L4UHC
LEADERSHIP FOR UHC

GENDER IN THE LEADERSHIP FOR UHC PROGRAMME

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PURPOSE OF THIS NOTE

The aim of this note is to prompt reflection by the country action groups within the L4UHC programme on the gender and equity implications of their planned actions for UHC and whether there are adaptations which could make them more gender equitable and inclusive. While UHC, with its universalist approach, is inherently focused on extending coverage and so including more population groups, it does not necessarily proceed in an equitable (and gender-equitable) manner, unless strategised as such.

Definition

Gender = *Socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women and people of other genders (WHO). They vary from society to society and can be changed.*

WHY GENDER AND INTERSECTIONALITY MATTER

Women make up half of the global population and face discrimination in many societies – in relation to rights, employment, education, protection, and access to resources, all of which impact on their and their children's access to health care. In addition, women often face barriers in the health care workforce – dominating in low-paid, caring roles, and underrepresented in the managerial cadres. However, paying attention to gender is not just about a concern for women, it requires a focus on barriers to care and exclusion, whatever form they may take in different contexts. In some settings, men face barriers. LGBTI (lesbian, gay, bisexual, transgender, and intersex) populations commonly also face discrimination in accessing services. Moreover, these gendered aspects are often overlaid by other factors which may create exclusion – such as class, caste, ethnicity, disability, marital status (e.g. widowhood), location or nationality (e.g. migrants), health condition (e.g. HIV-positive) or religion. Underlying these features is an unequal distribution of power. In aspiring to leave no one behind with UHC, it is important to consider these intersecting factors when designing and implementing UHC reforms.

Health systems are not gender-neutral: Gender is a key social stratifier which affects health system needs, experiences, and outcomes. It influences:

- Vulnerability to ill-health.
- Household decision-making and health-seeking behaviour.
- Access to and utilisation of health services.
- Design and use of medical products and technology.
- Nature of the health labour force.
- Implications of health financing.
- What data is collected and how it is managed.
- How health policies are developed and implemented.

ASPECTS TO CONSIDER

This note does not aim to give comprehensive guidance on this topic, but to provide prompts for country teams to reflect on. Underlying structural drivers are critical but here we focus on specific actions within the health system sphere.

The table below highlights some questions to ask of health financing arrangements, for example:

Health financing function	Examples of gendered questions
Revenue raising	**1.** Fairness of financial contributions: who is paying for health care? How is that changing over time? **2.** How far does the burden fall disproportionately on one sex? **3.** What is the gender implication of changing revenue sources (e.g. out of pocket likely to fall heavily on women; prepaid mechanisms may be more protective)? **4.** How do different payment systems affect men and women's access to health care? **5.** How are they affected by household arrangements (livelihoods, access to cash, decision-making power etc.) and how do they affect these in turn? **6.** What is the pattern of private and public funding and what does that mean for meeting the needs of different population groups?
Risk pooling	**1.** Who is protected under different risk pooling systems (tax-based, insurance, prepaid mechanisms etc.)? **2.** How effective are the risks pools in protecting men and women against health shocks (ensuring access and also financial protection)?
Resource allocation	**1.** How do patterns of resource allocation at different levels (national, regional, district) and within different systems and schemes affect equity of access and use for both genders, as well as quality of care? (Not just allocation of funding, but also infrastructure, human resources etc.)
Purchasing	**1.** Which programmes are being prioritised for funding and how do these reflect different gender needs? **2.** Does the public/private mix serve the interests of both men and women effectively? **3.** Are gender-sensitive services being purchased (e.g. facilities which provide confidentiality, sensitivity, right staffing mix, at appropriate opening times etc.)? **4.** Are provider payment mechanisms incentivising appropriate and high quality services for both genders?
Benefits package	**1.** Is there a clear and fair entitlement to services? **2.** Are different genders equally aware of them and able to access without stigma? **3.** Do utilisation patterns suggest that needs are being fairly met across the genders, or are there remaining financial and social barriers?
Health financing governance	**1.** Is there adequate and fair representation of different genders in health financing governance structures? Who is represented in health facility management committees, for example? Who decides on resource allocations? **2.** Does the regulatory system ensure fairness and quality of care for both genders?

Source: Witter, S., Govender, V., Ravindran, S. and Yates, R. (2017) Minding the gaps: health financing, universal health coverage and gender. *Health Policy and Planning*, 32 (5), v4-12.

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ACTIONS TO IMPROVE GENDER EQUITY IN UHC

Typical actions to improve gender equity in UHC might, in varying contexts, include the following:

Health financing

- Ensuring that social health insurance policies do not encourage female exclusion (e.g. by covering households, not just individuals, and having good provisions for coverage of the informal sector and household-based, unpaid workers).
- Ensuring that health care packages covered by social health insurance and other entitlements include priority services for women and girls (e.g. reproductive health care, including family planning; gender-based violence services; prevention and treatment of cervical cancer etc.) at facilities which are used by the bulk of the more vulnerable populations.
- Reducing dependence on cash in societies where women have less access to flexible resources (e.g. by removing fees for essential services, however small). Typically, this implies increasing public and pooled financing.
- In some cases, demand-side financing, such as targeted vouchers or cash transfers, may be needed to address non-facility financial barriers to accessing care.
- Ensuring that human rights are protected (e.g. by stopping coercive practices such as the detention of women or babies when facility bills are unsettled).

Service delivery

- Making service availability more acceptable (e.g. appropriate gender of providers, introducing zero tolerance for disrespectful treatment of women, ensuring confidentiality and minimum quality standards).
- Making service availability more accessible (e.g. in places and at hours when women, girls and vulnerable groups can safely reach them).

Leadership and governance

- Ensuring that the voices of vulnerable groups are heard within governance and accountability structures from national to local level (e.g. health facility committees or district steering groups).
- Ensuring that laws, regulation and policies address appropriately sensitive services such as female genital mutilation (FGM) prevention, treatment of fistulae, safe abortion care, and comprehensive sexuality education.
- Considering potential unintended negative effects of UHC reforms during planning stages – what adaptations might be prudent to ensure that they at least cause no (gendered or equity) harm?
- Promoting effective communication of health care entitlements to all population groups.

Human resources

- Ensuring equitable access to training and promotion for health staff and community providers.
- Providing training in gender-based violence and its management for all staff, including how to encourage safe reporting.
- Ensuring protection of health staff against violence and discrimination (e.g. during pregnancy and child rearing years).

Supplies and infrastructure

- Ensuring that essential commodities are available at service points most used by vulnerable groups, to avoid the (frequent) problem of cost-shifting, when patients have to fill supply gaps through private purchases.
- Ensuring appropriate choice of commodities to meet needs of different groups (e.g. in family planning commodities).
- Ensuring that facilities are matched to population distribution, are safe to access and have adequate water and sanitation facilities.

Health information and data

- Improving the disaggregation of data so that ongoing exclusion and vulnerability for different population groups can be tracked and acted on (ensuring that benefits of policies and services are not disproportionally captured by better off groups, for example).
- Ensuring that monitoring and evaluation reflect gendered considerations.

FURTHER READING

Morgan, R. et al. (2016) How to do (or not to do)… gender analysis in health systems research, *Health Policy and Planning*, Volume 31, Issue 8, Pages 1069–1078.

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Sen, G. (2018) Universal Health Coverage, Gender Equality and Social Protection: A Health Systems Approach. Background paper for UN Women.

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