POLICY BRIEF

Ensure Health for All

Facts, Solutions, Case Studies, and Calls to Action

OVERVIEW

Healthy girls and women are the cornerstone of healthy societies. Provide girls and women access to health throughout their lives, and they deliver a healthier and wealthier world. While many countries continue to face socio-cultural, legal, and financial obstacles to realizing health for all, there are demonstrated strategies that can help break down these barriers. Recognizing that health cannot be addressed in isolation,[1] this brief discusses some of the approaches that can help communities improve girls' and women's access to a comprehensive range of services for their enjoyment of physical and mental health and rights. These approaches include implementing women-centered care, integrating service delivery, optimizing the health workforce, realizing health for all through universal health coverage (UHC), and boosting the prevention of noncommunicable diseases (NCDs). Importantly, girls and women should be involved in the design, implementation, evaluation, and accountability of policies, programs, and services.

SECTION 1: FRAMING THE ISSUE

Healthcare is a human right, not a privilege. Yet each year, more than 3 billion people do not receive the health services they need,[2] 800 million people face financial challenges while accessing healthcare,[3] and nearly 100 million are impoverished by the costs of healthcare.[4, 5]

While treatment is becoming more accessible for certain diseases, it remains unaffordable and inaccessible for many people worldwide. Adequate healthcare is often out of reach when it comes to treating noncommunicable diseases that develop slowly over time, such as cardiovascular disease, diabetes, and cancer.[6, 7] A 2018 study on mortality in low-quality health systems showed that of 8.6 million preventable deaths in 137 low- and middle-income countries (LMICs), 5 million were caused by poor-quality care and 3.6 million were caused by non-utilization of healthcare.[8]

New HIV infections among young women ages 15 to 24 years are approximately 44% higher than they are among young men.[9] Every week, an estimated 6,000 adolescent girls and young women become infected with HIV.[10] Additionally, each year approximately 204 million women in developing regions have one of the four major curable sexually transmitted infections (STIs) (chlamydia, gonorrhea, syphilis, and trichomoniasis),[11] but 82% do not receive the health services they need.[12] Access to mental health care remains equally challenging, despite 10% of pregnant women experiencing a mental disorder globally, and self-harm being one of the leading causes of death for adolescent girls ages 15 to 19 years.[13, 14] Sexual and reproductive health issues such as unwanted pregnancy, gender-based violence, and discrimination based on sexual orientation or gender identity are among the factors that contribute to poor mental health.[15]

In order to respond to the needs of all girls and women throughout their life cycle, health systems must provide services across a women-centered continuum of care. In 2015, the World Health Organization (WHO) released a global strategy that called for a shift in the design of health systems toward a more integrated, people-centered approach.[16] For example, a 2016 WHO report described a detailed framework, strategies, and policy options for integrated, people-centered health services.[17] The framework sets forth a world in which "all people have equal access to quality health services that are co-produced in a way that meets their life course needs, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient, and acceptable."[18]

To attain health for all, in 2018 WHO launched its 13th general programme of work (GPW 13), emphasizing this shift toward a people-centered framework by focusing on the key priorities of achieving universal health coverage, addressing health emergencies, and promoting healthier populations.[19] The 2019 High-Level Meeting on Universal Health Coverage and the subsequent political commitment of UN Member States build on this agenda, establishing government commitment to UHC that leaves no one behind, with a solid grounding in gender equality and girls' and women's health and rights.[20] Also launched in 2019, the Global Action Plan for Healthy Lives and Well-being for All establishes a joint strategy for 12 UN health agencies to align and accelerate their work for better health outcomes on the road to UHC. It also incorporates a strong gender focus and establishes the imperative of mainstreaming gender in all of the agencies' work in order to achieve health for all.[21]

These strategies help outline what inclusive, equitable, and gender-responsive universal health coverage should look like. Women-centered care should focus on the health needs of girls and women and their context; it should be all encompassing across maternal, sexual, and reproductive health needs; and it should be inclusive of all women, from infancy to old age. It should emphasize patient empowerment, strong relationships with healthcare providers, and strengthening healthcare systems that account for the heterogeneity and vulnerability of the population.[22]

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Ensuring access to comprehensive healthcare for girls and women is linked to the achievement of the Sustainable Development Goals (SDGs) and targets, including:

SDG 1: End poverty in all its forms everywhere

- **1.3** Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable

SDG 3: Ensure healthy lives and promote well-being for all at all ages

- **3.1** Reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- **3.2** End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
- **3.3** End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases
- **3.4** Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
- **3.7** Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

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SECTION 2: SOLUTIONS AND INTERVENTIONS

While communities and countries face unique obstacles to achieving access to health services for all girls and women, there are demonstrated strategies that can help realize this goal:

- Ensure health for all through universal health coverage.
- Implement people-centered care, with a focus on all girls and women.
- Increase investments in integrated healthcare services, particularly at the primary care level.
- Optimize health workforce resources to enhance both the continuum and continuity of care.
- Maintain health information with lifelong individual medical records, ideally patient-held.
- Ensure medical products and technologies are safe and accessible.
- Ensure prevention, screening, and treatment options for noncommunicable diseases and mental health.

Ensure Health for All Through Universal Health Coverage

Universal health coverage is rooted in the human rights framework, with equitable access to resilient, people-centered health systems at its core. While initially conceived within the parameters of healthcare financing, UHC has evolved into a commitment to healthcare equity, quality, and accessibility.[23] Adhering to the principle of leaving no one behind, the 2017 Tokyo Declaration on UHC stressed the importance of prioritizing the most marginalized members of the population, including those affected by emergencies, migrants, stigmatized groups, and girls and women.[24] The 2019 Political Declaration of the High-Level Meeting on UHC built on this commitment and placed emphasis on guaranteeing access to essential health services without discrimination against poor, vulnerable, and marginalized segments of the population. It also established explicit political commitment to mainstreaming a gender perspective in the design, implementation, and monitoring of health polices and systems to meet the needs of all girls and women and help realize their internationally recognized human rights.[25]

Increasingly, countries are building momentum toward improving access to UHC to provide quality health services that are equitable and affordable for all. However, while coverage is on the rise, it varies significantly between countries. Although lower-income countries have seen great gains in coverage, they still lag behind in absolute numbers. Conflict-affected countries also lag behind their peers in coverage rates. Regionally, sub-Saharan Africa has the lowest coverage of essential health services, while the region of the Americas has the highest.[26]

Progress toward UHC needs to be human-rights centered, cost effective, and focused on equity and access. All countries can make progress toward UHC, even those with low levels of public spending on health (less than $40 per capita).[27] However, as the amount of public spending increases, there are generally more systematic improvements in health system performance.[28] While no one blueprint can apply to every country and every context, core guiding principles based on country experiences include the following:

- Combining funds from multiple sources, with compulsory contributions (often sourced from consumption taxes), can increase the amount of pooled capital to facilitate UHC.[29, 30, 31, 32] In many cases, development assistance for health is an important complement to domestic financing. Care should be taken that development assistance for health is sustainable, aligns with country priorities, and does not create redundancies.[33]
- Pooling resources across the population can aid in the redistribution of resources from the wealthy to the poor and from the healthy to the sick to better ensure health for all.[34, 35, 36] Pooling schemes should be integrated and draw across diverse income and social groups, including women, refugees, people with disabilities, and marginalized populations. Schemes that are fragmented may leave the most vulnerable behind. For example, social health insurance that covers the formal workforce may exclude women engaged in the informal economy.[37]
- Strategically designing benefits packages can help respond to the needs of women, low-income groups, and marginalized populations.
- Improving medicine-related efficiency and transparency can strengthen health system performance. This would include procuring medicines at the lowest cost through transparent, competitive bidding; testing and ensuring quality throughout the distribution chain; modifying regulations to encourage the use of generics; and encouraging the rational use of all medicines.[38, 39]
- Task shifting can increase access to quality healthcare, as health workers at lower levels take on more responsibilities, as appropriate.[40]
- Planning and implementing health system reform by determining the primary causes of current system inefficiencies; identifying which causes are feasible to change in the short, medium, and long term; developing country-specific indicators; and investing in data collection, evaluation, and health information systems.[41]
- Strengthening national civil registration and vital statistics (CRVS) systems to record and monitor causes of mortality across populations can help assess disease burden and inform programmatic, policy, and financial resource allocation.[42]

- **3.8** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all
- **3.b** Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
- **3.c** Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
- **3.d** Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

SDG 5: Achieve gender equality and empower all women and girls

- **5.1** End all forms of discrimination against all women and girls everywhere
- **5.2** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual, and other types of exploitation

- Using intersectoral planning for health equity by engaging other sectors of the government from the beginning, consulting the community and civil society, and examining existing inequities can help address various social determinants of health.[43]

Reviews suggest that comprehensive UHC schemes in low- and middle-income countries that include a full range of sexual and reproductive health services have a positive effect on access and use of health services; financial protection, as measured by out-of-pocket expenditures; and social empowerment,[44] especially when targeting low-income populations.[45, 46, 47] For example, eliminating fees for maternal health services often leads to increases in skilled deliveries and caesarean sections at public health facilities, which offer better health outcomes for women and children.[48, 49] However, appropriate measures are needed to offset the loss of revenue for fee-less services and to respond to the increased demand for services.

Additionally, to make progress toward realizing UHC, health systems need to acknowledge barriers beyond economic ones. These barriers can be geographic (where services are not within reach), epidemiological (where services delivered do not meet varying health needs of populations), or cultural (where the workforce does not possess context-specific sensitivity for effective service delivery).[50] Driving UHC for all requires varied and tailored approaches based on capacity, cultural context, and population vulnerability.

Quality healthcare that is accessible and available for all, particularly the most vulnerable, strengthens the resilience of communities and countries. It provides natural coverage continuity between emergencies to facilitate UHC and healthier populations.[51] Using these principles, UHC can form the foundation for serving populations in fragile or conflict-affected settings by integrating inclusive health systems with health emergency risk management.[52] In order to leave no one behind, health systems need to adopt a pro-equity approach that focuses on the needs and accessibility of the poorest, as well as people with disabilities, indigenous populations, and those in fragile settings.[53]

Implement People-Centered Care, With a Focus on All Girls and Women

Universal health and accessibility must be prioritized across all levels of the health system, and girls and women must be involved in this process to ensure that their perspectives and priorities are included. The table below shows the key principles of people-centered care, which are critical for the provision of holistic, high-quality care for girls and women throughout the life course.

PRINCIPLES OF PEOPLE-CENTERED CARE	
COMPREHENSIVE	• Includes all elements needed to enjoy the highest standard of physical and mental health
EQUITABLE	• Emphasizes accessibility, availability, and acceptability for all, especially marginalized populations
SUSTAINABLE	• Exhibits efficiency and effectiveness, aligned with principles of sustainable development
COORDINATED	• Facilitates integrated care across settings and providers
CONTINUOUS	• Continues throughout the whole life course
HOLISTIC	• Focuses on the whole person, not just a particular body part or disease
PREVENTIVE	• Promotes public health and addresses social determinants of health
EMPOWERING	• Recognizes people as decision-makers and agents for their own health outcomes, and supports them in taking responsibility
RESPECTFUL	• Acknowledges and gives due regard to people's characteristics, behavior, socio-economic context and cultural sensitivities
COLLABORATIVE	• Works with a team-based approach across all levels of care and sectors
CO-PRODUCED	• Centers people and their communities at all levels
SHARED RIGHTS AND RESPONSIBILITIES	• Respects inherent rights and responsibilities of all involved in the health care relationship
SHARED ACCOUNTABILITY	• Imbues all involved in the medical care relationship with the duty of quality of care and outcomes
EVIDENCE-INFORMED	• Based on the best available evidence to ensure the best quality outcomes
SYSTEMS-THINKING LED	• Takes a holistic view of health systems and understands the influence of non-health sector influences
ETHICAL	• Respects individual autonomy and human rights, protects privacy, distributes resources fairly, balances risk-benefit ratio in health interventions, and protects the most vulnerable

[Table adapted from the WHO global strategy on people-centered and integrated health services, 2015.[54]]

- **5.6** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

SDG 9: Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation

- **9.1** Develop quality, reliable, sustainable and resilient infrastructure, including regional and transborder infrastructure, to support economic development and human well-being, with a focus on affordable and equitable access for all

SDG 11: Make cities and human settlements inclusive, safe, resilient, and sustainable

- **11.2** By 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities, and older persons

Case Study: "What Women Want" Sheds Light on the Health Needs of 1.2 Million Women Globally [55]

White Ribbon Alliance launched the global yearlong campaign, "What Women Want: Demands for Quality Healthcare from Women and Girls," in April 2018. The aim of the campaign was to have individual girls and women identify their top priorities for quality maternal and reproductive healthcare services and to bring those demands to decision-makers. More than 350 groups in 114 countries collected the demands of nearly 1.2 million girls and women. The priorities they identified are diverse and far-reaching. Some of the top priorities are for respectful and dignified care; access to water, sanitation, and hygiene; access to medicines and supplies; and access to increased, competent, and better-supported midwives and nurses. The findings and analysis of the campaign can be used to advocate for policies and programs that strengthen women-centered care.

Increase Investments in Integrated Healthcare Services, Particularly at the Primary Care Level

The WHO has developed a framework of five key strategies for integrating health service delivery:[56] 1) engaging and empowering people and communities; 2) strengthening governance and accountability; 3) reorienting the model of care by training providers to offer various services and placing multiple services at the same facility; 4) coordinating services within and across sectors by providing referrals as needed among service providers; and 5) creating an enabling environment.[57] Integration is not about offering all possible services in a single package, but instead should consider the local epidemiological context. For example, as the onset of diabetes during pregnancy is associated with a range of risks to maternal and newborn health, integration of service delivery and care coordination for maternal health and NCDs is crucial, particularly in countries with a high burden of diabetes.[58, 59]

Integration also makes sense from the patient perspective. The ability to receive multiple services from a single provider, or at the same site, reduces travel time and increases the likelihood that girls and women will seek out these services.[60] And where treatment of stigmatized diseases such as HIV is integrated with other services, concerns about disclosure are reduced and testing becomes more normalized, as demonstrated in studies from Kenya and Malawi on the integration of HIV care with maternal healthcare.[61, 62]

At the primary care level, integrated services are important for meeting all people's health needs through comprehensive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course.[63] Achieving health and wellbeing for all requires primary care and essential public health functions to serve at the core of integrated services.[64] Alongside this focus on primary care, achieving the highest attainable standard of health and wellbeing for all requires systematically addressing the broader determinants of health—including social, economic, and environmental factors—through evidence-informed policies and actions across all sectors. Additionally, individuals, families, and communities must be empowered to advocate for and optimize their health.[65]

The Political Declaration of the 2019 High-Level Meeting on Universal Health Coverage recognizes primary healthcare as a cornerstone of ensuring health for all. Primary healthcare is an inclusive, effective, and efficient way for people to obtain healthcare that addresses their physical and mental health needs. The declaration places primary healthcare as the foundation of strong health systems that are essential for UHC, while recognizing the need to link to other levels of care.[66]

While government investment in primary care and intervention is essential to achieving UHC, building partnerships between the public and private sectors is also important in some settings.[67] Health systems in many low- and middle-income countries are heavily dependent upon private providers, with little accountability to protect patients and health systems. In such settings, the private sector needs to be complementary, integrated with the local health system, and equitably accessible for all. An integrated system with regulated public-private partnerships can align private practice with public needs, fill gaps in underdeveloped public systems, and bring forward new and innovative healthcare approaches while ensuring maximum impact.[68, 69] However, integrated public-private partnerships must be subject to a framework of accountability to effectively sustain impact. Managing accountability in public-private partnerships can include balancing different public demands, cost-effectiveness, risk sharing, innovation, reliability, transparency, and security. Although potentially challenging to regulate and hold accountable, public-private partnerships are important because they can improve government services. Similarly, leveraging private capacity can be valuable in fragile and conflict settings, where public infrastructure cannot serve healthcare needs alone.

Case Study: DREAMS Project Aims for an AIDS-Free Generation

Across sub-Saharan Africa, girls and young women make up 74% of new HIV infections among the adolescent population.[70] Launched in 2014, the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) project aims to reduce the high incidence of HIV infections among girls and young women in 10 countries (Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe) through integrated efforts.[71] DREAMS' holistic approach includes a core package that incorporates issues both within and outside of the health sector and addresses the structural drivers that impact HIV risk in girls, such as poverty, gender inequality, sexual violence, and education. The following six areas serve as a focus for the project: strengthening capacity for service delivery, keeping girls in secondary school, linking men to services, supporting pre-exposure prophylaxis (PrEP), providing a bridge to employment, and applying data to increase impact.[72] In 2017, data from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) showed significant declines in new HIV diagnoses among adolescent girls and women. In the 10 countries implementing

Relevant International Agreements:

- Declaration of Alma-Ata, International Conference on Primary Health Care (1978)
- The 1979 Convention on the Elimination of All Forms of Discrimination against Women (Articles 11 (1) (f), 12 and 14 (2) (b))
- The 1989 Convention on the Rights of the Child (Article 24)
- The Committee on Economic, Social and Cultural Rights, general comment N° 14 on the right to the highest attainable standard of health (2000)
- The UN General Assembly of September 2011 released Political Declaration on NCDs
- The UN Resolution on Universal Health Coverage (2012)
- The WHO launched the Global Action Plan for the Prevention and Control of NCDs (2013–2020)
- WHO Mental Health Action Plan (2013–2020)
- Sustainable Development Goals (SDGs) (2015–2030)
- Report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents (2017)
- Tokyo Declaration on Universal Health Coverage (2017)
- Declaration of Astana, Global Conference on Primary Health Care (2018)
- WHO's 13th General Programme of Work (2019–2023)
- Global Action Plan for Healthy Lives and Well-being for All (2019)
- UN High-Level Political Declaration on Universal Health Coverage (2019)

the DREAMS partnership, most of the highest HIV-burden communities saw around a 25% to 40% decline in new HIV diagnoses among young women. Additionally, new diagnoses decreased in nearly all DREAMS intervention districts.[73]

Case Study: Primary Healthcare in Costa Rica

Primary care is at the foundation of Costa Rica's healthcare system, which is recognized for its structural and functional cohesiveness. Managed by the Caja Costarricense de Seguridad Social (CCSS), primary care services are continuing to develop with the establishment of Centros de Atención Integral en Salud (CAIS).[74] *These centers represent an extended model of primary care and provide a variety of services, ranging from maternity care and rehabilitation to minor surgery. CAIS integrates upward to secondary care providers, and this clear vertical integration ensures care is provided at the appropriate level. Evidence suggests that 80% of the primary care presentations are solved at that level, without referral to secondary care.*[75]

Case Study: HIV and UHC Investments in Rwanda

Rwanda has made significant progress in health coverage by adopting coordinated programs between HIV and UHC.[76] *The Rwandan Ministry of Health prioritized integrated, community-based platforms by aligning HIV-specific interventions with strengthened primary care to ensure access and comprehensiveness of health services. Supply chains and information tracking systems developed for HIV were leveraged for other programs.*[77] *The ministry also adopted an inclusive governance approach, which involved reserving seats for civil society organizations on the board of the former National AIDS Control Commission (2001 to 2010) and the ongoing Global Fund Country Coordinating Mechanism. These efforts contributed to an 82% decline in AIDS-related mortality and an increase in national health insurance plan coverage to 90%.*[78, 79, 80, 81]

Optimize Health Workforce Resources to Enhance Both the Continuum and Continuity of Care

To ensure that women, youth, and adolescents receive comprehensive and timely care, the continuum and continuity of care should be based upon a system of referrals and coordination among community-based providers, primary care clinics, first-level hospitals, and referral hospitals. To realize this goal, the lack of skilled medical professionals must be addressed at every level of the system. For example, task shifting and task sharing can maximize operational efficiency and help close the human resources gap. This involves less-credentialed providers being trained to manage specific tasks. Such strategies are endorsed by the WHO and implemented in a number of low- and middle-income countries to deliver HIV-related services and essential interventions for maternal and newborn health.[82, 83]

Task shifting and sharing can involve a range of mid-level and lay health workers, including non-physician clinicians, nurses, midwives, and community health workers. A 2016 review of non-medical prescribing for acute and chronic disease management found nonmedical prescribers—nurses, pharmacists, allied health professionals, and physician assistants—were as effective as medical prescribers (doctors) in primary and secondary care settings.[84] Additionally, a 2017 literature review by the WHO found that care provided by mid-level health workers can be as effective as care provided by physicians in certain delivery areas.[85] Task shifting and sharing can have a significant impact in the scale-up of the health workforce and potentially bring more health workers to rural areas, since training these mid-level health workers requires less time and money. The review concluded that mid-level health workers who are embedded in the health system and receive sufficient training, recognition, and pay can play an important role in achieving UHC and the SDGs.[86]

Specific models take into consideration the local health workforce, disease burden, and existing gaps in service delivery. Such innovative responses to the shortage of human resources have substantial potential to improve girls' and women's access to health services. In the case of NCDs, non-physician health workers have been shown to successfully detect and manage these and other chronic conditions.[87] A review of studies utilizing community health workers for prevention and detection of NCDs in LMICs found that community health worker involvement resulted in improvements in tobacco cessation, lowering blood pressure, and diabetes management.[88] However, due to the small number of studies and low-quality evidence currently available, research must be expanded.[89, 90, 91]

It is important to emphasize that availability of health workers does not ensure quality of care in and of itself. To provide effective services, health workers need to be equipped with appropriate knowledge and skills, as well as an environment that supports access to quality care.[92] This includes the physical, financial, legal, and political conditions that integrate quality improvement into pre-service and in-service training in order to build a competent workforce that is capable of providing high-quality care, especially to those most in need.[93]

To reach those most in need, equitable distribution of the health workforce across social, economic, and geographic lines is necessary. This requires strategic investment that can translate into employment opportunities, especially for women and young people. The global demand for health workers is expected to double by 2030, with a need for an estimated 40 million new jobs, primarily in upper-middle and high-income countries.[94] Investment in the health workforce for the future should account for inequities of access, demographic shifts, technological changes, and socioeconomic transitions. The workforce should be geared toward addressing the social determinants of health as well as the physical ones.[95] To respond to these demands and potential opportunities, there is greater need for multi-sectoral engagement across the interconnected areas of employment, education, health, finance, and gender.[96]

Gender inequalities in health, especially in the health workforce, must also be addressed, particularly with respect to women's formal representation in the health sector and girls' and women's contribution to informal, unpaid care work.[97] Despite women's majority representation among health workers, the health industry is primarily led by men. Men head an estimated 72% of global health organizations and account for 71% of board chairs.[98] They are twice as likely to sit on governing boards than women are.[99] Fewer than 30% of global health organizations have gender parity in senior management,[100] limiting women's ability to have an equal say in the design of national health plans, policies, and systems that affect them, their families, and their communities.[101] Strengthening and using gender- and age-disaggregated data can help identify these structural gaps, while increased female representation in decision-making bodies can result in gender-transformative policy development that overcomes gaps and gender biases in the health labor market.[102] In addition, reformed policies can maximize women's formal participation in the health workforce, improve opportunities for formal education, and address issues related to women's security, work conditions, and mobility.[103]

Greater focus and investment in the health workforce is also needed in emergency settings, especially in terms of staff safety and mobility, surge capacity, training, and preparedness.[104, 105] The health consequences of disasters and emergencies can be devastating, resulting in loss of life, disability, and mental trauma. The aftermath and period of recovery is usually burdened by many challenges, including limited access to maternal, sexual and reproductive health.[106, 107] Although women are the main providers of care in crisis settings, gender biases, harassment, and physical and sexual violence remain persistent challenges for health workers.[108] During humanitarian emergencies, violence against health infrastructure, workers, and transport systems impairs access to safe and reliable

health services, particularly for girls and women. Health workers and facilities have increasingly become deliberate targets in conflict situations, with 943 reported attacks on healthcare workers in 23 conflict-affected countries in 2018 alone.[109] Health service delivery is more complicated in emergency settings, but maintaining the health workforce is especially important for building resilience, reducing health vulnerability, and recovering from the emergency itself.[110]

Case Study: Task Shifting the Management of Noncommunicable Diseases to Nurses in Kibera, Kenya

Kenya has a disproportionately high burden of noncommunicable diseases, which account for more than 50% of all hospital admissions and deaths. The situation is worse in informal settings and overwhelming for the health systems.[111] Tertiary health facilities manage NCDs, placing a workload strain on their staff. To address this issue, the Kenyan Ministry of Health and Médecins Sans Frontières (MSF) introduced a model that involved task shifting the care of stable NCD patients in Kibera clinics to nurses in primary health facilities. Results from early impact evaluations indicate that nurses working in resource-constrained primary settings can effectively manage NCD patients.[112]

Case Study: Building Community Trust in Emergency Response to the Ebola Outbreak in the DRC

The latest Ebola outbreak in the Democratic Republic of the Congo (DRC) began in August 2018, and it is, to date, the second-biggest Ebola epidemic on record. As of August 2019, there have been 2,899 confirmed cases and 2,006 deaths, and the WHO has declared the outbreak a Public Health Emergency of International Concern (PHEIC). Médecins Sans Frontières has implemented projects in certain parts of DRC since 2006, and it currently has 600 staff in the DRC responding to the Ebola outbreak. MSF and others face significant community mistrust of the Ebola response, which resulted in violent attacks on MSF's Ebola Treatment Centers in Katwa and Butembo in February 2019. Such attacks put the safety and lives of health workers and patients at risk. This is one reason why MSF and its partners believe it is critical to build trust between affected communities and emergency responders. Their approach includes a focus on health response authorities and workers listening to the needs of communities, strengthening people's agency for managing their health, and supporting community engagement in every aspect of the Ebola response.[113]

Maintain Health Information With Lifelong Individual Medical Records, Ideally Patient-Held

Individual medical records are the backbone of comprehensive care. They are important tools for planning and managing care coordination, documenting history, and monitoring the health needs of girls and women throughout their lives. The confidential aggregation of data from individual records also provides information that can be used to guide forecasting, supply planning, resource allocation, and evaluation.[114] Individual records are needed to permit continuity of information across encounters with the health system over services, time, and distance; they are also necessary for accurate reporting.[115]

Originally driven by HIV and tuberculosis programs, electronic medical record systems help achieve this goal.[116] The WHO outlined the considerations needed to introduce such systems, including educating staff, computer literacy, funding for infrastructure, data security, and quality assurance.[117] Electronic medical records are typically more efficient, accurate, and cost-effective than paper-based systems when large numbers of patients are involved.[118, 119] Some studies have shown that they also can support the chronic clinical management of HIV and TB patients.[120]

Increased digitization of medical records could also facilitate integrated care for individual patients,[121] as well as improve public health outcomes by facilitating big data analysis on a population-wide level. However, in many countries—especially low-income countries—data collection and analysis are not yet robust enough to see the benefits of this. Other barriers to optimal usage of electronic medical records include insufficient legal and governance frameworks.[122]

Case Study: Increasing Immunization Rates Through Electronic Immunization Registries in Tanzania and Zambia

In 2013, the BID Initiative was launched to increase immunization rates in Tanzania and Zambia by improving data collection, quality, and use.[123] Led by PATH, in partnership with the governments of Tanzania and Zambia, the initiative supported the roll out of a series of tools and interventions, including an electronic immunization registry integrated with supply chain information. By digitizing immunization and supply chain records, not only was the cumbersome process of manual record-keeping eliminated, but health workers were also empowered to improve service delivery through their use of an easily accessible platform to monitor, analyze, and visualize data trends in vaccine procurement, delivery, and uptake. Key to this effort was the BID Initiative's work to strengthen the capacity of local health workers to help ensure effective data collection and use. As a result of the technology and training provided through the BID Initiative, health workers in Tanzania reported a 55% increase in their ability to identify children who have missed vaccines, and each facility in Tanzania saved more than 70 hours each year. In Zambia, there was a 22% increase in the number of health workers who reported "good" or "excellent" data accuracy.[124]

Ensure Medical Products and Technologies Are Safe and Accessible

Equitable access to comprehensive health services requires the availability of essential medicines, vaccines, and technologies. Some medicines and technologies are chronically unavailable in LMICs as a result of countries failing to include medicines on the essential drug list,[125] inefficiencies in procurement and distribution systems, and unnecessarily high prices.[126] Another issue that hinders access to safe medical products and technologies is substandard and falsified medical products. Although substandard and falsified medical products are found in every region of the world, lower-income countries are most affected. It is estimated that up to 10% of medical products found in low- and middle-income countries are substandard or falsified.[127] The World Health Organization launched the Global Surveillance and Monitoring System in 2013 to improve capacity and coordination among countries to combat this problem.[128]

Countries should implement the framework recommended by the WHO to ensure equitable access to high-quality, safe, and cost-effective medicines, devices, and tools.[129] It includes the following components:

- Rational selection of medicines: Countries must develop active purchasing based on the costs and benefits of alternatives.[130]
- Affordable pricing: Governments should ensure transparency in purchasing and tenders by monitoring and publicizing medicine prices.[131] Policies that support the purchase of generic drugs—the norm for HIV/AIDS—should be extended to NCDs.[132]
- Remove taxes and duties: Countries should use their negotiating power to control mark-up, addressing excessive taxes and duties on medicines.[133]
- Universal health coverage and sustainable financing: Governments should seek private-sector partners willing to embrace a social business model, whereby firms seek to maximize social profit while making financial profit to cover their costs and provide returns to their owners.[134]

- Reliable health and supply systems: Governments need to team up with commercial partners and apply modern business techniques to optimize the efficiency and reliability of drug distribution systems. This includes a greater application of supply-chain optimization analysis, a technique commonly applied in the private sector to manage distribution.[135]

In emergency situations, medicines and devices must be available and standardized to allow for their efficient, effective, and safe use when the need arises.[136] Effective supply chain management is a vital component of successful service delivery, starting with needs forecasting and procurement, followed by transportation and distribution of essential medicines and supplies. In emergency settings, supply chains need to be strong, sustainable, and flexible from the onset of crisis through periods of recovery. Without access to relevant medicines, supplies, and equipment, health workers cannot provide essential services.[137]

Supply chains must be able to meet the diverse needs of all affected populations, including girls and women in all their diversity. Emergency response mechanisms should be integrated with national health systems in order to provide and sustain effective, gender-sensitive services at the onset of crisis and through periods of recovery.[138] This includes the initial provision of high-quality, integrated sexual and reproductive health services through the Minimum Initial Service Package (MISP).[139] In addition to being a source of essential equipment and supplies, the MISP forms a set of corresponding, priority activities that are carried out by trained staff to manage and respond to gender-sensitive health issues. Implementation of the MISP serves as a starting point to prevent maternal and newborn deaths, unwanted pregnancies, unsafe abortions, sexual violence, and the possible spread of sexually transmitted infections in crisis settings.[140]

Case Study: Social Business Initiatives to Improve Access to Essential Drugs in Kenya

Governments are increasing their partnerships with drug manufacturers for mutual gain. These alliances, known as social business interventions, pair commercial partners with governments or non-profit organizations. In 2012, the government of Kenya teamed up with a pharmaceutical industry partner, Novartis, to launch the Familia Nawiri program to increase access to essential drugs for under-treated conditions—including hypertension and diabetes—in the poorest communities.[141] Community health educators, often women, play a pivotal role in community engagement and linking community members with healthcare providers for care and access to medicines.[142] Since the start of the program, more than 736,000 people in Kenya have attended more than 23,000 health education meetings, and more than 43,000 patients have been diagnosed and treated at 287 health camps.[143]

Case Study: The Elimination of HIV Transmission from Mother to Child in Cuba

In 1997, Cuba introduced a program for preventing mother-to-child HIV transmission in a healthcare system that is universal and free of charge.[144] The Cuban Ministry of Public Health provided antiretroviral treatment for all HIV-positive pregnant women, along with breast milk substitutes.[145] While initial treatments were largely maintained through donations of antiretrovirals, in 2001 the government facilitated local production of generic antiretroviral drugs. With the introduction of locally produced drugs, the proportion of patients with access to antiretrovirals increased significantly.[146] By 2014, Cuba reported fewer than 100 HIV-positive pregnant women.[147] In 2015, Cuba was formally recognized by the WHO for eliminating mother-to-child transmission of HIV.[148]

Ensure Prevention, Screening, and Treatment Options for Noncommunicable Diseases and Mental Health

The proportion of the global disease burden caused by NCDs, measured in disability-adjusted life years (DALYs), grew from 43% to 62% between 1990 and 2017, with the fastest increase in low-and middle-income countries.[149, 150] NCDs among girls and women in particular are also on the rise. For example, there are currently more than 200 million women living with diabetes, and this is projected to increase to 308 million by 2045.[151] Improving mechanisms for prevention, screening, and treatment of NCDs is critical to achieving better health outcomes for girls and women throughout the life course.[152] For example, addressing gestational diabetes through prevention, universal early screening, postpartum screening, treatment, and management will not only improve maternal and newborn health, but also help prevent the onset of type 2 diabetes and other associated NCDs in women, their babies, and subsequent generations.[153] Mental health is also an important risk factor for premature mortality around the world. Many mental health conditions affect more girls and women than boys and men. Depression, for example, affects 5.1% of females, versus 3.6% of males.[154] Mental health disorders can be linked with chronic illnesses and can lead to behaviors that increase risk for other NCDs, such as substance abuse, harmful alcohol use, poor diet, and reduced physical activity.[155] Individuals with mental health conditions are also less likely to seek help for NCD symptoms, which may affect prognosis and treatment.[156]

Prevention of NCDs includes reducing risk factors such as tobacco use, physical inactivity, alcohol abuse, and unhealthy diet.[157] Malnutrition is also a concern. Children born to malnourished women or to women at risk of or diagnosed with diabetes in pregnancy are more likely to develop chronic illnesses such as diabetes or heart disease as they grow older.[158]

NCD prevention and management is also important in disaster and emergency settings, when health service delivery can become strained. For example, following a coup in Mali in 2012, the health system was severely impacted.[159] Non-governmental organization Santé Diabète developed a humanitarian response for patients with diabetes that included evacuating children, providing medicines and tools for management of diabetes, and supporting people who became internally displaced.[160] Emergency responses must consider an individual's particular context, such as whether they are internally displaced or remain in conflict areas.[161]

Governments play an important role in promoting healthy behaviors through policies and tools, both within and outside the traditional health sector.[162, 163] This is particularly relevant for the prevention and treatment of NCDs in girls and women. The WHO and *The Lancet* Commission on Investing in Health recommend high-priority, cost-effective, and achievable interventions such as taxation, regulation, and legislation to help foster health-seeking behaviors and environments.[164, 165] For example, many studies show that taxing tobacco reduces its use and can prevent deaths while also raising revenue.[166, 167] Taxation on alcohol and sugar-sweetened beverages can provide similar benefits.[168, 169, 170] People are responsive to tobacco tax and price increases, and raising these taxes has been shown to reduce overall infant mortality.[171] Yet implementation of these measures remains uneven. Of the 194 countries that completed a 2015 WHO NCD country capacity assessment survey, 87% reported taxes on tobacco and 80% on alcohol, whereas only 18% had fiscal policies on non-alcoholic beverages with a high sugar content.[172]

Involving girls and women as partners in the management of their health and as agents of change within their communities is not only essential to prevention, screening, and treatment efforts, but is also a fundamental aspect of women-centered care. Girls and women need to be equipped with better information about NCD risk factors and the health consequences of their lifestyle choices.

Case Study: ASHA — Women as Community Health Workers in India

India's National Rural Health Mission was launched in 2005, aiming to provide every village in the country with a trained female community accredited social health activist (ASHA).[173] ASHAs serve as a link between their own community and the public health system. As community health activists, ASHAs provide education on a range of health issues, including reproductive and sexual health, and healthy lifestyles and nutrition, which contributes to the prevention of diabetes and other NCDs.[174] ASHAs also counsel women about immunizations and receive performance-based incentives for promoting universal immunization by connecting community members to immunization services at health centers.[175] By counseling women on the importance of immunization, and mobilizing women, children, and vulnerable populations to immunization camps, ASHA workers have increased immunization rates between 12% and 17% in high-focus states that lagged behind in public health indicators.[176]

SECTION 3: THE BENEFITS OF INVESTMENT

There are multiple benefits to building health systems that provide care for all girls and women, in all their diversity and across the life course. First and foremost, it saves lives. Subsequently, it saves money. The return on investment in health is nine to one, and an estimated quarter of the economic growth between 2000 and 2011 in LMICs resulted from improvements to health.[177]

For example, implementing a set of cardiovascular disease prevention interventions in 20 countries with the highest NCD burden would cost US $120 billion between 2015 and 2030—an additional $1.50 per capita per year.[178] This investment would avert 15 million deaths, 8 million incidents of ischemic heart disease, and 13 million incidents of stroke.[179] The WHO estimates that implementing recommended interventions for the prevention and control of NCDs in low- and lower-middle-income countries could save 8.2 million lives, generating US $350 billion in economic growth between 2018 and 2030.[180] Additionally, fully meeting the needs for both modern contraception and maternal and newborn care would cost $53.6 billion annually—$8.56 per person—in developing regions.[181] And investing in both contraceptive and maternal and newborn services together results in a net savings of $6.9 billion compared with investing in maternal and newborn healthcare alone.[182] It is also estimated that every $1 invested in meeting the unmet need for contraceptives yields as much as $60–$100 in long-term benefits from economic growth.[183] More broadly, to make significant progress on SDG 3 in LMICs by 2030, an additional $371 billion in health spending would be needed each year, with 75% of that cost going toward health systems strengthening.[184] This is equivalent to about a 5% increase in spending from what is already spent globally each year.[185] As a result, 97 million lives would be saved and life expectancy would increase by three to eight years.[186] In addition to life expectancy gains, such investments have also proven to have economic benefits. For example, health workforce investments have been shown to have a strong effect on economic growth.[187]

Investing in prevention and screening helps reduce health risks and costs. Evidence shows that vaccinating girls against the human papillomavirus (HPV) over 10 years—at a cost of only $10 to $25 per person—would avert more than 3 million deaths from cervical cancer across 72 LMICs.[188] Additionally, screening vaccinated women for cervical cancer just three times in their lifetime would reduce mortality by another 20% to 25%.[189]

In order to ensure health for all across the life course, countries must also invest in health systems strengthening—to increase access, augment human resources for health, support and build quality processes, and ensure effective infrastructure.[190] Investing in integrating prevention and control of NCDs within other programmatic areas, such as HIV; maternal, newborn and child health; and sexual and reproductive health, may enhance synergies and linkages, and improve efficiencies in the delivery of services to women and families in LMICs.[191] Investments to expand and improve the health workforce also bring benefits in terms of job creation, economic growth, social welfare, and gender empowerment, in addition to health system strengthening.[192]

Furthermore, the moral and economic costs of failing to invest in integrated health systems are staggering. For example, the cumulative economic loss to LMICs from the four main NCDs—cardiovascular disease, cancers, respiratory diseases, and diabetes—is estimated to be more than $7 trillion between 2011 and 2025.[193] The evidence is clear: investing in health for all is both the right and the smart thing to do.

SECTION 4: CALLS TO ACTION

Governments bear the greatest responsibility to ensure that girls and women have access to comprehensive healthcare, but everyone has a role to play to reduce barriers to integrated services that promote the health and wellbeing of all.

Different constituents—governments, civil society, academia, media, affected populations, the United Nations, and the private sector—must work together to take the following actions for girls and women:

- Prioritize health for all through universal health coverage that meaningfully recognizes and addresses gender equality. (Most relevant for: governments and the private sector)
- Eliminate legal, financial, social, and institutional barriers that prevent access to comprehensive health services for all girls and women—in all their diversity—including age of consent for accessing services and barriers based on gender identity. (Most relevant for: governments)
- Set and meet national targets across girls' and women's health and wellbeing needs, including sexual and reproductive health, as well as communicable and noncommunicable diseases. (Most relevant for: governments)
- Promote all girls' and women's involvement in physical activity, including sports, as a critical way to foster wellbeing and healthy behaviors. (Most relevant for: governments, civil society, the United Nations, and the private sector)
- Focus efforts toward more integrated, women-centered care to address the needs of all girls and women along the life cycle. (Most relevant for: governments, civil society, the United Nations, and the private sector)
- Commit to data collection and data-based decision-making that promote equity and access. Invest in strong national health information systems, including a well-functioning civil registration and vital statistics (CRVS) system, human resource information systems, and electronic medical records, and implement strong legal frameworks to ensure privacy protection. (Most relevant for: governments and the private sector)

- Build the capacity of health workers and address health worker shortages and general wellbeing, particularly in rural and underserved areas and in emergency and conflict settings, and particularly for female health workers. Address gender-related workforce dynamics to increase women's leadership in the health workforce, integrate women's unpaid care work, and create a safe and dignified working environment. (Most relevant for: governments, civil society, the United Nations, and the private sector)
- Build and disseminate evidence of the impact of women-centered care. (Most relevant for: governments, civil society, academia, media, affected populations, the United Nations, and the private sector)
- Tailor responses in emergency settings to ensure the specific health needs of the population, especially vulnerable groups and girls and women, are factored into the plan. (Most relevant for: governments, civil society, and the United Nations)

Last reviewed and updated October 2019

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These briefs are intended to be used by policymakers, decision-makers, advocates, and activists to advance issues affecting girls and women in global development. These materials are designed to be open-source and available for your use.

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