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**Universal Health Coverage, Gender Equality and Social Protection:
A Health Systems Approach**

Background paper prepared by:

Gita Sen*

Public Health Foundation of India

(With Veloshnee Govender and Salma El-Gamal)

* The views expressed in this paper are those of the authors and do not necessarily represent those of the United Nations.

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List of Acronyms

CBHI	Community Based Health Insurance
DSF	Demand-Side Financing
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
NHIS	National Health Insurance Scheme (Ghana)
OOPs	Out-of-pocket payments
RSBY	Rashtriya Swasthya Bhima Yojana (India)
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
SRHR	Sexual and Reproductive Health and Rights
UHC	Universal Health Coverage
WHO	World Health Organization

Universal Health Coverage, Gender Equality and Social Protection: A Health Systems Approach

“... At present, no government in the world is systematically applying a gender lens to its UHC system...” (Rodin, 2013, p711)

“... Anyone who believes that design choices in social protection programmes...are purely pragmatic technical issues...is missing the point...Which choices are made, and for what reasons, reflects the kind of society that policymakers and technocrats with power to direct social policy wish to promote...Social protection is self-evidently about a vision of society...” (Devereux and Sabates-Wheeler, 2007, p2)

1. Introduction

This paper focuses on the interconnections between policies to move toward universal health care (UHC) as a key element of social protection, and those to advance gender equality, women’s empowerment and human rights. It is set against the backdrop of Agenda 2030 and the Sustainable Development Goals (SDGs).

Recent years, especially since 2010, have seen advances on each of these fronts, despite difficult economic circumstances, rising inequality, constrained political space, and continuing and new forms of political backlash and resistance (Sen, forthcoming; Tessier *et al.*, 2013; World Bank, 2018a). Slow and halting recovery from the global financial crisis of 2008 and continuing financial instability, combined with the worsening of global warming, have raised concerns about risk and vulnerability for large numbers of people, including importantly women, in both high and low / middle income countries (LMICs). Social mobilizing and advocacy on these issues has opened policy space for global agreements, such as ILO Recommendation No. 202 in 2012, and target 1.3 of the SDGs, which recognize the mitigating potential of national social protection floors (SPFs) as tools against poverty and vulnerability.

In this paper, we examine whether the experience with UHC as an important component of social protection has been gender-aware in its conceptualization and gender-responsive in its implementation. There has been considerable ongoing concern whether UHC is being designed to address women’s specific needs (Rodin, 2013; Witter *et al.*, 2017), and sexual and reproductive health and rights in particular (Kowalski, 2014; Sen and Govender, 2014).

The paper considers the current state of evidence on the implications, through a gender lens and where feasible an intersectionality lens, of UHC reforms based on an analysis of country experiences. This entails addressing the following questions:

- Under what circumstances does UHC lead to improving or worsening gender inequalities in terms of access, population coverage and services delivered?

- Are there examples of UHC reforms that have paid explicit attention to gender and inequalities in terms of design?
- Are there specific examples of targeting within universalism in the context of UHC?

1.1 UHC as a key component of Social Protection

Recognition of UHC as central to social protection has been relatively recent. It was consolidated with the passing of the Social Protection Floors Recommendation (No. 202) in 2012 by the International Labour Conference (ILO, 2012). This recommendation guides ILO member-states on how to build comprehensive social security systems, starting with national social protection floors (SPFs). The Recommendation calls for applying the principle of “non-discrimination, gender equality and responsiveness to special needs”.

Articles 22 and 25 of the Universal Declaration of Human Rights Articles 22 and 25 affirm the human right to social security and to a standard of living adequate for health and wellbeing, which includes access to food, clothing, housing, medical care and necessary social services. Anchored in these human rights, ILO Recommendation No. 202 includes UHC as one of four minimum elements for an SPF: “...access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality...”(Tessier *et al.*, 2013, p2).

UHC, Human Rights and Solidarity – need for a broader frame

Despite the above, much of the debate around social protection, including UHC, has focused on the relative merits of program instruments such as targeting and conditionalities, where human rights concerns do not have pride of place. They tend instead to be excluded and are evaluated (if at all) on par with efficiency, effectiveness and other criteria. It is important, therefore, to be clear about the place of human rights in the larger approaches that frame the instruments chosen (Devereux and Sabates-Wheeler, 2007; Sen and Rajasekhar, 2012). This is of importance for a gender analysis as we argue below.

A recent, useful UNDP Primer argues that social protection

*“...ensures access to basic social services to all, especially for groups that are traditionally vulnerable or excluded; stimulates productive inclusion through the development of capabilities, skills, **rights** and opportunities for the poor and **excluded**; builds resilience and protects people against the risks of livelihood shocks throughout their lifecycle; and **helps remove structural barriers, including barriers within the household, that prevent people from achieving well-being...**” (UNDP, p15-16: emphasis added).*

However, different multilateral agencies have used varying definitions of social protection, not all of which emphasize it as a right. While UNDP itself believes that social protection is a right, as do the ILO (under Article 22 of the UDHR) and UNAIDS, others such as the World Bank and the Asian Development Bank emphasize resilience, equity, opportunity, and efficient labour markets (UNDP, p14-15, Table 2.1).

While it is generally agreed that effective social protection is necessary to manage risk and vulnerability, there is often (political?) disagreement about the causes of that vulnerability and who is responsible for tackling it, and differing emphasis in the attention paid to human rights. Variations in whether and how rights are recognized are not trivial, as they underpin program design, implementation and monitoring. This has implications for UHC program direction, quality and effectiveness, and directly and indirectly for gender equality and women's human rights as our cases show below.

The politics of UHC and social protection more generally is also a function of the other, less understood, side of the rights coin, namely, the extent to which the idea of solidarity underpins policies and programs (Sen, 2007). Solidarity is the recognition by the 'haves' of the intrinsic importance of the basic needs of the 'have-nots', an issue that has special importance in the current era of soaring national and global inequality. It means that the better-off are willing to support the public provisioning of those needs because the poor cannot afford them at market prices, and not having them means hardship and deprivation. The rationale for solidarity is based on collective acceptance that the "basic needs of the poor are as worthy of fulfilment as those of the better off" (Sen, 2007, p183). This

"...does not necessarily mean they are identical, but that they are viewed as intrinsically having the same worthiness. Similarity may be measured on a number of different metrics, including common citizenship or common humanity. The fault-lines for solidarity are often precisely the commonly experienced bases of social difference – nationality, ethnicity, race, caste, gender and economic class. The more unequal a society and the more fragmented along such lines, the less likely it is to recognise solidarity as a value or to build it into institutions or behaviour..." (Sen, 2007, p180).

A rights-based approach combined with social acceptance of solidarity as a rationale for public action, provides the strongest and most sustainable basis for public provisioning that can ensure UHC (and indeed all social protection), and provide an ethical and durable framework for program choices and decisions. Even if historical processes have not established it as an accepted norm in a given context, recognizing the importance of solidarity can lead policy-makers to prioritize attention to creating it through the power of the government's 'bully-pulpit', and through intelligent program design intended to create 'win-win' processes rather than competition. In particular, the approach of solidarity may allow UHC policies to break through the existing fierce debate about the relative merits of targeting versus universalism, as we argue later (Sen, 2018).

From the perspective of gender equality, a human rights-based approach is essential to move beyond the limitations of a narrowly technicist view of UHC as we argue in the next section. Solidarity is important in health policies not only for the reasons given above. Because health

problems and their manifestations often entail physical (and other) differences between women and men (and between different groups), it can be all too easy for policy-makers who are usually male and from dominant social and economic groups to distance themselves from the 'other', while sliding into welfarist, top-down approaches. Such approaches can be blind to the common humanity underpinning basic health needs, and to the central role that all people should play in fulfilling their intrinsic right to health.

An essential question, therefore, is whether and how far the push towards UHC has gone beyond such blindness? The next section explores some of UHC's advances and limitations to date.

UHC – Advances and Limitations

Advances

Access for all residents to “**essential health care**” that meets the human rights criteria of availability, accessibility, acceptability and quality (AAAQ) is one of the four essential guarantees of ILO Recommendation No. 202 and was also picked up in Target 3.8 of the SDGs.

The field of global health has, however, had mixed and controversial experience during the 1980s and 1990s with identifying what ought to be included in a package of essential health services. That controversy pitted supporters of the Alma Ata approach based on comprehensive primary health care against promoters of selective care based on cost-effectiveness and as part of health sector reform packages supported by the World Bank (Magnussen *et al.*; Unger and Killingsworth, 1986). These bitter debates notwithstanding, progress towards and achievement of UHC is now widely recognized as central to improving health and equity, “lift[ing] people out of poverty and driv[ing] economic growth.” (WHO, 2014a). This UN resolution and global call urging member states to move towards providing all people with access to affordable, quality health-care services, has been given further impetus as a priority under Agenda 2030.

Specifically, SDG 3 (“ensure healthy lives and promote well-being for all at all ages”) includes UHC as target 3.8, “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.” (United Nations, 2015a). In addition, financial risk protection in health can play a crucial role in achieving SDG 1 (“end poverty in all its forms everywhere”), by reducing the known impact of catastrophic, out-of-pocket health expenditures in pushing people into poverty.

(WHO, 2014a) clarifies that UHC will be achieved through improvements in health care that

- Prioritize the poorest, with specific attention to addressing inequalities and focusing on the vulnerable;
- Increase reliance on public funding, recognizing that public financing is essential for UHC to cover people who cannot contribute financially;

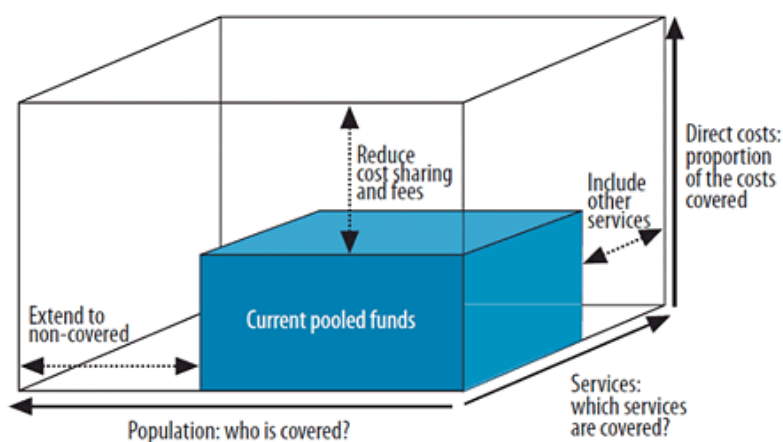
- Reduce, if not eliminate, out-of-pocket spending; and
- Develop the health system by going beyond health financing to strengthen essential components of the health system.

The acceptance of UHC (United Nations General Assembly, 2012) in recent global policies has opened space for what Gwatkin and Ergo (Gwatkin and Ergo, 2011) have called ‘progressive universalism’. It can be argued that UHC is constructed on the basis of Agenda 2030’s equity pillar (United Nations, 2015b) and should be operationalized in the following ways. Universalism means that no one should be left behind, and that health services should be allocated according to people’s needs. On the principle of vertical equity, those with higher needs (e.g. pregnant women) should receive more services than others. The notion of financial protection implies that people’s financial contributions towards funding health services should be according to their ability to pay. UHC, therefore, requires that healthy and wealthy members of society should cross-subsidise services for those more sick, vulnerable or poor, underpinned by the notion of social solidarity discussed earlier.

But will these expectations be met, and how? Broad notions of equity and universalism are built into both ILO Recommendation 202 and the SDGs, but how will they translate into the specifics of expanding coverage of people, financing, and services, as represented in the well-known UHC cube below (WHO, 2010a). The devil may well be in the details. On the road to UHC, countries are required to pay attention to three interconnected elements corresponding to the three dimensions of coverage used in the World Health Report 2010 (WHO, 2010a). These include 1) provide financial protection by reducing the reliance on out-of-pocket payments towards mandatory pre-payment mechanisms, 2) gradually expand services starting with essential services that are of good-quality according to need and, 3) ensure that everyone in the population is covered (WHO, 2010a, 2014b).

The next sub-section highlights some limitations, by first briefly examining the well-known UHC cube.

Figure 1 – The UHC Cube



Three dimensions to consider when moving towards universal coverage

(WHO, 2010a, pxv)

Limitations and Areas for Improvement

first, a *caveat*. The early years of UHC advocacy saw debates about whether the ‘C’ stands for coverage or care. The People’s Health Movement (PHM), founded in 2000, called for a broad approach going beyond financial coverage to addressing health care. Drawing on the legacy of Alma Ata, PHM highlighted the importance of comprehensive primary care, attention to social determinants of health, and a predominant role for the public sector in the provision of health care. WHO’s UHC cube is of course broader in that it *defines* coverage along three dimensions, including not only financing but also what services are covered and who is covered. Nonetheless, the serious questions raised by PHM about the limitations of private insurance, the need to focus on who provides health services and under what institutional arrangements, the excessive power of the private sector with its perverse incentives, the need for regulation, to name a few, can get lost in these semantics of coverage versus care. For the purpose of this paper, therefore, we are using UHC to mean universal health care in the broadest sense.

i. Over-simplification

The UHC cube was introduced as a heuristic device in the World Health Report (WHO, 2010a), but has two limitations as an analytical tool. The first is that, by itself, it cannot help in making a choice among the pathways by which UHC may be achieved, and especially how to ensure equity on the path (Sen and Govender, 2014). Policy implementers may be tempted, for instance, to first pick the low hanging fruit in terms of ease of coverage, at the expense of services or groups including poor and marginalized women and girls who may be more difficult to reach or cover. This would be an example of the ‘inverse equity hypothesis’ under which expansion of coverage first reaches the better-off, thereby worsening inequality (Victora *et al.*, 2018). The move towards universality may come, in such cases, at the expense of less equity. The limitation is that the cube in itself cannot distinguish between more and less equitable pathways.

The second challenge is that the three dimensions – people, services and financing - are not independent as the cube could be taken to imply. For instance, expanding coverage to adolescent girls will require a change in the kinds of services provided (e.g. comprehensive sexuality education), and more focused financing. Technologies such as intra-uterine devices may be covered in the essential benefit package and provided through the public sector but may entail co-payments. This can become a financial barrier for poor women and adolescents. Inclusion of services within an essential package does not automatically imply financial protection or services free at the point of care. Similarly, premiums within a community-based health insurance scheme (CBHI), which are unaffordable for women in the informal economy, may effectively block access and ultimately uptake of services.

The UHC cube is not well-suited to capture such interdependencies among people, services and financing mechanisms. It is clear, therefore, that the cube in itself has limited analytical value and should not be used to guide policy.

There are also other limitations, including from a gender perspective, to the way UHC is traditionally approached.

ii. The challenge of access – towards progressive realisation

Coverage is primarily about removing financial barriers to UHC through suitable health financing mechanisms, which reduce out-of-pocket expenses and aim to eventually do away with these. Access, on the other hand, depends on various social determinants, as well as on health system factors such as sufficient service delivery points, drugs and equipment, and availability of primary, secondary and tertiary services and trained providers.

The challenge of reaching UHC within highly restricted fiscal spaces (especially in low-income countries) and in the presence of high inequalities (especially in middle-income countries), implies difficult choices and politically sensitive trade-offs with respect to resource allocation. Expanded access is usually dependent on expanded financing. But, as stated in the World Health Report (2010a, p2), “Pooled funds will never be able to cover 100% of the population for 100% of the costs and 100% of needed services. Countries will still have to make hard choices about how best to use these funds”.

Progressive realisation is the guiding principle for countries on their own path to UHC and achievement of the SDG health targets. It refers to the governmental obligations to begin immediately and to progressively move towards the full realisation of UHC, recognising that countries are at different starting points, and are constrained by available resources (WHO, 2014b).

The WHO Consultative Group on Equity and UHC (WHO, 2014b) spelled out a three-pronged strategy to ensure progressive realization, fairness and equity on the path to UHC, beginning by categorizing services into priority classes based on priority to the worse off, cost effectiveness, and financial risk protection. The group argued this would mean expanding coverage for high-priority services to everyone; eliminating out-of-pocket payments and increasing mandatory progressive prepayment with risk pooling; and ensuring that disadvantaged groups are not left behind. The Consultative Group went on to identify a set of unacceptable choices from the viewpoint of equity and fairness. A similar approach has been taken in a recent one-pager based on the Background Paper prepared for the 3rd Annual UHC Financing Forum (Equity on the Path to UHC: Deliberate Decisions for Fair Financing) organized jointly by the World Bank and USAID.

Both sets of recommendations require close monitoring of the inequality consequences of different methods of financing health services. Useful as they are, however, the approach of identifying unacceptable choices is somewhat minimalist in that it can only go so far when it comes to ensuring gender equality in UHC. Advancing gender equality and equity typically require more than abjuring negative actions; positive measures are also required so that women’s and girls’ human rights are not only protected but also promoted and fulfilled.

These approaches put forward by the WHO Consultative Group on Equity and UHC and the World Bank are spelled out in more detail in Annex 1. What is striking about them is that they do not pay attention to the ways in which social factors such as gender inequality may translate into financing inequality. For instance, as pointed out by Sen and Iyer (Forthcoming),

girls and women within households may suffer from 'gender-biased household rationing' of limited household financial resources. This can result in less spending on their health needs, and worse access to health services than men and boys.

In addition, while these efforts mark important advances towards choices that support greater equity in UHC, their attention has been on financing, with relatively little on the other two dimensions (i.e. service and population coverage). From a gender perspective, all three dimensions and their interdependencies are important and warrant attention. As Kowalski (2014, p662) says, "The design and delivery of health programmes, the quality of health services, the strength of the institutions that governs them, health policies and social determinants of health, all play a role in determining whether people can access good quality health services, including sexual and reproductive health care." Similar arguments have been made by others, including Fried et al (2013). In other words, even if health financing is adequate at the household level, gendered barriers to access and utilization can be a major source of inequality and inequity.

Access and utilization are the outcome of both the supply-side (e.g. availability of health services in rural areas, or respectful and confidential care for adolescents seeking abortion services) and the demand side. On the demand-side, sex, age, geographic location, disability, and their interaction with socioeconomic stratifications and consequent inequalities (e.g. income, gender, age, race, sexual orientation, caste) are important. They are often the concealed determinants of men's and women's differential access to and claims on resources at multiple levels (i.e. household, community, state). Through their complex and multiple paths of interaction with the supply-side, demand-side factors shape both immediate perceptions and ultimate experiences of the health system.

Addressing such interactions requires going beyond narrow considerations of income and affordability as often currently conceived under UHC. It requires a broader, more intersectional approach, looking within and across households at the distribution of and access to resources. As argued by Sen and Iyer (forthcoming, p4), this requires tackling questions such as the following, "When health resources are scarce, what criteria are used to determine who gets access to them within the household? Even when policies are designed to augment household resources through public insurance or other schemes, are they sensitive to power relations and distributional challenges within households and across different sets of households, and do they attempt to mitigate them?" For groups at the bottom of the socioeconomic order, only focusing on economic barriers to access is not sufficient. Other forms of subordination and disadvantage such as ethnicity, gender, disability, widowhood, or caste *inter alia* can be barriers that call for sustained and focused policy attention.

An important issue that often comes up in the context of addressing the health needs and barriers faced by groups such as women or adolescent girls is whether this implies a form of targeting. If so, does it conflict with the basic premise of UHC, namely, universality? We believe this may be a misdirected debate. By arguing for attention to the specific needs and disadvantages of particularly deprived and subordinated groups, we are insisting on the importance of recognizing social factors and power relations that go deeper than household

poverty alone. Without this attention, such groups tend to be excluded and marginalized, and their needs and circumstances ignored or distorted. **Our approach ensures that the universalism built into UHC is *truly* universal, not only along a single dimension. This is not targeting but full, multi-dimensional universalism, built on a multi-dimensional anchoring in human rights and solidarity.**

iii. Partial approach to health system components

In addition to its weakness in relation to access, the traditional approach to UHC suffers from a second inadequacy. WHO has long defined the building blocks or components of a health system to include not only financing and services but also the health work-force, data and health information systems, access to medicines /diagnostics /supplies, and the critical function of health governance. It bears emphasizing that insufficient attention to these other components can make UHC unachievable since these are essential ingredients of a well-functioning health system.

Policy makers know, of course, that all of these components are important. Yet, too often, discussions on UHC and on the health system occur in separate silos to the detriment of both. **A central argument of this paper is that policies to achieve UHC need to address *all* of the health system building blocks as defined by WHO, not only financing and service provision.** Such an approach is not without precedent. In India, the High-Level Expert Group on UHC set up by the Planning Commission in 2010, took such a broad approach. It addressed health system components by focusing on financing and financial protection, health service norms (including essential packages), human resources for health, access to medicines and medical devices, management and institutional reforms (including information systems and regulation), and community participation (Planning Commission Government of India, 2010).

Attention to gender inequality within such a broader approach to UHC raises important issues that may otherwise be ignored, inter alia, gender inequalities and hierarchies within health work forces and in the provision of unpaid care in families and communities, the role of women and girls in community participation and accountability processes, and whether gender, age and other data are collected and used effectively in health management information systems. Such issues are not only important in themselves but can have significant impacts on availability, access and quality of health services, on whether financing mechanisms function equitably, as well as on ongoing monitoring and accountability.

Some might argue that to overcome the limitations discussed above, the approach to UHC needs not only to include all health system building blocks but should go further to address even broader social determinants of health. Socio-structural factors including cultural, socio-economic, geo-political and legal environments are critical contextual factors, which will influence not only the trajectory but also the time taken to strengthen health systems on the path to UHC. A further broadening along these lines would be in consonance with the SDGs themselves.

This paper does not, for reasons of length and focus, address the broader social determinants of health especially those contained in SDGs 1, 2 and 8 and their relevant targets (see Annex

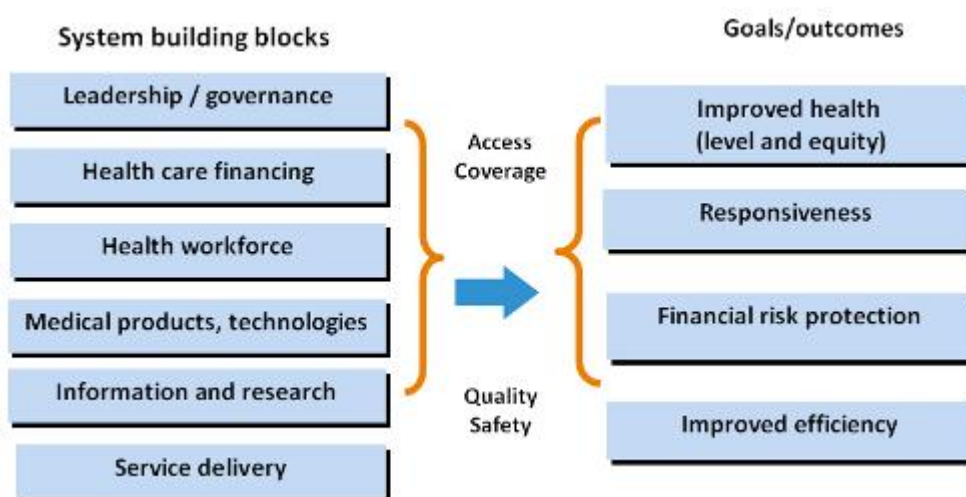
2). However, it takes a needed step in this direction in the context of SDGs 3 and 5 (on health and gender equality by applying a systematic gendered approach to the key building blocks of the health system). We turn to this discussion next.

2. Analytical Approach for Considering Gender, UHC and Health Systems

Strong health systems are essential for achieving UHC in terms of the long-term outcome of improved health (Kieny *et al.*, 2017). We apply WHO’s analytical framework for health systems (WHO, 2007) to assess the gendered implications for UHC.

The building blocks of the health system identified by WHO are governance, health service delivery, health information, human resources, financing, and medical products and technologies (WHO, 2007). Financing, the health workforce formal and informal, and medical products and technologies are key input components of service delivery by the health system. Leadership/governance and health information systems are cross-cutting components that provide the basis for overall policy and for the regulation of the other building blocks. How well the building blocks work, individually and in combination, affects the ultimate goals of health outcomes along with equity, responsiveness, handling of financial risk and efficiency. The bridge between system building blocks and ultimate goals / outcomes is provided by intermediate goals such as access, coverage, quality and safety. (WHO, 2007) .

Figure 2: WHO Health Systems Framework



Source: WHO 2007, p3

Applying a gender lens to UHC by examining the health system entails recognising and analysing how gender power relations affect all six of the health system building blocks. Table 1 provides an illustrative list of gendered questions to be considered in appraising the evidence. It should be noted that these questions are starting points in considering UHC and health systems through a gender lens. As countries gather momentum in policy and programme implementation, additional questions may be raised requiring further investigation.

Table 1: Applying a Gender Lens to UHC through a Health Systems approach

Financing	What is the extent of financial protection of essential services for addressing the health of adolescents and women? Are they affected by out-of-pocket payments?
	How is coverage for the informal sector (e.g. subsistence farmers, women in the informal economy) financed?
	Are health insurance scheme premiums affordable for women in the informal economy?
	Are services financed to ensure that women are not penalized at the point of service, such as detention of women or their babies in hospital wards because of inability to pay?
	Do co-payments exist for services and how does this impact on intra-household claims on resources?
	When policies are designed to augment household resources through public insurance or other schemes, are they sensitive to power relations and distributional challenges within households and across different sets of households, and do they attempt to mitigate them?
Health Services	Do service packages include the full range of sexual and reproductive health services needed by women, men, and adolescents (older and younger), including services for violence against women?
	Do they pay attention to providing services viewed as 'sensitive' or stigmatising? Do they ensure privacy and confidentiality?
	Is service provision designed to ensure access by adolescents and women, especially for SRH services such as contraception and safe abortion?
	How do women's roles in the care economy, such as for childcare, infant feeding, caring for the ill and infirm, affect their access to and utilization of health facilities?
Health Work-force	Do the financially covered services have adequate staffing (mix, competencies, geographical or other distribution) to meet the needs of the population covered, especially women and adolescents?
	Are health workers more likely to respond to certain groups of clients based on perceived ability to pay, gender, race, or other such criteria? Are they trained adequately to ensure ethics and equity in the services they provide?
	Are they trained at all levels (highest to lowest) to provide respectful care and to prevent disrespect and abuse? Is such training integrated into the core curricula for health staff?
	Are there gender and other socially based hierarchies among health workers? Are policies, programmes and training designed and implemented to reduce such hierarchies and their impacts on pay and conditions of work?
	Are policies designed to ameliorate the unpaid health care that women typically provide in the home, or do they take advantage of this labour and exacerbate its inequities?
Information systems	Are there data disaggregated by sex, age and other social criteria on population coverage under different health programmes and financing including insurance schemes?
	Are there data on barriers (e.g. geographic access, affordability, stigma) to women and adolescents experience in accessing services (e.g. violence against women, safe abortion)?
	Where such data are collected, are they analysed effectively, and acted upon?
Access to Medicines	How does expenditure on diagnostics and medicines differ for men and women and by socio-economic status?
	How do women and men within households and communities prioritise individuals' access to medical technologies, e.g. are boys or girls more likely be prioritized?
	How do drug stockouts impact on treatment adherence of men and women for chronic care? Is it gender differentiated?

Leadership Governance	/ <p>Who designs health financing including insurance policies? Are women or people from marginalized, key populations included in such decisions? To what extent are there policies in place guiding health services to be more gender-responsive? Do they have review procedures to ensure follow up?</p> <p>What are current regulations and policies for 'sensitive' services such as FGM prevention, treatment of fistulae, safe abortion care, and comprehensive sexuality education, which affect access and how does this impact on women and girls from marginalised groups?</p>
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3. State of the evidence: Gender, UHC and Health Systems

In considering the state of the evidence, this section is laid out as follows. It begins with an overview of the five country case studies followed by an analysis of the evidence, presented along the lines of the approach outlined in Table 1. Each of the six health system building blocks, on which UHC depends, are presented as sub-sections and the available country data evidence examined. Top-line messages and policy directions specifically focussed on gender are presented at the beginning of each of the sub-sections.

For Brazil and Mexico (two of the five country case studies), we were limited to publications in English and were unable to access the full breadth of publications in Portuguese and Spanish, their respective national languages. This is a limitation of this paper.

3.1 Introduction to the country case studies

The evidence presented is a synthesis of five country cases (see Annex 3) and individual topics presented in the boxes. The countries include Thailand, Rwanda, Ghana, Mexico and Brazil and were based on diversity in terms of their geographic location, stage of economic development and approaches to financing of UHC. Where gaps exist, additional country experiences will be cited.

Some countries are making considerable progress towards UHC (e.g. Ghana and Rwanda). Others, such as Thailand and Mexico claim to have achieved UHC. The content of reforms, financing and benefit packages also vary. With respect to financing, for instance, in Ghana and Rwanda, community-based health insurance schemes (CBHIs) covering the informal and rural economies operate alongside social health insurance (SHI) which typically focuses on the urban formal economy. In contrast, middle-income countries such as Thailand, Mexico and Brazil fund UHC primarily through taxation – alongside private insurance and government employee insurance - in order to ensure coverage for those outside the formal sector.

Table 2: Overview of Country Case Studies (UHC Reforms, Financing and Benefit Packages)

Country	Brazil	Ghana	Mexico	Rwanda	Thailand
(GDP/capita)	(\$11,339)	(\$1,604)	(\$9,741)	(\$619)	(\$5,473)
Reform	1988: Unified Health System (SUS). Publicly-funded services run at the municipal level.	2004: National Health Insurance Scheme. National network of CBHIs combined with national social-security (formal sector) insurance scheme.	2003: Seguro Popular. Publicly funded “insurance” system for poor and informal sector, to reduce disparities with social security in formal sector.	2003: Mutuelle de Santé. Heavily subsidized CBHI system integrated into a national network combining local accountability with national pooling and cross-subsidization.	2001: Universal Coverage Scheme. Newest and largest scheme covering everyone not included in the two schemes for formal sector workers.

Financing & Benefits Covered	General federal government revenues pooled at municipal level. Comprehensive benefits divided into three tiers: basic, specialized and high complexity.	General tax revenue combined with payroll tax of social security beneficiaries (formal sector) and limited premium contributions from beneficiaries (except most vulnerable). National pool with fee-for-service payment to fund a benefits package that covers 95% of reported health problems.	Government budget transfers. Original idea of enrolee premium tied to income largely dropped. Package covers 95% of causes for hospital admission.	Budget transfers (from tax revenues and donor aid) combined with sliding scale member contributions. National benefits plan with some scope for variation by each Mutuelle branch; must at least cover all services/drugs at health centres.	Solely general government revenues. Strong incentives for efficiency through various forms of active purchasing, global budgets and provider payment. Comprehensive benefits, includes both curative and preventive care; recently added HIV treatment.
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Source: (WHO, 2014a, Figure: Country-Specific Pathways to UHC, p2)

In considering the evidence, it is important to bear in mind as noted earlier that the health systems building blocks are inter-connected. While unique in terms of scope, content and function, they are closely linked both conceptually and at the point of policy and programme implementation.

3.2 Health Financing

Top-line Messages:

- ❖ Financing mechanisms are primarily designed around risk protection addressing financial barriers arising from economic exclusion at the household level.
- ❖ Health financing mechanisms often do NOT pay explicit attention to gender and other markers of exclusion and discrimination (e.g. race, caste, ethnicity, origin, religion etc.) in either design, implementation or impact. Such sources of marginalisation may operate both across households and within them.
- ❖ Women, particularly those who are poor and marginalised, continue to experience financial barriers in accessing health services and when they do access care, bear OOP expenses particularly for services relating to their sexual and reproductive healthcare needs.
- ❖ Even when women are covered financially, this does not automatically translate into access and utilisation, particularly when services are not free at the point of provision. They may still have to bear the direct costs (e.g. payment for drugs, supplies, transport) and indirect costs (e.g. loss of income) of seeking care. This is especially the

experience with CBHIs, which often cover a very limited package of health services and sometimes require co-payments.

- ❖ Practices such as detaining women in hospitals (maternity and other) on grounds of non-payment of user fees continue in many contexts, in violation of women's human rights.
- ❖ Anchoring UHC in the right to health requires government to plan, design and implement mechanisms for funding health systems that pay attention to gender, vulnerability and marginalization.
- ❖ A major challenge is how to ensure that solidarity principles are brought to bear to ensure adequate coverage and to reduce gender and other gaps, especially in low and low-middle income contexts where the informal sector is large, and tax resources are low. Central authority may be needed to ensure that UHC truly reaches the marginalized including women, especially given the growing reliance on CBHIs in such countries.

Policy directions:

- Paying attention to gender requires ensuring that UHC is reached through either tax revenue or through social insurance schemes, that cover all members of household (including those with little financial means and decision-making powers) by enrolling them as a unit.
- Ensuring a gender and rights-based approach to health financing will establish solidarity, non-discrimination and equity as guiding principles, ensuring prioritisation of the most vulnerable and marginalised.
- Secure sustainable domestic and international financing to achieve full access to the essential sexual and reproductive health package (Starrs *et al.*, 2018).

It is important to note that for this background paper, we were not able to track literature (either published or grey) of UHC funding mechanisms in countries regarded as having achieved or being on the path towards UHC, which explicitly adopted a rights-based approach or considered solidarity as a guiding principle in support and prioritisation of groups which face discrimination or exclusion based on considerations (i.e. gender, race, caste, religion etc) other than income-poverty. This included considerations of gender and social exclusion in the design and goals of their UHC strategies. Nonetheless, on the basis of the cases studied and select evidence from others, we have been able to draw out the gendered implications of key elements of health financing mechanisms.

In this section, we focus on the gender implications of two key elements of health financing. The first is mandatory pre-payment mechanisms as the recommended modality for funding the health system under UHC, or their alternative - voluntary CBHIs. We focus on CBHIs given their growing prominence in recent years in LMICs as a mechanism for extending financial coverage and protection to the informal sector. From a gender perspective, they are also

important given that women are disproportionately represented in the informal sector compared to the formal sector.

The second element is demand-side financing (DSF). Like CBHIs, DSF (through cash transfers and/or vouchers) has also gained currency over the past two decades as a component of broader social protection programmes. We pay special attention to DSF in this paper, given that it is primarily targeted towards women and has been promoted as an approach for addressing issues of affordability and improving access, particularly in relation to reducing maternal mortality.

Mandatory prepayment schemes

Publicly financing health systems through either tax revenue or pre-paid, mandatory health insurance (i.e. SHI, CBHI) or a combination of both have been recommended as the most equitable route towards UHC (WHO, 2010a). As described earlier, publicly-funded and pre-paid mandatory schemes have the potential to 1) build solidarity through cross-subsidisation (i.e. rich to poor, and healthy to sick), 2) improve access and utilisation by the most marginal, including women, and 3) reduce the financial burden on women and households. These improvements are necessary for reaching the twin goals of universal coverage of effective health services and financial protection from the costs of accessing these services.

However, the extent to which countries can rely upon public funds for their health systems is a function of the size of their formal economy and resulting tax base, as well as other competing claims on public resources. Upper middle-income countries such as Brazil, Thailand (Tangcharoensathien V Chaturachinda K and Im-Em, 2014) and Mexico (Andión Ibáñez *et al.*, 2015) rely largely on a combination of tax revenue which covers the financial contributions of those who are economically vulnerable (i.e. poor, children, elderly, informal sector) and compulsory SHI, which covers those who are formally employed and salaried. In contrast, low-middle and low-income countries (e.g. Rwanda and Ghana), with relatively limited potential for generating tax-revenue given the size of their formal economy, depend on a combination of compulsory SHI (covering formal sector and often civil servants), CBHIs, overseas development assistance and out-of-pocket payments (OOPs).

CBHIs: an equitable alternative to user-fees?

In low-middle and low-income countries, the primary challenge is extending financial coverage to the informal sector. While middle-income countries have been able to progressively provide financial coverage to the informal sector through tax revenue, this avenue remains limited in lower-income settings. In Rwanda and Ghana, CBHIs emerged as an alternative to user fees and have taken centre stage. CBHIs are often driven by donors as a promising approach for extending population coverage, increasing revenue generation and improving financial protection under the UHC umbrella. Although there is considerable variation in the design, scope, premiums and entitlements under CBHI schemes, they have two defining features. They are typically voluntary and are based on principles of solidarity, built along lines of location, occupation, ethnicity, religion and gender (UN Women, 2015a).

In both Ghana and Rwanda, CBHIs were integrated within national funding and pooling schemes, but remained autonomous in terms of being community- and district-managed. Evident from both these countries are the trade-offs between levels of membership premiums on the one hand and financial protection and benefits offered on the other (Mathauer *et al.*, 2017). As Chuma *et al.* (2013) argue, when the membership premiums are kept at a low level to ensure affordability and allow a larger enrolment of the poorer population, the actual revenue that is generated and the financial capacity of the insurance pool remains low. This means the level of financial protection and range of services offered in the benefit package are relatively small, ultimately limiting the attractiveness of the scheme.

From the literature, it is evident that much of the focus remains on addressing exclusion based on economic status. In Thailand, population coverage increased from about a third of the population in 1991 to over 95% in 2003 through a pro-poor intervention which entailed the government subsidising the inclusion of the near-poor population into the Universal Coverage Scheme (Yu and Nonkhuntod, 2017). As Chuma *et al.* (2013, p4) observe “Key issues from the Asian experience include the need to heavily subsidise services for the poor and vulnerable groups, mainly through tax funding and in some cases a combination of tax and donor funds. Governments and donors should be prepared to put aside significant funds to offer coverage (population, service and cost coverage) to these groups.” This has been the experience in Rwanda where *Mutuelles de Santé*, a mandatory CBHI scheme that provides coverage to the rural population and informal sector through donor funds, subsidizes premiums for those who cannot afford them (Chuma *et al.*, 2013) (See Box 1).

Box 1: Subsidising *Mutuelles de Santé* for Universal Coverage in Rwanda

Rwanda

“CBHI schemes have been part of an overall strategy of the Government to rebuild the country’s health system after the 1994 genocide. *Mutuelles de Santé* were piloted in three districts in 1999 and later extended to other districts. The *Mutuelles* enrol entire households and provide a minimum service package at the primary care level as well as a complementary services package at district level. Users contribute through co-payments, but the poorest quarter of the population is exempt thanks to international donor funding. The service package includes family planning, antenatal and postnatal care, childbirth, HIV testing and treatment as well as prescribed drugs. By 2011/2012, the coverage of the *Mutuelles* had reached 91 per cent of the population. Together with pre-existing private and social insurance schemes, this has brought Rwanda close to universal coverage within a decade.” (UN Women, 2015a, p163). The importance of the subsidy in expanding population coverage is clear, although calling this UHC is questionable. Important as the covered services are, they do not include many primary care and higher level services that should arguably be covered by a well-functioning health system “ (UN Women, 2015a, p163).

While subsidies such as these can expand population coverage, it is not only the poor who are left out of CBHIs. Viewed through the lens of gender and intersectionality, CBHIs often exclude the vulnerable and marginalised based on other markers of exclusion (i.e. gender, location, language, race, religion etc.), the very groups that the schemes are seeking to reach (Oxfam, 2013). This is illustrated in the experiences with CBHIs schemes targeting the informal sector in Ghana under NHIS and the *Rashtriya Swasthya Bhima Yojana* (RSBY) scheme, , which targeted poor households in India. In both these cases (See Box 2), women and other

marginalised groups (Dalits, tribal communities, non-Hindus in India; poor women in the informal economy in Ghana) were not explicitly targeted for subsidies, and as a result were excluded due to unaffordability of premiums (Ghana), due to gender power relations within households (India), and inadequate administrative and managerial capacity (India and Ghana).

Box 2: NHIS in Ghana and RSBY in India excluding the poor and marginalised women

Ghana and NHIS

The National Health Insurance Scheme (NHIS) was created as a “pro-poor” health system, alleviating the need to pay out of pocket at the point of service delivery and specifically through District Wide Mutual Health Insurance schemes (DWMHI). DWMHI membership is voluntary and schemes are managed at the district level. Within limits set by the NHIA, DWMHI are able to set their own premiums. However, challenges with variability in premiums and criteria for establishing the socio-economic status of potential member have been identified. Affordability of premiums remain a challenge for those in the poorest quintiles, most of whom are in the informal sector. The informal sector employs two-fifths of employed Ghanaians aged 15 years and older; sex-disaggregated data reveal that the informal sector employs a larger percentage of currently employed females (47.8%) than males (35.5%) (Ghana Statistical Service, 2014) .

A study of women in the informal economy revealed that “...while the informal workers who participated in the study have welcomed the idea of the NHIS, there are significant barriers to them accessing it. The major factor for poorer workers was the cost of the premiums, which often sit well above the mandated minimum in urban areas. For better off workers, the major barrier was the chaotic administration of the district schemes, which meant that a significant amount of time had to be spent trying to register with the NHIS. It was also discovered that there has been very little direct involvement of informal workers particularly women in either the design or the ongoing management of the scheme, with the result that it does not take into account the particular needs of informal workers... it was concluded that...NHIS reflects the wider inequalities of Ghanaian society and is itself reproducing them... The implication is that if the NHIS is to ever truly promote the ideal of universal access to healthcare, systemic changes in social and economic policy are necessary” (Alfers, 2013, p1).

India and RSBY

RSBY is a nation-wide Indian scheme catering to the needs of poor and informal sector workers in parts of some states, providing coverage for households Below the Poverty Line (BPL). Up to five members may be insured in a household, entitled to receive cashless, in-patient services in empanelled public and private hospitals, with a ceiling on expenses at the household level per year. Through the lens of intersectional equity, there are several challenges associated with the scheme. Enrolment rates are lower in remote areas inhabited by *Dalits* and tribal communities and among socio-economically backward castes. Further, certain categories of poor families eligible for inclusion in the scheme are systematically kept out: those without BPL cards; those that have lost the “household head” whose name appears on the government’s list; and migrants who cannot present themselves during enrolment drives. In some instances, RSBY cards were more likely to be found in the possession of better-off Hindu households than among poor *dalit* and non-Hindu households. “Women in these uninsured households - products of multiple intersecting sources of disadvantage - are also the ones most likely to suffer from deep poverty, an amalgam of economic, caste and gender disadvantages. Even among insured households, more male members tend to get enrolled than their female counterparts. At a national level as estimated on 31 March 2012, the ratio of male to female enrolees was 3:2 with significant state-level variations (Cerceanu 2012). Gender relations may determine the selection of the three dependents to be included in the five-member list for each eligible household (other than the head of household and his/her spouse). Women have very little influence on this selection (Cerceanu 2012), which is usually biased against daughters in families that have more than five members (Sun 2011). In joint families, the brothers and sons of the household head may make it to the list at the expense of unwanted girls, daughters-in-law and widows.”

(Sen and Iyer, p12 – 15; *passim*).

As highlighted in Box 2, in highly unequal societies such as Ghana and India, schemes such as NHIS (Ghana) and RSBY (India) often mirror and perpetuate patterns of exclusion and marginalisation, not only arising from economic status but also from gender, location, language, religion, caste, or other social markers, which challenge both solidarity and inclusion. Have there been attempts to foster solidarity going beyond economic status? In Rwanda, within *Mutuelle de Santé*, churches and community members took deliberate steps to build solidarity and inclusion in helping to pay enrolment fees for the poor, widows, and orphans (Schneider and Diop, 2004). Such initiatives to build solidarity specifically targeting groups that are marginalised are not, however, widely cited in the literature. While such practices fostering solidarity and inclusion at a community level are critical, they need to be supported by higher level, national legislation and policies anchored in a human rights-based approach, which articulate a commitment to equity and non-discrimination.

The other side of the UHC insurance coin is financial protection. A growing body of evidence is unequivocal: even when there is financial coverage through either publicly funded health systems or pre-payment schemes, beneficiaries may still have to bear the direct costs (e.g. payment for drugs, supplies, transport) and indirect costs (e.g. loss of income) of seeking care. This is especially the experience with CBHIs, which often cover a very limited package of health services and sometimes require co-payments (Chuma *et al.*, 2013).

As Ravindran (2012) observed, women shoulder a higher burden of OOPs for health care services than men who have similar levels of insurance coverage, largely due to non-coverage or limits on coverage for sexual and reproductive health (SRH) services. Therefore, as noted earlier, financial coverage does not automatically translate into access and utilisation, particularly when services are not free at the point of provision. In such contexts, OOPs typically limit women's access to health care due to their lack of control over financial resources. According to WHO (2010b, p23), '[w]omen incur more out-of-pocket payments than men...paying for delivery care and other reproductive health services places a higher financial burden on women...[and] out-of-pocket expenditure may prevent more women than men from utilizing essential services.'

The burden of OOPs on women is also borne out in the country case studies. Evident from both Ghana and India (Box 3 below), even under pre-paid health insurance schemes, women, particularly those who are poor, or less-literate are offered inadequate financial protection. In India, the lack of a comprehensive benefit package responding to the priority health needs of women, challenges not only access but also has implications for health outcomes (RamPrakash, 2018).

Box 3: Financial protection missing the mark for women under NHIS in Ghana and Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) in Tamil Nadu, India

Ghana

In Ghana, under NHIS, exemptions were introduced for certain groups of individuals to improve their access to health services. These groups include pregnant women, children under 18 years of age, elderly people over 70 years, the indigent (poor and vulnerable), and persons with mental health disorders. In addition, pregnant women, indigents and persons with mental health disorders are not required to make any payment as

processing fees before being registered under the NHIS. The free maternal health policy sought to enhance the utilisation of ANC, skilled attendance at childbirth and postnatal care. The policy entitled a pregnant woman registered with the NHIS to free health services which covered pregnancy, labour and birth and up to three months postpartum. However, it was found that women and their families still bore considerable expenses including payment for drugs and ultrasound scan services. Sixty-five percent of the women used savings, whilst twenty-two percent sold assets to meet the out-of-pocket costs. Some women were unable to afford payments due to poverty and had to forgo treatment (Dalinjong *et al.*, 2018).

Migrant girls and women who work in Accra as head porters reported challenges in obtaining insurance and accessing health care. Although eligible (poor, pregnant) for NHIS exemptions, they experience challenges in accessing formal health services, even when needing care. Financial barriers prevented them from registering with NHIS, renewing their expired health insurance policies, or taking time away from work. Both insured and uninsured migrants did not seek formal health services due to the unpredictable nature of OOPs. Catastrophic and impoverishing medical expenses also resulted in them searching for work to repay loans and hospital bills. They also reported being unable to access care either because they did not have a valid health insurance card in Accra or they lost their cards or left them behind when migrating (Lattof, 2018, p505).

Tamil Nadu, India

Tamil Nadu, a southern state in India with an estimated 80 million population has been implementing a publicly financed health insurance scheme since 2009 for households with annual income less than 972 USD. The scheme covers all members of the enrolled households for a range of surgical and medical procedures mostly tertiary in nature provided through empanelled public & private hospitals. Doctoral research was undertaken between 2015-2018 to study the gendered dimensions of the scheme's design, implementation and impact. Findings indicate a number of exclusions and gender-based barriers to women benefitting from the scheme. In spite of having comparable enrolment rates, the study revealed lower share of insurance claims from females than males. This was especially surprising as women had equal rates of hospitalization to men for sex-neutral illnesses. The design of the scheme was found to exclude financial protection for non-communicable diseases, SRH procedures (except hysterectomies) and other secondary or outpatient care procedures frequently sought by women. Due to lack of documentary evidence, women were at risk of being excluded from scheme entitlements even within male headed 'enrolled households'. The nature of paid/unpaid care work and the bargaining position of women within the household also determined their utilization of scheme benefits. Ineffective awareness generation, inequitable distribution of hospitals, cherry-picking, information asymmetry and lack of effective grievance redressal formed the health system barriers for women. The study found insurance-based mechanisms distorting public healthcare systems on which the poor, women and marginalized sections of society depend upon. The CMCHIS policy by accentuating existing barriers or imposing new forms of barriers to access healthcare was thus found to be gender blind rather than gender neutral.

(RamPrakash, 2018)

Recent evidence from across several countries, including Ghana and India also indicate how the rights of women are violated when they are detained in health facilities for non-payment of fees (Yates *et al.*, 2017, Box 4).

Box 4: Detentions of Women in hospitals for non-payment of fees

"In some parts of the world it is common practice for patients to be detained in hospital for non-payment of healthcare bills. Such detentions occur in public as well as private medical facilities, and there appears to be wide societal acceptance in certain countries of the assumed right of health providers to imprison vulnerable people in this way. The true scale of these hospital detention practices, or 'medical detentions', is unknown, but the limited academic research to date suggests that hundreds of thousands of people are likely to be affected every year, in several sub-Saharan African countries and parts of Asia. Women requiring life-saving emergency caesarean sections, and their babies, are particularly vulnerable to detention in medical facilities. Victims of medical detention tend to be the poorest members of society who have been admitted to hospital for emergency treatment, and detention can push them and their families further into poverty. They may also be subject to verbal and/or physical abuse while being detained in health facilities.

Such detentions occur in public as well as private medical facilities, and there appears to be wide societal acceptance in certain countries of the assumed right of health providers to imprison vulnerable people in this way. Victims of medical detention tend to be the poorest members of society who have been admitted to hospital for emergency treatment, and detention can push them and their families further into poverty. They may also be subject to verbal and/or physical abuse while being detained in health facilities. The practice of detaining people in hospital for non-payment of medical bills deters healthcare use, increases medical impoverishment, and is a denial of international human rights standards, including the right not to be imprisoned as a debtor, and the right to access to medical care.” (Yates *et al.* 2017, p1).

Given the challenge of OOPs and other barriers to accessing care, there has been increasing attention to addressing the barriers on the demand or patient side through DSF. DSF is one example of targeting within universalism.

Demand-Side Financing (DSF)

The past two decades have witnessed increasing use of DSF as a mechanism for improving utilisation of under-used services. This is best exemplified, starting in the MDGs-era, by the increased attention being paid to the need to improve access to targeted services for specific populations, particularly those MDG targets like maternal mortality, which demonstrated the slowest progress. DSF programmes aimed at reducing maternal mortality (MDG 5) through cash transfers and vouchers is perhaps the most widely implemented intervention across several regions. The underlying assumption is that the potential beneficiaries of the scheme, face mainly financial barriers including transport costs and opportunity costs of time relating to household responsibilities including care for dependents and income-generation (Hunter and Murray, 2017, p2 of 28). It is not surprising that in addition to seeking to reduce the financial barriers to access, DSF also attempts to increase household income and incentivise ‘healthy behaviours’.

More recently, there has been increasing attention to addressing also challenges on the supply-side. It is recognised that increasing demand is only part of the story in the face of poorly-resourced and poorly-functioning health systems. It is necessary that quality health services are available to meet increased demand arising as a result of DSF. Tangible efforts to improve infrastructure, staffing, and quality and availability of services are likely to improve service use. However, performance incentives may not be sufficient without such tangible improvements. The case of Rwanda below (Box 5), illustrates the introduction of a supply-side pay-for-performance scheme alongside DSF.

Box 5: DSF alongside Pay-for-Performance Scheme in Rwanda

Two incentive schemes were introduced alongside Rwanda's national Performance-Based Financing program at the health facility level. One scheme rewarded community health worker cooperatives for the utilization of five services by their communities. The analysis found no impact of the cooperative performance payments on coverage of the targeted services, behaviours of community health workers, or outcomes at the cooperative level. The second scheme provided in-kind transfers to users of three services. Although health centres experienced frequent stock outs of the gifts, the demand-side intervention significantly increased timely antenatal care by 9.3 percentage points and timely postnatal care by 8.6 percentage points. This study shows that demand-side incentives can increase service utilization also when provided in addition to a supply-side pay-for-performance scheme. (Shapira *et al.*, 2018)

The ILO’s 2015 Social Protection Report (2014) concluded that DSF has increased utilisation of health services, resulting in improved maternal and child health (MCH) outcomes. Table 3 below presents the key findings from a systematic review of the enablers and challenges underlying the effectiveness of DSF in the context of MCH (Hunter and Murray, 2017).

Table 3: Factors Enabling and Challenging DSF for Improving Access to MCH Services

DSF is successful in improving access when:	DSF is less successful in improving access when:
<ul style="list-style-type: none"> • Accompanied by investment in health facilities or staff (see Box on Rwanda) • Well-supported and -supervised, community-based workers • Attention to programme eligibility in terms of beneficiaries • Size and timing of cash payments • Adequate package of entitlements (including transport costs) in voucher schemes. • Participation of community leaders and women’s groups in awareness raising 	<ul style="list-style-type: none"> • Insufficient attention paid to vulnerable and marginalised groups (e.g. migrants, young and multiparous women) in terms of inclusion criteria and distribution mechanisms of benefits • Lack of investment in improving service delivery, quality of care, availability of staff. • Staff charging informal fees once at the facilities • Perceived poor behaviour of staff at participating facilities • Overly bureaucratic process for determining eligibility • Poor awareness of the programme among target groups

Source: Hunter and Murray (2017)

In addition to improvements in access and uptake of services, cash transfer programmes (based on a study of almost 30 countries), were reported to have reduced the gender poverty gap and increase women’s access to personal income (UN Women, 2015b). These findings are important for their potential to improve women’s status within the household as well as decision-making over household resources and sexual and reproductive health care. This is clearly encouraging from a gender equality and economic empowerment perspective.

At the same time, equally important, but neglected by donors, programmes and researchers, are the following questions. To what extent does DSF:

1. address and more critically *transform* socially-ingrained gender-based discrimination in norms and power relations? Stated otherwise, does DSF and specifically cash transfers influence household decision-making over resources and alter intra-household power dynamics?
2. perpetuate and reinforce gender norms and stereotypes (e.g. holding women primarily responsible for the health and well-being of their children)?
3. undermine solidarity by placing individual responsibility on the recipients, who are primarily women?

While some of the above questions have been raised by global organisations such as UNRISD (2016), the background literature search for this paper has not been able to identify any studies that actually investigate them. These questions demand prioritised investigation recognising that in societies with high gender inequality, maternal mortality not only arises because of poor financial access but is located and constructed in social, economic and cultural institutions, both formal and informal which undervalue women and girls. In such instances, tackling the proximate financial and geographic barriers on the patient and service delivery side are insufficient. This requires multi-sectoral policies and interventions across the SDGs (combining poverty alleviation, food security and nutrition, safe housing, gender equality, female education, secure employment etc.), anchored within a rights-based approach to health and gender equality (OHCHR, 2010).

3.3 Health Services and Delivery

Top-line messages:

- ❖ A drive towards UHC does not automatically ensure equity on the path as the operation of the ‘inverse equity hypothesis’ shows. Despite significant progress towards UHC, inequities in access to services often persist along a range of intersecting dimensions including gender.
- ❖ Focused strategies to reach the most marginalised can improve access to essential service packages for vulnerable groups. But such packages can themselves be gender-biased or discriminatory. They need to include not only maternal health and safe delivery but a broader range of essential services (e.g. safe abortion, access to contraception, cervical cancer screening and treatment, adolescent health services, prevention and treatment of violence including rape).
- ❖ There is growing evidence that poor quality of services, including disrespect and abuse in maternal care, has negative effects on maternal mortality and morbidity, and in women’s willingness to access services.
- ❖ Improving the quality of health services is essential for improving access and UHC.
- ❖ Poor quality services are a barrier to access for women who are poor and marginalised, and challenge achievement of UHC and Agenda 2030, particularly in relation to SDGs 3 and 5.
- ❖ It is imperative that global health institutions (i.e. WHO, World Bank) charged with driving UHC anchor service delivery and quality health services in the right to health to ensure multi-dimensional universalism.

Policy directions:

- Ensure that the range of services packages go beyond antenatal care and family planning to a comprehensive set of SRH services, including sexuality education and treatment for survivors of violence including rape (Kowalski, 2014; Starrs *et al.*, 2018; UN Women, 2018).

- Design and implement gender-sensitive codes and training programs for provider-patient interaction to ensure meeting respectful care, quality, clinical, ethical and specific needs for all people following human rights standards (Ravindran, 2012; Sen and Govender, 2014).
- Tracking and monitoring service coverage and access for especially political sensitive services such as SRHR which risk slippage from the 'essential services' packages through accountability mechanisms for existing human rights commitments.

Under UHC, the evidence indicates that there is often a gap between what the benefits package entitlements are on paper versus what the health system is able and ready to deliver. In this section, the evidence will be reviewed with respect to:

1. equity in access to services, with special attention to SRH services; and
2. quality health services judged by respectful care, focusing on institutional violence as a gender and rights issue.

We focus on SRHR and institutional violence given that they disproportionately affect women and girls, particularly those who are caught in the intersections of gender and other forms of marginalisation. The discussion illustrates that, unless policy and programme action ensuring access to quality health services is situated within a gender and human rights-based approach, current approaches will fail to achieve the ambitious targets set in SDG3.

Equity in access to health services

In all the country cases, significant investment in service infrastructure has contributed to overall improvements in service availability and access. In Rwanda, the infrastructure designed to respond to the HIV epidemic, has been scaled up to strengthen primary care and support an expanding package of health services based on need and equity. This has contributed to significant improvements in life expectancy and other health outcomes. In Brazil, considerable progress in expanding community-based primary care was made through the Family Health Strategy (Atun *et al.*, 2015a).

However, across all the country case studies, and most notably in Brazil, Mexico and Ghana, despite making significant progress towards UHC, health inequities persist across a range of services by location, socio-economic status, insurance status and by type of provider (i.e. public or private) etc. In Mexico for example, a 2012 Health Secretariat report indicated that in almost 500 (of 2,488) municipalities in Mexico, more than 70% of the population speak an indigenous language. These municipalities also have fewer, health facilities, hospital beds health workers (specialist doctors and nurses) medical infrastructure compared to other municipalities. Moreover, in these municipalities, there are 10 times more medical interns in charge of health facilities compared to other municipalities (Government of Mexico, 2012). In Ghana, patients received differential treatment based on their NHIS status. Health facilities, especially private ones, had separate queues for NHIS card holders and those willing to pay OOP from the beginning. The preference for those willing to pay OOP was on account of delays in receiving reimbursements from the NHIS (Haw, 2018). Often women, especially the

poor, in the face of OOPs, either are discouraged from seeking or delay care and when they do, incur significant costs.

These inequities are an outcome of a complex mix of intersecting factors. Challenges in addressing the social determinants of health and underlying factors shaping exclusion and discrimination, inadequate and poor distribution of health infrastructure in relation to health care needs, and poorly functioning health systems overall heighten discrimination, inequity and inequality (Fried *et al.*, 2013). These inequities also illustrate the working of the inverse equity hypothesis (Victora *et al.*, 2000). As observed by Sen and Govender (2014, p234) “...where whenever an innovation appears on the scene, it is often the ‘haves’ who will benefit first and most, leading to an initial worsening of inequality of both access and outcomes. This worsening may last for quite a while before it is reversed. Although this hypothesis is not specific to UHC, it provides a salutary warning against assuming that universality will automatically translate into equitable access.”

Brazil’s Estratégia de Saúde da Família (ESF, Family Health Strategy) represents a strategy for reaching those hardest to reach and most marginalised. In Brazil, health access and health outcomes traditionally showed significant disparities by socio-economic status, gender and race. Under the country’s ESF programme, a community-based PHC was the key initiative for delivering UHC in the country. Evidence suggests that the PHC expansion, including accelerated expansion in poorer and more deprived areas as well as outreach services by community health workers, contributed to overall reductions in mortality for all racial groups. As a result, black Brazilians experienced a 2-fold greater reduction in mortality than white Brazilians (Hone *et al.*, 2017a).

But, as noted in the country cases below, ‘essential service packages’ can be gender-biased or discriminatory, when they exclude and fail to address the SRH needs of women and girls across the life-cycle. Often essential service packages include maternal health and safe delivery but exclude a broader but equally essential range of services (e.g. safe abortion, access to contraception, cervical cancer screening and treatment, adolescent health services, violence including rape).

Box 6 below highlights in brief the gender inequalities in relation to SRH services in Mexico, access to safe delivery for adolescents in Brazil, and legal restrictions and geographic disparities in abortion access in Thailand.

Box 6: Inequities in Service Coverage and Access to SRHR Services: Mexico, Brazil and Thailand

Mexico

Under “Seguro Popular” there has been significant progress in insurance coverage, access to health services and reducing the prevalence of catastrophic and impoverishing health expenditures, especially for the poor. However, inequalities persist in relation to sexual and reproductive health services. Services (prevention, early detection, and treatment) relating to cervical cancer are unevenly distributed across the country with incidence and death rates remaining higher in the poorer, southern states than elsewhere in the country (Andión Ibáñez *et al.*, 2015).

Brazil

Brazil has made substantial progress in improving access to most maternal-health and child-health interventions and has experienced success in reducing regional and socioeconomic inequalities in access to

these interventions. However, age disparities persist in access to pregnancy care for adolescents and young women, even though more than 20% of all infants in Brazil in 2008 were born to adolescent mothers.(Victoria *et al.*, 2011). The proportion of sterilizations has decreased; yet lower-income women are more frequently sterilized. Abortions are mostly illegal; but women with more money have better access to safe abortions in private clinics. Poorer women generally self-induce abortion with misoprostol, seeking treatment of complications from public clinics (Diniz *et al.*, 2012).

Thailand

In Thailand almost all relevant SRH services envisioned in the Programme of Action (POA) of the International Conference on Population and Development (ICPD), including treatment of reproductive tract cancers have been included in the UHC benefit package' (Tangcharoensathien *et al.*, 2015, p246). However, access to safe abortion is a challenge. Although abortion is legally restricted in Thailand, both safe and unsafe abortion are widespread across all socioeconomic groups. Many abortions take place in private sector facilities, in unmarked abortion clinics, or by self-induction. Factors influencing access to abortion services include socio-cultural, religious beliefs and attitudes of providers and politicians, and service availability including service providers. The majority of providers are located in Bangkok and this is a challenge for women living outside the capital city. The case of Thailand illustrates that legal reforms need to be accompanied by improvements in availability and acceptability of safe abortion services to improve access (Arnott *et al.*, 2017).

As is evident from the above, there are various non-financial barriers that impact on access to SRHR services, particularly those which are politically and culturally sensitive (i.e. safe abortion, access to contraception for adolescents). These range from restrictive laws and policies, gendered cultural norms and practices and poor-quality care. This is in effect a violation of women's sexual and reproductive health rights. As Sen and Govender argue ((2014, p230), "Attention to human rights would have meant reorienting service provision as well as data gathering and monitoring systems to 'follow' the individual rather than the services provided, but few health reforms have taken this approach."

Right to respectful and non-discriminatory care

There has been renewed focus under target 3.8 (of SDG 3) on "access to quality health-care services". This is based on evidence indicating that despite improvements in access to essential health services achieved during the MDG era, poor quality service delivery is a key driver for failure to address maternal and child mortality amongst those hardest to reach in LMICs (WHO *et al.*, 2018). Weak and poorly functioning health systems, characterised by poorly trained staff, lack of essential inputs and infrastructure, particularly in lower level facilities compromise service delivery and ultimately both access and quality of care.

This has translated into stepped-up calls for investing in improving the quality of health services. This is evident in the recently published joint report by WHO, OECD and the World Bank, titled "*Delivering quality health services: A global imperative for universal health coverage*"(2018). The Report indicates that while quality of care is primarily a challenge in LMICs and results in poor health outcomes, it is also a problem in high income countries (HICs), where 1 in 10 patients 'are harmed while receiving health care. In LMICs, wider challenges relating to the slow pace of social and economic development, spill over into the health system, where poor sanitation and lack of water continue to hamper service delivery. Even when basic infrastructure is addressed, mal-distribution of health services challenges access.

With respect to gender and specifically women, the joint report indicates that, even when financial and geographic barriers have been addressed, access to respectful and compassionate care and voice in decision-making during delivery not only affect women's experiences of services, but also have implications for health outcomes. This is evident from numerous countries including India, where an increase in institutional deliveries from 14% to 80% in India had ambiguous results in terms of maternal and child mortality because of poor quality of care (Ng *et al.*, 2014). Several countries have embarked on programmes to improve quality of care (WHO *et al.*, 2018).

Quality health care has measurable characteristics: effectiveness, safety, people-centredness, timeliness, equity, integration of care and efficiency (WHO *et al.*, 2018). Through a human rights lens, the AAAQ approach links quality to availability, accessibility, and acceptability of services.

Acceptability is a critical dimension of effective coverage in the context of SRH which is understood as "SRH services must be acceptable to consumers, culturally appropriate and be sensitive to vulnerable groups." (Kähler *et al.*, 2017, p5). Therefore, acceptability goes beyond availability and accessibility to encompass cultural acceptability, respectful care, free of discrimination based on gender, culture or religion.

At its core, acceptability deals with the relationship between health workers and patients. As noted by Govender and Penn-Kekana (2008), people's experiences of the health system are shaped by the nature of their relationship with health care workers. In turn, health care workers' attitudes and behaviours are shaped by the social context in which they live and work. The gaps between the provider and patient with respect to gender, class, caste, ethnicity, and other social stratifications (i.e. the social distance) are important in shaping the interaction. Gender roles, norms and relations, which are context-driven, shape perceptions, experiences and ways in which men and women as healthcare users define their health and health needs. As is well established in the literature across a diverse range of settings, this in turn contributes to gender-based differences in treatment-seeking behaviour and communities' interaction with the health care system across a range of conditions and services. Health workers, particularly those operating at the 'coal face' of service delivery, are central for providing quality, safe and effective health care and be responsive to communities and patients' needs. It is not surprising then that health worker attitudes - admittedly only one dimension of acceptability and effective coverage and access - are critical for facilitating access, particularly for the most marginalised and vulnerable.

Research from several countries indicates that women and girls suffer discrimination, violence, abuse and disrespect in health care institutions, particularly in relation to delivery and access to contraception (Maya *et al.*, 2018; Sen *et al.*, 2018; Solnes Miltenburg *et al.*, 2018). As noted by Sen *et al.* (2018) "Across Latin America and in India, systematic documentation of religious, ethnic and racial minority women's interactions with providers speak of the "triple burden" they face when seeking institutional childbirth". Box 7 describes institutional violence in health facilities in Brazil and Mexico.

Box 7: Institutional Violence: Undermining quality of care and access in Brazil and Mexico

Brazil

An evaluation of the quality of abortion care for women admitted to public hospitals in three of Brazil's state capitals (Salvador, Recife and São Luís) found that that care provided was far below the standards set by the Brazilian government, and pain management was frequently inappropriate. It also found other forms of discrimination, such as the postponement of curettage until night shifts. Continuity of care and provision of post-abortion contraceptive information were also almost absent. Abuse and disrespect in health care, has been recognised as a form of institutional violence. The Perseu Abramo Institute report, based on interviews with 2,365 women and 1,181 men in urban and rural areas in all Brazilian states reported that among women who were hospitalized for complications of abortion, 53% reported some form of violence from health care providers (men and women), including refusal of information, failure to obtain consent, delay and neglect in assistance, being threatened with prison, and verbal abuse. Among women asked about such violence during childbirth, 25% reported some form of violence (27% in the public sector and 16% in the private sector), including verbal abuse and abuses such as refusal of pain relief and painful, repeated vaginal manipulation. Women at the top of the social hierarchy (white, married, with higher education) were less vulnerable to but not free from such violence. (Diniz *et al.*, 2012).

Mexico

In Mexico, institutional violence is a serious challenge for all women, especially indigenous women. A 2013 study of Jalisco in north-western Mexico indicated that Huichol Indigenous reported abusive behaviour by the local health personnel (Castro *et al.*, 2015a). Castro *et al.* (2015, p107) argue that these forms of institutional violence are "embedded in both the country's medical education system and in the hierarchical power structures within hospitals. Discriminatory actions by medical providers certainly reflect personal prejudices, however, they also stem from the medical field's overarching norms that all too often portray women as inferior or undeserving of medical citizenship and other rights".

The Joint WHO/World Bank/OECD report acknowledges the role of quality of care in contributing to maternal and neonatal mortality and with specific reference to the above discussion on institutional violence. Although it does not mention "institutional violence" as such, it recognises that a "growing body of research on respectful maternity care indicates that women experience poor interactions with health care providers and exclusion from care decision-making, and are often not informed about the details of their care" (p34) However, the report is disappointingly silent on making the link between the right to health¹ and the right to quality care, as the critical linchpin for mobilising policy and action towards arresting maternal and neonatal mortality. The closest the report gets to the issue of rights and accountability is framed in terms of "Formalized community engagement and empowerment...can function as an additional accountability mechanism." (p67). A rights-based approach to UHC demands specific obligations on states to uphold, fulfil and protect those rights. This clearly falls short in terms of the bold messages that are required for addressing issues of violation and inequality.

3.4 Health Workforce

Top-line messages:

¹ articulated in UHC and in the Framework on Integrated People-Centred Health Systems

- ❖ The health workforce is deeply gendered in terms of its composition, its professional hierarchies, seniority, pay and conditions of work. It includes both formal and informal, paid and unpaid workers, with women typically being at the lower ends of the workforce hierarchy.
- ❖ Women and girls are disproportionately represented in unpaid health-care work.
- ❖ Addressing the burden of unpaid care work in the context of UHC will require substantial investments in health systems, particularly in areas of long-term and palliative care, guided by principles of solidarity and integrating gender into policy and programme implementation.
- ❖ Violence against health workers, particularly those operating at the front line is a growing challenge. Gender-based violence, despite its implications for the working environment, patient outcomes and performance of the health system is an under-recognised area. It requires critical attention in the context of advancing the health and rights of women as health workers.

Policy directions:

- Implement international agreements that protect and promote the economic and labour rights of health care workers, paying special attention to those working at the front-line (i.e. community care workers, traditional midwives, caregivers in the informal economy) (ILO, 2018). This requires implementation of policies supporting SDG 5.4² as well action on SDG 3 (health), SDG 4 (education) and SDG 8 (decent work) and the Global Strategy on Human Resources for Health: Workforce 2030(WHO, 2016)³
- Strengthen country level HRH databases beyond the more established, formal health workers (doctors, nurses, pharmacists, dentists and midwives) to better account for these less-qualified (e.g. community care workers) and those in the unpaid economy.
- Track the unpaid care economy to quantify, monitor and effectively respond to the burden on households and especially women and girls in the health system.

The Global Strategy on Human Resources for Health: Workforce 2030 (WHO, 2016) and the United Nations High-Level Commission on Health Employment and Economic Growth (2016) represent bold and unprecedented calls to action advocating for increased investments in human resources for health (HRH). This comes at a time when there is also recognition that HRH are a key part of resilient, people-centred health systems and essential to achieving UHC (WHO *et al.*, 2018). These global calls for action are necessary and urgent responses to addressing the critical shortage of HRH both in terms numbers and quality globally, but more acutely experienced in LMICs, as posing a severe challenge for the functioning of health systems (WHO, 2016).

² SDG 5.4: Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

³ Aims to guarantee the “right of health workers to be free from gender discrimination and violence in the workplace and ensure ‘decent work for all.’”

Equitable access to health care depends not only on the number and quantity of health workers, but also their distribution. The density of health workers measured by the number of health workers per 1,000 population is a gauge of the availability of health workers. Table 4 below indicates the density of health workers (nursing and midwifery and physicians) across the country case studies.

Table 4: Availability of Health Workers (Density Per 1 000 Population) Across Country Cases

Health worker density per 1 000 population	Brazil (2013)	Mexico (2015)	Thailand (2015)	Rwanda (2015)	Ghana (2010)
Nursing and midwifery	7.444	2.645	2.294	0.832	0.998
Physicians	1.852	2.231	0.47	0.064	0.096

Source (WHO Global Health Observatory, 2018)

While there are more severe shortages in Rwanda and Ghana for both types of health workers compared to Brazil, Mexico and Thailand, inequalities in the distribution of the health workforce are present in all countries, challenging access for certain groups of the population based on geographic location, and socio-economic status.

Brazil, despite displaying relatively favourable availability of health workers overall (Table 4), suffers from their unequal distribution. Health workers are concentrated in the richest sections of the country, leading to reduced access for the poorer regions and populations. This has persisted despite major health reforms focused on improved access of health services for the poor (Sousa *et al.*, 2012). Similar problems are experienced in Thailand, where inequities in the distribution of health workers occur by geographic location (between capital city and other provinces) and between public hospitals and private facilities (Sakunphanit, 2016).

Turning to countries with lower health worker density, the challenges are expectedly more acute. In Ghana for example, despite a free Maternal Health Care Policy, poor access and low levels of utilisation are a challenge especially for poor and marginalised women in the informal economy (Alfers, 2013). This is driven in part by the concentration of doctors and university-trained nurses in the two major metropolitan areas, to the detriment of remote and rural districts (Rachel *et al.*, 2013). In Rwanda, as a consequence of the genocide which resulted in many trained health workers fleeing the country, there is a shortage of competent trained healthcare providers (Binagwaho *et al.*, 2013a). One of the interventions used by the Ministry of Health to overcome this was task-shifting and introducing community health workers in the context of HIV scale-up (Shumbusho *et al.*, 2009).

The above discussion (i.e. availability of health workers) primarily speaks to the formal economy of care and does not take account of the large numbers, particularly women, who are involved in health work, caring for ill family members or in the community as community health workers or volunteers (i.e. the informal care economy). The health system is deeply gendered in terms of its composition, its professional hierarchies, seniority and ultimately experience of the health system, both informal and formal, paid and unpaid.

It is widely recognised that the health workforce is gendered in many ways (see Box 8). Although women comprise often more than two-thirds of health workforces, they occupy lower-status health occupations and are poorly represented among more highly trained professionals and in positions of management (WHO, 2016). The under-representation of women in positions of leadership may not only contribute to gender-blindness of the working conditions that women experience, but also in relation to the gendered health needs of women (WHO, 2009).

Box 8: The Gendered Health Workforce

- Workforce structures and concentration hierarchies
- Client-provider interactions
- The female composition of the workforce particularly at the primary level
- The experiences of female nurses, community health workers, and home carers, including the unpaid, underpaid, unsupported, and disproportionately female workforces that often constitute the informal care economy
- The ways in which (especially) female workers' normal life experiences (for example, pregnancy, child care) become problematized due to their incompatibility with male work models that do not take life course events into account
- Access to non-pecuniary rewards, continuing education, and professional training
- Differences in wages
- Disparities in workplace safety knowledge
- Blindness of occupational health research
- Health worker mobility
- Perceptions of health and quality of life among health workers

Source: (Newman *et al.*, 2011)

There are numerous issues relating to gender discrimination and inequality which not only challenge the personal and professional experience of health workers but often have adverse implications for service delivery and performance. However, given the focus of the paper and constraints of space, we will focus on one of the most critical, but least addressed issues facing health workers, namely gender-based violence in the workforce and informal care economy.

Nurses are three times more likely, on average, to experience violence in the workplace when compared to other occupational groups (ILO, 2003). Of concern is the finding that nurses are subjected to verbal and physical abuse so frequently that these events are often accepted as “part of the job” (Speroni *et al.*, 2014). In India, the prevalence of workplace violence against resident physicians in a tertiary facility was estimated to be 56%-75% (Tanu *et al.*, 2016).

Violence against health workers was reported in all case studies (Díaz-Olavarrieta *et al.*, 2001; ILO, 2003; Newman *et al.*, 2011; Tanu *et al.*, 2016). Violence against health workers is committed by patients and their relatives and also committed by hospital co-workers, particularly emotional abuse and sexual harassment. In several countries a pattern seems to emerge (although this is not true for all countries) whereby patients and their relatives are the main perpetrators of physical violence while staff are the main perpetrators of psychological violence. In Thailand, 72% of cases of physical violence were committed by patients and the majority of cases of verbal abuse were committed by staff (di Martino, 2003). Further, female health workers not only experience higher rates of violence but also suffer

greater physical and psychological harm from such violence (Di Martino, 2003). In Mexico, younger health workers reported more abuse and health workers who were separated or divorced and having suffered physical/sexual abuse during childhood were associated with physical/sexual abuse in adulthood (Díaz-Olavarrieta *et al.*, 2001).

Box 9: Workplace violence and gender discrimination in Rwanda's health workforce

Newman *et al.* (2011) investigated the link between workplace violence and gender among health workers in Rwanda. They found that violence was experienced by 39% of the health workers sampled, with similar rates of verbal abuse, bullying and physical violence among men and women, and higher rates of sexual violence among women. These findings suggest that workplace violence is an occurrence that most health workers may feel they can or must live with, almost as a normal part of the job, but that the experiences of bullying and sexual harassment are more likely to result in a female health worker leaving a job. Gender inequality at work (unequal treatment and unequal access to jobs) was associated with increased odds of workplace violence. Gender-based violence at work emerged as one component of wider gender discrimination that reduces women's employment opportunities, penalizes them for their biological reproductive role, and limits their economic freedoms. The gender-sensitive, multisectoral recommendations made by the stakeholder institutions and recent changes in Rwanda's labor law to address workplace violence are promising steps towards a goal of making the health sector safer and more gender-equitable for its workforce. (Newman *et al.*, 2011).

Violence in the health system and specifically gender-based violence, despite its implications for the working environment, job satisfaction, patient outcomes and ultimately the performance of the health system is an under-recognised and under-studied area. It requires critical attention in the context of advancing the health and rights of women as health workers in addition to being clients in the health system.

Alongside formal health care delivery is the informal care economy. The responsibility of caring, whether it is for children, sick or the elderly has traditionally across all societies fallen upon women and girls. This was particularly severe in the wake of the HIV/AIDS epidemic, where in the context of weak and severely under-resourced health systems, girls and women, often had little choice but to interrupt their education and employment in order to care for the ill (UNESCO, 2010).

As noted in the recently published ILO report (2018), as populations age - a phenomenon first in high-income countries, now increasingly so in LMICs – the burden of care for the elderly, as well as for household members who are ill (short-term or chronic) or with disabilities, often falls on women and girls. A study of the determinants of informal care supply for older adults in Yucatan, Mexico found that almost 80% of caregivers were women and less than a quarter were men, with girls more likely to take on the role as caregivers (Angst *et al.*, 2019). A larger proportion of men in comparison to women worked while providing care, and women provided more hours of care work per month on average than men. The burden of unpaid care work is a barrier to women entering the labour force. It is reported that in 2018, more than 600 million working age women (compared to 41 million men) said that they were not able to do so because of unpaid care work. The ILO has called for urgent action to prevent a looming global care crisis (2018). It is not only a crisis from the perspective of a loss of economic empowerment for women, but it also shifts the burden of care including both

financial and time costs onto households. This requires that if the burden of unpaid care work is to be addressed in the context of UHC, it will require substantial investments in health systems particularly in areas of long-term and palliative care, guided by principles of solidarity and integrating gender into policy and programme implementation.

3.5 Health Information Systems

Top-line messages:

- ❖ In LMICs, weak health information systems challenge effective tracking of critical gender and rights concerns by UHC indicators on service coverage and financial protection.
- ❖ There is an urgent need to prioritise and invest in strengthening national health information systems and prioritise reporting disaggregated data by sex and other markers of social exclusion.

Policy directions:

Timely and robust information and evidence is key for engendering, holding and advancing the health of women, adolescents and girls in the context of UHC and Agenda 2030. This requires action in the following areas:

- Tracking gender and rights in monitoring progress of UHC (SDG Target 3.8), other gender-related SDG 3 targets as well other SDGs particularly SDG 5
- Investing and strengthening country level capacity for monitoring and analysing relevant sex-disaggregated data along the six building blocks
- Monitoring progress on gender and rights through tracking population and service coverage, financial protection and health outcomes by stratification of the population into groups paying attention to gender and other markers of vulnerability and marginalisation (Sen and Iyer, Forthcoming).

To be able to effectively monitor UHC progress and broader health systems policy and programmes by gender and specifically for women, adolescents and girls, sex-disaggregated data is required. This entails the availability of necessary health information systems to collect and track civil registration and vital statistics by gender, income, age and location. However, as argued in the joint UNICEF and WHO report on Tracking Progress towards Universal Coverage for Reproductive, Newborn and Child Health (UNICEF and WHO, 2017, p2-3), “...lack of timely data and major data gaps preclude disaggregation for better targeting of programmes and services to the populations most in need. The gaps are particularly serious for causes of death, quality of care, nutrition programmes, adolescent health, and financial and health system inputs.”

In the context of the MDGs and now Agenda 2030, global multi-institutional collaborations such as Countdown to 2030⁴ charged with tracking progress for maternal, new-born, and child survival for more than a decade have been key in tracking progress. A key challenge in all countries are the National Civil Registration and Vital Statistics Systems⁵. Gender and HRH experts have also argued for more research and sex-disaggregated data to strengthen understanding of gender as it affects health workers, especially in developing countries. These enormous gaps in data quality and what gets collected, analysed and monitored is a cross-cutting challenge across all the building blocks.

3.6 Access to Essential Medicines and Health Technologies

Top-line messages:

- ❖ Expenditures on medicines are an important contributor to catastrophic health expenditure.
- ❖ Research on the role of gender in determining access to medicines and health technologies and the financial burden of payment is currently very limited.

Policy directions:

- Policy and programmatic action are required with respect to two important global calls including the Lancet Commission on Essential Medicines Policies for Universal Health Coverage (Wirtz *et al.*, 2017) which identified five areas that are crucial to essential medicines policies including making essential medicines affordable. With respect to affordability, the following recommendations were made (Wirtz *et al.*, 2017, p1):
 1. “Governments and national health systems must provide adequate financing to ensure inclusion of essential medicines in the benefit packages provided by the public sector and all health insurance schemes.
 2. Governments and national health systems must implement policies that reduce the amount of out-of-pocket spending on medicines.
 3. The international community must fulfil its human rights obligations to support governments of LICs in financing a basic package of essential medicines for all, if they are unable to do so domestically.
 4. Governments and national health systems must invest in the capacity to accurately track expenditure on medicines, especially essential medicines, in both the public and private sectors, disaggregated between prepaid and out-of-pocket expenditure, and among important key populations.”

⁴ Global collaborations of academics, governments, international agencies, healthcare professional associations, donors, and civil society organizations (CSOs) focuses on monitoring and reporting coverage levels of effective interventions and health system functionality, as well as health policies, financing, and equity.

⁵ Civil registration systems are used to record vital events such as births, deaths, and marriages.

- Of relevance for this paper, is a paucity of data disaggregated by gender in each of the identified five policy areas and those specific to financing of essential medicines. Therefore, as these recommendations are integrated within national UHC plans, there is need for advocacy for incorporating gender within planning, programme monitoring, evaluation and service improvement.

The *Lancet* Commission on Essential Medicines Policies (Wirtz *et al.*, 2017, p1) indicated that “Globally, a quarter of all health expenditure is on medicines. In many countries, the main source of financing for medicines is direct payment by the individual and households—this source is both highly inequitable and inefficient, and its reduction is a key target for UHC”. In the context of UHC, multiple health financing schemes imply variations in benefit schemes including access to medicines and health technologies. This is the case in Mexico, where drug coverage differs by social health protection scheme (OECD, 2016a). It was found that between 78% and 89% of beneficiaries of private and public-sector insurance schemes received their prescriptions free of charge compared to only 60% of beneficiaries covered under Seguro Popular (generally covering poorer population groups).

Equally concerning is that expenditure on outpatient medicines are a major driver of catastrophic health spending (WHO and The World Bank, 2017, p38). In India, healthcare expenditure on medicines is the single largest component of the total OOP payments by households (Sakthivel Selvaraj *et al.*, 2012, See Box 10).

Box 10: Out-of-pocket payments on medicines contributing to impoverishment in India

India has implemented several health insurance schemes. However, the majority of the country’s population are burdened by OOP payments on medicines while seeking outpatient care. In India (in 2011–2012), total OOP payments and OOP payments for medicines were catastrophic for 17.9% and 11.2% households, respectively, at the 10% of total consumption expenditure threshold. This implied that 29 million households incurred catastrophic OOP payments and OOP payments on medicines pushed 38 million persons into poverty over that period. Therefore, there is limited access to medicines. Cancers, injuries, cardiovascular diseases, genitourinary conditions and mental disorders were the leading cause of diseases that caused significant OOP payments. Non-communicable diseases (e.g. cardiovascular diseases) which require multiple consultations and long-term or lifelong medication support contribute to catastrophic expenditure for households even in the absence of hospitalisation episodes. (Sakthivel Selvaraj *et al.*, 2012)

A review of the literature for this paper both for the country cases and more widely indicates significant evidence gaps. These gaps include lack of national level data which examine and estimate the burden of health expenditure on medicines. There was little evidence which examined how access to medicines differed between men and women and the role of gender therein. An important question is the extent to which the rationing of health resources within households might mirror gender, age and other hierarchies in determining differential access to medicines. One of the few studies which examined access for women to drugs and specifically continuous prescription drugs for a group of chronic diseases was a study from Brazil (Katrein *et al.*, 2015). It was found that higher access was associated with residence in a rural area, having one or two chronic diseases, and higher socioeconomic status. These are critical areas of financial protection that need to ongoing monitoring and go beyond aggregates to capture the burdens by gender and other markers of vulnerability.

3.7 Governance

Top-line messages:

- ❖ Governance and accountability are central to UHC, Agenda 2030, the work of the Commission on Information and Accountability for Women's and Children's Health, and of the International Accountability Panel of the UN Secretary General's *Every Woman, Every Child, Every Adolescent* Initiative.
- ❖ For effective accountability, it is obligatory on states to ensure that women and groups that are marginalised are aware of their right to health, including SRHR and are empowered to claim their rights.
- ❖ Compel the compilation of monitoring and evaluation indicators that track human rights and gender.

Policy directions:

In the context of UHC, Agenda 2030 and country level commitments to advancing the right to health and the gender equality, hold governments accountable is essential. This requires action in the following areas:

- The evidence on governance and specifically accountability requires deeper understanding of the barriers to women's engagement in different political spheres in engaging and strengthening social accountability programming and efforts therefore requires an understanding of potential barriers.
- Increase and facilitate social accountability through strengthening the participation of women and marginalised groups to engage in more formal political processes. More specifically, this entails public participation and involvement in the design, implementation, monitoring and evaluation of UHC policies and programmes.

In recent years, as efforts to strengthen health systems and health service delivery, and more recently in the context of UHC and Agenda 2030, have gathered momentum, governance and specifically accountability have begun to receive increasing attention. Governance is a cross-cutting building block of the health system and is defined in terms of 'stewardship'. It calls for strategic policy frameworks combined with effective oversight, regulation, incentives and accountability (WHO, 2000). More recently, health system governance has been described as 'an aggregation of normative values such as equity and transparency within the political system in which a health system functions' (Balabanova *et al.*, 2013). Much of the focus remains on monitoring improvements of service delivery and health performance judged by improved access and quality of care. As McGinn *et al* (2015, p30) argue, "It is precisely at the service delivery level where failures in government policy, financing, management, and administration are felt most acutely by citizens, through the absence, or poor quality, of certain services, including respectful care."

While there are several aspects to governance, we will focus on accountability for the following reasons. First, accountability is inextricably linked to gender, human rights, transparency, and participation. Second, accountability is central to Agenda 2030 and more recently to the work of the Commission on Information and Accountability for Women's and Children's Health (WHO, 2011), and of the International Accountability Panel (IAP, 2018).

A systematic review by Van Belle *et al* (2018) of accountability relating to SRHR found that there were five health areas of focus. These include maternal, neonatal and child health services, HIV services, gender-based violence, lesbian/gay/bisexual/transgender access and access to reproductive health care in general. Key strategies for building accountability in SRHR include performance⁶, social⁷ and legal⁸, and key instruments include citizen report cards, community scorecards, social audits, budget analysis (See Box 11) and participatory output monitoring (Van Belle *et al.*, 2018).

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Box 11: Budget Analysis and Community Scorecards: Instruments for Building Accountability in Mexico and Ghana

Budget analysis for accountability for maternal health in Mexico

'In Mexico, two civil society organisations (CSO) partnered for budget tracking government budgets, specifically monitoring how federal allocations are used at the local level for maternal health. The CSOs were Kinal Antzetik, a grassroots CSO with a strong health promoter and indigenous network, and Fundar, an organization experienced in budget analysis and federal-level advocacy. This process of tracking relies on data provided by government institutions and are supported by Federal Access to Information Law. Data obtained through budget tracking was complemented with interviews and field observations to determine whether and how the allocated funds were actually spent to improve local services. This information was reported back to the federal level and used for advocacy by Fundar at the state level for improved tracking and transparency. This process contributed to providing evidence that could influence decision-making in the executive and legislative branches of government as well as strengthened CSO networks' ability to influence public policy while contributing substance to public debate through media collaboration. Knowledge of earmarked federal budgets has become a tool to demand service provision at the community level. '(MacArthur Foundation, 2012, p6)

Scorecards and social accountability for improved maternal and newborn health services in Ghana

In response to limited availability of quality emergency obstetric and newborn care (EmONC), the MamaYe-E4A programme initiated a pilot intervention using a social accountability approach (that is, when ordinary people or civil society are involved in how the accountability operates) in two regions of Ghana. Through the use of scorecards to assess and improve maternal and newborn health services, the intervention study evaluated the effectiveness of engaging multiple, health and non-health sector stakeholders at district level to improve the enabling environment for quality EmONC. It was concluded that social accountability initiatives can have great potential create a culture of accountability for improved quality of care in MNH. Scorecards and social accountability for improved maternal and newborn health services (Blake *et al.*, 2016)

From a gender, equity and empowerment perspective, processes and systems which build accountability of the health system are essential for advancing the health and rights of women

⁶ In relation to service, managerial, administrative or programmatic issues (Van Belle *et al.*, 2018)

⁷ In relation to capacity of communities to demand improved service delivery and provider responsiveness through raising community awareness and voice (Van Belle *et al.*, 2018)

⁸ In relation to holding the government accountable to wronged citizens and communities (Van Belle *et al.*, 2018)

and girls. Murthy defines it as “...the processes by which power holders in the health sectors engage with and answer to citizens, and enforce actions in such a manner to reduce gender inequalities in health and address gender-specific health concerns and rights of women and men.” (Murthy, 2007, p7). But as Waldman *et al.* (2018, p81) observe, “there has been little work which brings together these two bodies of work [i.e. gender and accountability] from a health systems strengthening perspective; and this is an important gap that needs addressing.”

Given the expanding focus on accountability, there is opportunity for building gender analyses into intervention programmes to shed light on critical areas that Waldam *et al.* (2018, p82) identify as critical gaps including “how gender and accountability interact, what mutual benefits and tensions exist, and what opportunities there are for developing gender-transformative accountability processes that address and transform unequal gender norms, roles, and relations at all levels”. This also suggests the potential of the health system to take the lead in advancing gender and social transformation.

3.8 Implications for Research and Evidence

It need hardly be reminded that building the evidence base of UHC-related policies and programmes within and outside of health and how they impact on the health and rights of girls and women is critical. Notwithstanding the challenges of locating research published in English from Brazil and Mexico, a glaring finding from the literature search for this paper background, are the worrying evidence gaps in several areas:

- Overall lack of disaggregated sex data with respect to several health systems building blocks, most notably access to medicines and the health workforce, including unpaid health care work.
- Weak if not absent inclusion of gender and rights-based approaches (i.e. differential access to resources, participation in decision-making processes from the household to health governance) under-scored by principles of solidarity in terms of the design of both UHC financing and governance and accountability mechanisms (and now more recently social accountability).
- A dearth of evidence on the impact of UHC reforms in terms of building access analysed along lines of gender and intersectionality.
- Insufficient context-relevant implementation research of what works in health systems strengthening policies and programmes across the six building blocks.

Research agendas must be derived through participatory processes and meaningful engagement of key stakeholders including those hardest to reach (i.e. women, adolescents, marginal, vulnerable and key populations) and civil society, in addition to government and researchers and regional and global partners. Given the central importance of SRH for achieving UHC, research agendas will have to be built around a framework which embeds gender and SRH within the objectives of UHC. They must take account of specific issues such

as accountability, quality of care and inter-sectoral action, which are necessary for addressing the underlying social determinants of health.

4. Concluding Remarks

Human rights and solidarity may receive attention in global and national principles, statements. However, as warned earlier, the devil lies in the detail. Unless human rights and solidarity are the pillars upon which UHC is designed and implemented, policy, programme and impact attention will remain steadfast on improvements in addressing health socio-economic inequalities. Other markers of social exclusion and marginalisation (i.e. gender, race, ethnicity, language etc.) will either be postponed or neglected.

In highly unequal societies, the chasm between “them” and “us”, the “haves” and “have-nots” although best documented in terms of income inequality, are also pervasive across of other social markers (i.e. gender, caste, race, language etc.). However, in highly unequal societies irrespective of the social marker, it remains a challenge to build solidarity and collective responsibility for ensuring the inclusion and prioritisation of resources of those worst off. In such instances, it requires a re-examination of the role of the state and its obligations in terms of fulfilling the right to health.

The right to health, guided by principles of solidarity obliges government to reorient public spending towards ensuing increase public spending on health and redistributing resources to those with priority needs especially those facing intersecting inequities. Given that the health system itself often mirrors the very patterns of exclusion at a societal level, through tackling inequalities in health and health care access, the health system has the potential to play a transformative role.

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Annex 1: Equity on the Path to UHC: Deliberate Decisions for Fair Financing

Two major sets of policy directions to advance equity in UHC have both used an approach that spells out what kinds of choices are unacceptable. The WHO Consultative Group on Equity and UHC (WHO, 2010a; Norheim, 2015) illustrates some of the difficult real-world situations which may be faced by policy-makers on the way to UHC and provides guidance, from an ethical perspective on what would be unacceptable trade-offs. They also called for robust accountability mechanisms including effective monitoring along the three dimensions of the UHC cube as well as the processes used. The Group argued that the following five trade-offs can be considered *generally unacceptable* and incompatible with fair progressive realization of UHC.

1. To expand coverage for low- or medium-priority services before there is near universal coverage for high-priority services. This includes reducing OOP payments for low- or medium-priority services before eliminating OOP payments for high-priority services.
2. To first include in the universal coverage scheme only those with the ability to pay and not include informal workers and the poor, even if such an approach would be easier.
3. To give high priority to very costly services (whose coverage will provide substantial financial protection) when the health benefits are very small compared to alternative, less costly services.
4. To expand coverage for well-off groups before doing so for worse-off groups when the costs and benefits are not vastly different. This includes expanding coverage for those with already high coverage before groups with lower coverage.
5. To shift from OOP payment toward mandatory prepayment in a way that makes the financing system less progressive.

Source: (WHO 2010a)

A similar approach has been taken in a recent one-pager based on the Background Paper prepared for the 3rd Annual UHC Financing Forum (Equity on the Path to UHC: Deliberate Decisions for Fair Financing) organized jointly by the World Bank and USAID. Ten unacceptable choices were identified across the three core financing functions of raising revenue, pooling funds, and purchasing services (World Bank, 2018a).

Raising Revenue

1. Raise additional revenues for health that make contributions to the public financing system less progressive without compensatory measures that ensure that the post-tax, post-transfer disposable income distribution is not less equal.
2. Increase out-of-pocket payments for universally guaranteed personal health services without an exemption system or compensating mechanisms.
3. Raise additional revenues for universally guaranteed personal health services through voluntary, prepaid and pooled financing arrangements based largely on health status, including pre-existing conditions and risk factors.

Pooling

4. Change per capita allocations of tax revenue or donor funds across prepaid and pooled financing schemes in ways that exacerbate inequities, unless justified by differences in need or the availability of funds from other sources.
5. Within financing schemes, change per capita allocations from higher to lower administrative levels in ways that exacerbate inequities, unless justified by differences in need or the availability of funds from other sources.
6. Within schemes or pools, change allocations of funds across diseases in ways that exacerbate inequities, unless justified by differences in need or the availability of funds from other sources.

Purchasing

7. Introduce high-cost, low-benefit interventions to a universally guaranteed service package before achieving close to full coverage with low-cost, high-benefit services.
8. Increase the availability and quality of personal health services that are universally guaranteed in ways that exacerbate existing inequalities unless justified by differences in need.
9. Expand the availability and quality of key inputs to produce a universally guaranteed set of personal health services in ways that exacerbate existing inequalities unless justified by differences in need.
10. Increase the availability and quality of core public health functions in ways that exacerbate existing inequalities unless justified by differences in need.

Source: (World Bank, 2018b)

Annex 2: Social Determinants of Health and Key SDGs

The following SDGs and their targets are of particular importance to the social determinants of health:

- SDG 1 (End poverty in all its forms everywhere) - *Target 1.3* (Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable);
- SDG 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture) – *Target 2.1* (By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants to safe, nutritious and sufficient food all year round);
- SDG 2 – *Target 2.2* (By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons);
- SDG 3 (Ensure health lives and promote well-being for all at all ages) - *Target 3.7* (By 2030, ensure universal access sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes);
- SDG 3 - *Target 3.8* (Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all);
- SDG 5 (Achieve gender equality and empower all women and girls) - *Target 5.4* (Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate); and
- SDG 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all) - *Target 8.5* (By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value).

Annex 3: Country Case Studies

Brazil

Health Financing

The Brazilian Unified Health system (SUS) is financed by pooling funds in three levels Federal Government transfers, municipalities, and states reaching a universal health coverage for all citizens including informal sector, the poor, unemployed, and people living in both urban and rural areas. Moving from a formerly segregated highly in-equal health system, through implementation number of reforms for financing – The family health program, the community health agents' program, and the per-person payments to municipalities - resulted in an expanded comprehensive primary care provision to the poorest regions under principles of universalism and equity. (Atun *et al.*, 2015a). A study examining the impact of expansion reforms of the FHS program between 2000 to 2013 showed a increased utilization of health services and greater reduction in deaths caused by infectious, chronic diseases, anaemia and nutritional deficiencies two folds greater among black and mixed race population than white population. These results suggested that FHS facilitated access, reduced unmet needs and reduced health inequality gaps. (Hone *et al.*, 2017b).

Conditional cash transfer schemes such as Bolsa Familia are another form of social reforms that are designed to reduce poverty, empower women, and expand access to health services, education and nutrition (Atun *et al.*, 2015a). The Bolsa Familia program designating women as transfer recipients, designed to compensate mothers for their traditional domestic and care work role. Studies examined the impact of Bolsa Familia on households showed that it helped women in improving their control over household resources and decision-making power. Also, significant increase in the use of contraception was associated with cash transfers, positive impacts on child-bearing and women's welfare and protection of the household aspects, suggesting more equity in power relations in the household (de Brauw *et al.*, 2014).

For over 25 years Brazilian SUS provided free universal healthcare for the population at all levels of care. FHS (providing PHC) and CCT programs jointly have succeeded in complementing health care services, increase access and utilization especially among the most vulnerable and consequently increasing equity in coverage; however, inequalities persist in secondary and tertiary care. (Barreto *et al.*, 2014).

Studies examining the effect of CCTs on healthcare utilization and health outcomes, showed increased utilization of preventive healthcare services, especially among the poor families. This was resulted from improving quality of health services and linking conditionalities to utilization of effective underutilized health services. (Shei *et al.*, 2014). However, reducing financial barriers through different schemes is not the only factor affecting utilization of health services. Institutional violence in the form of abuse and disrespect is a gender issue that women in Brazil face when utilizing health services. A report published in 2011 on a large sample of men and women at all levels of care in both urban and rural areas, showed that more than half of women hospitalized for abortion complications faced different forms of institutional violence by healthcare providers ranging from verbal abuse, refusal of assistance and information, prison threats and failure to obtain consent. Also, 25% of women reported provider's violence during childbirth (in public and with lesser rate in private sector) ranging from verbal abuse, refusal of pain relief, repeated vaginal manipulation and privacy violation. (Diniz *et al.*, 2012).

In 2011, The National Program for Improving Access and Quality of Primary Care was launched to support sustainability and improve efficiency of FHS programs through flexible funding pay for performance scheme. This program focused on improving quality and user satisfaction and at the same time improve the health team capacity and development (Massuda *et al.*, 2018).

In Brazil, abortion is criminalized by law except for limited case. Therefore, access to safe abortion is only provided illegally by private providers and limited to women with money. Many women who are eligible for induced abortion under the law cannot obtain services. (Diniz and Araújo, 2015).

Health Services and Delivery

The Unified Health system (SUS) in Brazil is decentralized, a mix of public and private providers, Tax-financed with contributions from federal, state, and municipal budgets. All publicly financed health services and most common medications are universally accessible and free of charge at the point of service for all citizens — even the 22.8% of the population enrolled in private health plans.(Macinko and Harris, 2015; Massuda *et al.*, 2018). The Brazilian Health System main approach is primary health care in the form of community health programs. The Family Health Strategy Program (FHS) which started first as a maternal and child health program then was scaled up into comprehensive community-based program providing cost-effective primary healthcare functions to cover underserved populations. FHS team are composed of a physician, nurse and community workers offering a wide range of preventive health services and bridging the gap between primary care and public health efforts.(Macinko and Harris, 2015).

Between 2002 to 2013, Brazil social protection policies resulted in rolling out the conditional cash transfers (Bolsa Familia) programs, expanding the Family Health Strategy (PHC) program, increasing coverage to public health programs (Immunization, TB and HIV) and costly complex interventions such as cancer treatment, organ transplants and kidney dialysis. These policies had a direct impact in reaching near universal access to essential health services such as antenatal care and reducing the social and racial health inequalities among the Brazilian population. (Hone *et al.*, 2017b; Massuda *et al.*, 2018).

The expansion of the Family Health Strategy (FHS) between 2000-2016 has given a rise to the population coverage and access to community-based PHC from 8% to 58.5% of the population (Massuda *et al.*, 2018). This rise in access and utilization of FHS was more prominent within settings with higher poverty rates and mixed-race groups. A recent study comparing the effect of the FHS services expansion on health outcomes showed greater reduction in mortality and improvement in health outcomes among black and mixed-race population, which suggested an improvement in health inequality gaps between different races in Brazil (Hone *et al.*, 2017b).

The United Health System (SUS) is publicly accessible and free at the point of service to the whole population, in which Women represent 2/3 of outpatients' population (similar ratio in private sector), that includes utilizing different SRH services ranging from contraceptives and antenatal care to screening and treatment of cervical and breast cancers (Diniz *et al.*, 2012). Studies shows that adolescents as a group are overlooked in the context (FHS), and they only seek treatment for high risk conditions of pregnancies, STDs and drug use. The study examining responsiveness of SRH services to adolescents' needs supported this view. Results showed that despite the fact that health units are actually more distributed, proportionally staffed with physicians as well as sufficiently supplied with essential SRH supplies of male condoms and contraceptives where there is higher adolescent population. However, services are designed to serve the general population and lack specific adjustments to meet adolescents needs from private treatment spaces, flexibility in service hours and

enough information and brochures to answer their health questions. Also, although emergency treatment services are accessible to this cohort, but mostly constricted by the guardian's presence mandate that is required even in cases of victims of violence and abuse.(Taquette *et al.*, 2017).

The Brazilian (SUS) provides comprehensive curative and preventive healthcare services universally covered and provided at the primary, secondary, and tertiary levels and community participation for all (Barreto *et al.*, 2014). Investment in expansion of emergency and mental health centres was one of the policies adopted by the Ministry of Health targeting reducing the demand on hospital services, decreasing waiting times and improving quality. However, due to shortage of competent specialized workforce, limited administrative capacity and weak coordination between hospitals, PHC and emergency services, it failed to improve the efficiency and the quality of care. (Massuda *et al.*, 2018)

Regulations to enhance coordination and management of the Brazilian (SUS) were adopted in order to grantee accountability, quality, efficiency and access (Atun *et al.*, 2015a). However, results of a study evaluating the quality of abortion care for women in public facilities in three major cities showed the quality of care provided was less than the standards set by the Brazilian government. (Diniz *et al.*, 2012).

Health Workforce

Health care provided under the umbrella of FHS –the community based PHC program- is comprised of a team of a physician, a nurse, a nurse assistant, and four to six full-time community health workers. These teams are geographically distributed to provide care to 1000 households each without gaps in population coverage. Each team roles and responsibilities are organized according to structures based on national treatment guidelines. Community health workers proactively reach out to patients through homes visits dealing with problems before patients need the health facility and deliver immunizations and different public health preventive interventions. Nevertheless, Brazil has suffered from physicians' shortage especially in rural areas due rapid expansion of the FHS and specialists' concentration in private sector, that Brazil has responded to with the controversial Mais Médicos (More Doctors) program in 2013, importing nearly 18,000 physicians from Cuba and other countries. (Macinko and Harris, 2015; Massuda *et al.*, 2018).

Despite the fact that, women count for the majority of health workforce in Brazil (71% at university level and 85% of technicians), managerial and upper hierarchy levels are disproportionately more men focused (Diniz *et al.*, 2012). SRH services in Brazil was not found to be sensitive to the specific health needs of adolescents as a group of patients. Shortage in providing gender-responsive technical content in healthcare professional training schools is the main reason behind the lack of healthcare providers with the capacity to serve the adolescent group of the population in an appropriate and competent way. This is reflected in the fact that less than one third of doctors show some type of capacity in adolescent sexual and reproductive health. (Taquette *et al.*, 2017).

Quality of abortion care provided by public hospitals in Brazil is below the standards set by the Brazilian government. A study examining the quality of abortion care for women admitted in public hospitals, showed inappropriate standards of pain management and applied procedures. Women had to endure long waiting periods, overnights stay, deep sedation and some forms of discriminations. Also, Continuity of care and provision of post-abortion contraceptive information were also almost absent.(Diniz *et al.*, 2012).

Institutional violence by healthcare providers in Brazil is the systematic gender issue and represent a major barrier that impede women's accessibility to SRH services. This includes: verbal abuse, refusal of information and assistance, threats, refusal of pain relief, discrimination against unmarried women, disrespect of privacy and patient's choice. Higher status women (white, married, with higher education) are less vulnerable to but not free from such violence. (Diniz and Araújo, 2015). Additionally, women from ethnic minorities face discrimination and violence that prevent them from accessing quality health services, discrimination is manifested in behaviours practiced by medical personnel, including promoting inequitable power structures between doctors and patients limiting the provider's ability to address patient needs. (Castro *et al.*, 2015b).

Access to Medicines and Health Technologies

Access to medicine is extremely important since it is one of the main components of household budget. In the Brazilian context, although catastrophic health expenditure was declining since 2004, however improving access to medicine was always high on the policy agenda especially due to high reliance on public programs – medicines in particular- by the Brazilian population especially those with lower income. ((Álvares *et al.*, 2017). Since 2004, the Popular Pharmacy Program (Farmacia Popular) was implemented to expand access to medicine through four phases. First, it was adopted by publicly owned pharmacies then it expanded subsidies to private pharmacies, encouraged the use of generics and introduced low level copayments. Finally, by 2012 medicines for hypertension, diabetes and asthma were free in both public and private pharmacies under the “Health has no Price” policy. (Tavares *et al.*, 2015). The number of drugs included on the essential medicines list reached 869 by the year 2017. (Massuda *et al.*, 2018).

Regulations and strategies to improve access to safe and effective medicines to the whole population was adopted by the Brazilian health system since 1990. Started with the law 8080/1990 establishing the right of all citizen in therapeutic and pharmaceutical services. followed by the National Medicine Policy in 1998 ensuring access to essential medicines through (RENAME) the national list of Essential medicines. The Brazilian United Health System then in 2004, adopted expansion of access through development of domestic production for essential medicines to cover the population needs, improving measures for qualification of healthcare professionals and enhancing policies for rational use.(Álvares *et al.*, 2017). And in 2011, a National Commission was established to support the decision making based on evidence for approval of new medicines and technologies in The Brazilian United Health System. (Massuda *et al.*, 2018).

Governance

UHC, decentralization and community participation are the foundations for an equitable health system in Brazil as identified by the National Constituent Assembly. Management of different SUS functions from financing, delivery of health care, and codified inter-governmental funds transfers for health is subjected to regulations aiming to improving accountability, quality and efficiency. The organic law of Brazilian health system defines different roles and responsibilities at different levels of government. (state-level and municipality-level responsibilities in the management of the health system, the mechanisms for inter-governmental transfer of funds, and the arrangements for community participation. Contracting has been introduced between federal and state levels and between states or municipalities and private health-care providers. Public participation and

engagement in health system decision making is facilitated by the decentralized management of health system and increased community participation. (Atun *et al.*, 2015a).

New regulations were adopted by the Ministry of Health, introducing low-cost private health insurance “Popular Health Plans” with limited benefits. Individuals covered by these private plans are partly subsidized by the government through tax breaks when obtaining high-complexity procedure in SUS aiming towards reducing the demand on public services. The expansion of FHS and private plans increased coverage to health services but failed to improve access to quality care among disadvantaged populations (Massuda *et al.*, 2018).

In 2004, a national Comprehensive Woman’s Health policy was launched by the federal government aiming towards expanding the PAISM agenda- PAISM is a woman-focused healthcare program- aiming towards improving access to SRH services, contraceptives, and different aspects of women health. The policy also, was pushing towards integrated services against domestic and sexual violence against women. However, policies pushing towards universalization of access resulted in uneven increased distribution of physicians over the rest of key actors in healthcare team of the integrated services (nurses, midwives and others) (Diniz and Araújo, 2015).

Ghana

Health Financing

Ghana was the first sub-Saharan African country to introduce NHIS in 2003 through an Act of parliament and full implementation started in 2004, with every Ghanaian required to enroll in a health insurance scheme (Alhassan *et al.*, 2016). The NHIS is financed through a central National Health Insurance Fund (NHIF) which is sourced from the National Health Insurance Levy (NHIL) of 2.5% tax on selected goods and services; 2.5% of Social Security and National Insurance Trust (SSNIT) contributions, largely by formal sector workers; payment of premiums, and donor funds. Individuals who are employed in the formal sector and contribute to SSNIT are exempted from premium payment. As at 2012, over 70% of the NHIS financial inflows came from the NIL; 17.4% from SSNIT contributions and 4.5% from premium payments. Other sources of funding to the NHIF include money allocated by parliament of Ghana, grants, donations, gifts/voluntary contributions, and interests accrued from investments.

Premiums are determined on a sliding scale based on income and geographic location, although most districts set a flat rate due to challenges in assessing socioeconomic status. Affordability of the premiums was reported as a barrier to membership. NHIS membership has been found to be positively associated with urban residence, higher educational attainment and higher socioeconomic status (Akazili *et al.*, 2014). Exemptions were offered for groups who cannot pay, such as the elderly, children, and indigents— defined as persons who are unemployed, without a fixed income and fixed residence, or not living with someone with a fixed income and residence. The Maternity Exemption Policy allows all pregnant women to be exempt from paying health insurance premiums and yet receive coverage under the NHIS for a limited period following pregnancy with the incentive that they would join the NHIS.

Although several categories of people may receive an exemption from the premiums (e.g. children, elderly, indigents and pregnant women), many Ghanaians have not utilized these exemptions (Kanchebe Derbile and van der Geest, 2013)(Kanchebe Derbile and van der Geest, 2013). Without clear guidelines/criteria for identifying 'indigents' and without detailed costing analysis data, few benefit from the indigent exemption. Individuals receiving premium exemptions must pay the processing or renewal fee unless exempt due to pregnancy, mental disorder or poverty. However, indigents have little access and membership remains pro-rich and pro-urban, with some 'squeezing out' of non-members from healthcare services (Mills *et al.*, 2012).

Therefore, only About 40% of Ghanaians are registered with the NHIS as active members and high enrolment premiums deter participation among informal sector workers, particularly women (Alfers, 2013; Lattof, 2018). NHIS enrolment of people working in Ghana's informal sector remains low. The informal sector employs two-fifths of employed Ghanaians aged 15 years and older; sex-disaggregated data reveal that the informal sector employs a larger percentage of currently employed females (47.8%) than males (35.5%) (Alfers, 2013; Lattof, 2018). Problems with poor information on the scheme not reaching the poorest and most marginalised. Women in the informal economy falling between the cracks. Migrant girls and women from northern Ghana who work in the capital as head porters (kayayei) report challenges obtaining insurance and accessing health care (Lattof, 2018). The living and working conditions of the kayayei are such that the women are prone to ill health; common issues include body pain, malaria, and sexual assault. They cannot afford the NHIS premiums, and neither can they afford the fees charged by health facilities. They complained that their employers (market traders and chop bar owners) "neglect" them when they are ill. As a result, they self-medicate,

except in really serious cases when they will pool money to send a co-worker to hospital. The failings of the exemption system are clear in this case – it ignores the large numbers of “working poor” in Ghana who, because they work, cannot be classified as indigent, yet do not earn nearly enough to afford the most basic premium available (Lattof, 2018).

Health Services and Delivery

The package covered health service costs and drugs for 95% of diseases in Ghana. It included outpatient consultation, essential drugs, in-patient care, shared accommodation, maternity care, eye care, dental care, and emergency care. It did not cover echocardiography, renal dialysis, heart and brain surgery, organ transplantation, or HIV/AIDS drugs. There are no co-payments, deductibles, or co-insurance payments or any additional payments at the point of service (Witter and Garshong, 2009). There has been increased utilisation of outpatient services correlating with growth in NHIS membership, suggesting that NHIS has increased service use (Witter and Garshong, 2009). Services are delivered through public, private, and faith-based health care facilities. More than half of the facilities are public, a third are private and less than 10% are operated by the Christian Health Association of Ghana (Wang *et al.*, 2017).

The Maternal Exemption Policy, which was specifically targeted towards the poorest women maternal care benefits include four prenatal visits, delivery care and one postnatal visit. insurance coverage shows a positive impact on women making at least four antenatal visits (Dalinjong *et al.*, 2018). However, access is also dependent on other financial barriers including lack of available transportation, and the banning of traditional practitioner delivery, dramatically influence the access and use of maternal health care. The NHIS registration period after birth was a main concern for many women. Since the MEP only covers mothers and children for 3 months after delivery, women experienced difficulty generating sufficient money to register both themselves and their children as full members in the NHIS (Rishworth, 2014). A study of the impact of maternity-related fee payment policies on the uptake of skilled birth care amongst the poor in Ghana found that there was a pro-rich uptake in skilled birth care (Johnson *et al.*, 2016); coverage rate in highest quintile (96.7 percent) is more than double that of lowest quintile (46.9 percent) (Wang *et al.*, 2017).

Health Workforce

The Human Resources for Health Strategic Plan (2007–2011), which integrated the accessibility, acceptability and quality dimensions, was instituted to improve deployment and retention strategies, accreditation, regulation and licensing and continuous professional development for staff. In 1990–2009, Ghana witnessed a rapid increase in its supply of professional health workers: 185% more midwives, 260% more nurses and 1300% more physicians. A large share of national health expenditure – approximately 85% – is committed to health workforce salaries and incentives, but the steps taken in 1990–2009 have reduced workforce attrition, increased the capacity of health training institutions – Ghana is now one of the largest producers of physicians in sub-Saharan Africa – and improved the number and distribution of health workers (Campbell *et al.*, 2013).

Greater Accra has a high number of health workers per capita due to the concentration of doctors in the capital city, while the Upper East and Upper West regions have high numbers of health workers per capita due to their low population density (Wang *et al.*, 2017).

Health Information Systems

Poor monitoring and control systems within the NHIS, although a new IT system is being introduced which may improve the situation (Witter and Garshong, 2009). The Claims processing by NHIA is labour-intensive and inefficient with most claims are evaluated manually (1,200–4,800 staff weeks vetting each month's claims), requiring hundreds of staff members (Wang *et al.*, 2017). Obtaining routine service data from all health facilities remains a serious challenge for all levels for planning, budgeting and decision-making as well as tracking both reporting and non-reporting facilities (Nyonator *et al.*).

Medicines and health technologies

The MoH procurement unit has an annual budget of about US\$40 million, of which US\$35 million is provided by development partners. Centrally procured medicines are limited to antiretroviral drugs, antimalarial drugs, oxytocin, snake antivenin, rabies vaccine, and a few other special items. An estimated 80 percent of pharmaceuticals dispensed in public health facilities are procured by regions or facilities directly from private distributors (Wang *et al.*, 2017).

Governance

National Health Insurance Council (NHIC) established to oversee NHIA and licence schemes (every two years). Includes representatives of main stakeholder groups, such as Ministry of Health, Ghana Health Services, regulatory bodies, consumers, and Executive Secretary of the NHIA. Chair and Executive Secretary appointed by the President. NHIC proposes formula for allocation of funds to Parliament for annual approval, and provides annual report to Parliament on its use of funds. Each DHMIS governed by a Board. Rules established for handling complaints against providers or schemes (Witter and Garshong, 2009).

National Health Insurance Authority (NHIA) established to regulate the market, including accreditation of providers, agreeing contribution rates with schemes, resolving disputes, managing the NHIF, and approving cards. Each district to have a DMHIS (with a minimum of 2,000 members). Benefits to be transferable across district schemes. Each DHMIS to submit annual reports to NHIA and to undertake annual audit of accounts.

Mexico

Health Financing

The Mexican health system is financed through four mechanisms, primarily linked to employment status. The Public Employees Social Security Institutes covers the public formal sector workers (37.5% of population), the Mexican Institute of Social Security covers informal sector workers, Social Security for Underserved (*Seguro Popular*) provides coverage for approximately 47% of the population, targeting those living in poverty and the marginalized rural and urban areas and the Ministry of Health provide services to people who are not covered by any of these schemes (Atun *et al.*, 2015b; Villalobos *et al.*, 2017). Mexico like other Latin American countries introduced health reforms as part of social and welfare reforms which included conditional cash transfer schemes to address challenges of poverty, empowerment of women, nutrition, education, and health (Atun *et al.*, 2015b). This was linked to health as a fundamental human right and entitlement based on citizenship (Knaul *et al.*, 2012). In 2012, 52.6 million Mexicans, previously uninsured were incorporated into the System of Social Protection in Health (SSPH), primarily financed through tax revenue. Under SSPH, special fund covers catastrophic illness and complex disorders such as paediatric cancers. A strategic objective of the reform and specifically *Seguro Popular* was to reduce OOPs and provide protection against catastrophic health expenditure. OOPs as a percentage of total health expenditure were reduced from 50.9% in 2000 to 44% in 2013 (Knaul *et al.*, 2012).

OOPS is still a challenge reflecting problems of providing effective insurance coverage and high-quality services (Strategies, 2015). Fragmentation remains a challenge in the health system, which includes several health insurance schemes offering different benefits packages and having their own sources of funds, their own provider networks, contributing to differences in health care access (Bonilla-Chacín ME and Aguilera N, 2013). Beneficiaries are unable to choose their insurer since this depends on their employment status. The long term sustainability of SSPH is of concern given the increasing burden of NCDs (Squires and Betran-Sanchez, 2013).

This paper has not been able to locate studies which have examined financial protection through a gender lens.

Health Services and Delivery

In Mexico, ambulatory health-care services were expanded with the introduction of *Seguro Popular*. The Mexican Social Security Institution for Workers and Civil Servants also offer a comprehensive package of personal and primary health-care services to their beneficiaries

In Mexico, the broader social protection scheme *Seguro Popular* covers 90% of the population, provides access to more than 250 essential interventions in addition to and a package of 57 costly interventions free at the point of service, offered in the ambulatory units and general hospitals of the Ministry of Health (Bonilla-Chacín ME and Aguilera N, 2013).

The Mexican Ministry of health prioritised the rights for women and reductions in maternal mortality through promoting SRHR since the start of SPSS. Measures were taken to expand coverage of antenatal care and institutional deliveries, with emphasis on timely diagnosis and treatment of obstetric emergencies, as well as monitor maternal deaths. The revision of the family planning policy was one of the changes that made a real difference, through the introduction of three contraceptive

methods in the essential drug list: the sub-dermal implant, the female condom, and emergency contraception. Including the emergency contraceptive was a revolutionary move in the year 2005, that went through long public discussions, opposition from the religious authorities and advocacy from woman's right organizations and scientific society. Which resulted in the favour of the inclusion of this tool in the family planning guidelines and public services. (Frenk et al., 2012).

Comprehensive SRH services are offered under the umbrella of '*Seguro Popular*'. These services include: maternity care, STI and HIV prevention and treatment, safe abortion services where legal and contraception (including female condoms, emergency contraception and the sub-dermal implant, among others in the essential drug list), in addition to providing financial aid for critical services like cervical and breast cancer treatment and mental health. Additionally, there are two programs which provide enrolment for pregnant women and their families and cover the rural areas through mobile and midwives (Frenk et al., 2012; Andión Ibáñez and Garita, 2015).

As part of the social and welfare reforms, *Oportunidades* (previously known as *Progressa*) is a conditional cash transfer (CCT) programme targeting the poor especially women in rural and urban communities with the objective of increasing utilization of essential health services particularly maternal and child health and preventive care. *Oportunidades* focuses on improving education, health and nutrition of beneficiaries and their children through linking transfers to regular school attendance and health clinic visits. (World Bank; Atun et al., 2015b).

Despite these expansions in service delivery, access to comprehensive antenatal and postnatal care is not optimal (Serván-Mori et al., 2017) arising from bottlenecks in the maternal healthcare continuum that need to be address through a combination of supply side interventions and interventions directed to social determinants of access to health care. Only 6 out of 10 pregnant women actually completed the diagnostic and treatment procedures recommended by Mexican health norms (Urquieta-Salomón and Villarreal, 2016). Further, differences existed between insured and uninsured mothers.

Adolescent SRH services are poor quality and insensitive to the specific needs of adolescents, particularly for those requiring care from rural health units (Villalobos et al., 2017). Mistreatment and institutional violence against female patients and in particular those from minor ethnicities is a barrier to care (Castro et al., 2015b). These practices arise from social norms and misconceptions embedded in the country medical school systems and power structures around the medical community which treats women as a second class citizen undeserving of rights and choices (Castro et al., 2015b).

In 2003 the MoH established the National Center for Gender Equity and Reproductive Health with the authority of proposal, monitoring and evaluation of public maternal and SRH, gender equality and domestic violence prevention policies. The Center also adopted the approach of production of gender-sensitive budgets, health information disaggregated by sex, and surveillance of gender biases in access to health services and quality of care (Frenk et al., 2012). Also, in 2006 The Mexican government adopted a gender-based violence resistance policies that resulted in passing the General Law (Guaranteeing Access to All Women to a Life Free of Violence). This program was implemented in response to the National survey on Violence against Women by the MoH, that showed that one out of every five women accessing healthcare facilities was subjected to violence mostly by their partners. The new law enforced strong punishments against the aggressors and provided protection and treatment for the victim (Frenk et al., 2012). Also, the General law mandates all health institutions in Mexico permitting immediate access to emergency health services to victims of a crime or human

rights violations, independent of their economic capacity or nationality and without the need to comply with any previous requirement.

Health Workforce

Mexico suffers from an overproduction of doctors, many of whom are not being absorbed in the health sector (Nigenda *et al.*, 2005). More women are being trained as doctors compared to men. There is an under-supply of nurses. However, shortages and maldistribution of health workers persist. In addition, health workers have protested against their working conditions citing challenges of shortages of essential drugs and supplies arising from mismanagement and corruption, which lead to doctors altering the treatment based on drug availability (Yucatan Times, 2016). Drug-related violence impacts adversely on the health workforce contributing to issues of retention (Squires and Betran-Sanchez, 2013).

The SPSS reform in the SRH services focused on improving the availability of skilled human resources through strengthening of the community health network to respond to the needs of the rural and indigenous communities. This also included training programs focusing on traditional birth attendants under the supervision of NGOs and the reintroduction of obstetric nurses as part of the maternal health reform (Frenk *et al.*, 2012). Despite these reform, discriminatory actions and institutional violence towards women in general and especially those from indigenous communities, reflecting the social norms that portray women as inferior and undeserving citizen deeply embedded in medical education system and hierarchical power structures within hospitals (Castro *et al.*, 2015b).

Governance

The Mexican health system comprises three subsystems: Social Security, the Social Protection System in Health (SPSS), and the private system. The health sector is governed by the federal government agency and is responsible for health policy formulation, co-ordination of the different departments in the health sector, epidemiological surveillance at a national level. In addition, the Ministry of Health is responsible for the System for National Health Information or Sistema Nacional de Informacion en Salud (SINAIS), which collects and publishes statistics about all issues related to the health of Mexicans and their health services (Castro, 2014). Challenges in data transparency is a challenge for accountability and it is recommended that “Ministry of Health should co-operate closely with other governmental oversight institutions such as Secretaría de la Función Pública (Ministry of Public Administration) in their efforts to increase managerial transparency and accountability at the level of states and municipalities, including through the promotion of an integrated information system allowing regular collection and auditing of information about institutional purchases and spending.” (OECD, 2016a, p29).

Mexico illustrates the importance of collective action to improved service delivery for the poor. Collective actors can impose social accountability, even where formal accountability mechanisms are weak (Houtzager *et al.*, 2007). Related to this is social monitoring. Social monitoring is an accountability mechanism that allows for transparent collaboration between civil society organizations and government institutions. Adolescent pregnancy is recognised as a priority public health issue and the government undertook to improve access to modern contraceptive to adolescents between 10 to 19 years old that request them (Mexfam, 2017). The Mexican Foundation for Family Planning (Mexfam) together with a local advocated for social monitoring” as a mechanism to assess the extent to which adolescents can access a range of contraceptives in public health units. These entailed adolescents holding health providers accountable through the deployment of trained

youth health champions who were responsible for monitoring providers. The results from a pilot were presented to national and state health authorities along with recommendations for improving youth access to contraception and two of the recommendations were integrated into the 2017 MoH Plan for Sexual and Reproductive Health for Adolescents Program.

Health Information Systems

There are two key information systems. The first is that of the routine health information systems of the Ministry of Health and SPSS's own information systems linked to *Oportunidades* beneficiaries (Bonilla-Chacín ME and Aguilera N, 2013). A gap in administrative data on provider performance, technical quality and/or output volume information and case mix of hospitals under the SPSS has been identified. However, the fragmented system of data collection is a challenge for effective policy and programme action and "health system managers, whether at national, state or institutional level, are rarely able to point to projects that have used data to identify areas of excellence or weakness, or that have been used as a basis for quality improvement work."(OECD, 2016b, p19) .

Rwanda

Health Financing

Mutuelles de Santé in Rwanda is the community-based health insurance schemes that were scaled up into social health insurance. The government started *Mutuelles de Santé* in 1999 from small CBHI schemes. *Mutuelles de Santé* was designed as a low-cost insurance to provide access to healthcare services to the poor and vulnerable population. Then upgrading the CBHI into a national scheme started by testing it in three pilot district programs that was followed by expanding the schemes to the rest of the country in 2005 (Lagomarsino *et al.*, 2012; Collins *et al.*, 2016). By the year 2006, the government adopted a plan to expand coverage nation-wide to equitable access to quality health services, through a national policy community-based insurance and performance-based financing systems providing free premiums formally to the poor and standardizing the service in 96% of the health centers. (Binagwaho *et al.*, 2014; Shapira *et al.*, 2018)

Members of CBHI are categorized in 3 groups, according to the MoH report of 2012, Category 1 the poorest group with the lowest premium and highly subsidized (24.8% of members). The middle group are Category 2 (68.8%) and the richest members are in Category 3 (2.17% of the members) that pays the highest premium per person. The contribution is made at the individual level, but the whole family is enrolled. This means that households with many members (mainly the poor) are mainly affected because they incur more expenses. Nevertheless, despite the new policies members of Category 2 of the scheme still face regressive co-payments and the poorest quintile of this category spend over 0.25 of their income on OOP expenditure compared to the better off members. (Collins *et al.*, 2016; Shapira *et al.*, 2018)

CBHI structure in the decentralized Rwandan health system was based on linking risk pooling from districts to the different levels of health system, and premiums are collected from the enrollees at the community level and used to reimburse public health care providers for services. The CBHI, which was originally governed and managed (policy development and management) by the Ministry of Health, was shifted to the Rwanda Social Security Board (RSSB) —an umbrella organization of all health insurances in Rwanda with the aim improving its management and subsidization from other insurances. Since the transfer of CBHI to RSSB, the pooling arrangements has changed from districts risk pooling into collecting the fund in one national pool that is managed separately. CBHI now is the largest insurer in Rwanda.

In 2011-2012, several policy decisions were made adjusting the premium structure of the scheme in order to make it more progressive and to remove equity gaps between different quintiles of the population. (1:4 ratio of outpatient service utilization in 2010 between the poor and the rich). The new adjustment was based on the socioeconomic status of the enrollees, in which the wealthier members paid higher premiums than poorer members, aiming to generating more revenue to reduce government subsidizes, strengthen management capacity and insure financial sustainability of the scheme (Finnoff, 2016).

During the pilot phase of the CBHI implementation, membership rates between female and male-headed household were relatively equal due to efforts done by church groups in targeting and subsidizing vulnerable population especially female widows' households, HIV patients and indigenous groups. After the scaling up of the program, the government provided insufficient institutional structure design to reduce gender inequalities and increase marginalized groups inclusion and

targeting. This might explain the reduced numbers of female-headed households' enrolment in addition to an extra set of challenges ranging from gender-based discrimination, low-quality of health services, limited flexibility and sociocultural practices in some parts of the country (Finnoff, 2016).

Targeting women especially vulnerable female-headed households was not explicitly included in the program design (Lu *et al.*, 2012; Finnoff, 2016). Enrolment in *Mutuelles de Santé* was optional at the start of the implementation then it became mandatory and legally household must participate with the policy expansion nationwide (Finnoff, 2016). Premiums are paid as an annual fee per family member depending on the economic status in addition to a flat fee paid at the point of service delivery of 200 Rwf at health centre level and 10% at hospital level (Dohlsten, 2014). In 2011, a series of reforms were implemented to the schemes, increasing the premiums collected from the wealthier members and heavily subsidizing the most vulnerable aiming towards achieving more equitable system covering the majority of the population by 2013. (Shapira *et al.*, 2018)(Kalisa, et al., 2016) & (Finnoff K., 2016). Enrolment in CBHI increased from about 0% at the baseline (2000/2001) to 42% in 2005/06 and this peaked at 84.3% in 2016/17. Although CBHI enrolment has increased, the contributions are not substantial to adequately provide health services for the over 84% of the population enrolled.

Results of 2013 CBHI survey showed positive outcomes of the scheme implementation especially after the premiums modifications in 2011, these results stated lower healthcare costs (97%), increased access to medicines (73%), improved hospital and emergency care access (24%) and timely curative care coverage (87%). However, many households still find co-payments and premiums impeding their access to needed healthcare. (Collins, et al., 2016) as the poorest quintile of households have lower rates of health services utilizations (Lagomarsino *et al.*, 2012; Lu *et al.*, 2012), 2012).

While the government has tried to improve domestic expenditure on health (compared to other Sub-Saharan countries), there is still dependency on donor funds to support *Mutuelles de Santé* and subsidise the contributions of those who cannot afford the premiums. This has implications for health service delivery, infrastructure, health workforce and quality of care (Dohlsten, 2014; O'Connell *et al.*, 2014; SCHS/USAID, 2014)

Health Services and Delivery

The comprehensive list of services covered by *Mutuelles de Santé* included a minimum service package at the health centres consisted of promotional, preventive; curative, chronic disease and skilled attendance normal deliveries. At the district hospital level, complementary package comprised of prevention activities, including preventive consultations for referrals, risky pregnancies' prenatal consultations; family planning activities and curative care for referrals including the management of difficult and caesarean deliveries, medical and surgical emergencies, minor and major surgery, hospital care, drug provision, labs and medical imaging (Lu *et al.*, 2012). In addition, transportation to the local district hospital in cases of medical emergency (Finnoff, 2016).

In Rwanda's CBHI system, enrolled households can access covered primary care delivered in their affiliated health centers, secondary care at the district hospitals, in addition to tertiary care at the public national referral hospitals (Dohlsten, 2014). The package of services covered by the scheme is provided through public providers in which beneficiaries can use in their catchment area as well as anywhere in the country through the Patient roaming system. The health centres serve as

gatekeepers to mitigate moral hazard at the hospitals. Ambulance costs are also reimbursed by CBHI and a referral system is used to determine the route by which different services are accessed.

In the field of SRH, Rwanda has adopted the WHO model of standardizing four antenatal care visit for pregnant women. According to key findings from Rwanda DHS 2014/15, only 44% of women made the recommended 4 antenatal visits during their pregnancy (NISR *et al.*, 2015). While 99% of women with live births in the 5 years preceding the survey received at least one antenatal care from a skilled health provider, 91% of live births in the 5 years preceding the survey were delivered in a health facility and assisted by a skilled health provider and 43% of women who gave birth in the two years preceding the survey received postnatal care in the first two days after delivery. Despite the improvement of overall health status of Rwandan generally, however maternal mortality rates remains relatively high (Binagwaho *et al.*, 2013b). Despite these challenges, Rwanda is the first African country to implement a national strategic plan for cervical cancer treatment and prevention (Binagwaho *et al.*, 2013b). In 2015, Rwanda achieved a 90% vaccination coverage rate against 12 pathogens which became possible after a comprehensive advocacy work from Rwanda first lady led to successful partnership between the MoH and Merck & Co. the manufacturer of HPV aimed for a national provision of HPV vaccine and wide vaccination campaigns among adolescent girls. (Gatera *et al.*, 2016).

Health Workforce

In Rwanda, one of the main barriers for access and utilization of financially covered health services is the insufficient number of competent trained healthcare providers, as in 2011 the number of trained doctors were one per 18,000 of the population (Dohlsten, 2014). Also, there is great disparities when it comes to coverage of healthcare providers comparing the urban and rural settings especially in essential SRH services and skilled attendant deliveries (O'Connell *et al.*, 2014).

One of the interventions used by the Ministry of Health to overcome this was task shifting and community health workers. The program started with assigning one CHW per village then it was increased to three per village elected by village members reaching approximately 45,000 CHW across 14 thousand villages in Rwanda trained by the Ministry of Health to provide preventive, diagnostic and primary healthcare services at the community level (Binagwaho *et al.*, 2014; O'Connell *et al.*, 2014). CHW are mostly female workers that are motivated by non-financial rewards of respect and giving back to the community (O'Connell *et al.*, 2014; SCHS/USAID, 2014). CHW working in maternity wards also receive special training in HIV programs to prevent mother-to-child transmission during delivery (Jay *et al.*, 2016). Training on palliative care and end of life program is another approach adopted by the Ministry of Health in Rwanda to tackle the insufficient human resources issue. In parallel to the National cervical cancer program, The National Palliative Care Policy was launched in 2011. 85% of healthcare providers all over the country received training and guidelines for palliation. Morphine was added to the list of essential medicines and the supply chain procurement process, in addition comprehensive palliative care training programs to CWH for patients with chronic conditions, cancers and HIV (Binagwaho *et al.*, 2013b).

Reports assessing health workers' attitudes in providing health services to certain groups revealed discrimination practices and stigma based on criteria related to economic status. People who are covered by insurance complained that they had to endure longer waiting times than those paying for the service. Also, certain groups – homosexual or young unmarried women- reported institutional unresponsiveness, disrespect and discrimination when trying to access contraceptives, condoms and other SRH services. (SCHS/USAID, 2014). Discrimination against women attending the prevention of

HIV mother to child transmission services was reported but was not disclosed by the victims due to cultural norms (Newman, 2014). There are gaps in gender-sensitive service delivery among healthcare providers, given that gender inequality and violence against women is one of the key policy priorities receiving major attention in Rwanda. Other marginalized groups like HIV/AIDS patients, LGBT and young single women face stigma and discrimination, and poor customer services when accessing healthcare facilities. This is attributed to poor understanding of their specific needs by health professionals, lack of adequate trainings, cultural and societal beliefs coupled with insufficient number of staff at the facilities (O'Connell *et al.*, 2014; SCHS/USAID, 2014).

Gender inequality and violence is not just a problem faced by women as patients but also among female health workers as women account for the majority in the health workforce; however, DHS studies of 2010 and 2014/2015 have revealed improvements (NISR *et al.*, 2012, 2015). A national study in Rwanda's employment system revealed the negative impact of gender-based discriminatory practices against female workers such as bullying, sexual harassment and discrimination against pregnant workers. Reports showed that female staff violence was faced with silence, and led to personal traumatic experiences, low productivity and leaving the job even after years of experience. Special attention from policy makers is needed in the form of gender-sensitive HRH policies to protect female health workers' in workplace (Newman *et al.*, 2011).

Health Information Systems

The health management information system in Rwanda is considered robust in terms of collecting basic data on demographics, diagnoses, treatments, and health outcomes by facility (O'Connell *et al.*, 2014). The monitoring and evaluation systems using information technology platforms and cell phones to respond and track HIV treatments and maternal and child health measures were scaled up to track a comprehensive set of different treatments (Binagwaho *et al.*, 2014; Quick *et al.*, 2014). The Ministry of Health applies random audits on the data reports, and a quarterly review report on quantitative data methods in order to keep standard quality on data collection across healthcare facilities, improve health outcomes and expenditures and improve research methods for equitable health service delivery (O'Connell *et al.*, 2014).

In 2009, with the support of UNICEF a rapid SMS reporting system was implemented and distributed across 30 districts to collect data and reports on immunization, pregnancies, deliveries and antenatal visits through CHW on the community level. The system receives a daily report of on average 15,000 texts on health indicators, however gaps remain in information collected related to essential medicines supplies (O'Connell *et al.*, 2014). In addition, challenges of sex-disaggregated data with respect to access, utilization out of pocket expenditure has been identified. These limitations cause the Rwandan health system to lag behind in conducting and analysing data based on sex-disaggregation (SCHS/USAID, 2014) (SCHS/USAID, 2014). While the Rapid SMS reporting system is regarded as an effective tool in terms accessing real time data and timely action to address any maternal threatening condition, concerns have been raised regarding its cost of operation and operational sustainability in face of declining donor resources.

Access to Medicines and Health Technologies

In the past few years the Ministry of Health adopted several approach to improve access to medicine and vaccinations nationwide. These approaches included scaling up HIV donor supported

interventions and platforms to strengthen primary healthcare, vaccination services and the package of health services, scaling up supply chains implemented originally to deliver HIV (ART Program) treatments into a wide range of drugs and agents for different conditions. This resulted in a significant improvement in vaccination coverage among Rwandan infants reached above 90% are fully vaccinated against ten different diseases; adolescent girls are also vaccinated against human papillomavirus (Jay *et al.*, 2016).

Marginalized populations especially women and adolescents face many gender-related barriers in accessing medicines (SCHS/USAID, 2014). These barriers include cultural norms, discrimination practices, inability to articulate their health needs, difficulty in transportation to delivery points and lack of financial resources to pay for drugs outside the covered essential list (SCHS/USAID, 2014). Also, large number of the population residing in the rural areas have challenges in accessing quality medical products and other critical medical technologies normally provided in national referral hospitals and private facilities (External Evaluation Team, 2015).

Governance

The Ministry of Health is the key actor in the Rwandan health system through adoption and development of different health policies, creation and launching of national health insurance scheme to extend coverage to non-insured population, allocating resources, purchasing healthcare services, and development of incentive schemes and performance-based financing programs to improve quality of provided services (Lagomarsino *et al.*, 2012). The Ministry of Health is responsible on ensuring laws implementation in delivering health services equally to all citizens without discrimination regardless of their socioeconomic quartiles, gender, sexual orientation, insurance coverage status (SCHS/USAID, 2014). Governance approaches are also implemented in the Rwandan context in the form of civil society representation in the boards of national health programs like the National AIDS control commission (2001-2010). Additionally, the biannual Joint Health Sector Review convenes government, development partners, and civil society to assess all national health programs inclusiveness. Ten civil society representatives join this review on behalf of a range of key populations and constituencies (Jay *et al.*, 2016).

The central governments' sustained capacity building at the decentralized levels created a strong backbone through which public services are delivered to the target population (in general and women in particular) . The flow of government and donor resources to improve health services delivery in public health facilities were possible due to improved capacity in public financing management, including accountability across different governance levels of the health system (WHO, 2013). *Mutuelle de Santé* that was recently shifted from the Ministry of health to the Rwanda Social Security Board in order to improve its sustainability and improve management and governance and attain operational sustainability.

Thailand

Health Financing

Healthcare services are largely financed by general taxation paid through three major public health-insurance schemes (Civil Servant Medical Benefit Scheme (CSMBS); Social Security Scheme (SSS) and Universal Coverage Scheme (UCS)) and the Migrant Health Insurance Scheme (MHI), covering nearly 100% of population in Thailand (Patcharanarumol W, Tangcharoensathien V and P., 2014; HERA, 2017):

1. UCS: covering about 76% of the population, providing a comprehensive healthcare services package, is financed by a progressive tax-based system.
2. SSS: covering 15% of the population, is a compulsory health insurance for private sector employees, financed by contributions shared between employees, employers and the government. Provides a comprehensive health services package provided through public and private providers. Providers are primarily reimbursed through capitation. Emergency and dental care- are not covered in the contracted facilities.
3. CSMBS: covering 7% of the population, including government employees, pensioners and their dependents. It is a fully tax funded schemes providing a wide range of benefits and healthcare packages same as UCS and offers a free choice of public providers for beneficiaries. In some exceptions and emergencies, beneficiaries can access private hospitals and reimbursed up to a ceiling. Providers of services for this scheme receive their payment on fee for service basis (HERA, 2017).
4. MHI: managed by the Ministry of Public Health and includes migrants regardless of their documentation status with undocumented migrants encouraged to join voluntarily. Provides a comprehensive package of services and tied specific health facilities.

Undocumented migrants' women face a set of cultural, societal and financial barriers when accessing essential healthcare services, these barriers range from enrolment complications, restrictive coverage, the cost of annual examination and policy renewal, access to information, language barriers, location and working hours of the healthcare facilities, fear and reluctance to identify themselves to the authorities. (HERA, 2017). In addition to, the transportation's cost and the fear of losing the job or the day wage as most of them reside in location closed to their work and further from health service facilities.

By 2015, 0.1% of the population is uninsured. The uninsured are allowed to register at any time and eligible to receive free care immediately after. UHC in Thailand extended coverage to those who were not covered by social health insurance schemes, financing is provided through tax revenue including the entire household as a unit. These schemes succeeded in reducing OOPs and household impoverishment caused by medical expenses and providing an equitably distributed package of services for the whole population across rural and urban settings closing the gap between the rich and the poor.

Health Services and Delivery

In Thailand, UHC was reached by the year 2002 after the implementation of the three main health insurance schemes (CSMBS, SSS and UC) including MHI, an additional scheme for migrant workers

covering the whole population with an extensive benefit package of preventive, promotive, curative, and rehabilitative services with a small number of exceptions. (ARROW, 2012). The government commitment in expanding the health insurance coverage, increased investment in the health infrastructure, expanding the geographic coverage of district and sub-district hospitals and health facilities, adopting the pro-rural policy mandating and facilitating the implementation of quality publicly-provided primary healthcare (PHC) services by a variety of medical cadres are the main reasons behind a relatively equitable health system in Thailand.

Besides removing the financial barriers to health care access on the demand side, Thailand also implemented supply side interventions to improve efficiency of the healthcare system by establishment of a gatekeeper system and different purchasing strategies such as capitation and DRGs to improve cost control functions. Challenges remain in the quality of available drugs and healthcare personnel. Addressing these issues led the MOPH to consider adopting pay for performance (P4P) system to increase fairness and quality among healthcare personnel but this approach is still under discussion by policy makers.

The SRH services covered under the health insurance schemes include preventive services comprised of family planning; antenatal care; sex education and promotion of condom use; screening for syphilis; HIV testing; prevention of mother-to-child transmission among pregnant women; pap smear; clinical breast examination; and general counselling services for sexual and gender-based violence. In addition to curative services that included abortion in cases of rape and risk to maternal health; treatment of abortion complications; essential and emergency obstetric care for the first two deliveries; treatment of reproductive tract infections; definitive treatment and care for opportunistic infections for HIV/AIDS patients; and reproductive cancer treatment. Public facilities provide SRH services during day time, and emergency curative are available 24 hours. SRH are available in the private sector with more flexibility in operating hours. Increased utilization of public providers' services was reported in rural areas where the majority of population lives (Kongsri *et al.*, 2011; HERA, 2017). With respect to SRHR, services are relatively equitable in relation to distribution and quality of care (Limwattananon *et al.*, 2011; Tangcharoensathien *et al.*, 2015). Essential obstetric care is only free for the first two deliveries and safe abortion services are only covered for victims of violence incidents or when the woman's health is at risk (ARROW, 2012). Public facilities provide SRH services during day time, and emergency curative are available 24 hours. SRH are available in the private sector with more flexibility in operating hours. Increased utilization of public providers' services was reported in rural areas where the majority of population lives (Kongsri *et al.*, 2011; HERA, 2017). In responding to violence against women, the Department of Prevention of Crimes in the Royal Thai Polices established a unit to handle cases of violence against women. Alongside this, the Ministry of Public Health introduced One Stop Crisis Centres (OSCC) staffed with trained health professionals in 300 hospitals across the county to provide physical and mental health services, legal assistance, and recovery and rehabilitation for women survivors of all forms of violence.). In 2013, the prime minister expanded this crisis center (OSCC) network into 22,000 center and 1,300 mobile units across the country. In 2014, a revision of the laws for parental consensual requirement on under 18 years old access to HIV testing and treatment took place, led to improving the access and utilization of young people to HIV prevention and treatment.(HERA, 2017).

Despite the highly equitable health system in Thailand and the major reforms established removing financial barriers to accessing SRH, some disparities in form of limitations faced by women when trying

to access some essential reproductive health services. These limitations include legal safe abortion care, obstetric care for women with more than 2 children, unequal service delivery geographic distribution, quality of care, availability of drugs, supplies and equipment (ARROW, 2012). Abortion in Thailand is legal and publicly provided performed by a physician only in limited cases of health threatening conditions to the women, or if resulted from rape and sexual assault (Tangcharoensathien *et al.*, 2015). There is a high incident of unsafe pregnancy termination estimated as 300,00 to 400,000 illegal abortions per year might be due to the restrictive abortion laws, in addition to personal and religious beliefs and misconceptions across the Thai society and health workers that abortion is illegal in all cases (HERA, 2017). An equally important challenge is that of adolescent pregnancies. Adolescents and migrant women specially face several systematic barriers when accessing healthcare services. Studies showed high prevalence of unintended births, unsafe abortions, rising numbers of adolescent pregnancies, high rates of unmet contraceptive needs, increased usage of emergency contraceptive and late diagnosis of HIV and AIDS among women aged 15-19. These barriers might be caused by decentralized management system, unavailability of proper SRH education and regulations like the law that requires parental consent for accessing SRH services for children under 18.(Tangcharoensathien *et al.*, 2015). In an attempt to address these limitations, the Thai government promoted for a “Positive Youth Development” approach focusing on increasing knowledge of sexual and reproductive health among youth, offering a youth-friendly health services and enhancing youth empowerment. The Ministry of Public Health revised the national reproductive health plan, and adopted adjustments to improve adolescent health plan. Also, the Ministry of Education started a sex education program for children and young people provided in schools, however there were issues with the quality of the educational material and the instructors’ training and qualifications.

Health Workforce

The number and distribution of the health workforce between the capital and other provinces and between public hospitals and private facilities is inequitable. The expansion of healthcare access to achieve UHC has placed additional demand on the health system especially on the health workers in the public sector who are the major providers of health services (Ruangratanatrai *et al.*, 2015). This has led to health policy reforms including hospital payment methods which allowed public hospitals more flexibility in hiring additional staff have in some parts been successful in attracting staff to rural areas (Sakunphanit, 2016).

Violence against health workers has been cited by several studies (di Martino; Sripichyakan *et al.*, 2001)(Di Martino, 2003; Sripichyakan, 2001) which included verbal abuse, bullying/mobbing, physical violence, sexual harassment, and racial harassment. We were not able to locate more recent documentation that examined the prevalence of violence and interventions to address it.

International organizations played a great role in providing gender sensitivity approach among healthcare personnel through guidelines and training programs on Gender and Rights in Reproductive Health and providing skill lists for gender concerns into programs planning, and policy development. In Thailand, gender responsive pre-service training is implemented in the undergraduate medical curriculum. The Chulalongkorn Medical School in Thailand is among the schools that recently established integrating gender rather than Women’s health in the medical curriculum development and implemented a problem-based course to serve the purpose of improving gender competencies among medical graduates and subsequently to be integrated in the health system (WHO, 2010b).

Health Information Systems

Health-care data of the Ministry of Public Health Facilities are collected and pooled at the ministry level (Aljunid *et al.*, 2012). It is required by law that all health facilities submit reports and information to the ministry. This is mainly used for administration and monitoring of performance of health facilities. Health-care data that are collected and available include routine reports on revenues, expenses, throughputs, and common diseases group of outpatient and inpatient departments; disease surveillance (legally required for notifiable diseases, routine reporting, and specific disease surveillance); patient registry, that is, cancer, diabetes, hypertension, and so on. Among all these data, active surveillance of new emerging communicable diseases, for example, bird flu and 2009 influenza, had better compliance from other public and private providers. In addition to routine data, periodic national surveys on health and welfare are also conducted. Household income-expenditure surveys, health and welfare surveys, and elderly surveys are conducted by the National Statistic Office while health examination surveys are conducted by the National Health Examination Survey Office (Aljunid *et al.*, 2012). There is also an administrative database on inpatient care to support the development of the Thai Diagnosis Related. Together, these data are used for the development of health policy and planning by the ministry.

Access to Medicines and Health Technologies

Each scheme (i.e. UCS, SSS, CSMBS) guarantees access to a basic benefit package of health services, including medicines listed on the National List of Essential Medicines (NLEM) (Sruamsiri *et al.*, 2016). As Sruamsiri *et al.* (2016) point out, there are differences across schemes in access to medicines not on the NLEM list. While those covered under UCS and SSS pay out of pocket for non-NLEM medicines; CSMBS enrollees are covered for most NLEM and non-NLEM medicines. This means that the majority of Thais pay OOP for non-NLEM medicines. Through the introduction of the E2 access programme ('E2 program'), the government attempted to address this problem and increase access to especially high-cost medicines and improve clinical outcomes through requiring all three insurance schemes to subsidise selected high-cost specialty medicines for patients meeting eligibility criteria. This review has not been able to locate any studies evaluating the gendered implications of improved access to medicines under the different schemes.

Governance

A combination of strong political leadership and active citizen engagement provided the motivation for investments in UHC policy reforms (Patcharanarumol W, Tangcharoensathien V and P., 2014; Suriwan Thaiprayoon and Suwit Wibulpolprasert, 2017). As Thaiprayoon and Wibulpolprasert (2017) indicated, civil society also have been allocated seats on the National Health Security Board to CSOs and they participate actively in policy development, implementation and assessment process and are advocates of UHC. In addition, accountability is also driven through strategic purchasing, the development of quality standards and technical capacity for health technology assessment (Reich *et al.*, 2015) (Reich *et al.* 2015). The literature review was not able to locate documentation which undertook a gender analysis of governance in UHC reforms.