WORLD BANK GENDER THEMATIC POLICY NOTES SERIES:
EVIDENCE AND PRACTICE NOTE

ACHIEVING GENDER EQUITY IN HEALTH: KEY AREAS OF FOCUS UNDER UNIVERSAL HEALTH COVERAGE

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OVERVIEW

Gender and health are intrinsically connected. Gender influences an individual's way of living, well-being, health, and patterns of seeking and receiving health care throughout their life. Reducing gender gaps in health can increase human capital while ensuring that all sexes have the best possible start to life, have their health care needs met, and have the opportunity to reach their full potential.

Achieving gender equity in health requires a systematic approach across health systems. Universal health coverage (UHC) provides such a platform, especially through integrated primary health care (PHC) services. Drawing on World Bank operational knowledge and experience, this thematic note presents five priority areas where investments can help to solidify gains and further reduce gender gaps in health.

- Providing comprehensive **sexual, reproductive, adolescent, and maternal health services** (including family planning) empowers women, girls, and other gender identities and supports their health.
- Coverage of healthcare for older adults, especially women, under UHC supports healthy aging. Integrating with models of long-term and community-based care brings services closer to people.
- Supporting **gender equality in health leadership** can have a cascading effect on laws, policies, and regulations, as well as on the environment in which women and other gender identities work and receive healthcare. This includes addressing gender biases in medical training, career advancement, leadership training, and mentorship, as well as supporting inclusion, intersectionality, and diversity in decision-making bodies.
- **Covering mental health** under UHC (including better training for health care providers and social and behavior change communication) will facilitate reducing gender gaps in access to and use of services for women, men, and other gender identities.
- Reducing gender disparities in **pandemic preparedness and emergency response** will support continuity of essential health services; better communication; diagnosis and treatment of (drug-resistant) infections; adequate training, pay, and equipment for frontline workers, particularly women; and inclusion in leadership and decision-making bodies.

ACCELERATE EQUALITY | WORLD BANK GROUP Gender

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This thematic policy note is part of a series that provides an analytical foundation for the World Bank Gender Strategy (FY24–30). This series seeks to give a broad overview of the latest research and findings on gender equality outcomes and summarizes key thematic issues, evidence on promising solutions, operational good practices, and key areas for future engagement on promoting gender equality and empowerment. The findings, interpretations, and conclusions expressed in this work are entirely those of the author(s). They do not necessarily reflect the views of the World Bank or its Board of Directors.

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INTRODUCTION

Gender and health are intrinsically connected. Addressing gender disparities in health care services has the potential to increase human capital by 22 percent (Mousa et al. 2021). As a social determinant, gender influences an individual's way of living, well-being and health, and patterns of seeking and receiving health care (Heise et al. 2019; Weber et al. 2019). Both the biological sex[1] and social constructs of gender (gender norms) influence health outcomes across the life cycle. Gender inequalities impact the health of women, men, and other sexual and gender minorities within lesbian, gay, bisexual, transgender, and intersex (LGBTI) communities. These inequalities can take various forms, affecting not only health outcomes but also access to and use of preventive and curative health services. They influence how easily people can access services, their ability to make decisions about their own health care and bodies, their ability to pay for services, and the quality of services received. Differences in health needs and opportunities accompany people throughout their lives, from infancy to adolescence, adulthood, and old age (Vlassoff 2007; World Bank 2016; Lancet Series on Gender Equality, Health, and Norms 2019). Moreover, gender biases in the health sector (e.g., in health research and limited representation of women in health leadership) affect how the sector is managed and the quality of services and treatments provided.

In lower-income countries, vulnerable populations, especially women, girls, and other gender identities, face multiple barriers to accessing health services. Vulnerable groups encounter the broader, persistent challenges within the health sector, such as low government spending on health; an underdeveloped, inaccessible, or cost-prohibitive private health sector; low quality of public health care; and limited human resources for health, especially in rural and remote areas (Booty 2020; Banerjee et al. 2021). These shortcomings contribute to inadequate availability of quality health services, especially at the primary level of care. Gender and social norms, especially in lower-income settings, can further impact women, girls, and other gender identities by limiting their access to jobs and financial opportunities, as well as their decision-making power regarding when, why, and how to access and use health care. Such barriers can contribute to delays in seeking health care, especially concerning women's own health.

The World Bank recognizes gender as a core social determinant of health as it works to mitigate gaps in universal health care, strengthen primary health care access, and improve the quality of health care. It is committed to achieving gender equality through its policies, strategies, analytical work, and operational action on health. Targets set under IDA commitments since IDA18 support the flow of development funds to strengthen

[1] The differences in the biological determinants of health and illness include differential genetic vulnerability to illness, reproductive and hormonal factors, and differences in physiological characteristics that can contribute to gender gaps in health over the life cycle.

countries' programs and enhance the Bank's response to gender in its health projects. High-priority areas include maternal and reproductive health, as well as training and deployment of women health care providers. The Global Financing Facility for Women, Children and Adolescents (GFF) multi-donor trust fund also focuses on improving reproductive, maternal, newborn, child, and adolescent health and nutrition through evidence-based interventions and targeted strengthening of primary health care systems. Since its inception in 2015, the GFF has been pivotal in bringing together stakeholders for focused, government-lead, sustainable funding for women and children's health in 36 low and lower middle-income countries.[2]

GENDER AND THE HEALTH SYSTEMS FRAMEWORK

Addressing gender inequalities in health requires a systematic approach across health systems. Universal health coverage (UHC), with a specific focus on primary health care (PHC), provides a compatible platform for addressing gender gaps. UHC aims to "*ensure that all people have accessible, affordable, and quality health provision, regardless of their wealth, gender, or other circumstances*" (WHO and World Bank 2021a). It aims to ensure that everyone receives the necessary high-quality health care without suffering from financial hardship. UHC is a key World Bank commitment under the Sustainable Development Goals (SDGs). Simultaneously, PHC services are the first point of contact with the health system for most people and an important one for survivors of gender-based violence (GBV). Ensuring that affordable, quality, and appropriate health care is available at the PHC level supports better health by establishing regular care and facilitating access to more specialized health care when needed.

Implementing UHC has the potential to address gender gaps in health by facilitating access to affordable and quality health care. For instance, including sexual and reproductive health services as part of the package of essential health care services under UHC can support women, girls, and other vulnerable groups (including LGBTI) in accessing essential reproductive care by making it affordable. Similarly, where health insurance is available, such as employer-based health insurance, it needs to be accessible, affordable, and equitable for women as they age. Alternatives to traditional health insurance and pensions[3] can enable coverage for women who work in informal sectors or who may not participate in the labor market due to social norms and/or care giving responsibilities.

Despite this potential, UHC interventions are often designed without gender issues in mind. This includes foundational elements of UHC, such as collection, analysis, and use of data for decision making; measuring and improving quality of care, including patient-reported outcomes and experiences; and design, access, and use of digital platforms for UHC. Evidence from countries, such as India, Brazil, and Ghana, indicates that the lack of gender consideration in UHC design can perpetuate gender-based gaps in health.

For instance, women may face barriers to registering for UHC-supported programs due to financial or physical constraints or a lack of identity and civil registry papers. Women may continue to pay high out-of-pocket costs for sexual and reproductive health services due to misinformation, limited coverage, or other costs that are either not covered under UHC or are hidden, such as the cost of transport and lost income earnings (Sen, Govender, and EL-Gamal 2020). Designing health projects and programs that are responsive to gender issues in PHC can help reduce gender gaps and achieve UHC.

Simultaneously, gender norms, social and cultural beliefs, and other socio-economic determinants can influence women's, men's, and other gender identities' access to and use of health services, affecting their health outcomes over their life course. Women's limited voice and agency due to regressive gender norms reduce their ability to make decisions about their own bodies. Their restricted mobility in some parts of the world increases their dependency on men to be able to reach health facilities, which can cause delays in receiving appropriate health care. Gender norms around masculinity can become barriers to men seeking health care for themselves, including for mental health. Discrimination against other gender identities can limit when, where, and how LGBTI people access health care, even when it is available.[4] Ensuring that health care providers are trained to recognize and provide services without bias, can improve access for other gender identities, who often face high barriers to health care due to societal discrimination.

The World Bank's Health Systems Flagship[5] framework identifies three performance goals of a health system: improvement in health status, citizen satisfaction/

[2] Information on GFF investments and results available at: https://data.gffportal.org/.

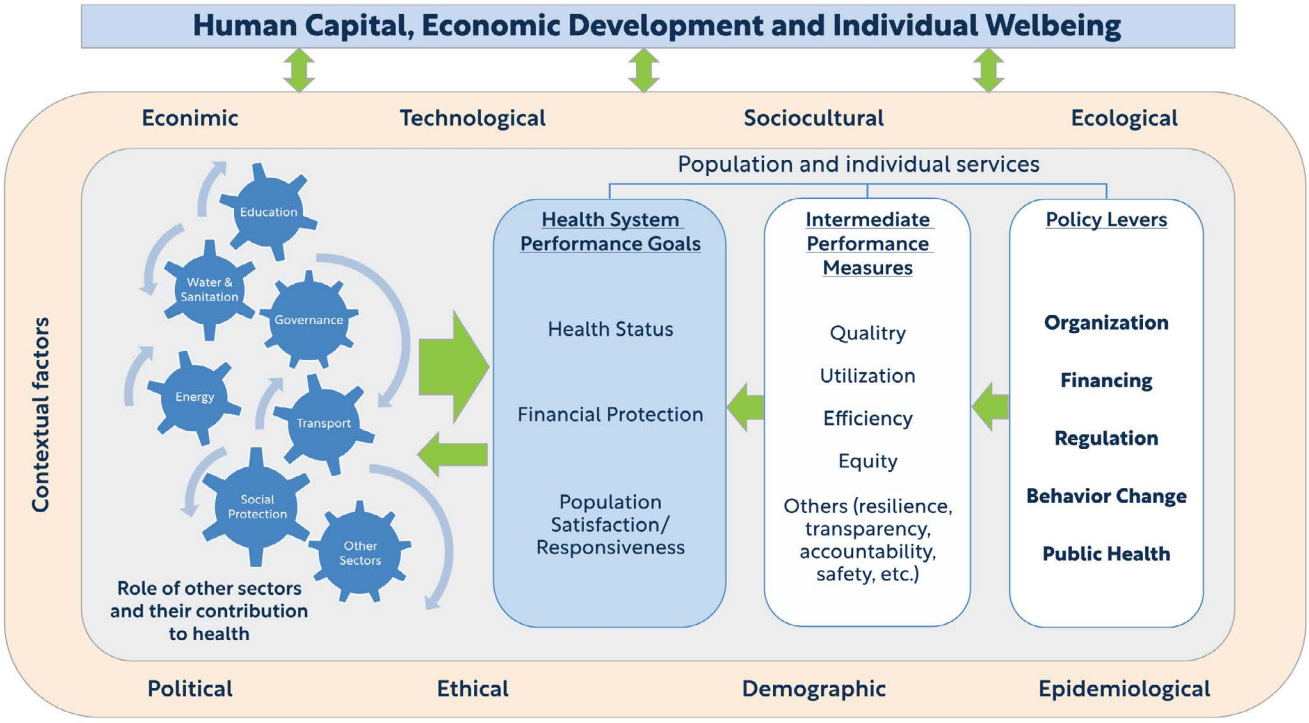
[3] For example, non-contributory programs or mechanisms, such as allowances or cash transfers, are often used in lower income countries for maternal and child health and in some cases, for the provision of social security to older people and those with disabilities, such as the Karama program in Egypt, universal pensions in Mexico and Georgia, and monthly allowances in Timor-Leste (DeMarco et al. 2024). UHC can also be funded through taxation (as in the United Kingdom or Canada); microfinance or micro-pensions; social security credits for family caregivers for time out of the labor market caring for young or elderly family members (as in France and Germany); and funded schemes based on family savings or investments rather than individual savings and investment (Cameron 2019).

[4] For more on this topic, see the World Bank Gender Thematic Policy Note on Sexual Orientation and Gender Identity (SOGI) Inclusion and Gender Equality

[5] This framework updates the approach to modeling a health system and encompasses the linkages between social determinants of health (including gender), health systems, health outcomes, and human capital.

responsiveness, and financial risk protection (see Figure 1). Addressing gender inequality in health is important for achieving these goals. For instance, barriers to timely access to health services rooted in gender norms (e.g., women's limited mobility or provider bias against LGBTI) or capacity to afford these services contribute to gender gaps in women and men's health status and their satisfaction with the health care they receive. All three goals of the health system can be met by supporting the availability of primary health care in or near villages or neighborhoods where women live, implementing universal health coverage that supports women's capacity to afford health care, and ensuring that essential packages of care under UHC cover women's health needs (e.g., sexual and reproductive health, including for menopause).[6]

FIGURE 1: HEALTH SYSTEMS FLAGSHIP FRAMEWORK



Source: HNP Health Systems Flagship Course

Achieving gender equality in health requires addressing barriers within and outside the health system with a focus on improving health outcomes for women, men, and other gender identities. A holistic approach capitalizes on the Bank's current engagement on gender gaps in health and sharpens focus on other emerging or priority areas, such as pandemic preparedness and women's leadership in health and more broadly.

THE ROLE OF THE PRIVATE SECTOR IN HEALTH SYSTEMS

The private sector plays a critical role across the health value chain, including in areas, such as research and development for new products (such as vaccines) and innovation that can enhance the effectiveness and reach of a response. The private sector is active in the manufacture and distribution of lifesaving products with the capacity and agility to scale at times of high demand, and in the provision of diagnostics and health care services complementary to the public sector. In some developing countries, the private sector constitutes up to 80 percent of health service capacities. Moreover, the mobilization of private capital can enable large-scale expansions of capabilities in response to an emergency. The health sector provides opportunities for entrepreneurs, including those in health tech, to close access gaps and advance innovation. Women entrepreneurs, although small in numbers, serve critical areas in health, including patient care, health care service delivery, and facilitating access to medical equipment and clinical services.

[6] The World Bank's self-paced e-learning module on Gender and UHC details how gender interacts with different aspects of the health system. The course is part of the Health Systems Flagship series.

PRIORITY AREAS FOR HEALTH AND GENDER EQUITY UNDER UHC

The World Bank's Gender Strategy 2024–2030 provides an opportunity to review and build on progress toward reducing gender gaps in health. An array of World Bank interventions has shown that achieving UHC supports the achievement of gender equality. In alignment with the Bank's focus on UHC and PHC, the following five priority areas can help solidify gains and reduce gender gaps in health.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Sexual and reproductive health and rights (SRHR) encompass a comprehensive understanding of the right to well-being and choice over one's own body and sexuality accompanied by a package of comprehensive sexual and reproductive, maternal, and adolescent health services (e.g., Starrs et al. 2018). Lack of access to SRHR, such as family planning, hinders girls and women from delaying childbearing, determining the size of their families, and pursuing education, employment, or other activities. Improving SRHR is crucial for reducing gender gaps in health with reverberating impacts across other aspects of people's lives (Starrs et al. 2018).

Creating space for SRHR means supporting better physical, mental, and social well-being, especially for women and other gender identities, through enabling their access to comprehensive, respectful, and inclusive health care and supporting their voice and agency. Since the establishment of the Millennium Development Goals (MDGs), sexual, reproductive, and maternal health has been a global priority and progress has been made. Between 2000 and 2015, maternal deaths worldwide declined by 33 percent, from 451,000 to 303,000, and continued to decrease with an estimated 295,000 maternal deaths in 2017 (WHO 2019a).

Yet, poor reproductive and maternal health remains a significant challenge in many countries, with uneven progress within and across countries. Persistent social and gender norms act as barriers to seeking knowledge and health care, while policies and legal frameworks hinder women, adolescents, and other gender identities from exercising their rights. On the other hand, multisectoral action such as expanding girls' secondary and higher education and labor market opportunities can help improve SRHR outcomes by reducing early marriages and births and giving women more autonomy over their own health.[7]

Harmful practices and reproductive morbidity (e.g., sexually transmitted infections, obstetric fistulas, and female genital cutting/mutilation, among others) still cause considerable suffering. Attention to these issues in development discourse is sporadic and action often encounters stigma. The majority of maternal deaths (86 percent) are in lower-income countries, mainly in Sub-Saharan Africa and South Asia (Sahoo et al., 2021). Unsafe abortion represents one of the main preventable causes to maternal deaths. In developing countries, an estimated 220 maternal deaths occur per 100,000 unsafe abortions (Ganatra et al. 2017).

[7] Gender Thematic Notes on Education, Social Norms, and Labor Force Participation further discuss these areas.

Progress on adolescent SRHR is also uneven across regions, with adolescents in Sub-Saharan Africa and low-income countries still experiencing high adolescent fertility and pregnancy-related mortality (Liang et al. 2019). An estimated 19 percent of adolescent births are in Sub-Saharan Africa (Kassa et al. 2019). As of 2013, an estimated 10 percent of adolescent girls in lower and middle-income countries gave birth, compared to less than 2 percent in high-income countries (Salam et al. 2016). Limited improvement in this pattern means more disadvantaged adolescents are more likely to become pregnant, give birth, and have higher fertility (Huda et al., 2020; UNFP 2022). While the proportion of adolescents using modern contraception has increased globally, especially among unmarried adolescents (at 51 percent) over the past two decades, only 21 percent of married adolescents report using modern contraception, and unmet need remains high at 41 percent and 23 percent, respectively (Liang et al. 2019). At the same time, maternal mortality among adolescents is as high as 570 deaths per 100,000 in Africa (Liang et al. 2019).

These challenges and negative outcomes are rooted in women and adolescent girls' limited access to sexual and reproductive health services (especially family planning), dependence on others, and a lack of financial control and decision-making power over their own bodies. The COVID-19 pandemic further increased the vulnerability of reproductive-age and pregnant women due to disruptions in essential reproductive and maternal health care. At the height of the pandemic, 94 percent of 112 countries surveyed by the WHO reported disruption in at least one essential health service, and 35 percent of countries reported disruptions across reproductive, maternal, newborn, child, and adolescent health (RMNCAH) and nutrition services (WHO 2021b).

The World Bank has a long history of working on sexual and reproductive health, especially supporting interventions that improve maternal health outcomes, facilitate women and girls' access to family planning, and enhance the enabling environment. This is built on strong analytics and evidence-based policy dialogue, first captured in the Bank's reproductive health action plan (2010–2015), which defined priority areas for investing in sexual, reproductive, and maternal health (including for adolescents). During the five years that followed, investment increased with approximately $2 billion invested in reproductive and maternal health projects.[8] In 2015, the Bank along with partners launched the Global Financing Facility (GFF) to further support countries in advancing the RMNCAH agenda. Since partnering with the GFF, countries' investments have reached over 96 million pregnant women with four or more antenatal visits, over 103 million women with safe delivery care, 111 million newborns with early initiation of breastfeeding, and over 500 million users of modern contraceptives, with more than 187 million unintended pregnancies averted (Global Financing Facility 2022). Some recent examples of work in this area include the following:

The Sierra Leone Health Service Delivery & System Support Project aimed to improve the quality and use of essential maternal and child health services in Sierra Leone and to support the country in responding to health crises. Investments helped strengthen the delivery of maternal and child health services, including ante-natal care, skilled attendance at birth, and childhood immunizations, especially for hard-to-reach and remote populations. These investments contributed to a 15-percentage point increase in skilled attendance at birth, from 72 to 87 percent between 2013 and 2020. During the same period, the percentage of hard-to-reach communities with at least one dedicated community health worker increased from 37 to 93 percent.

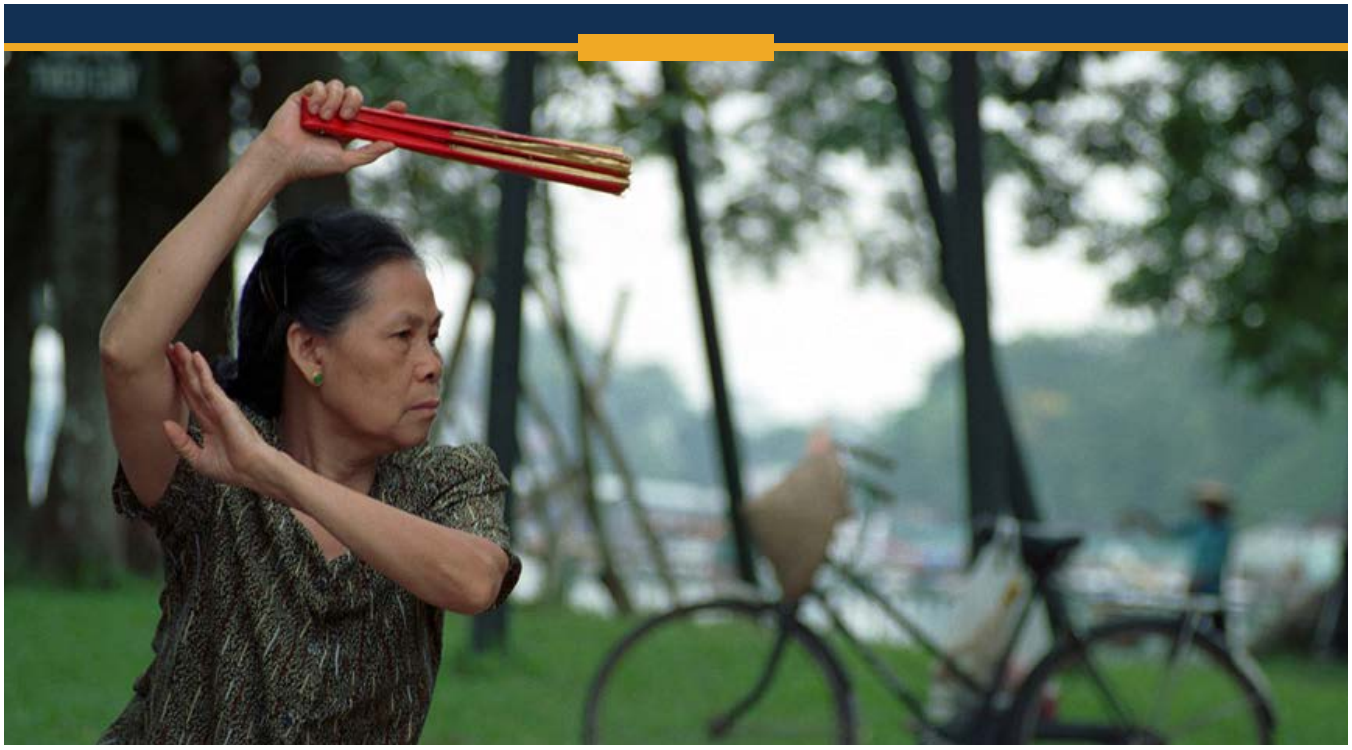
The Uganda Reproductive, Maternal, and Child Health Services Improvement Project sought to improve the utilization of essential reproductive, maternal, and child health services along with scaling up birth and death registration services critical for ensuring accurate reporting on maternal and child survival and mortality. Under this project, skilled attendance at birth increased by 21 percentage points between 2015 and 2022, from 50 to 71 percent, and maternal death audits increased significantly from 33 to 89 percent.

The Investing in Maternal, Child, and Adolescent Health project in **Senegal** also aims to improve the utilization of essential RMNCAH and nutrition services meeting quality standards. Investments have contributed to a rise in the utilization rate of modern contraceptive methods by adolescent girls in a relationship (ages 15–19) from a baseline of 8 percent to 16 percent between 2018 and 2023.

The First Laying the Foundation for Inclusive Development Policy Financing supports **Niger's** Ministerial Order in enabling married adolescent girls to access family planning without parents' or husbands' mandatory accompaniment. It also supports the establishment of Child Protection Committees at the national, regional, communal, and village levels as part of efforts to cease child marriage. These are important steps toward women's empowerment and reducing the risk of intimate partner violence and sexual exploitation of young girls.

The Sahel Women's Empowerment and Demographic Dividend (SWEDD) flagship program works to enhance the status of adolescent girls, empower women, and increase their access to quality education and reproductive, child, and maternal health care services in Benin, Burkina Faso, Chad, Côte d'Ivoire, Mali, Mauritania, and Niger. Each country has its own country-level project under the SWEDD umbrella. The initiative mobilizes the

[8] Based on an analysis of the IBRD/IDA portfolio.



entire community—from religious leaders, politicians, and health professionals to mothers and husbands—to harness recognition of women's enormous economic potential. It invests in health service delivery, social and behavior change, and girls' education and employment. SWEDD has helped over 9,000 midwives complete basic training and receive short-term continuing education, contributed to an increase in contraceptive use with over 300,000 new users in target areas, and reached 4 million people with social and behavior change communication (SBCC). In addition, SWEDD has supported 300,000 girls with financial and in-kind support to stay in school and helped 120,000 out-of-schoolgirls learn life skills between 2015 and 2021.

Lessons learned on improving reproductive and maternal health outcomes for women and girls

The World Bank's experience and lessons from the global development community's support for sexual and reproductive health suggest the following key elements of successful interventions to improve women's health outcomes.

- It is important to provide comprehensive sexual, reproductive, and maternal health services (including ante-and post-natal care, skilled birth attendance, and family planning information and services) to ensure a continuum of care.
- Family planning is a best buy because it empowers girls and women to make decisions about childbearing (when and how many) and facilitates their potential for higher education and labor market participation.
- Communicating via multiple delivery channels and in local languages helps to deliver family planning information and products, including both facility and community-based efforts, to the most vulnerable women and girls
- SBCC is pivotal for encouraging the uptake of timely sexual, reproductive, and maternal health care. This includes interventions that engage men and boys to improve their knowledge and promote better health-seeking behaviors for both women and men.
- Coupling SRHR with nutrition interventions supports better reproductive and maternal outcomes along with improved newborn and child health outcomes.
- Coverage of the continuum of care under UHC enables affordability and reduces financial constraints.
- Conditional and in-kind transfers can support equity in access to maternal and child health care, as well as better performance among providers, but this needs to be applied with caution to avoid coercion.

HEALTHY AGING AND ACCESS TO HEALTH FOR OLDER WOMEN

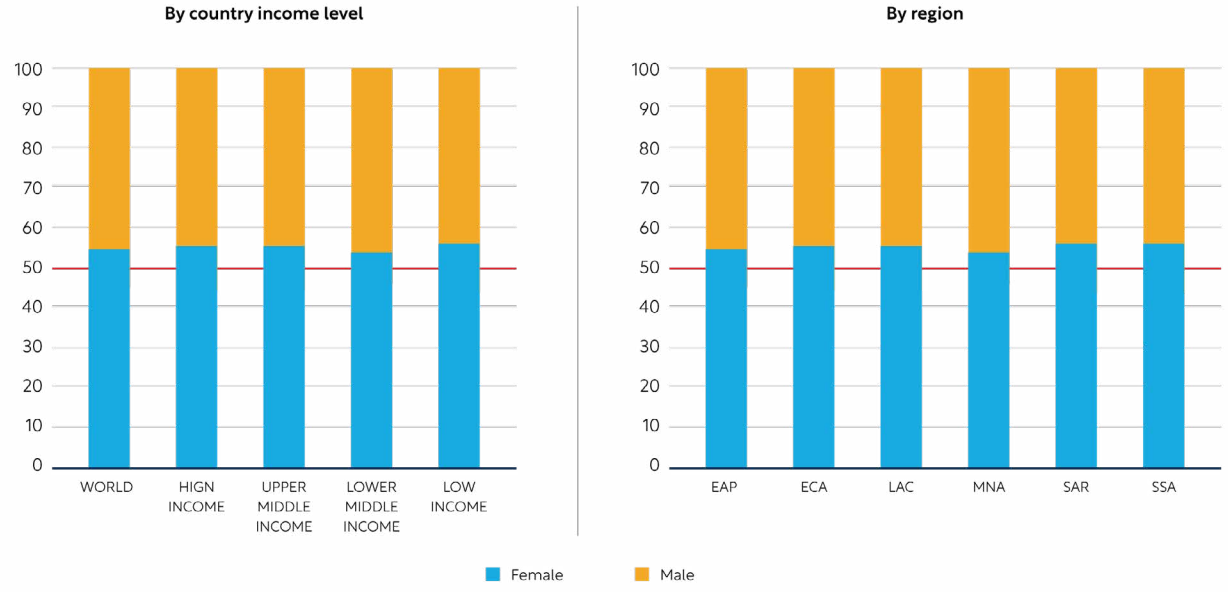
Women make up nearly half (49.5 percent) of the world's total population of 7.8 billion people.[9] Due to a combination of biological and behavioral risk factors, women tend to live longer than men. While the proportion of women ages 0 to 59 years is 42 percent of the total population at the global level (a deficit of 8 percent), the proportion shifts as the

[9] Health, Nutrition, and Population Statistical Database, World Bank.

population ages, with women ages 60 and above making up over 55 percent of older age groups (see Figure 2). As the world population continues to age, the cohort of older women will also increase. These women may be living with multi-morbidities and may be financially constrained, especially in low and middle-income countries with limited or no coverage under health insurance or social protection programs (where they exist), since women constitute a smaller proportion of the labor market and often drop out after childbirth or due to other care responsibilities or are more often engaged in informal markets. This is the feminization of aging and old-age poverty.

Moreover, women may not seek or receive care in a timely manner. For example, across Sub-Saharan Africa, women come to health care facilities with stage 3 or 4 breast and/or cervical cancers because they do not access diagnostic services early on due to barriers in access and affordability, cultural norms, and stigma (Gebremariam et al., 2023; Ngwa et al., 2022). This not only compromises their survival but makes treatment even more unaffordable or inaccessible. However, innovations in digital technology can address such issues (see Box 1).

FIGURE 2: PROPORTION OF FEMALE TO MALE POPULATION, AGES 60+ (2020)



Source: Health, Nutrition, and Population Statistical Database, World Bank, accessed 2-23-2023.
Note: EAP = East Asia & the Pacific; ECA = Eastern Europe & Central Asia; LAC = Latin America and the Caribbean; MNA = Middle East & North Africa; SAR = South Asia Region; SSA = Sub-Saharan Africa

Women's quality of life as they age can deteriorate considerably due to illness and lack of resources. Control over financial resources and access to care are two important dimensions of healthy aging where women are often constrained (McMaughan, Oloruntoba, and Smith 2020; Read, Grundy and Foverskov 2015; Miszkurka et al. 2012). For example, in India, widowhood is associated with women's use of public health services in older ages but not so for men or married women, who are more likely to use private health care, which may offer higher quality of services (Hossain et al. 2021). In 2017, it was estimated that about half a billion people were pushed or further pushed into extreme poverty, and 2.2 times as many went into or further into relative poverty because of out-of-pocket health expenditures (WHO and World Bank 2021b). Women, particularly older women who are dependent on others, are vulnerable to delayed or foregone health care due to the high and prolonged cost of services for age-related health conditions.

Although data on LGBTI is limited, and often from higher-income countries, it points to worse experienced health outcomes. In Canada, a recent large-scale study found that a significantly higher share of LGB persons reported poorer functional health than their heterosexual counterparts with bisexual females faring the worst: 20 percent reported fair or poor health compared to 11.2 percent of heterosexual

BOX 1: DIGITAL TECHNOLOGY INNOVATIONS BRING SERVICES CLOSER TO PEOPLE

Beyond availability and affordability of services, two key barriers to women's access to health care are limited information and mobility. This is exhibited in the delays in seeking care, especially for noncommunicable diseases, such as diabetes or cancers, which can often be overlooked without knowledge, regular screenings, and preventative care. Investing in health education through social messaging and targeted campaigns, coupled with innovative digital technologies, can help to address these barriers.

In 2022, the World Bank partnered with the Consumer Technology Association for the Global Women's HealthTech Awards. NIRAMAI and UE LifeSciences were two of four winners for private sector innovation. NIRAMAI has developed a novel software-based medical device for detection of early-stage breast cancer in a simple and private way. Their solution is a low cost, accurate, automated, portable cancer screening tool that works for women of all age groups and breast densities, addressing a key unmet need in cancer screening. UE LifeSciences has developed iBreastExam, a radiation-free device that enables earlier stage detection of breast cancer at low-cost and minimal training compared to other options. To date, the company has reached over 500,000 women in countries such as Egypt, India, and Botswana, helping to detect over 200 cases of breast cancer.

Source: Global Women's HealthTech Awards, 2022 winners

females (Rauh 2023). Work by Fredriksen-Goldsen and colleagues in the United States highlights that older lesbian and bisexual females faced similar physical health issues as their heterosexual counterparts but reported more disability and poorer mental health. They were also less likely to have health insurance and more likely to face financial constraints (Fredriksen-Goldsen 2013).

Traditionalism, negative attitudes toward aging, and stigma can also contribute to a lower quality of life and health, whether perceived or experienced, for women and men (Sun et al. 2022; Nair et al., 2021), including within the LGBTI community. Women's limited voice and agency, financial dependence on others, and living longer with multi-morbidity contribute to their lower levels of self-rated health (Carmel 2019). Similarly, experiences of discrimination contribute to poor health among LGBTI people. A recent Finnish study, for example, found that in the aftermath of COVID-19, women reported more symptoms and a lower quality of life than men (Lindahl et al. 2022). Earlier studies in Brazil and the United States found that older women will experience higher levels of physical disability compared to men due to socio-economic inequalities across the life course (Guerra, Alvarado and Zunzunegui, 2008; Thorpe et al., 2008). As populations continue to age, the prevalence and severity of disabilities are expected to increase (UN Women, 2012).

Moreover, with COVID-19 becoming endemic, there is likely to be increased levels of illness and mortality due to the disease, impacting women and men differently. Current patterns from a handful of higher and middle-income countries indicate a higher rate of male hospitalization and mortality due to the disease compared to women (Global Health 50/50). On the other hand, a larger proportion of survivors of COVID-19 are likely to be women, who may live with the long-term side effects of COVID-19 as well as other noncommunicable diseases as they age (Lindhal et al. 2022). Health systems must take action to reduce this burden of male mortality and ensure people, especially older women, receive appropriate and affordable care.

The World Bank has done analytical work to address cross-cutting issues, such as social protection and long-term care, for aging populations in middle-income countries. In some cases, particularly in Eastern European economies, data do not reveal significant gender gaps in access to social services, but data are also not geared to examine other issues, such as the feminization of old age and old age poverty. Gender gaps are most often examined in the context of women's employment and care responsibilities. There is a need and opportunity for dedicated data collection and analysis on gender gaps among aging populations regarding access to health services and health outcomes (beyond mortality), especially for countries with greater gender inequalities.

With a significant proportion of the global population expected to be over the age of 60 by 2050, including in Sub-Saharan Africa, women will constitute a larger proportion of the elderly. They need interventions that will empower them across their life course with access to resources, such as income, social protection, and health insurance, and more control over decision making about their health and well-being.

Interventions to reduce gender disparities in healthy aging

As governments establish UHC systems, these systems must address gender disparities in access and affordability of care for older cohorts. This should come with other cross-cutting interventions that support women's empowerment across the life course. The following interventions can help to improve gender equity in healthy aging:

- Provide coverage for women under UHC or other payment arrangements for health services beyond reproductive and maternal health (i.e., coverage across the life cycle).
- Provide PHC services that address the health care needs of older populations, such as management of noncommunicable diseases, psychosocial support, menopause care, and osteoporosis, and ensure these are integrated with models of long-term and community-based care for older populations.
- Support better access to information on health and social services, their availability, coverage eligibility, and how to access these, with dedicated campaigns targeted at women and in local languages.
- It is essential that UHC systems respond to the gender gaps in access and affordability for older and elderly cohorts. Better coverage for older and elderly women can help reduce financial constraints on households that often lack this knowledge.
- Introduce SBCC to promote healthy habits and normalize the use of psychosocial services, especially among men.
- Enable cross-cutting solutions that empower women and other gender identities and increase their capacity to have financial coverage, such as pensions.

SUPPORTING WOMEN'S PARTICIPATION IN HEALTH LEADERSHIP FOR GENDER EQUALITY

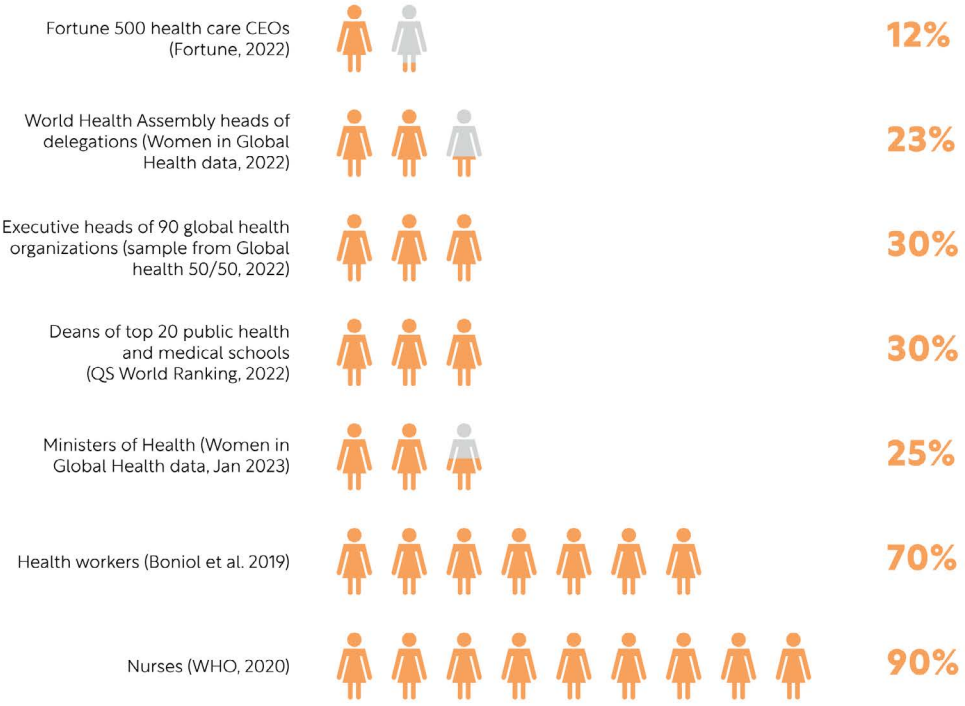
The gender gap in health leadership is glaring. Although women account for 71 percent of all global workforce professionals and 59 percent of all graduates in the medical, biomedical, and health sciences fields, only 25 percent of senior leadership roles are held by women (Mousa et al. 2021) and of these, only 5 percent are women from low and middle-income countries (WGH 2023). Fewer than 9 percent of health tech startups are founded by women entrepreneurs, and women comprise only 11 percent of partners in health tech companies (Raphael 2019). Similarly, on average, women hold only 30 percent of executive positions and 18 percent of board seats in the biotech industry (Pagliarulo 2020). In 2023, less than 10 percent of investor funding went to health tech companies founded by women entrepreneurs (Tecco 2017). Yet, women make up 70 percent of frontline health care workers globally, often as lower-paid, junior-level staff, or unpaid volunteers. The vast majority of registered nurses, 80 percent, are women (see Figure 3).

These gaps are the result of barriers created by social and gender norms that impact women's lives and by decisions that influence their health, education, employment opportunities, and career advancement. For example, unconscious (or visible) bias in school systems that discourage girls in science, technology, engineering, and mathematic (STEM) education (McDaniels 2016; Liu 2018; Raabe, Boda and Stadtfeld 2019; Sansone 2019) or in the workplace create glass ceilings for women. In addition, women's double burden of care for children, elderly, or disabled family members can limit their interest, capacity, and/or opportunity to access employment, equal pay, or leadership opportunities (Pérez-Sánchez, Madueño, and Montaner 2021; McDonagh et al. 2014; Albertini 2016; Mahtad et al. 2019; Ahmed et al. 2023). In Cambodia, for example, women represent 20 percent of the senior roles in the Ministry of Health. When offered leadership positions, women, by necessity, have to take a consensual approach

to acceptance, seeking approval from families first (Dhatt et al. 2017). Similar experiences of discrimination can also limit the participation of LGBTI people in leadership positions.

Even in countries where women form a significant proportion of the formal labor market, their numbers dwindle at the upper levels of leadership where decisions are made. This can have a cascading effect on laws, policies, and regulations, as well as the environment in which women work and the care they receive. In the United States, for example, women make up about 40 percent of all physicians and surgeons, but only 16 percent of permanent medical school deans (Warner, Ellmann, and Boesch 2018). In Spain, an analysis of regional hospitals found that, while 74 percent of professionals were women, only 24 percent were service chiefs (Pérez-Sánchez, Madueño, and Montaner 2021). Evidence from the European Society for Medical Oncology shows that although women and men doctors have similar career trajectories in their early years, women are five times more likely to experience career interruptions due to family needs, which can be a significant barrier to their career advancement (Bergoff et al. 2021). In other instances, women decline leadership roles due to family obligations and concerns over harassment (Mathad et al. 2019).

FIGURE 3: WOMEN'S LIMITED LEADERSHIP IN HEALTH



Source: Adapted from WGH 2023; WHO 2020; Boniol et al. 2019

Gender gaps in leadership are a considerable barrier to reducing gender gaps in policy and programs across economic, political, and social dimensions, including in health care (Mousa et al. 2021). Such gaps in leadership contribute to a lack of understanding of the barriers women and LGBTI people may face in accessing and paying for health care, and how policies and legal frameworks perpetuate the problem. Gender-biased understanding of the constraints that women health care providers may face in the workplace can lead to poor planning and structural weaknesses, as well as supply chain inadequacies.

For example, women made up the majority of frontline health care providers during the COVID-19 pandemic, but in most cases, the personal protective equipment (PPE) provided to them was too big as it was sized for men (Women in Global Health 2021). Even when efforts were made to have more balanced gender representation on COVID-19 task forces, only 4 percent of the 334 COVID-19 task forces in 137 countries had gender parity, and 18 countries had no women at all (UNDP/UN Women/University of Pittsburgh 2021). Similarly, limited representation of women as team leads of clinical trials or in other bodies that contribute to policy and decision making

means that medical research, protocols, diagnoses, and treatments can overlook gender-specific issues and concerns, not only for women and girls but also for LGBTI populations.

Reducing and eliminating gender gaps in health leadership has the potential to reduce gender gaps in service delivery. Advancing women as leaders in health requires intentionality and the commitment of institutional and discipline leaders (Hobgood 2022). It requires addressing barriers within the health system and on cross-cutting issues, such as social norms, education, and labor market challenges. The World Bank increasingly supports countries in promoting women's leadership.

For example, the GFF piloted the **Greater Leaders Program** as part of the broader Country Leadership Program to train current and upcoming women leaders in the health sector. Group and one-on-one advisory sessions enabled participants to tap into their individual leadership capacities to better serve the sector, overcome obstacles, and use personal networks and experience to create positive, meaningful results. The participating leaders gained greater self-awareness and confidence in their management style and were able to put their learning into practice at work and inspire others.

In response to the growing recognition of the business case for gender diversity in private health care leadership, IFC published the Women's Leadership in Private Health Care Report in 2019 and launched the **Women's Leadership in Private Health Care Global Working Group** in 2020. The initiative brought together CEOs and human resource directors from 17 health care companies in a community of practice dedicated to identifying and addressing the barriers to women's leadership in the health sector. IFC hosted four peer-to-peer knowledge sharing and networking events to guide working group members in identifying actions to move the needle on gender equity in their organization. It also delivered nine learning webinars on key gender themes, which engaged 376 participants representing 169 organizations from across the globe, with a satisfaction rating of over 85 percent. Participating companies implemented initiatives on gender equality and inclusion in their operations to better foster women's leadership. Specifically, health care companies conducted gender workforce diagnostics; created gender strategies; appointed internal gender equality committees; implemented respectful workplace and GBV prevention policies; and revised their recruitment and human resources practices through a gender lens. The IFC's Women's Employment Program also supports women's leadership in health care provision (Box 2).

BOX 2: WOMEN'S EMPLOYMENT PROGRAM

In Mexico, IFC investment client Grupo Neolpharma partnered with IFC to conduct a Corporate Gender & Inclusion Assessment in 2022 under the Women's Employment Program. The company is implementing an action plan to increase women's representation in leadership positions, set a talent development framework, and create a policy and practices framework for promoting an inclusive and respectful workplace. By June 2023, the company had hired three women in C-suite positions, increasing the number of women leaders from five to eight. The number of promotions granted to women employees more than doubled, going from 65 to 147 women promoted (53 percent of the total promotions granted) and the retention rate of women 12 months after returning from maternity leave increased from 60 to 90 percent. By March 2024, the company had implemented leadership training for women, and the number of employees trained in Respectful Workplaces increased by 60 percent (from 1,200 in 2022 to 2,000 employees in 2024). In addition, grievance channels have been implemented across all locations.

In Ethiopia, four women physicians founded the Hemen Maternal and Children's Specialty Medical Center (in 2008 to offer high-quality women's reproductive and children's health care services. As a Women's Leadership in Private Health Care Global Working Group member, the company conducted a Corporate Gender & Inclusion Assessment in 2021and found that, while the company was founded and led by women and women represented 80 percent of its employees, men were more likely to be promoted and there was a gender pay gap. By 2022, the company introduced a new gender policy, established a gender diversity policy committee, reviewed their employee promotion tool to ensure equal representation in leadership positions, addressed their gender pay gap, and implemented flexible work arrangements and other policies to ensure employee retention.

Ways to Encourage Women's Leadership in Health

The benefits of gender parity in leadership are emerging and there is increasing evidence that women leaders positively impact maternal and health care policies, strengthen health facilities, and reduce inequalities (Downs et al. 2014). Within health, it is necessary to facilitate women's opportunities to advance their careers through interventions to support skills development and mentoring. However, this alone is not sufficient.

Concerted effort is needed to address policy, institutional, and structural biases that hinder women's advancement within leadership roles (Harrison et al., 2022; Moyer et al.2018). Training programs in science and medicine and other interventions should include awareness and education around gender stereotypes, intersectionality, and the value of diversity in improving outcomes in science and medicine (Coe et al. 2019). At a structural level, it also means acknowledging and creating space for different leadership styles and tackling labor market

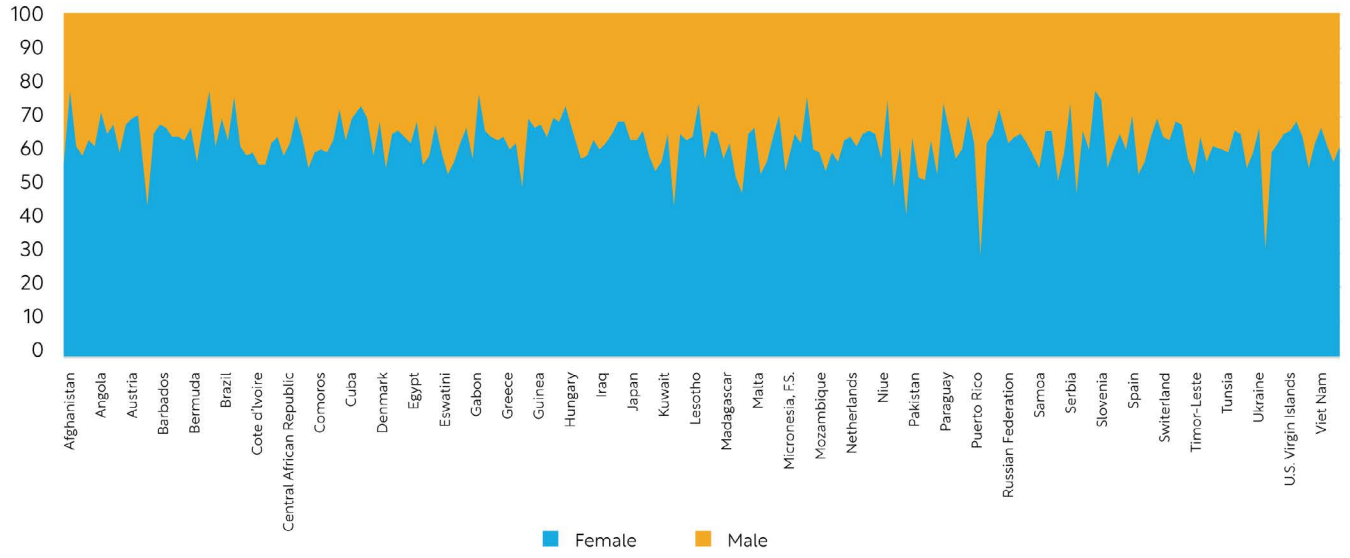
challenges, such as gender-based pay gaps and placement opportunities. Other proactive interventions to help increase women's representation in health leadership include the following:

- Encourage leadership that cements gender transformative approaches into institutional frameworks and human resource policies. Health institutions in both the public and private sectors can conduct gender assessments to quantifiably measure gender dynamics and gaps, including recruitment and promotion, and identify policies and actions to reduce gender pay gaps, provide maternity and paternity leave, enable women to have shared caregiving responsibilities and reduced disruptions to their careers, and enforce strong frameworks to address sexual harassment and workplace violence
- Support enabling environments for women's leadership, such as fostering mentorship and networking for women health care workers (Chung et al. 2023) and providing opportunities to participate in decision-making bodies, such as hospital committees, and in leading clinical trials.
- Ensure that research and data are disaggregated and reflexive in terms of sex and gender, especially since data on leadership in private sector institutions are not available for most countries, and international standards do not exist to measure this (Bonfert et al. 2023).
- Engage in cross-cutting dialogue and interventions, such as social and behavior change communication that engages both women and men on a range of topics to address social and cultural barriers, like encouraging girls' participation in STEM education, reducing sexual harassment and violence, and sharing household and care responsibilities equitably.

ADDRESSING GENDER DIFFERENTIALS IN MENTAL HEALTH

Emotional and mental well-being is an important part of overall health. Both women and men suffer from the negative consequences of poor mental health, but their health outcomes vary. A significantly larger proportion of women live with major depressive disorders compared to men (see Figure 4). There are some exceptions, such as the United Arab Emirates, Qatar, and Lao PDR, where the highest levels of depressive disorders are among men, even in comparison to other countries. In other countries, such as Vietnam, Ukraine, and Pakistan, the prevalence of depressive disorders among women is double that of men. (IHME 2020).

FIGURE 4: PREVALENCE OF MAJOR DEPRESSIVE DISORDERS BY SEX (ALL AGES, 2019)



Source: IHME (2020)
Note: Data for 204 countries and territories.

For women, post-partum depression (PPD) takes a significant toll on mental health, but it is often not recognized, and women receive limited, if any, support. The global prevalence of PPD is estimated at 17 percent, with Southern Africa having the highest prevalence rate at 40 percent. While PPD can affect women of all backgrounds, data suggest poverty is a major risk factor, with 25 percent of new mothers living in poverty (and lacking access to quality health care and education) experiencing PPD (Wang et al. 2021).

Another major factor contributing to women's poor mental health outcomes is post-traumatic disorders (PTSD) after rape[10] or other incidents of gender-based violence (GBV) and abuse (see Box 3). Exposure to rape often leads to psychological problems, including depression, dissociation, substance abuse, feelings of guilt and shame, and suicidal ideation (Covers et al. 2021). Approximately 70 percent of rape or sexual assault victims experience moderate to severe distress—a larger percentage than for any other violent crime (RAINN 2020).

BOX 3: THE HEALTH SECTOR RESPONSE TO GENDER-BASED VIOLENCE

GBV is a global development challenge and a public health issue. It affects survivors across cultures and economies. One third of women worldwide—736 million women—have experienced intimate partner violence or sexual violence from a non-partner in their lifetime (WHO 2021b). Nearly 12 million girls are married each year before reaching the age 18 (UNICEF 2022) and at least 200 million girls and women have undergone female genital mutilation in 31 countries with representative data on prevalence (UNICEF 2023). GBV also takes other forms, such as emotional and financial abuse, which are more widespread but less discussed. The risk of violence can be even higher in emergencies, conflict, and natural crises.

Two forms of GBV, reproductive coercion and obstetric violence, are based in denying women their right to health care. Reproductive coercion takes the form of contraceptive sabotage, impregnation of a female partner against her will, and control of pregnancy outcomes (Grace and Anderson 2016). It is often directed at women experiencing intimate partner violence. These women are less likely to report using condoms with their male partners (Grace and Anderson 2016; Maxwell et al. 2015). Obstetric violence is an act of mistreatment, abuse, negligence, or disrespect during childbirth, perpetrated often by health professionals (Jardim and Modena 2018). Not only does it go against the health sector's fundamental role in preventing and responding to GBV, but it can also disincentivize women to seek maternal and reproductive health care. Respectful maternal care is an essential component of quality care (WHO 2014).

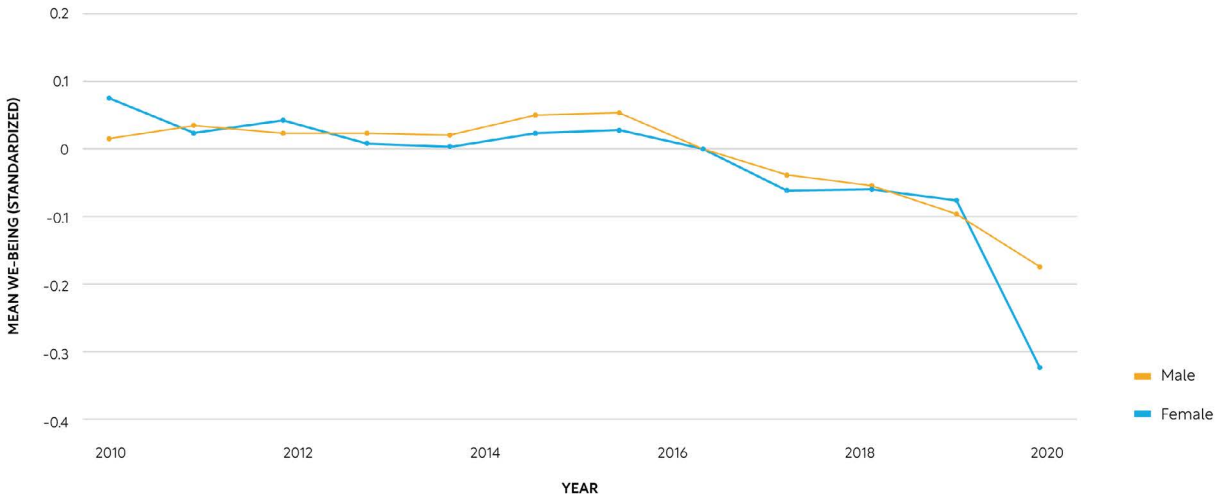
The consequences of GBV are significant. GBV impacts physical and mental health of survivors with far reaching impacts, such as injuries, mental health problems, a higher rate of substance abuse, and poorer sexual and reproductive health outcomes, including unwanted pregnancies. It can lead to adverse impacts on children (Ellsberg et al. 2008; WHO 2021c; Grose et al. 2020; Acharya et al. 2019). Violence against women is estimated to cost countries up to 3.7 percent of their GDP—more than double what most governments spend on education (WHO 2021b).

The health sector provides opportunities to identify survivors of violence, provide care, and prevent future harm (Arango et al 2015). Health care providers are well positioned to provide screening and clinical interventions to improve health outcomes during obstetric care and annual examinations (The American College of Obstetricians and Gynecologists 2013). Quality medical services, including mental and psychological care, emergency contraception, and prevention and treatment of sexually transmitted disease and HIV are vital to meet the needs of survivors (WHO 2020).

The COVID-19 pandemic further contributed to worsening mental health outcomes and expanding gender gaps. Evidence from the United Kingdom shows large declines in mental health for both men and women, with women faring significantly worse (see Figure 5) and the pattern persisting even after one year (Etheridge and Spantig 2022). Contributing factors include anxiety, stress, the burden of care often borne by women, and the associated loss of income (UN Women).

[10] Post-traumatic stress disorder (PTSD) is a mental health condition characterized by symptoms of intrusions, avoidance, negative cognitions and mood, and hyperarousal related to exposure to the traumatic event.

FIGURE 5: IMPACT OF COVID-19 ON MENTAL HEALTH IN THE UNITED KINGDOM



Source: Etheridge and Spantig (2022)

Despite the higher burden of mental health disorders among women and evidence of comparable or higher levels of attempted suicides, men are more likely to die by suicide (El Halabi et al. 2020; Roh, Jung, and Hong 2018; Tucker 2020; Värnik 2012). Figure 6a shows the prevalence of self-harm by sex, with roughly similar numbers of women and men inflicting self-harm at the global level, albeit with variation by country. Figure 6b shows that, compared to women, men are more likely to die due to self-harm (IHME 2019). Men tend to use more violent methods to harm themselves than women (El Halabi et al. 2020; Mergl et al. 2020).

FIGURE 6A: PREVALENCE OF SELF-HARM BY SEX (ALL AGES, 2019)

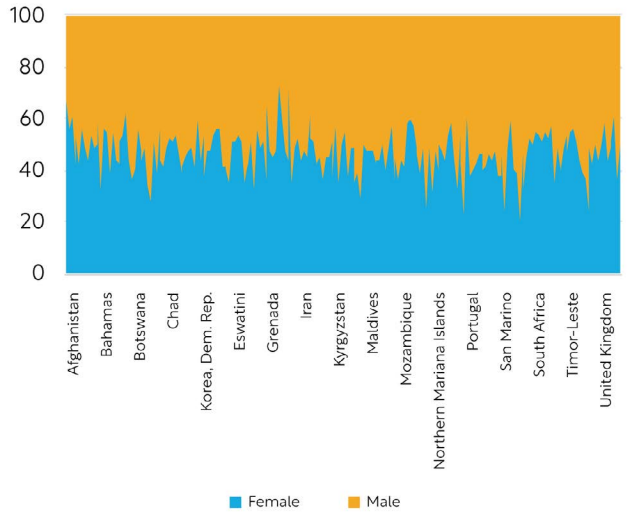
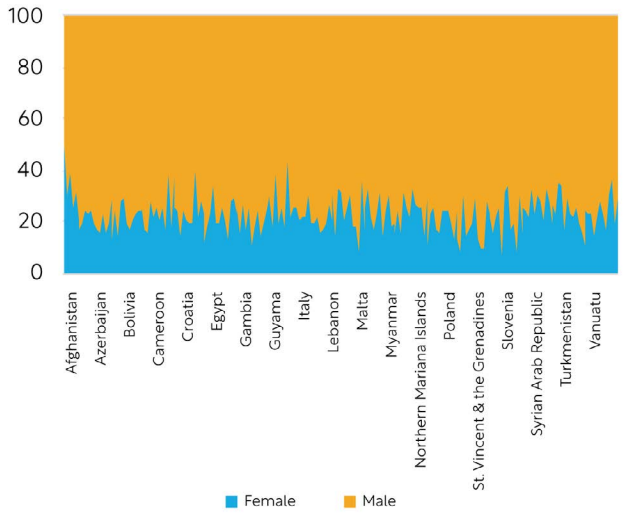


FIGURE 6B: DEATHS DUE TO SELF-HARM BY SEX (ALL AGES, 2019)



Source: IHME (2020)
Note: Data for 204 countries and territories.

Gender differences, societal pressures, inequalities, and stereotypes widen gaps in how mental health impacts women and men, how it is managed, and the outcomes. Norms surrounding masculinity can act as barriers to men seeking help or treatment for mental health issues. Women, on the other hand, may be more willing to seek help, but other factors, such as limited financial capacity, lack of information, care responsibilities, or distance from health care providers, can hinder access to professional care.

Although data on LGBTI is limited, evidence from higher-income countries with generally more favorable environments for LGBTI, points to continued stigma and discrimination against LGBTI populations and, consequently, an increased burden of poor mental health among this population. For example, a survey of 7,126 young LGBTI people ages 16–25 in England found that 52 percent of the surveyed participants experienced depression; while one in eight people (13 percent) reported attempting suicide, often driven by the discrimination they face. Fourteen percent reported avoiding seeking health care due to fear of discrimination, and roughly the same proportion had experienced discrimination personally (Stonewall 2018).

Across the world, such challenges point to the need for interventions to destigmatize mental health disorders, address norms that prevent people, especially men, from seeking help, and invest in mental health services for women, men, and other gender identities and sexual minorities.

The World Bank's work on psychosocial and mental health is limited but growing in the wake of the COVID-19 pandemic, when several operations provided psychosocial support, especially to health care workers. Prior to the pandemic, the Bank invested in mental health as part of its health response in countries experiencing some form of fragility, such as the following examples.

Liberia is a post-conflict fragile state and one of the poorest countries in the world, with 63 percent of the population below the age of 25 years. The civil unrest and instability due to two devastating civil wars between 1989–1997 and 2001–2003, and the 2014 Ebola epidemic have had a strong impact on the mental health of its population. The 2010 Global Burden of Disease showed that mental health disorders accounted for more disability-adjusted life years (DALYs) than any other noncommunicable disease in the country. Between 2015 and 2018, the World Bank's **Supporting Psychosocial Health and Resilience in Liberia Project** responded to the intermediate psychosocial and mental health impact of the Ebola crisis and helped build long-term psychosocial health and resilience for people and communities. The project contributed to improved mental health for 66 percent of the project beneficiaries and increased the share of service providers trained to provide psychosocial and mental health services from 15 to 68 percent.

In the Cox's Bazar district of Bangladesh, GBV remains highly pervasive within the Rohingya Displaced Population and host communities. Despite the urgency, there is a critical gap in service delivery for GBV survivors due to skills gaps and scarcity of resources. **The Health and Gender Support Project for Cox's Bazar District Project** supports the strengthening of GBV services at different tiers of health facilities. It helps reduce gaps in service provision by expanding mental health and psychosocial support for survivors of violence, including age-appropriate GBV response services for adolescents.

Interventions to Improve Access to Mental Health Care

Prevention and promotion of mental health are required to reduce the growing magnitude of mental illnesses. The following interventions can help to improve mental health services and outcomes.

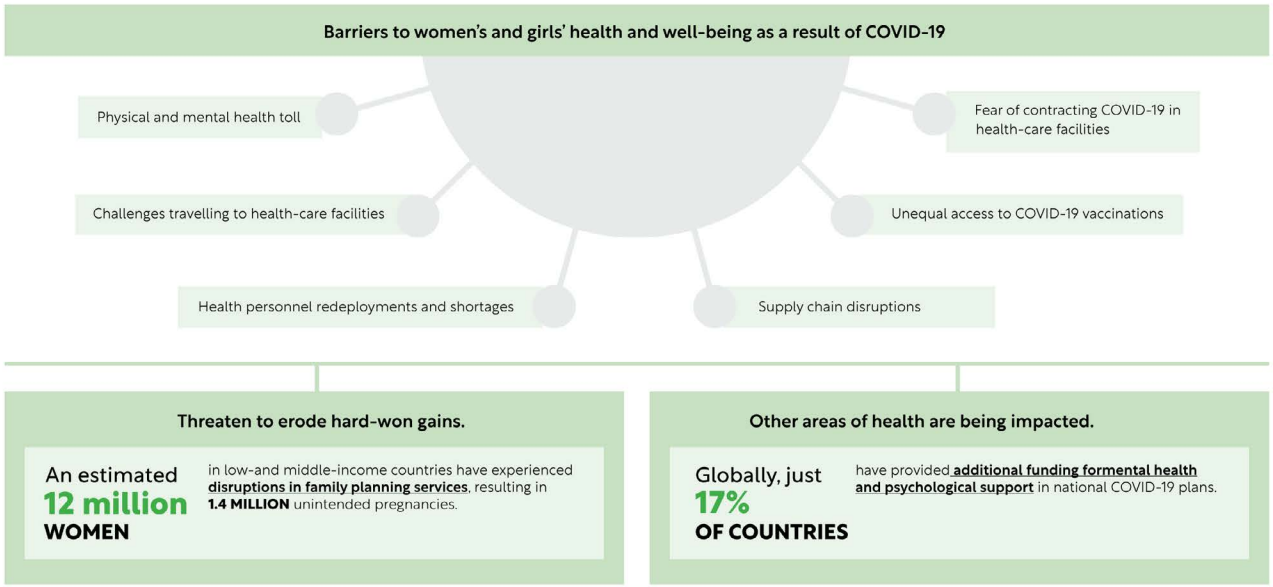
- Develop mental health promotion programs and policies that take a gendered, life course approach and are holistic, community-based, client-driven, and supported by advocacy services.
- Since the health sector is often the first point of contact for survivors of violence, establish an integrated health system with health care providers across specialties. Health care providers should be trained to recognize signs of GBV and engage strong referral systems to support greater awareness, early identification, and prompt intervention for at-risk individuals.
- Use SBCC to engage communities and men to discourage violence, reduce stigma for survivors, and share information about the availability of services, along with improving access to emergency health care and psychosocial support.
- Support cross-cutting solutions that can serve as a protective factor, such as promoting educational attainment for girls. For example, the gender gap in depression in the United States closed by 39 percent between 1955 and 1994 due to women's attainment of college degrees (Platt et al. 2020). In Zimbabwe, evidence shows an extra year of education lowered the likelihood of depression by 11 percent and anxiety by 10 percent (Kondiroll and Sunder 2022).

ENHANCING GENDER EQUITY IN PANDEMIC PREPAREDNESS AND EMERGENCY RESPONSE IN HEALTH

The COVID-19 pandemic exposed weaknesses in health systems and exacerbated gender gaps. Health systems around the world regardless of income level struggled to curb the rapid spread of COVID-19, but those in low and middle-income countries were particularly vulnerable. The stress of COVID-19 disrupted essential health services., including childhood immunizations, family planning, reproductive and maternal care, and treatment and prevention of other communicable and non-communicable diseases, such as HIV, tuberculosis, and diabetes.

For example, a year into the COVID-19 pandemic, an estimated 12 million women across 115 low and middle-income countries had experienced disruptions in access to timely family planning services, with 1.4 million unintended pregnancies (UNFPA, 2021). Figure 7 captures the challenges to women and girls' health and well-being due to the COVID-19 pandemic.

FIGURE 7: IMPACT OF COVID-19 ON WOMEN AND GIRLS' HEALTH



Sources: CARE, *She Told Us So Rapid Gender Assessment*; 2020; Frederiksen et al, "Women's Experience with Health Care During the COVID-19 Pandemic: Findings from the KFF Women' Health Survey", 2021; United Nations Population Fund, World Health Organization and International Confederation of Midwives, *The State of the World's Midwifery*, 2021; United Nations Population Fund, Survey on the Impact of COVID-19 on Mental, Neurological and Substance Use Services, 2021; World Health Organization COVID-19 Vaccination Data Dashboard, 2021; World Health Organization, 2020; and Yost and Moffat, "Women in Supply Chains: On the Frontlines of COVID-19's Impact", 2020.

Studies indicate that, to varying degrees, countries saw increases in maternal, neonatal, and child mortality due pandemic-related service disruptions (Marchand et al. 2022) and maternal exposure to COVID-19 (Stevenson 2022; Michels, Marin and Iser 2022; Maza-Arnedo et al. 2022), with higher risks among unvaccinated women (Atak et al, 2022).

Women's health and well-being were affected in other ways during the pandemic. For example, women were more likely to experience domestic violence. Reported incidents of violence increased by 5 percent in Australia to up to 35 percent in some states of the United States (Mittal and Singh 2020). One community case study in Lagos, Nigeria found that half the women in the community had suffered domestic violence within the first three months of the lockdown (Wada et al. 2022). As frontline health workers, women were also at a higher risk of exposure to disease. Women also stayed home to take care of children, the elderly, and the sick, which not only increased their burden of care but also contributed to higher levels of stress and anxiety (Shahbaz et al. 2021; Awan et al. 2021; Mehta et al. 2021).

These challenges are indicative of gender gaps across different areas of health. Box 4 highlights the persistence of gender gaps in health through the lens of addressing anti-microbial resistance.

Interventions to address gender disparities in the health response to pandemics and other emergencies

Strengthening health system resilience with a focus on PHC is central to maintaining and strengthening essential health services that are responsive to health emergencies and crises like the COVID-19 pandemic. This includes addressing gender gaps in access to health care and taking appropriate measures to support frontline workers, especially women. Prior experiences with reaching populations in emergencies, such as the Ebola crisis in West Africa, or during fragility or conflict situations across the globe underscore the unique challenges women face in accessing hygiene and health care. The following list of gender-responsive actions recommended by the World Bank during COVID-19 draws on lessons learned and can be taken forward to continue building the resilience of health systems.

BOX 4: THE GENDER EFFECT ON THE GROWING THREAT POSED BY ANTI-MICROBIAL RESISTANCE

In December 2023, the World Health Organization (WHO) convened a technical consultation around a people-centered approach for addressing Anti-Microbial Resistance (AMR) in health. Research shows the persistent gender gaps that exist in the health sector including its AMR response. Analysis of 178 National Action Plans (NAPs) for AMR across countries found little focus on equity in use and access to antimicrobials and limited recognition of the need to address cultural and gender drivers of health-seeking and health-providing behaviors (Charani et al., 2023; Patel et al., 2023).

A further review of 145 publicly available NAPs for gender confirmed the lack of attention to gender considerations in most NAPs, with approximately 86 percent of NAPs not having any mention of sex or gender. Research indicates that prescribing patterns, participation in infection prevention behaviors, and access to health care can all differ by gender (Gautron et al., 2023; Jones et al., 2022; WHO, 2022). Gender also plays a role in who has the resources and decision-making power to access appropriate care and treatment for resistant infections that can contribute to differences in the quality of care (Jones et al., 2022; Batheja & Goel, 2022), and may impact people differently based on the risk of infection associated with their occupation (Gautron et al., 2023; WHO, 2022). The technical group recommended considering a more practical cross-sectoral approach at country level that supports costed Gender-Responsive National Action Plans on prevention and response to AMR.

Source: WHO Informal Expert Group Meeting on Antimicrobial Resistance and Gender, 30 November – 1 December 2023,.

Organization:

- Consider measures that bring services closer to women, such as mobile services or home visits.
- Ensure continuity of essential health care services, including reproductive and maternal health services, at the community level; implement mobile services, online, or telehealth visits where possible.
- Ensure health care workers are provided and use PPE for their own safety.

Financing:

- Provide financial support, such as subsidized or free testing, treatment, or vaccination, to ease access barriers for women and other vulnerable populations.
- Provide hazard pay or incentives to frontline workers and death benefits for their families to encourage retention.
- Take actions to reduce pay disparities and formalize informal workers and volunteers.
- Set targets for women-owned firms in supply chains where such firms and entrepreneurs are identified. (e.g., masks, hand sanitizers, cleaning supplies).

Regulations:

- Include actions and targets for reaching women and other vulnerable populations in pandemic response plans.
- Take extra care in situations of fragility, conflict, and violence (FCV) to ensure women have access to health and social services (e.g., relax ID card requirements or issue other forms of ID)
- Include women in pandemic response committees and management structures.
- Consider developing and implementing gender-responsive National Action Plans to address the growing threat posed by antimicrobial resistance.

Behavior Change:

- Engage men and community leaders to ensure women's access to health care.
- Provide access to psychosocial services for at-home caregivers and health care workers.

Public Health:

- Ensure information on illness, symptoms, preventative measures, and management options (testing, treatment, vaccines) is communicated widely.
- Communicate in local languages and through various media, such as radio and TV, and use visual aids so that illiterate women can also access and understand information.
- Ensure public health messaging conveys where and how people can seek services.
- Train health care workers to provide health emergency and pandemic-related information and services; train them on the proper use of PPE.

- Collect data disaggregated by sex and age to monitor who receives services, where, how, and for how much money.

Cross-cutting actions:

- Ensure women participate in clinical trials and treatment research so that research and findings are cognizant of and reflect any sex-based differences in trial outcomes.

PROPOSED ACTIONS TOWARD GENDER RESPONSIVE AND TRANSFORMATIVE POLICIES AND PROGRAMS

The following priorities and action areas support a continuation of the World Bank's existing focus and work to reduce gender gaps in health and build on its engagement to further bolster the right to health.

STRENGTHENING SEXUAL AND REPRODUCTIVE HEALTH CARE AND RIGHTS

The World Bank will continue to support sexual and reproductive, maternal, and adolescent health as part of the essential package of health services under UHC. This includes the provision of family planning information and services and coverage of adolescents through youth-friendly services for SRHR and RMNCAH. To encourage the uptake of service, the Bank will continue to support investments in SBCC to build community awareness and acceptance, enhance knowledge, and create positive attitudes and norms toward sexual and reproductive health and rights. Other areas of intervention include training health care providers at all levels of the health system to improve the quality of services, facilitating women and adolescents' access to these services, and advancing legal and policy frameworks that bolster women and girls' right to control their own bodies. The Bank will continue to use instruments that have had some measure of success in delivering results, such as pay-for-performance and cash transfers.

Given the cross-cutting nature of gender and rights, the Bank will explore opportunities to support multi-sectoral action that enhances women's empowerment, voice, and agency. This will be especially important when working with client countries to support policy actions that strengthen peoples' sexual and reproductive health and rights. Action areas include the following:

- Improve access to, availability of, and quality of SRH health care for women and adolescent girls through integrating SRH services and information under UHC, particularly at the PHC level.
- Encourage the integration of GBV prevention and management services with SRH at the PHC level (including information, medical, and psychosocial support for GBV).
- Support implementation of policies, protocols, and standards for improving access to, and quality of care for LGBTI people.

- Support countries in strengthening SRHR and GBV awareness and acceptability of services (including for adolescents) through policy and legal reforms, SBCC, comprehensive sexuality education, and other actions.
- Support training for service providers—men and women at all levels, not just frontline—to enhance services free of stigma and discrimination, especially for LGBTI people.
- Support multi-sectoral action, such as secondary and higher education, to enhance women and girls' voice and agency and reduce discrimination against LGBTI people.

PROMOTING GENDER EQUITY IN HEALTH FOR AGING POPULATIONS

As the world population continues to age, it is important to pay attention to gender gaps. Men are more likely to die of noncommunicable diseases than women, but women are vulnerable to the feminization of aging characterized by prolonged morbidity, poverty, and a lack of health care. Affordable access to health care and health information for middle-aged and elderly populations supports healthy aging and reduces the burden of disease on populations as well as on health systems. More analytical work and learning from cross-sectoral operational experiences are needed to strengthen the gender analysis and response of UHC operations. Action areas include the following:

- Invest in analytical work on the feminization of aging, including disaggregated data, to understand the challenges that older women face and how to address them, especially in low and middle-income countries.
- Explore further and in-depth analytical work on aging and access to health care for other gender identities.
- Facilitate health systems investments within the UHC framework that address identified gender gaps in access to health care, especially for older women, such as limited coverage under social protection and insurance schemes.
- Ensure UHC interventions cover health care for women and other gender identities across the lifecycle, including for GBV.
- Encourage governments to examine ways to support informal caregivers, particularly women.

SUPPORTING GENDER EQUALITY IN HEALTH CARE LEADERSHIP

One of the main challenges to achieving gender equality and equity in health is the gender imbalance in health care decision making and leadership. The implications of gender imbalance are reflected in the lack of understanding of how disease symptoms may appear differently for women and men, treatments that are based on men's physiologies, and the limited representation of women in leadership positions in the health care sector, including clinical research and medical decision-making bodies. It is evident in PPE that does not fit and pay that is not equal. While women make up a large proportion of the health care workforce, they are mainly frontline and lower-level workers. Few women are in decision-making positions to influence financial coverage for health, research in health, or management and administration.

A growing body of evidence shows that women's leadership in political decision-making processes improves women's leadership overall (UN Women, 2022). It is critical that women's potential for leadership is developed, and health systems are supported to promote women within their ranks and encourage their voice and agency. Cross-cutting interventions can help close gender gaps by supporting greater participation of women in decision-making roles, building mentorship programs, and requiring project committees and other bodies to include women. Action areas for building women's leadership in health include the following:

- Support interventions to promote women's leadership development, such as mentorship programs, care support, and equal pay for equal work.
- Enable SBCC to reduce gender biases and stereotypes in education and labor markets and to reduce sexual harassment in the workplace.
- Encourage and establish guidelines for women's inclusion in decision-making bodies. Similarly, ensure inclusion of LGBTI representatives on decision-making bodies responsible for establishing health care protocols and standards for LGBTI populations.
- Include measurement indicators on women's leadership to assess the proportion of women in decision-making committees.

IMPROVING ACCESS TO MENTAL HEALTH SERVICES

The World Bank is focused on ensuring available and affordable mental and psychosocial health services are part of essential health services under UHC. This includes SBCC to encourage the uptake of services for those who need them without the fear of stigma. The Bank's work in this area continues to expand, building on operational experiences in FCV contexts and COVID-19-related emergencies. A clear action plan is needed to encourage better inclusion and monitoring of mental health interventions in UHC with data disaggregated by sex to address gender gaps. Action areas include the following:

- Cover mental health and psychosocial support, including for survivors of GBV, under UHC.
- Include interventions to provide mental health support to health care workers.

- Include SBCC and other interventions to normalize seeking mental health care for women, men, and LGBTI people, which may require different types of messaging.
- Support the establishment of protocols and standards that protect the right to health of LGBTI populations.
- Support innovative community measures that promote the re-integration of patients with mental illness into a productive society as full members.
- Measure mental health coverage, disaggregated by sex and age, and to the extent possible by gender identity.

ENSURING GENDER-RESPONSIVE PANDEMIC PREPAREDNESS

The COVID-19 pandemic and epidemics related to Ebola and Zika underscore the importance of reducing gender gaps in health systems' response to health emergencies. As countries focus on building the resilience of health systems, it is important to include gender-sensitive interventions in contingency plans, such as ensuring access to health information, maintaining continuity of essential care, and enabling affordability of care for women. Similarly, on the supply side, health systems can be prepared for the next health emergency by ensuring women health care providers have appropriate training and gender-based pay gaps are reduced. Action areas include the following:

- Cover essential and emergency services within UHC, especially at the primary level, to support the availability and affordability of services.
- Promote the safety of health service providers and protect them from GBV, especially in the event of health emergencies.
- Ensure information related to health emergencies is available in local languages and through diverse media, such as radio, TV, and visual aids, to maximize reach to women who speak local languages or may be illiterate.
- Support the inclusion of women in decision-making bodies, especially within the health care system.
- Provide appropriate training and support (including pay, PPE, psychosocial support) for women frontline workers.
- Support the gender-friendly costing of national action plans to address the growing threat posed by antimicrobial resistance.
- Ensure data monitoring is gender-sensitive and includes key indicators that measure gaps specific to women, such as women receiving ante-natal care or the availability of messaging in local languages.
- Explore the potential of including indicators disaggregated by gender identity to assess the implementation of plans and programs.

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