Learning Support

Gender and Health Systems
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International
Cooperation
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Introduction

Richard Horton writing recently in the Lancet said that Sustainable Development Goal 5 – the goal committing countries to achieve gender equality is the neglected Sustainable Development Goal for health (Horton 2015). Gender analysis is critical to building more responsive health systems and promoting universal health coverage.

This learning support tool is designed to complement current EC resources on gender, and help EC delegates to consider a range of gender sensitive health responses to operationalise within their complex portfolios of health systems strengthening projects and in the context of the EU second Gender Action Plan 2016-2020 (GAPII)[1]. Initiated by the DEVCO B4 health team, following the launch of the GAP II, during the fall of 2016, it was developed with the support of gender global health experts (Professor Sarah Hawkes, Professor Sally Theobald, Dr. Joanna Raven and Dr. Rosemary Morgan) in interaction with EC health staff in delegations, with contributions from Zimbabwe (Dr. Beatrice Ndarugirire) and Guinea Bissau (Dr. Joan Casanova). Other complementary resources include a u-tube video and a brief from the interactive health thematic seminar held with EC delegates on Weds 28th Sept, 2017[2].

The learning resource is structured as follows

- Part 1 ***"Definitions and concepts with links to different resources*** defines key gender concepts and links to relevant open access tools, resources and frameworks here which can be applied to support gender analysis in different contexts and across different health systems issues.

- Part 2 ***Sharing experiences: learning from difference*** has 2 components.

    - The first uses 3 case study examples of different health areas (tobacco, tuberculosis and mental health) to explore how gender influences rates of risk-exposure to common drivers of ill-health, patterns of health-care seeking for women and men and analyses and assesses the implications for health systems and global health institutions.

    - The second component illustrates how gender analysis applies to specific health systems contexts – those which are fragile and conflict affected, drawing learning from across the health systems building blocks and identifying the attributes and processes required for a gender equitable health system.

- Part 3 ***What did we learn in the 2016 health thematic seminar?*** synthesises learning from EC delegates' ongoing work in Zimbabwe and Guinea Bissau, highlighting how common challenges of

[1] Joint staff working document "Gender Equality and Women's Empowerment: Transforming the Lives of Girls and Women through EU External Relations 2016-2020", European Commission, Brussels, 21.sept.2015
Council Conclusions on the Gender Action Plan 2016-2020, 26 oct. 2015

[2] free access to the Video:
http://capacity4dev.ec.europa.eu/public-gender/blog/qa-gender%E2%80%99s-impact-healthcare-systems-sally-theobald-and-sarah-hawkeshttp://capacity4dev.ec.europa.eu/public-health/blog/qa-gender%E2%80%99s-impact-healthcare-systems-sally-theobald-and-sarah-hawkes-0
https://www.youtube.com/watch?v=Iy4lXY4Gai4#

gender equity can be addressed through both multi-stakeholder and multi-sectoral collaboration to improve health outcomes for all.

Part 1: Definitions and concepts with links to open access different resources

Concept	Definition	Resources
Gender	The 'socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for men, women and people of other genders. As a social phenomenon, the meaning of gender is negotiated by individuals and societies and therefore varies over time and across contexts; in contrast to sex, which refers to the chromosomal characteristics that distinguish men, women and intersex people. Gender affects how females, males and people of other genders live, work and relate to each other at all levels, including in relation to the health system.	Source: How to do (or not to do)… gender analysis in health systems research. (Morgan et al. 2016) Additional Resources: How to do gender analysis in health systems research: A guide. (RinGs 2016)
Gender identity	Gender identity: Gender identity is understood to refer to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms. Transgender refers to a state of gender incongruence – people who have a discordance between their own sense of their gender (their gender identity), and the sex assigned to them at birth.	The Global Fund Strategy in Relation to Sexual Orientation and Gender Identities
Gender Equity	The process of being fair to women and men, boys and girls and people of other genders. To ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men, boys and girls from operating on a level playing field.	Source: Gender-related Terms and Definitions (IGWG 2016) Additional Resources: Unequal, Unfair, Ineffective and Inefficient – Gender Inequity in Health: Why it exists and how we can change it (Sen et al. 2007) How can gender equity be addressed through health systems? (Payne 2009)

Gender Equality	The state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources. Genuine equality means more than parity in numbers or laws on the books; it means expanded freedoms and improved overall quality of life for all people.	Source: Gender-related Terms and Definitions (IGWG 2016) Additional Resources: How can gender equity be addressed through health systems? (Payne 2009)
Gender Analysis	The process of analyzing how gender power relations and roles affects women's and men's lives, creates differences in women's and women's needs and experiences, and how policies, services, and programs can help to address these differences.	Source: How to do (or not to do)… gender analysis in health systems research. (Morgan et al. 2016) How to do gender analysis in health systems research: A guide (RinGs 2016) Additional Resources: Gender Analysis Toolkit for Health Systems (Jhpiego 2016)
Gender Mainstreaming	The process of incorporating a gender perspective into organizational policies, governance, strategies, actions, administrative functions, and systems-related issues, as well as into the institutional culture of an organization. This process at the organizational level ideally results in meaningful gender integration as outlined below. One way to apply gender mainstreaming would be to consider its role when tackling the different health systems 'components or functions (please see below "health systems")	Source: Gender-related Terms and Definitions (IGWG 2016) Additional Resources: Gender mainstreaming for health managers: a practical approach (WHO 2011)
Gender Integration	Strategies applied in programmatic design, implementation, monitoring and evaluation to take gender considerations into account and to compensate for gender-based inequalities.	Source: Gender-related Terms and Definitions (IGWG 2016) Additional Resources: Gender mainstreaming for health managers: a practical approach (WHO 2011)
Gender analysis frameworks	A framework is a tool to help researchers, policymakers, and planners to organize thinking, research questions, data collection, and analysis. Gender analysis frameworks lead you through a process of thinking about and answering questions related to how different domains of gender power relations affect the topic or area of interest. Common domains of gender power relations include: who has what (access to resources); who does what (the division of labour and everyday practices); how values are defined (social norms, ideologies,	Source: How to do gender analysis in health systems research: A guide. (RinGs 2016) Additional Resources: Ten Gender Analysis Frameworks & Tools to Aid with Health Systems Research (RinGs 2015)

	beliefs, and perceptions) and who decides (rules and decision-making).	
Gender health impacts	Socially constructed (as well as biological) differences between men and women which lead to different health impacts. Gender can have an impact on health in various ways. As a power relation, for example, gender influences: vulnerability to ill-health; household decision-making and health seeking behaviour; access to and utilization of health services; the design and use of medical products and technology; the nature of the health labour force; the implications of health financing; and how health policies are developed and implemented.	Source: How to do (or not to do)… gender analysis in health systems research. (Morgan et al. 2016) Additional Resources: Addressing gender in impact evaluation: What should be considered? (Fletcher 2015)
Intersectionality	Intersectionality is an analytical lens which examines how different social stratifiers (such as gender, class, race, education, ethnicity, age, geographic location, religion, migration status, (dis)ability and sexuality, etc.) interact to create different experiences of privilege, vulnerability, and/or marginalization. These interactions occur at multiple levels and within a context of connected systems and structures of power (e.g. laws, policies, state governments and other political and economics unions, religious institutions, media). Experiences of privilege and oppression as a result of these interactions lead to differences in health outcomes. The common experiences of discrimination and social exclusion based on sexual orientation and gender identity (SOGI) has led to the identification of common measures for ensuring that the human rights of everyone are promoted, protected and realised. SOGI approaches include those that are particularly focused on people who experience discrimination/exclusion as well as the general population at large.	Source: 10 Best resources on... intersectionality with an emphasis on low- and middle-income countries. (Larsen et al 2016) How to do (or not to do)… gender analysis in health systems research. (Morgan et al. 2016) Additional Resources: Intersectionality 101 (Hankivsky 2014) The Global Fund Strategy in Relation to Sexual Orientation and Gender Identities Council of Europe recommendations
Health systems	A health system is defined as 'all organizations, people and actions whose primary intent is to promote, restore or maintain health'. The WHO breaks down the functions of the health system into a set of six essential 'building blocks': service delivery, human resources, health financing, leadership/stewardship/governance, information and research and supply	Source: How to do (or not to do)… gender analysis in health systems research. (Morgan et al. 2016) Everybody's business: strengthening health systems to improve health outcomes. (WHO 2007) WHO UHC revised version on Health systems http://www.who.int/healthsystems/publications/nhpsp-handbook/en/

	systems for medical products/technologies. Incorporating gender analysis into health systems strengthening seeks to explore how gender power relations leads to inequities in health system's needs, experiences, and outcomes, as well as the extent to which the research or planning process itself progressively transforms gendered power relations, or at least does not exacerbate them. In relation to the health system, gendered norms, for example, can affect the health workforce (e.g. whether informal care provided at home is recognized and supported; recruitment, retention and harassment policies); health financing (e.g. extent of financial protection availability to different groups, out-of-pocket expenditures); and governance (e.g. representation of women and men in planning and oversight of all areas of health care including individual and collective prevention). Within the broad SDG it is clear that gender shapes the social determinants of health, experiences of discrimination and access to (un) healthy environments, with complex and remote impacts on health status (such as violence or inequalities). This therefore requires strengthening leadership within and beyond health systems to address inequities in health experiences and outcomes. In short intersectoral action driven by a strong health leadership is also required. Gender Budgeting – Governments (and others) promote equality through their fiscal policies. Gender budgeting analyses the differing impacts of financial policies (including in the health sector) on women and men, and redirects funds, as necessary, to achieve targets of equality. Synergies with Health Systems Strengthening approaches and with the specifics of health financing should develop in context, at country levels.	Additional Resources: Gender Analysis Toolkit for Health Systems (Jhpiego 2016) Gender budgeting guide : Guide for the formulation of public budgets in the health sector using a gender perspective. UNWOMEN, 2004.

Northern Uganda – Ssali, Flickr

Directrelief, Flickr

Part 2: Sharing experiences: learning from difference

2.1. Gender, and its impact on health outcomes, health systems and global health institutional responses

Gender, defined by WHO as the socially constructed roles, behaviours, activities and attributes that any society considers appropriate for men and women, is an important determinant of health status – both acting alone and in its intersection with other drivers of health and illness, such as poverty, inequality, sexual orientation, age, socio-demographics, disability, education levels, race/ethnicity and biological sex. Gender influences rates of risk-exposure to common drivers of ill-health, patterns of health-care seeking, and the response of the health system and health workers to people's health care needs. Below we explore 3 health issues (tobacco, tuberculosis and mental health) and look at the impact that gender has on rates of illness as well as responses to illness among both individuals and health systems. These are not obviously not exhaustive and gender needs considering and addressing across all health issues and challenges including areas which are critical from a gender perspective: Gender Based Violence and Female Genital Mutilation, which are not the focus of this learning support brief. We then review the responses of major global health institutions in addressing gender and health.

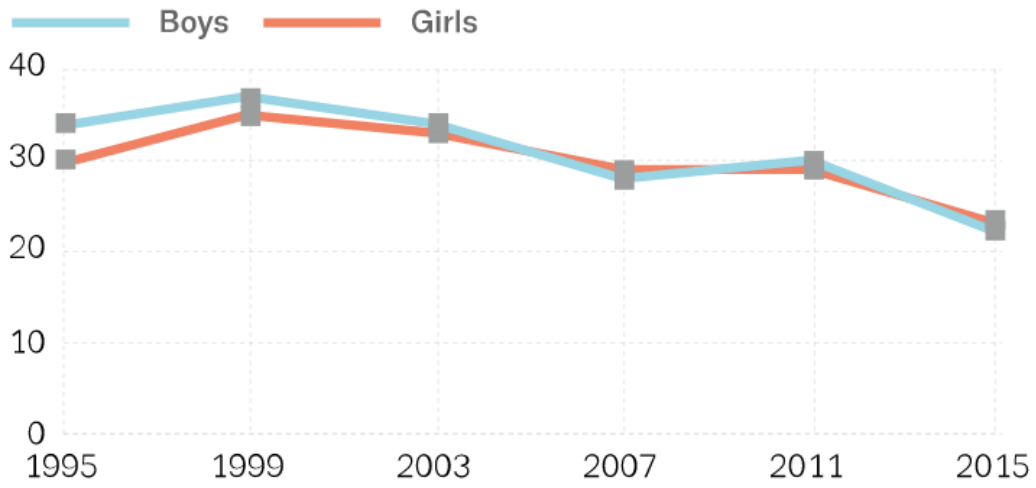
Tobacco and Gender: The quest for new markets

In 2015 WHO estimated that 1.1 billion people smoked tobacco, and approximately 6 million people died from the effects of tobacco; half of all smokers die in middle age (45-54 years). Tobacco use continues to increase in many countries – and is shifting more towards low- and middle-income countries (LMIC), including across Africa and much of Asia. Approximately 80% of smokers globally are in LMICs, according to WHO.. The proportion of smokers who are male far exceeds those who are female, and the large majority of deaths from tobacco occur in men. The disease burden associated with tobacco is three times higher in men globally than in women. Studies in some countries indicate that tobacco use among transgender people (as well as among lesbian, gay and bisexual people) is higher than in the rest of the population.

In addition to the gender differences in smoking rates by gender, there is some evidence of sex-specific differences in risks of illness. WHO reports that women are at risk of lung cancer at lower exposure rates compared to men, and also have faster rates of development of lung diseases such as chronic obstructive pulmonary disease. Men who are never-smokers but whose spouses are smokers have a higher risk of developing lung cancer compared to female never-smoking spouses.

Although the gender gap in tobacco-smoking rates are widest in Asia, Africa and the Middle East, the tobacco industry is currently targeting women (and particularly young women) in LMIC in order to make smoking more acceptable (Gilmore et al, 2015). These industry tactics build upon years of (successful) experience in persuading women in industrialised high-income countries to smoke. Women in the USA and Europe have been the target of tobacco marketing campaigns since the beginning of the 20th Century, and in public perception tobacco has been closely associated with fashion, body image (slim women) and emancipation. Surveys across 25 European countries with young people aged 15-16 years has shown a closing of the gender gap in tobacco smoking rates over the past 20 years, with slightly more girls than boys now reporting cigarette use in the past month – see Figure 1. With the recognition of Asia and Africa as "untapped markets", particularly among women and especially young women, similar marketing tactics and strategies are now being employed by tobacco companies to persuade young women in these settings to smoke.

Figure 1: Cigarette use by adolescents in past 30 days by gender, 25 European countries 1995-2015



Data are gathered from the European School Survey Project on Alcohol and Other Drugs (ESPAD). These surveys include 15- and 16-year-old respondents from 25 countries. Full data set available at: http://www.espad.org/report/trends-1995-2015/trends-across-25-countries

***Health system responses**:* Gender has an impact on how individuals respond to tobacco control measures, and should be taken into account when implementing the comprehensive public health measures promoted by the Framework Convention on Tobacco Control (FCTC, which is currently ratified by 180 countries globally). Experience in many countries has shown that women are slower to respond to public health campaigns to give up smoking, and may also be less likely to remain non-smokers. Conversely, men may be less likely to come into contact with health care professionals who can advise individuals on the risks of smoking and offer access to smoking-cessation programmes.

Given the gendered nature of risk-taking in relation to both using and stopping the use of tobacco, a gendered analysis of tobacco control programmes should be undertaken to determine specific risk mitigation strategies for men, women and adolescents.

Gender and Tuberculosis: insights on health systems and security

Tuberculosis (TB), which currently kills 1.5 million people per year, and causes illness in a further 7 million, mainly affects adults in their economically productive years, and 95% of cases are in LMIC. TB rates are higher in men than women with 60% of new diagnoses and almost two-thirds of deaths occurring in men. One reason for the gender difference may be that health systems in limited resource environnments emphasise diagnosis of pulmonary TB and are generally poorly equipped to detect the most current form of TB among women, which is extra-pulmonary TB[3]. Risk of developing TB is strongly associated with other gender-influenced health issues, namely tobacco and HIV. TB is a leading cause of death among people who are HIV positive – including among HIV-positive women who are more likely to die from TB than are HIV/TB co-infected men. In southern Africa, the gender-gap in TB diagnosis rates and mortality rates has all but

[3] Rieder H. Epidemiologic Basis of Tuberculosis Control. First edition 1999. IUATLD, Paris

disappeared, and TB is now estimated to have killed more women than men – with HIV rates playing a significant role in the TB figures.

The gender gap (excess male disease and male mortality) is widest among people who are HIV negative – and mortality rates may be more than twice as high in men compared to women. The reasons for these observed differences are not clearly understood but in the case of incident diagnosis it may be due to a combination of both sex and gender. Men may be biologically more vulnerable to infection with the TB bacillus, but, conversely, TB may be more difficult to diagnose in women – possibly due to less severe symptoms, a higher rate of sputum-negative diagnostic test results and a form of TB whose diagnosis requires access to X-ray services.

Gender plays a role in these differences in TB rates between men and women. Exposure to tobacco smoke is significantly associated with tuberculosis – including risk of recurrent disease and risk of death. Current differences in tobacco use by gender may explain some of the differences between TB rates seen in men and women (WHO, 2002). The shift in gendered norms of smoking rates may have an impact on TB rates as more women are predicted to take up smoking in the future in countries where TB is prevalent. Other aspects of predominantly male behaviours are also thought to contribute to higher rates of TB in men. TB is associated with certain occupations – particularly mining, but may also be associated with alcohol use – which, again, is predominantly a gendered behaviour more common in men globally.

Pregnant women who are living with HIV/TB coinfection have a high risk of adverse outcomes including maternal mortality (double the risk), infant mortality (risk increases three-fold), and mother-to-child transmission of HIV (2.5times higher). Diagnosing TB during pregnancy is challenging as the symptoms can be non-specific.

Health behaviours and health system responses: The evidence on the contribution of gender compared to sex in the observed differences in rates of TB diagnosis in men and women is somewhat contested. As noted, the contribution of sex-related differences may play some role in contributing to the higher rates of TB in men, but gender-driven differential exposure to risk factors (smoking, alcohol, occupation) plays a role too. Lower rates of TB diagnosis in women may be driven by poorer access to health services (including inability to pay), or by higher rates of stigma and shame experienced by women with a TB diagnosis compared to men – thus making women more reluctant to seek care. There is some evidence from some countries (but not others) that women delay treatment seeking for longer than men do.

Once women reach health care, some evidence suggests that they have longer wait times for both diagnosis and treatment compared to men, and that some diagnostic procedures (testing of sputum) may be misunderstood by women in some settings – presumably due to the inadequacy of explanations provided by health care workers and how these can be shaped by gender. Conversely, the time-consuming nature of TB treatment regimens may act to dissuade some men from treatment programmes (either starting or completing them) due to loss of income opportunities – and evidence has shown that men are less likely to complete a full course of treatment compared to women. Community-based approaches to TB diagnosis can counter the barriers women face in accessing TB diagnosis (Yassin et al, 2013); and may also help men to achieve better rates of treatment adherence.

Gender and mental health: asymmetric determinants and the struggle for measurement

Gender is a strong determinant of mental health outcomes – and common mental disorders (depression, anxiety, somatic complaints) are more common in women than in men (WHO, n.d.). For example, unipolar depression is twice as common in women compared to men, and this is seen across a wide variety of societal and social contexts. Furthermore, transgender people have

higher rates of mental health disorders than the rest of the population – with strong evidence of higher levels of depression.

Other mental health issues are more common among men – alcohol dependence is more than twice as frequently seen in men compared to women, and men are three times more likely to be diagnosed with an antisocial personality disorder than women. In contrast, the severe mental illnesses (bipolar disorders, schizophrenia, etc) are equally common among men and women.

Why do we see these marked differences in rates of common mental disorders between men and women? Some of the differences may be driven by exposure rates – for example, exposure to poverty, gender-based violence and socioeconomic disadvantage may predispose women to becoming anxious or depressed. Women's lower social status in many societies may also contribute to feelings of isolation, hopelessness and despair. In contrast, the reluctance of men to admit to signs of "weakness" associated with mental health issues may lead them either to use alcohol (and other substances) more frequently than women, or may contribute to their higher willingness to admit to alcohol use during a consultation with a health care provider.

***Health system responses**:* Evidence from studies around the world shows the impact that gender norms and stereotypes have on both the diagnosis and treatment of mental health issues in women and men. In general, however, it should be realised that a large proportion of people with mental health disorders do not seek or receive any kind of health care.

While patterns of health care seeking are influenced by a wide range of factors, including health care financing and insurance coverage (where present), in general it has been found that women with mental health problems are more likely to seek care at primary care levels, while men are more likely to see a specialist and to receive inpatient care.

Women and men presenting with the same symptoms or the same scores on standardised measures of depression will experience differences in diagnosis – women are more likely to be diagnosed as depressed, and men are more likely to be diagnosed as having a problem with alcohol; although the latter may be somewhat confounded by the greater willingness of men to admit to alcohol abuse. Aspects of comorbidity (e.g. men who are depressed and also abuse alcohol, or women who are both anxious and depressed) are often overlooked – which has a particularly high impact on women who are generally more likely to have comorbidities compared to men. Once a diagnosis has been given, women are more likely to be prescribed psychotropic drugs compared to men.

THE RESPONSE OF GLOBAL HEALTH INSTITUTIONS

In the preceding few pages we have looked at three examples to illustrate **the complex relationships between gender and health outcomes. Gender rarely acts alone to directly influence health, but instead intersects with other variables to determine health exposures and risks, as well as define the nature of how the health system and health care providers respond to individuals**. Looking at the case of one health risk (tobacco use) as well as evidence from both communicable (tuberculosis) and non-communicable (mental health) diseases, we have seen that gender plays a pivotal role in determining health behaviours (rates of risk exposure as well as patterns of health care access and seeking), and also influences both rates of diagnosis as well as the kinds of treatment that individuals may receive.

The influence of gender on health outcomes is pervasive across the health and wellbeing outcomes of men, women and people of different genders. **There is no simple 'rule' that determines whether or not any particular gender confers greater advantage or disadvantage on health status** – and as we have seen from the three examples above, the

impact of gender needs to be considered and addressed across the entire health sector response and in intersectoral partnerships and collaborations.

So how do the global health institutions respond to this strong body of evidence around the influence and impact of gender on health? The ability of global health institutions to recognise, understand and address the influence of gender on health has been characterised as "missing, misunderstood and sometimes mainstreamed". Reviews of major actors in global health (funders, normative agencies, programmes, partnerships), find that despite the adoption of a goal gender mainstreaming over 20 years ago (dating from the Beijing Platform for Action in 1995), the reality for many health institutions is that gender is seen as something pertaining to "addressing gender inequalities and strengthening the response for women and girls" – with the result that **policies and programmes tend to focus entirely on the health needs of women and girls, and particularly on their needs in relation to sexual and reproductive health (**Hawkes and Buse, 2013, Payne and Doyal, 2015**)**. For a large number of influential global health institutions, gender is absent from their strategic plans and core aims. Gender approaches often fail to **consider both the impact on and the involvement of men in strategizing for change**.

A recent review of 18 **global public-private partnerships in health**, for example, found that only 3 of the partnerships had a specific gender strategy – and that in all three strategies gender was defined as a focus on women and girls (Hawkes et al, 2017). A further 5 partnerships included mention of gender in their overall strategies, but none referred to the health needs of men and boys. Only one of these global partnerships (addressing TB) had embraced the notion of gender sensitive policies and gender-specific approaches that "strengthen the response to fulfil the right to health of women and girls, men and boys in all their diversity". Among CSOs, the ability to embrace the relevant power dimensions and targets for action, beyond an initial focus on women's SRHR, appear to come with the maturity of projects and NGOs[4].

These results from the global health community are disappointing, but, as noted in the introduction to this document, there are a wide variety of tools and guidelines that institutions can use to both conduct gender assessments and design and implement gender-equitable responses to realise everyone's right to health.

2.2. Gender and Health Systems Strengthening Approaches in Fragile Contexts

Gender affects all levels of the health systems and we need to address gender inequities from a health systems perspective in all contexts. The WHO Building Blocks are a good starting point here. Table 1 below, presents learning of missed opportunities to promote gender in health systems from a literature review and from case studies in fragile and conflict affected contexts: Sierra Leone, northern Uganda, Mozambique and Timor Leste.

There is also need to address gender in humanitarian responses[5], and specifically address gender within different crisis situations such as Zika[6] and Ebola[7]. This section does not specifically refer

[4] http://www.coordinationsud.org/document-ressource/etude-etat-lieux-de-lintegration-genre-organisations-francaises-de-solidarite-internationale/

[5] http://gbvguidelines.org/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf

[6] https://www.chathamhouse.org/publication/ia/gendered-human-rights-analysis-ebola-and-zika-locating-gender-global-health

[7] http://resyst.lshtm.ac.uk/sites/resyst.lshtm.ac.uk/files/docs/reseources/RinGs%20-%20Ebola%20and%20Gender%20Resources_0.pdf

to these contexts or crises, but provides information on health systems approaches and strategies to build gender responsive health systems in Low and middle income contexts, with a specific focus on fragile contexts where there is limited learning and action to date. Any discussion of the

Sustainable Development Goals, Universal Health Coverage (UHC) and gender equality cannot afford to ignore fragile and conflict affected settings (FCAS). These settings are sadly on the increase, have been referred to as the 'new normal' and affect 1.2 billion people (Eliasson, 2016); although these is sadly limited research in these areas. **Definitions of fragility are contested: countries recovering from conflict are one category of those classed as 'fragile' where more than one third of all maternal deaths and half of all child deaths occur (Newbrander W, 2011).** Countries which are conflict affected or fragile have the lowest health indicators, high levels of gender inequity and the weakest health systems. There are also opportunities for profound change, social norms are in flux, and donor funds (often) flow. Promoting gender equity in these contexts, and "Building Back Better" will have positive impacts on multiple levels.

Table 1: Addressing gender across the building blocks, drawing on a literature review and case studies in fragile contexts[8]

Building Block	Findings from the Literature Review	Case Study Examples
Health Service Delivery	Basic Package of Health Services does not always include comprehensive Sexual and Reproductive health and Rights for all groups	Mozambique: • Women are disproportionately affected by challenges in accessing health care services, given their reproductive and care-giving roles. • In 2011, just 54% of live births were attended by skilled health workers. • Most pregnant women and adolescent girls in a study in Maputo were unable to make the decision by themselves to seek care, and had to rely on their husband or family.
Health Workforce	Gender bias in recruitment, retention, promotion & pay within different cadres	Northern Uganda: • Number of health workers in post-conflict districts of northern Uganda is very low. • Staff data is not broken down by sex or role. • Human resource planning is "gender blind" and the specific needs and challenges of the predominantly female health workers in Gulu district are not considered, curtailing training and promotion opportunities.
Health Information Systems	Need to break down by sex, age and income and use data to inform responsive health systems	Northern Uganda: • Health Information Systems are weak and no data is available, broken down by sex, on the leading causes of death. • Lack of data to measure equitable and free access to health services.
Health Systems Financing	Scarce information on impact of different approaches on different groups, although strong	Mozambique: • Women face significant financial barriers in accessing care. • Budgeting which is sensitive to gender concerns is limited to

[8] Adapted from the Building Back Better resource and website: http://www.buildingbackbetter.org/#overview

	evidence on user fees	just three areas. Pregnant women, mothers and the poor are meant to be exempt from user fees, however, these exemptions are not always enforced.
Medical Products and Technologies	Gender biases influence access to medicine and throughout life cycle	Timor-Leste: • In towns and cities, only 26% of girls under two are likely to be fully immunized, compared to 40% of boys. • Women in remote areas must travel long distances to access reproductive technologies when local midwives have not been trained to deliver a range of modern contraceptives.
Leadership and Governance	Promoting women's voices in health reform critical – how does this play out within de-centralising processes	Sierra Leone: • No documentation in the National Health Sector Strategic Plan of gender equity in leadership positions in health reform or the need to include women in the governance of health systems. • The Ministry of Health and Sanitation developed an Ebola recovery plan, including inputs from different working groups focusing on health workforce; patient and health worker safety; community ownership; information and surveillance; and essential services. This plan contains no reference to gender, despite the development of a multisector impact assessment of gender dimensions of the Ebola virus produced by the Ministry of Social Welfare, Gender and Children's Affairs. This is a lost opportunity in ensuring a gender responsive plan that addresses the multiple ways in which Ebola affects and is shaped by gender roles within and beyond the health sector.

So what does a gender equitable health system look like? And what strategies can we deploy here in LMIC and FCAS settings.

A "GENDER EQUITABLE HEALTH SYSTEM"[9]

- **Rests on the principles of gender equality, and identifies and responds to the different health needs of women and men, ensuring equitable access and health.**

Consultative processes with women, men and people of other genders are critical here, to ensure that health systems respond to their needs and priorities. There are different strategies that can be used here; Participatory Learning and Action (PLA) methods were successfully used to challenge the root causes of gender inequality and impacts on maternal mortality in South Sudan. At 2,054 deaths /100,000 live births South Sudan has the highest maternal mortality in the world. South Sudan is in transition – with years of conflict and the construction of a new nation. In some areas, existing gender norms which expect women to bear many children are intensified in order 'to replace the ones that were lost'. Gender and societal norms are also in transition. The South Sudan Health Action and Research Project (SHARP) used PLA methods with different groups of women and men to better understand and challenge the ways in which gender norms promote child marriage, restrict use of contraception and birth spacing etc. with positive transformative results. In 2016, 36 communities participated in these activities and the approach will be further rolled out and hopefully continue to challenge and change views and practices that undermine women's maternal health; address these in health service delivery; and where appropriate develop links with other sectors e.g. the education sector.

[9] From the contribution of Professor Sally Theobald to the 2016 DEVCO Health Seminar; adapted from Building Back Better website; REBUILD: Research for stronger health systems post conflict & Percival, V. Richards, E. Maclean, T. Theobald, S. (2014) Health Systems and Gender in Post-Conflict Contexts: Building Back Better? *Conflict and Health*, **8**:19

- **Provides health care services to address the most urgent health needs of men and women across the life cycle;**

Older women and men are too often forgotten in health care services that are targeted around sexual and reproductive health for example. Life histories conducted with vulnerable individuals and households in Cambodia, Sierra Leone, Zimbabwe and Northern Uganda showed that many older female and male respondents were suffering from multiple chronic conditions that partly reflect their age but are also often traced to events or processes of the conflict period; widows emerged as a particular vulnerable group from our life histories in northern Uganda as they face challenges in raising resources for health care and often delay care seeking.; and special resources need to be developed for these groups such as an integrated approach to addressing complex and multiple health care needs, development of local income generating activities so that they can access services, and health financing policies that protect older women from poverty.

- **Ensures that men and women can access and use those services, free from social, geographic and financial barriers; Ensures equitable health for men and women of all ages;**

For example, with respect to financing, policies need to be matched to the particular needs of communities in conflict or crisis affected contexts. Policies that focus on reducing the costs of health care are well targeted at addressing key processes that drive and maintain poverty at the household level and how they affect women and men. ReBUILD's analysis of post conflict financing approaches in Cambodia shows that health equity funds and community based health insurance are often helpful in addressing access issues; although the findings give clear insights into how they could have a greater impact. For example, they could cover a wider range of the costs of accessing health care than just facility fees such as transport and child care costs, and they could ensure that users are not discriminated against when they try to access health care.

- **Produces relevant health information broken down by sex to inform policy;**

Fragile and conflict affected contexts may have relatively weak data systems; and an influx of multiple players (for example during and post conflict) can bring additional challenges to coordinated approaches to data quality and strategic data sharing. To promote gender equity ensuring data sets for example on health service utilization are disaggregated by gender, age and analyzed to identify gaps is an important first step in developing equitable health services. Data disaggregation can be usefully complemented by feedback through community consultative processes, and qualitative research, which can develop better understanding of "the why" behind certain groups' access challenges, or insights into quality of care; and also be part of strategies to develop and strengthen working relationships with communities.

- **Provides equal opportunities for male and female health workers**

Governance is a core pillar of health systems - if we are to strengthen health systems and meet the gender and health related Sustainable Development Goals greater gender parity and gender responsive, transformative leadership are essential. Health systems both reflect their environments and are spaces for change; with potentially powerful role models who people come into contact with throughout their lives. Health is arguably a key interface for society – most people have more engagement with health professionals across their lifespan than other sectors such as education. ReBUILD analysis of gender and health workers in Sierra Leone, Zimbabwe, Cambodia and northern Uganda shows that in all contexts women predominate in nursing and midwifery cadres; are under-represented in management positions and tend to be more clustered in lower paying positions. Gender roles, shaped by caring responsibilities at the household level, also affect attitudes to rural deployment and women in all contexts faced particular challenges in accessing both pre- and in-service training as compared to their male counterparts (for example in Zimbabwe). Most HRH regulatory frameworks did not sufficiently address

gender concerns (with the possible exception of Cambodia). Key priority areas for addressing gender equity in the health workforce in FCAS include ensuring gender is integrated into policy and fostering dialogue and action to support change for gender equity within institutions and households.

Key Points: Health systems are not gender neutral – gender is a key social stratifier which affects health system needs, experiences, and outcomes (Percival et al, 2014)

- **Gender equitable societies are more peaceful and prosperous;**
- **Health systems both reflect and shape their context;**
- **Health systems rebuilding is too often gender blind**

Part 3: What did we learn in the seminar?

We reviewed the opportunities and challenges in two contexts: Zimbabwe and Guinea Bissau and the learning generated is summarised in the following two illustrative boxes. We finish the section with learning generated that has a broader resonance across all contexts.

ZIMBABWE:

- **Zimbabwe is a fragile context, undergoing huge economic crisis.** There are numerous causes underlying the current instability including forthcoming presidential elections; controversial land reforms which continue to shape Zimbabwe's economic recovery, poverty and relation with international actors; human rights abuses and impunity which have diminished political participation of citizens and civil society; and huge economic challenges which include long term economic stagnation, the informalisation of the economy, closure of factories, unemployment, inflation, resulting in food insecurity, increased poverty, out migration of health workers and limited provision of basic services. This economic crisis is having wide reaching effects on society, and high levels of unemployment are leading to increased levels of gender based violence and drug abuse, especially among the unemployed youth (DAI, 2016).

- **This impacts on gender and the health sector.** The country relies mainly on external resources such as the Global Fund, EU, bilateral donors for financial and technical support. There are unmet needs for health care at all level with vulnerable groups marginalised despite political and institutional will to address their needs. The crisis period of hyper-inflation has led to increased levels of expenditure by households who were less able to cover costs. Three main causes are identified: facility fees, now charged in hard currency are unaffordable for many respondents; policies which aim to exempt the poor are inadequately funded and have ceased to operate; and under-funded public services have become unreliable, increasing private sector use, most often small drug shops, stretching household budgets. Due to financial crisis many individuals and households are increasingly relying on traditional doctors and herbs for their health care needs. Access to quality health care is being undermined, and this is shaped by gender and generation. Discriminatory social norms mean that women are still viewed as second class citizens, subservient to men in all circumstances, which results in women's lack of decision-making power over their health (DAI, 2016). In addition, comprehensive sexual and reproductive health education for young women and men is missing.

- **Responses to these issues.** Gender is not always integrated as a transversal theme in public and private health institutions as well as amongst development partners. There are few programmes that address gender issues using a holistic approach. However, the Ministry of Women Affairs, Gender and Community Development was established in 2000 and multiple strategic documents have been developed

such as the National Gender Policy 2013-2017. The health-related priorities of the Zimbabwean EU Gender Action Plan II focus on the promotions and protection and fulfilment of individual rights to have full control over and decide freely and responsibly on matters related to sexuality, sexual and reproductive health, free from discrimination, coercion and violence; and to challenge and change discriminatory social norms and gender stereotypes.

- **Challenges remain.** There is some government commitment to address the gender issues, however better use of the existing decision making mechanisms, and the development of a consultative platform is needed. Better coordination across sectors and partners is required in terms of integrating gender in all health programmes, efficient resource mobilisation, and avoidance of duplication.

- **Opportunities need to be grasped**. The Health Development Fund (2016 – 20) has a core component on Sexual and Reproductive Health and Gender Based Violence, which could be integrated into the delivery of basic health services. The development of the EU Gender Action Plan is a key opportunity to mainstream gender across the health sector (including the National Health Strategy) and beyond. Strong partnerships to make this a reality and ongoing Monitoring and evaluation of indictors will be critical to ensure the focus on gender and sexual and reproductive health does not 'evaporate' in practice

GUINEA-BISSAU

- **Guinea Bissau is a fragile state.** Guinea Bissau ranks 17th on the global Fragile States Index (2016 data), and is one of the lowest income countries in the world. The fragility of the state is driven by a precarious economic situation compounded by poor state legitimacy, an unstable political situation and results in public sector services under strain. Although democratic elections in 2014 provided an opportunity for stability, a power struggle a year later led to frequent changes in political leadership, and further compounded the fragile nature of state rule. The country has suffered a history of widespread violence, with weak infrastructure to respond to ongoing threats to the security of individuals and institutions.

- **The impacts on gender and the health sector.** Over 30 years of repeated military coups and political instability in Guinea Bissau have undermined socio-economic and institutional development which would otherwise have contributed to both health sector and gender-equitable development. Conditions for the majority of women and men are marked by poverty, lack of basic infrastructure and absence of basic services of health, education and justice. Although near gender-parity is seen in primary education enrolment, school participation rates at secondary school level are very low – and worse for girls compared to boys. The country is estimated by WHO to have well below the Africa-wide average for number of doctors, nurses or midwives per 100,000 population. Although health services for pregnant women are free, the country has one of the highest maternal mortality rates in the world – UNICEF estimates the lifetime risk of maternal death at 1 in 25. This is compounded by low levels of contraceptive use, low levels of recommended (4 visits) antenatal care coverage, poor maternal nutrition, and fewer than half of births taking place in the presence of a skilled provider. Of note, the lack of female health workers (driven by the poorer educational attainment levels for girls), is thought to contribute to poor health care seeking patterns among women, particularly pregnant women.

- **Responses to these issues.** The Government has identified gender as a key component of a social determinants of health (SDH) approach, and has three gender-relevant targets in the health programme: prevention of female genital mutilation; child protection (from violence, sexual abuse and trafficking); reduction in maternal mortality rates. Gender equitable development programmes are

supported by all main development partners, including EU.

- **Challenges remain.** Despite Government and development partner voicing commitment to gender equity, there is no specific action plan currently in place, and the extent to which gender-equity is a Government priority is unclear. The lack of an educated female workforce makes implementation of many female-focused health services challenging. Health service data sets are available (focus on coverage, outcomes), much of the data is not gender-disaggregated, thus making resource-targeting a challenge.

- **Opportunities need to be grasped.** More action is needed to ensure Government commitment – and evidence of a positive impact from a gender-equitable approach could help secure Government buy-in. Nascent models from other countries could be trialled in Guinea Bissau to show the positive impact of gender-equitable approaches on the health of both women and men. These could include task-shifting activities or literacy classes for more effective and acknowledged female involvement in the health workforce, and programmes focused on promoting men's positive roles as carers for their children's health and wellbeing. The feasibility and adequacy of such interventions require first an appraisal of the contexts at sub national levels for acceptability, and for support, consultation with development partners

Key lessons from the session in general and Guinea Bissau and Zimbabwe in particular

We need locally relevant information on gender and axes of inequity that respond to the realities of context: Countries and contexts differ and hence there is need to develop tailored approaches relevant to addressing the problems identified locally. Health management and information Systems data and quantitative indicators from all key components of health system (public, private, religious) need to be complemented by qualitative and contextual approaches. For example in rural Guinea Bissau, in contrast to most other contexts, the formal health care workforce at primary level is composed of men – in part a reflection of the low levels of formal education attainment by women, meaning they cannot apply to work in the formal health services. In such areas, women in need of SRH services don't want to, and/or are constrained by gender norms to receive reproductive health care that is provided by male health workers. Traditional birth attendants, who are female remain in the informal sector with little reward or support, and limited means to report and communicate with health services agents. While the Zimbabwe case highlights how the current economic crisis has led to increased use of private sector facilities, meaning that certain groups – shaped by gender and generation - are facing particular challenges in access quality care.

Working in partnership and supporting local ownership supports sustained change: experiences and reflections from both country contexts show that developing partnerships, linking to key developments and emerging national and local policy processes and priorities through practical actions and demonstrations is proving a more promising approach than a formal systematic top down approach.

Addressing gender in health means partnerships within and beyond the health sector: EUDs Technical and financial development partners are also allies to harness progresses wherever possible. Within the health sector, many partner countries joined the WHO International health partnership initiative (IHP, 2012 now IHP for UHC2030), to foster joint programming under the leadership of countries MoH. Such for a are opportunities to discuss gender and health actions. Forging alliances across different sectors (e.g. health and education in Guinea Bissau; or health and the Ministry of Women Affairs, Gender and Community Development in Zimbabwe), sharing actions and budgets can create positive synergies and have the potential to bring more sustained change.

Addressing gender means understanding the norms, roles, laws and customs that can act to influence the health outcomes of everyone in society. The impact of gender on health is not limited to women and girls alone; men and boys' health outcomes are also influenced by their gender-determined health behaviours, health care seeking patterns, and the way that health systems respond to gender. Using gender disaggregated data is critical as gender can affect the health of women, men, girls and boys in complex and unexpected ways. Developing partnerships that include men is strategic and important; addressing hegemonic masculinities should operate in the interests of many women and men (Tolhurst et al, 2011). Building resilient, sustainable health systems that respond equitably to gender and its influence on health, means recognizing the impact that gender has on the health and wellbeing of everyone in society and forming strategic partnerships for action.

LEARN MORE: Further reading and resources

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