roles, and relations are also shaped by the health system.

To work towards a more equitable health system that serves everyone, and meets health goals, policy makers should consider gender at all levels of the health system, and in all activities. Integrating gender into policy analysis is an issue of rights and social justice. Gender inequity always intersects with other areas of inequity such as those related to class, race, income, ethnicity, age, disability, migrant/settled status, and

sexuality. This should be considered in decision making. In this guide, we define what a gender-equitable health system might look like, provide a set of benchmarks that health policy makers can work toward. Subsequent sections of the guide are structured according to the health systems building blocks with an introduction to gender-related issues and a set of considerations that policy makers should take into account in their actions.

In order to prompt reflections on how gender affects health systems in the real world, we have included case studies from a range of countries, including Cambodia, Democratic Republic of Congo, Kenya, Liberia, Malawi, Sierra Leone, South Africa, Tanzania and Uganda. These illustrate how decision making that does not take gender into account leads to sub-optimal health systems and provide practical examples of strategies that have been effective in addressing gender barriers in health systems. Each section concludes with a list of further resources which are accessible online.



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What does a gender-equitable health system look like?

Most of the health systems models that we have deal poorly with questions of gender. In 2018, Percival and colleagues conducted an analysis of post-conflict health systems to define the attributes of a gender-equitable system. They argued that a gender-equitable health system would:

- Present equitable opportunities for men women and people of other genders who are health professionals working within the health system.
- Produce relevant sex-disaggregated health information that shapes policy.
- Ensure men, women and people of other genders, across the lifespan, are able to access and utilize services unimpeded by financial, social, and geographic barriers.
- Address the most urgent needs of men and women across the life span in an appropriate manner.

They undertook a benchmarking exercise which was organised according to the building blocks of the health system. While their analysis was focused on fragile and conflict-affected settings it offers many useful lessons that can be applied to many health systems.

In the section below we have adapted their benchmarking system adding other gender classifications to male and female and additional points based on experiences from our own settings and our research. These benchmarks have been useful in organising how information is laid out in this guide.

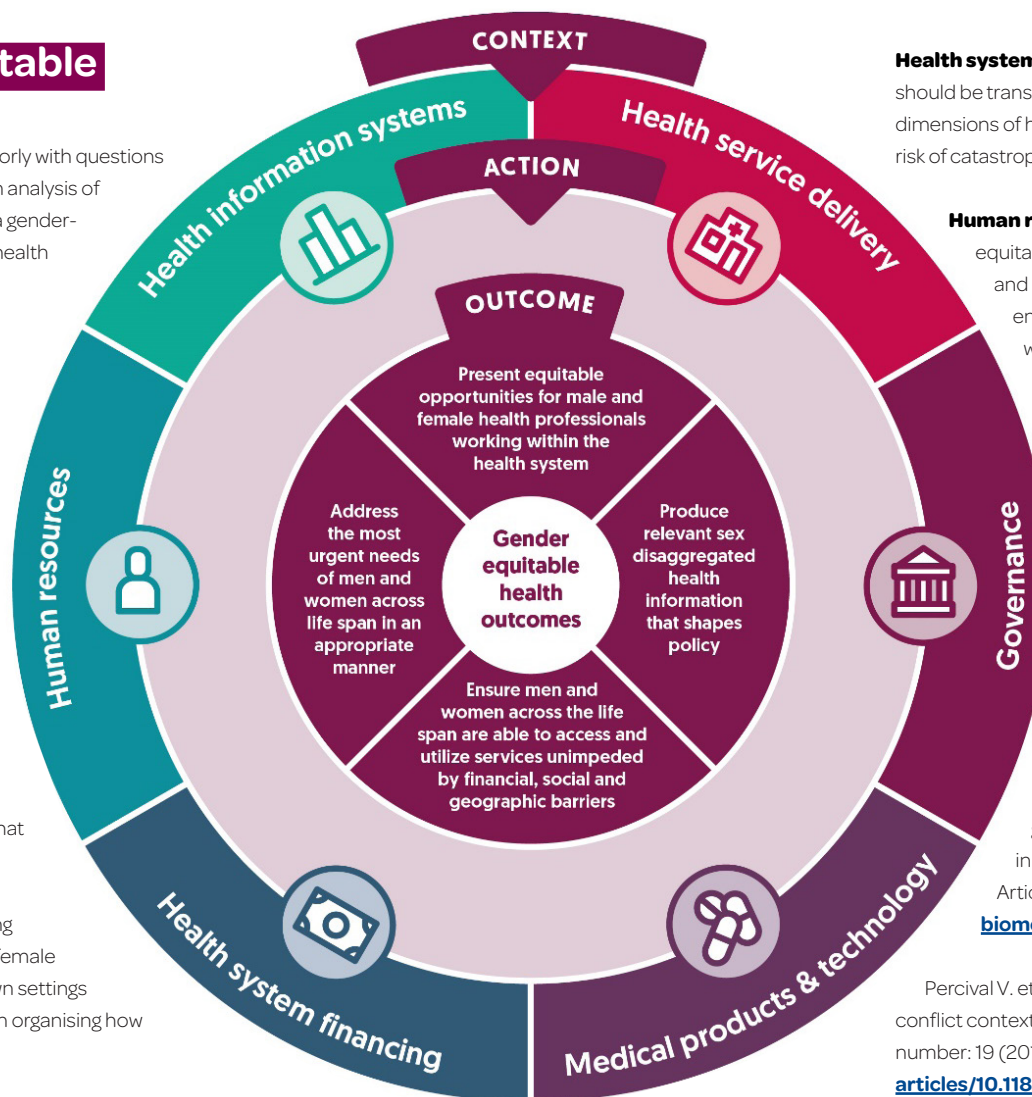
Building block benchmarks

Health service delivery: To be gender equitable, health services should ideally be accessible, integrated to ensure an efficient provision of a basic or essential package of health services that meets the needs and rights of women, men, girls, boys and people of other genders, including, but not limited to, full sexual and reproductive health services. This should include the effective regulation of private practice.

Governance: The government, and health system leaders at all levels of the health system, must meaningfully promote gender equity within the

health system. Public administration reforms in the health sector, such as decentralization of healthcare to provincial and district and community levels, should increase the responsiveness of the health sector to frontline staff and the differential needs of men, women, girls, boys and people of other genders.

Medical products and technology: Health systems should ensure equitable access to and utilization of medical products and technologies to meet the needs and rights of women, men, girls and boys and people of other genders.



Health systems financing: The allocation of financial resources should be transparent and allocated in a way that reflects the gendered dimensions of health. Financing systems must be equitable, minimizing the risk of catastrophic health expenditures.

Human resources: Gender-equitable systems should promote equitable opportunities for health workers who are men, women and people of other genders across all cadres. They should ensure that gender disparities are addressed in health workforce remuneration, planning, recruitment, deployment, retention and motivation, and particularly health worker advancement across all skills and levels of the health workforce.

Health information systems: Health information systems should identify gendered dimensions of health outcomes. Data should be sex-disaggregated, and health systems should ensure the rapid collection, collation, analysis of data and use of this data to address inequities.

Further reading:

Percival V. et al. (2018) Are health systems interventions gender blind? examining health system reconstruction in conflict affected states, *Globalization and Health*, 14, Article number: 90 (2018) <https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-018-0401-6>

Percival V. et al. (2014) Health systems and gender in post-conflict contexts: building back better? *Conflict and Health*, 8, Article number: 19 (2014) <https://conflictandhealth.biomedcentral.com/articles/10.1186/1752-1505-8-19>

Morgan R. et al. (2018) Gendered health systems: evidence from low- and middle-income countries, *Health Policy and Planning*, 16, Article number: 58 (2018) <https://ringsgenderresearch.org/resources/gendered-health-systems-low-middle-income-countries/>

JHPIEGO (2016) Gender Analysis Toolkit for Health Systems <http://reprolineplus.org/system/files/resources/Gender-Analysis-Toolkit-for-Health-Systems.pdf>

1. Health service delivery

Providing accessible, acceptable, affordable and available health services is the core function of a health system. The ability of the system to perform this role is reliant on the five other building blocks. There is a tendency to assume that a focus on maternal, newborn and child health, and sexual and reproductive health is enough to address gender concerns in the health system. While access to these services is important, providing them is not a sufficient response to addressing gender inequity which relies on a system that provides comprehensive services for people of all genders.

Health service delivery is strongly affected by gendered norms and social relations. The needs, rights, access, and experience of health services differ for men, women, and people of other genders as a result of a range of demand- (patient-led) and supply-side (health service-led) factors.

| Demand-side factors | Supply-side factors |
|---|---|
| Biological differences | Facility and outreach service location |
| Biological differences | Facility and outreach service location and timing |
| Gendered roles and responsibilities, expectations and norms | Facility and outreach service lay-out (accessibility, availability of private examination rooms etc.) |
| Unequal levels of decision-making power | Health worker recognition of and sensitivity to gendered influences on service delivery |
| Access to financial and social resources | Health worker gender across cadres |
| Health care seeking behaviour | Respectful care |

Other social, political and legal influences such as age, education, marital status, migration status, and disability also impact the effectiveness of access to health services for men, women, and people of other genders.

Service delivery systems must therefore be designed and configured in ways that pay attention to people's different positions, opportunities and vulnerabilities.

Case studies

Men's care-seeking for chronic cough and tuberculosis symptoms in Blantyre, Malawi

Tuberculosis (TB) is a leading cause of adult morbidity and mortality globally, and gender norms, roles, and relations differentially affect TB incidence, prevalence, and health seeking behaviour among men and women. While more men than women are diagnosed with TB and die from it, among women it is more prevalent during their reproductively active years with severe consequences. National surveys in Malawi consistently show a much higher burden of undiagnosed infectious TB in men than women, and men's healthcare-seeking delay results in higher mortality while on HIV or TB treatment.

This study explored the ways in which contemporary notions of masculinity influence TB-related healthcare-seeking in an urban slum setting in Malawi. The authors found that an expectation to provide for and lead their families, and to control various aspects of their lives while facing limited employment opportunities and small incomes leaves men feeling inadequate, devoid of control, and anxious about being marginalised as men. Men were fearful about being looked at as less than men, and about their wives engaging in extramarital sex. Articulate and consistent concepts of men's bodily strength or appropriate illness responses were absent from the accounts. These notions affected their health care seeking behaviour.

The study highlights the importance of facilitating men to seek care early as an urgent public health imperative and that men should be targeted by TB campaigns which take their understandings of gender into account. These interventions should challenge harmful notions and seek gender transformation.

Resource

Chikovre J. et al. (2014) Control, struggle, and emergent masculinities: a qualitative study of men's care-seeking determinants for chronic cough and tuberculosis symptoms in Blantyre, Malawi, BMC Public Health, 14, Article number: 1053 (2014) <https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-14-1053>

Making health facilities in Kibuku district in Uganda friendly for physically disabled women

Around 12.5% of the total population of Uganda are living with one form of disability. Maternal and newborn mortality remains unacceptably high. Most efforts to improve maternal, newborn and child health in Uganda have focused on access and quality of care for women in general, paying no attention to special populations with a high likelihood of poor outcomes, such as women with physical disabilities.

Like elsewhere in Uganda, physically disabled mothers in Kibuku district face unique barriers in accessing maternal and newborn health services. Simple everyday activities like climbing stairs, using a latrine and getting onto a bed for a physical examination become impossible tasks. Women with walking disabilities have psychosocial, mobility, special services and personal needs that were not met. They face challenges such as: a lack of acceptance from family, community and health workers and on occasion partners; unsuitable and expensive transport; inaccessible physical infrastructure; unresponsive midwives; and low awareness of the needs of women with physical disabilities.

The study recommends that all health facilities assign at least one latrine for physically disabled people and budget for ramps and handrails to make the latrine user-friendly for people with disabilities. It also recommends that those responsible for health facilities install climbing supports for existing beds to enhance access and use by physically disabled mothers. Furthermore, training should be conducted with facility staff about how to offer disability-friendly services and there should be advocacy to secure an appropriate budget for these changes to ensure that disabled women's rights to equal access to respectful and dignified maternity care are met.

Resources

Apolot R. (2018) Challenging the Status Quo: Making health facilities in Kibuku district, Uganda friendly for physically disabled women, RinGs brief <https://ringsgenderresearch.org/resources/uganda-health-facilities-kibuku-disabled-women-maternal-health-access/>

Apolot R. et al (2019) Maternal and newborn health needs for women with walking disabilities; "the twists and turns": a case study in Kibuku District Uganda, International Journal for Equity in Health, 18, Article number: 43 (2019) <https://ringsgenderresearch.org/resources/maternal-newborn-health-women-walking-disabilities-uganda/>

Gendered decision-making about joining community-based child nutrition interventions in rural coastal Kenya

This study, in rural Coastal Kenya, explored the interaction between household gender relations and a community-based child nutrition programme, with a focus on household decision-making dynamics related to joining the intervention. Decisions about accessing the service were highly gendered.

The decision to join the programme was usually taken by the main female carer in a household – usually mothers or grandmothers. It was seen as a part of routine childcare which was under women's domain. This differed to decision making about other forms of child healthcare or enrolment in other health research studies which men considered serious (such as those that required blood to be drawn). Community members – especially mothers within the community, friends and neighbours – also played a part in encouraging women to join the scheme. Women played a key role in collecting the supplemental food for the targeted children from the health facilities and maintaining continued engagement with the programme. Men were largely absent from the decision-making process. They were not always at home when researchers visited and considered nutrition “women's business”.

The intervention did not challenge these gender norms, promote changes in attitude or involve men by design. But employing these strategies could have been an opportunity to raise the profile and importance of child nutrition, improve understandings of its negative effects and strengthen a culture of joint decision making about the health of children. The location of the intervention in primary healthcare services may have also inadvertently excluded men as these are perceived as spaces for women and children.

Resource

Muraya K. et al. (2018) “If it's issues to do with nutrition...I can decide...”: gendered decision-making in joining community-based child nutrition interventions within rural coastal Kenya, Health Policy and Planning, Volume 32, Issue suppl_5, December 2017 <https://ringsgenderresearch.org/resources/nutrition-gender-children-kenya/>

What can policy makers do?

- Invest in addressing demand-side social and gender related barriers by creating spaces for communities to appraise health services provided from a gender perspective.

- Assess the gender sensitivity of health service delivery and health facilities to identify what interventions are needed to ensure facilities are gender sensitive.
- Support community leaders and other key stakeholders in local communities to understand how gender norms impede access to care, and work to expand awareness of, and build demand for gender equitable care and expand the focus beyond maternal care.
- Ensure that all service users feel welcomed in facilities, by carefully considering facility layout, the interpersonal skills of the staff, and conducting local, and context-specific outreach activities designed to be responsive to groups with specific intersecting vulnerabilities (e.g. lowest income disabled groups, male labourers etc.).
- Develop systems to encourage service providers at local level to engage men, including the husbands/partners of women. This is an important strategy toward strengthening woman-centred services but should ensure that male-involvement does not undermine women's decision making and autonomy.

Further reading

Irani L. et al. (2015) A tool to assess the gender sensitivity of a health facility: Pilot Tested in Afghanistan, Washington, DC: Futures Group, Health Policy Project https://www.healthpolicyproject.com/pubs/843_FINALAfghanistanGenderSensitivityTool.pdf

Barman D. (2018) Are women of Indian Sundarbans living in the dark? A gender analysis of eye health in the Indian Sundarbans for responsive health systems, RinGs Brief <https://ringsgenderresearch.org/resources/are-women-of-indian-sundarbans-living-in-the-dark-a-gender-analysis-of-eye-health-in-the-indian-sundarbans-for-responsive-health-systems/>

Ezumah N. et al. (2016) Strengthening male involvement in the prevention of mother-to-child transmission of HIV in Enugu State, Nigeria, RinGs Brief <https://ringsgenderresearch.org/resources/male-involvement-prevention-mother-child-transmission-hiv-enugu-nigeria/>

Shaikh M. et al. (2018) Sex differences in utilisation of hospital care in a state-sponsored health insurance programme providing access to free services in South India, BMJ Global Health, 2018 <https://gh.bmi.com/content/3/3/e000859>

Morgan R. et al. (2017) Gender dynamics affecting maternal health and health care access and use in Uganda, Health Policy and Planning, Volume 32, Issue suppl_5, December 2017 https://academic.oup.com/heapol/article/32/suppl_5/v13/4718137



Photo: Nena Terrell, USAID Ethiopia

2. Human resources for health

Health workers are the backbone of the health system. Women, men and people of other genders experience different gendered barriers within the three pillars of human resources for health: production (education and other forms of training), deployment (the positions people are employed in), and retention (turnover of staff). These affect health workers' experience within the health system, their motivation, satisfaction and well-being.

Evidence shows that gender norms, roles, and responsibilities within households, communities and institutions can act as a barrier or facilitator to people's ability to take up training and promotion opportunities and career progression within different cadres, and across different contexts. Women tend to predominate in nursing and midwifery cadres, are clustered in lower paying positions, and are under-represented in management positions.

Furthermore, gender norms affect the ways in which jobs are designed and who does what type of work within the health system. For example, women are often expected to embody personal service, nurturance and being nice while men are seen to be more competent in areas of leadership and being rational.

Most human resources regulatory frameworks in health do not sufficiently address gender. The role of gender in relation to the production of health care has received much less emphasis even though health systems are very gender segregated with women being concentrated in specific segments of health care labour force (for example as frontline workers and Community Health Workers).

Unless these gender imbalances across the health system are proactively addressed, the health workforce will remain inadequate, poorly distributed, and unable to meet the health needs of the whole population. Human resources policies, and institutional norms and practices should explicitly address the gendered needs of men, women, and people of other genders. This could also have a positive effect on health service delivery.

Case studies

Women and leadership in the Cambodian health sector

In Cambodia, only one in five leadership positions in the Ministry of Health are held by women. Just 16% of senior health workers (such as doctors) are female, compared to 100% of midwives. This is problematic for several reasons. Women's concerns are not reflected in health policies, including human resources for health strategies. Human resource policies, such as those related to career advancement, do not take into account women's life course events, such as childbearing and childcare. And, finally, in a country where most women prefer to be cared for by female health workers, the shortage of female doctors limits women's access to health services.

This study looked at the facilitating and constraining factors that affected women's leadership in the health sector. It discovered that women are increasingly aware of their right to study and work outside the home. The government has strengthened its policy and support for gender equality, and respect for human rights. Nevertheless, gender norms and expectations perpetuate the division of traditional roles, with domestic tasks largely assigned to women and decision-making to men.

Women are still significantly under-represented in health leadership positions. Research with women leaders highlighted factors contributing to their success. These women are highly motivated. Support from partners, family members and male managers is a crucial factor in supporting their leadership, illustrating the importance of achieving gender equity at home as well as at the workplace. Finally, skills and qualifications are necessary.

The study found that organizational cultures (embodied by male and female managers and role models) that value women's capacity and qualifications, and believe in the agency of women leaders, are key to achieving gender equity within health system leadership. Promoting gender equity in the health workforce requires gender mainstreaming processes in recruitment, retention and upward mobility of women in all cadres, including in pre-service and in-service training opportunities.

Resource

Vong S. et al. (2019) Why are fewer women rising to the top? A life history gender analysis of Cambodia's health workforce, BMC Health Services Research, 19, Article number: 595 (2019) <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4424-3>

Community health workers: A gender lens in Sierra Leone, Liberia, and Democratic Republic of Congo

While some Community Health Worker (CHW) policies and programmes have an explicit commitment to gender equality, this may not have a significant impact at the community level. Efforts to treat men and women equally may fail to take account of the fact that gender influences male and female CHWs' ability to perform their role because of the influence of gender norms at programme, community and household level. Policies that appear progressive, or at least aim to do no harm, may not be as neutral as is first perceived.

Research in Sierra Leone, Liberia and Democratic Republic of Congo found that access to education and literacy is gendered and this can mean that men are prioritised in the selection of CHWs – a process conducted at the community level. In settings where CHWs are volunteers there is a possibility that this can reinforce 'gender segregation' in the health workforce – with men at the higher levels of the system and women at the bottom – as women and girls made up the bulk of the people providing informal and unpaid care.

Gender norms also play out in different ways to shape community preferences – some community members would prefer to discuss maternal health concerns with a woman CHW. Gendered expectations influence career progression and other opportunities and research findings showed that in some cases women may have limited opportunities to input into decision making and for career progression, which can be de-motivating.

Resource

Steege R. et al. (2018) Gender and Community Health Worker programmes in fragile and conflict-affected settings. Findings from Sierra Leone, the Democratic Republic of Congo, and Liberia, RInGs Brief <https://ringsgenderresearch.org/resources/gender-community-sierra-leone-democratic-republic-congo-liberia/>

Intersectionality at work in health system staffing in India

A study of experiences of postings and transfers among health system personnel in four states of India revealed several intersections of disadvantages: Gender, age, marital status, employment status (permanent/contract), cadre, system of medicine (allopathic/non-allopathic) practised, and social community (caste or tribe) interacted to enhance the vulnerability of many health workers to harassment or tensions in the workplace, as also in the community. Women form the overwhelming majority of frontline community health workers, who are, by the design of their jobs, exposed to high workloads and intensive social interactions. Three vignettes of female health system personnel are presented here:

A young, female staff nurse, in permanent employment, reported experiencing pressures of professional and personal natures at work, and social and personal pressures from community members, including excessive workloads, inadequate support at the workplace and at home, and sexual harassment from administrative superiors, such as doctors in charge. The concomitance of family responsibilities, job demands, and lack of power was reported by many, e.g., junior nurses were also likely to be young mothers with small children. The combined burden of these stresses often drove nurses, such as this person, to seek transfers away from adverse work conditions, or long leave, even unpaid, to recoup.

The professional functioning of practitioners of non-mainstream systems of medicine posted at government health facilities was greatly encumbered by the existing lack of awareness of traditional, complementary, and alternative systems of medicine in most communities. Non-allopathic doctors and compounders found that they needed to put in immense effort to raise awareness of their systems of medicine, distinguish the different systems of medicine offered in public health facilities, and motivate people to try their treatment. Contract workers reported feeling highly insecure about continued employment. Many also reported being treated disrespectfully by permanent workers of different cadres, based on the non-permanence of their jobs. In addition, they often faced inadequacies of infrastructure, logistics, and technical assistance, all of which hampered their ability to work effectively. The administrative hierarchy in government health facilities usually placed allopathic medical officers above contract non-allopathic doctors, leading to some interpersonal tension. A female, non-allopathic practitioner, in contractual employment, reported a gulf between the salary and perquisites offered to permanent workers and contract employees. Benefits such as subsidised

housing, admission to educational institutions for children, free healthcare for dependents, and personal loans based on employment status, available to permanent employees were not available to contract workers.

A female practitioner of non-allopathic medicine, in permanent employment, reported her experiences of negotiating her work life with a physical disability. In view of her disability, she was not required to be transferred to different facilities in the district as frequently as her colleagues. However, even the postings within the circumscribed subdistrict zone that she worked in necessitated changes in housing, and in the employment of, and the support that she needed from, some of her family members. She interacted very little with staff outside her department and was keen to get through the few remaining years of her government employment keeping as low a profile as possible, to avoid controversies, complications, and repercussions from involvement in the politics of employment.

Resource

Public Health Foundation of India (unpublished) Posting and transfer policies and practices in the health system: Report of a research project conducted by the Health Governance Hub, Public Health Foundation of India (PHFI), Supported by funds from DFID India

What can policy makers do?

- Improve understanding of the workforce by collecting gender disaggregated data at all levels including among CHWs and volunteers.
- Eliminate gendered discrimination in hiring practices.
- Work towards a gender balance in health workers at all levels, including at managerial and community levels, and ensure that community preferences about the gender of health workers are considered.
- Put in place strategies to promote women's advancement in the health system hierarchy where leadership is unbalanced.
- Ensure all health systems staff – of any gender, and seniority in health system hierarchies – are trained in respectful and gender-sensitive care and understand how gender norms intersect with other social stratifiers (e.g. age, social class, disability, race) to influence different people's use and experience of care.
- Ensure that health worker job descriptions and occupational targets are linked to gender equity goals within the health system.
- Provide safe and decent working environments, including workplaces that are free from violence and harassment. Also ensure that there are mechanisms in place to file complaints and to address violence and harassment at the workplace.

- Ensure equal and appropriate remuneration, which includes financial and non-financial incentives for CHWs.
- Create equal opportunity for capacity building, continued professional development, and career progression in the health workforce by removing gendered barriers to training opportunities.
- Ensure that mentorship and training accommodate those with familial, domestic and caring responsibilities. Support initiatives to share caring responsibilities within households and communities.
- Ensure that deployment opportunities are distributed fairly by considering how staff can accommodate their families in their deployment.
- Create workplaces that are supportive of those with families by providing paid parental leave, childcare, and spaces and flexible timings for breastfeeding within the institution.
- Support health workers in addressing gender in their workplace. Health workers can be agents of change but may need gender training, support, and supervision structures to discuss how best to address the gendered experiences of their clients.

Further reading

WHO (2011) Gender mainstreaming for health managers: a practical approach, World Health Organization, Geneva http://www.who.int/gender-equity-rights/knowledge/health_managers_guide/en/

Muraya K. et al. (2019) 'Gender is not even a side issue...it's a non-issue': career trajectories and experiences from the perspective of male and female healthcare managers in Kenya, Health Policy and Planning, Volume 34, Issue 4, May 2019 <https://academic.oup.com/heapol/article/34/4/249/5479979>

Musoke D. et al. (2018) Reflecting strategic and conforming gendered experiences of community health workers (CHWs) using photovoice in rural Wakiso district, Uganda, Human Resources for Health, 16, Article number: 41 (2018) <https://ringsgenderresearch.org/resources/gendered-experiences-community-health-workers-chws-using-photovoice-uganda/>

Dhatt R. et al. (2018) The role of women's leadership and gender equity in leadership and health system strengthening, Global Health, Epidemiology and Genomics, (2017), 2, e8 <https://ringsgenderresearch.org/resources/womens-leadership-gender-equity-health-system/>

Witter S. et al. (2017) The gendered health workforce: mixed methods analysis from four fragile and post-conflict contexts, Health Policy and Planning, Volume 32, Issue suppl_5, December 2017 <https://ringsgenderresearch.org/resources/the-gendered-health-workforce-mixed-methods-analysis-from-four-fragile-and-post-conflict-contexts/>

Steege R. et al. (2018) How do gender relations affect the working lives of close to community health service providers? Empirical research, a review and conceptual framework, Social Science and Medicine, Vol 209, July 2018 <https://www.sciencedirect.com/science/article/pii/S0277953618302375>

Manzoor M. et al. (2019) Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce, Geneva: World Health Organization; 2019 (Human Resources for Health Observer Series No. 24) https://www.who.int/hrh/news/2019/gender_CSW/en/

Newman C. (2014) Time to address gender discrimination and inequality in the health workforce, Human Resources for Health, 12, Article Number: 25 (2014) <https://human-resources-health.biomedcentral.com/articles/10.1186/1478-4491-12-25>



Richard Nyberg, USAID

3. Governance

Health systems governance includes the systems of daily management, leadership, accountability, oversight, regulation. Leadership is not just about who is Minister of Health or a Member of Parliament, but also about leadership at the local level. Gender shapes the functioning of health systems governance at international, national, subnational, and community levels, and each level impacts every other.

Often, governance processes within the health system are guided by legal standards such as constitutional law, which lay out a progressive vision for equality. Furthermore, many governments have committed to some form of gender mainstreaming or gender focus in policy.

Despite this, many health systems governance structures and processes fall short of their potential when it comes to gender equity. Gender, and specifically gender discrimination, are associated with the ways in which leadership is defined (mainly favouring masculine traits). There is a lack of goal setting for higher representation of women in leadership and policy spaces in the form of targets, quotas and affirmative action. There also remains a lack of understanding of structures, systems, cultures, leadership and power within which discrimination occurs.

Weaknesses and challenges also include a lack of accountability to marginalised communities, and inaccessible accountability structures. Too few policies and implementation frameworks have an explicitly gender transformative aim. Where strong policies do exist, they may not be turned into strategic actions, particularly at district and community levels. Political figureheads, civil servants, and regional and health facility managers may lack gender training or knowledge which leaves them ill-prepared to develop policy and guidance in this area, which can be detrimental to service users and staff within the health system. In the absence of this their decision making may fall back on gendered social norms that are discriminatory or stereotypical.

Case study

Gender mainstreaming in prevention of mother to child transmission of HIV in Tanzania

In Tanzania, the prevention of mother to child transmission of HIV (PMTCT) is a health sector priority. Mainstreaming gender concerns into PMTCT programming is expected to lead to increased coverage, efficiency, and effectiveness of services, contributing towards a reduction of child and maternal illness and death. Addressing gender concerns includes

consideration of gender-related barriers to accessing PMTCT services and understanding the challenges patients experience in adhering to the professional advice given in those services.

Gendered challenges include:

- Unequal ownership of resources between men and women (women not going or going late to PMTCT clinics due to lack of money for travel; or women being unable to make appropriate decisions about health due to financial constraints).
- Unequal decision-making power in sexual relationships, contraceptive use, and in choosing infant feeding options.

This research assessed the gender content of key policy documents in order to better understand how this area could be strengthened. It used the Gender-Responsive Assessment Scale (GRAS) which is a tool to measure programmes and policies as either gender unequal, gender blind, gender sensitive, gender specific or gender transformative.

Gender-related issues are mentioned in all of the guidelines, indicating some degree of gender responsiveness. The level of gender responsiveness of PMTCT policy documents, however, varies, with some graded at GRAS level 3 (gender sensitive), and others at GRAS level 4 (gender specific). None of the reviewed policy documents could be graded as gender transformative. Gender sensitive policies included the National Scale up Plan for The Prevention of Mother to Child Transmission of HIV and Paediatric HIV Care and Treatment, 2009-2013, The National Guidelines for Comprehensive Care Services for Prevention of Mother to Child Transmission of HIV and Keeping Mothers Alive (2013) and the National Communication Strategy for the Elimination of Mother to Child Transmission of HIV (2014 – 2017). These documents have sections acknowledging the influence of gender on PMTCT, but lack sections on remedial measures.

When documents did consider gender, they were often too general to offer effective guidance. Policies rated at GRAS level 4 went beyond indicating gender awareness to also state measures for addressing specific concerns of women and men and addressing gender inequity. This was the case only for the National Training Refresher Package: Services for Comprehensive Care and Prevention of Mother-to-Child Transmission, Participant Manual, 2013. The analysis showed that policies do not set out to transform gender relations. Even when policy documents recognise gender inequality in decision-making and access to resources as barriers to accessing PMTCT services by women, no specific remedial actions to transform harmful gender norms, roles, or relations are identified. For example, the policy

documents do not include actions to transform norms around masculinity that discourage men from seeking care, taking an HIV test, or accompanying their partners to PMTCT clinics.

The fact that many of the guidelines and policies refer to gender without including concrete measures to address inequalities might be explained by the fact that in the design stage of a policy or strategy, gender is handled as an “add on” in order to fulfil certain requirements, rather than being made an integral part of the entire policy. Overall, this study revealed limited integration of gender concerns. There was a lack of attention to the disadvantageous position of women in terms of inequality in ownership of resources, power imbalance in decision-making, asymmetrical division of roles, and masculine norms that distance men from maternal and childcare in PMTCT guidelines. Ensuring that health programme guidelines effectively integrate and mainstream gender considerations is greatly needed if services are to effectively contribute towards health outcomes.

Resource

Nyamhanga T. et al. (2017) Prevention of mother to child transmission of HIV in Tanzania: assessing gender mainstreaming on paper and in practice, Health Policy and Planning, Volume 32, Issue suppl_5, December 2017 https://academic.oup.com/heapol/article/32/suppl_5/v22/3970854

Key issues in gender and accountability mechanisms

Governance and accountability mechanisms operate at multiple levels – among senior policy makers, civil servants, and politicians; at the facility level; and within the community. Gendered power relations exist within policy making processes, facilities and communities and inform who is able to engage (e.g. by influencing access to resources and norms of engagement), what the terms of engagement might be (e.g. what forms of engagement are acceptable for whom), how much ability different actors have to negotiate accountability (e.g. who has the power to hold another actor accountable), and who can meaningfully implement change (e.g. who has the power to implement changes in support of accountability practices).

This research reviewed different types of accountability mechanisms and how they were affected by gender. They found that governance and accountability mechanisms within the health system often focus on generic categories of users, and do not adequately examine the differences that impact users' experience of health system delivery. Users are homogenised and certain categories elevated to the norm (male, urban, educated, heterosexual users). Alternatively, in an attempt to include 'vulnerable and marginalised groups' in accountability mechanisms, such

as community scorecards, token representatives from such groups – such as poor women, disabled men, young women, old men – are often included to represent an entire group of ‘marginalised’ people. There is often little consideration of how gendered power relations may affect the ability of different groups to participate in governance at different levels and share their experiences and challenges. Women’s increased reliance on the health system as a result of their reproductive roles may also negatively influence their willingness to hold service providers accountable when they experience poor services or discrimination. This is especially true when accountability mechanisms do not effectively or sensitively include or empower women, and in particular women with limited voice, such as migrant women, or women with disabilities.

Resource

Waldman L. et al. (2018) Key Considerations for Accountability and Gender in Health Systems in Low- and Middle-Income Countries, IDS Bulletin, Vol 49, No 2 (2018) Accountability for Health Equity: Galvanising a Movement for Universal Health Coverage <https://bulletin.ids.ac.uk/idsbo/article/view/2967/Online%20article>

What can policy makers do?

- Ensure that Ministries responsible for the health system link and align with their counterparts who have a responsibility for gender equity, e.g. Ministries for women and family issues and gender units to develop policy and indicators for the health system.
- Ensure oversight, regulation, system design, and accountability that addresses the causes of gender-based health inequalities, and contributes to the transformation of harmful gender roles, norms, and relations.
- Through training and other incentives cultivate gender champions and a culture of gender sensitivity within staff responsible for decision making and the creation of health system policy and financing.
- Assess strategic policy frameworks to ensure that they are gender transformative.
- Ensure gender balance and gender sensitivity of governance structures at all levels down to the facility and community level.
- Assess whether processes to integrate gender into decision making have taken place and introduce gender responsive budgeting if needed.
- Develop governance mechanisms within the community to engage in dialogue about gender, rights, accountability (of governance actors and health workers), and good health, and to solicit feedback which is used in policy and practice.

Further reading

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Muraya K. (2019) Gender quotas: Foe or friend for health leadership?, Health Policy and Planning Debated <http://blogs.lshtm.ac.uk/hppdebated/2019/09/25/gender-quotas-foe-or-friend-for-health-leadership/>

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Shung-King M. et al. (2018) Leadership experiences and practices of South African health managers: what is the influence of gender? -a qualitative, exploratory study, International Journal for Equity in Health, 17, Article number: 148 (2018) <https://equityhealth.biomedcentral.com/articles/10.1186/s12939-018-0859-0>



Photo ID: DS-RY080 World Bank

4. Health information systems

A well-functioning health information system is one that ensures the production, analysis, dissemination, and use of reliable and timely information on health determinants, health system performance, and health status. This information is key to good decision making. The health information system has four functions: to generate data, to compile this information, the analysis of data and its synthesis so it can be communicated and used by others. Each of these functions is influenced by gender biases and presents opportunities for addressing gender inequities and barriers.

Data generation: The creation or updating of data generation systems provides an opportunity to discuss issues related to gender of data collectors and how this might affect the quality of the data that are collected. Efficient systems would address the structuring of data (disaggregation etc.), the methods of collection (timings and venues) and breakdown to different types of data. These systems should include gender-sensitive and gender-specific indicators. Qualitative data can provide context and explanations behind gender inequities.

Compilation: Thought should be given to how to highlight gender, and other intersectional differences in the consolidation of data to ensure equity data is not masked as it gets aggregated.

Analysis and synthesis: Those involved in data analysis should have the capacity to identify patterns that reveal inequalities, and barriers to service access related to gender, and to devise strategies to overcome these. This should be cascaded down from the national level in systems which are decentralised. When data is synthesised care should be taken not to erase gender inequalities.

Communication and use: Data users should be trained in how to present health information data and analyses in ways that are actionable for reducing gender inequity and gendered barriers to care.

Case study

A gender analysis of community health data in Kenya

A key role of Community Health Volunteers (CHVs) in Kenya is to refer women and children to primary healthcare facilities for essential health services such as antenatal care, skilled delivery, postnatal care, immunization, and growth monitoring. As they carry out this role, CHVs collect data at community level in a tool designed by Kenya's Ministry of Health – they are expected to report this data on a monthly basis. This should be a source of data provided at regular intervals that is used by policy- and decision-makers.

Focus group discussions to explore data quality, conducted with CHVs in rural and urban sites in Kenya, revealed direct impacts of gender on the quality of data reported by CHVs due to gendered barriers in data collection. For example, some health issues are perceived to be the domains of men or women. Both men and women CHVs felt that certain issues should only be discussed with either men or women. Because of this it is likely that the data that was collected would reflect a very gendered view of the health issue under discussion.

CHVs tend to collect data from women. Although men were consulted on issues like latrines, CHVs tend to interact more with women, and as such men's perspectives may be missing from the data routinely reported. CHVs reported that frequently, men in households do not engage with them because they do not see this as part of their roles as men. CHVs felt that it was difficult for women to visit households of men, especially bachelors and especially at night, due to concerns around safety and negative impact on their reputation. Similarly, young men reported facing difficulties in conducting household visits in that they are often treated with suspicion of having ulterior (possibly criminal) motives, due to their gender and age.

These gendered elements of data collection impact on dimensions of data quality such as accuracy, completeness, reliability and confidentiality. When CHVs are not able to openly discuss important health issues due to cultural or gendered norms, they are unable to fully assess the health status of their clients, which is reflected in the data collected. There is a need to explore and further establish the effects of gender on data collection and what this means for reporting, so that findings are incorporated in training and supervision of CHVs.

Resource

Njoroge R. et al. (2017) How does gender impact the quality of community-level health data? Examples from rural and urban settings in Kenya, RinGs blog <https://ringsgenderresearch.org/how-does-gender-impact-the-quality-of-community-level-health-data-examples-from-rural-and-urban-settings-in-kenya/>

What can policy makers do?

- Train health information management staff and statisticians in gender and data and add metrics related to gender to standard operating procedures.
- Analyse available data routinely by sex and other social stratifiers (age, race, income, ethnicity, etc.)
- Where Ministries of Health draw on different sources of data, e.g. population surveys, DHS, MICS, GATS, LSS, use these data to identify the intersection between sex and other stratifiers.
- Create DIHS2 dashboards that present sex-disaggregated data for use at different levels of the health system.
- Develop gender-sensitive indicators that go beyond disaggregation by sex.
- Ensure that policy for human resources for health is informed by sex-disaggregated and gender-sensitive information systems in relation to production, deployment, and retention of health workers.
- Collect data on how health interventions impact upon the social determinants of health, for example gender equity.
- Commission complementary in-depth research (e.g. qualitative research) to understand the why behind different inequities identified in sex disaggregated data to inform action.
- Consider how gender of data collectors may impact quality and accuracy of data collected.

Further reading

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Measure Evaluation (2018) Standard Operating Procedure for Integrating Gender in Monitoring, Evaluation, and Research, Measure Evaluation <https://www.measureevaluation.org/resources/publications/fs-17-247b>

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Lin V. et al. (2007) Comparative evaluation of indicators for gender equity and health, International Journal of Public Health, February 2007, Vol 52, Supp 1 <https://link.springer.com/article/10.1007%2Fs00038-006-6050-1>

Gardner J. (undated) Using gender statistics: A toolkit for training data users UNECE <http://www.unec.org/stats/gender/toolkit.html>



Photo |Emacaryan (talk | contribs)

5. Medical products and technologies

A well-functioning health system ensures equitable access to essential medical products, vaccines, and technologies of assured quality, safety, efficacy, and cost-effectiveness, and their scientifically sound and cost-effective use.

Except for the area of mHealth, there is very little analysis or awareness of how medical products and technology are gendered within the health system. For medicines, there is the assumption that all medicines have the same efficacy in all bodies. The essential drug list does not reflect the gendered health needs of specific country contexts, and no analysis has been done on how to enhance the gender-sensitivity of this very significant global initiative. We know, however, that poorly functioning pharmaceutical supply chains, which result in drug stockouts, disproportionately impact women due to their reproductive and care roles.

While technologies have massively advanced the field of health service delivery in a wide range of areas (e.g., diagnostics, data gathering, and referral), it remains within the broader social context and is subject to the influence of gender norms. Who decides what medicines and what technologies are important for a particular context (local, regional, national)? To what extent do these decisions explicitly aim to address gender inequities? How is the effectiveness of policies on access to medicines and technologies impacted by the social context of gender and power relations? Is the distribution of medicine and technology advantaging certain people (and thereby disadvantaging others)? Do persons of all genders (elderly, middle-aged, adolescent, young) have access to the medicines they need most?

Case studies

The gendered effects of medicine stockouts in Mozambique, Timor Leste, Northern Uganda, and Sierra Leone

This study analysed each of the building blocks of the health system against the benchmarks mentioned at the beginning of this guide. It found that in all of the countries under review there were frequent stockouts because of weaknesses in the supply chain. This impacted women most because of their reproductive and care giving roles. In Sierra Leone and Northern Uganda, stockouts led patients to pay for medicine. In Timor Leste, the lack of vaccines appeared to have a greater impact upon girls, who were less likely to be fully immunized than boys.

Resource

Percival V. et al. (2018) Are health systems interventions gender blind? examining health system reconstruction in conflict affected states, Globalization and Health, 14, Article number: 90 (2018) <https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-018-0401-6>

mHealth and sexual and reproductive rights in Bangladesh, South Africa, and India

Few people doubt that information and communications technology (ICT) innovation offers massive potential for changing the way healthcare is delivered, and health systems operate. There are already many successful mHealth (health initiatives typically involving mobile phones) programmes and pilots, such as the Mobile Alliance for Maternal Action, or MAMA, which operates in Bangladesh, South Africa, and India. MAMA uses social networking and mobile services to provide pregnant women and new mothers with stage-relevant health information.

The research found that as long as people do not have to share phones, and are literate, mHealth offers opportunities to ensure that patients' privacy is protected. Health workers can relate directly to the patient, and share confidential information, which the patient can revisit and reread in his or her own time. It also allows people – especially young adolescents – the opportunity to ask questions anonymously. This provides them with protection while enquiring about stigmatised or taboo behaviours.

However, mHealth also disseminates information to the telecommunication companies and private companies that fund these projects. As long as the messages are relayed through SMS (Short Message Service) formatting,

or through mobile platforms online, companies can access a wealth of information about the people using the platforms or services. This includes names, ages, numbers of children, sexual interests, and health and illness information. How this information is used is not obvious, and the long-term consequences of tailored marketing for the poor, on issues of sexuality, pregnancy and ill-health, have yet to be explored.

One of the main attractions of mHealth is its ability to supplement the lack of health services and health information in rural and remote areas. Mobile phones, now ubiquitous throughout low- and middle-income countries, offer an attractive combination of speed and remote telecommunication technology. Telemedicine, referrals, health apps, and the provision of timely information can all help poor rural communities, reducing the need for clinic visits and out-of-pocket health expenses. Yet, while many of the rural poor (particularly men) might own mobile phones, there are few political or financial incentives to address the hardware deficits. There remains a lack of broadband connectivity in many rural areas as privately-owned telecommunication companies benefit little from ensuring infrastructural developments in 'the last mile', and governments do little to help women access and own mobile phones. Without political will, or incentives, it is possible that mHealth will create new forms of rural health.

There is no official guidance on the use of ICTs for the provision of adolescent sexuality information, and the sites tend to be moderated by technical, as opposed to content, experts. Finally, there is little opportunity or incentive for the developers of these online platforms to follow up with health-related information on contested areas (abortion, contraception, pornography) or to better connect online fora with health systems.

ICTs and mobile phones have already changed our world, and more transformation lies on the horizon. But will mobile phones provide solutions to health system challenges, and address the needs of the poor around the world? The answer lies in whether we can address underlying gendered and other power relations, recognise hidden challenges, and foresee long-term consequences.

Resource

Waldman L. and Stevens M. (2015) Sexual and Reproductive Health Rights and Information and Communications Technologies: A Policy Review and Case Study from South Africa, IDS Evidence Report, No 113 <https://www.ids.ac.uk/publications/sexual-and-reproductive-health-rights-and-information-and-communications-technologies-a-policy-review-and-case-study-from-south-africa/>



Photo ID: Hoel_080521_DSC8746

What can policy makers do?

- Prioritise social accountability and efficiency of procurement and supply systems with community involvement to bring to light gender-related issues.
- Recognize that medical products may affect men and women differently, and commission studies to explore these differences.
- Ensure that essential drug lists reflect the gendered health needs of men, women and people of other genders and ensure that essential medicines needed for gender-specific care are available.
- Engage with diverse members of the community to assess the impact of technological innovation on both health and other indicators (time, resources, empowerment, etc.)
- Recognise the role of technology and gender in health system-related policies, including in relation to maternal health and sexual and reproductive health policy.

Further reading

Waldman L. (2015) mHealth and Gender: Making the Connection, RinGs Brief <https://ringsgenderresearch.org/wp-content/uploads/2018/07/mHealth-and-Gender-Making-the-Connection.pdf>

Steege R. et al. (2018) “The Phone Is My Boss and My Helper” – A Gender Analysis of an MHealth Intervention with Health Extension Workers in Southern Ethiopia.” Journal of Public Health 40, no. suppl_2 (December 1, 2018) https://academic.oup.com/jpubhealth/article/40/suppl_2/ii16/5247465

Waldman L. et al. (2018) “We Have the Internet in Our Hands”: Bangladeshi College Students’ Use of ICTs for Health Information.” Globalization and Health 14, no. 1 (December 2018) <https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-018-0349-6>

6. Health financing

Health financing is the accumulation and allocation of funding by and within the health system to ensure service quality and access. Often, this includes preventing severe financial hardship as a result of ill-health. The extent that financial protection is available to different groups needs to be considered, in addition to how out-of-pocket expenditure is experienced differently by men, women, and people of other genders. This affects policy makers' ability to deliver Universal Health Coverage.

In many low- and middle-income countries, insurance schemes and publicly funded health services have limited availability, compelling people to pay for their own healthcare. Incurring out-of-pocket expenses for services adversely affects women. This reflects hardship and injustice as women tend to have lower incomes, and less control over their incomes, and yet have to pay for health services that are more likely to not be covered by financial protection schemes. Financial protection packages (i.e. prepaid health services under Universal Health Coverage schemes) often exclude essential and routine sexual and reproductive health services, such as childbirth and emergency obstetric care, family planning, cancer care, such as for prostate cancer, and safe abortion. There has been little investigation of the gendered elements of insurance schemes.

Even when services are free, there are gendered opportunity costs, for example, women may have less access to transport, which enables access to services. Services may be offered at times that do not meet the needs of those who work full time, which is often the case for men.

Case studies

Pro-poor health financing reforms in Kenya: an exploration of intersections of gender, disability and poverty in influencing equitable access

Glaring inequities in access to healthcare services exist among the poor in Kenya despite the existence of health financing reforms that target them, especially poor disabled women who experience unique barriers when accessing healthcare services.

This research uncovered that women with disabilities living in poverty often opted to forgo seeking free healthcare services because of their roles as the primary household providers and caregivers. Due to limited mobility, they needed someone to accompany them to health facilities, leading to

greater transport costs. The absence of someone to accompany them, and high transport costs, meant that some women did not seek antenatal and skilled delivery services despite the existence of a free maternity healthcare programme.

The layout and equipment at health facilities offering care under pro-poor health financing policies were disability-unfriendly. Also, the healthcare workers had negative attitudes towards women with disabilities, which discouraged them from seeking care. Negative stereotypes against women with disabilities in society led to their exclusion from public participation fora thereby limiting their awareness about health services.

Intersections of gender, poverty, and disability therefore influenced the experiences of women with disabilities living in poverty, with pro-poor health financing policies in Kenya. Addressing the healthcare access barriers they face requires a mixture of demand- and supply-side interventions including ensuring availability of disability-friendly health facilities, and public transport systems, building cultural competence in health service delivery, and facilitating their participation in society.

Resource

Kabia E. et al. (2019) "We are called the et cetera": experiences of the poor with health financing reforms that target them in Kenya, International Journal for Equity in Health, 18, Article number: 98 (2019) <https://equityhealth.biomedcentral.com/articles/10.1186/s12939-019-1006-2>

Kabia E. et al. (2018) How do gender and disability influence the ability of the poor to benefit from pro-poor health financing policies in Kenya? An intersectional analysis, International Journal for Equity in Health, 17, Article number: 149 (2018) <https://equityhealth.biomedcentral.com/articles/10.1186/s12939-018-0853-6>

Male involvement in the National Health Insurance Fund (NHIF/KfW) prepaid insurance card for pregnant women in Pangani District, Tanzania

In 2010, the National Health Insurance Fund (NHIF) of Tanzania piloted a programme aimed at improving maternal and child health through the provision of insurance coverage to poor families. The pilot programme used the NHIF platform to support and strengthen expansion of social health insurance coverage to the informal sectors by providing free maternal and child health insurance cards named NHIF/KfW prepaid insurance card to poor pregnant women and their newborns in selected regions of Tanga and Mbeya.

In Pangani District men were involved in the implementation of the NHIF/KfW prepaid insurance card scheme in various ways: during its design; inauguration; registration; and in community sensitization at the village level and health facilities. At healthcare facilities, women are encouraged to attend with their partners during antenatal visits. This is to ensure they are all tested together for HIV, as well as educated on how to take care of the pregnancy and prepare for delivery. Participants often stated that while men increasingly go with their wives for their first antenatal care (ANC) visit and tests for a number of diseases together, they were not always told about the insurance programme while at the facility.

Maternal and child healthcare services should be free of charge as per the healthcare policy. However, in many cases families and partners incur costs related to transport and purchase of supplies. During the implementation of the project, the costs related to the service provision to the women and the family were borne by the programme. This encouraged male involvement because they were sure that they wouldn't pay for extras at the point of provision.

Women had different views with regard to men's involvement in the provision of reproductive and child healthcare services. It is not a usual thing to see a man accompanying the partner as well as carrying a baby to the hospital. In addition, a number of women claimed that they did not involve men directly when they went for ANC services and registered for the programme because men were at work. This reflects the perception that the role of men in the community is to work and that women should care for the family.

Participants identified strategies to improve male involvement in the implementation of the NHIF/KfW prepaid insurance card. Communication between partners was one of the ways to increase men's involvement. Some of the men who have been involved in the programme are now responsible in taking their children to the health facility for growth monitoring and when they are sick. In the villages, there are routine meetings every three months which could be used to discuss the scheme. Men pointed out that one strategy to increase their participation is education, as they would gain more knowledge about healthcare services and what happens in the facilities.

Programme implementation together with health system factors, economic factors and social norms act as facilitators and barriers in terms of male partner involvement in the implementation of the NHIF/KfW insurance programme. Largely these factors were complex and

interrelated. Improvement in the healthcare provision and community sensitization of the importance of male partner involvement in the implementation of maternal and child healthcare programmes should be prioritised to improve their participation and mitigate the effect of socio-economic and cultural factors.

Resource

Kassimu T et al. (2016) Male involvement in the National Health Insurance Fund (NHIF/KfW) prepaid insurance card for pregnant women in Pangani District, Tanzania, RinGs Blog <https://ringsgenderresearch.org/male-involvement-in-the-national-health-insurance-fund-nhif-kfw-prepaid-insurance-card-for-pregnant-women-in-pangani-district-tanzania/>

What can policy makers do?

- Integrate gender concerns into stakeholder consultations and policy development related to Universal Health Coverage.
- Conduct a gender audit of essential health packages to ensure that gender equity is a focus.
- Introduce financing mechanisms and initiatives that reduce direct and indirect costs for those with least financial access.
- Ensure that research into out of pocket expenditure and the benefits of various health insurance schemes include a gender analysis.
- Ensure that financial protection packages (i.e. prepaid health services under Universal Health Coverage schemes) include essential and routine sexual and reproductive health services, such as childbirth and emergency obstetric care, family planning, cancer care, such as for prostate cancer, and safe abortion.

Further reading

Witter S. et al. (2017) Minding the gaps: health financing, universal health coverage (UHC) and gender, Health Policy and Planning, Volume 32, Issue suppl_5, December 2017 <https://ringsgenderresearch.org/resources/uhc-financing-universal-health-coverage-gender/>





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