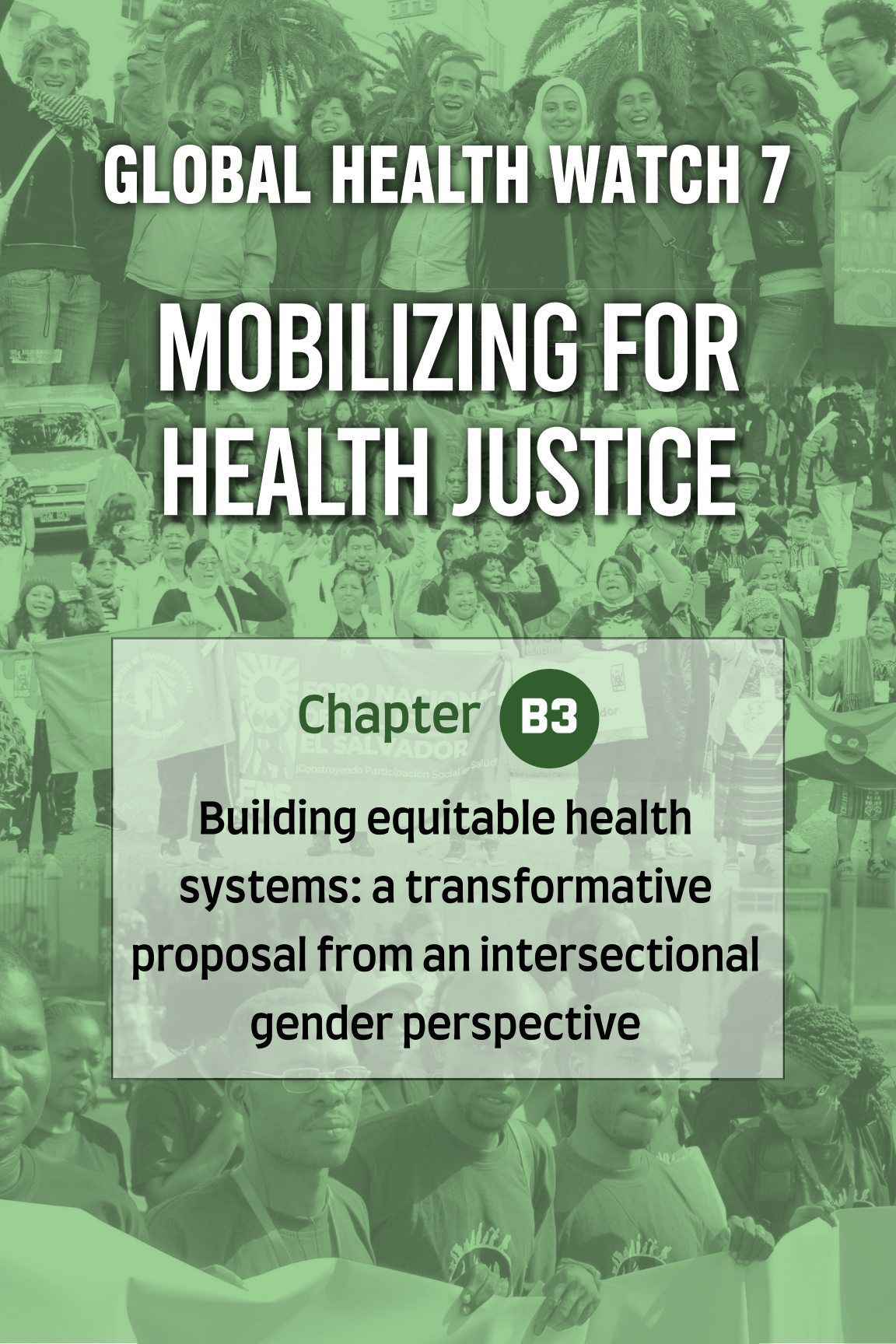

GLOBAL HEALTH WATCH 7

MOBILIZING FOR HEALTH JUSTICE

Chapter B3

Building equitable health systems: a transformative proposal from an intersectional gender perspective

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Introduction

Gender transformative approaches refer to practices, interventions or policies that aim not only to address gender inequalities but to actively challenge and change the underlying structures, norms and power relations that perpetuate gender-based discrimination. Such an approach goes beyond simply providing equal opportunities or improving access to resources and services for all individuals. It involves reshaping societal structures and behaviors that create or sustain inequities rooted in power dynamics and social norms. In that sense, gender-transformative public services refer to services that are intentionally designed and delivered to challenge and transform unequal norms, roles and power dynamics rooted in societal structure.

The idea of gender transformative health services was developed in response to the recognition that health systems and services often perpetuate inequalities, particularly in areas such as reproductive health, sexual rights and maternal care; and that this must change. Although the gender transformative concept has been adopted by mainstream development institutions that do not necessarily promote strengthening of public services, such as the World Bank and UN Women, its roots lie in feminist theory, gender equality and intersectionality frameworks that aim to challenge power relations in society.

Adopting a gender transformative approach to assess the social impacts of health systems with a more holistic gender lens, this chapter presents three case studies from the Global South, one each from Africa (Nigeria), Asia (India) and Latin America (Paraguay). The case studies focus on the health system response to gender-based violence and reproductive health needs with a critical eye on the power relations at play. The extended case studies were originally published in 2023 by Public Services International a global federation that joins under its umbrella unions of healthcare workers, as part of an effort to understand how the concept of gender transformative health services can help in advocating for stronger quality public healthcare.[1]

This chapter aims to continue this effort by looking jointly at the three cases and extracting lessons and proposals for strengthening public health services.*

*The case studies primarily concerned affected cisgender women in health systems. However, the focus of this chapter understands exclusions and discrimination to be intersectional in nature. Therefore, the conclusions on gender transformative health systems consider women in all their diversity: cisgender, transgender and non-binary, as well as recognizing that exclusions also affect (in a similar way and with their particularities) LGTBQIA+ populations.

Figure 1: Rally supporting abortion rights at the 5th People's Health Assembly (Mar del Plata, Argentina, 2024)

People's Health Movement

Evidence from the Global South

Health system response to survivors of violence in Paraguay

Paraguay is a small, South American country with a population of approximately 6.3 million inhabitants and a democratic political system that has faced significant challenges in terms of stability and governance. These challenges have resulted in a fragile institutional framework and an inefficient bureaucracy. The population suffers the consequences of public institutions with little capacity to meet the needs of the population, lack of resources, corruption and political clientelism.

The national budget has historically reflected these difficulties, since governments (except for the 2008-2012 government of President Fernando Lugo, who was deposed by a coup d'état) have limited social spending and give priority to macroeconomic conditions favoring the entry of transnational capital and the accumulation of capital by national companies in export sectors, mainly livestock and soybean. The tax system has been sustained at the lowest rate in the entire region, affecting the ability of the governments in office to ensure quality public services.

In the area of health, Paraguay faces serious problems of access and quality. Although the health budget has increased in recent years, reaching an average public investment of 4 per cent of GDP, it is still insufficient to meet the needs of a dispersed and sometimes remotely located population, and is lower than WHO / PAHO recommendations for a minimum of 6 per cent of GDP.[2] Health

Box B3.1: What does a gender transformative approach to health systems mean?

Definitions of gender policies and gender mainstreaming vary between countries, but the possible goal is the same: to eliminate gender inequality. It is useful to develop definitions of what a gender approach to health systems means, such as distinction between policies that are gender blind, gender sensitive and gender transformative, as this creates a gradual continuum, a possible pathway for health systems to achieve a gender transformative approach.

- "Gender blind" health policies are those that do not consider gender-based inequalities and their effects on health. Gender blind policies forget or ignore the gender norms at play. Therefore, they fail to see and address gendered power relations and their effects on health.
- "Gender sensitive" health policies recognize the role of gender norms in their relationship to health, but do not question or challenge the power structures that underpin them. They fail to incorporate actions that address the deeper connections between gendered social norms, inequalities and health.
- "Gender transformative" health policies challenge the hierarchy of power that underpins gender inequalities, the consequences of which affect women's access to and maintenance of comprehensive health, and discrimination that negatively impacts their health status and outcomes. They involve the creation of systemic actions which address patriarchal structures within health systems, public policies and society at large. In addition, gender transformative health policies promote accountability of the relationship between individuals and public institutions, with the aim of providing comprehensive and equitable health services that challenge the legislative and cultural norms that sustain inequality, rather than conforming to and confirming them.

system underfunding forces people to pay for their health with an out-of-pocket expenditure of around 38 per cent of the total investment in health, which places Paraguay as one of the countries with the highest out-of-pocket expenditure per capita in the region.[3] Disparities in health infrastructure between urban and rural areas are notorious. The Primary Health Care (PHC) strategy, with a population coverage of less than 30 per cent, is concentrated in rural areas with health facilities that do not have sufficient conditions to solve the health problems of the population, while the best equipped hospitals and health centers are mainly located in the capital, Asuncion, and in a few other nearby cities. The lack of medical specialists, combined with the low responsiveness of referral and referral systems, imposes significant barriers to health care access. In addition, the availability and cost of medicines are a constant challenge, disproportionately affecting the most vulnerable sectors of the population, particularly women, who require greater access due to conditions related to their sexual and reproductive health.

In this context, Paraguay has implemented an inter-institutional policy of prevention and care for women affected by gender-based violence (GBV), where the public health system, through sexual and reproductive health services, plays a fundamental role as a gateway. According to the last national survey conducted in 2021, eight out of ten Paraguayan women have suffered some type of violence throughout their lives, and 60.9 per cent have been victims of sexual violence, with 77 per cent of them being young women between 18 and 29 years of age.

The mandate of public health services includes comprehensive protection of sexual and reproductive rights (SRHR), based on international treaties ratified by the country. Within this international human rights framework and other national regulations such as the law against all forms of violence against women (No. 5777/2016), the sexual and reproductive health policy established a protocol for health system care of victims of sexual violence. The protocol defines key concepts such as gender, violence and types of violence; and identifies a wide range of conditions, risk factors and mandatory guidelines that health professionals must follow in the care process. It also explicitly points out the processes and actions within the health services themselves that can victimize and re-victimize women, so that the necessary measures are taken to guarantee the protection of their rights during bio-psycho-social interventions and to ensure the organic, coherent and effective functioning of the system.

A case study conducted by PSI published in 2023 detailing the therapeutic journey of a woman victim of violence who had suffered a sexual assault, revealed that GBV policies, even when designed with a gender sensitive approach, can still have pernicious effects on women.[4] When a woman victim of GBV arrives at public health services at the first level of care, this level is unable to provide an adequate approach and is limited to referring victims to hospitals at higher levels that are usually located at a greater distance. When women arrive at these hospitals, the quality of care is seriously affected by the lack of adequate resources, such as the lack of prophylactic drugs or mental health professionals. This is compounded by insufficient training and sensitization of medical professionals and other hospital staff. Despite the existence of regulations and training processes, many of these professionals do not adjust their attention to the specific needs of the victims or to their vulnerable conditions (such as impoverishment, lack of knowledge or lack of family support). In addition, they reproduce patriarchal stereotypes that re-victimize women, subjecting them to comments that hold them responsible for the aggressions they have received or cast doubt on their stories when they are reluctant to file a formal complaint. This sometimes leads to the victims not having timely access to the necessary medical care to prevent sexually transmitted infections and unwanted pregnancies, and they are not properly referred to other social support institutions that can accompany them.

The intervention of feminist organizations in the health system has been, in many cases, crucial for the victims to receive the necessary care. However, this

care does not always follow established protocols and does not always guarantee comprehensive protection against GBV. Barriers, both visible and invisible, in public health services create a notable disconnect between gender sensitive sexual and reproductive health normative policies and their effective implementation.

Health system response to survivors of gender-based violence in India

The women's movement in India has played a significant role in highlighting the issues of gender-based violence (GBV) and discrimination. This has led to increased awareness and advocacy, resulting in greater mobilization and legal reforms. Despite the global prevalence of GBV, the issue is often overlooked in public health discussions and systemic responses. There is a need to address this gap to improve reporting, intervention mechanisms, and multi-sectoral coordination within healthcare systems. A gender transformative approach is necessary to address the systemic gaps and ensure comprehensive healthcare for women, girls, and gender non-binary individuals.

Despite clear policies in India mandating the health system's role in addressing GBV, there are challenges in implementation and gaps in the systemic response. An analysis employing a gender-intersectionality framework has highlighted these challenges and identified existing gaps for our understanding. While there have been efforts to examine how factors such as race, caste, class, religion, sexuality, disability, age and work intersect to exacerbate vulnerabilities to violence, the healthcare system has yet to fully integrate these insights. It is crucial to emphasize that, despite this understanding, barriers persist for survivors seeking healthcare and justice, underscoring the need for further implementation of intersectional analyses, particularly within health policies and systems. The existing legal and policy frameworks in India, along with national guidelines and protocols, highlight the role of healthcare providers in responding to sexual violence and domestic violence. However, there is a need for better implementation and adherence to these guidelines to ensure effective support for survivors of GBV.

The health system in India currently prioritizes "medico-legal compliance" over comprehensive care for survivors of GBV. While there are some improvements in select health facilities, overall policies and practices lack the necessary comprehensiveness. For instance, certain forms of violence, such as marital rape, are often overlooked because they do not fit neatly within legal definitions. Even without a criminal charge or acknowledgment of an offence, the healthcare needs and traumas faced by survivors remain significant. Just because a survivor of sexual assault within a marital relationship cannot pursue a criminal case against their perpetrator (husband), it does not mean they should be denied care and support to address the health impacts of that assault. Although the Supreme Court of India has recognized the healthcare needs of marital rape survivors, the health system continues to demonstrate bias and ignorance in its practices.[5] This oversight leads to significant gaps in healthcare for survivors.

Moreover, the focus on medico-legal aspects places disproportionate emphasis on identifying physical injuries and collecting forensic evidence. This is problematic as it neglects other critical dimensions of violence, including emotional, psychological and economic abuse. Additionally, the realities faced by survivors—such as delayed reporting due to societal stigma, victim-blaming and a general lack of awareness about available systems and provisions—are often overlooked. The current discourse on GBV responses tends to overly rely on criminalization and medicalization as primary solutions. Consequently, survivors encounter systemic gaps during their interactions with the health system impacting their health and human rights. There is a pressing need for strengthened public health services that are sensitive to the complexities of GBV and can address the significant challenges faced by women, girls and gender non-binary individuals, as a first step towards gender transformative services.

It is important to emphasize that the health system is ideally positioned to take on a much larger role in addressing stigma and the normalization of violence. This can be achieved through a proactive approach aimed at adopting gender transformative public health services that not only respond to the needs of individual survivors, but that also contribute to building public awareness that challenges stigma and the normalization of violence. By doing so, the health system can establish a violence prevention response as a fundamental aspect of primary healthcare.

The recent incident of sexual violence and killing of a young woman doctor in the Indian city of Kolkata* has reiterated discussions about the 2013 POSH Act—Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal). The incident raises an important question: why, after nearly a decade, do we still need to demand that this law be effectively implemented in the healthcare sector across the country? While the current protests have primarily focused on demanding punishment for the offenders, many young women doctors and others are also calling for a re-examination of the system itself while demanding justice and better security and facilities at medical campuses and hospitals.[6]

The COVID-19 pandemic related lockdown in India was also a significant testament to these ground realities. The lockdown exacerbated challenges for GBV survivors, as many had become isolated with their abusers. With limited access to support services, transportation and social spaces, individuals seeking help faced significant barriers. This situation had reportedly led to an increase in violence and adverse health impacts requiring comprehensive healthcare services, including emergency care, medico-legal assistance, psychological counseling and sexual and reproductive health services, all of which were disrupted during the lockdown.[7]

An intersectional understanding of GBV and health system responses underscores the need for a comprehensive approach to women's health. Normalizing GBV can lead to underreporting and silencing, thus advocating for a zero-

*The incident took place in August 2024 at the hospital where the trainee doctor worked.

tolerance approach becomes essential. This still prevalent silence often aligns with societal norms of stigmas and patriarchal control surrounding women's sexuality and reproduction. GBV is strongly associated with adverse sexual and reproductive health (SRH) outcomes. While emphasizing reproductive choices and autonomy, it is crucial to recognize that a woman's reproductive and sexual health is shaped not only by individual and notional choices, but also by various factors within her life-cycle experiences, family and community. The debilitating impact of violence and the empowering influence of health should be considered together. The focus should be on providing opportunities through health education, supportive laws and guaranteed access to quality healthcare for everyone. In essence, GBV interventions should not be limited to addressing violence alone, but should also aim to enhance knowledge, capacities and equal opportunities for marginalized identities to improve their SRH and overall health outcomes.

Adopting a gender-transformative approach in public health allows for the examination of long-standing and historically significant issues that are often overlooked in public health and rights analysis and advocacy.

Reproductive health services in Nigeria

Nigeria is the most populous African nation with, as of 2023, a population of close to 228 million people. In 2024, it ranked 125th out of 146 countries on the Global Gender Gap Index published by the World Economic Forum (WEF).[8] This low ranking reflects widespread barriers to women's rights, gender stereotypes and socio-cultural norms that negatively impact women in many areas, including in the provision of, access to, and uptake of quality care, especially maternal and reproductive healthcare services such as family planning, antenatal care and contraceptive use.

Women in Nigeria face serious health impacts from a lack of access to adequate reproductive health services. While nearly 100 per cent of global maternal deaths occur in countries of the Global South, more than half of these deaths occur in sub-Saharan Africa with Nigeria accounting for nearly 20 per cent of all global maternal deaths. Nigeria's maternal mortality rate is among the highest in the world.[9] Unsafe abortion has been shown to be a leading cause of maternal mortality, to which unmet needs for contraception contribute.[10] Access to modern contraceptives among women of reproductive age is low, estimated to be between 12 per cent and 20 per cent and there is a high prevalence of unintended pregnancies.[11]

Compared with countries with similar income, the country's health outcomes are poor, with drastic differences between wealthy and poor, urban and rural populations and different regions.[12] The system is grossly underfunded and relies heavily on out-of-pocket expenditure, leaving the population with the ever-present risk of catastrophic expenditures.* Primary health care constitutes 88 per cent of health facilities in the country[13] but are worse affected by this underfunding

* In 2021, Nigeria's health expenditure was 4% of its GDP, much below the recommended 15%, out of which out-of-pocket health expenditure accounts for about 77%.

due to the decentralization of their management to local government authorities, the weakest governing structures in the country.[14] These limitations play out in accessing reproductive healthcare services too.

Despite laws, policies and legal frameworks to promote women's health and reproductive rights, gaps in implementation add to the weakness of the health system and combined with gender inequalities and low levels of reliable health care data, lead to poor access to reproductive health services.[15] Regressive laws, such as restrictive abortion laws, present an additional barrier to accessing reproductive health services. According to Nigerian law abortion is illegal except when pregnancy threatens the life of the mother, though some states, such as Ogun State, permit abortion for victims of rape and incest. The penalization of the health practitioner's role in performing abortion is a strong deterrent.

Public services are social equalizers as they play a fundamental role in power and resource redistribution. In applying the core principles of equality and equity they can significantly contribute to social transformative change. The design of key sexual and reproductive healthcare programs in Lagos State has the potential to progress towards gender transformative approaches. In the face of restrictive abortion laws, prohibitive costs, poor access to safe health services and intense social stigma that prevent women from accessing safe and legal abortion, efforts towards reforms that liberalize abortion clubbed with progressive health policies provide steps towards improving reproductive health services. The Lagos State House of Assembly amendment of its Criminal Code to the Criminal Law of Lagos State 2011 expanded the lawful grounds for which abortion can be carried out: preservation of a mother's life and preservation of a woman's physical health (Section 201). To this, Guidelines were added in 2022 that provide a guide to standardize and build capacity for medical practitioners to save lives of women whose pregnancy continuation is a danger to their lives and physical health. Both are the result of concerted efforts by women's rights advocates.*

However, the strong social stigma that women's rights face manifested in religious groups pressuring the Lagos State government to revoke the guidelines, which were suspended just a month after they were unveiled. A strong social movement led to actions such as petitions and press conferences expressing concerns over the suspension of the abortion guideline. On 23 August 2023, over 800 people marched to the Government House to pressure the Governor of Lagos State, Babajide Sanwo-Olu, to lift the suspension on the guidelines.[16] More than two years later, intense pressure is still on to reinstate them.†

The path towards gender transformative health systems also requires strengthening the health system itself, in quality, accessibility and universality. Approximately 60 to 70 per cent of women in Nigeria are financially dependent[17]

* Such as Women Advocates Research and Documentation Centre (WARDC) – https://bit.ly/3GwqVRY

† On 8 March 2024, 150 organizations urged the government of Lagos to reinstate the suspended guidelines on safe termination of pregnancy. See https://bit.ly/3Sb21K9

which means that women's ability to exercise autonomy in making decisions about their maternal and reproductive health is dependent on the approval and financial support from their family before accessing care. Prioritizing maternal healthcare is also made difficult due to the system of power imbalance that allows men to control women's mobility. Availability of geographically accessible and free services are important elements too.

Finally, in Nigeria and across the world, deep seated gender inequalities and restrictive norms were exacerbated because of the pandemic, leading to a surge in GBV[18] intimate partner violence and disruption to healthcare services, widening the gap in access to health services and resources among women.[19]

Key findings from country experiences

Definitions of gender policies and gender mainstreaming vary between countries, but the possible goal is the same: to eliminate gender inequality. It is useful to develop definitions of what a what a gender approach to health systems means, such as distinguishing between policies that are gender blind, gender sensitive or gender transformative (see Box B3.1), as this creates a gradual continuum, a possible pathway for health systems to achieve a gender transformative approach. This can be a useful tool for assessing public policies and thinking about the steps to take to reach our goal.

The public health system as women's entry point to the protection system. The public health system is the main gateway for women to access institutional responses to sexual and reproductive health and gender-based violence. However, the underfunding of public health services in all three case study countries means that all have gaps in their capacity to respond to these needs. Health professionals have a social responsibility to their communities, but they may also bring their own biases into the health system. This is where policies and guidelines become crucial to ensure that service delivery is based on the principles of human rights and equality. Conversely, the lack of adequate response and denial of services by the health system leads to further victimization of victims, as demonstrated in all three countries.

Changing laws is not enough, but it is a first step. There are systematic gaps between written (normative) guidelines and their implementation in practice, reflecting the invisible barriers created by the social constructions of patriarchy and other hierarchies. The role of social movements, especially the women's movement and community movements, becomes central in changing the status quo based on exclusion and inequality. These interventions have led to changes at different levels, from shifting the focus from one step to another (India) to improving access to services at the local level (Paraguay) or even to holding public institutions accountable (Nigeria).

Proposals towards gender transformative health services

What can public health services do to become gender transformative?

Based on the case studies and research and experiences from many other countries, there are several goals to which gender-transformative health policies and practices must aspire:

1. Promote women's autonomy and decision-making capacity

According to UNFPA data, only 55 per cent of women can make decisions about their sexual and reproductive health. Gender transformative public health services are those that create the conditions for women to be able to make autonomous decisions about their lives and their bodies, without patriarchal or sexist barriers. The goal is for 100 per cent of women to have access to quality sexual and reproductive health services.

2. Prevention and elimination of GBV

The UN Global Data Base on Violence against Women estimates that over 30 per cent of women worldwide suffer physical or sexual violence at least once in their life.[20] Gender transformative health services identify the different forms of violence that affect women, take care of their health when they enter the services, guarantee good treatment and avoid re-victimization. They take a leading role in primary prevention, care and rehabilitation. They guarantee effective measures and reduce the statistics of violence through effective prevention measures and victim support.

3. Equitable access to sexual and reproductive health resources and services

Sexual health problems account for 20 per cent of the global burden of women's ill health. A transformative health policy ensures equitable access to contraceptive methods and reproductive health services. Regardless of intersectionality of gender, class, ethnicity or place of residence, access is universal and territorialized. Services are tailored to local needs, and barriers to access are removed.

4. Reconceptualizing quality of care as an enforceable right

The protection of women's rights is still a global debt. Significant differences exist within countries, but also between countries. Gender transformative policies need to redefine the quality of health services as an enforceable right, ensuring that they are technically adequate, humanized and empathetic.

5. Contributing to empowerment and emancipation

Patriarchy, macho relations and a state that reproduces power relations based on gender inequality perpetuate processes of tutelary empowerment, where women have access to certain rights as long as they do not undermine the patriarchal system. A transformative gender health policy contributes to non-protected empowerment. It creates conditions for the emancipation of women, recognizing them as full and equal citizens, capable of defining their life projects and their own relations with the state.

How can health services become gender transformers?

There are several ways in which health services can contribute to addressing gender inequalities, within their own care provisions but also more generally across public and private institutions.

1. Build a social alliance

In a stable alliance between the public health system, women, social movements and organizations are and must become promoters of social change for a gender-equal structure.

2. Strengthen the primary health care strategy

It is necessary to build health systems with solid structures in the territories, based on strengthened primary health care (PHC) and aligned with the Alma Ata principles, emphasizing the importance of integrated health care. These systems must be transformative, since in contexts where inequality, violence and life projects truncated by gender injustices persist, it is not possible to achieve integrated health.

The infrastructure available to PHC health systems is insufficient and, in many systems, do not have the conditions to attend to women, much less to generate spaces for collective health promotion, which is why it is essential to provide the system with the necessary infrastructure.

On this path, health teams within PHC play a fundamental role due to the trust they have gained within the community and can promote and lead meeting spaces with organized women and/or contribute to their organization, accompanying the processes of women's empowerment over their bodies and territories. Similarly, the creation of spaces made up of men will contribute to the empowerment of their bodies and the deconstruction of violent masculinities, as well as to knowledge about women's bodies, their rights and respect for their autonomy.

3. Reconceptualize the quality of health systems with social participation

The reconceptualization of the concept of quality in public health systems and their policies requires the active participation of women and people of diversity. States are called upon to design mechanisms for effective participation, where quality translates into enforceable rights, helping to reduce inequality and ensuring that the needs and experiences of this population are considered for continuous improvement.

4. Systematically apply an intersectional approach to policy design, implementation and evaluation

Health policies can only achieve their objectives if they are implemented from an intersectional approach. Women are diverse and policies need to recognize this rich diversity of experiences and needs, and take into account factors such as class, ethnicity, sexual orientation and territory in order to provide appropriate and differentiated health responses.

5. Provide ongoing training for health workers

Eliminating patriarchal structures and building systems that transform gender inequality implies a major effort that includes the re-education of health professionals in quality care, respect for women's rights and gender equality, as well as the development of internal policies that sanction machista practices that reproduce violence within the systems, along with policies that promote and reinforce these changes. Staff training policies must be continuous, not sporadic or intermittent, to avoid the loss of skills in the systems due to turnover and mobility of health personnel.

6. Proactively promote inter-institutional alliances from the health system.

Health systems must be proactive in generating inter-institutional and intersectoral alliances, although the leadership of the actions can often be other institutions, as in the case of the interaction of the public health system with the educational sector. This intersectoral alliance aims to strengthen education in equality and human rights, with special emphasis on integral sexual education that can contribute to improved erotic, sexual-affective and family relationships, and to the construction of less violent societies.

Likewise, social organizations and the health system know the territories and their problems, while institutions such as the police, public prosecutor's office, ministries of women, family, social affairs, etc. have the conditions to contribute to the prevention and guarantee of justice in the face of gender violence. The design of intersectoral and inter-institutional policies led and / or promoted by transformative health systems, respectful of women's rights and diversity, accompanied in the territory by social organizations, can positively influence the work of other institutions. These synergies can contribute to removing the machista structures of these institutions and undermine the patriarchal structures of the state, sowing the seeds for institutions to design and promote gender-transformative policies.

Conclusion

Gender transformative public health services represent a historic opportunity to reshape social structures that perpetuate inequality and discrimination. Through these case studies from Nigeria, India and Paraguay, it is evident that although health systems face structural challenges, such as lack of funding, persistent patriarchal norms and the gap between policy and implementation, there are significant advances that demonstrate the viability of this approach. Gender transformation in health is not just about ensuring equitable access to services; it involves dismantling the power dynamics that marginalize women and other non-binary identities, and reframing quality of care as an enforceable right.

One of the central conclusions is that women's autonomy in making decisions about their sexual and reproductive health must be a fundamental pillar of any transformative policy. However, this cannot be achieved without a strong

alliance between health systems, social movements and communities. The active participation of these actors is crucial to ensure that policies are not only gender-sensitive but also challenge the social norms that perpetuate violence and exclusion and become gender transformative.

In addition, ongoing training of health workers in intersectional approaches and human rights is essential to avoid re-victimization and to ensure empathetic and quality care. The cases analyzed show that, even in resource-limited contexts, training and sensitization can make a significant difference to the experience of people affected by intersectional discrimination.

Gender transformative health systems cannot therefore operate in isolation. They require inter-agency and inter-sectoral partnerships that address multiple dimensions of inequality, from education to justice. The experience of Nigeria, where social mobilization achieved progress in liberalizing abortion, and Paraguay, where feminist organizations have been key in caring for victims of violence, underline the importance of civil society as a driver of change.

Finally, gender transformation in the health system is not only a possible goal, but an ethical and political obligation. States have the responsibility to lead this process, but its success will depend on their ability to integrate all social actors in a collective effort to build health systems that not only heal but also empower and emancipate. The road ahead is complex, but the progress made in various contexts shows that, with political will and social commitment, it is possible to move towards truly transformative public health.

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