



Task Force 1
Global Health and COVID-19

Policy brief

BEYOND THE TYRANNY OF THE URGENT: LONG-TERM SYSTEMIC AND INTERSECTORAL REFORMS ON GENDER-RELATED HEALTH BARRIERS IN COVID-19 RECOVERY

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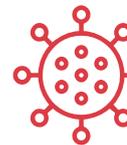
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ABSTRACT

The COVID-19 pandemic has exacerbated gender-related structural inequalities and barriers in women's healthcare access – a phenomenon similarly observed in past economic and health crises. Yet long-term, intersectoral and structural reforms are given low priority. G20 leaders have an opportunity to use COVID-19 recovery initiatives to build more gender-equitable health and non-health systems through collaboration between states, experts, social movements and markets. We propose cohesive actions that counter sources of gender inequalities in health and non-health policies, including health financing and delivery arrangements, the valuation of all forms of care work and data systems that support the visibility of gendered health experience and inform policy reforms.



CHALLENGE

WELL-ESTABLISHED GENDER-RELATED BARRIERS AND INEQUITIES IN HEALTH ACCESS AND DELIVERY REMAIN UNRESOLVED

Women are both providers and users of health within healthcare systems, but gender-related barriers and inequalities influence their work and access to health resources. For instance, women generally have greater healthcare needs over their life course. Yet they often have fewer resources and less agency to pay for healthcare, including indirect costs such as travel even when services are free or subsidized (Witter et al., 2017a; Vijayasingham et al., 2020). Women can also have less autonomy to make decisions about their health and the related use of their income or household resources. Even within health systems, women tend to do more unpaid or undervalued care work, receiving lower remuneration and less employment protection, which affects their healthcare access. Additionally, multiple intersecting forms of structural marginalization: race/ethnicity, indigeneity, socio-economic and migration status, age, disability or pre-existing conditions and sexual orientation amplify these challenges.

Yet action on the gender-related barriers in access to and delivery of healthcare services is fragmented and poorly addressed at systemic and structural levels (Levy et al., 2020), largely ignoring, maintaining or building upon existing, inherently inequitable gender dynamics (Morgan et al., 2018; World Health Organization, 2019a).

COVID-19 HAS EXACERBATED GENDERED HEALTH BARRIERS, AND CURRENT SHORT-TERM POLICIES DO NOT SUFFICIENTLY ADDRESS GENDERED NEEDS

The COVID-19 pandemic has exacerbated gender-related circumstances. Gaps in data systems have led to the invisibility of real-time impacts. There has been a reliance on anecdotal and advocacy-based messaging in shaping the programme and policy response. Women continue to be largely excluded from leadership, decision-making and policy-shaping discussions.

Disruptions in access to essential health services, such as sexual and reproductive health (SRH) services, have jeopardized global achievements in improving development indicators and closing gender inequality gaps (World Health Organization, 2020). Recent reviews outline an increase in unmet need for contraception, unwanted and teenage pregnancies, and worsening mental health, maternal outcomes and infant mortality, particularly in low resource settings (UNDP, 2020; Chmielewska et al., 2021; UNFPA, 2021). The COVID-19 response has also led to a disproportionate increase in women's unpaid care work, employment loss and safety concerns within the home (Roesch et al., 2020; United Nations, 2020). The increase in unpaid care work, income loss and school closures has also put adolescent and



young girls at higher risk of child marriage and gender-based violence, including trafficking and exploitation, all with long-term impacts on their health and economic wellbeing (Save the Children, 2020). Increases in unpaid care work, risk and experience of violence, and financial insecurity have also affected the women in the health workforce.

Previous financial crises, disease outbreaks and pandemics (HIV, MERS, Ebola and Zika) document similar gendered impacts (Harman, 2016; Smith, 2019; Wenham et al. 2020; Wenham, Smith and Morgan, 2020). Unfortunately, lessons from the past have not been adequately incorporated into structural reforms or policy responses (Davies and Bennett, 2016; UNDP, 2020).

Current responses are also primarily driven by the ‘tyranny of the urgent’ (Smith, 2019) – controlling the pandemic and providing short-term economic stimulus and social protection. It is a concern to note that many of these approaches are unsustainable in the longer term, especially in the looming era of cost-containment in public spending.



PROPOSAL

Long-term structural reforms that address the entrenched gender-related barriers and inequities in the demand and supply of health resources will not only support pandemic recovery but also contribute to resilient, efficient and sustainable health systems that will be robust and responsive in any future systemic crisis.

We propose a set of entry points and actions that proactively respond to specific challenges that link women's economic status and roles with health access and delivery.

The overall goal should be to alter how terms of paid work, unpaid care work, individual agency, education and other factors influence health access. Leveraging this concept requires a whole-of-government and whole-of-society approach to pursue policy and structural coherence between health and non-health policies. Policy implementation should be data-driven, adequately resourced, prioritize both the production of health and healthcare delivery, and incentivize the demonstration of outcomes from both the health and non-health sectors that address gender inequities.

Broad tactical approaches that underlie the recommendations include:

- better research and data collection on the specific nuances of context, current policies and influences of intersectional disadvantages such as age, employment type, sexual orientation and migration status;
- reversing health system financing policies founded on gender and other inequities;
- updating the means and platforms of delivery through innovations such as digital health;
- better valuation of gendered paid and unpaid care work within health systems, social protection systems and the economy;
- advocating, influencing and realigning partnerships to prioritize structural interventions within and beyond the health system;
- working with the various stakeholders, including civil society and the non-health sector, to value and co-create interventions that also produce health gains and address gender barriers to health access.

G20 country leaders are well placed to champion and drive the proposed inter-ministerial and intersectoral policy reforms, and to hold relevant leaders accountable for the strategic coordination, integration, implementation and monitoring of holistic and cohesive gender-responsive policies.

It is an opportune moment to emphasize health and gender equity as a public good and to leverage the reciprocal and instrumental contributions of health and gender equity in achieving economic recovery and resilience. As political, social and economic influencers, G20 leaders can communicate, shift and normalize the dominant narratives around why and how gender is integrated into policy and implemented at global, regional and national



levels beyond short-term fixes. They can also resist and counter initiatives that instrumentalize the crisis as an opportunity to roll back women's rights.

Proposed recommendations and entry-points for action:

1) Develop a global evidence base to inform policy decisions and to monitor and evaluate the gendered impact of policies through the creation of infrastructure for the production and sharing of gender data.

a) Support the development of data infrastructure, particularly in low- and middle-income countries, to collect epidemiological data by sex and gender and key socio-demographic characteristics such as age, race, ethnicity and disability status.

Gender data, whether collected through official or unofficial agencies, is paramount to understanding and mitigating the effect of the pandemic on the lives of women, men and gender-diverse groups. The global COVID-19 pandemic response has relied on data and digital technologies for case identification, monitoring and surveillance, accelerating the transformation of our lives into various forms of digital data. Pandemic control measures have also halted several initiatives for data collection.

Gender considerations in the design of data systems are crucial to reveal the long-term impacts of COVID-19 and future crises and to evaluate the efficacy of policy decisions. Gender analysis and gender-related budgeting in policies are also essential to emphasize investments in care work and health infrastructure.

Therefore, failure to collect gender and other key demographic characteristics of individuals impedes the ability to measure, predict and respond to the negative impact of the ongoing and future pandemics. Gender omissions also jeopardize current data collection efforts by incorporating biases and inaccuracies into data systems and algorithms. A vicious cycle of reinforcing existing inequalities happens when biased evidence informs policy decisions (O'Neil, 2016; Eubanks, 2018).

However, data biases can be corrected or their impact on decisions understood if the data reflect marginalized communities and socio-demographic variables are collected through robust ethics and data privacy frameworks.

b) Adequately resource the production and use of gender data in areas where women's and girls' lives are disproportionately affected by the pandemic and improve the representativeness of marginalized or excluded populations across the national statistical system.

In the sustainable development goals measurement framework, 80 per cent of indicators to monitor gender equality lack adequate data, mainly owing to insufficient demand from governments and insufficient support to national statistical systems for the modernizing of administrative data collection (UN Women Data Hub, 2021). Data collection, therefore, should prioritize the development, standardization, validation and cross-national comparability use of gender indicators that underline the constraints women encounter, an example being time-use surveys to recognize the invisible contribution of women's unpaid care work.



Sampling frames that include marginalized or excluded population groups – people who are illiterate, digitally unconnected or excluded by language – need to be created to improve the representativeness of national samples. A proven strategy to improve data representativeness is to support citizen-generated data initiatives that amplify voices through a participatory process driven by issues that affect them. The objective is to influence policies and programmes directly through advocacy and indirectly by bringing visibility and legitimization to these issues (Global Partnership for Sustainable Development Data, 2019). The production of citizen-generated data, trusted by government and citizens, should be supported by initiatives to develop consensus on guidelines, standards, and ethical and privacy principles with national statistical offices and other stakeholders.

c) Invest in new theoretical, policy and legal frameworks for governing data that allows the interoperability of systems and data-sharing between governments, academia and the private sector.

It is necessary to create bidirectional engagement across data producers and users to make gender data a public good (McDougall, 2021). For example, prioritizing gender analysis in the reporting of COVID-19 related indicators communicates results that are disaggregated by gender and other key characteristics and makes datasets available for global access. Data collaboration between academia, governments and the private sector, where tools, methods and data can be shared and optimized, can coordinate collection and access efforts (GovLab, 2021).

National independent ethics committees for data collection and processing during pandemics should be developed and prioritized. The ethics committees' purpose would be to ensure that non-official data producers adhere to the same quality standards and ethical principles as the official data producers, focusing on the surveillance of marginalized communities.

2) Reform gender inequities in health systems and policy design.

a) Strengthen government accountability for gender equity and non-discrimination within health systems

Parallel health schemes must deliver equal quality, benefits, and financial protection to everyone, regardless of life circumstance. Health entitlements that are linked to direct payments and employment status can create discontinuous and changing levels of health access over the life course, particularly during times of financial crisis, or illness when health-care access may be most needed.

In many countries, including G20 countries, healthcare access is frequently tied to employment type and status that is gender-differentiated across formal, informal and non-standard work sectors. Designed around existing gender and intersecting inequities, they often disproportionately offer better quality healthcare to one group over another (Vijayasingham et al., 2020; Yazbeck et al., 2020). In many cases, women's non-continuous work trajectories – unpaid care and reproductive work, structural discrimination – are not well accounted for, leading to disruptions in high-quality healthcare access. In Mexico, for example, where women often change employment and often move between the formal and informal sectors,



the result is precarious access to quality healthcare and negative health outcomes (Guerra et al., 2018; Doubova et al., 2018). The gender inequities in out-of-pocket health expenditure and entitlement-based systems are hence a reason to move towards mandatory, universal and tax-based health financing systems, where entitlements and coverage are delinked from individual contributions and employment status.

Existing entitlement-based systems must also ensure that gender-discriminatory pricing strategies are banned. For instance, the European Union and the USA have legislated a ban on gender-discriminatory pricing strategies within health insurance plans (Sherman et al., 2017; Huang and Salm, 2020). Before the 2010 Affordable Care Act (ACA) in the USA, gender-rating and differential premiums were allowed. Women paid about US\$1 billion more than men for voluntary employment-based health insurance (Witter et al., 2017a). Other forms of intersecting discrimination must also be simultaneously addressed. For instance, in the USA, sexual minorities experience higher levels of employment discrimination, unemployment and resultant underinsurance, with bisexual women most at risk – even more than sexual minority men and heterosexual women (Charlton et al., 2018).

Existing schemes must also ensure the inclusion of distinct gender-specific needs for health services within benefits packages. Again, before the ACA, women in the USA received comparatively fewer women-specific interventions in their coverage despite paying higher premiums; only about 12 per cent of plans offered maternity benefits, while even fewer provided SRH coverage (Witter et al., 2017a).

Systems must also enhance and protect women's power and choice to ensure that the terms of their healthcare access do not constrain their healthcare, employment, reproduction and care decisions. A possible solution is to harness the collective bargaining and advocacy potential of community groups and trade unions, particularly for informal and non-standard work, to support this agenda.

Inequities in the health workforce that impact women need to be addressed, including those that affect informal and community health workers. Gaps in remuneration need to be closed and opportunities for career progression and leadership provided. Paid care work should be equally valued in all sectors and meet decent work conditions to support increases in the number and quality of care jobs, and their wages. Within the health sector, women represent 70 per cent of the workforce and are a minority in leadership positions and highly trained professionals. They are concentrated in lower level occupations that pay less and offer poorer conditions than those more often filled by men (ILO, 2018). Gender inequalities and discrimination prevalent in training and employment systems contribute to clogged health worker educational pipelines, recruitment bottlenecks, attrition and worker maldistribution in formal and non-formal health workforces (Newman, 2014). Gender equality should be a priority to strengthen the health workforce and achieve better health coverage and population health outcomes.

Similarly, the profile of the community health workforce (CHW) is highly gendered, including women with low levels of formal education (Sarin and Lunsford, 2017; Witter et al., 2017b). There is some evidence that the gender composition of CHWs varies considerably between countries and cadres, which lends support to the idea that programmes and policies play an important role in shaping them (Lehmann and Sanders, 2007).



b) Build innovative systems and enabling environments for alternative means of access to affordable health resources, including COVID-19 vaccines, SRH services and mental health services.

During the pandemic, disruptions to healthcare access highlighted the need to consider alternative processes and platforms to deliver healthcare services such as SRH services and mental health services. Under the right terms and ecosystems for operations, shifting health delivery to digital, market and community-based systems can solve bottlenecks within health facilities without compromising equity for those who need health access the most.

For instance, down-scheduling self-care resources such as contraception to complement provider-based care would enable their provision outside or partially outside primary healthcare services through market and community systems with minimal involvement of healthcare personnel (WHO, 2019b; Remme et al., 2019). Improving accessibility can increase ease and autonomy in health-seeking behaviour, reduce indirect costs such as travel and time off work involved in facility-based healthcare, and alleviate the time and cost burden on health systems (WHO, 2019b; Remme et al., 2019). Engagement with intersectoral and private sector actors can also enable innovative delivery models such as mobile application-based delivery, mixed-financing through public subsidy and private sector financing to avoid the additional burden of out-of-pocket payments.

In low- and middle-income countries, digital technologies have the potential to reinvent current healthcare delivery systems by simultaneously providing preventive, well-being, self-management and clinical interventions to populations at scale (Merchant et al., 2020). Investments in digital healthcare infrastructure such as telemedicine and mobile application-based services can address some of the inequalities that exist in access to healthcare services (Figueroa and Aguilera, 2020; Merchant et al., 2020).

However, universal access to digital technologies is compromised by inequalities and threatened by safety, privacy and other ethical issues that disproportionately impact the rights of women and girls (Cosgrove et al., 2020; Marzano et al., 2015). Governments should be committed to overcoming the digital gender gap by investing in digitizing the information and services that women find most valuable and thereby reducing the gender gap in connectivity. Governments also need to re-emphasize and realign their policies to improve women's digital literacy and empower women and girls in general. These initiatives require intersectoral partnerships, particularly with the private sector.

The COVID-19 vaccination roll-out also provides an immediate entry point to address gender-related barriers to healthcare access. The roll-out could set a precedent in embedding a gender perspective into health delivery. Tackling gender-related barriers in vaccination can also help ensure a reduction in the burden of preventable morbidities and mortality, while economic recovery is not delayed and the impact of gender inequalities exacerbated by the pandemic are reversed (Portnoy et al., 2020; SDG3 Global Action Plan for Healthy Lives and Wellbeing: Gender Equality Working Group and Gender and Health Hub, United Nations University International Institute for Global Health, 2021).

Here are some strategies to tackle gender-related barriers in COVID-19 vaccination:



- gender balance and representation from women's groups and marginalized high-risk groups in coordination and decision-making bodies responsible for COVID-19 vaccine deployment;
- mobilization of sufficient resources to implement the gender-related actions at scale;
- the use of sex and age disaggregated data on pre- and post-market vaccine trials as an essential requirement for regulatory approval;
- differentiated vaccine delivery strategies such as community and periphery health centres and on-site workplace vaccination.
- addressing gender-related barriers to vaccine information and uptake through tailored messages and communication channels.
- ensuring the safety of healthcare workers in vaccine deployment.

3) Influence and contribute to reforms of health and non-health policies to better value care work.

- a) *Reflect the value of unpaid care and changing family or household structures by providing equitable health benefits, coverage, financial protection and linkage to social protection schemes and economic security for carers.*

The health system benefits from the paid and unpaid care work performed within and outside the formal healthcare sector, such as through family-based care, community networks and paid care services or domestic care workers.

Investments in care roles within economies and health systems can help counter the intergenerational effects of gender inequalities on economic status and finance-related health-seeking barriers. Globally, women and girls do most paid and unpaid care work (Beghini, Cattaneo and Pozzan, 2019). Economic productivity, future labour force strength and health systems are dependent on unpaid family-based, formal and informal paid care arrangements. However, economies and health systems are yet to value paid and unpaid care work adequately as productive economic work (Morgan et al., 2018; Steege et al., 2018; Beghini, Cattaneo and Pozzan, 2019).

In health systems, coverage and benefits for non-child dependents, who are often spouses or family members who engage in unpaid care work, are often conferred through different schemes than those considered "economically productive" (Vijayasingham et al., 2020). The compulsory employment-based national schemes in Thailand and Vietnam do not include coverage for dependents but suggest voluntary enrolment in the general or informal sector schemes that often come with fewer entitlements (Van Minh et al., 2013; Paek, Meemon and Wan, 2016). In the USA two decades ago, older women were more likely to be insured as wives than employees (Meyer and Pavalko, 1996), something that could still exist in other parts of the world.

Reforms are also an opportunity to reconceptualize family and household structures used in health insurance or health access schemes to ensure that no one is left behind. Policy designs that restrict the number of enrolments per households, for instance, have been known



to marginalize more women than men (Witter et al., 2017a). Changing family structures and household compositions, especially in a crisis linked with mortality such as COVID-19, can also pose challenges to healthcare access. Women who have lost spouse-linked healthcare access – single mothers, widows, divorced women – or those who live with extended families or engage in polygamous relationships, are likely to be more at risk of facing financial barriers and unmet healthcare needs.

b) Advocate for and invest in intersectoral policy reforms to produce better care resources that will support population health gains.

Health system actors must advocate for and pursue policy coherence and linkage with social and income protection schemes to provide accessible, acceptable and affordable high-quality healthcare services for children, the elderly and people with disabilities. Strong evidence demonstrates that investments in women's health and access to health services and social protection produce high economic and social returns (Onarheim, Iversen and Bloom, 2016). Lessons from the HIV sector also demonstrate that structural interventions in non-health sectoral programmes and policies on economic empowerment for women often generate gains across multiple sectors and domains, including health (Hardee et al., 2014; Remme et al., 2014; Delany-Moretlwe, 2018).

In these times of looming austerity measures, health system actors should advocate for a gender-responsive and healthcare-based recovery, with fiscal decisions that do not undermine access to healthcare resources, now or in the future (Heintz, Staab and Turquet, 2021; Henau and Himmelweit, 2021). An analysis by Oxfam revealed that seventy-six out of the ninety-one International Monetary Fund loans negotiated with eighty-one countries since March 2020 pushed for fiscal consolidation measures to reduce deficits after the pandemic (Daar and Tamale, 2020). Lessons from history suggest that such measures could result in deep cuts to public healthcare systems and pension schemes, wage freezes, loss of benefits for workers and the elderly, and increases in regressive forms of taxation that exacerbate economic and gender inequalities. For example, during the 2007–8 economic crises in Greece, where employment-based health insurance covered about 40 per cent of health spending, sudden and high unemployment rates led to a nearly 30 per cent reduction in health expenditure (Liaropoulos and Goranitis, 2015). The resultant austerity policies regressively affected employment policies, including gender integration and equality measures, through prioritization of more neo-liberal and market-based reforms, with less focus on health and structural employment protection (Rubery, 2015)



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