RACS Global Health Gender Learning Paper

Gender influences the experience of health care, affecting affordability, access to and use of services, and interactions with healthcare providers. Gender impacts admission to training opportunities, remuneration and development across the healthcare workforce. Globally, most health workers are women, yet they are disproportionately concentrated in lower-earning health care roles. Women are under-represented in senior health administration and across health leadership. Gender also intersects with other axes of inequity to shape experiences of health and health-seeking within households, communities and health systems. RACS Global Health's programming approach is built on the UN Sustainable Development Goals' acknowledgement that equality between women and men, girls, and boys, is not only a human rights issue but a precondition for equitable health and surgical outcomes.

The Royal Australasian College of Surgeons (RACS) envisions a world where *'safe surgical and anaesthetic care is available and accessible to everyone'*. Our theory of change supposes that by improving patient access, building capacity, strengthening health systems and advocating for sustainable action in global health we can bring about lasting change to improve access to surgical and anaesthesia care in the Asia-Pacific region.

RACS Gender Equality Policy provides a framework for defining and promoting gender equality and women's empowerment in our Global Health programs. Inclusive development practice should support the empowerment of women and girls, reduce gender disparities, and not in result in unintended negative consequences.

RACS Global Health has identified the following pathways that are critical to increasing access to quality health and surgical care. They are:

Domain of Change 1: Improve access to surgery and other health services by supporting the delivery of vital health services that contribute to improved access, inclusion, and agency.

Domain of Change 2: Develop the capacity of the health workforce by supporting clinical and surgical training, mentorship, education, and essential equipment.

Domain of Change 3: Strengthen health systems by working with services and decision-makers to improve service coordination, support workforce planning, priority setting, and investment.

Domain of Change 4: Advocacy for sustainable surgical and health care by building partnerships for action at global, regional, and national levels.

With reference to these Domains of Change, our work in gender centres around four objectives. To:

1. Close the gender gap in access to surgical care
2. Train, support and empower women clinicians, surgeons, and health leaders
3. Support the ongoing development of inclusive health services, and
4. Advocate for the rights and needs of women and girls across the global surgery agenda

Purpose of learning paper

As a step toward understanding and addressing these four objectives, RACS Global Health has undertaken a gender analysis of literature and key indicators. The intent of the review is to understand the differential needs, opportunities and rights that affect men, women, girls, and boys and how these affect access across each of RACS Global Health's Domains of Change.

About this paper

This paper is divided into four parts:

Part 1: *Potential barriers* reviews evidence related to accessing health care for women and girls and how RACS can better support the particular needs and vulnerabilities of women and girls as patients and clinical service users.

Part 2: *Access to education* looks at how women healthcare workers are affected by socio-cultural and financial barriers. There is a need to provide support and enable access to female mentors. RACS can better support the particular needs and barriers women surgeons face in service and educational settings through its programming. Options explored include training, support networks, scholarships, and efforts to develop and expand the scope of surgery-adjacent services (such as post-operative nursing and anaesthesia).

Part 3: *Gender inclusive decision-making* looks at why health systems strengthening is more effective when decision-makers incorporate gender considerations to inform more strategic, effective and equitable health systems interventions, programmes and policies.

Part 4: *Advocacy approaches* looks at effective advocacy approaches that aim to integrate gender into sustainable surgical and health planning and policy at a global, regional and country programming level.

Methodology

Within this paper, gender is defined as the *'socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for men and women and people of other genders'* (WHO 2016). RACS GH is committed to a **gender transformative approach to development which means that we actively challenge gender norms, promote positions of social and political influence for women in communities, and address power inequities between persons of different genders.**

Given the number of countries in which RACS operates, the review has drawn on global indicators from the UN, World Bank and WHO databases and nationally representative surveys (i.e. the USAID Demographic and Health Survey), to convey trends and enable cross-country comparison for the themes of health, education, household decision-making and financial access, and health workforce participation. Available data were mapped for the 15 countries in Asia and the Pacific where RACS operates including Fiji, Timor Leste, Papua New Guinea, Solomon Islands, Samoa, Cook Islands, FSM, Kiribati, Marshall Islands, Nauru, Samoa, Tonga, Tuvalu, Vanuatu and Indonesia. Selected indicators are detailed in each *Domain of Change chapter*. Where possible, estimates for females and males were compared to assess relative access to health services.

Domain of Change 1: Improve access to surgery and other health services by supporting the delivery of vital health services that contribute to improved access, inclusion, and agency

Access to healthcare is an essential driver of health outcomes and can encompass awareness (about the existence of a service, how to reach it, and what it can achieve), acceptability (social and cultural factors that affect health-seeking behaviour), availability (ability to reach the service in an appropriate timeframe), affordability (ability to pay for services) and appropriateness (the degree to which the service meets patient needs).

Women and girls across the Asia Pacific experience significant barriers to accessing healthcare including geographical, financial barriers and lower agency in decision making. Women and girls residing in rural areas face additional challenges to accessing quality healthcare as specialised care is concentrated in capital cities. In addition, limited access to transport can prevent women and girls from accessing healthcare. Globally, women are more likely to be engaged in agricultural, irregular, and informal work and earn less than their male peers. Across many country contexts, women and girls have less power in decision making about their health and bodies inhibiting their agency to seek treatment, even where it may be available or requiring consent from partners or family members. Power differentials in household decision-making are especially pronounced in relation to financial expenditure, where women may not be able to access household financial resources to cover costs associated with treatment.

The following analysis explores indicators related to financial imposition, geographic remoteness, household decision making regarding healthcare and financial expenditure, and gender inequality indices to assess the extent to which these factors are likely to differentially affect women and girl health-seekers.

Snapshot of the data reviewed (DoC1)

	Countries available
Gender Inequality Index	**3**
Human Development Index	10
Life expectancy at birth	10
Expected years of schooling	8
Mean years of schooling	8
Estimated gross national income	9
UHC coverage	
UHC coverage index*	10
Remoteness	
Rural population (% of total population)*	13
Financial impost	
Out-of-pocket expenditure per capita, PPP (current international $)*	13
Risk of impoverishing expenditure for surgical care (% of people at risk)*	4
Household decision making	
Proportion who feel they have a say in decisions related to household expenditure (by sex) ‡	3
Proportion who make own decisions about health care (by sex) ‡	3

Data source: * World Development Indicators: World Bank, † Gender Indices: United Nations Development Program, ‡ The Demographic and Health Surveys: USAID.

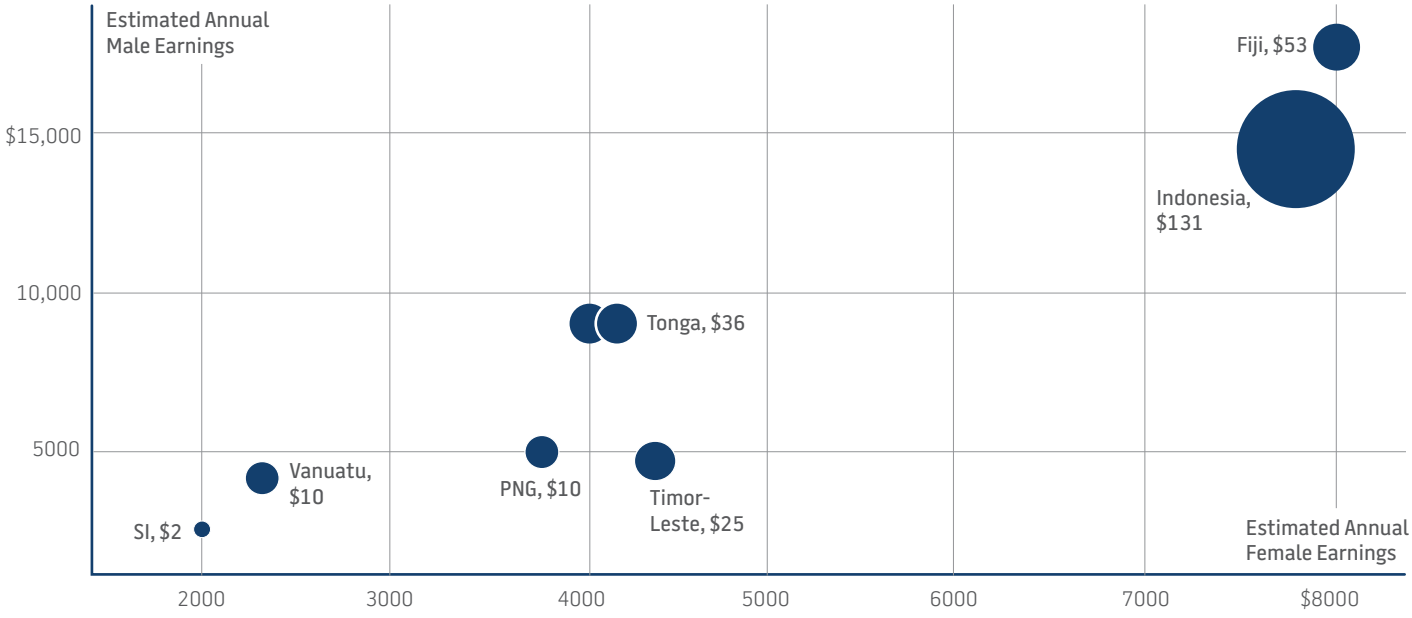
Key findings: Barriers to health care are compounded by access to financial resources

Across the Asia Pacific, access to health care is mediated by geographic and financial constraints with out-of-pocket expenditure to health seekers ranging from $130.74 in Indonesia to $0.27 in Kiribati (figures based on purchasing power parity). Women who are at greatest risk of catastrophic expenditure include female-headed households, women with disability and women living in countries where both health care decision-making power and access to financial resources is low (i.e. Indonesia). In most Asia Pacific countries, the use of health services is nominally free at the point of care.

However, out-of-pocket expenses associated with surgical care are common and tend to be regressive, placing a higher burden on women who earn on average half (Fiji, Samoa, Tonga and Indonesia) to 78 per cent (PNG and Solomon Islands) what their male counterparts earn*. Many factors contribute to women's heightened vulnerability to poverty including unequal access to paid work, lower earnings, lack of social protection and limited access to household assets.

*Timor-Leste is a notable exception where women and men are at earning parity according to UN Gender Equality Index for estimated gross national income per capita.

Estimated Annual Male Earnings vs Female earnings



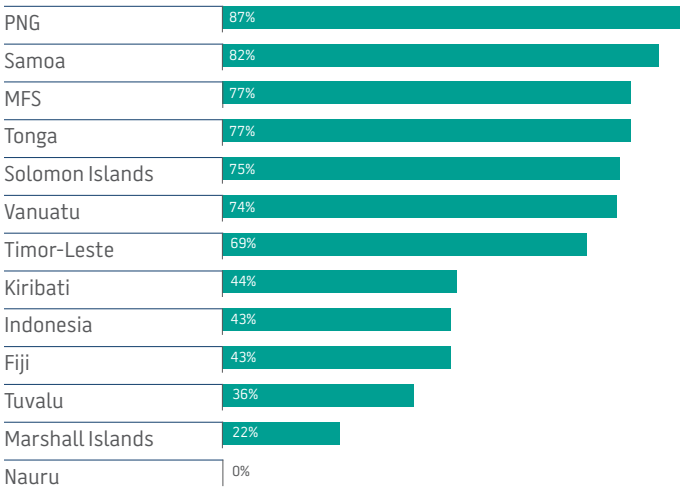
The size of the icon shows the relative size of out-of-pocket expense

Data source: World Bank: Out-of-pocket expenditure per capita adjusted using Purchasing Power Parity 2018 and UNDP: Estimated gross annual earnings, 2019. Data accessed Sept 2021.

Secondary costs associated with transport and accommodation represent barriers to access for rural poor

The concentration of services in urban centres often necessitates the need to travel for health care and may present a cost-barrier for low-income patients among whom women, widows and women with disabilities are known to be at higher risk of catastrophic health expenditure. While travel to seek care represents a significant cost burden for all people who reside in rural populations, there is evidence to suggest women (and particularly women from female-headed households/widowed women) face additional constraints on their mobility due to decreased access to household financial resources and concerns about safety while travelling and away from home.

Rural population (% of population)



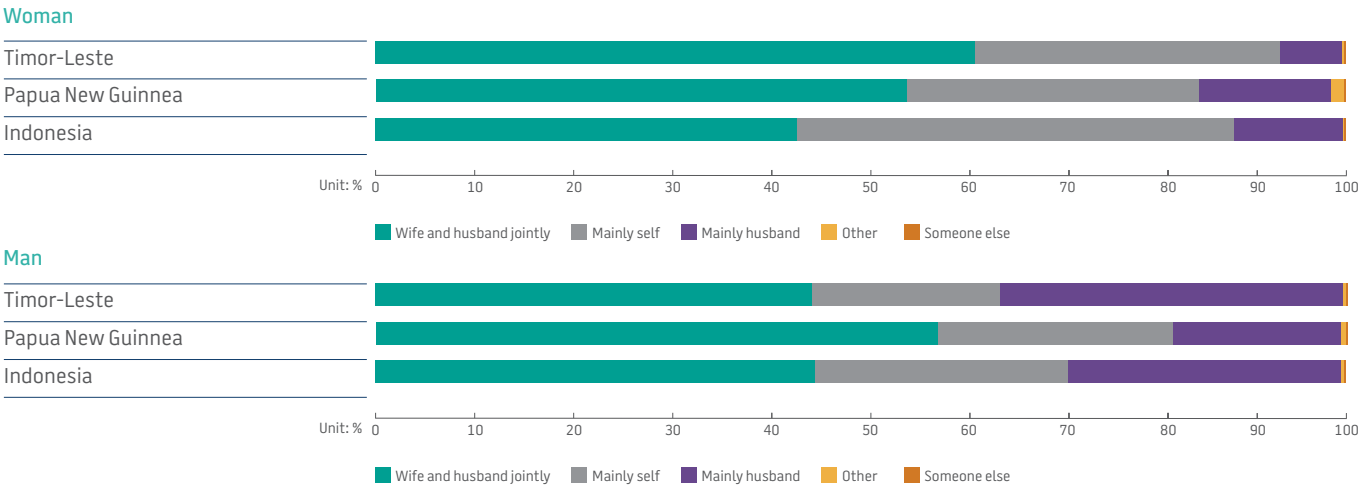
Data source: World Bank: Rural Population (% of total population). Latest available data used between 2016-2020. Data accessed Sept 2021.

Women play an active role in supporting other family members to seek health care but have less financial decision-making power and household preferential 'invest' in males

It has been observed across most country contexts (Afghanistan and India being the exception) women play a strong role as healthcare decision-makers within their households. For PNG and Timor-Leste, most health decision making is made jointly between husband-and-wife dyads while a slightly larger proportion of women in Indonesia make health care decisions independently of their spouse.

Women are more likely to make healthcare decisions for their partners and families and participate in sole decision making related to their care. Within a global health and programming context, this suggests that health promotion that targets women as decision-makers is essential in reaching the whole family.

Who makes decisions relating to your health care?

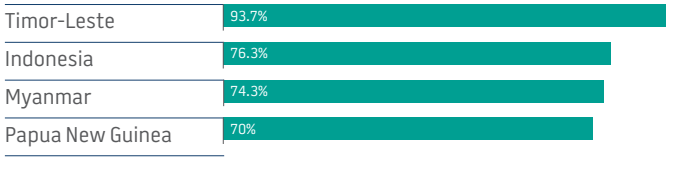


Data source: Demographic Health Survey: Indonesia: 2017; Papua New Guinea: 201-18; Timor Leste: 2016. Data accessed Sept 2021.

Household financial decision making

While data shows most households tend to make decisions related to health care jointly, women have less access to household financial resources. For instance, in PNG, Indonesia and Myanmar, around three-quarters of women-spouses report they participate jointly in decision-making related to major household purchases.

The proportion of women who feel they participate jointly in household decision making for major purchases (unit: %)



Data source: Demographic Health Survey: Indonesia: 2017; Papua New Guinea: 201-18; Timor Leste: 2016. Data accessed Sept 2021.

Women and girl's health service access is further disadvantaged in emergencies and pandemics

The COVID–19 pandemic has undermined health gains made in the Pacific over recent decades. As cited in A Feminist Future for the Pacific: Envisioning an Inclusive and Transformative Response to the COVID-19 Pandemic *"the threat of the virus remains and the wider social and economic impacts are already evident."* A feminist approach to COVID–19 acknowledges the pandemic's gendered impact and focuses on the concerns of women who are disproportionally represented in healthcare, social services and caring roles, placing them at higher risk of contracting the virus.

Recommendations for increasing access to surgical care for women and girls

RACS' vision is *safe anaesthesia and surgical access for all*. RACS Global Health identifies barriers to accessing quality healthcare and implements strategies to overcome these as core to our rights-based approach to surgical development. RACS undertakes activities that promote gender equality, delivered in response to local needs and tailored to the local context. We do so by working in partnership with local stakeholders, and by actively seeking opportunities to collaborate with other organisations to build partnerships and deliver activities that progress gender equity across our program scope.

The review found that women and girls can face additional barriers to accessing health services. This can include concerns about safety on transport or in accommodation, and financial barriers and decreased agency in decisions related to household expenditure that make it difficult for them to attend consultations or remain away from home for treatment. The recommendations, therefore, focus on ways to address some of these social barriers.

Recommendations	RACS GH commitment to action
1. Reduce the travel and cost burden for women and the rural poor through community outreach screening and referral models. Outreach models can overcome the significant cost and travel burden to health seekers by providing community-based triage. With a significant population residing in remote and rural areas across the Asia Pacific, outreach models significantly improve access for the rural poor and women and girls.	RACS to undertake analysis of gender participation across all programs including those with outreach and screening components.
2. Provide subsidies for health seekers to cover secondary costs associated with care. Outreach enables health screening coverage to be extended to rural and remote populations, but in some cases, specialised services may necessitate referral to a central hospital. While health care is nominally free in most countries in the Asia Pacific, secondary costs still represent a significant barrier for poor health seekers, among whom women and girls are likely to be over-represented.	RACS to apply principles of gender-responsive budgeting that ensure gender-equitable distribution of resources in our programs to enable access by women and girls.
3. Set and monitor gender targets for patient beneficiaries. Women and girls have differences in exposure and susceptibility to disease and injury compared to men and boys which can make meaningfully setting targets and monitoring gender skew challenging. Ensure gender-based targets are established in consultation with a clinical expert and are informed by country estimates on disease prevalence by sex.	RACS to continue tracking of gender-disaggregated data and target low or inequitable results/outputs.
4. Sensitise community members to the importance of health inclusion for women and girls	RACS to identify and empower community and medical/ health female leaders to work with, and enable a message of inclusion of women and girls and support referral for their treatment.
5. Ensure community health messaging targets women as household health care decision-makers	RACS to empower women as household health decision-makers and leverage their influence to affect the uptake of household members targeted by community health programs.

Domain of Change 2: Develop the capacity of the health workforce by supporting clinical and surgical training, mentorship, education, and essential equipment

The participation of women in the health workforce is essential to achieving Universal Health Coverage (UHC) and the 2030 Global Surgery Agenda. Women make up 70 per cent of the global health workforce and hold only 25 per cent of senior roles. They are often clustered into lower status and lower-paid jobs[6] which require less education and have less employment security and earning potential. In addition, women are often promoted less frequently and earn less than men for the same work[7and8].

For healthcare systems, this represents a significant opportunity cost and implications for workforce attrition of talented women who may exit the workforce due to lack of progression opportunities. More female leaders will increase the number of female mentors for both men and women, breaking stereotypes of men as 'natural leaders' and also contributing to making decisions more 'gender sensitive/inclusive'. Furthermore, greater participation by women in health leadership has led to inclusion in the global health agenda, of issues such as sexual and reproductive health that apply to all but have the greatest impact on women and girls.[9]

The following analysis explores indicators related to women's workforce participation in health care roles across the Pacific, and pre-service education and workforce participation and factors likely to affect women's entry into tertiary and post-tertiary training programs.

Snapshot of the data reviewed (DoC2)

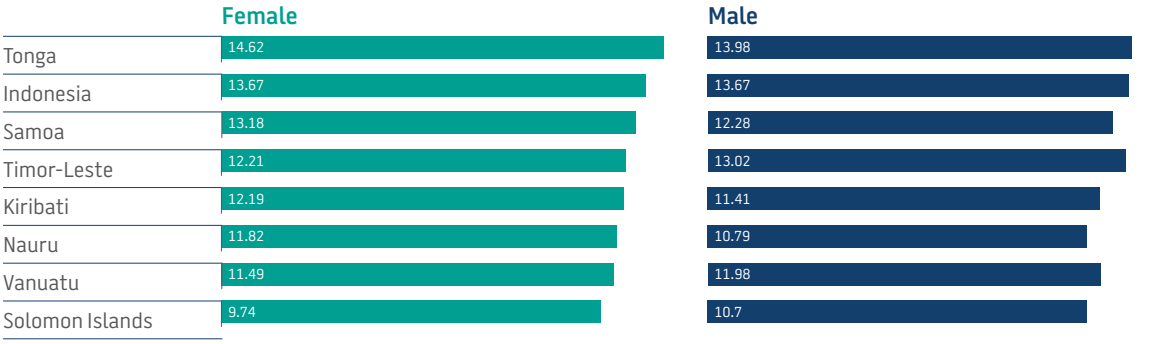
	Countries available
Workforce participation	
Gender composition of nursing workforce*	5
Gender composition of medical workforce*	5
Employment to population ratio (by sex)†	8
Pre-service training and education	
Proportion of foreign trained nurses*	13
Proportion of foreign trained doctors*	5
Expected years of schooling (by sex)†	8

Data source: *National Health Workforce Accounts Portal: WHO, †World Development Indicators: World Bank.

Key findings: Rates of female education are at or exceeding parity with males across almost all Asia Pacific countries

Girls and women are forging ahead of boys when it comes to educational attainment with the number of years of expected schooling exceeding the male average for Tonga, Indonesia, Samoa, Kiribati, and Nauru.

Expected years of schooling

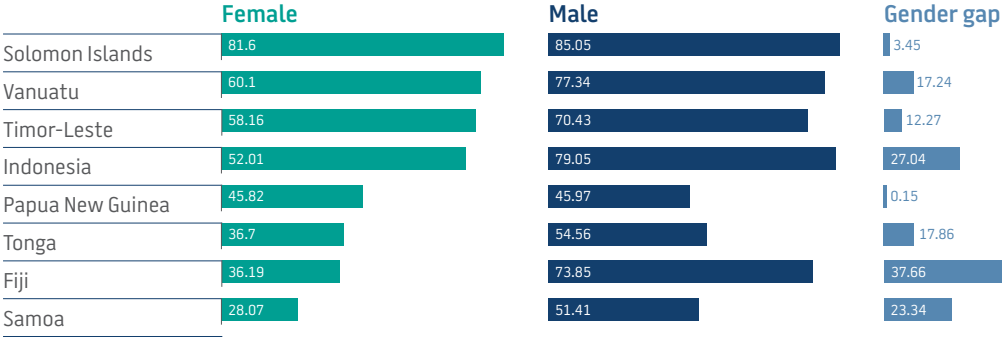


Data source: UNDP: Expected years of schooling, 2019. Data accessed Sept 2021

High rates of education have not yet translated into matched rates of workforce participation

Despite high female participation in secondary and university education, progress in education is not matched by higher labour force participation with gender gaps observed in Fiji, Samoa, Tonga, Indonesia and Vanuatu.

Employment to population ratio, 15+, (%)

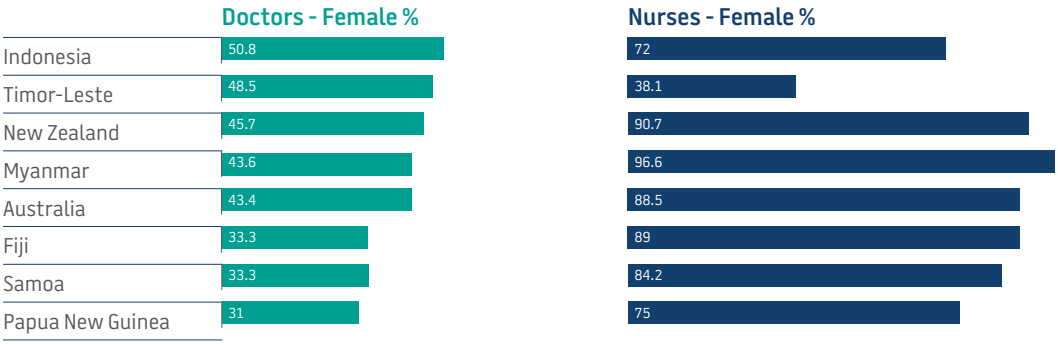


Data source: World Bank: Employment to population ratio, modelled ILO estimate, female and male 15+ population, 2019. Data accessed Sept 2021.

Gender composition of health workforce varies between countries with several Pacific countries outperforming their OECD neighbours

Nursing and medicine remain highly gendered professions although with significant variation between countries. The proportion of women in nursing for countries reviewed was highest (96.6 per cent) in Myanmar, followed by New Zealand (90.7 per cent), and lowest in Timor Leste (38.1 per cent) while female participation as doctors was at near parity in Timor Leste (48.5 per cent) and exceeds parity in Indonesia (50.8 per cent).

Gender composition of national health workforce



Data source: World Bank: National Health Workforce Accounts Data Portal, report updated July 2019. Data accessed Aug 2021.

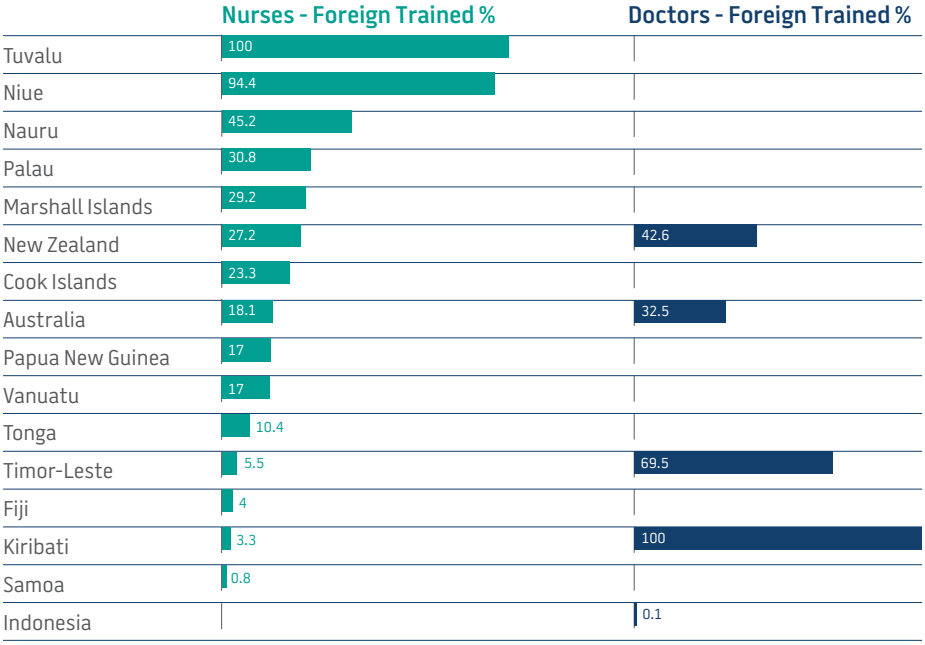
Lack of in-country tertiary education necessitates international travel and ESL competency which may disproportionately affect access for women

Within countries with tertiary programs, (i.e. PNG and Fiji) nursing and medical education programs are primarily situated in urban centres with universities and hospitals, leaving potential students from rural and remote areas with reduced access.

The need to travel internationally or overseas may represent a barrier for many Pacific students, and women in particular, who may encounter unsupportive attitudes related to women's perceived role as family caregivers.

Proportion of foreign trained health workforce

Blank rows indicate missing data



Data source: World Bank: National Health Workforce Accounts Data Portal, report updated July 2019. Data accessed Aug 2021.

Recommendations for training, supporting and empowering women clinicians, surgeons, and health leaders

RACS will continue to support our partner governments in longterm planning for health system strengthening, including efforts to develop their national health workforce. Whether this involves co-designing a clinical educator strategy with government partners to scale national training capacity for health workers in **Timor Leste**, strengthening training pathways for anaesthesia in the **Solomon Islands**, or supporting the development of audiology services in **Samoa**, we support governments to build the capacity of the health workforce at all levels of health systems.

A coordinated approach is needed to link health human resource planning and education (including an adequate and gender-balanced pathway of qualified trainees) and collaborative professional practice. Gender mainstreaming in health workforce strategies is needed for health workforce planning, training, and development.

Recommendations	RACS GH commitment to action
Support regional training institutions to address gender equity, conscious and unconscious bias, and stereotypes in curricula and training programmes for healthcare workers	RACS undertakes gender training with partners, volunteers and GH staff and will explore gender training within healthcare worker training for clinical educators and trainees.
Target recruitment campaigns to attract women to training programs	RACS to consider scholarship program targeting Pacific women
Identifying senior champions for gender equality in the workplace and incorporate progress indicators into performance management goals	RACS to leverage Women In Surgery program to promote women's participation and leadership in global health across the Pacific.
Setting targets and quotas for training participation to achieve gender parity where a gender(s) is underrepresented	RACS to continue to track and report against gender participation of women health workers participating in training programs.
Establish formal and informal networks for the advancement of women's leadership	RACS to consider surgical mentor program which pairs women in Pacific with women Fellows.

Domain of Change 3: Strengthen health systems by working with services and decision-makers to improve service coordination, support workforce planning, priority setting, and investment.

Large inequalities in health outcomes and service coverage persist across the Asia Pacific and globally. While Universal Health Coverage (UHC) emphasises equity, as demonstrated in Domain of Change 1, some groups (i.e. women, children, people with disabilities) have higher health needs and lower financing capabilities than others. The inclusion of gender analysis into health system strengthening approaches is core to supporting UHC.

As countries plan and implement strategies to achieve UHC they will need to address a broad range of health systems reforms, involving all of the WHO 'building blocks' governance: health care financing, health workforce, medical products and technologies, information and research, and service delivery. This should be done in a way that prioritises and counteracts the systemic barriers women and girls face.

Gender analysis has been shown to lead to better recommendations, more strategic interventions and programs and more effective policies,[10] as demonstrated in studies from Cambodia, Nigeria and Tanzania.[11] Policy and interventions which consider and address gendered power relationships are vital to transformation within health systems and are key in UHC. System-level interventions that have been shown to significantly improve access for women in LMIC include:

- public financing of health care services[12],
- reforms to improve cost efficiencies in healthcare delivery through task-shifting to nurses and community health workers,
- decentralization of health care to district settings, and
- extension of health financing reforms that include and extend beyond maternal health.

These are discussed in brief below.

Public financing of health care services stands to significantly improve access for the poor and women

Lack of access to resources and inequitable decision-making power means that when poor women face out-of-pocket costs such as user fees when seeking health care, the cost of care may become out of reach. In terms of coverage, the poorest and those without access to cash – including women – are less likely to be able to participate in voluntary health insurance schemes, even when these involve relatively modest payments to micro-insurance schemes[13].

Studies show that increased government health spending per capita can lead to decreased child, adult, and maternal mortality[14]. For instance, countries that have introduced or increased levels of health spending have demonstrated significant gains in population health coverage with the greatest gains to felt by the poorest healthcare seekers[15], among whom women are over-represented. Using studies on maternal health service utilisation, the impact of nationalized health insurance has been shown to have the greatest potential to increase access among women from lower-income groups. Studies from Rwanda[16], Ghana[17] and Indonesia[18] provide a powerful demonstration of the impact of public financing models to significantly improve health service coverage to all, and the rural poor and women, in particular.

Case study- Impact of Indonesia's National Health Insurance scheme on maternal health access

In 2014, the Indonesian government launched the largest compulsory health insurance program in the world. Jaminan Kesehatan Nasional (JKN), or National Health Insurance is nation-wide and offers differentiated levels of support to all income classes with premium assistance provided to the poor and near-poor; informal workers; and non-salaried workers[19]. *"Prior to its introduction, Indonesian healthcare was highly fragmented with private insurance schemes for those who could afford it, basic state provision for the very poorest, and NGOs in specialised areas providing support in between. Through the JKN, the Indonesian Government sought to improve the situation for the 'missing middle', those citizens too poor to afford health insurance but deemed not poor enough for government support."*[20]

A study of maternal health access to the scheme showed that women insured by JKN had improved access to maternal health care services along the continuum of care, compared with uninsured women and that the affect was most pronounced among women in the poorest quintile of insured households and those residing in less developed, Eastern Indonesia.

Decentralization of health services and task-shifting to improve cost efficiencies in health system design

Task shifting is a WHO-recommended strategy for countries with severe health worker shortages. It involves the redistribution of healthcare tasks to make efficient use of available workers. LMIC settings this can mean deploying the least expensive human resources compatible with safe service delivery. A systematic review of 37 studies in LMIC countries found consistent cost-efficiencies were reported for health system interventions that entailed task-shifting from doctors to nurses or community health workers, or facilities into community settings. The study also indicated that task-shifting had a neutral impact on patient outcomes indicating similar health outcomes requiring less investment, and a had positive impact on nurse workforce satisfaction, morale and self-perceived competence.

The State of the World's Nursing 2020 report identifies advanced practice roles as one potential policy option to improve health access globally. This includes expansion of nurse-led clinics, authority for prescribing and strengthening of nursing education and training.

RACS Global Health commitment to action

Efforts to scale up safe surgery and health access for women rely on adequate supporting infrastructure and service readiness. RACS works with service delivery partners including hospitals, clinics, and training facilities to improve service performance at a system-level. Key opportunities for RACS to lead and support gender-responsive system changes that positively benefit women and girls include:

Recommendations	RACS GH commitment to action
Supporting task-shifting capacity development interventions that are demonstrated to be low-cost and empower female workers i.e. training of anaesthesia nurses Task shifting has been shown to improve access at the patient level and elevate the status of nurse and community healthcare workers.	RACS continues to support the training of community healthcare workers to undertake outreach and triage. For example, in Kiribati, RACS supported facility upgrades and training for nurses and primary health care workers to undertake audiology screening and basic treatment.
Building capacity at the district and community level Prioritising capacity development at the district and provincial level ensures that investment and capacity development directly impact the rural, poor and women.	RACS continues to support the development of community health workers including health workers supporting outreach in Samoa and Timor Leste through vision and hearing programs. Both extend health access into rural areas by training community workers to undertake screening in community settings that would otherwise typically be undertaken in hospitals.
Promoting the incorporation of gender analyses into evaluations of new health initiatives	RACS supports the inclusion of gender analysis across program design and evaluation and acknowledges that stronger health systems gender analysis leads to better recommendations, more strategic interventions and stronger health development outcomes.

Domain of Change 4: Advocacy for sustainable surgical and health care by building partnerships for action at global, regional, and national levels.

It is well demonstrated that gender influences healthcare requirements, experiences, and outcomes at all levels of the health system.[23] Even so, health policy development does not always pay adequate attention to gender in part, because policymakers often have limited capacity or knowledge about gender and gender inequities. Responding to gender inequitable health systems requires institutions, services and decision-makers to take a human-rights and people-centered approach to drive more strategic, effective and equitable health systems interventions, programmes, and policies.[24]

Policy background for NSOAP and UHC

The global community including the WHO, the Lancet Commission for Global Surgery, surgical development partners, and national governments are working together to improve surgical, obstetric, and anaesthetic care systems across the Asia Pacific. In support of this, the Lancet Commission on Global Surgery introduced the national surgical, obstetric and anaesthesia plan (NSOAP) as the agreed platform for building quality and sustainable surgical systems. Within this arena, RACS plays a critical role in advocacy, a championing surgical system development through the development of NSOAP, in Fiji Tonga and Vanuatu. When operational, these plans will be nested within national policy frameworks which aim to strengthen all domains of the surgical system.

Supporting integration of gender across health policy

The pursuit of UHC requires a globally inclusive movement and a strong voice for change. With the adoption of the 2030 Agenda for Sustainable Development, Member States have pledged to leave no one behind and to reach the furthest behind first. To this end, NSOAPs reflect a unique opportunity to make progress to address gender-based barriers to access health services. Crucial to this is consideration of the ways that development of surgical and health planning can integrate women and girls as participants, beneficiaries and leaders.

Opportunities to ensure gender integration into the development of surgical development policy and priority setting.

1. **Defining current gaps in surgical care access and delivery:**
   - Ensure the selection and analysis of baseline indicators clearly define the problem to be addressed with reference to the differential barriers faced by women and girls to accessing health and surgical services.
   - Establish a conceptual framework to guide evidence gathering and interpretation of the service and access barriers for women, men, girls and boys.
2. **Consultation and stakeholder engagement:**
   - Engage in targeted consultation with national women's health organisations
   - Ensure representation from Ministries of Women's Affairs and ensure women are represented among decision-makers and participants at all levels of engagement.
3. **Prioritizing solutions and setting targets**
   - Ensure gender-based targets are established at the outset and include sex-disaggregated indicators which portray the 'baseline' situations and impact on women and girls as new policies and initiatives are implemented.
4. **Consensus building and synthesis of ideas**
   - Design for evaluation which prioritizes assessing the impact of policies and programming on women and ensures evaluation shape improvements to design.
   - Empower local gender champions, such as clinicians, professional societies, and other stakeholders to contribute to the ongoing implementation of inclusive surgical, obstetric and anesthesia care system development.

Defining gaps and tracking progress— learnings from the UN Millennium Development Goals

On 25 September 2015, the United Nations General Assembly adopted the 2030 Agenda for Sustainable Development as the agreed framework for international development and successor to the Millennium Development Goals (MDGs).

The 2030 Agenda marked a shift from targets set around national averages to a focus on specific groups, such as women and girls, who have been systematically left behind. This was in part due to criticism of the earlier MDG framework which had overseen significant but uneven strides made in poverty reduction and education within and between countries. For example, a survey of primary school attendance in 108 developing countries showed that while gender parity has been reached in urban areas and among the richest 40 percent of households, girls in poor households and rural areas were still significantly more likely to be excluded. This necessitated a shift in approach through the 2030 Agenda which included the elevation of gender across all goals and the inclusion of a stand-alone Goal on gender equality and the empowerment of women and girls. In addition, gender equality targets in other Goals, and a more consistent call for sex disaggregation of data across many indicators expressed a strengthened commitment to inclusive development.

RACS GH commitment to action

RACS is supporting the NSOAP development process in collaboration with Pacific governments, funding partners, and implementation experts to develop national plans for surgical workforce development. Key opportunities for RACS to support the integration of gender in the NSOAP development process include:

Recommendations	RACS GH commitment to action
Engaging proactively with Australian Government and Regional Organisations that represent gender advocacy, to support policy changes that support integration of a gender transformative approach to development	RACS leads advocacy regarding equitable health and gender considerations when engaging with ACFID/CID and/or Australian Government program and policy discussions.
RACS representation at ACFID Gender Special Interest Groups and Australian/Regional based INGO's with a gender focus.	RACS will engage actively in Sector wide gender events and advocacy.
RACS to continue to develop gender specific Learning Papers and invest in independent research with NGO partners to inform best practice gender integration into programming.	RACS will prioritise gender based health research across the Asia-Pacific Region to inform effective program design and implementation.

Conclusion

RACS Global Health considers gender equity as a key component of the design and implementation of our health and development programs. We will continue to work towards meeting our Gender Equality Policy for defining and promoting gender equality and women's empowerment in the context of the RACS Global Health programs. We understand that inclusive development practice should support the empowerment of women and girls, reduce gender disparities, and not in result in unintended negative consequences for women and girls. RACS Global Health looks forward to meeting its vision of 'safe surgical and anaesthetic care is available and accessible to everyone' and ensuring a transformative gender approach to its portfolio of programs and global advocacy approaches.

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