WE ASK YOU TO

1) **DISSEMINATE** - our ASKS to member states & influencers

2) **ADVOCATE** - for our ASKS with your government for the UN HLM

3) **INCLUDE** - our ASKS in your advocacy platforms

4) **ASK** - for gender balanced delegations to the UN HLM

5) **USE** - our ASKS to promote Gender and UHC

#HealthForAll

Gender equality and women’s rights in UHC drive better health for all. This is everybody’s business.
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**Women in Global Health asks Member States to address the following in the UN High Level Meeting on Universal Health Coverage 23 September 2019 and Political Declaration:**

1. Gender equality and women’s rights are central to the design and delivery of UHC

1.1 Prioritise the health needs of the most marginalised women and girls in UHC design and delivery, taking an intersectional approach to leaving no one behind (including youth, race, ethnicity, caste and class, disability, older women and any other marginalized identity according to social context).

1.2 Address in UHC design and delivery the gender determinants of health that drive risk and ill health based on socially assigned gender roles for all genders (women/girls, men/boys, trans, non-binary).

1.3 Adopt a life-course approach to UHC design and delivery addressing the different health needs and priorities of women and girls at critical stages throughout their lifetime.

1.4 Implement the commitment in the Astana Declaration¹ to

‘Primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;’

since this will facilitate access for the most marginalised women and girls.

1.5. Ensure that UHC financing enables access to health services for the poorest women and girls, acknowledging that women on average have less income and fewer assets than men.

1.6 Include women in equal numbers to men in UHC decision making at all levels from community to global and adopt a gender transformative approach to the design, delivery and leadership of UHC.

1.7 Build the policy evidence base for UHC on gender-disaggregated data.

1.8 Acknowledge the principle in the Call to Action² from the Partnership for Maternal, Newborn and Child Health (PMNCH) that

‘For UHC to be realized, especially for women, girls and adolescents, we must commit to building a collective health for all movement, inclusive and promotive of sexual and reproductive health and rights (SRHR).’

Women in Global Health endorse the PMNCH Call to Action “Sexual and reproductive health and rights: An essential element to achieving universal health coverage”.

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¹ Declaration from Astana Global Conference on Primary Health Care 2018 [https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf](https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf)

2. The female health workforce is central to design and delivery of UHC

2.1. Acknowledge the role of women as 70% of the health workforce, in delivery of UHC. Women are drivers of health and agents of change, in addition to being consumers of health services.

2.2. Invest in education and training to expand the female health workforce and fill the 18 million health worker jobs essential to achieving UHC.

2.3. Address the gender inequalities and rights deficiencies in the health workforce, especially occupational segregation and gender gaps in leadership and pay, that are obstacles to UHC delivery.

2.4. Ensure decent work for female health workers that protects their fundamental rights, provides a fair income, and ensures a safe work environment free from violence, harassment and discrimination.

2.5. Integrate the unpaid health and social care work done by women into the formal labour market and end the practice of engaging women as unpaid and underpaid community health workers.

2.6. Include female health workers in equal numbers to men at all levels of decision making and monitoring of health systems.

2.7. Adopt a gender transformative approach to national health workforce planning, making gender analysis integral to labour market analysis as agreed in the WHO-ILO-OECD ‘Five-year action plan for health employment and inclusive economic growth (2017–2021)’

3. Women’s voice and leadership is critical to the UN HLM process

3.1. Demonstrate strong political will for gender equality through statements by DG WHO, President UNGA, President WBG and Eminent Champion UHC in the Opening Session of the UN HLM.

3.2. Implement the commitment in the Modalities Resolution and ensure speakers and panelists for the Multi stakeholder Meeting and UN HLM on UHC ‘taking into account gender equity, level of development and geographical representation.’

3.3. Ensure UN Member States have gender balance in their delegations to the UN HLM on UHC.

3.4. Implement the commitment in the Modalities Resolution to select participants for the Multi stakeholder Meeting and UN HLM on UHC ‘taking into account the principles of transparency and equitable geographical representation, with due regard to the meaningful participation of women.’

3.5. Include gender equality and UHC as a stand-alone item on the official agendas of both the Multi stakeholder Meeting and UN HLM on UHC.

3.6. Institute gender-responsive / family friendly arrangements at the Multi stakeholder Meeting and HLM.

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4 Para 4 (d) Resolution A/RES/73/131 Scope, modalities, format and organization of the high-level meeting on universal health coverage, UN General Assembly on 13 December 2018

5 Para 11 Resolution A/RES/73/131 Scope, modalities, format and organization of the high-level meeting on universal health coverage, UN General Assembly on 13 December 2018
Key Messages: Why Gender Equality and Women’s Rights Matter in UHC

1. Gender equality and women’s rights are central to design and delivery of UHC

- The ‘Universal’ in UHC means that it must reach everyone regardless of gender, ethnicity, caste, race, class, disability, age, sexuality, income etc. In many countries, women and girls from marginalised social groups have the least access to health services and will be the hardest to reach.
- Women are the majority of the world’s poor and therefore less able to afford health services than men. UHC will bring major change to the world’s poorest women, evening up life chances, reducing premature death and suffering, and removing catastrophic health costs that mean many women currently do not get the health services they need.
- UHC is based on the principle that people should receive health services according to their health needs. UHC delivery must factor in different health needs of women and men throughout the lifecourse, the most significant being women’s greater need for health services related to pregnancy and childbirth.
- Gender-based determinants of health drive risk and ill health based on socially assigned gender roles. Women in some contexts are subject to damaging traditional practices such as Female Genital Mutilation and women everywhere are at higher risk of gender-based violence than men. Equally, gender roles put men at higher risk of death and disease related to tobacco use and suicide, and increase the risk of violence for trans people. Prevention of gender-based drivers of ill health lie largely outside the health sector and must be addressed in context for successful implementation of UHC.
- Political decisions determine the funding and scope of UHC at country level. Globally, only 23.5% of parliamentarians are female so women do not have an equal say in national political decisions on UHC. Gender-balanced parliaments would give greater priority to health services and health-related issues that impact on women’s health. The voices of women are critical in health decision making at all levels, from community to national and global, and ensure UHC meets the needs and priorities of all genders.
- UHC is based on the principle of leaving no one behind but to achieve this it must be grounded in respect for the human rights of girls and women, especially their sexual and reproductive health and rights.
- In 2017 60% of 140 global health organisations surveyed failed to cite gender equality as a priority in their programme or strategy documents. There can be no assumption that gender equality and women’s rights will automatically be given due priority in the UHC HLM process. Targeted action will be needed to ensure gender equality and women’s rights are not left behind in the UHC HLM process.

2. The female health workforce is central to design and delivery of UHC

- Women comprise around 70% of the global health workforce and are therefore central to delivery of UHC but the majority of female health workers are in lower status, low paid roles and sectors, often on insecure conditions. Ensuring female health workers have decent work is central to the delivery of UHC.
- An estimated 18 million health worker jobs must be created in low income countries by 2030 to reach UHC. Investment in the female health workforce taking a gender-transformative approach is essential to fill those jobs. The resulting expansion of formal sector jobs for women will have wider benefits for gender equality, social development and economic growth.
- Although women are the majority of the health workforce, men hold the majority of senior leadership roles in the health sector. Women in leadership positions in health expand the agenda, giving greater

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priority to health-related drivers such as sexual and reproductive health and rights (SRHR) which apply to all genders, but where absent, have the most negative impacts on women’s health.

- Lack of gender balance in health leadership means global health loses female talent, perspectives and knowledge. The women who deliver global health do not have an equal say in its design and delivery. This must be addressed if UHC is to succeed.
- Women’s work in health contributes an estimated US$3 trillion to global GDP but around half is unpaid. Women provide unpaid care in the absence of UHC and skilled care workers. Strong global health and UHC delivery rest on bringing women’s unpaid work into the formal labour market as decent work and ending the subsidy the poorest women make to health systems through their unpaid work.

3. Women’s voice and leadership is critical to the UN HLM process

- Women are in the minority in global health decision making at the World Health Assembly. In 2018, only 31% of health ministries were headed by women and only 25% of Member State Chief Delegates to the World Health Assembly 2015-2018 were female. Global health decision making driving UHC is lacking women’s perspectives, particularly women from the Global South.
- Women hold a minority of decision making posts in leading global health organisations. In 2017, 69% of executive heads and 71% of Board Chairs of 140 global health organisations were male. Women’s voices are therefore not represented equally in the leadership of the global health organisations that control significant resources and will support UHC design and delivery.
- Women’s limited opportunity to enter leadership roles in health is compounded by the intersection with other factors such as race, religion, caste, class, transgender and ethnicity which can further disadvantage women with a marginalised identity. UHC must take an intersectional approach to include perspectives from diverse groups of women, especially from low and middle income countries.
- The current gender gaps in health leadership result from power imbalances, gender stereotyping, discrimination and structures that create pathways for one gender to excel while others remain segregated in subordinated roles. When one gender has a greater say than other genders, health systems’ priorities become distorted in favour of more powerful groups and UHC is diminished.
- The persistent absence of female talent from leadership positions is a significant barrier to the rapid scaling up of the global health and social care workforce needed to achieve the SDGs, including UHC.

Gender equality and women’s rights in UHC will drive better health for all. This is everybody’s business.

Women in Global Health
9 March 2019

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7 Women in Global Health
8 GlobalHealth5050. https://globalhealth5050.org/gh5050-summary-findings-on-leadership-and-parity/