
What Works for Gender and Health in the Global South

Summary of an evidence review on advancing women's health and gender equality

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Research, evaluation and learning are core components of Co-Impact's work. As we embark on a concerted effort to contribute to achieving gender equality at scale in the global south, we need to learn about and build on the existing evidence and knowledge. As part of our broader learning effort, we commissioned a series of rapid reviews of literature by area experts to help us understand major trends as well as new directions about what we know works - and doesn't work - to achieve gender-equitable outcomes at scale in the global south. While these reviews serve as a core component of our evolving thinking, they do not represent official opinions of Co-Impact.

Given that these reviews are focused on critical evidence of initiatives that have been evaluated at scale, we understand there are experiences and knowledge that may not be captured in these documents. We hope to invest in additional reviews in the future to cover other areas of inquiry, and also to build on a wider spectrum of evidence and perspectives.

This important work underpins the development of our own research and learning strategy, in which we will prioritize the questions and needs of practitioners working to achieve gender equitable outcomes, and also to amplify the voices and experiences of women, girls, and other marginalized groups. We hope that this evidence and knowledge, in turn, will contribute to building the global evidence base.

Introduction and background

This review assesses evidence from 2000–2020 on the effectiveness of select interventions and outcomes on women’s health to provide guidance to Co-Impact on the type of systems change efforts that can be supported to advance women’s health and gender equality in the Global South. The analysis is structured around a conceptual framing of the gendered dimensions of three key drivers of women’s health care utilization and outcomes: accessibility, affordability, and quality, with women’s agency, choice, and respectful care positioned as elements of all three drivers. It is argued that for systemic, sustainable change, gendered barriers need to be synergistically addressed both on the supply side—at the health systems level—and on the demand side—at the woman, family, and community levels.

Health risks and disorders that women share with men as well as those that are biologically exclusive to them are both strongly affected by the systems, ideologies, and politics of gender inequality. The last two decades have shown significant gains in some health outcomes for women in the Global South, but structural shifts in health systems to address gender inequalities have been lacking. Demographic, economic, and epidemiological shifts are exacerbating these inequalities as women in the Global South now carry the double burden of health complications during the reproductive years along with the growing incidence of non-communicable diseases later in life. Moreover, weak health systems survive not only on women’s health care provision in families, but also on the unpaid and underpaid work of female health workers. Recent evidence documents the power imbalance reflected in 70% of the global health workforce being female, but 70% of the leadership being male. The ongoing underutilization and lack of relevant, respectful, and quality health care for disadvantaged women in the Global South were well documented even before the disproportionate gendered impact of COVID made it apparent that efforts at health sector reform or universal health care need to more fundamentally address gender inequality if reconfigured health systems are to serve all of humanity.

Scope of evidence review

Evidence on the effectiveness of interventions in advancing gender equality and women’s health can guide action for more systemic change. Due to gender biases in biomedical and public health research, lack of routine sex-disaggregated data, and lack of attention to gender issues in most areas of health, much of the relevant evidence comes from the area of sexual and reproductive health (SRHR). With a history of advancing feminist perspectives, SRHR can provide many transferrable lessons for the health sector more broadly. Still, even in SRHR, there are critical evidence gaps on structural interventions and a bias toward small scale, donor-funded, demand-side efforts directed at changing women, families and communities rather than fundamentally shifting health systems. This is especially the case for programs with an explicit gender focus. To incorporate evidence from at scale or supply-side programs addressing service delivery, the review also targeted SRHR evaluations focusing on gender more implicitly. This two-pronged

search allowed for a more balanced review of demand and supply side interventions and the inclusion of more at scale evidence, although the range of systems focused interventions is still limited.

Based on this search approach, the review focuses on three subareas of SRHR--maternal health, family planning, and safe abortion-- to examine a few key strategies and their success in addressing gender barriers on the accessibility, affordability, and quality of women's health care. From a gender and health perspective, avoiding or terminating an unwanted pregnancy or completing one to deliver a child, are some of the most fundamental life experiences for women, and ones where their interactions with the health system have significant consequences. These subareas of SRHR have a long activist, program and research history and allow for the extraction of evidence from a large base of reports and systematic reviews, published between 2000-2020 and covering a range of settings among the LMICs in Africa, Asia, and Latin America. The specific intervention strategies provide some diversity in assessing how accessibility, affordability and quality of care are affected by different demand and supply approaches, and also in the role played by feminist activists in moving several of these efforts forward. They include:

Maternal Health: we examine the impact of two demand side strategies that are embedded in financing for health systems: 1) conditional cash transfers (CCTs) and subsidies (at scale); and 2) vouchers (mostly at scale). The main aim of both approaches was to improve affordability and access, but improved quality was also an aim for a subset of the interventions.

Family Planning: we examine the impact of one supply side strategy to expand service delivery options and one demand side community-based effort to increase partner support for women: 1) community and mobile outreach (mostly at scale); and 2) male engagement (not at scale). The primary aim of both approaches was to improve access, but quality in terms of reassurance for women was also an aim.

Safe Abortion: we examine the impact of two health systems interventions in terms of biomedical innovation and task shifting: 1) medical abortion (at scale); and 2) task-shifting to lower-level providers and selfcare by women (at scale). Both approaches were aimed at improving access and quality of care.

Findings

The review points to some level of success for most interventions, but with a number of limitations. The most common challenges were addressing sustainability, scale, and most of all, quality, respectful care.

CCTs for Maternal Health

Governments in a wide range of countries in Latin America, Asia, and Africa were able to implement CCTs and subsidy programs at scale to improve women's accessibility and affordability of maternal care by reducing financial barriers conditional on service use. The CCT-maternal health connection was made later than for child health outcomes,

and only in response to pressure by advocates. Several robust studies from large-scale government programs show a positive impact of CCTs on antenatal care and skilled delivery, with more tenuous evidence of better postnatal care, quality and choice of care. Evaluations ranged from the national to state level in countries including but not limited to El Salvador, Guatemala, Honduras, India, Indonesia, Mexico, Nepal, Nicaragua, Nigeria, Uganda, and Uruguay.

In Asian and African settings, CCTs often worked as a patchwork to hide rather than overcome fundamental weaknesses in the quality of the health infrastructure which did not receive the necessary concurrent investments. Frequently, key pre-requisites for success were not in place, including macro-economic stability, good infrastructure and information systems, alignment between maternal health and economic expertise, and most importantly—a point noted by studies universally— the provision of quality services. In particular, guidelines on quality and respectful care were not executed, undermining sustainability and results. In some cases, results were also undermined by inadequate targeting of intended beneficiaries, insufficient subsidies, or failure to prevent corruption and high out of pocket expenses. For example, travel to accredited facilities and/or informal payments to providers resulted in higher net costs for women in India's JSY program. In Uganda, the subsidy amount was sufficient to incentivize antenatal care, but not skilled delivery. Without deliberate mechanisms to ensure that women specifically received both the money and information on their right to care, the one-time limited subsidies were not sufficient to position women as entitled consumers who could command respectful care from providers. Thus, uptake in care did not always lead to improvement in maternal health.

In contrast, some CCTs in Latin America more effectively integrated elements of women's agency and entitlement to quality maternal health services by specification of women as payees for regular, longer term rather than single event cash payments; informing women on the purpose and quality of services; and deliberate monitoring of service quality. As informed consumers, women demanded higher quality. The absence of this sense of entitlement and agency in the programs in Asia and Africa left in place existing power imbalances between service providers and women, denying women respectful care.

Vouchers for Maternal Health

Based on fewer studies and less robust evidence, vouchers also show evidence of some success in improving antenatal care, skilled delivery, and postnatal care by incentivizing women and providers on maternal care. Vouchers are referral coupons that women can take to their choice of accredited provider, and as such, are intended to improve access, choice and quality of maternal health services. The evidence shows that in combination with NGO or social franchise service delivery, vouchers can be an intermediary solution to improving maternal care access in settings with weak government health and financing infrastructures. But in order to set a new equilibrium, vouchers would have to be adapted through government funding, investment and scale-up toward some type of maternal health insurance.

Vouchers have shown success in improving maternal care in several Asian countries (e.g. Bangladesh, India, Cambodia, Pakistan) and have been an emerging strategy in African settings (e.g. Kenya, Uganda). They can provide a full care package and ease concerns about catastrophic obstetric costs for poor women who would otherwise not get maternal health services. However, the evidence from Pakistan shows that vouchers through social franchising can also draw away services from the public to the private sector and increase demands for informal payments on women. In Kenya, even a small cost to obtain the voucher was prohibitive for the most-poor women. Also, women accessing more expensive private sector maternal care received better interpersonal care, but it was technically substandard. The studies highlight the current lack of capacity in programs to prevent such tradeoffs for women.

Community and Mobile Outreach Services for Family Planning

Evidence indicates that community or mobile outreach can successfully improve family planning use among women facing geographic, economic, or social barriers to using contraception by bringing services to them. In countries struggling to reach the most disadvantaged in the context of severe health infrastructure, supply, and capacity constraints, family planning outreach services have demonstrated success across Asia (Bangladesh, India, Pakistan) and Africa (Ethiopia, Ghana, Kenya, Malawi, Nigeria, Senegal, Tanzania, Uganda, Zambia). They have addressed distance, travel, and socially imposed mobility barriers for women in different contexts, from constraints on their presence in public spaces in countries like Bangladesh, Pakistan or India, to remote locations and poor transportation for women in places like Senegal, Ghana or Uganda. In Africa, mobile outreach is also helping to reduce gender barriers around maintaining privacy and providing long acting and permanent contraceptive method options.

At the same time, these approaches have reinforced decision-making on contraceptive selection by policymakers and providers rather than women themselves. They also pre-determine the limited set of contraceptive options--short term methods through community outreach and long-term methods through mobile outreach—that would be made available to women rather than providing them with a full menu of choices. Outreach approaches also less frequently target adolescent girls. Government engagement and domestic resourcing are important factors in sustaining outreach services as demonstrated successfully in Bangladesh and not so successfully in Ghana. This is also a looming issue for donor subsidized outreach efforts run by NGOs and social franchises in other African countries.

Male Engagement on Family Planning

The evidence base for male engagement to improve partner communication, couple relations and gender norms in family planning programs is largely from small scale, donor funded programs and less robust evaluations. These show positive change on knowledge and attitudes in most Asian, African, and Latin American settings, but less conclusive results on family planning use or pregnancy prevention. Most evaluations do not measure potential negative impacts, as for example greater constraints and

interference for women in problematic relationships, and backlash for men who become models of more equitable relations. A large number of varied indicators to measure mostly short-term knowledge and attitudinal change have hindered consolidated insights on the nature, depth, and duration of these changes, or on understanding why they do not always result in behavioral change.

Safe Abortion

Although women in the Global South face disproportionate legal, political, cultural, and health systems constraints in the accessibility, affordability, and quality of safe abortion, two innovations and trends in the last two decades continue to radically alter the national and global landscape around this issue. The first is innovation in biomedical technology with the combination regimen of mifepristone and misoprostol which has revolutionized medical abortion by offering a noninvasive, safe, and effective option for pregnancy termination. The second is the formalization of “task shifting” from physicians to mid and lower-level providers in healthcare throughout the world, but especially in the area of sexual and reproductive health and in the Global South, in part due to necessity and professional shortages, but also due to the willingness of health systems and policies to adapt to this modality. Authoritative recommendations and guidance from the WHO have also facilitated both trends which have combined to make safe abortion more accessible, affordable and simpler for women across the Global South. Women’s health activists have played a major role in most countries—especially in Latin America—in subverting restrictions and supporting the widespread safe use of medical abortion. They are now on the frontlines in advocating the shift toward selfcare, giving women greater autonomy and control over safe abortion, a trend that has accelerated under COVID. The success, in turn, is generating a growing policy backlash against the expansion of medical abortion, task-shifting and selfcare as viable options.

Conclusion

Despite the growing rhetoric around gender as a focus in global health efforts, the evidence suggests that most policies and programs have not attempted fundamental reforms toward more gender equitable health care delivery systems, but rather limited themselves to partial, stopgap, and less far-reaching measures. This lacuna illustrates the limitation of the space gender issues have been able to forge within the broader health sector: they continue to be addressed at the periphery rather than at the core. For systemic, sustainable change toward better and more gender equitable health care outcomes for women, interventions need to address accessibility, affordability and quality through both health systems and community-based efforts, recognizing the interconnectedness of both these drivers. In particular, the provision of quality services is an essential, but often forgotten pre-requisite to any demand side intervention. Increasing financial or normative support helps women only if quality services are there in the first place. Improvements are needed on not just facilities, providers, or treatments,

but on shifts in power relations between providers and women to ensure respectful and dignified care.

Despite quality of maternal care and informed choice on family planning having been integral to SRHR frameworks for decades, prioritizing quality of care was a challenge for almost all interventions. The other frequent challenge was lack of domestic financing and investment for long term sustainability and scale. Innovations in the health workforce and medical technology present powerful but less frequented pathways to more effectively integrate gender in the core functioning and priorities of the health sector. The radical nature of these innovations is in part evident from the backlash building against them with regard to safe abortion, reemphasizing the importance of continued activism and vigilance.