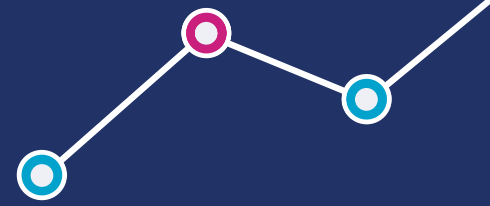
MAGE

Monitoring and Action for Gender and Equity

Monitoring and evaluating gender-responsive health financing for RMNCAH-N

Johns Hopkins Bloomberg School of Public Health

Global Financing Facility



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Monitoring and evaluating gender-responsive health financing for RMNCAH-N

Introduction

Health financing plays a significant role in determining the availability of health care, who can access care, and the degree of financial protection provided to poor and vulnerable populations[1]. Gender-responsive health financing for Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAHN) entails recognizing and analyzing how gender power relations affect the financing of access to and utilization of RMNCAH-N by women and men, boys, and girls[1,2]. Gender refers to the socially constructed roles, norms, and behaviors that a given society considers appropriate for individuals based on the sex they were assigned at birth[3]. Gender norms, which constitute beliefs about women, men, boys and girls, and gender minority individuals, and gender roles that pertain to what men, women, boys, girls, and gender minority individuals are expected to do (in the household, community, and workplace) in a given society often create hierarchies and unequal power relations between and among groups of men and women, boys and girls, and gender minorities disadvantaging one group over another[3].

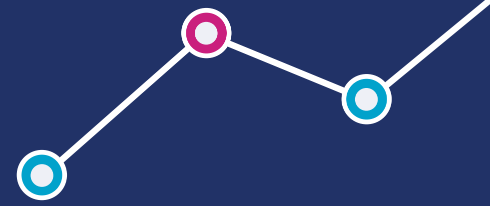
Below is an explanation of gender-responsive health financing, highlighting the gender implications of health financing schemes, and providing gendered considerations in the form of questions and indicators to make the schemes increasingly gender-responsive.

User fees

User fees are out-of-pocket (OOP) payments made for services at the point of use[1]. Associated gender implications of user fees include: user fees can be expensive for those who do not have a source of income, for example, stay-at-home spouses and children; women who have limited to no control over financial resources may require permission from a male family member to access and utilize resources to pay for health care; and women have a higher demand for RMNCAHN services because of their biological role as child bearers which leads to increased OOP payments for reproductive, delivery and obstetric healthcare. Further, in some cases, health workers may use OOP payments as an opportunity to charge informal user fees (under-the-table payments). This burden falls more on women since they are more frequent users of the health system[1,4,5].

Below are suggested considerations for gender-responsive OOP payments:

- Has gender-disaggregated information on OOP expenditures on health been obtained? What RMNNCAH-N services incur the greatest expenditures for men and women? And what is the impact of OOP payments on women/men/girls/boys and households?[6]
- How does the burden of OOP expenditure affect men's and women's, and boys' and girls' access to health care?[1]
- To what extent do user fees or the removal of user fees have more impact on women and girls from marginalized groups, because they have less access to cash for other needs such as transport, cost of services that are not available, and other indirect costs?[6]



- How do OOP payments affect men's and women's and boys' and girls' access to health care, for services such as family planning, cervical and prostate cancer? How are they affected by household arrangements (livelihoods, access to cash, decision-making power, etc.)?[1]

- Are guidelines for user fees and waivers available, clear, and known by patients and their caregivers? To what extent are women and girls or other marginalized groups less likely to follow up on financial claims because of less assertive social norms, or a history of government discrimination?[6]

- To what extent are men involved or engaged in health care? Are there systems or mechanisms that encourage men to go to health facilities for services such as family planning[4], or systems where women have the autonomy and support to make their own financial decisions about their health care?

- Are girls, women, boys, or men more or less likely to know about user fee exemptions, cash transfer entitlements, and health insurance benefits?[6]

- Are services financed to ensure that women and men, boys and girls are not penalized for inability to pay at the point of service delivery? Research shows that in some settings women and children have been imprisoned and denied medical care because of their inability to pay hospital fees.[2,7]

Example indicators

- Percentage of women and men, girls and boys who incur OOP expenditures for RMNCAH-N health services.

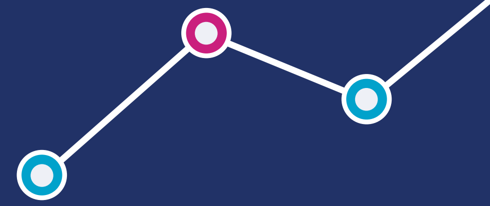
- Percentage of women and girls who report that they need to seek permission from their husbands/spouses, or other relatives to visit a health facility for RMNCAH-N health services.

- Percentage of women and men, girls and boys who are aware of the cost of the various types of RMNCAH-N health services.

- Percentage of women and men who report that they experience financial difficulties in utilizing RMNCAH-N health services.

Social health insurance

Social health insurance is mandatory health care financing for individuals employed in the formal sector[1,8]. This scheme benefits only a section of the population who have a regular source of income, leaving out those in the informal sector, the unemployed, and those in unpaid work. According to the World Bank, globally, informal workers are predominately women[9] in sectors such as street vending, domestic work, and seasonal agriculture among others, leaving them ineligible for many social health insurance schemes[1,8]. Such schemes often allow legally married women and their children to be covered as dependents on their husband's insurance; meaning that unmarried, widowed, and women in polygamous

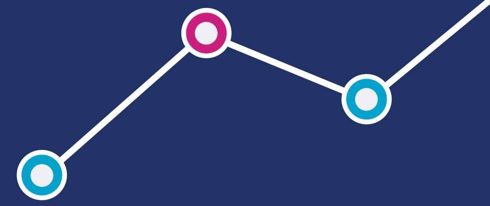


marriages and their dependents are not covered or may require proof of marriage in the form of marriage certificates and civil registries[8]. In some countries, husbands are not allowed to be covered under their employed wives' insurance[8].

Even when covered under this insurance scheme, one might incur indirect OOP payments because not all routine and essential health services are necessarily covered. Such services include comprehensive sexuality education; counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods; antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care; safe abortion services and treatment of complications of unsafe abortions; prevention and treatment of HIV and other sexually transmitted infections; prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence; prevention, detection, and management of reproductive cancers, especially cervical cancer; information, and services for sub infertility and fertility, information, counselling and services for sexual health and wellbeing and insured services might be unavailable so one must pay for the services in another health facility, or one might incur transport costs to reach a health facility where the insured services are available[5,8,10,11]. Such extra payments affect women more because they are likely to have lower incomes than men, yet they have a greater need for health care services.

Below are suggested considerations for gender-responsive social health insurance:

- To what extent are services that are needed by different populations (such as contraception, safe abortion, emergency obstetric services, sexuality education, prevention, and treatment for survivors of violence including rape, prevention, and treatment of sexually transmitted infections, etc.) included in health insurance plans? Do insurance packages include reproductive health services exclusively used by women? Do they include services for men's sexual and reproductive health?[6]
- Which services are prioritized for funding and how do these reflect different genders' needs?[1]
- To what extent are men involved or engaged in health care? Are there systems or mechanisms that encourage men to go to health facilities for services such as family planning[4], or systems where women have the autonomy and support to make their own financial decisions about their health care?
- What is the extent of financial protection of essential services (by reducing the reliance on OOP payments towards mandatory prepayment mechanisms) for addressing the health of girls and women? Are they affected by out-of-pocket payments?[2]
- How does the payment method affect men's and women's, girls', and boys' access to health care? How are they affected by household arrangements (livelihoods, access to cash, decision-making power, etc.)?[1]
- Are girls, women, boys, or men more or less likely to know about user fee exemptions, cash transfer entitlements, and health insurance benefits?[6]



Example indicators

- Proportion of RMNCAH-N health services for women and men, boys and girls covered by health insurance.
- Percentage of women and men, boys and girls who incur out-of-pocket expenditures for RMNCAH-N health services.
- Percentage of women, men, boys, and girls who report using their spouses' or parents' social health insurance as dependents.
- Percentage of women and men, boys and girls who report that they require permission from their spouses to be covered as dependents under their spouse's social health insurance.

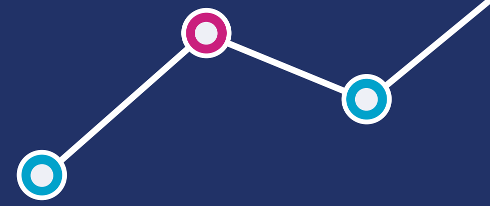
Voluntary health insurance schemes

Private Health Insurance
Private health insurance is a health financing mechanism where individuals voluntarily choose to purchase health insurance[1,8]. Such schemes are available to those with a steady flow of income. This method is expensive, excluding people with low or no income[8]. Private health insurance is also based on risk calculation, so women with a greater need for health care tend to pay more[1,8]. Research shows that such schemes may exclude individuals with pre-existing conditions and may not cover all sexual and reproductive health services[1,8].

Community-based health insurance scheme
Community-based health insurance (CBHI) is a voluntary scheme that covers those in the informal sector[1,8]. Commonly used in low- and middle-income countries, local communities come together and set aside resources for health care services. Individuals pay lower premiums which often makes the scheme affordable to those with low incomes. In addition, premiums can often be paid in installments, payment is flexible for those with seasonal and unsteady incomes, and those who cannot afford to pay can be exempted because the scheme relies on mutual agreements[1,8]. However, CBHI schemes have gender implications. Because the scheme is community-based, in patriarchal societies, men and boys can be covered or are covered first leaving out women. Women are likely to occupy managerial positions with minor roles, where decision-making is minimal[8], which can lead to minimal prioritization of women's health needs. In addition, women are less likely to participate in such schemes because they have low access to or no income[8]. Low participation from community members also leads to a lower risk pool which will mostly affect women who have a higher demand for healthcare services[8].

Voluntary health insurance schemes can address gender by considering the following:

- How effective are the risk pools in protecting men and women, girls and boys against health shocks (ensuring access and financial protection)?[1]
- Are all genders represented on the community health management committees? What is the distribution of men and women in the various roles?



- How is coverage for informal workers in paid domestic service, in seasonal or part-time work, or unpaid home-based caregiving financed?[2,6]

- How does the payment method affect men's and women's, girls', and boys' access to RMNCAH-N health care? How are they affected by household arrangements (livelihoods, access to cash, decision-making power, etc.)?[1]

- Are services financed to ensure that women and girls, men and boys are not penalized for inability to pay at the point of service delivery?[2]

- To what extent are services that are needed by only some populations included in health insurance plans such as prevention and treatment of HIV, prevention, and treatment of reproductive health cancers, GBV prevention and counseling, infertility, etc.? Do insurance packages include services exclusively used by women such as giving birth, abortion, breastfeeding, removal of IUD, etc.? Do they include services for men's sexual and reproductive health such as prevention and treatment of prostate cancer?[6]

- To what extent are men involved or engaged in health care? Are there systems or mechanisms that encourage men to go to health facilities for services such as family planning[4], or systems where women have the autonomy and support to make their own financial decisions about their health care?

- Do insurance policies require high levels of paperwork and verification that are not possible for marginalized groups?[6]

Example indicators

- Proportion of RMNCAH-N health services for women and men, girls and boys covered by health insurance.

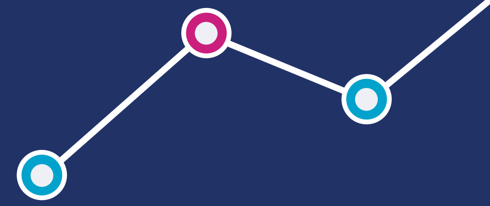
- Percentage of women and men who report having challenges in filing for health insurance.

- Proportion of women and girls who report that they require permission and support from their spouses or other relatives to seek RMNCAH-N health care.

- Proportion of women who are in key decision-making positions on community health insurance management committees.

Cash transfers and vouchers

Cash transfers and vouchers are cash-based interventions where cash or vouchers (for goods and services) are directly offered to poor and vulnerable households to increase the demand for services such as health and education[7,12–14]. Because cash transfers and vouchers target women, they tend to increase women's caregiving responsibilities[13,15]. Targeting women for cash transfers and vouchers might perpetuate intimate partner violence as men might often feel left out and made to think that they are incapable of managing caregiving responsibilities[13].



While cash transfers and vouchers effectively increase the demand for health care services through reducing the financial barriers to access and utilization of health services, they can negatively affect quality of care and health outcomes. Community groups working on the ground in several countries revealed weakness in care received for expectant mothers due to an increase in the application of practices that are meant to speed up delivery such as discharge from the labor wards too soon after delivery, routine episiotomies, application of excessive fundal pressure, unnecessary oxytocin injections and unnecessary cesarean sections[7]. Furthermore, in rural areas, pregnant women and mothers may have to travel long distances to reach health facilities where vouchers are accepted which may be inconsistently open for service, while the cost of transport could be unaffordable during emergencies[5,15]. Additionally, there is evidence in some settings that patients who use vouchers are given less attention by health workers who prefer to first attend to patients with cash[5] thus increasing waiting times. Cash transfers and vouchers also do not address power relations between men and women as women might need to ask for permission and sometimes funds for transport from their husbands to get to healthcare settings[5,16], and vouchers might not cover all routine and essential sexual and reproductive health services that men and women require, such as discontinuing a service that has a fee attached, for instance, removal of an IUD[17].

Below are considerations to increasingly achieve gender-responsive cash transfers:

- How can cash-based programming enable the empowerment of women and girls in different contexts?[13]. Are there systems or mechanisms to prevent gender-based and intimate partner violence?

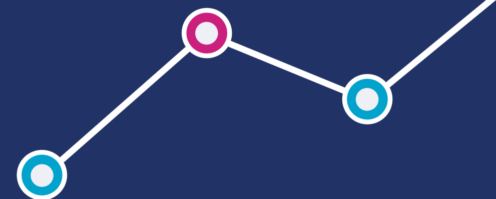
- To what extent are men involved or engaged in health care? Are there systems or mechanisms that encourage men to go to health facilities for services such as family planning[4], or systems where women have the autonomy and support to make their own financial decisions about their health care?

- How does the payment method affect men's and women's, girls' and boys' access to health care? How are they affected by household arrangements (livelihoods, access to cash, decision-making power, gender stereotypes, etc.)?[1]

- To what extent do user fees or the removal of user fees have more impact on women and girls from marginalized groups, because they have less access to cash for other needs such as transport, cost of services that are not available, and other indirect costs?[6]

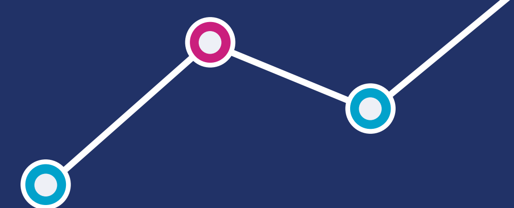
- Are girls, women, boys, or men more or less likely to know about user fee exemptions, cash transfer entitlements, and health insurance benefits?[6]

- Are health workers in public facilities more likely to provide care better quality care to certain groups of clients based on perceived ability to pay, gender, etc.?[6]

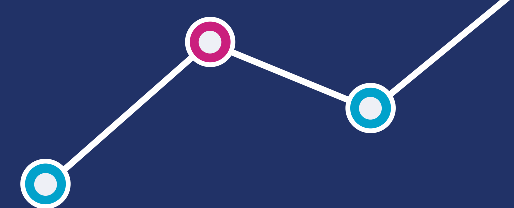


Example indicators

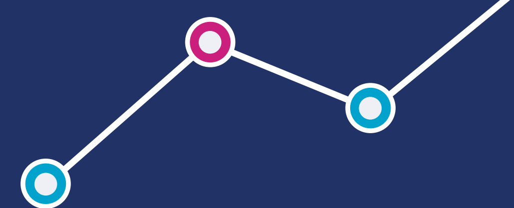
- Percentage of women and girls with cash transfers and vouchers who report that they require permission from their spouse or other relative to seek RMNCAH-N services at a health facility.
- Percentage of women and girls with cash transfers and vouchers who report that they incur OOP expenditures for various RMNCAH-N health services and other non-medical expenses such as transport.
- Percentage of women and girls who report that they experience gender-based and intimate partner violence because of having cash transfers and vouchers.
- Percentage of women and girls who report disrespect and mistreatment by health workers because of using vouchers to finance RMNCAH-N health services.



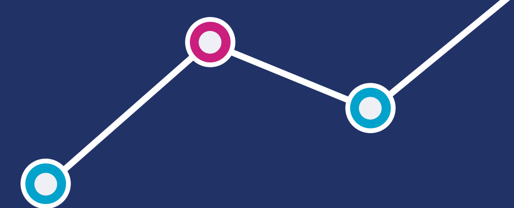
Health financing scheme	Gender implications	Gender-responsive measures	Indicators
User fees Are out-of-pocket (OOP) payments made for services at the point of use [1].	• Can be expensive for those who do not have a source of income, for example, stay-at-home spouses and children[1,4,5]. • Women who have limited to no control over financial resources may require permission from a male family member to access and utilize resources to pay for health care[1,4,5]. • Women incur more expenses because they have a higher demand for RMNCAHN services for reproductive, delivery, and obstetric healthcare[1,4,5]. • In some cases, health workers may use OOP payments as an opportunity to charge informal user fees (under the table payments). This burden falls more on women since they are more frequent users of the health system [1,4,5].	• Has gender-disaggregated information on OOP expenditures on health been obtained? What RMNNCAH-N services incur the greatest out-of-pocket expenditures for men and women? And what is the impact of OOP payments on women/men/girls/boys and households?[6] • How does the burden of OOP expenditure affect men's and women's, and boys' and girls' access to health care?[1] • To what extent do user fees or the removal of user fees have more impact on women and girls from marginalized groups, because they not only have less access to cash for other needs such as transport, cost of services that are not available, and other indirect costs?[6]. • How do OOP payments affect men's and women's and boys' and girls' access to health care, for services such as family planning, and cervical and prostate cancer? How are they affected by household arrangements (livelihoods, access to cash, decision-making power, etc.)?[1] • Are guidelines for user fees and waivers available, clear, and known by patients and their caregivers? To what extent are women and girls or other marginalized groups less likely to follow up on financial claims because of less assertive social norms, or a history of government discrimination?[6]	• Percentage of women and men, boys and girls who incur OOP expenditures for RMNCAH-N health services. • Percentage of women and girls who report that they need to seek permission from their husbands/spouses, or other relatives to visit a health facility for RMNCAH-N health services. • Percentage of women and men, girls and boys who are aware of the cost of the various types RMNCAH-N health services. • Percentage of women and men who report that they experience financial difficulties in utilizing RMNCAH-N health services.



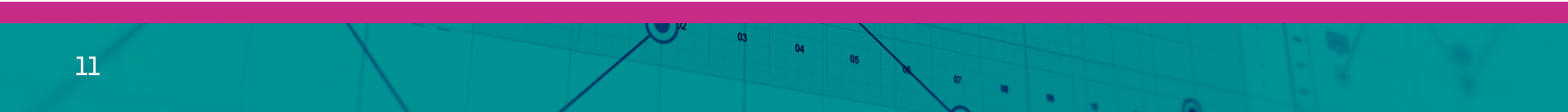
Health financing scheme	Gender implications	Gender-responsive measures	Indicators
User fees Are out-of-pocket (OOP) payments made for services at the point of use [1].		• To what extent are men involved or engaged in health care? Are there systems or mechanisms that encourage men to go to health facilities for services such as family planning[4], or systems where women have the autonomy and support to make their own financial decisions about their own health care? • Are girls, women, boys, or men more or less likely to know about user fee exemptions, cash transfer entitlements, and health insurance benefits?[6] • Are services financed to ensure that women and men, boys and girls are not penalized for inability to pay at the point of service delivery? Research shows that in some settings women and children have been imprisoned and denied medical care because of their inability to pay hospital fees.[2,7]	
Social health insurance A mandatory health care financing for individuals employed in the formal sector[1,8]	• Benefits only a section of the population who have a regular source of income, leaving out those in the informal sector, the unemployed, and those in unpaid work[1,8] • Often allow legally married women and their children only to be covered as dependents on their husband's insurance[8].	• To what extent are services that are needed by different populations (such as contraception, safe abortion, emergency obstetric services, sexuality education, prevention, and treatment for survivors of violence including rape, prevention, and treatment of sexually transmitted infections, etc.) included in health insurance plans? Do insurance packages include reproductive health services exclusively used by women? Do they include services for men's sexual and reproductive health?[6] • Which services are prioritized for funding and how do these reflect different genders' needs?[1]	• Proportion of RMNCAH-N health services covered by health insurance. • Percentage of women and men who incur OOP expenditures for RMNCAH-N health services. • Percentage of women, men, boys, and girls who report using their spouses' or parents' social health insurance as dependents.

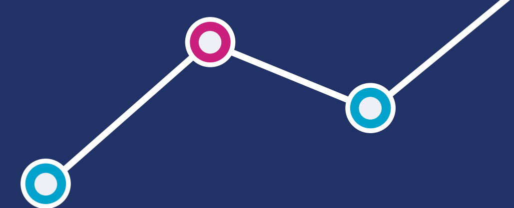


Health financing scheme	Gender implications	Gender-responsive measures	Indicators
Social health insurance A mandatory health care financing for individuals employed in the formal sector[1,8]	• In some countries, husbands are not allowed to be covered under their employed wives' insurance[8]. • One might incur indirect OOP payments because not all routine and essential health services [5,8,10,11]. Such extra payments affect women more because they are likely to have lower incomes than men, yet they have a greater need for health care services.	• To what extent are men involved or engaged in health care? Are there systems or mechanisms that encourage men to go to health facilities for services such as family planning[4], or systems where women have the autonomy and support to make their own financial decisions about their own health care? • What is the extent of financial protection of essential services (by reducing the reliance on OOP payments towards mandatory prepayment mechanisms) for addressing the health of girls and women? Are they affected by OOP payments?[2] • How does the payment method affect men and women's, girls' and boy's access to health care? How are they affected by household arrangements (livelihoods, access to cash, decision-making power etc.)?[1] • Are girls, women, boys, or men more or less likely to know about user fees exemptions, cash transfer entitlements and health insurance benefits?[6]	• Percentage of women and men who report that they require permission from their spouses to be covered as dependents under their spouse's social health insurance.
Voluntary health insurance schemes	Private health insurance (a health financing mechanism where individuals voluntarily choose to purchase health insurance[1,8] • Available to those with a steady flow of income excludes people with low or no income [8]	• How effective are the risk pools in protecting men and women, girls and boys against health shocks (ensuring access and financial protection)?[1] • Are all genders represented on the community health management committees? What is the distribution of men and women in the various roles?	• Percentage of women, men, boys, and girls who report using their spouses' or parents' social health insurance as dependents.

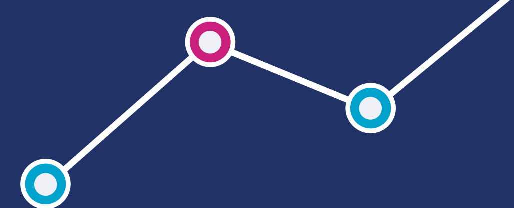


Health financing scheme	Gender implications	Gender-responsive measures	Indicators
Voluntary health insurance schemes	• Women with a greater need for health care tend to pay more because the method is based on calculation of risk[1,8] • The scheme might exclude individuals with pre-existing conditions[1,8] • It may not cover all sexual and reproductive health services[1,8] Community based health insurance (A voluntary scheme that covers those in the informal sector[1,8] • In patriarchal settings - - Women and girls in patriarchal settings might be left out. - Women are likely to occupy managerial positions with minor roles, where decision-making is minimal[8], which can lead to minimal prioritization of women's health needs. - Women are less likely to participate in such schemes because they have low access to or no income[8]	• How is coverage for informal workers in paid domestic service, in seasonal or part-time work, or unpaid home-based caregiving financed?[2,6] • How does the payment method affect men and women's, girls' and boys' access to health care? How are they affected by household arrangements (livelihoods, access to cash, decision-making power etc.)?[1] • Are services financed to ensure that women and girls, men and boys are not penalized for inability to pay at the point of service delivery?[2] • To what extent are services that are needed by only some populations included in health insurance plans prevention and treatment of HIV, prevention, and treatment of reproductive health cancers, GBV counselling etc.? Do insurance packages include services exclusively used by women such as giving birth, abortion, breast feeding, removal of IUD etc.? Do they include services for men's sexual and reproductive health?[6] • To what extent are men involved or engaged in health care? Are there systems or mechanisms that encourage men to go to health facilities for services such as family planning[4], or systems where women have the autonomy and support to make their own financial decisions about their own health care? • Do insurance policies require levels of paperwork and verification that are not possible for marginalized groups?[6]	• Percentage of women and men who report that they require permission from their spouses to be covered as dependents under their spouse's social health insurance. • Proportion of women and girls who report that they require permission and support from their spouses or other relatives to seek RMNCAH-N health care. • Proportion of women who are in key decision-making positions on community health insurance management committees.





Health financing scheme	Gender implications	Gender-responsive measures	Indicators
Voluntary health insurance schemes	• Low participation from community members also leads to a low risk pool which will mostly affect women who have a higher demand for healthcare services[8].		
Cash transfers and vouchers Cash-based interventions where cash or vouchers (for goods and services) are directly offered to poor and vulnerable households to increase the demand for services such as health and education[7,12–14].	• Tend to increase women's caregiving responsibilities [13,15]. • Might perpetuate intimate partner violence as men might feel left out and made to think that they are incapable of managing caregiving responsibilities[13]. • Can negatively affect quality of care and health outcomes through increasing the application of practices that are meant to speed up delivery such as discharging mothers from the labor wards too soon after delivery; routine episiotomies, application of excessive fundal pressure, unnecessary oxytocin injections and unnecessary caesarean sections[7].	• How can cash-based programming enable the empowerment of women and girls in different contexts?[13]. Are there systems or mechanisms to prevent gender-based and intimate partner violence? • To what extent are men involved or engaged in health care? Are there systems or mechanisms that encourage men to go to health facilities for services such as family planning[4], or systems where women have the autonomy and support to make their own financial decisions about their own health care? • How does the payment method affect men's and women's, girls' and boys' access to health care? How are they affected by household arrangements (livelihoods, access to cash, decision-making power, gender stereotypes, etc.)?[1] • To what extent do user fees or the removal of user fees have more impact on women and girls from marginalized groups, because they have less access to cash for other needs such as transport, cost of services that are not available, and other indirect costs?[6]	• Percentage of women and girls with cash transfers and vouchers who report that they require permission from their spouse or other relative to seek RMNCAH-N services at a health facility. • Percentage of women and girls with cash transfers and vouchers who report that they incur OOP expenditures for various RMNCAH-N health services and other non-medical expenses such as transport. • Percentage of women and girls who report that they experience gender-based and intimate partner violence because of having cash transfers and vouchers.



Health financing scheme	Gender implications	Gender-responsive measures	Indicators
Cash transfers and vouchers Cash-based interventions where cash or vouchers (for goods and services) are directly offered to poor and vulnerable households to increase the demand for services such as health and education[7,12–14].	• Pregnant women and mothers may have to travel long distances to reach health facilities where vouchers are accepted[5,15]. • Health facilities where cash transfers and vouchers are accepted might be inconsistently open for service [5,15]. • Associated with indirect which could be unaffordable during emergencies[5,15]. • Health workers tend to prefer to first attend to patients with cash[5], which might increasing waiting times. • Do not address power relations between men and women as women might need to ask for permission and sometimes funds for transport from their husbands to go for healthcare [5,16].		• Percentage of women and girls who report disrespect and mistreatment by health workers because of using vouchers to finance RMNCAH-N health services.

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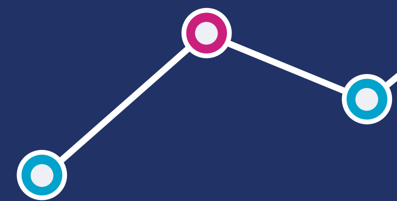

About the MAGE Project

The Monitoring & Action for Gender & Equity project (MAGE) is a partnership between Johns Hopkins University and the Global Financing Facility for Women, Children and Adolescents, a multi-stakeholder partnership housed at the World Bank that is committed to ensuring women, adolescents, and children can survive and thrive. The overall aim of MAGE is to advance and strengthen the capacity and execution of gender-intentional monitoring and evaluation and to support the use of data to improve gender equality and RMNCAH-N outcomes for women, children, and adolescents.

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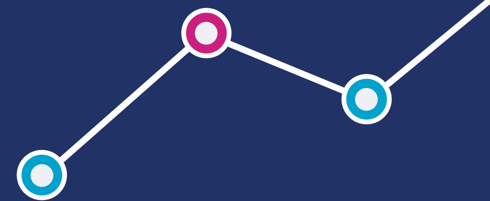

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