

# How is gender addressed in Kenyan policies on access to health services?

To achieve Universal Health Coverage by 2030, efforts will be needed to ensure marginalized groups are identified and reached, and that the barriers they face in accessing services are removed. Particular attention will need to be paid to understanding and addressing the complex gendered dimensions of marginalization and exclusion. The starting point for this is to understand the ways in which women and men are marginalized, the different realities of women and men in marginalized communities, and the effects of gender roles and norms such as those related to labour and masculinity and other factors that affect health such as access to education. However, it must also take into consideration the intersections of different types of exclusion – for instance how women of different age groups are affected.

Health care providers may unintentionally amplify some of the stigma and structural attitudes that lead to marginalization and lack of access to health care for some groups, and may not be equipped to see or address different forms of marginalization. Policies therefore also need to provide for measures to ensure health care providers have the skills needed to serve marginalized groups; and they should also provide for reporting and accountability mechanisms in order to document and redress cases where the health system falls short.

This brief provides a summary of a number of Kenyan health policy documents that have relevance to efforts to reach marginalized populations, in order to assess their gender focus and rank them in accordance with a continuum of approaches to action on gender and health (Figure 1). It suggests measures that can be taken to make these policies more gender equitable.

## Non-Communicable Diseases (NCDs) Policy Brief

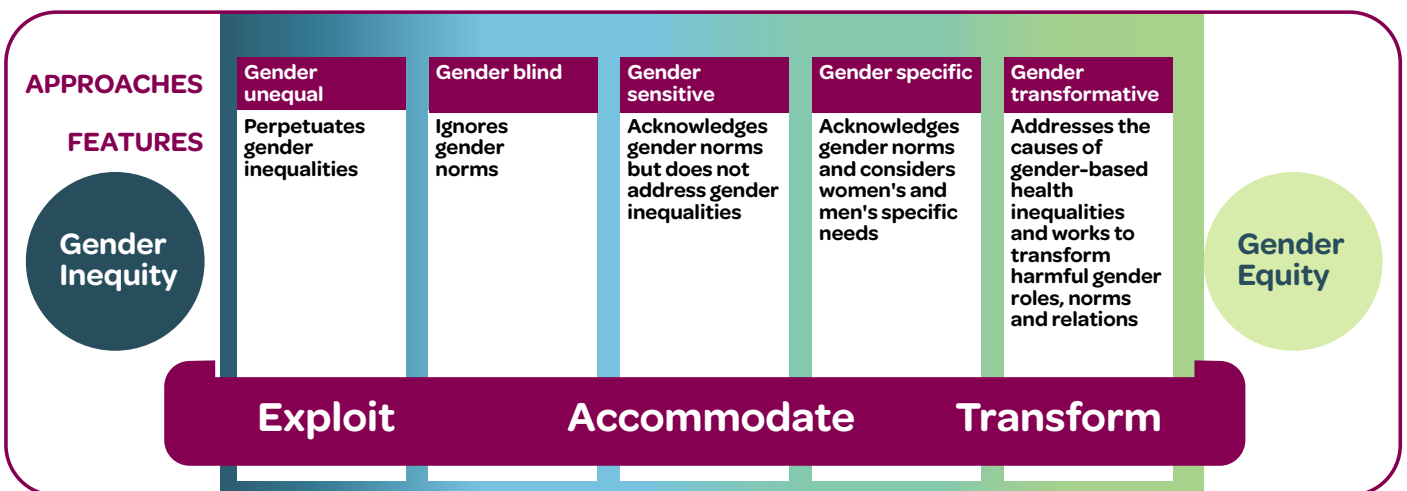
This is a four-page policy brief to assess progress towards achieving national health targets with a focus on NCDs such as cancer, diabetes, and hypertension, as well as risk factors like obesity. Violence and injuries are also discussed. NCDs accounted for over 55 percent of hospital deaths in Kenya while more than 50 percent of all the hospital admissions were due to NCDs, hence the importance of prioritising this area.

Data presented on the different focus areas is not gender disaggregated and there is no discussion on the impact of gender on risk or outcomes. There is also no specific reference to marginalized groups even though some NCDs can be considered symptomatic of marginalization.

On the other hand, gender is highlighted in relation to ability to access/uptake services, one key example being the low uptake of cervical cancer screening overall; uptake rates are shown to be lowest in rural areas (sometimes as low as 0%), which can be considered a proxy for marginalization. Violence and injury data suggests very low reporting of sexual violence and acknowledges this as a failure of attempts to increase reporting and access to care without explicitly naming it as a gender or marginalization issue. Data on women is also presented to show sharp increases in obesity rates.

Recommendations include improvement of systems to better capture NCD data, but make no reference to gender disaggregated data or other factors which would provide data/insight on the increased morbidity of specific individuals or marginalized groups. Similarly, recommendations to strengthen

Figure 1: A continuum of approaches to action on gender and health



Inspired by remarks by Geeta Rao Gupta, PhD, Director International Center for research on Women (ICRW) during her plenary address at the XIIIth International AIDS Conference, Durban, South Africa. July 12, 2000

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NCD interventions at community level lack analysis or guidance as to who, within these communities, interventions should specifically target. Causes of NCDs impacting on women or marginalized groups are not unpacked nor are specific relevant recommendations made.

This brief can be considered gender-sensitive particularly with allowance made for its brevity. It highlights differences in gender data (where available) but makes no reference to underlying gender norms or specific recommendations to address these.

### **Communicable disease policy brief**

This four-page policy brief on communicable diseases is based on desk review of global and Kenya health sector reports. The main concern addressed in this brief relates to funding, specifically given that communicable diseases are heavily reliant on funds from external donors who have signalled their intention to reduce funding to countries like Kenya achieving middle-income status. The brief notes successes in HIV, TB and malaria programming albeit without highlighting specific achievements related to marginalized groups. Some good progress in reaching women in HIV programmes can be assumed given the strong and improving performance of PMTCT efforts. At the same time HIV prevalence among women remains 60%, higher than among men. Geographical variations are noted including very high HIV prevalence in the environs of Lake Victoria, which can be taken as one proxy of marginalization. The brief also highlights increased TB related vulnerability and morbidity among men.

No specific attention is paid to other marginalised groups in the brief. Given some references to gender differences despite its brevity, it can be graded as gender sensitive, however gender and marginalization overall do not come across as primary areas for analysis or action.

### **Kenya mental health policy 2015-2030**

The Kenya Mental Health Policy 2015-2030 provides for a framework on interventions for securing mental health systems reforms in Kenya with an explicit goal 'to attain the highest standard of mental health'. It focuses on measures to ensure mental health services are included in the essential package of services and that the rights of people with "mental disorders" are promoted and respected.

In terms of impacts related to marginalization it recognises that "Homelessness and inappropriate incarceration are far more common among people with mental disorders than for the general population, and having mental disorders exacerbates their marginalization and vulnerability," and acknowledges that people with mental disorders are at greater risk of human rights violations, abuses and harmful treatment – including within health facilities. It notes that they, "often live in vulnerable situations and may be excluded and marginalized from society."

This document emphasises the importance of equity with no discrimination based on gender, age, caste, colour geographical location, culture, and social class in access to services; it also calls for a focus on "inclusiveness, non-discrimination, social accountability, and gender equality." Recognising that some social groups are more vulnerable, it calls for targeted mental health interventions for children and adolescents, women, older persons, prisoners and people emerging from conflicts and disasters. The reference to women is particularly notable as it states that, "The traditional role of women in societies exposes them to greater stresses as well as making them less able to change their stressful environment," and that, "Women's vulnerability to factors such as poverty, sexual and domestic violence, discrimination and conflicts has exposed them to high prevalence of certain mental disorders such as depression and anxiety."

This policy integrates elements of gender-specific approaches and considers the need of developing response for marginalised groups. Albeit that priority actions are high level, the policy does acknowledge need for targeted interventions, and begins to take an intersectional analysis of marginalisation and gender.

### **Kenya Health Sector Strategic and Investment Plan (KHSSP)**

In its analysis of the national health burden, the plan shows that the mortality and morbidity burden in Kenya is driven to a large extent by diseases that are all known to have a strong association with inequality and marginalization. It also highlights some gaps in critical areas of women's health particularly the stagnation of efforts to improve maternal health.

Analyses of specific health problems point to exclusion factors, such as the increase in the burden of injuries and violence felt particularly among young and unemployed people and the prominence of gender-based violence. And even where progress is recorded, the plan acknowledges that it remains slow in some marginalized areas, such as rural areas, slums, and in various at-risk population groups. The role of social determinants on women's health is also acknowledged, for instance low women's literacy in poor regions and high variations in the gender development index scores between regions.

These analyses justify the plan's focus on contextual determinants of health and a stronger equity focus. Identified actions include monitoring of the impact of contextual factors on health and a commitment to equity disaggregated measures, and preferential resource allocation to hard-to-reach areas and vulnerable populations. "Investments are defined to ensure access to services is equitable, irrespective of persons gender, age, caste, color, geographical location and social class."

Given the length and level of detail of this document it can be considered gender specific. However, it is important to note that many of the references to gender are probably better understood as focuses on "women's health" and so do not address or discuss the role of gender norms or gender inequalities in health as much as they might. Moreover, despite the commendable concrete commitments on inequalities; the analysis stops short of being intersectional which would enable us to consider it 'gender transformative' – which it aspires to be.

### **National Hospital Insurance Fund (NHIF) Strategic Plan 2014-18**

The NHIF's 4th strategic plan articulates the urgent need to increase the level of health insurance population coverage with the intention that the majority of poor Kenyans will have access to quality and affordable health care in line with the constitutional commitment to healthcare for all. In emphasising universality it refers to coverage in the informal employment sector (the original NHIF was focused on the formal sector) and the "indigent" population.

Despite the strategic focus on people living in poverty, and removal of out of pocket payments in order to end catastrophic health expenditures, the strategy gives less attention to the need for special actions for marginalized groups, of any type of exclusion other than poverty. It makes no explicit reference to gender, despite literature and evidence showing that health care burdens and costs often fall on and disproportionately affect women. As a result, the Strategic Plan is considered gender blind as well as requiring strengthening in terms of overall recognition of marginalized groups.

Refocusing on quality of care and increasing demand for services; Essential elements in attaining universal health coverage in Kenya

This four-page policy brief focuses on UHC. It highlights an increase in demand for health services attributable in part to increased government focus on provision of free maternity and primary healthcare services but does not refer specifically to whether these improvements are benefiting marginalised groups.

In terms of future efforts towards achieving UHC the brief notes efforts that are relevant for marginalized groups at a strategic level such as health insurance subsidies for the poor, vulnerable, and the old – as well as overall increases to the provision of services. While the brief notes that health care demand is improving it states that, “continued existence of certain cultural and religious beliefs and practices that threaten demand/access for essential health services and reduced coverage for essential health services to needy communities.” The brief also refers to the slum upgrading project addressing social and economic challenges and providing mobile clinics. While these examples are not unpacked further they can be taken to be a reference to forms of marginalisation – albeit with no reference to the role gender may be playing.

Overall recommendations do not pay specific attention to inequalities, gender, and increasing access for marginalised groups. Although the brief makes reference to sex-specific health needs, the brief is ranked as gender blind according to the ranking scheme since it does not adequately consider the role of gender in creating inequality or marginalisation.

## What next?

Despite many efforts to include gender issues in a range of health systems policies the review found limited consideration of marginalization or of its association with gender inequalities and norms in a number of key health policy documents. This may partly be explained by the fact that for the most part, the documents reviewed were general in nature, dealing with multiple health issues or indeed health in general (for instance UHC). It is

likely that disease-specific policies and strategies provide more granular detail on marginalized groups, and possibly on the intersection between gender inequalities, norms and marginalization. Indeed, the one document reviewed that provided detailed focus on one area – the mental health policy – came out strongest in the assessment of gender responsiveness and detail on marginalization. Nonetheless, achieving UHC, by definition, will require a proactive stance on addressing marginalization and gender issues. While these are broadly acknowledged, the overall assumption appears to be that scaling up insurance coverage and services will suffice to ensure everyone is reached. There is limited recognition of the need to understand forms of exclusion and marginalisation, how they intersect with gender factors, and how they impact on health. To the extent gender factors are acknowledged they are largely limited to specific women’s health issues rather than acknowledging how gender inequalities and norms negatively affect health overall.

## Key questions

- In the context of the drive towards UHC, how can analyses of overall health needs and insurance and service coverage identify and address gender marginalized factors, both in terms of how different groups are affected by different health challenges, but also in terms of how gender norms and exclusions determine peoples’ health?
- To what extent are gender and marginalization analyses applicable and relevant to overall health care (e.g. UHC) policies, as opposed to them being a focus in specific sub-areas of health (e.g. disease programmes)?
- How can gender and marginalization analyses inform our understanding of the epidemiological transition? Is the transition affecting some groups more and if so how? How are gender norms and behaviours, and other forms of exclusion, driving the epidemiological transition?

## References

National Hospital Insurance Fund (NHIF) Strategic Plan 2014-18

[http://www.nhif.or.ke/healthinsurance/uploads/strategic\\_plan/Strategic\\_Plan\\_2014-2018.pdf](http://www.nhif.or.ke/healthinsurance/uploads/strategic_plan/Strategic_Plan_2014-2018.pdf)

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Refocusing on quality of care and increasing demand for services; Essential elements in attaining universal health coverage in Kenya

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