FERDI–Equipop Webinar Report

Gender and Health Economics:

Towards Fairer, More Effective Health Systems

Gender equality and gender-responsive approaches are receiving increasing attention in low- and middle-income countries and among national and international development institutions, particularly since the G7 meeting in Montreal in 2018. This also applies to institutions mandated to support the private sector, such as Proparco, a subsidiary of the Agence française de développement (AFD), and the International Finance Corporation (IFC), a member of the World Bank Group.

In many areas, however, progress remains too slow, and deeply concerning situations persist. Health is a clear example of this.

On 8 July 2026, Equipop (equipop.org) and FERDI (ferdi.fr) co-organised a webinar entitled “Gender and Health Economics: Linked Approaches for Better Health”. The event brought together researchers and development practitioners to explore how gender relations shape health inequalities and influence the effectiveness, equity and reach of public health policies.

SPEAKERS

Organised for alumni of the IHEDD–FERDI training programme “Strengthening Health Systems”, the webinar was supported by the Government of the Principality of Monaco and AFD. The speakers were:

- Dominique Pobel, moderator and Equipop’s focal point for health policy and health systems, who has worked on gender issues and sexual and reproductive health for more than twenty years;
- Jacky Mathonnat, Professor Emeritus of Economics at Université Clermont Auvergne, researcher at CERDI, Senior Fellow and Head of the Health, Research and Training Programme at FERDI;
- Aurore Pélissier, Associate Professor of Economics (HDR) at Université Bourgogne Europe and FERDI Fellow;
- Stevie Reine Yaméogo, Burkinabè sociologist, project manager at Equipop and specialist in community dynamics and health democracy;
- Beniel Ulrich Agossou, physician and technical adviser on health systems and sexual and reproductive health and rights (SRHR) at Centre ODAS.

In her introduction, Dominique Pobel, the webinar moderator, stressed that interventions that do not take gender into account “often render some of the needs, practices and barriers experienced by communities invisible, or even overlook certain health conditions and, in every case, underestimate the social determinants of access to care”. She also drew attention to a predominantly biomedical approach that does not adequately account for power dynamics within the health sector and society.

MAIN ISSUES HIGHLIGHTED

Bringing together research and practice, the discussions highlighted the need to mainstream gender analysis across health policies and systems. The aim is not simply to add gender considerations to interventions that have already been designed, but to gain a better understanding of the social and economic determinants of health inequalities in order to develop fairer, more effective and more efficient policies.

SLOW PROGRESS AND PERSISTENT BLIND SPOTS

Health outcomes have improved overall over the past twenty years, including in low- and middle-income countries. Overall, women and girls continue to have lower mortality rates and longer life expectancy. Nevertheless, Jacky Mathonnat drew attention to a worrying slowdown in progress over the past seven to eight years, with some indicators appearing to have plateaued. Major differences persist between countries and cannot be explained solely by their levels of income per capita.

Maternal health illustrates the scale of the remaining challenges. Maternal mortality, which remains a major cause of death among adolescent girls, has declined substantially in low- and middle-income countries, falling to around 200 deaths per 100,000 live births in 2023. Yet this level remains far above the Sustainable Development Goal target of fewer than 70 deaths per 100,000 live births by 2030.

Coverage of births attended by skilled health personnel has increased considerably in many countries over the past twenty years, but substantial disparities remain: for example, 34% in the Democratic Republic of the Congo (DRC), compared with 99% in Burundi and Botswana. These differences do not necessarily reflect differences in GDP per capita measured at purchasing power parity (PPP): in 2024, GDP per capita was around USD 1,500 for the DRC and USD 1,000 for Burundi. Changes in GDP per capita alone cannot explain the progress observed either.

Jacky Mathonnat also discussed the findings of a recent study involving two million women across 61 low- and middle-income countries. Around two-thirds reported facing at least one major barrier to accessing care: financial constraints, distance to services or insufficient autonomy in decision-making. Women who are poor, young, rural, less educated or without health insurance are particularly affected. Thus, even when overall access to care improves, it remains restricted for many women.

Moreover, despite gradual and substantial advances, women remain under-represented among health ministers and in senior positions within health systems, as well as in some specialised international institutions. Jacky Mathonnat also noted that, although significant and sometimes remarkable progress has been made in some countries in combating child marriage and female genital mutilation, major blind spots remain in these areas.

For economists, gender therefore cannot simply be treated as an additional social or individual variable. It is a cross-cutting factor that profoundly influences health needs, demand for care, care pathways, access to services and, in some cases, the quality of care received. Empirical economic analyses of health and health-system reforms increasingly take these factors into account.

Gender analysis is therefore central to efforts to expand and strengthen universal health coverage (UHC). Financial constraints can, however, hinder the integration of gender considerations into UHC. Nevertheless, several studies, including research conducted at FERDI, show that improvements in the organisation and management of health systems and facilities, as well as in certain practices within those systems, could lead to better outcomes without increasing expenditure. These efficiency considerations are essential to integrating gender into health policies: both the resources available and the way they are used must be examined, as well as who actually benefits from them.

FORGOING CARE: INSIGHTS FROM THE CAPABILITIES APPROACH

“We often ask to what extent women forgo care and why, without asking whether seeking that care is genuinely a choice available to them,” Aurore Pélissier stressed. Her contribution shifted the focus from individual decisions to forgo care towards the real opportunities people have to seek it.

She drew on a survey of 760 female and male students at the University of Lomé in Togo. Among respondents, 72% reported forgoing care the last time they needed it, mainly for financial reasons. Although women reported forgoing care less often than men overall, the rate among women exceeded 75% for gynaecological care. Barriers therefore vary considerably depending on the type of care.

To analyse this gap, Aurore Pélissier drew on Amartya Sen’s capabilities approach: “We need to examine real freedoms, not just individual rights. Can people actually choose to access certain types

of care when they need them?" Recognising a right or making a service available does not, in itself, guarantee that everyone has a genuine opportunity to benefit from it.

This perspective has an important methodological implication for health economics. Integrating gender does not simply mean adding a "male/female" variable to a model: it requires recognising that preferences, budget constraints and decision-making power are socially distributed. What appears to be an individual preference may, in reality, be a highly constrained choice. A cost–benefit analysis that neglects these constraints risks underestimating women's specific needs and the benefits of better access to care.

It is also important to quantify the consequences of forgone care. The "missed opportunities" for better health have economic effects, particularly on productivity, as well as effects outside the market: on children, household organisation and unpaid work. These indirect effects and externalities may be inadequately measured.

From a public policy perspective, Aurore Pélissier also challenged the perceived trade-off between effectiveness and equity: "A policy that ignores the specific constraints faced by part of the population will simply be less effective." The aim is not to create a separate branch of health economics "for women", but to develop an approach capable of describing actual behaviours and the conditions under which decisions are made more accurately.

TRANSFORMING HEALTH SERVICES THROUGH FEMINIST APPROACHES TO PARTICIPATORY HEALTH GOVERNANCE

The projects presented by Stevie Reine Yaméogo showed that barriers to accessing care are not only material: they are also social and institutional. Drawing on the SANSAS project in Senegal and the Jeunes en Vigie project in Burkina Faso and Senegal, she described how adolescent girls can face considerable social stigma, judgemental attitudes among health workers and a lack of confidentiality.

To address these barriers, Equipop applies feminist approaches to participatory health governance, including participatory social audits conducted by young people themselves. As Stevie Reine Yaméogo explained: "Beyond financial barriers, adolescent girls often avoid seeking care for fear of judgemental attitudes among health workers or breaches of confidentiality. Social audits empower these girls: by assessing how they are received at health facilities, they cease to be passive service users and become agents of change who can negotiate adaptations to services."

These participatory community assessments can help transform services and, more broadly, health systems. In particular, they can:

- highlight issues overlooked or inadequately addressed by conventional approaches, such as challenges relating to menstrual health or the extent of gynaecological and obstetric violence;
- adapt services to the needs expressed, particularly regarding opening hours, confidentiality and how patients are received;
- reshape power relations between health workers and people receiving care;
- strengthen adolescent girls' agency by enabling them to articulate their needs, voice their concerns and participate in decisions about their health.

These participatory, community-based approaches have received positive external evaluations and have been documented in academic publications.

Beniel Ulrich Agossou also pointed out that efforts to integrate gender considerations still face considerable political and technical resistance. Disaggregating data by sex is necessary but does not, in itself, capture power relations. Moreover, many decision-makers, even when convinced of the importance of the issue, lack practical tools to turn their commitments into concrete measures and gender-responsive budget allocations.

GENDER ANALYSIS AND HEALTH ECONOMICS: COMPLEMENTARY APPROACHES

The webinar highlighted the importance of closer links between gender analysis and health economics, while acknowledging the progress already being made in this area.

Gender analysis helps us understand how social norms, inequalities and power relations influence exposure to risks, how needs are expressed and the actual use of healthcare services. Health economics provides tools for analysing the determinants of health and demand for care, resource allocation, financial incentives, costs, and the effectiveness and efficiency of interventions.

Together, these approaches can show how more equitable health systems can also be more effective and efficient. Removing barriers to healthcare for women and young people can help make better use of public resources and avoid substantial long-term health and social costs. This is particularly important as most countries face significant financial constraints. It calls for a rigorous assessment of how more equitable policies can improve outcomes with the resources available.

FURTHER READING

- Equipop (2024). “En route vers la démocratie en santé féministe: Participation significative et inclusive des jeunes pour une redevabilité effective en santé”. *Practical guide for action*.
- Guttmacher Institute. “Adding It Up: A simulator for measuring the benefits of investments in contraception and reproductive health”.
- Memmi Machado, S., et al. (2025). “La démocratie en santé: adopter une approche féministe pour lutter contre les oppressions sociales”. *Revue Santé Publique*, no. 1, pp. 37–41.
- Pélissier, A., Alowou, A. P., & Atake, E. H. (2024). Use of gynaecological care by young women in Togo: focus on students and analysis of the determinants at the University of Lomé. *Public Health*, 233, 190–192.