



Research in Gender and Ethics (RinGs):
Building stronger health systems



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Ten arguments for why gender should be a central focus for universal health coverage advocates

To make universal health coverage (UHC) truly universal we need an approach which places gender and power at the centre of our analysis. This means we need a discussion about who is included, how health is defined, what coverage entails and whether equity is ensured.

To celebrate Universal Health Coverage Day RinGs has put together a list of ten arguments for why gender should be a central focus within UHC. If you agree, spread the word. Mail this list to a colleague or put it up on your website. If you think of other arguments in favour of a gender approach do let us know!

“Issues of gender inequity ... impede public health and development. Any effort toward universal health care ... must at inception be aligned with the broader goals of improving the status of women and girls in the country, or be destined to fail.” Raj

“Developing gender equitable health systems is central to making universal health coverage a reality. Our analysis of health systems reconstruction ... shows that the focus on physical reconstruction of health facilities needs to be matched with implementation of gender equitable financing mechanisms to ensure those most in need are not excluded from accessing vital services” Ssali, RinGs steering committee

1. Gender affects both vulnerability to illness and access to health care.

Gender influences how women, men, and people of other genders perceive, behave, interact and this impacts the social experience of being sick, seeking and receiving care. For example, gender norms and relationships in the Dominican Republic mean that women with lymphatic filariasis experience more social exclusion and shame than men, which in turn affect their health care seeking.





2. Gender combines with other social determinants in varied ways. How gender is experienced can change when interacting with other forms of inequality, such as age, poverty, geography, caste, race, ethnicity, disability, and sexuality. Women and men from different socio-economic or ethnic groups can have vastly different experiences of the health system, which influences their access to health care, their treatment by health professionals, and their health outcomes. In rural India, while non-poor men and poor women were at opposite ends of ability to access care, among middle groups, non-poor women and poor men had similar health care seeking outcomes, but their decision-making and pathways differed significantly.

3. Recognise power if you want to tackle inequalities in health systems. Marginalized people (ethnic minorities, inhabitants of informal settlements, people employed in illegal occupations, etc.) may have different access to health care or receive different treatment by health care workers compared to others. Power relations between individuals (for example, husbands and wives or health care professionals and patients) influences the effectiveness of policies and programmes to achieve universal health coverage. Despite being inclusive of the poorest, community based insurance in India still generated inequities among rural populations with those more financially better off, closer access to care and men submitting more claims than other populations. Moreover,

access facilitated by insurance was not always appropriate with insured women having higher rates of hysterectomies and hospitalisation for fever due to the lack of effective and quality primary care services.

4. Coverage can't be universal if some services and service users are routinely left off the list. 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 delivery and emergency obstetric care, family planning, and safe abortion. Where sexual and reproductive health care is offered, it often exclusively focuses on maternal health and doesn't address the needs of adolescent girls and older women or men. Trans people all over the world survive despite inadequate provision of services and financial coverage.

5. Coverage can't be universal unless it extends to all contexts. Universal health coverage will not be achieved without additional research, resources and health system development in fragile and conflict affected contexts. Realising universal health coverage in these neglected contexts means understanding and addressing the ways in which gender, power and conflict shape the experiences and needs of different communities and their ability to access services, as well as ensuring efforts to support and rebuild health systems meet the needs of all citizens.



6. Paying out-of-pocket expenses for services adversely affects women.

This reflects hardship and injustice as women tend to have less income and less control over it and yet have to pay for health services that are more likely to not be covered by financial protection schemes.

7. Health system researchers must factor gender into their research.

To properly understand whether health systems are universal, we need data disaggregated by sex as a matter of good practice, regardless of whether sex or gender is perceived to be a factor. Once identified, inequities need to be recognised and addressed. If this doesn't occur we will continue to put in place policy and programmes which are inefficient and discriminatory.

8. Policy makers need to use evidence that incorporates gender and power in their decision making around access to services.

For example, social roles for women in many societies include childcare and infant feeding and a potential consideration would be whether health facilities provide services for women and children at the right times (daylight, after school timings), with appropriate conditions (shelter from sun/rain in the waiting area, functional toilets, separate lines or waiting rooms for men and women), and with appropriate staff (breastfeeding consultants, female clinicians). When health centres are predominantly seen to cater to maternal and child health, mechanisms need to be explored to ensure access for men and other women.

9. Gender permeates all aspects of the health system and must be dealt with on different

levels. Gendered norms affect the health workforce (whether informal care provided at home is recognized and supported, recruitment and retention policies, staff security in remote areas or slums, maternity policies, workplace harassment policies and procedures). We need to address the gendered needs of all health workers, including close-to-community health providers who act as bridges between marginalised communities and health systems and are critical to universal health coverage. Gender also affects health financing (budgets for gender audits, the extent of financial protection available to different groups, out-of-pocket expenditures of different groups); and governance (representation of women and men in planning and oversight of all areas of health care; male involvement in maternal and child health).

10. We need this conversation to take place within and beyond the health system.

For example, men usually have more power and privilege than women, but they also have particular health needs. Men may be more likely to do dangerous jobs which can cause illness and disability, they are often influenced by harmful gender norms which encourage risk-taking, and in many settings they are less likely to visit a doctor when they are ill. Addressing these harmful manifestations of gender norms will require work beyond the health sector. We need to work with government ministries tasked with dealing with financing, gender, employment, education, and equality. Universal health coverage truly is everyone's concern.



Research in Gender and Ethics (RinGs): Building Stronger Health Systems, is a project bringing together three health systems focused RPCs: Future Health Systems, ReBUILD and RESYST to galvanise gender and ethics analysis in health systems. For more information about RinGs and our activities visit <http://resyst.lshtm.ac.uk/rings>.

Want to read more? This article is based on:

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