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From Principle to Practice: Universal and Gender-Responsive Health Care

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"… 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)

I. Introduction – Social Protection, Human Rights and Solidarity

This paper focuses on the interconnections between policies to move toward universal health care (UHC) as a key element of social protection, and 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 (Tessier *et al.*, 2013; Sen, 2018). Slow and halting recovery from the global financial crisis of 2008 combined with the inexorable worsening of global warming have raised concerns about risk and vulnerability for large numbers of people in both high and low / middle income countries (LMICs). This has opened policy space for global agreements, such as ILO Recommendation No. 202 in 2012, and target 1.3 of the SDGs, recognizing the mitigating potential of national social protection floors as tools against poverty and vulnerability.

In this paper, we examine whether the experience with UHC as an important component of social protection floors has been gender-aware in its conceptualization and gender-responsive in its implementation. While much of the debate around social protection has focused on the relative merits of program instruments such as targeting and conditionalities, it is important to be clear about the larger approaches – welfarist, instrumental, or rights-based – that frame the chosen instruments (Devereux and Sabates-Wheeler, 2007; Sen and Rajasekhar, 2012). While all three of these approaches agree that effective social protection is necessary to manage risk and vulnerability, they disagree about the causes of that vulnerability and who is responsible for tackling it, and in the attention they pay to human rights. This has implications for program direction, quality and effectiveness.

Policy approaches and human rights

Welfarist approaches typically perceive the causes of vulnerability as rooted in individual characteristics or behaviour, and absolve the state from responsibility for protection. Voluntary benevolence and philanthropy are viewed, instead, as the solution. The *instrumental* argument for policy is less concerned with causes, and more with rationales whether in terms of the benefits to future growth via universal education and health, or politically managing discontent. Enlightened self-interest provides the motivation for both policies and philanthropy in the instrumental approach. The *rights-based approach* traces historical and systemic causes largely beyond the control of the individual. Risk and deprivation are viewed as based on inherited economic class, race, ethnicity, gender, caste, disability, sexual orientation and gender identity (SOGI) or other identities, deriving from social relations of power and reproduced by the ongoing political economy. The state is the main duty-bearer, and policies must affirm, protect and fulfil the human rights of the people at risk while engaging with and empowering them through policy processes.

There are basic differences in how the three policy approaches view people or believe they should be treated. In the welfarist approach, people are recipients of charity, who should be grateful for what they receive – their specific needs and histories are not the primary focus. Nor does the approach emphasize their empowerment or recognize their ability to be involved in decisions or in asserting claims. By contrast, the instrumental approach acknowledges that meeting strategic objectives is often predicated on the behaviour of beneficiaries, and to that extent attention to what motivates needed behaviours and actions is essential.

Not surprisingly, it is the rights-based approach that begins with people in all their diversity, emphasizing the intrinsic importance of their humanity and rights, including their right to define their own needs, to articulate claims to fairness and justice, and to be centrally involved in policy and program decisions. It highlights the underlying socioeconomic / political power structures that reproduce deprivation and mark the histories of oppressed people. And it acknowledges the connections between those histories and individual motivations and behaviours. This leads, furthermore, to the recognition that, because oppression is often multi-dimensional and interlinked, the universality and indivisibility of human rights require close policy and programme attention. From the standpoint of a rights-based approach, there is no problem with having strategic objectives such as higher growth or better governance (as in the instrumental approach), provided these do not swamp attention to the autonomy, empowerment and human rights of people, or to the structures and histories of power.

Different multilateral agencies have used varying definitions as the UNDP Primer on social protection points out, not all of which recognize 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).

The UNDP Primer defines social protection as follows:

> *"…as a set of nationally owned policies and instruments that provide income support and facilitate access to goods and services by all households and individuals at least at minimally accepted levels, to protect them from deprivation and social exclusion, particularly during periods of insufficient income, incapacity or inability to work… On a more operational level, social protection systems provide contributory or non-contributory forms of income support that reduce and prevent poverty; 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. Social protection systems can include various schemes and programmes, including universal schemes, social assistance, social insurance, employment guarantees and other public employment programmes, and measures to facilitate access to education, health and care services."* (UNDP, p15-16: emphasis added).

Variations in whether and how rights are recognized, are not trivial as they underpin program design, implementation and monitoring.

The Role of Solidarity

The politics of social protection 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' in a society of the intrinsic importance of the basic needs of the 'have-nots'. 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. This rationale goes beyond the traditional neoclassical economics justification based on public goods, externalities, transactions costs or imperfect information. None of these criteria may be met, and yet solidarity provides a robust rationale for public action. 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).

The creation of sustainable institutions often hinges on solidarity, defined

> *"… **as an other-directed trait that views the needs and interests of others as inherently similar to one's own*** (emphasis added) … *The idea of being "inherently similar" 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 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 fierce debate about the relative merits of targeting versus universalism (Sen, 2018).

An important question for this paper is the extent to which different current approaches to social protection (including UHC) are guided by principles of human rights and / or solidarity. The next sections of the paper elaborate on this.

II. Agenda 2030, Social Protection and Gender Equality

The ILO's efforts to gain recognition for the creation of a social protection floor (SPF) gathered momentum after the 2008 financial crisis. In the following years, as economic recovery faltered, the UN Chief Executives Board for Coordination adopted the Social Protection Floor Initiative as an important tool to address the fallouts of the economic crisis. Jointly supported by the ILO and the WHO, the SPF Initiative brought together a group consisting of UN agencies, the Bretton Woods institutions, regional development banks, bilateral donors and NGOs. These efforts came to fruition through the Social Protection Floors Recommendation (No. 202), passed 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 SPFs. The Recommendation calls for applying the principle of "non-discrimination, gender equality and responsiveness to special needs".

Anchored in human rights through UDHR Articles 22 and 25 (affirming 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), the Recommendation includes four minimum elements for an SPF:

"(a) 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;

(b) basic income security for children, at least at a nationally defined minimum level, providing access to nutrition, education, care and any other necessary goods and services;

(c) basic income security, at least at a nationally defined minimum level, for persons in active age who are unable to earn sufficient income[1], in particular in cases of sickness, unemployment, maternity and disability; and

(d) basic income security, at least at a nationally defined minimum level, for older persons." (Tessier *et al.*, 2013, p2).

The SPF is an essential tool for poverty alleviation and for promoting gender equality, empowering girls and women, and fulfilling their human rights. The above listed elements of the SPF were also affirmed in Agenda 2030 and the SDGs, through a number of targets and indicators[2] (UNSTATS 2018). Of particular relevance for this paper are:

- 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); Tier 2 indicator;
- 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); Tier 1 and Tier 2 indicators;
- 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); Tier 1 indicator;

[1] This clause marks an important departure from earlier approaches to social protection that typically treated unemployment as the main reason for insufficient income. By treating insufficient income as the umbrella, the clause opens the door to consideration of a range of possibilities including the so-called working poor (those who work full time or more and still do not earn enough). Without stating it explicitly, it thus opens consideration of the 'precariat' (Standing, 2014), and thereby the recognition that the majority of those who work in LMICs and increasingly in higher income countries work are in the informal economy with low pay, high vulnerability and poor working conditions. It also includes those who do not or cannot seek work (a requirement in many statistical systems for being treated as unemployed) including women with care responsibilities, and those who may have dropped out of the labour force for different reasons. Both elements – informal work and care responsibilities - are of critical importance from the standpoint of women.

[2] The Inter-agency and Expert Group (IAEG) has been working to regularly review and update the progress on SDG indicators, which are classified into 3 tiers – Tier 1 where concepts and methodology are clear, and data are widely available; Tier 2 where concepts and methodology are clear, but data are inadequate; and Tier 3 where work is needed on all three. Some indicators are on fast track. The latest updating of the tier classifications was done in May 2018.

- 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); Tier 1 and Tier 2 indicators;
- 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); Tier 2 fast track; affordable medicines is elaborated in Target 3.b and has a Tier 3 indicator;
- 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); Tier 2 indicator; 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); Tier 1 and Tier 2 indicators.

As can be seen, the specific needs of women and girls are mentioned in a number of the above targets although not in all (UN Women, 2018a). Nonetheless, UN Women's explicit strategy to advocate, together with civil society partners, for both a specific gender SDG and targets across a number of the other SDGs, paid significant dividends in terms of greater inclusiveness and recognition on a number of fronts, including SPF and specifically UHC.

Empirical literature on the extent to which gender equality has been incorporated into social protection policies and programs provides the following lessons (Tessier *et al.*, 2013):

- Social protection does not automatically advance gender equality or girls' and women's empowerment;
- Gender-blind / gender-neutral social protection tends to ignore women's and girls' specific risks and vulnerabilities in a number of ways that derive broadly from the implications of care-work responsibilities, informal sector predominance, and long-standing gendered traditional practices and violence against women and girls;
- Gender inequality intersects with other social and economic inequalities, requiring specific policy attention to such intersections in the design and implementation of SPFs (Sen and Iyer, forthcoming);
- Targeting within universalism (TwU) to address inequalities is possible, as in Argentina's Universal Child Allowance that makes family benefits available to those not covered through a contributory system. But there are few (no?) clear examples of similar TwU in the context of health services.

III. **Social Protection Floors and Universal Health Coverage**

Common to both SPF and UHC is a changing paradigm: a shift from the narrow safety nets of the 1990s (targeted, fragmented and needs-based) to universalism (integrated, coherent, holistic and rights-based). Yet, there has been concern whether UHC itself 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).

As pointed out in the previous section, 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 90s with identifying what ought to be included in a package of essential health services. The controversy pitted supporters of the Alma Ata approach based on full primary health care against promoters of selective care based on cost-effectiveness as part of health sector reform packages supported by the World Bank. Despite these bitter debates, the acceptance of UHC (United Nations General Assembly, 2012) in recent global policies reopens space for progressive universalism (Gwatkin and Ergo, 2011) in terms of the three key dimensions of coverage – people, financing, and services.

Progress towards and achievement of UHC is seen as central for improving health and equity and "lift[ing] people out of poverty and driv[ing] economic growth." (WHO, 2014a). The 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 top priority under Agenda 2030. Specifically, Goal 3 (i.e. to ensure healthy lives and promote well-being for all at all ages) includes UHC as sub-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, SDG1 endorses the objective "to end poverty in all its forms everywhere" by 2030, where financial risk protection in health can play a crucial role.

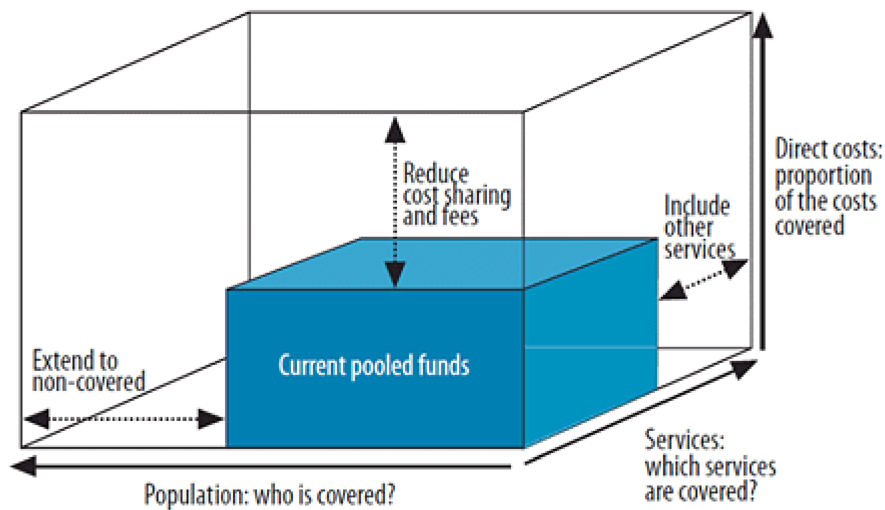
It is expected that specifically Goal 3 with implications for Goal 1 under the drive towards UHC will be achieved through focus and improvements in (WHO, 2014a):

- Prioritize the poorest: with specific attention to addressing inequalities and focus on the vulnerable
- Increase reliance on public funding: Public financing is essential for UHC to cover people who cannot contribute financially.
- Reduce, if not eliminate, out-of-pocket spending:
- Develop the health system: beyond health financing, strengthen essential components of the health system

UHC is constructed on the pillar of equity (United Nations, 2015b) and is operational in the following ways. Universalism specifies that nobody should be left behind. It is explicit in stating that health services should be allocated according to people's needs. This speaks specifically to the concept of vertical equity which means that those with higher needs (e.g. pregnant women) should receive more services than others. Lastly, the notion of financial protection is understood as 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 cross-subsidise services for the sick, the vulnerable and the poor, underpinned by the notion of social solidarity.

The notions of equity and universalism have implications for the three dimensions of coverage (i.e. people, financing, and services), represented through the well-known UHC cube (WHO, 2010). But, useful as it is as a heuristic device that was first introduced in the World Health Report of 2010 (WHO, 2010), the cube has two challenges. The first is that, by itself, it cannot delineate the pathways by which UHC may be achieved, and especially how to ensure equity on the path (Sen and Govender, 2014). In particular, there could be a temptation for policy implementers to 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. The move towards universality may come at the expense of less equity. The other challenge is that the three dimensions are not

independent, but the cube is not really well-suited to capture interdependencies among people, services and financing mechanisms.



Three dimensions to consider when moving towards universal coverage

(WHO, 2010, pxv)

Challenge of reaching UHC within highly restricted fiscal spaces (especially in low-income countries) and high inequities (especially in middle-income countries), requiring difficult choices and politically sensitive trade-offs with respect to resource allocation. As stated in the World Health Report (2010, 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 immediately and progressively move towards the full realisation of UHC, recognising that countries are at different starting points, they are constrained by available resources. The importance of country context and particularly fiscal space is supported by Article 23 of the UN declaration on UHC.

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 cost-effectiveness, priority to the worse off, 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. Ten unacceptable choices were identified across the three core financing functions of raising revenue, pooling funds, and purchasing services (World Bank, 2018a). These approaches put forward by the WHO Consultative Group on Equity and UHC and the World Bank will be revisited later in the paper in the discussion on policy implications.

While these efforts mark important advances towards greater equity in UHC, much of their attention has been on financing; 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. This also requires moving beyond the notion of *coverage* as captured in UHC to that of *access*. Coverage is primarily about removing financial barriers to care 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 health systems factors such as sufficient service delivery points, drugs and equipment, and availability of primary, secondary and tertiary services and trained providers.

IV. A Gender analytical approach

The gender analysis of this paper will draw on the analytical framework developed by (Morgan *et al.*, 2016), which put forward an approach to examine gendered power relations in health systems. This approach is appropriate for unpacking UHC reforms and starts with an understanding of gender as a power relation, which Morgan *et al.* (2016) conceptualised according to key domains addressed through the following questions:

- “Who has what (access to resources);
- Who does what (the division of labour and everyday practices);
- how values are defined (social norms, ideologies, beliefs and perceptions),
- and who decides (rules and decision-making).” (Morgan *et al.*, 2016, p 2-3)

Further, as they argue, the domains are dynamic and shaped through “people and their environments”, emphasising that “Health systems are not gender neutral; gender is a key social stratifier, which affects health system needs, experiences and outcomes, and driver of inequality” (Morgan *et al.*, 2016, p2). This conceptualisation of gendered health systems highlights:

i. the interconnected nature of the different components (i.e. health services, financing, health workforce, information system, access to medicines, and governance) that make up the health system
ii. ‘people-centredness’ i.e. emphasises how health systems are ‘constituted by people and operate in social, political and economic contexts defined by people and groups’ with varying interests, values and power (Sheikh *et al.*, 2014)
iii. socially constructed power relations between and among men, women and people of other genders can lead to different health system needs, experiences, and outcomes
iv. gender and intersectionality (i.e. recognizing that gender is shaped by other hierarchies related to sexuality, class, race, ethnicity, education, age, and (dis)ability), requiring “exploring how power plays out at multiple levels and through diverse pathways to frame how vulnerabilities are experienced” (Morgan *et al.*, 2016, p2).

Access and ultimately utilization are the outcome of both the supply-side (e.g. availability of health services in rural areas, respectful and confidential care for adolescents seeking abortion services) and the demand side. On the demand-side, e.g. sex, age, geographic location and their interaction with social stratifications and consequent inequalities (e.g. income, gender, age, race, sexual orientation, caste) are important but often concealed determinants of men’s and women’s access to and claims on resources at multiple levels (i.e. household, community, state). Through their often 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 addressing challenges of affordability as currently conceived under UHC) to a broader conceptualization of intersectionality, requiring looking within households at the distribution of and access to resources. As argued by Sen and Iyer (forthcoming, p4), this requires tackling the following questions "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?"

V. State of the evidence: Gender and UHC reforms

(NOTE: This section of the paper is still in the form of a rough draft, to be finalized after the EGM)

The empirical literature on UHC will be reviewed according to its dimensions (i.e. financial, population and service coverage). This analysis will be guided by the gender analytical framework outlined in Section 2.1 and considerations of the health systems components as informed by the dimensions outlined by Sen (2013). (see Table 1 below).

Table 1: Gender Analytical Framework: UHC and Health Systems Reforms

<table>
<tr><th rowspan="3">Dimensions of UHC</th><th colspan="6">Components of Health System</th></tr>
<tr><th>Health services</th><th>Financing</th><th>Health Workforce</th><th>Information system</th><th>Access to Medicines</th><th>Governance</th></tr>
<tr><td colspan="6">Gender Analytical Approach
• Who has what (access to resources);
• Who does what (the division of labour and everyday practices);
• how values are defined (social norms, ideologies, beliefs and perceptions),
• who decides (rules and decision-making).</td></tr>
<tr><td>Financial Coverage</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Population Coverage</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Service Coverage</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

While the empirical evidence will be drawn and presented from all countries, this paper will also focus on and present six country cases (i.e. Thailand, Rwanda, India, Ghana, Mexico and Brazil). These countries were selected as case studies based on diversity in terms of their geographic location, stage of economic development and approaches to financing of UHC (See table 2). Some countries have made considerable progress (e.g. Ghana and Rwanda) towards UHC. Others, such as Thailand and Mexico are considered to have achieved UHC. In addition, their reforms, financing and benefit packages also vary (see Table 2). With respect to financing for instance, in Ghana and Rwanda, community-based insurance schemes covering the informal and rural economies operate alongside social insurance which typically target the urban and those in the formal economy. Thailand and Brazil

fund UHC through primarily taxation – alongside private insurance and government employee insurance - in order to ensure coverage for those outside the formal sector.

Table 2: Profile of country case studies: UHC Reforms, Financing and Benefits Covered

Country	**MEXICO**	**RWANDA**	**THAILAND**	**BRAZIL**	**GHANA**	**India**[1]
(GDP/capita)	($9,741)	($619)	($5,473)	($11,339)	($1,604)	
Reform	**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 community-based health insurance 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.	**1988: Unified Health System (SUS).** Publicly-funded services run at the municipal level.	**2004: National Health Insurance Scheme.** National network of community-based insurance schemes combined with national social-security (formal sector) insurance scheme.	
Financing & Benefits Covered	Government budget transfers. Original idea of enrollee 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 centers.	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.	General federal government revenues pooled at municipal level. Comprehensive benefits, divided into three tiers: basic, specialized and high complexity.	General tax revenue, mainly 2.5% levy on VAT, 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	

Source: (WHO, 2014a, Figure: Country-Specific Pathways to UHC, p2)

1. Case summary of India under preparation

Financial Coverage

WHO (WHO, 2010) identified the three main functions of a health financing system to include; 1) how revenues for health services are collected, 2) how they are pooled to spread financial risks and 3) what purchasing mechanisms are used to pay for health services. In this section, these functions will be considered light of the evidence through a gender lens.

Health financing mechanisms can be classified into two broad groups. The first are those that are private and voluntary (e.g. private health insurance, community-based health insurance, out-of-pocket) in nature and those that are public, pre-payed and compulsory (WHO 2010a). Under UHC, the latter are preferred given their potential for building solidarity through cross-subsidisation (i.e. rich to poor, and healthy to sick), for improving access and utilisation and averting out-of-pocket payments.

Upper middle-income countries such as Brazil, Thailand (Tangcharoensathien V Chaturachinda K and Im-Em, 2014) and Mexico (Andión Ibáñez *et al.*, 2015) rely primarily 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 social health insurance, which covers those who are formally employed and salaried. In contrast, low-middle and low-income countries, with relatively limited potential for generating tax-revenue considering the size of their formal sector, pool funding from also compulsory social health insurance (covering formal sector and often civil servants), community-based insurance schemes (CBHIs), overseas development assistance and out-of-pocket payments (e.g. India, Ghana, Rwanda).

In both these contexts (i.e. upper middle-income versus low-middle and low-income countries), extending financial coverage to the informal sector remains a challenge. While middle-income countries have been able to progressive provide financial coverage to the informal sector through tax revenue, this avenue remains limited in lower-income settings. In India and particularly in Rwanda and Ghana, community-based health insurance (CBHI) schemes, played a pivotal role in health financing reforms towards UHC. There is considerable variation in the design, scope, premiums and entitlements under CBHI schemes, but given that they are often voluntary, they are based on principles of solidarity. In these instances, solidarity is built on shared characteristics along lines of location, occupation, ethnicity, religion and gender (UN Women, 2015).

In both African countries (i.e. Ghana and Rwanda), CBHI were integrated within national funding and pooling schemes, but remained autonomous in terms of being community and district managed. As evident from both these countries, is the trade-off between level of membership premium and financial protection and benefits offered (Mathauer *et al.*, 2017). As Chuma *et al.* (2013) argues, “When the membership premiums are kept at a low monetary level to allow wider enrolment of poor people, the financial capacity of the pool remains low. This means the level of financial protection and benefits offered are relatively small, which ultimately limits the attractiveness of the scheme. Overall evidence of CBHIs schemes improving financial protection is rather mixed. A systematic review and meta-analysis of factors influencing initial voluntary uptake of CBHIs in LMIC), and renewal decisions

found that “enrolments in CBHI were positively associated with household income, education and age of the household head, household size, female-headed household, married household head and chronic illness episodes in the household.” In addition, factors enabling enrolment include: (a) knowledge and understanding of insurance and CBHI, (b) quality of healthcare, (c) trust in scheme management. Overall, it was concluded that “…educated, mature and female household heads attach more value to CBHI membership; gender matters most, followed by education and age.” (Dror *et al.*, 2016)

Box 1: Insuring the informal sector in Ghana and Rwanda: gender implications for financial coverage

Ghana

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 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).

Rwanda

“The experience of CBHI in Rwanda has been more positive. 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, 2015, p163).

Levels of financial protection may vary across within schemes. Even when services, including SRH services are included in an essential package of services, beneficiaries may still have to bear the direct costs (e.g. payment for drugs, supplies, transport) and indirect costs (e.g. loss of income). As Ravindran (Ravindran, 2012) observed, women shoulder higher burden of out-of-pocket costs 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 services.

In Ghana, under NHIS, exemptions were introduced for certain groups of individuals to improve their access health services. These groups include pregnant women, children under 18 years of age, elderly people 70 years, indigent (poor and vulnerable), 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 NHS 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). Therefore, as noted earlier, financial coverage does not automatically translate into access and utilisation, particularly when services are not free at the point of service. As described in the following section, this failure to translate coverage into access, sustains and in some instances deepens existing inequalities in access by gender, income and other social stratifications.

Population Coverage

SDG10 is to "Reduce inequality within and among nations". As observed by UN Women, "Between 1990 and 2010, income inequality rose by 11 per cent in LMICs. With less income and fewer assets than men, women, particularly single-mother households, are more likely to live below 50 per cent of median income. Evidence suggests that inequality between women and men in a household is a strong contributing factor to overall income inequality in society." (UN Women, 2018b). For countries such as Brazil, Mexico and Rwanda, that have made significant progress towards UHC, marked by increased coverage and higher levels of access and utilization, health inequities remain almost intractable. These inequities linked to a range of factors including challenges in tacking the social determinants of health and discrimination, poor quality of services, inadequate and poor distribution of health infrastructure in relation to health care needs or a mismatch in health care (Fried *et al.*, 2014).

These inequities above reflect 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." Box 2 below highlights in brief the gender inequalities in service coverage across the country cases.

Box 2: Inequities in Service Coverage: Mexico, Brazil, Ghana 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.

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 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.(Victora *et al.*, 2011).

Ghana

‘Migrant girls and women from northern Ghana who work in Accra as head porters reported challenges in obtaining insurance and accessing health care. Although poor, young and pregnant migrant, these migrant girls and women may qualify for NHIS exemptions, they still struggle to access formal health services. Although recently ill/injured participants (38.4%) desired health care, less than half (43.5%) sought care. Financial barriers overwhelmingly limit kayayei migrants from seeking health care, preventing them from registering with the National Health Insurance Scheme, 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 out-of-pocket expenses. Catastrophic and impoverishing medical expenses also drove participants’ migration in search of work to repay loans and hospital bills. Health insurance can help minimize these expenditures, but only 17.4% of currently insured participants (58.2%) reported holding a valid health insurance card in Accra. The others lost their cards or forgot them when migrating. Access to formal health care in Accra remains largely inaccessible to kayayei migrants who suffer from greater illness/injury than the general female population in Accra and who are hindered in their ability to receive insurance exemptions.’ (Lattof, 2018, p505).

Thailand

Migrant workers still face healthcare access barriers, despite being covered by the Voluntary Migrant Health Insurance scheme targeting both documented and undocumented migrants (UNFPA, 2018).

Service Coverage

‘Essential service packages’ can be gender-biased or discriminatory, when they exclude and fail to address the specific sexual and reproductive health 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, treatment services violence including rape). In contexts such as Thailand, where ‘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), essential services addressing specific sexual and reproductive health needs of women and girls across the life-cycle remain. One of the critical services remains in addressing violence including rape against women and girls (Sen and Govender, 2014).

One of the important challenges remains quality of services, which require strengthening essential elements of the health system. In Thailand, for example, where a policy of UHC has been in place since 2002, shortages and poor distribution of trained health professionals have been cited as the greatest barriers to fulfilling universal access (Evans *et al.*, 2012). In Ghana, despite a free Maternal Health Care Policy, access and utilisation, especially for poor and marginalised women in the informal economy remains a challenge (Alfers, 2013). In addition, weak health systems, characterised by poorly trained staff, lack of essential inputs and infrastructure, particularly in lower level facilities compromise both quality of care and access. Research from several countries indicate 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 2 describes institutional violence in health facilities in Brazil and Mexico.

Box 2: 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 was 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, recognised as 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 has also been observed, particularly as experienced by indigenous women. A 2013 study of Jalisco in north- western Mexico found reports of Huichol Indigenous women feeling shame and being treated as morally and intellectually inferior by the local health personnel. It is argued 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 overarching norms that all too often portray women as inferior or undeserving of medical citizenship and other rights" (Castro *et al.*, 2015)**.**

VI. Policy Implications

(NOTE: This section of the paper is still in the form of a rough draft, to be finalized after the EGM)

As mentioned earlier in the paper, 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, 2010; 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.

More recent work for the Background Paper for the World Bank – USAID organized 3rd Annual UHC Financing Reform in 2018 also emphasized fair processes with strong accountability, and effective monitoring, but was able to identify 10 unacceptable financing choices from an equity standpoint for the 3 elements of financing:

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.

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 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.

In applying a gender frame to UHC policy below, we emphasize two principles: the first is to identify positive measures to advance gender equality, building on the unacceptable choices spelled out above; and the second is to expand the dimensions of relevance from the three identified in the UHC cube (finance, people and services) to the full set of health system components: financing, services, health workforce, access to medicines, governance and information systems, as well as people. These will be considered below.

Policy Implications related to Financing

- Ensure 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.

- Pursue 'Bold approaches for creating universal access to financial risk reduction schemes without complex eligibility requirements, premium structures and tiered subsidies, in order to achieve high coverage levels at minimal transaction costs. Pooled health financing schemes should be promoted.'(UNFPA, 2018).

- Secure sustainable domestic and international financing to achieve full access to the essential sexual and reproductive health package (Starrs *et al.*, 2018).

- Ensure health services are available to all citizens free of charge at the point of delivery.

- Guarantee both individual contributions in social insurance coverage and taxes under taxation system is progressive, taking into account gender, intersectionality in addition to income to ensure that no one is left behind (Sen and Iyer; Ravindran, 2012; Staab, 2015).

- Ensure that social protection health schemes like cash transfer programs integrate gender-responsive elements and are free from conditionality and administrative procedures to reduce women's unpaid care burdens and improve accessibility to essential health services (Fried *et al.*, 2014).

- Promote women's empowerment by linking cash transfer programs with services such as preventive healthcare measures and support for victims of domestic violence (Ravindran, 2012; Staab, 2015).

Policy Implications related to Health Services

- Address and change all laws, policies and social norms that obstruct people's access and use of services, like parental or spousal consent policies; laws preventing access to safe abortion; laws that criminalize consensual sex activities; drug use or sex work (Kowalski, 2014), laws that prevent groups as people living with HIV, men who have sex with men, transgender people, and sex workers from accessing antiretroviral therapy (Fried *et al.*, 2014).

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

- Increase staffing of trained health workers in remote areas, setting up a reliable emergency transport system for women reach and facilitating voluntary choice are also important measures for greater accessibility (Germain *et al.*, 2015; UN Women, 2018b).

- Ensure adolescents (married and unmarried) have access to appropriate, confidentially-sensitive SRH services without discrimination in addition to comprehensive sexuality education(Germain *et al.*, 2015). Special attention should be given preventing violence or early and forced marriage of children (Jejeebhoy and Santhya, 2015).

- Pay attention to groups that are mostly overlooked in package coverage (like transgender individuals), by adding gender-transition services to coverage schemes as well as gender-specific care that might be denied based on individuals' gender on insurance paper like, treatment of ovarian cancer for female-to-male transgender people (Kowalski, 2014).

Policy Implications related to Health Workforce

- 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).

- Ensure and upholding respect for the patient's right of choice (Germain *et al.*, 2015).

- Put in place measures that prevent institutional violence and abuse including discrimination against unmarried women seeking sexual health services; denial of care to men who have sex with men; or forced or coerced sterilization of women with disabilities or from ethnic minorities (Kowalski, 2014; Sen *et al.*, 2018; Solnes Miltenburg *et al.*, 2018).

Policy Implications related to Information System

- Develop and implement appropriate and easily accessible data collection systems for stratification of the population into groups according to their economic and social aspect, such as income/wealth, caste, gender, religion, ethnicity and others (Sen and Iyer).
-
- Monitor and analyze the data collected through Information systems to communicate impacts of policies implementation to policymakers and the public in a timely fashion (World Bank, 2018b).

Policy Implications related to Access to Medicines and Technologies

- Ensure scaling up public spending on Medicines procurements, providing free essentials medicines for all and implement drug regulation and price control policies for drug market.
- Secure the availability of vaccines by strengthening the public sector and supporting the private sector market competition to produce low cost drugs and vaccines needed.

- Strengthen institutional mechanisms for procurement, distribution and delivery of drugs to the public and ensure staffing drug control authorities with skilled and gender-sensitive workforce. In addition, tighten the regulatory mechanisms and continuously testing for better drug quality control. (Planning commission of India, 2011).

Policy Implications related to Governance

- Facilitate public participation and involvement in the design, implementation, monitoring and evaluation of all UHC policies and programs with special consideration to gender equality policies and programs (including purchasing decisions and resource allocation).

- Ensure communication of development and assessment of domestic resource mobilization strategies and its distribution for women and men is done transparently and with accountability (UN Women, 2018a; World Bank, 2018a).

- Apply accountability mechanisms to services purchasing in pooled funds, including the details, criteria and justifications for decisions made, appeals and modification mechanisms for decisions over time and regulations that organize these processes and penalize misuse of public funds (World Bank, 2018a).

- Define terms of engagement and criteria for public private partnerships and strengthen accountability mechanisms for private sector participation by conducting regular human rights and gender impact assessments (World Bank, 2018a).

- Institutionalize accountability mechanisms for service providers to women and girls, including effective monitoring and incentive systems to make health services more gender-responsive (UN Women, 2015).

Embedding SRHR and Gender Equality in UHC: Towards a Conceptual Framework

(NOTE: These are only rough notes – this section is still to be properly drafted)

There is a risk of slippage of essential elements of SRH from the UHC research agenda. Below is a proposed framework, as a starting point for embedding SRH and gender within UCH.

The framework will be expanded to include violence against women and disrespect and abuse in obstetric care under both quality and accountability in addition to other critical areas.

Research implications

(NOTE: These are only rough notes – this section is still to be properly drafted)

Countries are already embarking on UHC reforms, and research priority setting for SRH and gender within UHC will depend on robust and timely evidence which includes analysis of both epidemiological and social science data. This is necessary for informing the development of key gender and SRH indicators for monitoring gender equity, quality of care and accountability. It is also essential for learning what does and does not work and why in the context of implementation research.

Gender and SRH indicators for monitoring progress within UHC will depend on defining the relevant research questions at a national, sub-national and community level derived through participatory processes (i.e. meaningful engagement of key stakeholders particularly those hardest to reach (women, adolescents, marginal, vulnerable and key populations) and civil society, in addition to government and researchers and regional and global partners.

Research questions will have to be built around a framework which embeds gender and SRH within the objectives of UHC and takes account of specific SRH issues such as accountability quality of care and inter-sectoral action which is necessary for addressing the underlying social determinants of health.

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Appendices: Country cases: Gender Analysis of UHC and Health Systems Reforms

(Detailed country case studies for India, Thailand, Mexico, Ghana, Rwanda are under preparation).

Brazil

Health-system Blocks/ UHC	Financial Coverage	Population Coverage	Service Coverage
Health Services	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 26% of the population enrolled in private health plans. The Family Health Program (FHS) which started first as a maternal and child health program then was scaled up into comprehensive community based program providing primary healthcare functions (Brazil's health system main approach). FHS community workers help bridging the gap between primary care and public health efforts. (Macinko, J. & Harris, M.J.,2015).	Women represent 2/3 of outpatients in SUS (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, S.G. 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. A study examining responsiveness of SRH services to adolescents' needs supported this view. As 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 SR, 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). 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 S.G., et al.,2012)

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. 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, R. et al., 2015). 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 (Brauw, A., 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 ML, 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)	Abortion is criminalized by law in Brazil except for limited case. Therefore, access to safe abortion is only provided illegally by private providers is limited to women with money. Many women who are eligible for induced abortion under the law cannot obtain services, however, it was stated that they initiate abortion using misoprostol then seeking medical care. Reports of institutional violence by healthcare providers were among half of women receiving post-abortion care (Diniz S.G. & Araújo M.J.,2015)

Health Workforce	Despite the fact that women count for the majority of health workforce in Brazil (71% at university level and 85% of technicians), however managerial and upper hierarchy levels are disproportionally more men focused (Diniz, S.G. et al.,2012). Health care provided under the umbrella of FHS – the community based PHC program- is compromised 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. Brazil has suffered from physicians' shortage due rapid expansion of the FHS, that Brazil has responded to with the controversial Mais Médicos (More Doctors) program, importing nearly 15,000 physicians from Cuba and other countries. (Macinko, J. & Harris, M.J., 2015). 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.	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, S.G. 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, S.G. et al.,2012). Additionally, women from ethnic minorities face discrimination and violence that prevent them from accessing quality health services, discrimination is manifested in behaviors 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, 2015).

	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 SR, et al.,2017).		
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, R. et al., 2015).	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 S.G.& Araújo M.J,2015)	