

# Fair share for health and care:

gender and the undervaluation  
of health and care work



World Health  
Organization



# **Fair share for health and care:**

**gender and the undervaluation  
of health and care work**



**World Health  
Organization**

Fair share for health and care: gender and the undervaluation of health and care work  
ISBN 978-92-4-008285-4 (electronic version)  
ISBN 978-92-4-008286-1 (print version)

© World Health Organization 2024

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: “This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition”.

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (<http://www.wipo.int/amc/en/mediation/rules/>).

**Suggested citation.** Fair share for health and care: gender and the undervaluation of health and care work. Geneva: World Health Organization; 2024. Licence: [CC BY-NC-SA 3.0 IGO](https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

Cataloguing-in-Publication (CIP) data. CIP data are available at <https://iris.who.int/>.

**Sales, rights and licensing.** To purchase WHO publications, see <https://www.who.int/publications/book-orders>. To submit requests for commercial use and queries on rights and licensing, see <https://www.who.int/copyright>.

**Third-party materials.** If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

**General disclaimers.** The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Design and layout by Sarah K Jones.

# Contents

Contents	iii
Preface	iv
Acknowledgements	v
Abbreviations	vi
<b>Executive summary</b>	<b>vii</b>
Uncovering a global undervaluation of health and care work	vii
Making the case to reset the value of health and care work	viii
Identifying the Gender Value Gaps	viii
<b>1. Introduction</b>	<b>1</b>
<b>2. Background</b>	<b>3</b>
2.1 A global undervaluation of health and care work	3
2.2 Health and care work, and its perceived value	4
2.3 Health and care work, gender, and intersecting crises	5
2.4 The road to recovery requires a reset	6
<b>3. Approach</b>	<b>8</b>
3.1 Resetting the value of health and care work and transforming the value of women’s work	8
3.2 Centring gender in health and care work	8
3.3 Introducing the Gender Value Gaps framework	11
3.4 Methods	11
<b>4. Findings from the Gender Value Gaps in health and care work</b>	<b>15</b>
4.1 The Gender Gap in Care	15
4.2 The Gender Gap in Participation	26
4.3 The Gender Gap in Earnings	38
4.4 The Gender Gap in Working Conditions	44
4.5 The Gender Gap in Data	48
4.6 The Gender Gap in Investment	49
<b>5. Closing the Gender Value Gaps: policy levers to better value health and care work</b>	<b>58</b>
5.1 Closing the Gender Gap in Care	64
5.2 Closing the Gender Gap in Participation	66
5.3 Closing the Gender Gap in Earnings	68
5.4 Closing the Gender Gap in Working Conditions	69
5.5 Closing the Gender Gap in Data	70
5.6 Closing the Gender Gap in Investment	72
References	74
<b>Annex 1: The Gender Value Gaps data</b>	<b>93</b>
Annex 1.1: Gender Value Gaps database sources	93
Annex 1.2: Data limitations	95
Annex 1 References	95

# Preface

As we mark the halfway point to the Sustainable Development Goals (SDGs) the world is described as still ‘failing women and girls’. A failing that is further compounded by emerging global polycrises; economic uncertainty, political instability, war and climate emergencies. Gender inequalities cut across all of these challenges.

Even in the health and care sector with an global average of 67 percent of the workforce being women, gender inequalities pervade. Women in many parts of the world still face barriers to entering and remaining in the paid health and care workforce as they are charged with carrying a large portion of the world’s unpaid care work. Even those in paid employment are not receiving equal pay, with women earning on average 24 percent points less than men who are doing similar work. Nor are they adequately represented at decision-making tables. Our key message is that a strong gender equal health and care workforce is critical in taking us forward in the SDG era, to achieve primary health care and universal health coverage. It presents an opportunity for better health, better economies and a better planet.

Yet, advancing gender equality among the health and care workforce will not happen on its own. In 2022, WHO together with the International Labour Organization launched a first-ever global report on gender pay gaps in the health and care sector which showed not only that women in the sector are underpaid, but the sector as a whole is undervalued. This present report uses data and a gender lens to further explore the undervaluation health and care work showing that decades of chronic underinvestment in health and care work is contributing to the growing global crisis of care and demonstrating that universal health coverage and gender equality are tightly wound objectives.

The Fair Share report outlines how gender-equitable investments in health and care work can help fully recognize the value of this work and drive fairer and more inclusive economies. The agenda in the SDG era and beyond needs to better recognize and value of women’s work. This report provides the necessary foundation for the collective effort required to meet the pressing needs for gender equality in the health and care sector. I urge you to take action and deliver a fair share for health and care.



A handwritten signature in black ink that reads "James Campbell".

**James Campbell**  
Director, Department of Health Workforce, WHO



# Acknowledgements

WHO gratefully acknowledges the experts and agencies who contributed to the planning, development and review of this report.

This report was produced under the overall strategic leadership of Jim Campbell, Director, Health Workforce Department, World Health Organization (WHO). Michelle McIsaac, Economist, Health Workforce Department, WHO, was responsible for the conceptualization and coordination of the report. Pascal Zurn, Unit Head, Health Labour Markets, Health Workforce Department, WHO, provided technical guidance on the overall content of the report.

The report was drafted by Geordan Shannon and Michelle McIsaac.

An evidence synthesis was prepared by United Health Futures group, with contributions by Winnie Chelagat (Kenya), Jeremy Lauer (the United Kingdom of Great Britain and Northern Ireland), Casey McAndrew (United States of America), Geordan Shannon (Australia), Chloe Wood (the United Kingdom) and Zahra Zeinali (Islamic Republic of Iran). The statistical analysis was conducted by Jean Louis Arcand (Switzerland), Geordan Shannon (Australia) and Chloe Wood (the United Kingdom).

The report was subject to a comprehensive review by global experts. WHO thanks Beverley Essue (Institute of Health Policy, Management and Evaluation, University of Toronto, Canada), Maren Hopfe (Sectoral Policies Department, International Labour Organization, Geneva, Switzerland), Felicia Knaul (Institute for Advances Study of the Americas, University of Miami, USA), Zitha Mokomane (Department of Sociology, University of Pretoria, South Africa), and Amber Parkes (Economic Empowerment Section, UN Women, New York, USA) for their valuable inputs to this report.

Technical inputs and feedback were also received from Mathieu Boniol (Health Workforce Department, WHO), Giorgio Cometto (Health Workforce Department, WHO), Margrieta Langins (Health Workforce and Service Delivery Unit WHO European Office) and Isabel Yordi Aguirre (European Office for Investment for Health and Development, WHO).

All contributors submitted Declaration of Interest forms, no interests were declared.

## **Financial contributions**

WHO gratefully acknowledges the financial contributions to the development and production of this report provided by the Government of Canada Department of Foreign Affairs, Trade and Development.

# Abbreviations

<b>CHWs</b>	Community health workers
<b>GBV</b>	Gender-based violence
<b>ICLS</b>	International Conference of Labour Statisticians
<b>ILO</b>	International Labour Organization
<b>ISIC</b>	International Standard Industrial Classification of All Economic Activities
<b>LTC</b>	Long-term care
<b>LMICs</b>	Low and middle-income countries
<b>NHWA</b>	National Health Workforce Accounts
<b>OECD</b>	Organisation for Economic Co-Operation and Development
<b>PPP</b>	Purchasing power parity
<b>SIGI</b>	Social Institutions and Gender Index
<b>SDGs</b>	Sustainable Development Goals
<b>UNDP</b>	United Nations Development Programme
<b>UHC</b>	Universal health coverage
<b>WHO</b>	World Health Organization
<b>GHO</b>	WHO Global Health Observatory





# Executive summary

**Health and care work involves a variety of activities, occurring across different contexts, with varying degrees of recognition, compensation and regulation. Women are the backbone of the care economy, comprising 67% of the global health and social care workforce (1,2) and performing 76% of unpaid care activities.(3) As a result of the pandemic, women’s health and care responsibilities – including unpaid care – almost doubled, with women shouldering more work relative to men. (4–8) Unpaid care was recognized as a "critical mainstay of the COVID-19 response".(9)**

Health, and the work that supports it, is one of our greatest shared societal resources. Yet, health and care work is vastly undervalued.(1,10) This undervaluation is anchored in pervasive attitudes towards caregiving and reproductive labour, based on harmful gender norms.(11,12) Underinvestment in health systems can lead to a shift towards unpaid health and care work, which lowers women’s participation in paid labour markets and acts as a barrier to women’s economic empowerment and gender equality (Sustainable Development Goal 5). Underinvestment in health and care work impacts health systems’ ability to respond to complex crises like the COVID-19 pandemic, and contributes to a growing global “crisis of care”.(3,13,14)

## **Uncovering a global undervaluation of health and care work**

The way that health and care work is valued is a gender issue that affects the health workforce, impacts the perceived value of the health and care sector and entrenches the dependence of

society on underpaid and unpaid health and care work. Unpaid health and care work represents an extreme form of undervaluation that has the effect of subsidizing both public and private institutions,(2,15–18) with unpaid health and care work, and those that perform this work, remaining largely invisible in national statistics.(10,15)

Some health and care occupations are treated as extensions of women’s domestic and unpaid work. They are highly feminised and often carry a lack of social recognition, poor working conditions, low pay and are frequently perceived as low status.(2,12,17) As a highly feminised sector, the double pay penalty in health and care work (that is, the dual reality of lower sector-specific pay and women’s relatively lower pay across the sector) drives down the apparent value of health and care work, and culminates in a lower economic footprint in national accounting systems.(1,19,20) In addition, data gaps mean that gender inequalities in health and care work are inadequately recognized and acted upon. (17,21,22)

## **Making the case to reset the value of health and care work**

Health and care work supports human wellbeing and survival. It also promotes economic prosperity, is an important source of gainful employment, provides an essential social safety net, fosters social cohesion and stability, drives innovation, diversifies economies, is central to global security and creates virtuous cycles of equity.(23–25) As we recover from the COVID-19 pandemic there is an opportunity for a global reset that addresses the care crisis, reorients economies towards valuing and supporting human and planetary health and invests in long-term social infrastructure to support universal wellbeing. (26,27) Central to this is revaluing health and care work and those that deliver it. This report uses a gender-transformative approach to make the case for a global reset in how we collectively value health and care.

## **Identifying the Gender Value Gaps**

This report lays out and quantifies critical Gender Value Gaps. It demonstrates how health and care work is undervalued, why this is a gender equality issue, and what can be done about it. The Gender Value Gaps framework builds on feminist research and advocacy, and outlines four key gender gaps:

1. the Gender Gap in Care
2. the Gender Gap in Participation
3. the Gender Gap in Earnings
4. the Gender Gap in Working Conditions.

These are underpinned by the Gender Gap in Data – characterized by a lack of sex or gender-disaggregated data – and culminate in sector-wide underinvestment (the Gender Gap in Investment).

## **Closing the Gender Value Gaps**

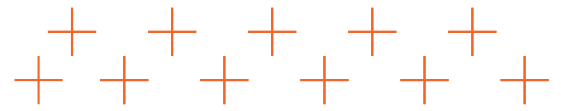
Investing in health and care work is one of the most important choices a country can make to safeguard human health, ensure inclusive economic development, reduce gender inequalities and protect against crises such as the COVID-19 pandemic.(14,23,28–30) Health and care systems drive inclusive economic growth by increasing population health and productivity, promoting a “care economy”, providing social protection, fostering social cohesion and equity,

driving innovation and economic diversification and promoting health security.(24,30) Further, health and care work creates “virtuous cycles” which help tackle inequality.(24,30,31)

Health and care investments require a critical assessment of where and how financing can be used most strategically.(32) This report highlights precisely where and how gender-equitable investments in health and care work, coupled with gender-transformative policies, could reset the value of health and care.

Six supportive actions are needed:

1. Address the Gender Gap in Care, support quality care work and uphold the rights and wellbeing of all caregivers and care recipients.
2. Support gender-equitable labour force participation.
3. Enhance wage conditions in the health and care workforce and ensure equal pay for equal work.
4. Improve working conditions for all forms of health and care work, especially for highly-feminised occupations.
5. Ensure that the full spectrum of health and care work is accounted for, measured, valued and included in national statistics.
6. Invest in robust public health and care systems.



# 1. Introduction

**Health, and the work that supports it, is one of our greatest shared societal resources. Health and care work<sup>1</sup> involves a variety of activities with varying degrees of recognition, compensation and regulation. Since everyone is dependent on some form of health care during their lives, it is difficult to overstate its importance to society.**

Health and care work promotes human wellbeing, is both foundational to economic prosperity and an important source of gainful employment, provides an essential social safety net, fosters social cohesion and stability, drives innovation, diversifies economies and is central to global security.(23–25,30) Increased employment in the health and care sector can create virtuous cycles of equity, particularly for women, because as a source of decent work<sup>2</sup> it offers viable pathways to overcoming barriers to labour force participation. (23,24,31) Outside the labour market, unpaid health and care work is critically important for families and communities, particularly in contexts where public health infrastructure is weak. (16,18,35) Health and care work is also central to a socially just and prosperous future for people and the planet.(3,16,18,22,36)

Yet, health and care work is vastly undervalued. (1,10) This undervaluation is anchored in pervasive attitudes towards caregiving and reproductive labour, based on harmful gender norms.(11,12) Paradoxically, the work labelled essential during times of crisis is continually devalued by markets and inadequately supported by governments. (18,26,27) Decades of underinvestment in health and care, combined with growing and ageing

populations, increasing economic precarity, climate change and political instability,(3,16,22,37) has created a “global crisis of care”.(3,22,38)

Underinvestment in health and care work hinders gender equality and the empowerment of women and girls. Devaluing caregiving, which is work performed largely by women, impacts wages, working conditions and productivity across the health and care sector. This lowers the economic footprint of health and care work and those that perform it. Underinvestment in the formal health and care sector can also lead to a shift towards unpaid health and care work, also disproportionately performed by women. This lowers women’s participation in paid labour markets and acts as a barrier to gender equality and women’s economic empowerment.

This report makes the case for a global reset in the value of health and care work on the basis of gender equality. The report aims to identify and quantify the impact of gender gaps in health and care work across four key domains: care, earnings, participation, and working conditions. These domains are all underpinned by data gaps, referred to as the Gender Gap in Data. The report demonstrates how these gaps are integral to the undervaluation of and underinvestment in

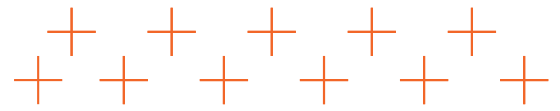
<sup>1</sup> In this report, the term “health and care work” refers to employment in the health and social care sector, including nonstandard employment and employment in the informal economy, as well as unpaid work that is primarily directed towards the health and care objectives of families and communities. Terms are described more fully in Section 2.2.

<sup>2</sup> Decent work refers to work that is productive, safe, fairly compensated, secure and upholds human rights.(3,33,34) Decent work is discussed further in Section 5.

health systems, referred to as the Gender Gap in Investment. Fundamentally, they are Gender Value Gaps.

The report is divided into four sections. Following this introduction, Section 2 provides context by exploring how and why health and care work is undervalued. Section 3 outlines the report's approach, and introduces the Gender Value Gaps

framework. Section 4 assesses the impact of each of the Gender Value Gaps and argues why closing those gaps is important. Section 5 discusses the policy levers that countries can use to support gender equality, strengthen health systems and ultimately reset the value of health and care work globally.



## 2. Background

### 2.1 A global undervaluation of health and care work

COVID-19 brought into sharp focus the critical importance of health and care work. Health and care work, in all its forms, increased in intensity and significance as other economic activities ground to a halt and health systems in affected countries were activated.<sup>(13,18,39)</sup> The pandemic also revealed deficiencies in current models of care. It exposed and worsened gender inequalities, particularly for women experiencing intersecting forms of discrimination or marginalization, and revealed the prevalence of precarious forms of work which women are more likely to perform than men.<sup>(1)</sup> Specifically, COVID-19 signalled an increased reliance on unpaid health and care work, also more likely to be performed by women.<sup>(5,6,16,18,40)</sup>

As the global majority of paid health and care workers, women are the backbone of the health and care economy, comprising 67% of the workforce.<sup>(1,2)</sup> Beyond paid work, it is estimated that women perform 76% of unpaid care activities.<sup>(3)</sup> Women tend to be highly represented in direct-contact health and care occupations such as nursing and long-term care (LTC).<sup>(6,8,41)</sup> Many improvements in population health can be attributed to women's often unrecognized work in health and care.<sup>(42)</sup> A stronger health and care workforce is positively associated with health equity, greater health care seeking, improved access to services and improved population health.<sup>(43–45)</sup>

#### 2.1.1 Underpaid, undervalued and under-resourced

The undervaluation of health and care work has implications for the health and care workforce:

it impacts the perceived value of the health and care sector and entrenches society's dependence on both unpaid and underpaid workers. The prevalence of unpaid health and care work is an extreme consequence of this undervaluation, and has the effect of subsidizing both public and private institutions.<sup>(2,15–18)</sup> This means that unpaid health and care work, and those who perform this work, remain largely invisible in national statistics.<sup>(10,15,21)</sup>

Some health and care occupations are treated as an extension of women's domestic and unpaid work: they are highly feminised and often imply a lack of social recognition, poor working conditions and low pay.<sup>(1,2,12,17)</sup> This impacts the value of the health and care sector as a whole. As a highly feminised sector, wage conditions are worse compared to other economic sectors with similar labour market attributes.<sup>(1,19)</sup> The double pay penalty (that is, the combination of lower sector-specific pay and women's relatively lower pay across the sector as a whole) produces a lower economic footprint in national accounting systems, especially for women.<sup>(20)</sup> Studies have shown that investments in highly feminised sectors are often lower than in sectors where men comprise the majority.<sup>(1)</sup> In addition, data gaps, such as a lack of sex or gender-disaggregated information on wage conditions, employment conditions and unpaid work, mean that gender inequalities in health and care work are inadequately recorded, reported and acted upon.<sup>(17,21,46)</sup> This has led to a pervasive undervaluing and underinvestment in the health and care sector which in turn undermines health systems.<sup>(14,20,30)</sup>

## 2.2 Health and care work, and its perceived value

Health and care work involves a variety of activities with differing degrees of recognition, compensation and regulation. While much attention has rightly been given to employment in the health and social care sector, health and care work extends beyond labour markets. This report aims to capture health and care work in the broadest sense, from a feminist perspective that recognizes and values the diverse forms of work, both paid and unpaid, occurring across domestic and public spheres. The report will focus on employment in the health and social care sector (referred to throughout as health and care employment), and other forms of unpaid or otherwise unrecognized work for the health and care of families and communities (referred to throughout the report as unpaid health and care work). Combined, this is referred to as health and care work.

Both health care and social care are needed to achieve a “state of complete physical, mental and social well-being”.<sup>(47)</sup> Productive health and social care activities, both paid and unpaid, can cross the formal, informal and household own-use and community sectors. There are ongoing global efforts to harmonize terminology and data on the subject, and to more effectively recognize care activities in global health workforce strategies.

The degree to which health and care work is recognized and valued can be considered as a spectrum, underpinned by gender norms. Using the statistical concept of work as any activity performed by persons of any sex and age to produce goods or to provide services for use by others or for own-use, Fig. 1 sets out the five forms of work in the International Conference of Labour Statisticians (ICLS) resolution on a spectrum.<sup>(48)</sup> Starting on the left side of the spectrum, unpaid health and care work performed in individual households for own-use appears as one of the least well recognized or measured – it also tends to be performed primarily by women.<sup>(15,16,49)</sup> Next, other less visible forms of health and care work include volunteer work performed for others without pay, “other work activities” which could include unpaid community service or unpaid civilian service, as well as unpaid trainee work performed for others without pay to acquire workplace experience or skills. These forms of work are all unpaid and less recognized in most national measures of work. Paid activities or employment work are comprised of work performed for others in exchange for pay or profit across both the formal and informal sectors.<sup>(48)</sup> Across these paid activities there also exists a hierarchy of recognition and value, where occupations that are deemed more caregiving tend to be more feminised, are often considered low-status and tend to have lower pay.<sup>(1,2,17)</sup>

**Fig. 1: The spectrum of the recognition of health and care work<sup>a</sup>**



<sup>a</sup> Categories of work derived from the 19th International Conference of Labour Statisticians (ICLS) resolution concerning statistics of work, employment and labour underutilization.<sup>(48)</sup>

Understanding health and care work as a spectrum not only enables a wider appreciation of all the various forms of health and care work, but also allows for an understanding of how health and care work can be revaluated to optimize for societal needs. It also shows how less visible forms of work often interact with more visible forms. For example, an individual might simultaneously

provide unpaid health or care work in their own home for their family while also participating in paid health or care employment. In some settings, health services might rely on certain services being provided through unpaid health and care work. The distribution of all forms of health and care work is a particularly important consideration for gender and labour force participation.<sup>(3)</sup>



## 2.3 Health and care work, gender, and intersecting crises

### 2.3.1 Work during intersecting crises

COVID-19 occurred at a time of drastic economic inequality, when people's livelihoods were increasingly precarious, public services weakened, democracy under threat, disinformation widespread, conflicts ongoing and the impacts of the climate crisis intensifying.(3,16,18,22,37) As a result, and exacerbated by chronic underinvestment, public health and care systems remain in continual "crisis mode".(22)

Health and care work provides a critical web of support for society in times of crisis. As a result of the pandemic, women's caregiving responsibilities – including unpaid care – almost doubled, with women shouldering more work relative to men, and women in disadvantaged groups shouldering more work compared to women in more privileged groups.(4–8) Certain activities, such as chronic disease care, that were previously taking place in health services were shifted onto families and communities as unpaid care work. This work was largely performed by women, and particularly by women experiencing multiple forms of marginalization, without pay or social protection.(4–9,18) The United Nations described this unpaid work as "a critical mainstay of the COVID-19 response".(9) This phenomenon is not unique to COVID-19: the shifting of health and care activities from public services onto households in the form of unpaid work occurred during the HIV/AIDS and Ebola epidemics, and in other contexts where health systems are weak, underfunded or highly privatized and unaffordable.(9,50–52) The unpaid health and care work performed by women also acts as an economic "shock absorber".(18,53,54) Taken as a whole, household economic activities related to unpaid caregiving and health care had the effect of an "automatic economic stabiliser" during the pandemic.(54,55)

### 2.3.2 Crises of widening gender disparities and weakening social infrastructure

Intersecting social, health and economic crises tend to widen gender disparities – with a

disproportionate impact on women experiencing overlapping forms of marginalization – and further entrench the undervaluation of health and care work.(5,6)

As a result of the pandemic, progress towards closing the global gender gap<sup>3</sup> reversed, with the average time to achieve gender parity globally estimated to take over 135 years from 2021.(56) Women and girls across the world – already facing substantial gender disparities before the pandemic – experienced increasing economic adversity, worsening health, a disproportionate responsibility for unpaid care and exponentially higher levels of gender-based violence (GBV).(4,5,9) Women were more likely than men to lose employment, forgo paid work to care for others, or drop out of school.(4) The economic impacts felt by women and girls were compounded by them earning less and saving less amid higher job insecurity prior to the crisis.(9) Combined, it is estimated that women lost over US\$ 800 billion in income in 2020 due to the COVID-19 pandemic.(57) Further, women's health was affected by the reallocation of resources away from key services, such as reproductive health care.(9) Global survey data suggest that women experienced greater disruptions in accessing health care across Europe, the Middle East, and the Americas.(4) Around 18 million women in Latin America and the Caribbean were estimated to have lost regular access to modern contraceptives because of the pandemic.(9,58) GBV also rose concerningly on a backdrop of restricted movement, social isolation measures and socioeconomic stress.(4,9)

Weakened social infrastructure, including policies, resources and services, as a result of health and economic crises further compounds gender disparities. Following the global financial crisis of 2008, austerity measures introduced by governments around the world often included cuts in public spending and reduced state provision of health and care services, leaving women and families to pick up the shortfall through unpaid work.(59,60) During economic crises, the demands on women's time are further intensified by their role in managing households and communities to help "make ends meet".(59) During conflicts,

<sup>3</sup> The Global Gender Gap Index reports national gender gaps in outcomes across economic participation and opportunity, educational attainment, health and survival, and political empowerment. The Global Gender Gap Index also reports national progress towards closing each gap and the estimated time to closing each gap based on national progress.

women and girls experience greater economic vulnerability, gender discrimination and often shoulder unpaid care responsibilities, alongside experiencing worse working conditions, pay and access to social protection.(35,61) Similarly, during environmental crises, women experience the compounded effects of gendered economic, health and social disadvantages.(62)

### **2.3.3 Worsening gender inequalities among health and care workers**

Against a backdrop of worsening gender inequality and weakened social infrastructure, women health and care workers faced additional challenges in the workplace due to COVID-19. Globally, health and care workers experienced gender inequalities prior to the pandemic, such as occupational segregation by gender, including the under-representation of women in leadership gender pay gaps, and GBV.(2,17,63,64) Studies have suggested that further to these challenges, direct-contact, majority-women occupations, such as nursing, midwifery and work in LTC facilities, were most negatively impacted by the pandemic.(6,8,41) The clustering of women in positions affected by longstanding gender, racial and socioeconomic hierarchies placed them at even higher risk.(5,65) Especially in the early stage of the pandemic, many health and care workers – often women, and particularly those from Black, Asian and Minority Ethnic backgrounds – were left without access to adequate personal protective equipment.(66,67) Some reports have described how in some cases the personal protective equipment supplied was not suitable for women’s bodies.(66,67) Women health and care workers also reported decreased access to leadership and decision-making opportunities, poor mental health and pointed to an increased “double burden”, with relatively higher workloads both in the workplace and at home.(6–8,68)

Women working in the informal economy and in nonstandard forms of employment faced particularly poor working conditions, alongside a pre-existing lack of legal and social protection.(4,64,69) Women in such roles often experience multiple, intersecting forms of marginalization, making their status even more precarious.(33,70) COVID-19 exacerbated gender inequalities in the informal economy, with women experiencing

heightening economic precarity and income losses, increased exposure to health and safety risks without formal legal or social protections, stress relating to job insecurity, and a lack of the social benefits that accompany formal employment.(4,40,57,69) The possibility of GBV was a concerning reality across all health and care occupations and a particular concern for domestic workers, where precarious working conditions were compounded by further social risks related to gender, poverty, migration and racism.(71)

## **2.4 The road to recovery requires a reset**

Following COVID-19, there is both an opportunity and an imperative for a global reset that addresses the care crisis, reorients economies towards valuing and supporting human and planetary health and makes long-term investments in social infrastructure to support universal wellbeing.(26,27) Central to this is a revaluation of health and care work and those who deliver it.

Health and care work provides the foundation for shared prosperity. It is estimated that around one quarter of growth in full income in low and middle-income countries (LMICs) between 2000 and 2011 was the result of the value added by improvements in the health of the population.(72) In 2018, global spending on health was US\$ 8.3 trillion, equating to 10% of global GDP.(73) In 2010, the financial value of women's contributions to health systems was estimated at almost 5% of global GDP - with almost half of this coming from unpaid health-specific work for which it is estimated women contribute almost three hours for each hour invested by men.(3,10) Improvements in health can contribute to productivity advances and help drive economic growth.(74–76) The “demographic dividend” of healthy societies means that reduced premature maternal mortality and subsequent lower child mortality positively influences household decisions on family planning which, in turn, can contribute to a faster demographic transition and economic development.(30,72)

Health and care work contributes in numerous other ways to human and planetary health.(77,78) While economic measures are a starting point to



examine the positive societal impact of health and care work, it should be noted that numerous, interconnected and important contributions remain undermeasured and not fully accounted for. The WHO Council on the Economics of Health for All calls for a transformation in economic thinking to reorient economies towards human and planetary health.<sup>(27)</sup> The success of wellbeing economies<sup>4</sup> – like that adopted by New Zealand – in addressing child poverty, mental health, and environmental protection, demonstrates the importance of social and economic systems that promote human and ecological wellbeing.<sup>(79)</sup>

---

<sup>4</sup> A “wellbeing economy” refers to the explicit design of economies to deliver human and ecological wellbeing.<sup>(79)</sup>



## 3. Approach

### 3.1 Resetting the value of health and care work and transforming the value of women's work

This report makes the case for revaluing health and care work using a gender-transformative approach. While previous analyses have focused on specific examples of women's contributions to health and care being undervalued,<sup>(1,17)</sup> attention to what drives this undervaluation of the health and care sector as a whole is now starting to come to the fore.<sup>(27)</sup> This report aims to fill this information gap by using a whole-systems approach combined with global data to demonstrate the impact of gender inequality across specific Gender Value Gaps, in order to show how these gaps culminate in the undervaluing of the sector overall.

Feminist research and advocacy, which draws attention to the gendered undervaluing of care work, were combined with analyses of data and information from a range of relevant national indicators – cutting across gender, health systems, sustainable development and national economic performance – in order to quantify these Gender Value Gaps (see Section 3.3 for more information about the framework and Section 3.4 for more information about data used).

Investment cases are used in global health to provide policymakers with the relevant evidence, supported by a structured decision-making process, to implement policy recommendations. Their aim is to offer compelling arguments to policymakers who can then tailor their approach to their national context.<sup>(80)</sup> However, investment cases for health are often gender blind, which risks devaluing the health and care work they are designed to support.<sup>(20)</sup> This report uses sex and

gender-disaggregated data to demonstrate how gender-equitable investment in health and care work can reap widespread benefits.

Global health investment cases present policymakers with the “why” and the “how” for putting evidence-based policy into practice. <sup>(80)</sup> The “why” is provided in Section 4, where a mix of global review evidence and original cross-sectional analyses are presented to describe each Gender Value Gap, their impact, and the case for closing each gap. The “how” is provided in Section 5, where evidence-based policy levers are outlined.

### 3.2 Centring gender in health and care work

Gender impacts how people live, work and relate to each other.<sup>(12,81)</sup> Gender norms and power relations shape the types of work that people do and the way that work is valued.<sup>(11,82)</sup> Gender analysis is a powerful tool that can be used to identify, understand and address inequalities in health systems.<sup>(12,83,84)</sup> Many different gender analysis frameworks have been developed and utilized in health systems research. Key areas commonly examined include attitudes and gender norms, gendered activities and the division of labour, access to and control over resources, and agency and decision-making. Box 1 describes these in more detail.

Gender is a crucial site where power and privilege operate to create inequalities. An intersectional approach recognizes that all human experiences are shaped by the intersection of different factors – including gender, race, class, migration status, disability/ability and religion – and interconnected

power structures.<sup>(85)</sup> There is an imperative to better understand the experiences of those who are most impacted by intersecting forms of discrimination so that more informed and

equitable decisions can be made. Where possible, this report highlights these experiences, but it must be noted that data limitations prevent a full intersectional analysis.

## Box 1: Critical gender concepts

### Attitudes, gender norms and structures of constraint

Attitudes are the ways that a person communicates their beliefs and values, and have the power to shape gender norms and stereotypes.<sup>(86)</sup> Norms are “shared beliefs about what is typical and appropriate within a cultural or social group”.<sup>(86)</sup> Gender norms are “ideas about how women and men should be and act. Internalized early in life, gender norms can establish a life cycle of gender socialization and stereotyping”.<sup>(87)</sup> Rigid gender norms can negatively affect health by influencing the health behaviours of men, women and those with gender-diverse identities.<sup>(88)</sup>

Attitudes and norms define social relationships among different people and groups, “which place some in positions of dominance over others and differentiate the choices available to them—including in relation to access to and control over resources”.<sup>(Folbre (1994) cited in (89))</sup> These have been termed “structures of constraint” and refer to “the social norms, values and practices which define inequalities between women and men in societies, generally allocating different roles and responsibilities and assigning a lower value to those aptitudes, capabilities and activities conventionally associated with women”.<sup>(Folbre (1994) cited in (89))</sup>

### Activities and the gender division of labour

The types of activities performed by women and girls<sup>5</sup> are shaped by gender norms and attitudes. There are numerous constraints to women’s time and their choice to undertake certain activities, including decent paid work, education, public life, rest and leisure. For example, it is estimated that 42% of women of working age globally are outside of the labour force, because of unpaid care responsibilities.<sup>(16)</sup>

The gender division of labour refers to “the way each society divides work among men and women, boys and girls, according to socially-established gender roles or what is considered suitable and valuable for each sex”.<sup>(90)</sup> Examples of the gender division of labour include:

1. The productive/reproductive work divide. This refers to the division of paid (that is, productive) and unpaid (that is, reproductive) work between women and men in private and public life.<sup>(91,92)</sup> Gendered attitudes ascribe caregiving to women and wage-earning labour to men, which often leads to a gender-unequal distribution of paid and unpaid work.<sup>(11,89,93,94)</sup>
2. Occupational segregation by gender. This phenomenon impacts labour markets on a global scale and refers to the tendency for women to work in different occupations and/or sectors to men.<sup>(1,17,95,96)</sup> Horizontal occupational segregation refers to the over or under-representation of a particular gender in certain jobs.<sup>(1,97)</sup> Vertical segregation refers to the over or under-representation of a particular gender within an occupation or sector at

<sup>5</sup> Gender shapes the experiences and activities of everyone, including men and boys, as well as people with gender diverse identities. The focus of this report is on how gender inequality disadvantages women in health and care work. This report uses sex-disaggregated data, where available, to compare the experiences of women and men, but it should be noted that there is a paucity of information on gender-diverse identities.

the top or bottom end of a ranking based on “desirable” attributes such as higher income, prestige or job stability.<sup>(97)</sup> A related term, occupational feminisation refers to when women enter or are “crowded in” to certain occupations or roles.<sup>(98)</sup> Feminised occupations are often low paid, insecure, and less socially desirable as a result of their status, time and socially-ascribed roles.<sup>(99–101)</sup>

3. Devaluing women’s work. In the labour force, women do not tend to gain the same level of recognition or reward as men.<sup>(93)</sup> Social norms regarding the lesser value of women’s work mean that women’s economic contributions are devalued.<sup>(102,103)</sup> This translates to feminised professions attracting a “wage penalty” relative to other sectors, which impacts men and women alike but tends to affect women the most, particularly women from marginalized backgrounds.<sup>(99)</sup>

### Access to and control over resources

Resources refers to “means and goods, including economic (household income) or productive means (land, equipment, tools, work, credit); political means (capability for leadership, information and organisation); and time”.<sup>(104)</sup> Access refers to “the ability to use and benefit from specific resources (material, financial, human, social, political, etc.)”.<sup>(104)</sup> Control over resources “entails being able to make decisions over the use of that resource”.<sup>(104)</sup> Access to and control over resources is shaped by gender norms and attitudes that operate at individual, family, institutional and societal levels.<sup>(105–107)</sup> This often leads to women having less access to and control over resources that are important to their wellbeing and livelihoods.

### Agency and decision-making

Agency refers to the degree to which people have the ability to challenge constraints in their lives.<sup>(89)</sup> This is closely linked to the concept of capabilities, which refers to “the capacity and agency that people need to exercise choice and achieve valued objectives, given the resources at their disposal and their location within relationships of power”.<sup>(Sen (1999) cited in (89))</sup> While everyone has some degree of agency, this operates within certain limits. Gender power relations constrain choice and agency: women are often denied their agency through patriarchal attitudes that assert men’s authority over women, lack of access to resources and the unfair distribution of reproductive labour.<sup>(Kabeer (2001) cited in (89))</sup>

While many women are powerful leaders of change, they are often excluded from decision-making in the household and in economic and political spheres.<sup>(108,109)</sup> Unfair distribution of caregiving responsibilities, lack of education, low income and discriminatory laws and practices are just some examples of gendered barriers to decision-making.<sup>(109)</sup> Participation in decision-making is a critical gender issue because equitable participation can help shape decisions that benefit everyone, in health and care work and beyond.

### 3.3 Introducing the Gender Value Gaps framework

The Gender Value Gaps framework (Fig. 2) developed for this report, helps demonstrate how health and care work is undervalued, why this undervaluation is a gender issue and what can be done about it. The Gender Value Gaps framework builds on the concept of the “gender division of labour” (Box 1) and is designed to address four key gender gaps:

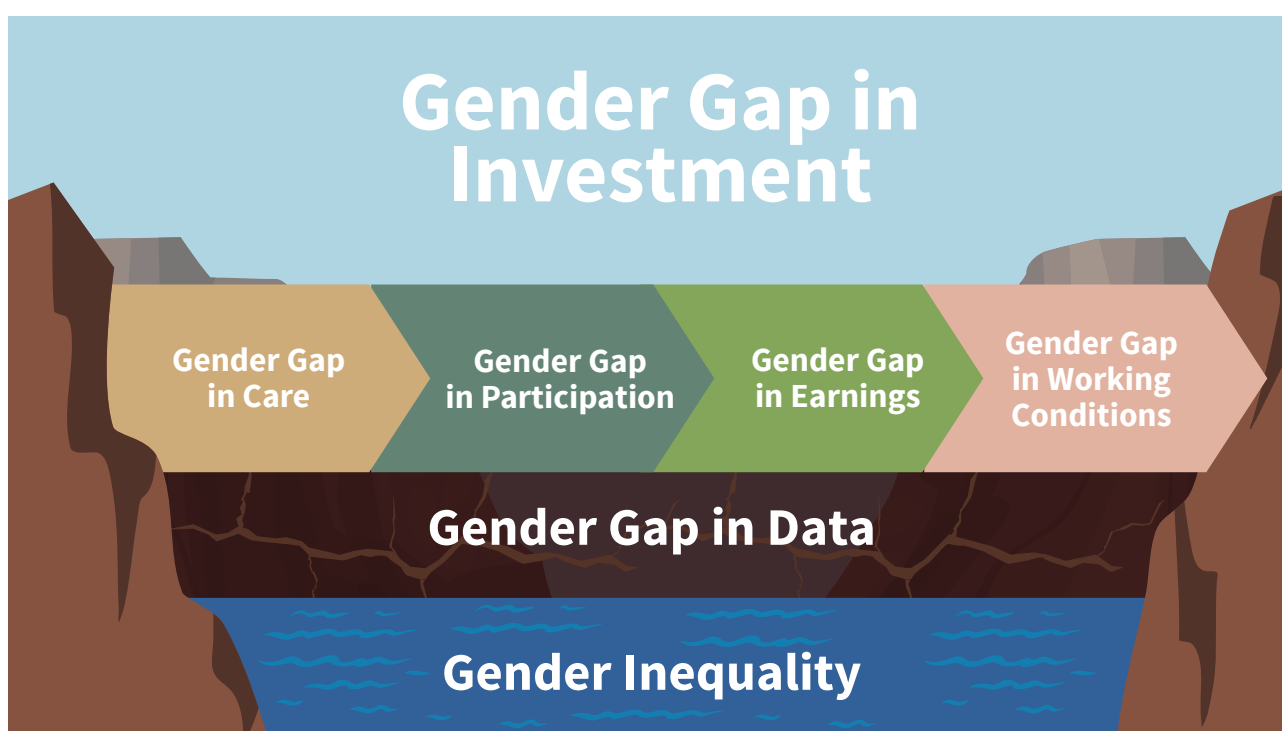
1. the Gender Gap in Care
2. the Gender Gap in Participation

3. the Gender Gap in Earnings
4. the Gender Gap in Working Conditions.

A lack of appropriate sex or gender-disaggregated data reinforces these gaps, and as a system these gaps culminate in sector-wide underinvestment. Respectively, these reflect the Gender Gap in Data and the Gender Gap in Investment.

The Gender Value Gaps framework will be used in Section 4 to explain the impact of each of the gender gaps in health and care work, and how they culminate in sector-wide undervaluation of and underinvestment in health and care work.

Fig. 2: The Gender Value Gaps framework



### 3.4 Methods

#### 3.4.1 Literature review

The Gender Value Gaps framework and subsequent analysis is based on a literature review that sought to understand the gendered nature of health and care work, why underinvestment in health and care is a gendered issue and the role of a gender-equitable health and care workforce in promoting an inclusive recovery from the COVID-19 pandemic. Note that this report does not refer to COVID-19 in a technical sense, but rather to the economic recovery from the economic downturn related to COVID-19.

A rapid scoping review was conducted between October and December 2021, and updated in March 2022 and June 2023, to understand and articulate the full spectrum of health and care work, gender inequalities in health and care work, the impact of COVID-19 on gender inequalities in health and care work and the investment case for gender-equitable health and care work. Rapid reviews are a “timely and affordable approach that can provide actionable and relevant evidence to strengthen health policy and systems.”(110) The rapid review approach is outlined in Box 2.

## Box 2: Summary of rapid review methods

Key steps in the rapid review process include topic selection and refinement, deciding on the scope of the review, identification of a target audience, searching the literature, extracting and synthesizing the evidence and developing a report.<sup>(110)</sup>

- **Topic:** the topic of the review was the understanding and articulation of the full spectrum of health and care work, gender inequalities in health and care work, the impact of COVID-19 on gender inequalities in health and care work and the investment case for gender equitable health and care work.
- **Scope:** the review was situated at the intersection between gender, labour, and health policy and research, with a focus on the health and care workforce in order to capture the fullest picture of women's contributions to health and care work across a range of settings.
- **Audience:** the review was designed to support Member States' dialogue on gender equality and health, building back from COVID-19 in a more gender-inclusive way, as well as to outline practical steps for policy implementation at the national level.
- **Type of review:** a scoping review and descriptive synthesis were performed. The review was designed to better understand and map out existing concepts and approaches. It attempted to outline the contribution of women to the health and care economy, and to begin to map how a gender equitable health and care workforce may contribute to societal objectives in the wake of COVID-19.
- **Resources used:** an internet-based search was used to identify relevant reviews, as well as policy and advocacy reports and other global-level evidence. The resources of UN organisations were prioritized. Academic literature was gathered through Scopus and PubMed databases, where necessary, but this was limited to international review articles. In particular, the search targeted World Health Organization (WHO), International Labour Organization (ILO), and Organisation for Economic Co-Operation and Development (OECD) reports, given their track record of publishing on health and care work. Reports were cross-referenced to include additional relevant information.

**Data extraction and synthesis:** information was extracted across six key areas:

1. articulating the impact of the COVID-19 pandemic on women's health and care work;
2. understanding the full spectrum of health and care work from a feminist perspective;
3. synthesizing critical gender concepts and analysis approaches relevant to understanding the Gender Value Gaps in health and care work;
4. outlining the contributions of women to health and care work, including identifying gender inequalities in health and care work;
5. mapping how gender equality in health and care work contributes to the economy;
6. articulating the investment case for gender-equitable approaches to health and care work.

This report draws on a broad array of resources from nursing, labour, gender, and private sector studies to feminist economics, advocacy initiatives and development research. The report uses information from policy reports published by UN and other international and intergovernmental

organizations, and draws on peer-reviewed literature. Several data and evidence gaps were noted, particularly for unpaid health and care work, informal health and care work and migrant health and care workers.

### 3.4.2 Data compilation

The data for the analyses were compiled using sex or gender-disaggregated information for the period 2000–2020 and were extracted from several sources, including the WHO Global Health Observatory (GHO), ILO, the National Health Workforce Accounts (NHWA), OECD, the United Nations Industrial Development Programme (UNDP), the United Nations Industrial Development Organization and the World Bank. Although data on unpaid, nonstandard and informal health and care work are sparse, they were included where possible. Data were cleaned and merged, using the commonalities of country

and year. Groups of indicators are summarized below in Box 3. More details on the indicators included in the database can be found in Annex 1.

The paucity of data, especially sex or gender-disaggregated data, limited the analyses. A complete case analysis approach was adopted, meaning that country-years with incomplete or missing data were not included. As a result, the sample size in most analyses was small and open to reporting and selection bias. Although the results provide new and important information, these data limitations mean that these results must be interpreted with caution.

#### Box 3: Summary of key indicators

##### Gender Gap in Care

- Sex-disaggregated data on time spent in all forms of unpaid work, including unpaid care work, in OECD countries and China, India and South Africa were derived from national time-use surveys taken from the OECD Employment Database.

##### Gender Gap in Participation

- Sex-disaggregated data on labour force participation rates in the health and care sector and other sectors by sex and economic activity were derived from the ILO Dataset on Employment and were available for 187 countries.
- Data on the density of health and care workers were derived from NHWA. Sex-disaggregated data on both doctors and nurses were available for 102 countries.

##### Gender Gap in Earnings

- Data for the earnings gap in all sectors and within the health and social care sector by sex and economic activity were derived from the ILO dataset on Wages and Working Time Statistics, utilizing the International Standard Industrial Classification for All Economic Activities (ISIC) category “health and social work”.

##### Gender Gap in Working Conditions

- Data on employment in the informal economy by sex and economic activity were derived from the ILO Labour Force Statistics dataset on employment outside the formal sector.
- Statistics on nonstandard forms of employment and domestic and migrant workers were derived from the literature.

##### Gender Gap in Investment

- Data on national total spending on health were derived from the WHO Global Health Expenditure Database.
- Other statistics on national spending in health services and on health and care workers were derived from the literature.



### Health system performance

- Health service coverage, reflected by data on universal health coverage (UHC), is represented by two components: the UHC service coverage index and data on financial protection.
- The UHC service coverage index reports data on the following sub-indexes: tracer indicators on reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access.
- UHC financial protection reports catastrophic household expenditure on health (that is, household expenditure that places significant financial hardship on families) and is captured by the following indicators:
  1. population with household spending on health at > 10% or > 25% of household income
  2. population pushed below poverty line at US\$ 1.90 per day and US\$ 3.20 per day marks
  3. population pushed below poverty line (> 60% of median daily income).

### Population health

- Data on population health outcomes by life expectancy at birth (years), maternal mortality (deaths per 100,000 live births) and infant mortality rates (deaths per 1000 live births) were derived from the GHO.

### Gender equality

- National-level data on gender equality were derived from the Social Institutions and Gender Index (SIGI) data, accessed via the OECD development database, and the Gender Inequality Index published by UNDP.

### National economic indicators

- National economic performance indicators, including GDP per capita in purchasing power parity (PPP) rates and GDP growth, were derived from World Bank national accounts data, and the OECD National Accounts data.

### 3.4.3 Data analysis

A series of unadjusted, bivariate and descriptive analyses were performed using data disaggregated by country and year to outline, where possible, the extent and impact of each of the gender gaps. These exploratory analyses were structured around the Gender Value Gaps framework. First, descriptive analysis was performed to summarize each of the Gender Value Gaps. Then, to understand the impact of each Gender Value Gap, the following national-level and cross-sectional relationships were explored:

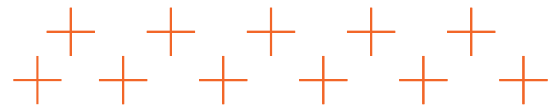
1. the relationship between care gaps, labour force participation, health system performance and population health outcomes;
2. the relationship between participation gaps, labour force participation rates in other sectors, gender inequality, health system

performance and population health outcomes;

3. the relationship between pay gaps and gender inequality in unpaid work, as well as the pay gap between the health and care sector and other sectors; and
4. the relationship between gender inequality, health systems performance, national economic performance, and unpaid work.

These exploratory analyses aimed to illuminate areas where addressing gender equality in health and care work could be most effective, and where the health and care sector could best promote gender equality at the national level. For most associations simple cross-sectional analyses to highlight correlations were completed using scatterplots and lines of best fit. Where appropriate, a simple linear regression was included to quantify the strength of the association.





## 4. Findings from the Gender Value Gaps in health and care work

**This section presents results from the global evidence review and analyses described in Section 3. Each of the gender gaps in health and care work is described, evidence is presented for each gap and, where salient, a case is made for closing the gap.**

### 4.1 The Gender Gap in Care

#### 4.1.1 What is the Gender Gap in Care?

The gender gap in care refers to the gap between women and men (and girls and boys) in the provision of care, namely unpaid care. Globally, it has been estimated that women spend between two and ten times more time on unpaid care than men.<sup>(15)</sup> Prior to the pandemic, women performed an estimated 76% of unpaid care work, amounting to a total of 16.4 billion hours per day.<sup>(3)</sup>

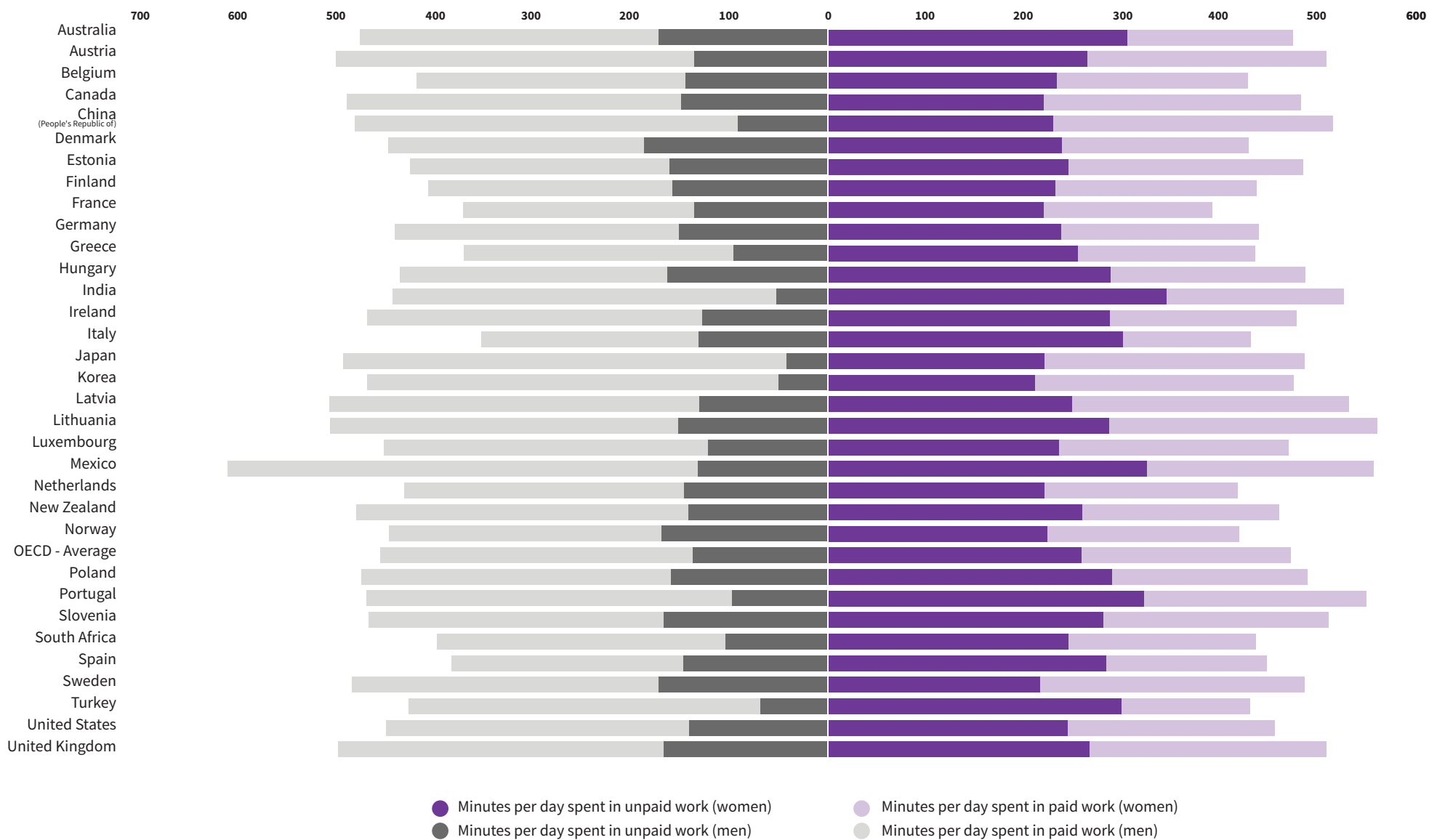
Fig. 3 presents sex-disaggregated time-use data for 2019 from OECD countries, China, India and South Africa. It shows that women in these countries spent on average between 215 and 352 minutes per day on unpaid work,<sup>6</sup> 1.3 to 6.8 times more than men. In India, women spent around 73% of their total daily working time (that is, the combined average time spent on unpaid and paid work recorded through national daily time-use surveys) on unpaid work, compared to men who spent around only 11% of their daily working time on unpaid work. Fig. 4 demonstrates the importance of the care gap for women's economic empowerment: in most countries where data are available, women spend substantially more time in unpaid work and less time in paid work activities than men.

Though there is a close relationship between unpaid care work and unpaid health and care work, the distinction between what constitutes unpaid health care and what constitutes other forms of unpaid work is often unclear, and unpaid health and care work performed in the domestic sphere remains particularly poorly defined.<sup>(10,46)</sup> Women and girls disproportionately provide unpaid, home-based health care “for family members, friends, and neighbours who are acutely or chronically ill or disabled, cannot or will not access health services, or are elderly or dying”.<sup>(10,20,111)</sup>

In the paid workforce there is also a Gender Gap in Care, particularly in roles that are traditionally associated with caregiving, such as nursing and midwifery, where women represent 9 out of every 10 workers globally.<sup>(112)</sup> In many countries, the Gender Gap in Care is influenced by both gender and race: in South Africa for example, black women are over-represented in caregiving roles, particularly in nursing.<sup>(113)</sup> The gender division of labour and participation gaps will be outlined in more depth in Section 4.2.

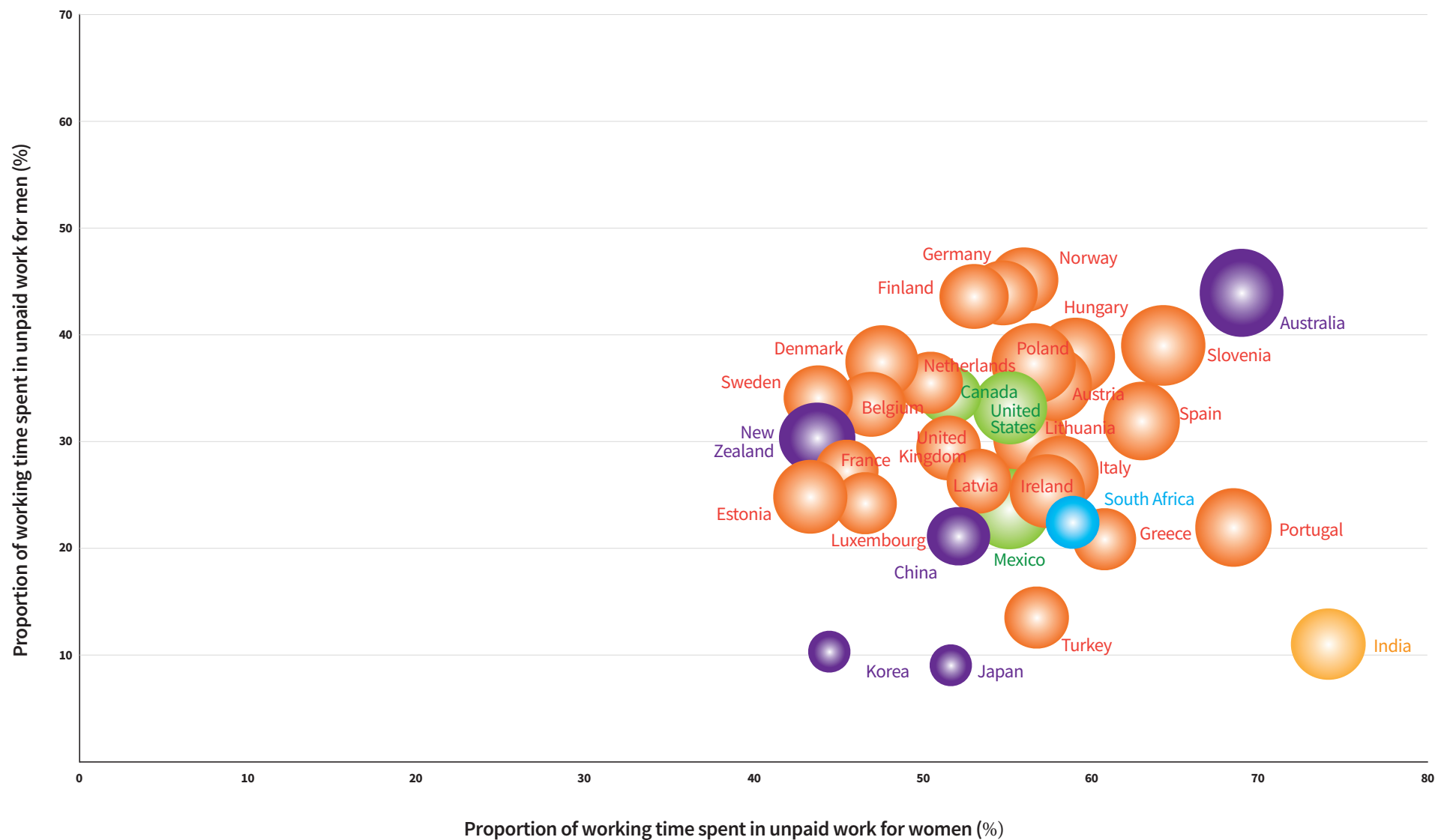
<sup>6</sup> Note that OECD time-use survey data on unpaid work includes: routine housework, shopping, care for household members, child care, adult care, care for non-household members, household activities and other unpaid activities. Time spent on unpaid health or care activities is not specified precisely. However, it is assumed that a substantial component of unpaid work activities constitutes unpaid health or care work.

**Fig. 3: Time spent on unpaid work in OECD countries, China, India and South Africa (2019)**



Source: Data were obtained from the OECD Employment Database, please see Annex 1 for more details.

Fig. 4: Proportion of daily time<sup>a</sup> spent on unpaid work by sex and country<sup>b</sup> (2019)



<sup>a</sup> Size of bubble proportional to total amount of unpaid work performed daily by men and women combined (range 264 minutes/day to 482 minutes/day)

<sup>b</sup> Colours represent WHO regions: African Region (blue); Region of the Americas (green); South-East Asia Region (yellow); European Region (orange); Western Pacific Region (purple)

Source: Data were obtained from the OECD Employment Database, please see Annex 1 for more details.

## 4.1.2 Three reasons why the Gender Gap in Care matters



Unpaid care has an often invisible health and social cost, often borne by women



Unpaid care acts as a barrier to entry into paid work, particularly for women



Unpaid care is exacerbated in resource-constrained settings and during crisis

### Unpaid care work and women's health

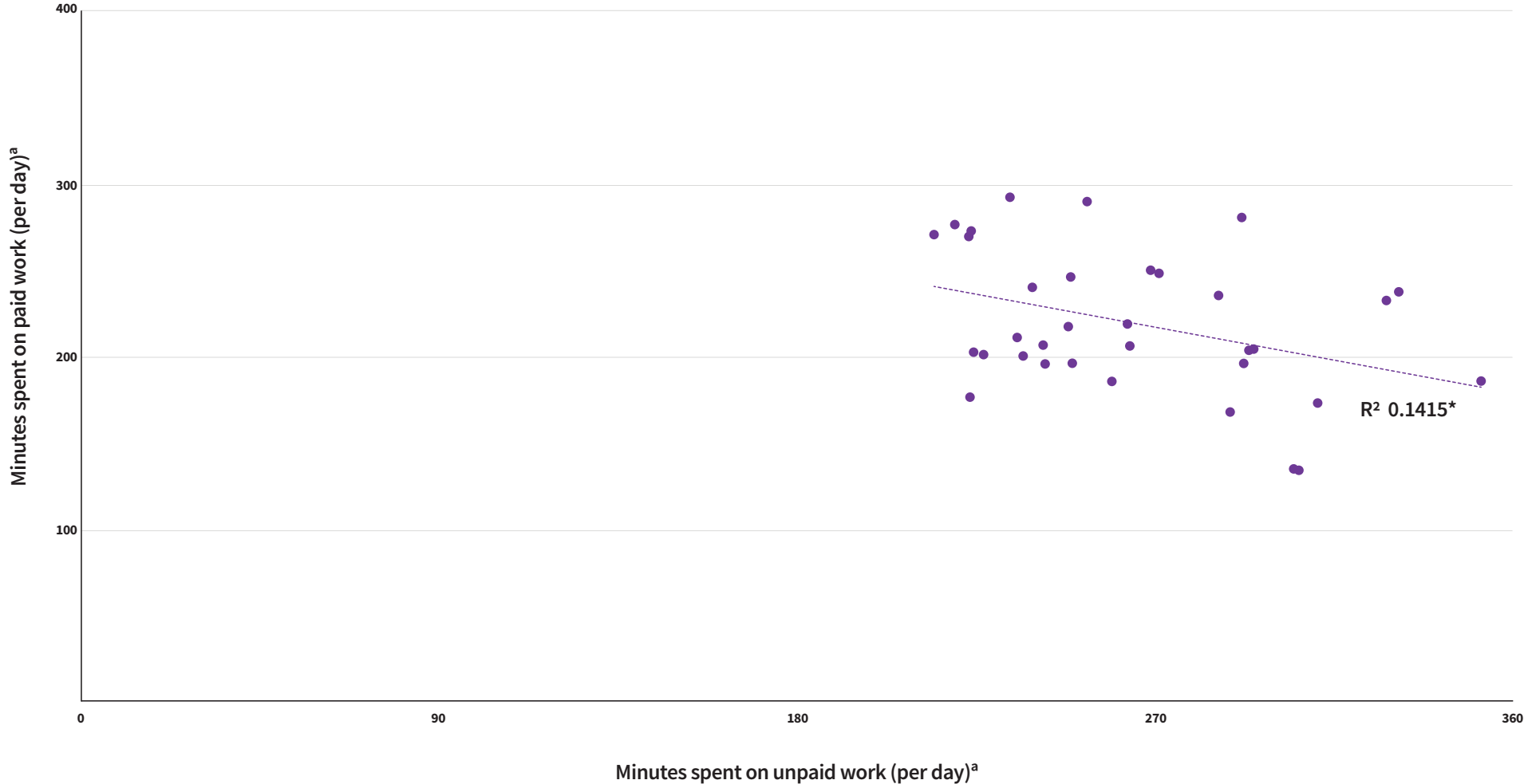
Unpaid care work can be deeply rewarding and enjoyable for those who give and receive it. However, the unequal gender distribution of unpaid care and the limited possibilities for redistributing this work (within the family, community or through formal institutions) can also have a substantial negative impact on caregiver health. For example, unpaid domestic care work has been associated with poorer mental health and reduced quality of life.<sup>(114,115)</sup> Evidence from Japan, Republic of Korea, the United Kingdom and the USA suggests that unpaid care work is associated with increased stress and fatigue, cognitive impairments, excess psychiatric morbidities and lower life satisfaction in women.<sup>(114)</sup> For women in the paid workforce, evidence from Australia, Canada, England, Finland, Ghana, Japan, Scotland, Spain, Sweden, the USA and other European countries suggests that greater amounts of unpaid work are negatively associated with mental health.<sup>(116)</sup> Of unpaid caregivers in the United Kingdom, 70% reported that caregiving during the COVID-19 pandemic had a negative impact on their physical and mental health, with many facing a range of financial

hardships, including having to use a foodbank.<sup>(117)</sup> Unpaid care responsibilities also represent an entrance barrier to the paid workforce and to full-time, secure work with decent pay, another under-recognized socioeconomic determinant of women's health.<sup>(118)</sup>

### Unpaid care work as a gendered barrier to labour force participation

Unpaid care work constitutes one of the most significant entrance barriers to the paid workforce for women: the more time women devote to unpaid care, the less time they spend in the paid workforce.<sup>(3,15)</sup> Gender inequalities in unpaid care have been identified as “the missing link” in the analysis of gender gaps in labour outcomes, largely because women's unpaid care work remains under-recognized and treated as “non-work”.<sup>(3,15)</sup> Fig. 5 and Fig. 6 show an inverse correlation between time spent on unpaid work and paid work for men and women, they suggest that the more time on average spent doing unpaid work, the less time on average is spent on paid work. This correlation is weaker for women than men, although on average women spend more time doing unpaid work and less time doing paid work.

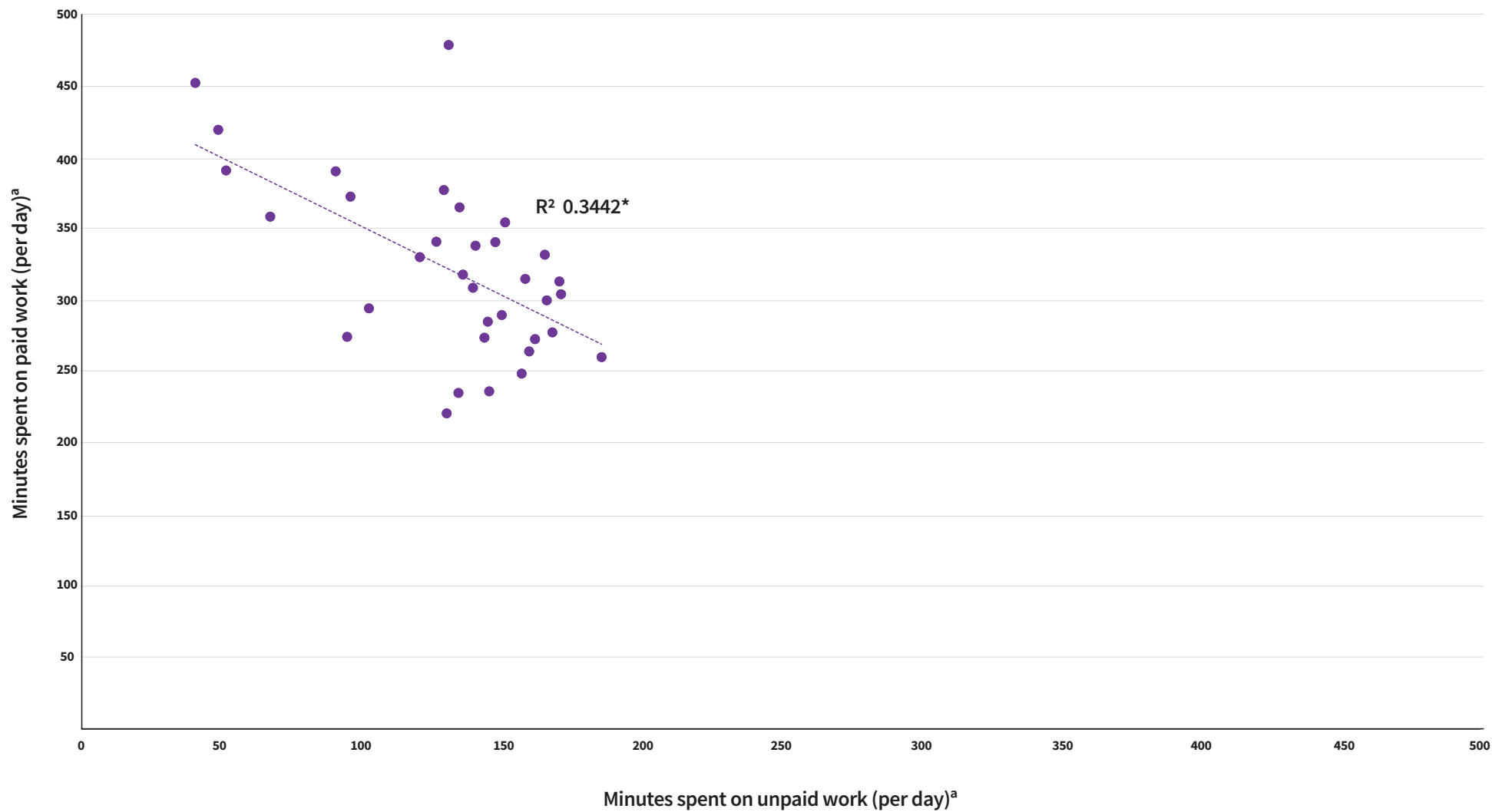
Fig. 5: Daily time spent on unpaid and paid work by women in OECD countries, China, India and South Africa (2019)



\* Coefficient of determination  
<sup>a</sup> Data are normalised to 1440 minutes per day

Source: Data were obtained from the OECD Employment Database, please see Annex 1 for more details.

Fig. 6: Daily time spent on unpaid and paid work by men in OECD countries, China, India and South Africa (2019)



\* Coefficient of determination

<sup>a</sup> Data are normalised to 1440 minutes per day

Source: Data were obtained from the OECD Employment Database, please see Annex 1 for more details.

There are over 3.8 million community health workers (CHWs) globally across at least 98 countries.<sup>(119)</sup> CHWs play a vital role in health systems by extending their impact in particular to remote communities and low-resource settings. However, many CHWs are not fully recognized, integrated, remunerated and supported by health systems. Although data are sparse, surveys in sub-Saharan Africa suggest that only 7–14% of CHWs in the region were salaried or received a stipend for their work.<sup>(120,121)</sup> Therefore, much of the work that CHWs are doing could be categorized as “volunteer work” (that is, work performed for others without pay or profit). This work, however, differs from unpaid health and care work carried out for one’s own household or family, but carries with it much less recognition than that attributed to paid health and care work. The WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes recommends remunerating practising CHWs for their work with a financial package commensurate with the job demands, complexity, number of hours, training and roles that they undertake.<sup>(122)</sup> However, research from a range of common CHW payment models in LMICs found that they do not meet the recommendations on CHW compensation.<sup>(123)</sup> WHO also suggests that a career ladder should be offered to practising CHWs, recognizing opportunities for progressive advancement to higher-level positions in a health system are important for motivation and retention.

### **Unpaid health and care work absorbs health systems functions**

The least well recognized work is unpaid health and care work, performed for the family or household (that is, own-production work). Such work can still act as an extension of health systems functions, for example nursing at home for a family member discharged early. When public health and care services are limited or where barriers to access exist, the amount of unpaid care performed in households can increase.<sup>(124)</sup> Women who live in low-income countries and/or rural areas, those from minoritized backgrounds, or those who have low education or income provide a disproportionate amount of such unpaid care work.<sup>(13)</sup> In the USA, for example, gender inequalities in unpaid care were higher in Hispanic and Asian households than in White households.<sup>(13)</sup>

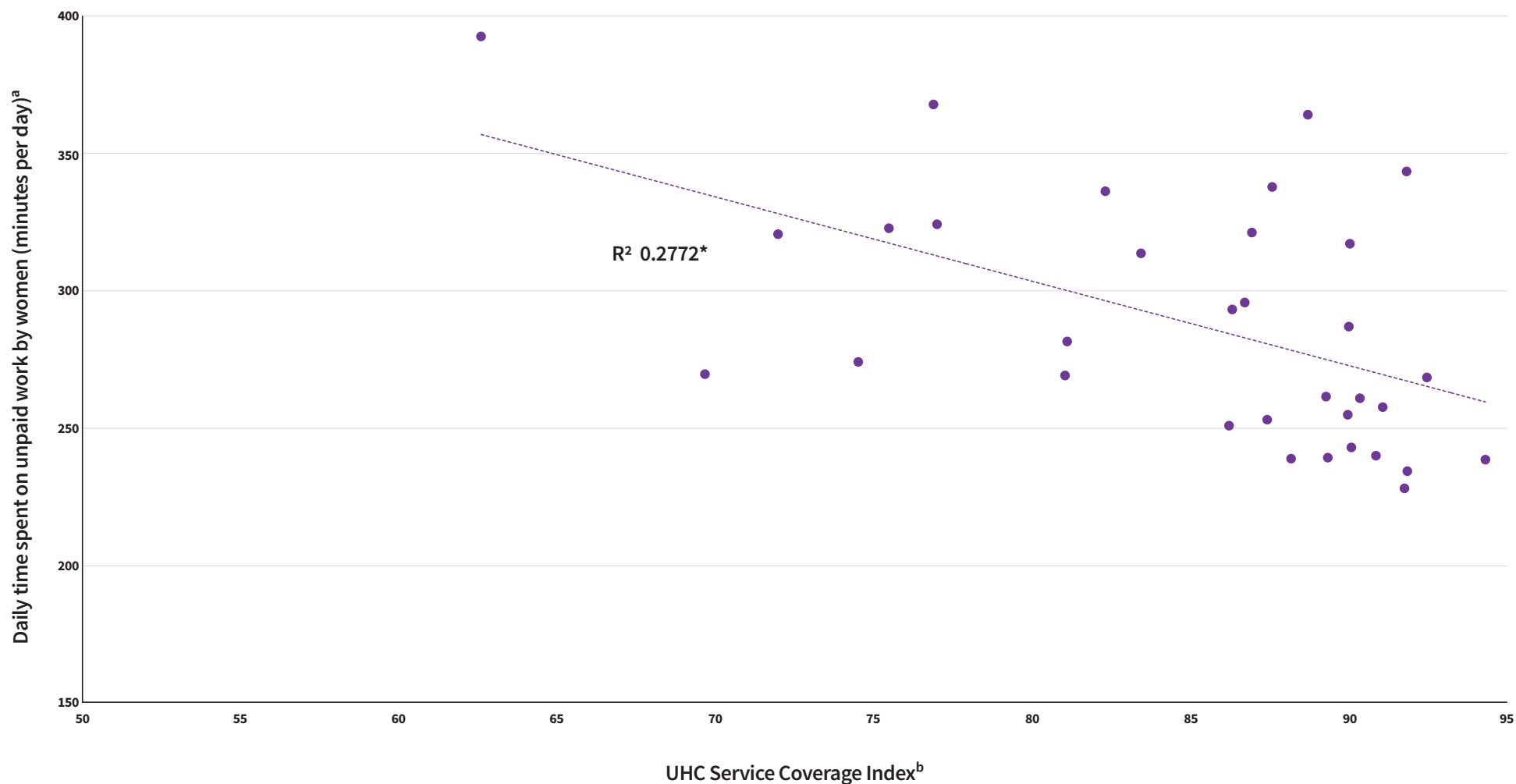
So-called savings in public sector health service provision – cutting hospital stays, for example – can actually represent a transfer of care work onto families and the community, much of which is performed by women.<sup>(49,52)</sup>

The pattern is similar during health emergencies, where reliance on unpaid care increases. Across the world, on average 56% of women reported increased time spent on unpaid care work because of the COVID-19 pandemic, with 33% taking on three or more unpaid care activities.<sup>(125)</sup> Women’s unpaid care responsibilities in OECD countries almost doubled as a result of the pandemic, with women taking on 31% more unpaid care work than men.<sup>(5)</sup> In Samoa, over 80% of women surveyed reported taking on more unpaid care work compared with around 50% of men.<sup>(125)</sup> In Afghanistan, Albania, Kenya and Nepal, over 70% of women reported spending more time on unpaid care work as a result of COVID-19.<sup>(125)</sup> In the United Kingdom, it is estimated that up to 4.5 million people became unpaid carers because of COVID-19, 59% of whom were women, with nearly 3 million juggling paid work with unpaid care work.<sup>(117,126)</sup> In the health and care sector and relative to men, women health and care workers were more likely to report increased workloads in their workplaces while simultaneously taking on more unpaid care work in domestic settings.<sup>(6–8)</sup>

Fig. 7 and Fig. 8 suggest that lower levels of health service coverage (represented by the UHC Service Coverage Index) are weakly correlated with higher levels of and higher gender disparities in unpaid work performed by women. This suggests that in the absence of health service coverage women may take on more unpaid work, and a more gender-unequal amount of unpaid work. Fig. 9 and Fig. 10 suggest that across OECD countries, China, India and South Africa, higher levels of women’s unpaid work are weakly correlated with both lower life expectancy and higher infant mortality.<sup>7</sup> This suggests that both higher levels of unpaid work and its unequal gender distribution are not as effective at achieving population health compared to well functioning health systems. A picture emerges that demonstrates the double negative impact of weak health services and higher levels of unpaid work: first on the health of the unpaid caregivers themselves and second on population health outcomes.<sup>(127)</sup>

<sup>7</sup> A similar relationship exists between gender inequalities in unpaid work (reflecting imbalances in time spent on unpaid work between men and women) and the population health outcomes of life expectancy and infant mortality. The relationship between levels of women’s unpaid work, gender inequality in unpaid work, and maternal mortality is similar to the shape of the relationship found between levels of women’s unpaid work and gender inequality in unpaid work and infant mortality.

Fig. 7: The relationship between health service coverage and daily time spent on unpaid work by women



\* Coefficient of determination

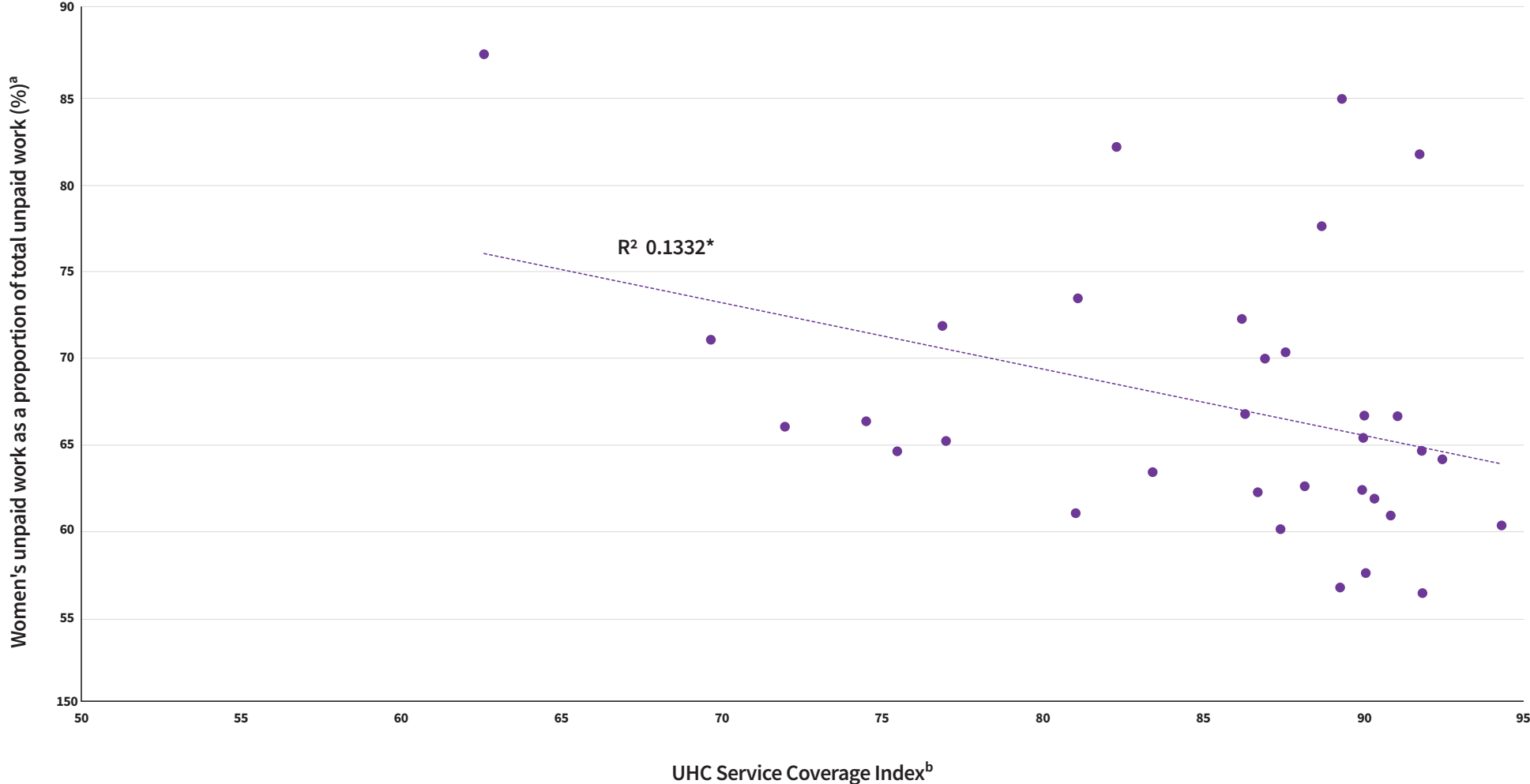
<sup>a</sup> Time use data reported for 2019, with daily time use normalised to 1440 minutes per day

<sup>b</sup> UHC Service Coverage Index expressed as a range of 0 to 100

Sources: Data were obtained from the OECD Employment Database and GHO, please see Annex 1 for more details.



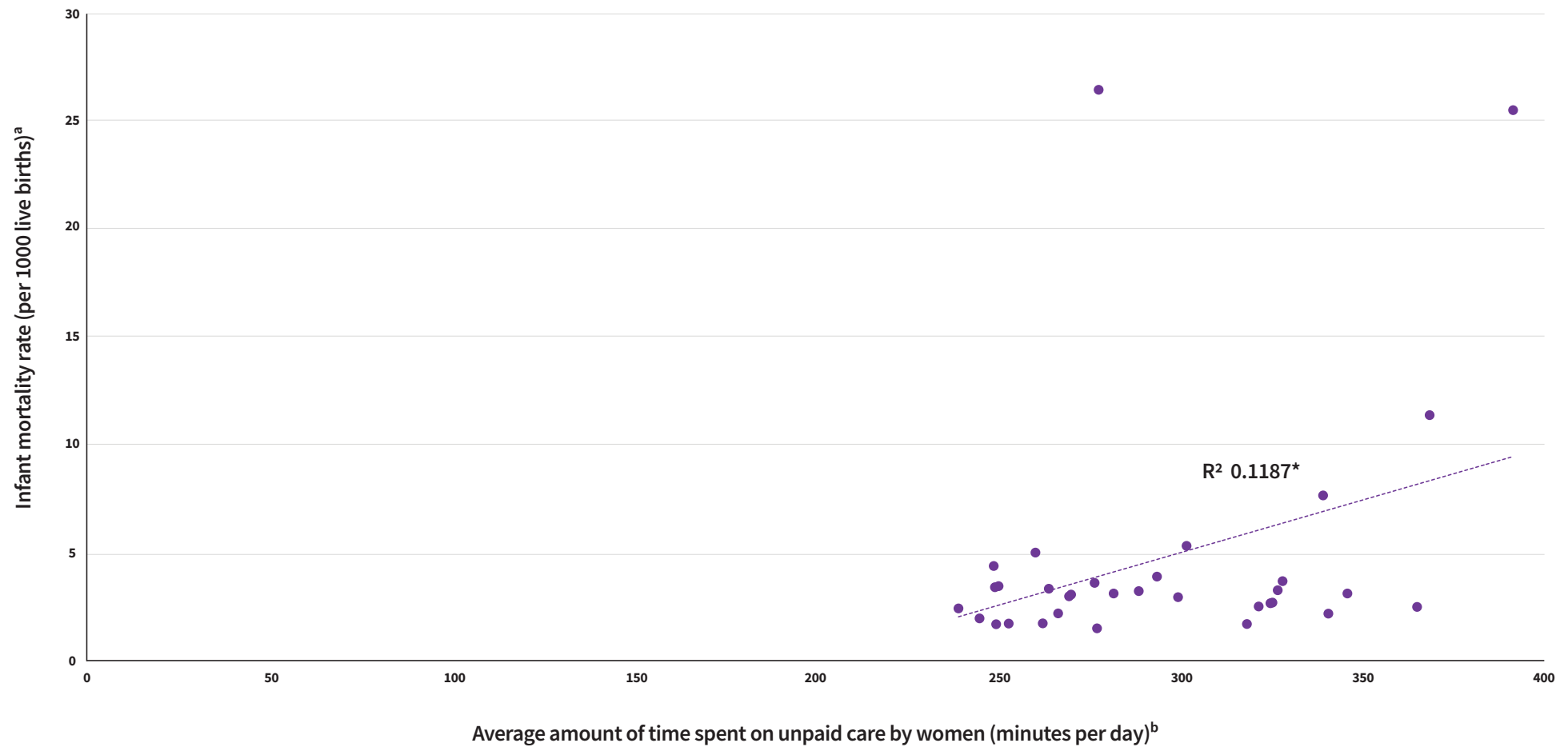
Fig. 8: The relationship between health service coverage and gender disparities in unpaid work



\* Coefficient of determination  
<sup>a</sup> Time use data reported for 2019, with daily time use normalised to 1440 minutes per day  
<sup>b</sup> UHC Service Coverage Index expressed as a range of 0 to 100

Sources: Data were obtained from the OECD Employment Database and GHO, please see Annex 1 for more details.

Fig. 9: The relationship between women's unpaid work and infant mortality



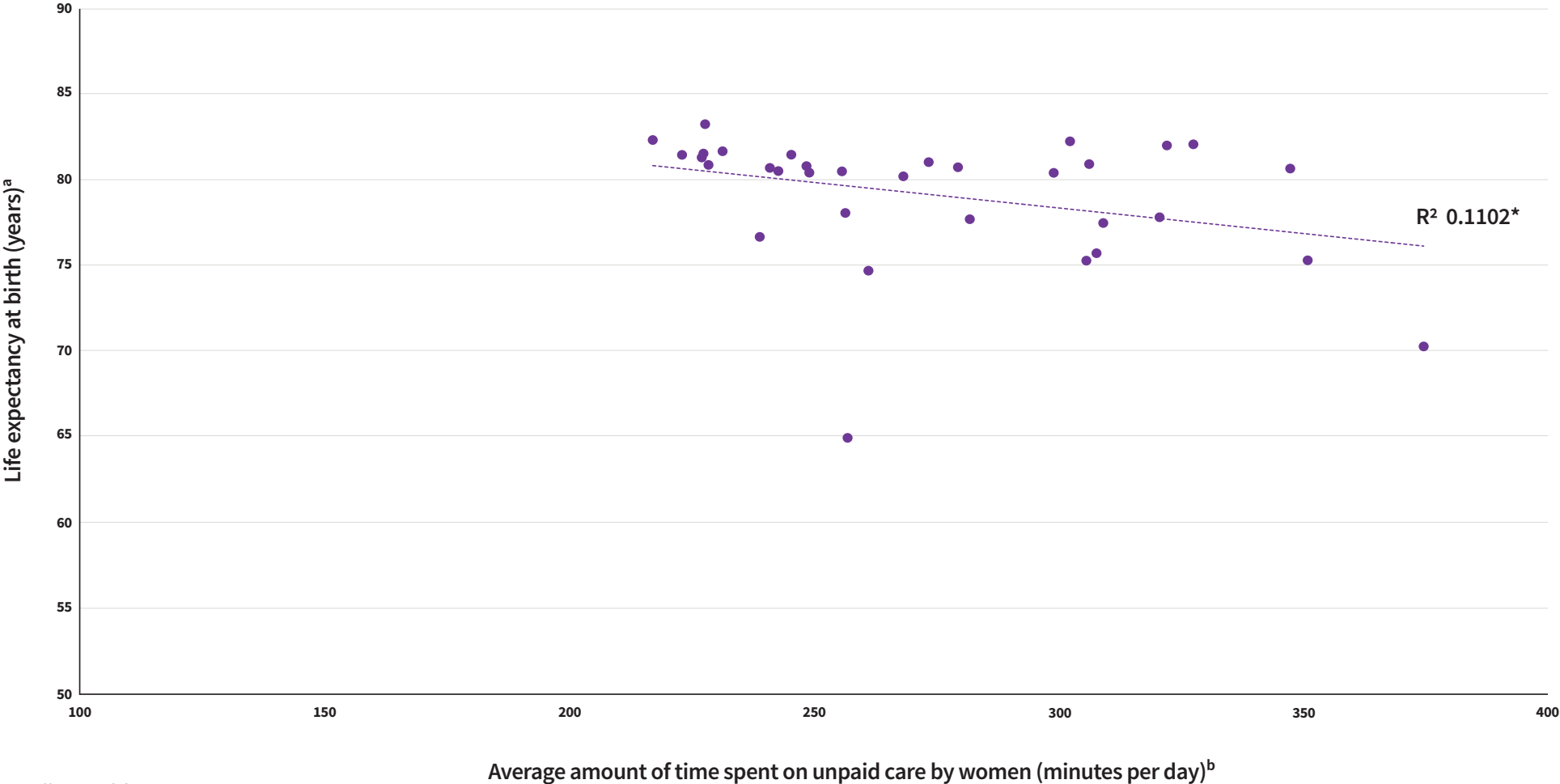
\* Coefficient of determination

<sup>a</sup> Data on infant mortality from 2021

<sup>b</sup> Time use data reported for 2019, with daily time use normalised to 1440 minutes per day

Sources: Data were obtained from the OECD Employment Database and GHO, please see Annex 1 for more details.

Fig. 10: The relationship between women’s unpaid work and life expectancy



\* Coefficient of determination

<sup>a</sup> Data on life expectancy from 2019

<sup>b</sup> Time use data reported for 2019, with daily time use normalised to 1440 minutes per day

Sources: Data were obtained from the OECD Employment Database and GHO, please see Annex 1 for more details.

### 4.1.3 The case for closing the Gender Gap in Care

Unpaid care is a mainstay of women's health and care contributions to society. It has been claimed that the current economic system only survives because of the care work sustaining it.<sup>(128)</sup> The economic value of unpaid care and domestic work from men and women to society is enormous: in 2018 it was estimated at over 9% of global GDP (\$11 trillion, purchasing power parity (PPP)<sup>8</sup> (2011)) annually.<sup>(3)</sup> Estimates suggest a large portion of this may be in the form of unpaid health-specific activities.<sup>(10)</sup> Recent survey data from Europe estimated that unpaid domestic care work contributed between 17% and 32% of total GDP.<sup>(10,129)</sup> The total value of unpaid work was estimated to be up to half of GDP in some countries.<sup>(10,130,131)</sup>

Unpaid care work sustains a healthy, capable and productive society. It has been estimated that between 50% and 60% of the global value of health contributions corresponds to unpaid health work, and that 65% and 70% of this unpaid work is provided by women.<sup>(10)</sup> Economic activities that support unpaid care work performed in households add substantial value to national economies: for example, the value added by unpaid household activities in the United Kingdom was estimated at 63% of GDP.<sup>(132)</sup> In Australia, the Gross Household Product (the economic value added by unpaid labour and household capital) was almost half of total economic activity, with the household economy estimated to be nearly 80% the size of the market economy.<sup>(133)</sup>

Recognizing, reducing, and redistributing unpaid care work – alongside strengthening the public provision of health and care services – will have the dual benefit of addressing population health while enabling women's economic empowerment. Public investment in social care infrastructure is directly linked to increased employment and improved working conditions for care workers, particularly women.<sup>(3,134)</sup> Direct public investment in the care economy across seven high-income countries would generate over 21 million jobs, most of which would go to women.<sup>(135)</sup> Universal provision of childcare services in South Africa could create 2.3

million new jobs and raise female employment by 10%.<sup>(22,29)</sup> The full case for investing in health and social care infrastructure will be outlined in Section 4.6.3 below.

## 4.2 The Gender Gap in Participation

### 4.2.1 What is the Gender Gap in Participation?

The Gender Gap in Participation refers to the gender gap in labour force participation, as well as occupational segregation in health and care work. Globally, in 2022 the labour force participation of women was 47%, compared to 72% for men; the gap of 25 percentage points means that for every economically inactive man there are two such women.<sup>(136)</sup>

However, women comprise a notably higher proportion (67%) of the global health and care workforce.<sup>(17)</sup> Fig. 11 shows that across most countries, women's representation in the health and care sector is higher than their overall economy-wide representation. However, this is not true for all countries: Fig. 12 shows that across low-income countries this pattern is reversed.

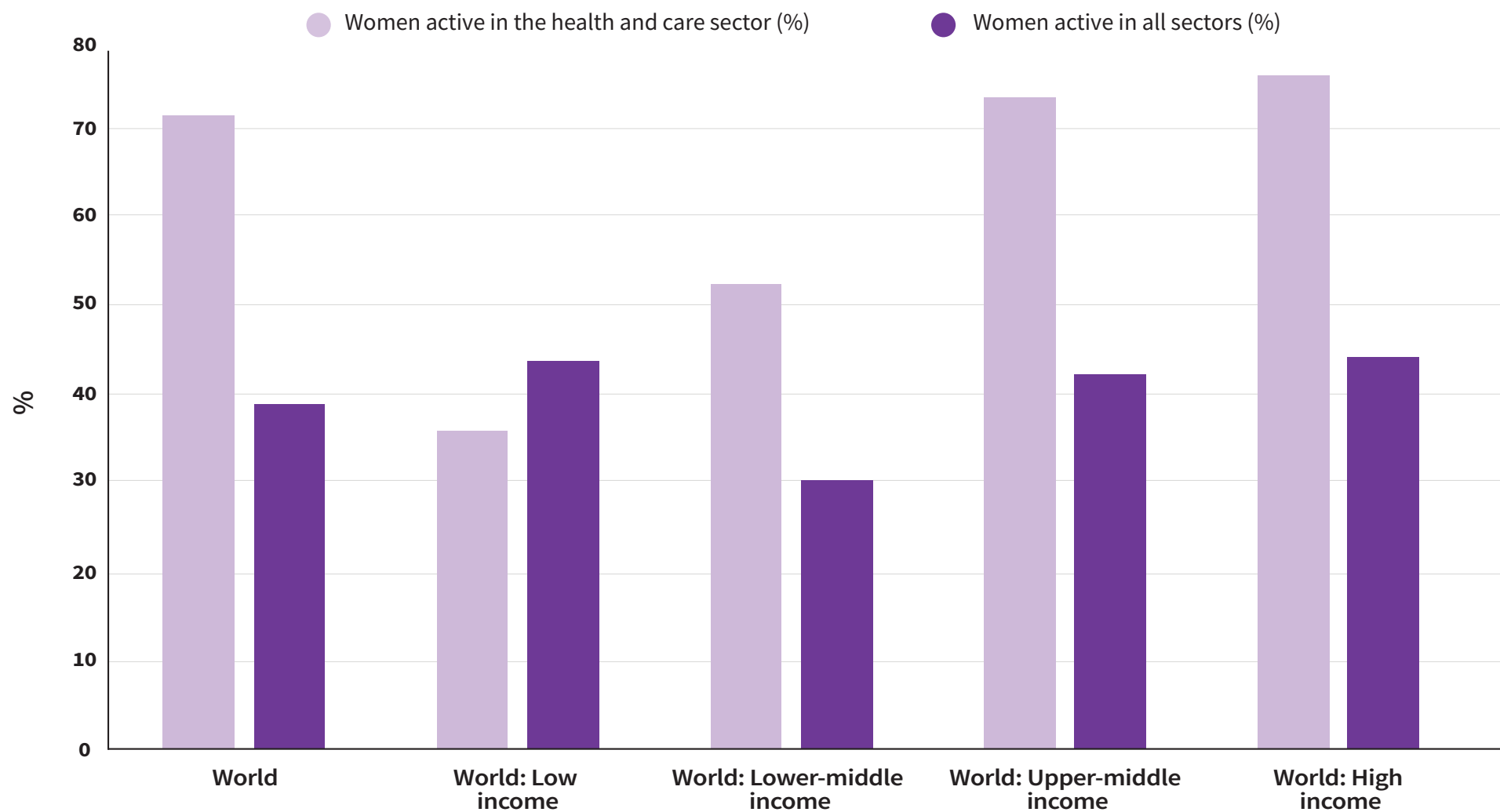
The health and care sector is particularly affected by occupational segregation by gender. Although women comprise the majority of the health and care workforce, they are over-represented in lower-status roles and under-represented in higher-status and leadership roles (vertical segregation).<sup>(17)</sup> Workers in lower-status positions often experience multiple, intersecting forms of marginalization.<sup>(70)</sup> Horizontal segregation<sup>9</sup> is also pronounced in many countries, with women comprising the majority of nurses and midwives, while medical specialties are dominated by men.<sup>(10,17)</sup> While more women are entering traditionally male dominated medical professions, gender imbalances remain.<sup>(2,17,19)</sup> Across 35 countries with available data, women represented between 25% to 60% of doctors and between 30% and 100% of nursing staff (Fig. 11). Sex-disaggregated data from other health and care occupations were not available.

<sup>8</sup> Data are in international dollars. An international dollar is a unit of measurement that has the same purchasing power parity that the US dollar has in the USA at a given point in time. Purchasing power parities (PPPs) are the rates of currency conversion that try to equalise the purchasing power of different currencies, by eliminating the differences in price levels between countries.

<sup>9</sup> Box 1 provides a definition of horizontal and vertical occupational segregation.

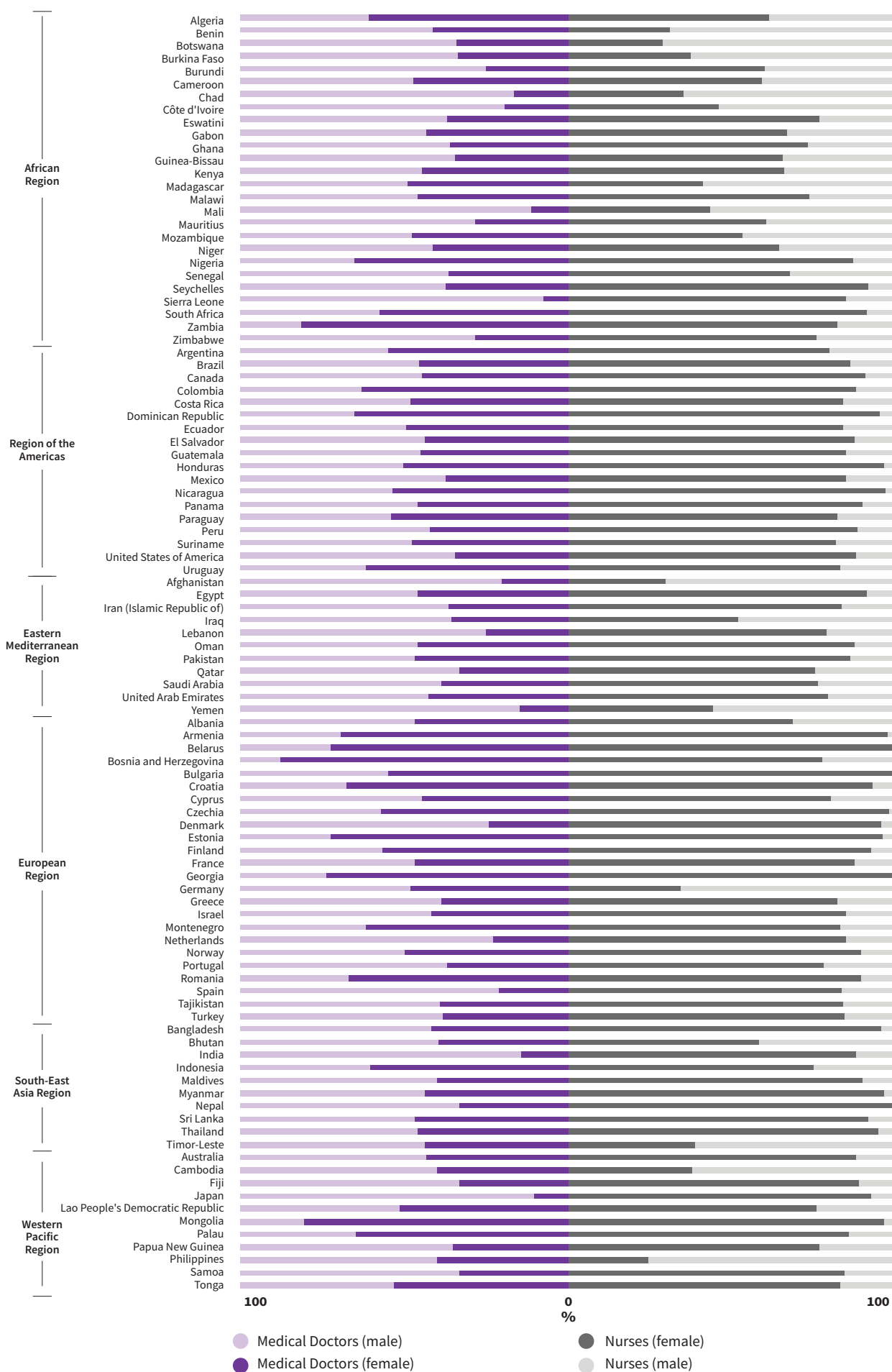


Fig. 12: Proportion of women active in the health and care sector compared to all sectors by national income levels (2019)



Source: Data were obtained from ILO, please see Annex 1 for more details.

Fig. 13: Doctors and nurses by sex and country (2011–2021)



Source: Data were obtained from WHO National Health Workforce Accounts Data Portal, please see Annex 1 for more details.

## 4.2.2 Three reasons why the Gender Gap in Participation is important



Gender inequality in labour force participation is associated with poorer health system outcomes



Occupational segregation and other forms of gender inequality have a limiting effect on the productivity, distribution, career progression and motivation of health and care workers



Occupational segregation affects the Gender Gap in Earnings, and means sectoral wage conditions in health and care are lower compared to other sectors

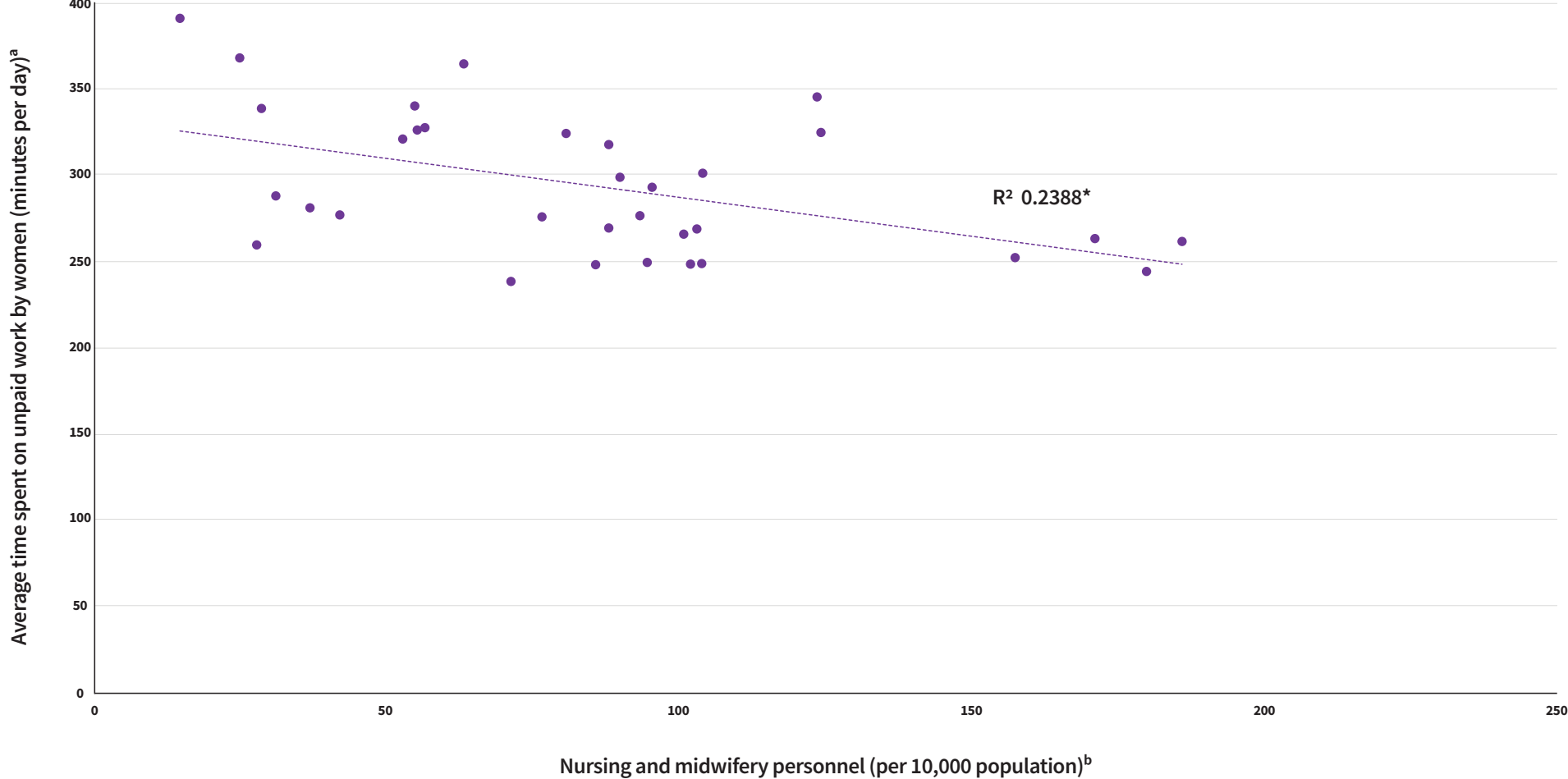
### Gender inequality in labour force participation

Gender inequality in labour force participation impacts health systems performance. First, gender inequality acts as a barrier to labour force participation: for example, Fig. 14 shows that lower nurse density is correlated with higher amounts of unpaid work performed outside of health systems. Lower health worker density also has implications for patient safety and quality of care, with staffing levels having been shown to impact patient morbidity and mortality.<sup>(137)</sup>

Second, women's labour force participation may be correlated with improved health system performance and health outcomes: Fig. 15, Fig. 16 and Fig. 17 suggest that relatively higher levels of women nurses are correlated with higher health service coverage, infant mortality and life expectancy. Fig. 18, Fig. 19 and Fig. 20 suggest that a more gender-balanced physician workforce may also be correlated with the same improvements, but the relationship appears weaker.



Fig. 14: Relationship between nurse and midwife density and the level of unpaid work performed by women



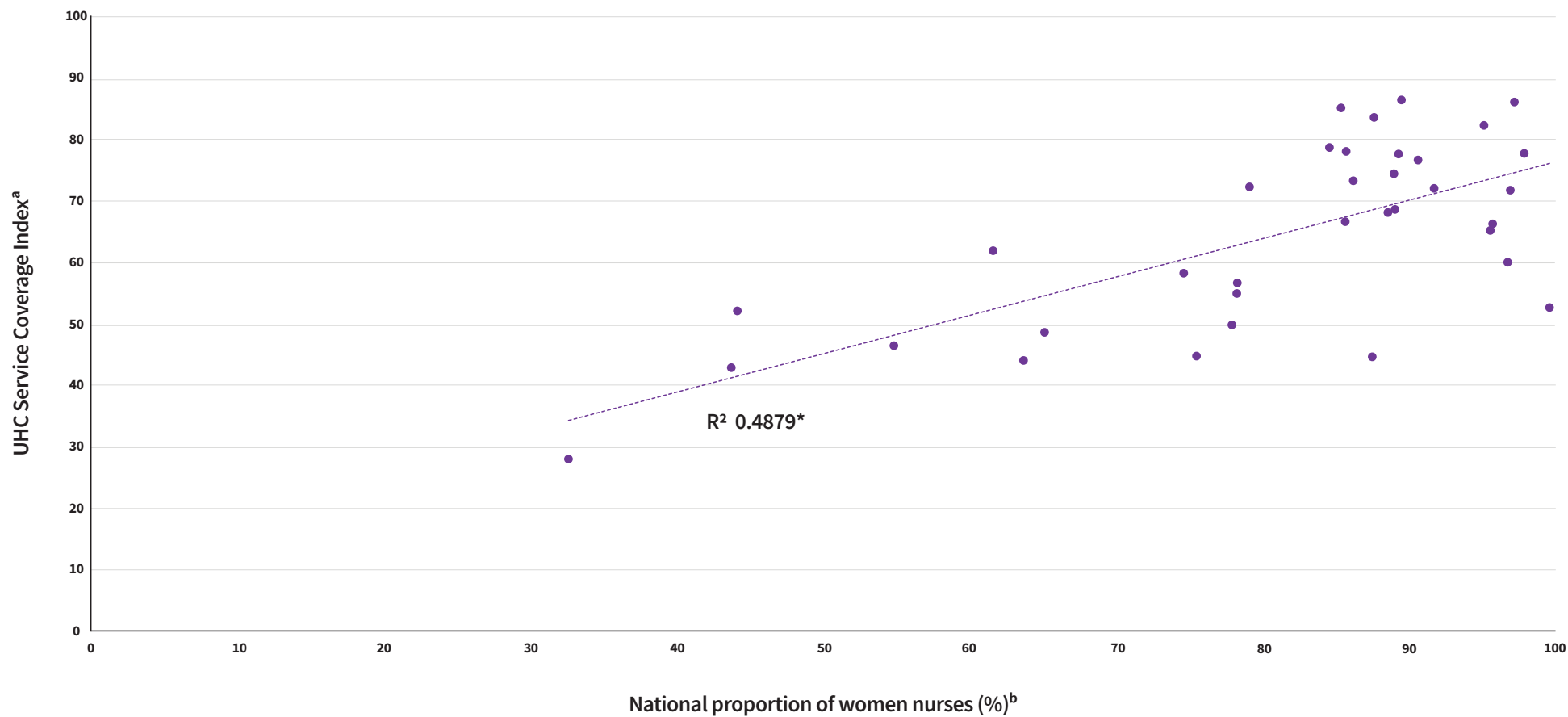
\* Coefficient of determination

<sup>a</sup> Data on time spent reported for 2019

<sup>b</sup> Data on nursing and midwifery density reported for 2018

Sources: Data were obtained from the OECD Employment Database and GHO, please see Annex 1 for more details.

Fig. 15: The relationship between proportion of women nurses and UHC service coverage



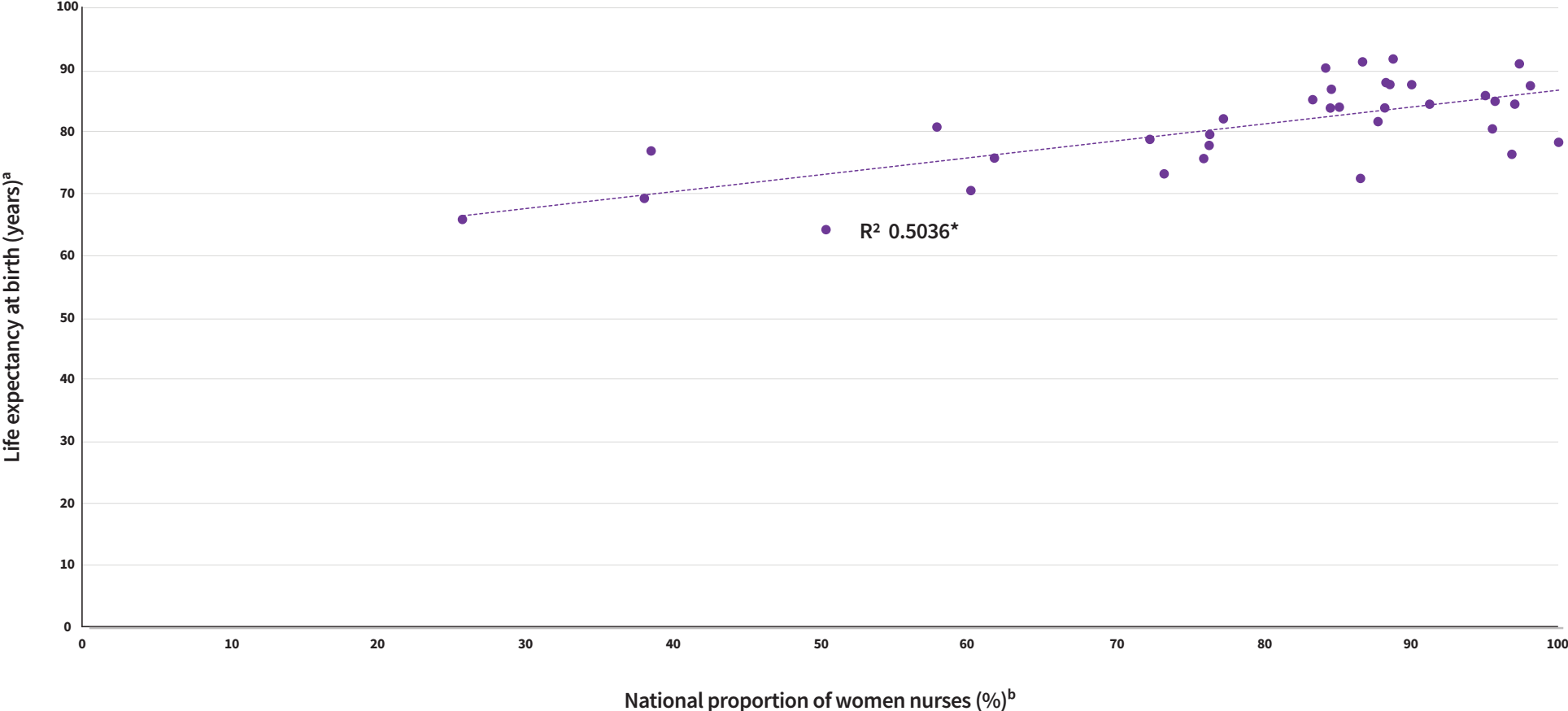
\* Coefficient of determination

<sup>a</sup> UHC Service Coverage Index expressed as a range of 0 to 100

<sup>b</sup> Data on nursing and midwifery density reported for 2018

Source: Data were obtained from GHO, please see Annex 1 for more details.

Fig. 16: The relationship between proportion of women nurses and life expectancy at birth



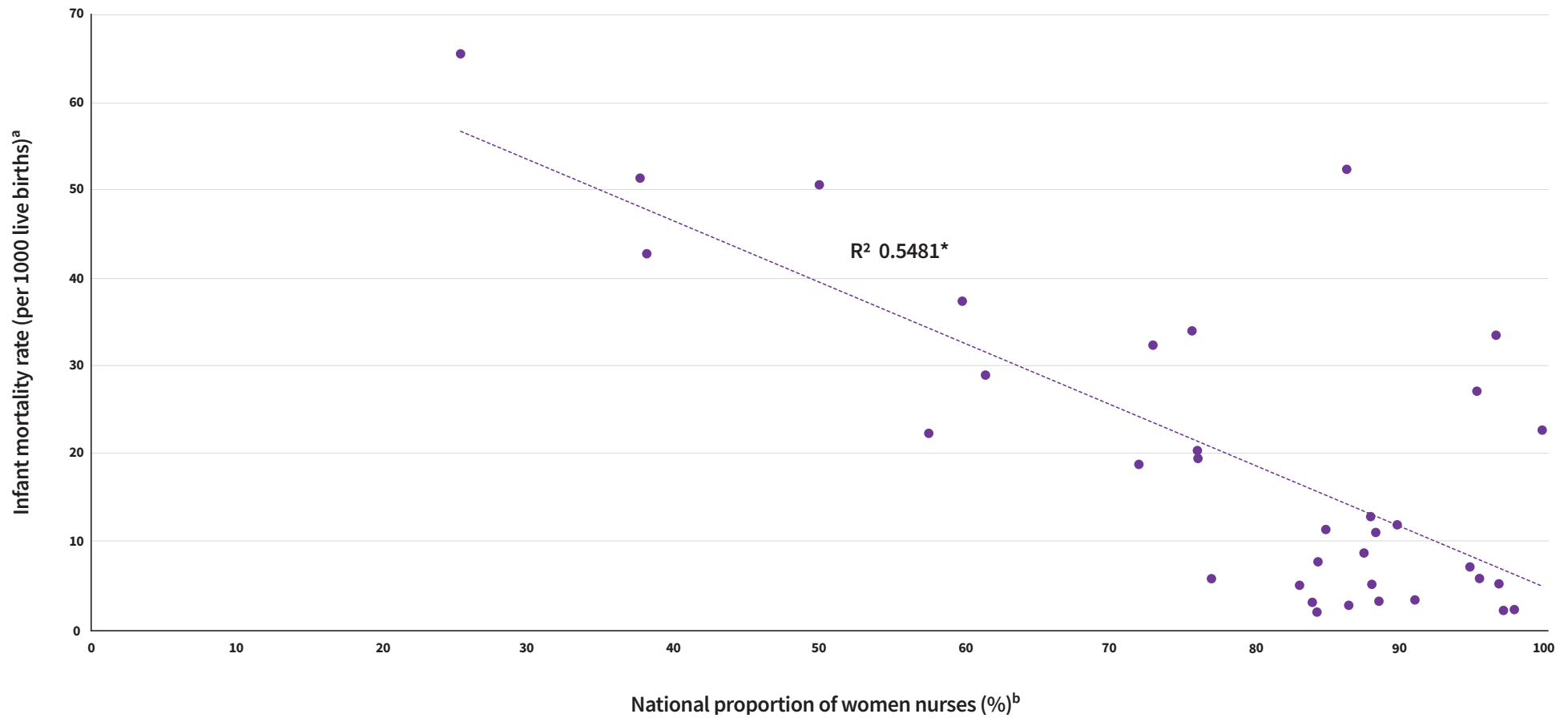
\* Coefficient of determination

<sup>a</sup> Life expectancy data reported for 2019

<sup>b</sup> Data on nursing and midwifery density reported for 2018

Source: Data were obtained from GHO, please see Annex 1 for more details.

Fig. 17: The relationship between proportion of women nurses and infant mortality rate



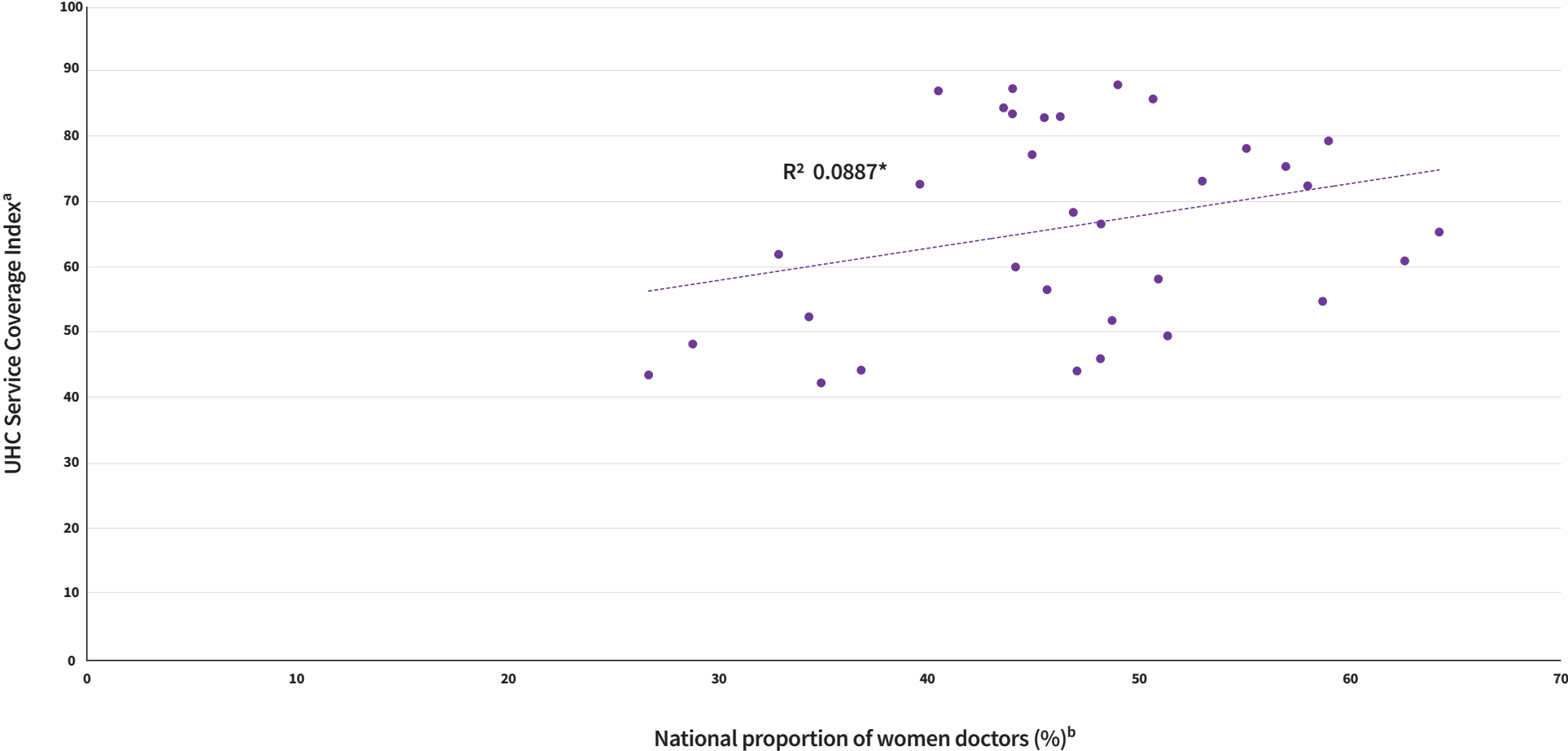
\* Coefficient of determination

<sup>a</sup> Infant mortality data reported for 2021

<sup>b</sup> Data on nursing and midwifery density reported for 2018

Source: Data were obtained from GHO, please see Annex 1 for more details.

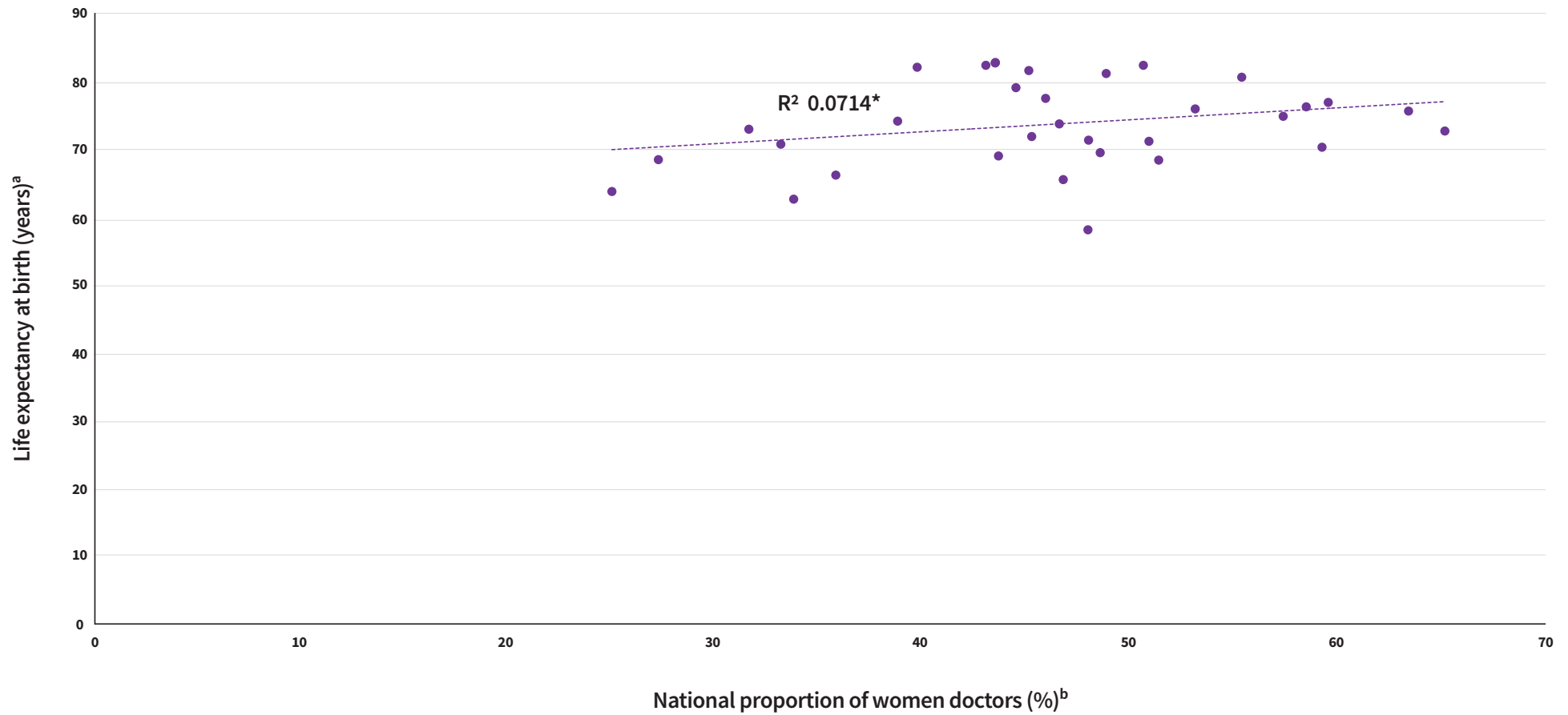
Fig. 18: The relationship between proportion of women doctors and UHC service coverage



\* Coefficient of determination  
a UHC Service Coverage Index expressed as a range of 0 to 100  
b Data on doctor density reported for 2018

Source: Data were obtained from GHO, please see Annex 1 for more details.

Fig. 19: The relationship between proportion of women doctors and life expectancy at birth



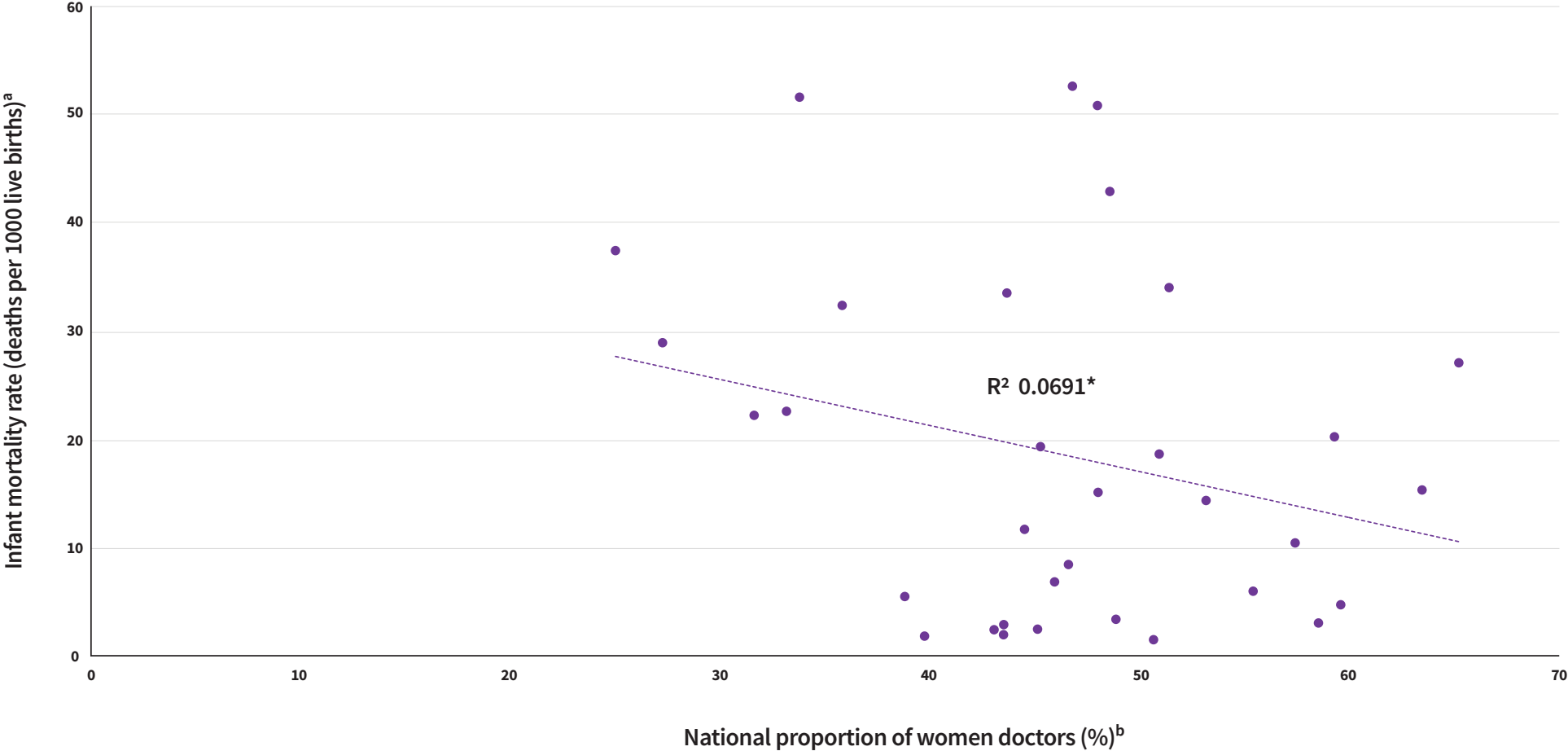
\* Coefficient of determination

<sup>a</sup> Life expectancy data reported for 2019

<sup>b</sup> Data on doctor density reported for 2018

Source: Data were obtained from GHO, please see Annex 1 for more details.

Fig. 20: The relationship between proportion of women doctors and infant mortality



\* Coefficient of determination

<sup>a</sup> Infant mortality data reported for 2021

<sup>b</sup> Data on doctor density reported for 2018

Source: Data were obtained from GHO, please see Annex 1 for more details.

## Occupational segregation by gender

Occupational segregation by gender results in health systems that are less efficient because of the limiting effect of gender inequality on productivity, distribution, career progression and the motivation of health and care workers. (23) Further, occupational segregation by gender is a contributing factor in gender pay gaps, with women over-represented in lower-status and lower-paid roles.(1) Gender segregation in labour markets impacts wages for all women but particularly, as discussed in Section 4.3, it has been shown to have a more detrimental impact on minoritized groups.(138,139)

## Workforce feminisation and wage conditions

As a feminised sector, health and care is impacted by the undervaluation of women's work. Feminisation in labour markets often means women are crowded into occupations that have less desirable working conditions, such as low pay. In addition, there is evidence to suggest that as more women enter jobs traditionally dominated by men, such as medicine, the overall wage conditions of these occupations may also decline.(19,99) This impacts both men and women working in health and care relative to other sectors, reducing the overall economic footprint of the sector while driving down the apparent economic value of health and care work.

### 4.2.3 The case for closing the Gender Gap in Participation

Globally, unequal labour force participation is one of the biggest missed opportunities for inclusive economic development. One of the most important determinants of a country's economic competitiveness is its human capital.(140) It has been estimated that gender-unequal labour force participation costs national economies between 5% and 27% of GDP,(141) or up to US\$ 28 trillion annually.(142) Across OECD countries, economies could grow by 12% of their total size if labour force participation rates between men and women converged by 2030.(143) Gender inequality in labour force participation impedes economic performance largely because women are unable to fulfil their full economic and social potential.(144) For example, though women are half the world's working-age population they generate only 37% of

GDP through formal economic activities.(145)

Health and care occupations represent an important and growing source of employment for women.(1,17) Employment growth rates in health and care occupations are around double the rate of overall employment growth.(23) The health and care workforce is predicted to grow even further to meet the demands of a growing and ageing population, and to respond to global social, environmental and health crises.(146) The health and care sector creates jobs for women, and enables lower-paid women to enter the workforce or increase their hours.(31,49) This helps reduce social divisions, gender inequality, barriers to employment in rural areas, and poverty.(31) Health employment for women also translates to social protection benefits often linked to employment, such as sickness and disability insurance and retirement pension benefits.(24)

Investment in health and care work not only creates jobs in the sector itself, but also provides potential sources of employment in adjacent industries that supply needed materials and services.(22,24,135) Such investment also has the potential to expand household income which in turn creates demand across a range of goods and services related to household consumption. (22,135) For every health and care worker, it is estimated there are another 1–2 workers employed to support them. In LMICs this ratio is higher, where 3–4 additional workers are employed for every health worker.(147)

## 4.3 The Gender Gap in Earnings

### 4.3.1 What is the Gender Gap in Earnings?

The Gender Gap in Earnings in health and care work has three dimensions. First, wage conditions are lower in sectors and occupations where women comprise the majority of workers. Second, women in the health and care sector earn less than men for similar work. Third, women accumulate lower lifetime earnings than men due to different patterns of workforce engagement.

Fig. 21 demonstrates that average monthly earnings in the health and social care sector tend to be lower than other sectors, such as education. Monthly earnings in health and care work were also lower than those for “professional, scientific,



and technical activities”,<sup>10</sup> with pronounced disparities in high-income countries.

Further, in the health and care sector women face an average pay gap of 24% compared to men, after controlling for working time, experience, education, occupational category and institutional sector (that is, public versus private sector).(1)

The gender pay gap is often wider for mothers and women experiencing forms of marginalization based on race, ethnicity, or migration status.

(149–151) Pay gaps across the sector are not well explained by differences in productivity relating to human capital, job-specific skill requirements and time investment.(1) Nor do they appear to be explained by choice of specialty or hours worked.(17) Even in occupations where they comprise the majority, such as nursing, women report a pay gap

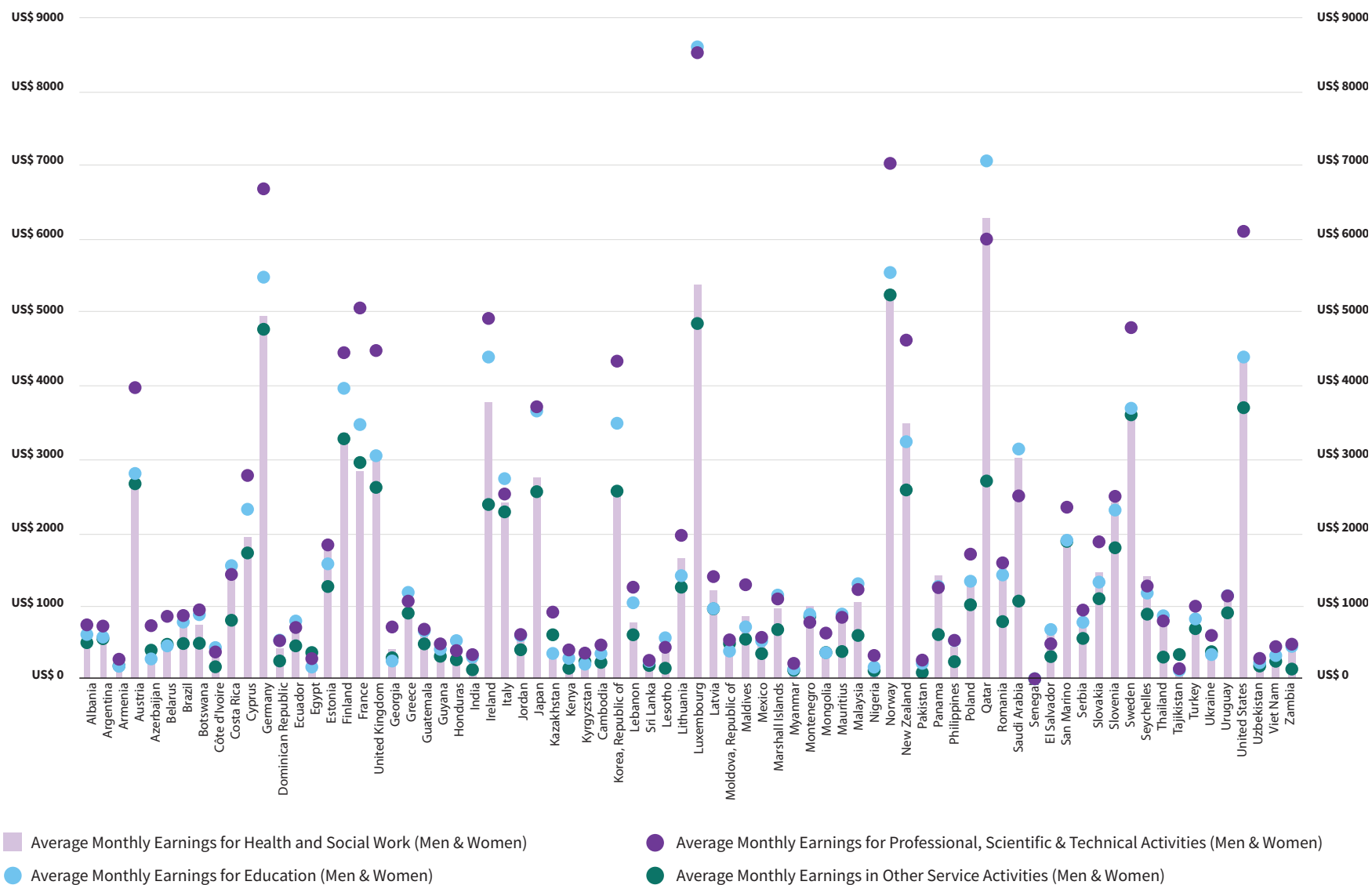
relative to men.(152,153) For a large number of countries the Gender Gap in Earnings in the health and care sector is higher than those in other sectors of the economy.(1)

The Gender Gap in Earnings also reflects different patterns of workforce engagement: namely, women tend to work fewer hours over their lifespan, which accumulates in lower lifetime earnings than men.(154,155) Across most countries where data are available, ILO evidence suggests that women are more likely than men to work part time or take time out of their jobs, which has been linked to the fulfilment of reproductive, unpaid care, and domestic work duties.(155) This culminates in a gender gap in both lifetime earnings and pensions.

---

<sup>10</sup> The ISIC code of “professional, scientific and technical activities” includes activities for which more advanced professional, scientific and technical skill levels are required, such as: translation and interpretation, business brokerage, appraisal, auditing, surveying, weather forecasting, and consulting.(148)

Fig. 21: Average monthly earnings by sex in the health and care sector compared to monthly earnings<sup>a</sup> in education, professional, scientific, and technical, and other service sector activities<sup>b</sup> (2019)



<sup>a</sup> Data on earnings were converted to US dollars as the common currency

<sup>b</sup> Information on sectoral activities were defined by ISIC categories

Source: Data were obtained from ILO Wages and Working Time Statistics Database, please see Annex 1 for more details.

### 4.3.2 Three reasons why the Gender Gap in Earnings is important



**The Gender Gap in Earnings means the overall wage conditions are lower compared to other sectors**



**The Gender Gap in Earnings impacts labour force supply and productivity, and leads to loss of talent in the health and care sector**



**Women suffer economically, limit their reinvestments in their family and community, and are more likely to retire into poverty**

The underpayment of women's work is both an equity and an economic issue. It is an equity issue because everyone has the right to equal pay for equal work without discrimination. It is an economic issue because pay gaps mean women suffer economically and limit their investments in their family and community.<sup>(10,156)</sup> Pay gaps also limit productivity: across all sectors and skill mixes, a wider gender pay gap equates to lower sectoral growth.<sup>(157)</sup> In the USA alone, research suggests that gender-unequal pay costs the economy US\$ 541 billion annually.<sup>(158)</sup> In the health and care sector, remuneration is a determinant of labour force supply and productivity, with poor wage conditions associated with supply-side inefficiencies and higher staff turnover.<sup>(138,139)</sup> Both occupational segregation and lower wages lead to a loss of talent in the health and care workforce, which is already facing substantial shortages.<sup>(17,31)</sup>

The undervaluing of women's work also impacts the economic footprint of the sector.<sup>(20,21)</sup> A substantial component of public expenditure on health comes from the wage bill,<sup>(159)</sup> and the relatively lower levels of remuneration for the sector, not to mention lower remuneration for women, may mean that the sector wage bill is lower than it should be, thus under-reflecting the true value of the health workforce in national accounting systems.<sup>(20,21)</sup> Thus, the Gender Gap in Earnings in the health and care sector may affect national employment expenditure statistics, with the effect of further driving down the apparent economic value of health and care work.

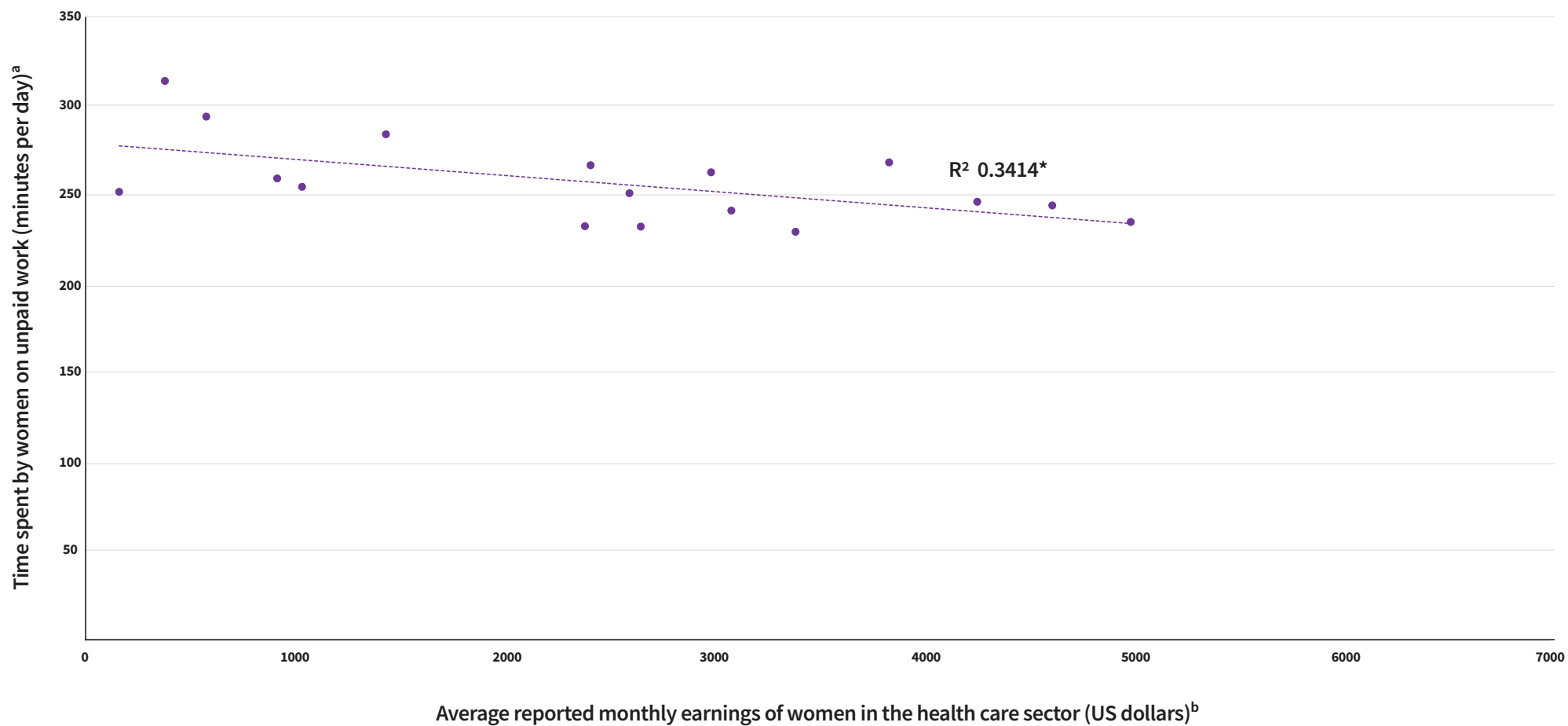
The Gender Gap in Earnings is closely linked to the gender pension gap, where a combination of unpaid, part-time, nonstandard and lower-paid work across women's working lifespans culminates in lower pension benefits. In particular, unpaid caregiving responsibilities mean women are more likely to take on more part-time and nonstandard work, which means they miss out on earnings and associated pension benefits.<sup>(160)</sup> Lower lifetime earnings, combined with a gender pension gap, mean that more and more women are retiring into poverty.<sup>(149,154)</sup>

### 4.3.3 The case for closing the Gender Gap in Earnings

Closing the Gender Gap in Earnings has substantial economic and social benefits. Women in LMICs could be US\$ 9 trillion better off "if their pay and access to paid work were equal to that of men".<sup>(161)</sup> The money women earn can have substantial economic ripple effects: data suggest that women are more likely to reinvest their earnings in their families and communities. Globally, on average 90% of women's earnings were directed towards their families' wellbeing, compared to only 30–40% of men's.<sup>(10,156)</sup>

Fig. 22 suggests that women's earnings in health and care are correlated with lower levels of unpaid domestic and care work. Fig. 23 shows that higher monthly earnings for women in the health and care sector were correlated with lower levels of unpaid work performed by women outside the labour market.

Fig. 22: The relationship between time spent by women on unpaid work and average monthly earnings of women in the health and care sector (2019)



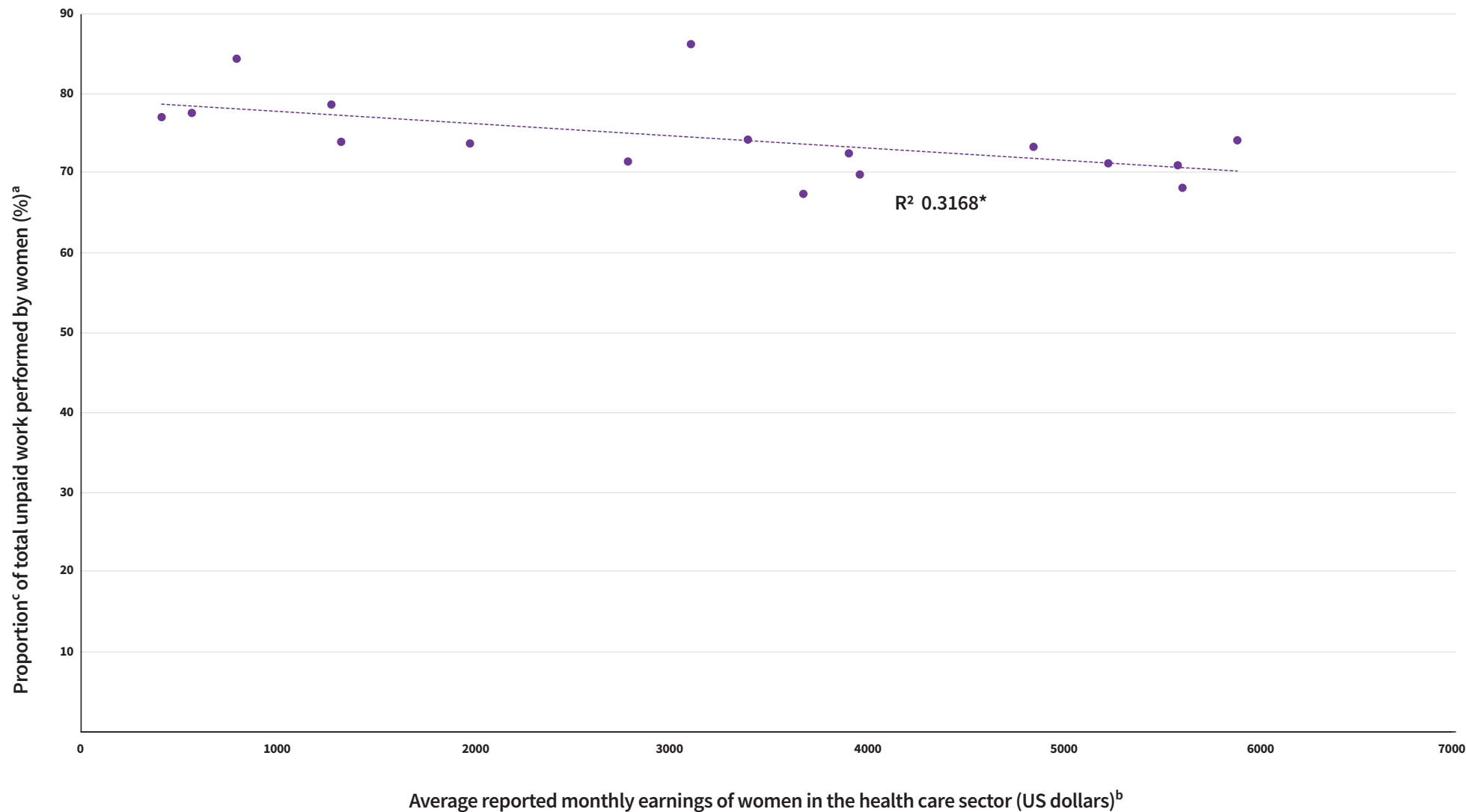
\* Coefficient of determination

<sup>a</sup> Time use data reported for 2019, with daily time use normalised to 1440 minutes per day

<sup>b</sup> Data on average monthly earnings in the health care sector reported for 2020–2021

Sources: Data were obtained from the OECD Employment Database and ILO, please see Annex 1 for more details.

Fig. 23: The relationship between the proportion of unpaid work performed by women and average monthly earnings of women in the health and care sector (2019)



\* Coefficient of determination

<sup>a</sup> Time use data reported for 2019, with daily time use normalised to 1440 minutes per day

<sup>b</sup> Data on average monthly earnings in the health care sector reported for 2020–2021

<sup>c</sup> To calculate the proportion of unpaid work performed by women nationally, the total average amount of unpaid work performed by women was divided by the total amount of unpaid work performed at the national level for both men and women

Sources: Data were obtained from the OECD Employment Database and ILO, please see Annex 1 for more details.

## 4.4 The Gender Gap in Working Conditions

### 4.4.1 What is the Gender Gap in Working Conditions?

The Gender Gap in Working Conditions reflects gender inequalities in health and care work. Contractual arrangements and harmful gender norms combine to devalue women's work, leaving many women vulnerable to discrimination, poor working environments and workplace violence. (162) This section focuses on violence in the workplace, precarious working conditions in the informal economy, and nonstandard forms of employment. These factors are underpinned by intersectional forms of discrimination related to gender, race, ethnicity, migration status, age, ability and class.

#### Workplace Violence and Gender

Women in the health and care workforce experience a range of challenges that threaten their wellbeing. One extreme form is violence. Workplace violence is often rooted in unequal gender power relations (that is, GBV) and exacerbated by intersecting forms of discrimination such as ableism, ageism, classism, racism and xenophobia. (163) Workplace violence is an urgent issue in the health and care sector, with some estimates suggesting that nearly a quarter of the world's workplace violence occurs in health and care workplaces. (164) It has also been reported that around half of all health workers have experienced violence in their working life. (165) However, women working in feminised health and care occupations such as nursing and midwifery “disproportionally face discrimination and sexual harassment at work, which increases poor health, stress, and attrition”. (112) National estimates highlight concerning patterns of violence against women health and care workers across the world: in the USA, around 30% of women academic medical staff reported sexual violence in the workplace; in the Republic of Korea, 64% of nurses reported verbal abuse and 42% reported threats of violence; in Rwanda 39%

of health workers surveyed reported at least one form of workplace violence; and in Nepal, 42% of women health workers surveyed reported sexual harassment. (163) Many health and care workers feel unsafe at work: in Bangladesh, skilled birth attendants feared that home visits, particularly at night, placed them at risk of sexual assault; in Malawi and Ghana, young unmarried women midwives reported concern for their personal safety; in Kenya, CHWs reported threats of violence from the husbands of women offered tests for HIV. (163) Outside the workplace, women health and care workers also face other serious forms of GBV, such as intimate partner violence. (166)

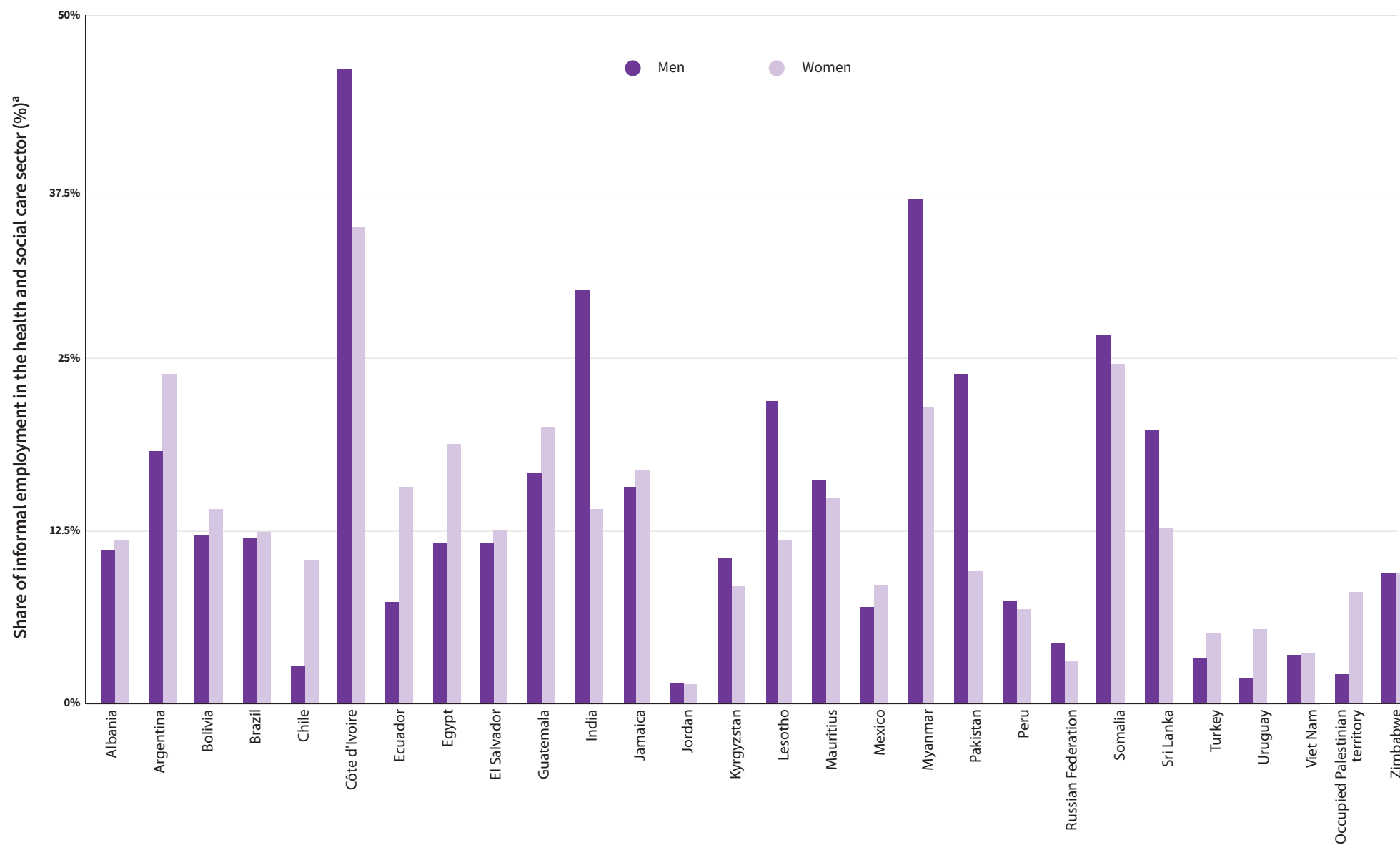
#### Nonstandard employment and employment in the informal economy

Nonstandard<sup>11</sup> forms of health and care employment and employment in the informal economy<sup>12</sup> have significant gender dimensions that affect the safety and quality of working environments. Nonstandard forms of employment, such as casual work and dependent contracting, are more common in occupations like nursing, which are simultaneously impacted by gender power dynamics. (168–170) At the same time, more than 2 billion people (over 60% of the world's employed population) are in informal work, of which an estimated 93% occurs in LMICs. (171) In the health and care sector, there is a lower proportion of informal employment compared with the wider economy. However, Fig. 24 shows that women tend to perform comparable or higher proportions of this informal health and care work relative to men in various countries, most notably in South and Central American countries. Currently, very few data exist to provide further details about the nature of informal employment in the health and care sector.

<sup>11</sup> Nonstandard employment has become a feature of contemporary labour markets and includes “temporary work, part-time work, temporary agency work and other multi-party employment arrangements, disguised employment relationships and dependent self-employment”. (167)

<sup>12</sup> The informal economy can be thought of as “all economic activities by workers and economic units that are – in law or in practice – not covered or insufficiently covered by formal arrangements”. (34)

Fig. 24: Share of informal employment in the health and social sector by sex and country (2019)



<sup>a</sup> Share of employment outside the formal sector is calculated by comparing the reported amount of informal employment to total employment at a national level

Source: Data were obtained from ILO's Labour Force Statistics Data, please see Annex 1 for more details.

## Paid work in domestic settings

Particular groups of health and care workers, such as domestic and migrant workers, may face notable gendered challenges attributable to their work environments. There are substantial overlaps in the experiences of these health and care workers: for example, globally 81% of domestic workers are informally employed, and nearly one in five are international migrants.<sup>(172,173)</sup> The workplace experiences of such workers in the health and care sector are shaped by intersecting factors relating to their gender, migration status, legal status, ethnicity, language and race.

LTC is one example of work that is often performed in a domestic setting, where informal and unregistered care workers, often migrant women, are directly employed by households.<sup>(174,175)</sup> There is a growing demand for LTC globally, although global data on the nature and conditions of the work remain scarce.<sup>(176)</sup> Where data are available, evidence highlights the overlapping gender, migration-related, and economic drivers of precarious domestic work conditions: in Austria, for example, a large portion of LTC is provided informally (over 54% by informal arrangements and 34% by mixed formal and informal arrangements) by women (63% in residential settings and 73% in home care) and self-employed migrants, brokered through intermediary agencies, who commuted between their home country (often Romania or Slovakia) and their workplace.<sup>(175)</sup>

## Migrant workers

There were around 232 million migrants and 150 million international migrant workers in 2013.<sup>(177)</sup> Globally, migration for work is an increasingly feminised phenomenon, with women comprising over 44% of migrant workers worldwide.<sup>(177,178)</sup> Migrants also comprise a large share of the health and care workforce, particularly in high income countries. For example, one in six doctors across OECD countries studied abroad; migrants make up 12% and 17% of the health workforce in the United Kingdom and the USA, respectively.<sup>(179–182)</sup> International health worker migration is increasing and becoming more complex, including within-country, within-region, LMIC to LMIC, and high-income country to LMIC migration.<sup>(183)</sup> This has substantial gender dimensions, with nursing – a women-majority profession – comprising the dominant form of migrant health work.<sup>(184)</sup> In care work “most care workers are women, frequently migrants and working in the informal economy under poor conditions and for low pay”,<sup>(3)</sup> often in hazardous working conditions.<sup>(184)</sup> This has life-threatening implications: for example, it has been reported that in the USA migrant nurses from the Philippines comprised 31.5% of nurses who died of COVID-19, despite representing only 4% of the national nurse workforce.<sup>(185)</sup>

### 4.4.2 Why do Gender Gaps in Working Conditions matter?

#### Two reasons why workplace violence matters



**Workplace GBV risks the health and safety of women health and care workers as well as undermines the quality of care and patient safety**



**Workplace GBV negatively impacts attractiveness of the sector, work retention, and career progression**



## Four reasons why nonstandard employment and employment in the informal economy matter



Workers in the informal economy are not covered by regulations that govern formal employment



Nonstandard workers face health risks in the workplace, and are at greater risk of workplace injuries, stress and mental ill health



Low or erratic incomes associated with temporary employment may also impact living standards and drive workers to take on multiple jobs



Precarity in working conditions in the informal economy translates to low productivity and lack of access to finance for enterprises

### 4.4.3 The case for closing the Gender Gap in Working Conditions

Workplace conditions are a major factor affecting health worker recruitment, retention and productivity. The functioning of the entire health and care sector, and the safety and quality of patient care, depends on workers that are safe and healthy.<sup>(137)</sup> The WHO Global Health and Care Worker Compact recognizes that “safeguarding the rights of health and care workers to decent work is also integral to overcoming health and care worker shortages and retaining existing health and care workers. This includes safe, healthy, and enabling work environments”.<sup>(186)</sup> In the workplace, gender inequalities are associated with lost investment, performance and human capital opportunities.<sup>(140,142)</sup> Ultimately, this impacts how health systems perform and compromises their ability to effectively deliver across health, development and sustainability objectives.

There is a strong case for preventing GBV in the workplace: review findings from the private sector in Cambodia, China, Democratic Republic of Congo, Europe, Fiji, Myanmar, Solomon Islands and others found that reducing GBV can improve individuals’ health and productivity, avoid litigation and pay-outs, enhance community

relations and trust, boost confidence in potential investors to increase access to potential finance, positively impact organisational culture, improve morale and productivity, reduce absenteeism and strengthen the recruitment and retention of workers.<sup>(187)</sup>

There is also a strong case for transitioning towards formal employment and investing in decent work for every health and care worker. Globally, “healthy workers have more energy, improved mental health, and are less likely to be absent from work than unhealthy ones”.<sup>(10)</sup> Lower national levels of informal employment are correlated with improved levels of national development, although the direction of causality remains unclear.<sup>(188)</sup> Since informal employment in the health and care sector is higher for women than for men in many countries, formalizing informal jobs and standardizing working conditions for both women and men is important for closing pay gaps.<sup>(1)</sup> Lower levels of informal employment could also signal potentially higher tax revenues for governments, which could in turn enhance states’ abilities to provide social protection.<sup>(188)</sup> Transposing informal employment to the formal economy gives private companies the ability to grow through enhanced productivity, linking to value chains and access

to finance and government supports.(189,190) As described in Section 4.3, providing decent wage conditions for women formerly in precarious employment has the potential to have wider economic ripple effects.

Migrant health worker remittances are an important source of income for their home communities and for women health workers themselves.(191) UN Women recognize that “remittances by women who have emigrated to work—a large proportion of whom migrate for work in the health sector, especially nursing—have an important but undervalued role in improvement of health, wellbeing, and economic development of communities in their new country and in their country of origin”.(192) Understanding and supporting these global care chains and the migrant women who provide health and care work has the potential to boost equality and provide meaningful inroads to financial security for a key segment of the global health and care workforce.

## 4.5 The Gender Gap in Data

### 4.5.1 What is the Gender Gap in Data?

The gender gaps in care, participation, earnings, and working conditions are all underpinned by a lack of adequate sex and gender-disaggregated

data. A lack of reliable data on such a large scale is a significant limitation to understanding and responding to the needs of the health and care workforce. Key information gaps that impede the health and care workforce include a lack of sex or gender-disaggregated data on the employment and wage conditions of all occupations, and data on the nature, extent and working conditions of informal, domestic and unpaid health and care work. For example, standardized sex-disaggregated data on informal employment are either lacking or not recorded consistently by a significant number of countries, rendering monitoring and accountability difficult.(22) Because sex-disaggregated data on many forms of informal, domestic and unpaid health and care work (for example, LTC) are seldom routinely measured in national statistics frameworks, they remain invisible and therefore unvalued.(21,64)

Furthermore, data systems are rarely equipped to examine the intersecting identities of health and care workers, leading to the exclusion of women who experience overlapping forms of discrimination.(70) Although the importance of intersectionality in the health and care sector is clear, these data are rarely available for many countries, particularly LMICs, which further entrenches their invisibility.(113)

### 4.5.2 Two reasons the Gender Gap in Data matters



**Accounting matters: the way that all forms of health and care work are measured and reported impacts the perceived value of the health and care workforce**



**A lack of disaggregated data means decisions are gender blind, and risks further entrenching gender inequalities**

### 4.5.3 The case for closing the Gender Gap in Data

A key factor driving the undervaluation of health and care work is the way it is measured and accounted for in conventional statistics. Inclusive and gender-sensitive<sup>13</sup> data are central

to building the investment case for health and care work because they value unrecognized forms of health and care work while accounting for the broader economic, environmental and social impacts of the health and care sector (discussed in more depth in Section 4.6 below).(21,32)

<sup>13</sup> Gender sensitive is a term that indicates an awareness of gender power dynamics.(84)

More robust, standardized data disaggregated by sex, gender or other intersectional drivers of inequalities has the potential to lead to improved analysis of the health and care labour market, more sustainable domestic and international investments and improved evidence-based national health workforce strategies and gender-responsive health and care policies.(17,193) Sex and gender-disaggregated data can support health and care systems to identify and respond to gender inequities in health, develop gender-transformative policies, more effectively allocate resources and strengthen health systems capacity.(194)

On a broader level, there is a need to rethink the metrics used to represent economic, environmental and social progress. The WHO Council on the Economics of Health for All calls for a transformation of economic thinking to centre health and wellbeing and enhance the value of health and care work through the use of a range of metrics intended to track progress across core societal values.(27) UN Women has also called for a move away from narrow measures of economic performance, such as GDP, towards alternative metrics more sensitive to inequalities, human capabilities and non-market domains such as unpaid care and ecosystem services.(22)

## 4.6 The Gender Gap in Investment

### 4.6.1 What is the Gender Gap in Investment?

Health systems around the world have suffered from decades of underinvestment.<sup>14</sup> Fig. 25 shows that, since 2001, growth in government expenditure on health has seen a global decline.(73) In 2017, there was an estimated US\$ 371 billion gap in funding and a global shortfall of health workers<sup>15</sup> required to achieve the health system targets of SDG 3.(3,196,197) Despite anticipated increases in health spending, projected global financing shortfalls were between US\$ 20 billion and US\$ 54 billion per year, with persisting dependence on out of pocket financing and worsening inequalities in

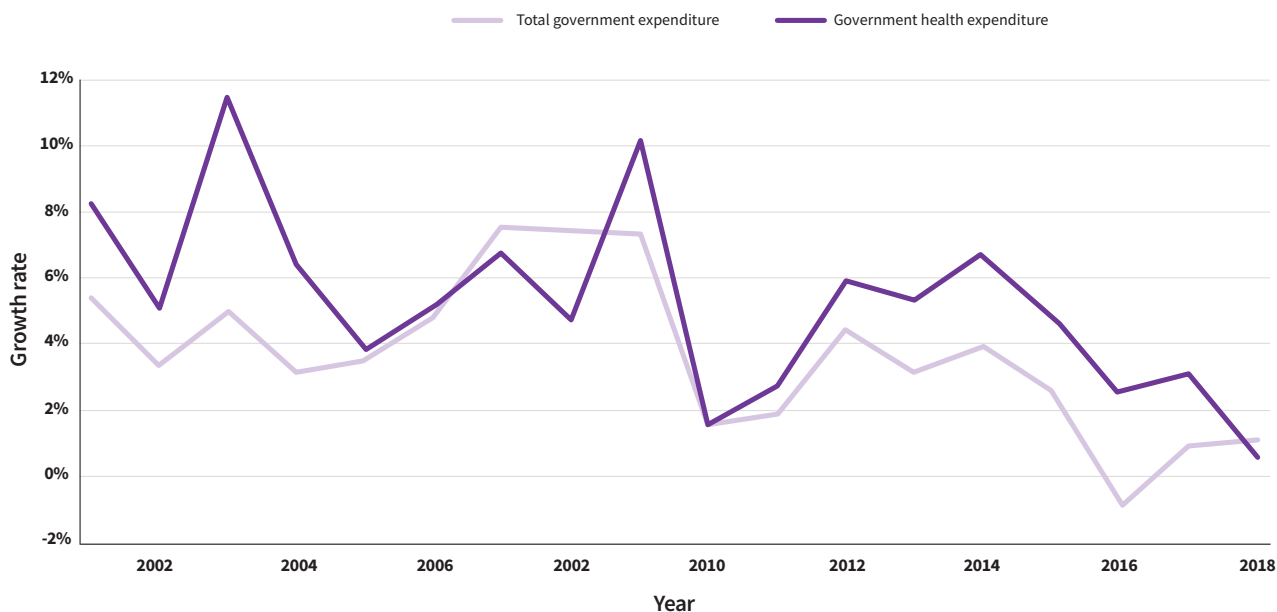
health financing between low and high income countries.(73,196,198) In 2016, a study modelling national health expenditure between 2013 and 2040 suggested that the majority of LMICs were off track for meeting the Chatham House goal of 5% GDP spending on health.(198) Across OECD countries, between 1998 and 2014 national per capita spending on human resources for health only accounted for between 5% and 10% of total national health spending.(199) In 2016, less than 4% of Development Assistance for Health was allocated to human resources.(200) Chronic underinvestment in the health workforce and their education and employment is a major challenge for health systems worldwide.(195)

Further, existing investment cases for health and care sector interventions often incorporate an implicit devaluation of the health and care work often performed by women.(20) Cost-effectiveness analyses are largely gender blind: they do not reflect the extent to which caregiving work and the women who perform it are devalued, and as a result may encourage the systemic overuse of unpaid or underpaid work in health systems initiatives.(20) So-called “cost-effective” service delivery models that actually depend on undervalued health and care work are unsustainable, and lead to undesirable long-term outcomes by harming the health, education and productivity of health and care workers themselves.(20)

<sup>14</sup> Underinvestment may occur at the same time as skewed investments that exacerbate rather than overcome health inequity.

<sup>15</sup> In 2016, the WHO Global Strategy on Human Resources for Health identified a health worker deficit of 18 million. This figure has since been updated to 10 million health workers by recent analysis by WHO.(195)

Fig. 25: Average yearly growth per capita of overall government spending and government spending on health in real terms (2001–2018)



Source: Reproduced from the World Health Organization, 2020.

#### 4.6.2 Three reasons the Gender Gap in Investment matters



Gender inequality in society impacts the valuation of the health and care sector. Underinvestment in the health and care sector exacerbates gender inequality in society



Underinvestment constrains health and care systems' performance, their ability to respond to crises such as COVID-19, and their wider economic impact



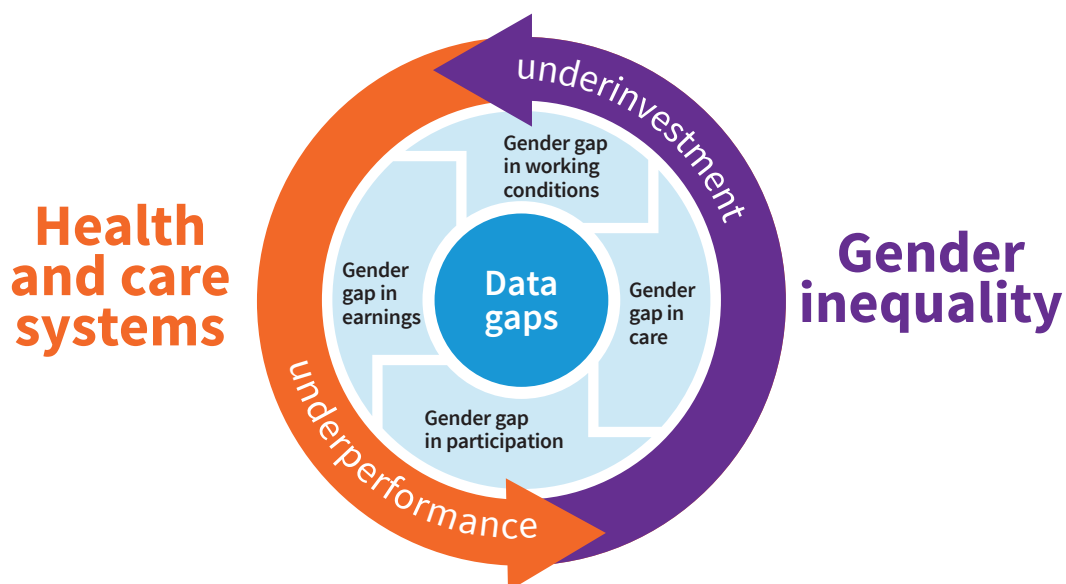
Weak health systems transfer work onto women, largely in the form of unpaid care

#### The nexus of gender inequality and underinvestment in health and care

Underinvestment in health and care work can be understood as a feedback loop: societal gender inequality impacts the valuation of the highly feminised health and care sector, leading to underinvestment and underperformance which in turn exacerbates societal gender inequality (Fig. 26).<sup>(20)</sup> This cycle of underinvestment and

underperformance is driven by the Gender Value Gaps in caregiving, participation, earnings, and working conditions, all of which are underpinned by a lack of the data required to fully understand and redress them. The Gender Value Gaps culminate in a lower economic footprint for health and care work while undermining its perceived societal value, driving further underinvestment.

Fig. 26: The relationship between investment, performance, and gender equality in health and care systems



### Underinvestment constrains health and care systems performance

Underinvestment in the health and care sector constrains the performance of health and care systems and reduces their capacity to positively impact society. A well functioning health and care system can contribute to improved population health and productivity, promote economic activities and diversification, and foster health security, social cohesion and innovation.<sup>(24)</sup> Weak health and care systems represent lost opportunities to generate jobs directly and indirectly, stimulate local economies, enhance the quality of social care and boost health and wellbeing.<sup>(28,29)</sup>

The investment gap negatively affected the ability of health and care systems to respond to the pandemic. Underfunding of the health workforce was a major component of the ineffective response of health systems to the pandemic,<sup>(14,201)</sup> and resources set aside for health emergencies and pandemic preparedness were deemed “wholly inadequate” prior to COVID-19.<sup>(202)</sup> The economic implications of an inadequate pandemic response are still being felt: to date, the COVID-19 pandemic is estimated to have cost the world more than US\$ 12.5 trillion.<sup>(203)</sup>

The pandemic itself had consequences for global investments in health and care systems. In LMICs, the pandemic widened the SDG financing gap through reductions in external private financing and the imposition of an additional US\$ 1 trillion in COVID-19 emergency response spending.<sup>(204)</sup> As a result of the pandemic, drops in direct foreign investment, remittances, tourism and government revenue outstripped overseas development aid in many low income countries and developing countries, thrusting them further into a cycle of poverty.<sup>(205)</sup> This all occurred against a backdrop of flatlining overseas development aid and development assistance for health, both in decline since 2016.<sup>(205)</sup> While development assistance for health reached US\$ 54.4 billion in 2020, a sizable portion of this (US\$ 13.5 billion) was directed to the COVID-19 response.<sup>(206)</sup>

### Weak health and care systems transfer work onto women

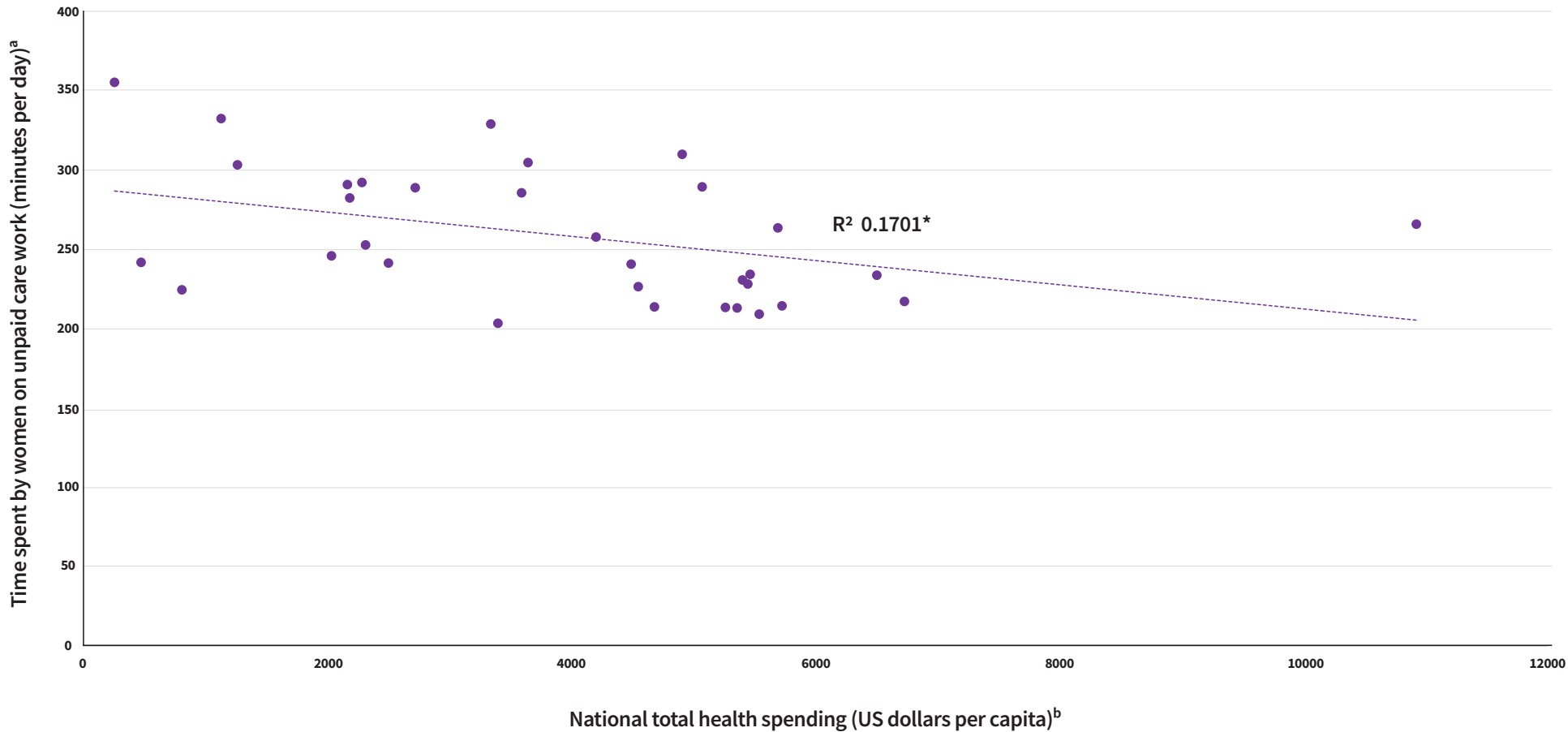
Underinvestment in the health and care sector also transfers more unpaid care work onto women, with substantial economic consequences. Fig. 27 and Fig. 28 suggest a weak inverse correlation between levels of national health spending<sup>16</sup> and women’s unpaid work: lower national total health spending was correlated

<sup>16</sup> Data on health spending covers a range of health financing schemes, including government health schemes, compulsory insurance (public or private), voluntary arrangements such as private voluntary health insurance or direct payments, and out of pocket payments by households.<sup>(207)</sup>

with both higher amounts of time spent per day on unpaid work performed by women, and higher gender gaps in unpaid work (that is, the ratio between the average amount of time women and men spend per day on unpaid caregiving) in OECD countries, China, India and South Africa. This suggests there is an important role for strategic spending on public health and care services to redistribute unpaid care work. This also has wider economic implications: higher amounts

of and acute gender imbalances in unpaid work effectively place a “time tax” on women, preventing them from contributing fully to the economy at a cost of between US\$ 12 trillion and US\$ 28 trillion of global GDP annually.<sup>(142,144)</sup> For women in marginalized groups this is even more important, since they tend to have higher levels of unpaid care and experience higher pay inequality.<sup>(13,113)</sup>

Fig. 27: The relationship between national health spending and time spent by women on unpaid care work



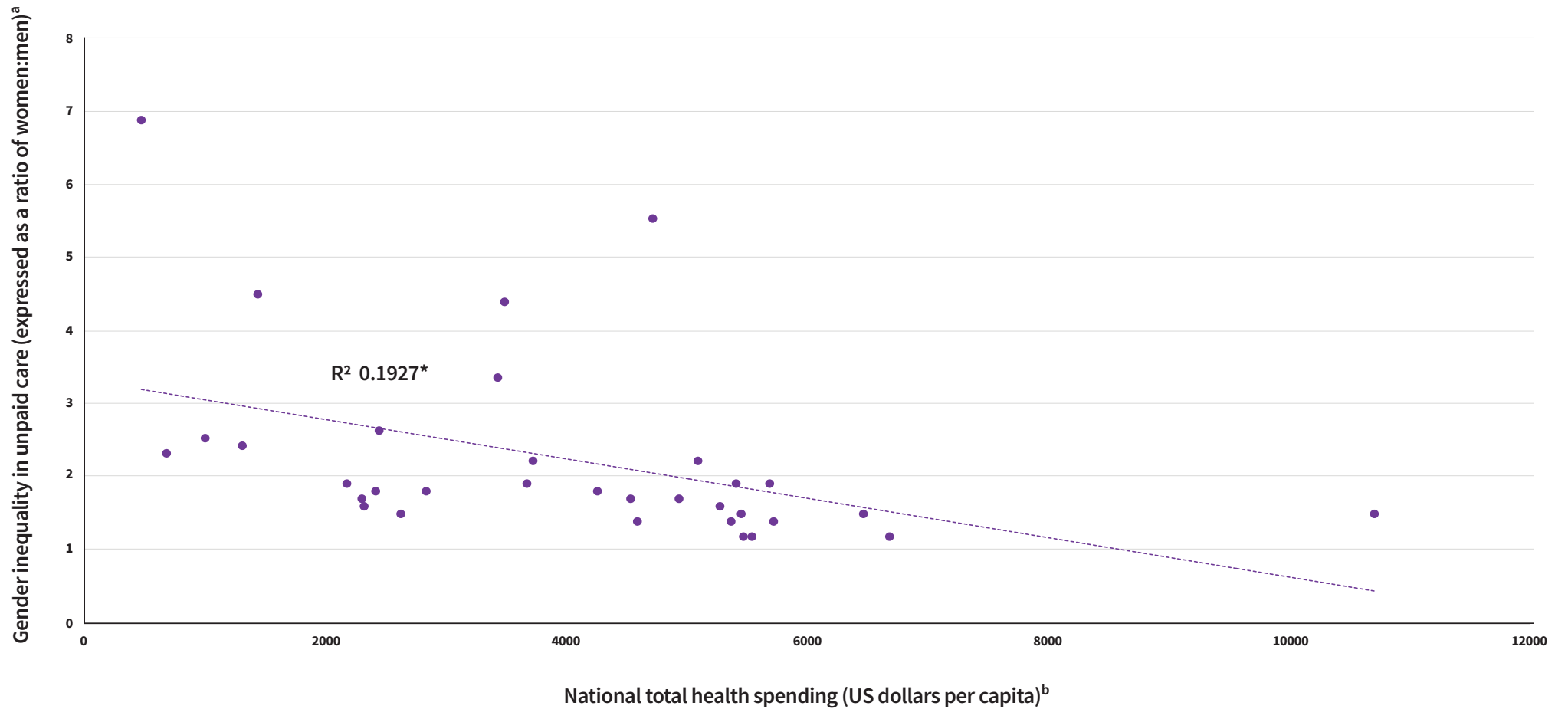
\* Coefficient of determination

<sup>a</sup> Time use data reported for 2019, with daily time use normalised to 1440 minutes per day

<sup>b</sup> Data on health spending reported for 2019

Sources: Data were obtained from the OECD Employment Database and the WHO Global Health Expenditure Database, please see Annex 1 for more details.

Fig. 28: The relationship between national health spending and gender inequalities in unpaid care work



\* Coefficient of determination

<sup>a</sup> Daily time spent by women on unpaid work:daily time spent by men on unpaid work

<sup>b</sup> Data on health spending reported for 2019

Sources: Data were obtained from the OECD Employment Database and the WHO Global Health Expenditure Database, please see Annex 1 for more details.



### 4.6.3 The case for closing the Gender Gap in Investment

Health and social care infrastructure play a central role in creating and sustaining robust, fair, inclusive and prosperous societies. Health and care systems stimulate inclusive economic growth in a number of ways: by improving population health, increasing productivity, stimulating economic activities related to health and care service provision, providing social protection, fostering social cohesion and equity, driving innovation and economic diversification and promoting health security.(24,30) Health and care work creates “virtuous cycles” which help tackle inequality by providing, for example, a diverse range of jobs in areas of need which may encourage entry to the labour force by lower skilled workers and those from rural areas. (24,30,31)

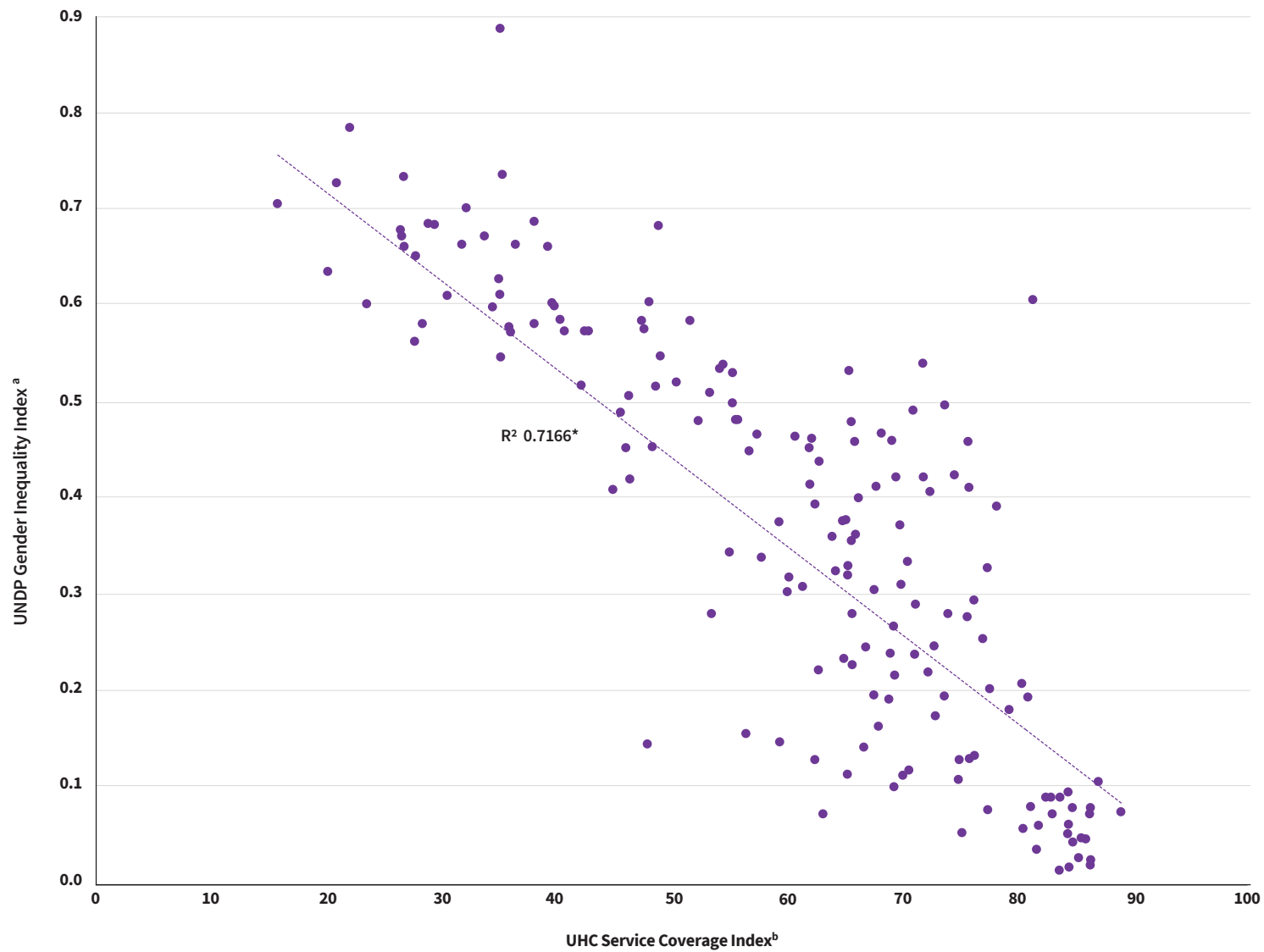
Strong global investment cases have been made for universal health and social care.(23,28,134) It is estimated that every US dollar spent in the health and care sector adds an additional US\$ 0.77 to economic growth as a result of indirect and induced effects.(23) Investment in the social infrastructure of health and care also has the potential to promote social cohesion, further strengthening community resilience against economic shocks.(208) Investments in health and care work coupled with targeted policy action have the potential to unleash enormous gains in education, gender equality, decent work, economic potential and health.(23,30,127) For example, the provision of gender-equal care leave, universal childcare, and long-term care services could generate almost 300 million jobs by 2035 globally.(134) Key to this is an adequately funded gender-equitable health and care workforce with quality working conditions.

#### **Addressing gender equality and investing in health systems must go hand in hand**

Investment in health and care systems can have a transformative role in redistributing unpaid care work and supporting wider gender equality objectives. At the macro level, gender inequality and health systems performance are closely related. Fig. 29 shows that, nationally, higher levels of gender inequality are correlated with

lower levels of health service coverage. Gender inequality is also associated with greater financial risks in accessing health services. Fig. 30 uses global SDG monitoring data on catastrophic out of pocket health spending between 1995 and 2019, and suggests that when gender inequality is severe, higher proportions of households may be pushed below the international US\$ 3.10 per day 2011 PPP poverty line due to catastrophic health expenditure. These findings are not fully explained by national income levels or GDP growth. Gender inequality is also associated with negative population health outcomes, including lower life expectancy and increased premature mortality. (209)

Fig. 29: The relationship between national-level gender inequality and UHC



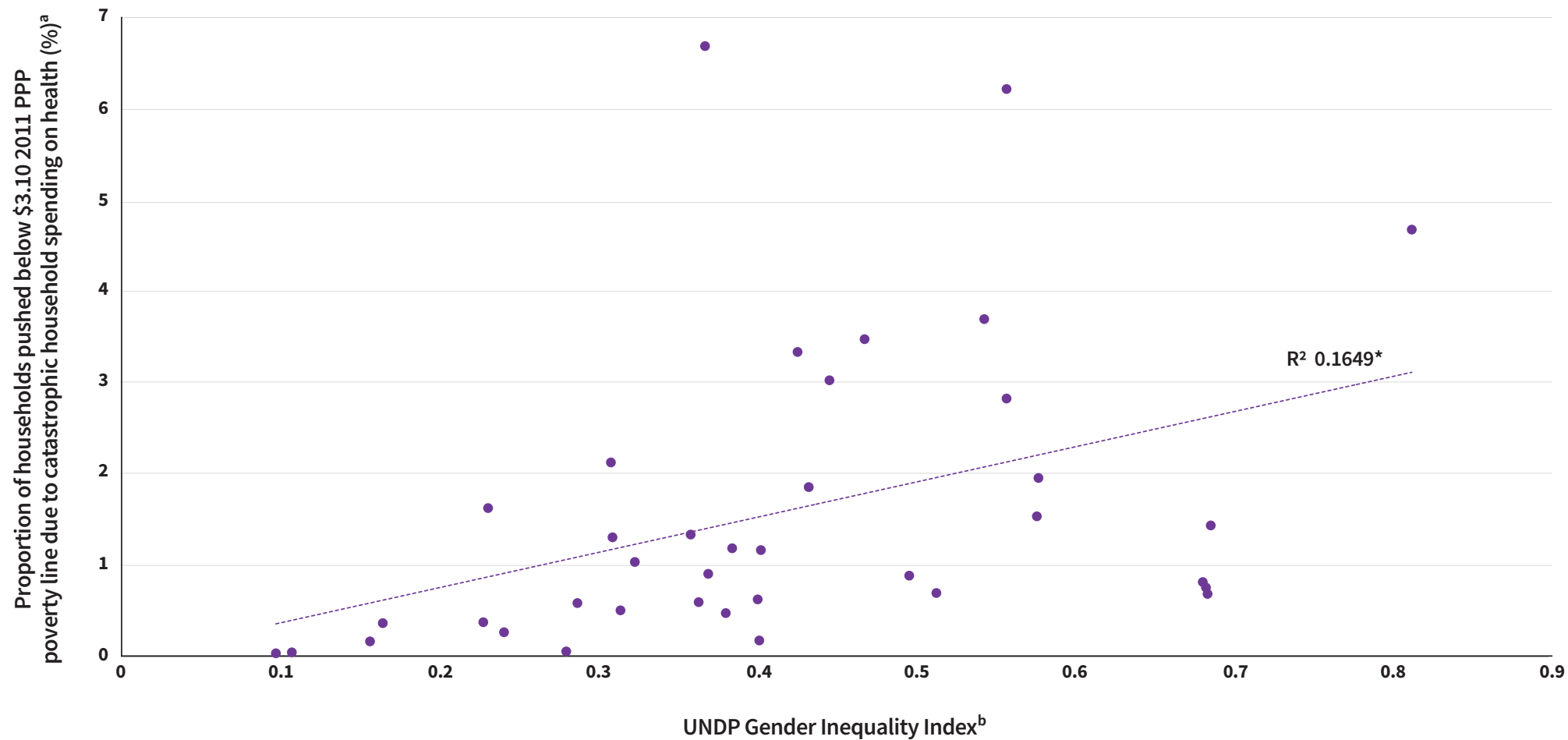
\* Coefficient of determination

<sup>a</sup> The UNDP Gender Inequality Index is scaled from 0 to 1.0, with a result closer to 1.0 representing greater inequality (data reported for 2021)

<sup>b</sup> The UHC Service Coverage Index is scaled from 0 to 100, with scores closer to 100 representing better service coverage

Sources: Data were obtained from UNDP Gender Inequality Index and GHO, please see Annex 1 for more details.

Fig. 30: The relationship between national gender inequality and the proportion of households pushed below the US\$ 3.10 per day 2011 PPP poverty line due to catastrophic health expenditure



\* Coefficient of determination

<sup>a</sup> Data reported for 2005–2018

<sup>b</sup> The UNDP Gender Inequality Index is scaled from 0 to 1.0, with a result closer to 1.0 representing greater inequality (data reported for 2021)

Sources: Data were obtained from UNDP Gender Inequality Index and reports by countries for global monitoring of SDGs, please see Annex 1 for more details.



## 5. Closing the Gender Value Gaps: policy levers to better value health and care work

**Investing in health and care work is an important step countries can take to ensure inclusive economic development and protect against crises such as the COVID-19 pandemic.(14,23,28,29) But not all health and care spending is equal: effective investments require a critical assessment of where and how financing can be used most strategically.(32) This report suggest that gender-equitable investments in health and care work, coupled with gender-transformative policies, are needed to reset the value of health and care work.**

This section outlines strategic policy levers to close the gender gaps in health and care work, to turn what is currently a “vicious cycle”(10) of gender inequality and underinvestment into a virtuous cycle, where health and care systems can effectively support gender equality and a wellbeing economy. The Gender Value Gaps framework is used as the basis for transformative policy action. Policy levers are outlined in Table 1 and are arranged by the principal gender gap they address: gender gaps in care, participation, earnings, working conditions, data, or investment. Policy options are tailored to the relevant decision-makers, but areas of possible synergy with local actors or regional and global partners are noted where relevant.

When tackling gender inequalities in health and care work, transformative policies are key. Gender transformative interventions consider gender norms, roles and relations that affect access to and control over resources in order to address the causes of gender-based health inequities and foster progressive changes in power relationships

between women and men.(3,84) More broadly, transformative policies should also respond to major social, political, technological, economic and environmental challenges or transitions.(210) Additionally, transformative policy making opens up the policy agenda to a broader set of policy domains involving multiple actors and global networks.(210) The WHO Council on the Economics of Health for All outlines 13 transformative policy dimensions. These include valuing health and care workers and investing in health systems, upholding human rights, promoting planetary health, quality long term finance, innovation for the common good and strengthening governance and trust.(27)

Actions taken to close the Gender Value Gaps in health and care work have the opportunity to simultaneously redress intersectional gender inequalities, connect different policy actors and domains and address social, economic and environmental transitions. These policy options should be thought of not as solitary actions, but as part of a system of connected and reinforcing levers for system-wide change.<sup>17</sup>

<sup>17</sup> When evaluating policy options, the national context must be considered. Some policies may not be feasible, whereas others may already be in place and may require revision or strengthening. An understanding of the political environment and the political economy of gender, labour and health systems dynamics – including an appreciation of vested interests, power dynamics and influential stakeholders – is essential and will support the effective implementation of all policy initiatives.

**Table 1: Policy domains, action levers and relevant stakeholders for closing the Gender Value Gaps**

Gender Gap	Policy Levers	Details	National Focus	Other Relevant Factors
<b>Address the Gender Gap in Care</b>	Establish care as a right	Guarantee the human rights, agency and wellbeing of caregivers and care recipients	National legislature Care service providers	Domestic and care worker unions Civil society
	5R framework Recognize, reduce and redistribute unpaid care work	Strengthen data on care work Invest in care services Labour policies to support entry into paid work Family and care-friendly working arrangements Gender equality education Guarantee the right to care Care-friendly and gender-responsive social protection Gender-responsive leave policies	Ministries of women or gender Ministries of finance Ministries of economic development Ministries of social affairs	Health and care facilities Social and health insurance providers Local service providers Households and private employers Academia
	Increase representation of care workers in decision-making	Equal participation and leadership opportunities Freedom of association and right to collective bargaining Advocacy and representation through civil society and trade unions		
	Reward care work with more and better jobs	Regulation of conditions of employment Equal pay for work of equal value Safe and enjoyable work environments Laws that protect migrant or other at-risk care workers		
	Universal social protection	Gender-sensitive health and social insurance programmes Cash for care programmes Gender-sensitive tax supports Gender-sensitive universal pension programmes	Ministries of finance Ministries of economic development Ministries of social affairs	
	Strengthen care infrastructure	Public investment in care services Prioritize the recruitment, training retention and quality of work for care workers	Ministries of health Ministries of labour Ministries of finance National treasuries	
<b>Address the Gender Gap in Participation</b>	Education and career progression	Promote access to gender-equitable higher education Educational curriculum reform to support gender equality and life skills for girls Health and care workforce education	Ministries of education Ministries of women or gender Ministries of health	Private sector Educational providers Professional bodies Technology and media providers Health and care facilities and employers

Gender Gap	Policy Levers	Details	National Focus	Other Relevant Factors
	Strengthen labour rights and anti-discrimination laws	<p>Enact/strengthen legislation against discrimination</p> <p>Zero tolerance policies for health and care worker discrimination</p> <p>Establish/strengthen monitoring and enforcement mechanisms</p> <p>Ensure health and care worker recruitment practices prohibit discrimination</p> <p>Promote inclusive health and care work environments</p>	<p>National legislature</p> <p>Ministries of labour</p> <p>Ministries of economic development</p> <p>Ministries of social affairs</p>	<p>Households and private employers</p> <p>Family planning providers</p> <p>Civil society</p>
	Equal treatment and non-discrimination of all health and care workers	<p>Legislation against discrimination</p> <p>Enforcing zero tolerance policies for health and care worker discrimination</p> <p>Monitoring and enforcement mechanisms</p> <p>Ensuring health and care worker recruitment practices prohibit discrimination</p> <p>Promoting inclusive health and care work environments</p>		
	Access to safe and free family planning	<p>Policies to address the legality, accessibility and quality of family planning services</p>	<p>Ministries of women or gender</p> <p>Ministries of health</p>	
	Gender-balanced parental and family leave and flexible working arrangements	<p>Legislate for gender-equitable maternity, paternity and family leave</p> <p>Flexible working arrangements: flexible work hours, carer and family leave, carer pensions, flexitime and teleworking</p>	<p>National legislature</p> <p>National legislature</p> <p>Private sector</p> <p>Ministries of women or gender</p>	
	Rectify economic disincentives to labour force participation	<p>Gender-equitable tax-benefit systems (addressing joint taxation for married couples, transferable tax credits, dependent spouse allowances)</p> <p>Rectify the gender pay gap</p>	<p>Ministries of finance</p> <p>Ministries of labour</p> <p>Ministries of economic development</p> <p>Ministries of social affairs</p> <p>Ministries of women or gender</p>	
Improve leadership and representation of women in decision-making	<p>Address exclusionary structures and laws</p> <p>Gender sensitive budgeting</p> <p>Professional networks and mentorships</p> <p>Quotas for political representation and representation on corporate boards</p>	<p>Ministries of women or gender</p> <p>Ministries of economic development</p> <p>Ministries of social affairs</p> <p>National legislature</p> <p>Private sector</p> <p>Ministries of health</p>		

Gender Gap	Policy Levers	Details	National Focus	Other Relevant Factors
	Inclusive infrastructure to support equitable labour force participation	Transport Urban planning Environmental policies	Ministries of transport Ministries of economic development Ministries of social affairs Ministries of urban planning and development	
<b>Address the Gender Gap in Earnings</b>	Legislate for equal pay for work of equal value	Equal pay laws mandating equal pay for equal work	National legislature Ministries of labour Ministries of health	Professional bodies Health and care facilities Patient and staff advocacy groups
	Increase pay transparency	Legal protections against pay secrecy Pay data collection and pay data reporting Gender audits	Private sector Ministries of labour Ministries of women or gender National legislature Ministries of commerce and industry	Academia Civil society Worker unions Private sector
	Ensure freedom of association and collective bargaining	The freedom of association to join organizations of one's own choosing, and the right to collectively bargain for better employment terms	Private sector Ministries of labour National legislature Ministries of commerce and industry	
	Promote diversity and inclusion in the workplace	Diversity, equity and inclusion organizational strategies for staff recruitment, retention and development Diversity in management and gender-equal leadership Accountability for leadership	Ministries of labour Ministries of women or gender National legislature Ministries of commerce and industry	
	Compensate for the impact of unpaid care on paid work	Social security programmes and pensions to provide caregiving credits	Ministries of labour Ministries of women or gender Ministries of commerce and industry	
<b>Address the Gender Gap in Working Conditions</b>	Ensure decent work for all	Ensure safe work, adequate earnings, decent working time, stability and security of work, social dialogue, employers' and workers' representation, employment opportunities, social security, family and personal life balance, the abolition of child and forced labour, and equal opportunity treatment	National legislature Ministries of labour Ministries of women or gender Ministries of commerce and industry Ministries of health	Civil society Workers unions Households and private employers Academia Health and care service providers Private sector

Gender Gap	Policy Levers	Details	National Focus	Other Relevant Factors
	Prevent violence and harassment	<p>National legislation preventing violence against women</p> <p>Effective enforcement mechanisms</p> <p>Zero-tolerance policies on harassment and discrimination in the workplace</p>	<p>National legislature</p> <p>Private sector</p> <p>Ministries of labour</p> <p>Ministries of women or gender</p>	
	Prevention of violence and harassment in health and care workplaces	<p>Laws, policies and strategies to prevent workplace violence and harassment</p> <p>Employer policies and accountability mechanisms</p> <p>Monitoring and enforcement mechanisms</p> <p>Extra precautions to protect health and care workers at heightened risk of violence and harassment</p> <p>Address misinformation and disinformation</p> <p>Provide educational materials</p> <p>Educate private household employers of care workers on protecting care workers from violence, harassment and forced labour</p> <p>Safe and gender-responsive complaint and reporting mechanisms</p> <p>Training to recognize, handle and communicate with potentially violent individuals</p> <p>Adequate security for health and care workers</p>	<p>Ministries of commerce and industry</p>	
	Address informality and nonstandard employment	<p>Support the transition to formality and regularisation of contracts</p> <p>Improve the quality of informal and nonstandard work conditions</p> <p>Extend social protection to all workers, regardless of contract or migration status</p> <p>Legislate to plug regulatory gaps</p> <p>Introduce safeguards or restrictions on certain types of employment</p> <p>Safeguard health and safety in informal workplaces</p> <p>Mechanisms of informal worker representation, social dialogue and collective bargaining</p> <p>Remove administrative barriers to business registration and licensing</p>	<p>National legislature</p> <p>Private sector</p> <p>Ministries of labour</p> <p>Ministries of commerce and industry</p> <p>Ministries of the interior or migration</p>	
<b>Address the Gender Gap in Data</b>	Strengthen health and care workforce statistics	Review and strengthen labour statistics and ensure information on informal, domestic, migrant and unpaid work is included in national accounts	<p>National offices for statistics</p> <p>Health services</p> <p>Local and national health governance</p> <p>Ministries of health</p> <p>Civil society</p> <p>Academia</p> <p>Ministries of information</p>	<p>Academia</p> <p>Health information systems</p> <p>Civil society</p>



Gender Gap	Policy Levers	Details	National Focus	Other Relevant Factors
	Collect sex-disaggregated data	Ensure sex-disaggregation of data on health and care work across all settings and in all occupations	Health Services Local and national health governance Ministries of health Civil society Academia Ministries of information	
	Identify evidence gaps	Articulate evidence gaps Invest in research and collaboration with academia and civil society	Health Services Local and national health governance Ministries of health Civil society Academia Ministries of information	
	Introduce gender-sensitive monitoring and evaluation, and public accountability mechanisms	Establish public accountability mechanisms and gender-responsive monitoring and evaluation frameworks, such as: participatory planning mechanisms, monitoring dashboards, citizens assemblies, community scorecards, social audits, public expenditure tracking systems, information campaigns, public hearings and patient rights charters	Health Services Local and national health governance Ministries of health Ministries of women's affairs	
<b>Address Gender Gap in Investment</b>	Align policies with the Sustainable Development Agenda	SDGs 3,4,5,8 and 17 Addis Ababa Action Agenda	Ministries of finance Ministries of health Ministries of labour Parliamentary budgetary committees	Local governments Community leaders (through participatory budgeting) Patient groups Professional bodies Professional unions
	Mobilize domestic resources for health	Progressive taxation Effective management of public finances	Ministries of finance Ministries of health Parliamentary budgetary committees	
	Strengthen UHC	National budgetary commitments Ensure financial risk protection Strengthen primary health care	Parliamentary budgetary committees Ministries of finance Ministries of health	
	Invest in human resources for health and care	Target the recruitment, development, training and retention of health and care workers Capacity planning for workforce needs, demands and supply Multisectoral action and support from ministries of education, finance, gender, and labour (or equivalent) Investing in decent conditions of employment through long-term public policy stewardship Education, training, recruitment, deployment and retention of domestically trained health workers	Ministries of labour Ministries of health Ministries of education	

Gender Gap	Policy Levers	Details	National Focus	Other Relevant Factors
		Promoting rights at work Enhancing social protection Strengthening social dialogue, national skills and national employment agendas Investments to boost the demand and supply of the health workforce in line with population health needs Mobilising resources through general budget commitments, progressive taxation, social health insurance, dedicated funds considerations and other innovative mechanisms		

Sources: (23,186,197,211–217)

## 5.1 Closing the Gender Gap in Care

<b>Policy levers to close the Gender Gap in Care</b>	<b>Establish care as a right</b>	Guarantee the human rights, agency and wellbeing of caregivers and care recipients
	<b>5R framework</b>	Recognition, reduction, redistribution of unpaid care work Representation of care workers in decision-making Reward care work with more and better jobs
	<b>Universal social protection</b>	Gender sensitive health and social insurance programmes Cash for care programmes Gender sensitive tax supports Gender sensitive universal pension programmes
	<b>Strengthen care infrastructure</b>	Public investment in care services Prioritize the recruitment, training, retention and quality of work for care workers

### 5.1.1 Care as a right

Guaranteeing the human rights, agency and wellbeing of caregivers and care recipients helps establish a foundation on which to improve the conditions of health and care work in all its forms.(218) Some of the most important policy interventions relate to such basic rights as appropriate housing, guaranteed minimum income, decent working conditions and access to health services.(49,52,218) If guaranteed, these rights may improve the conditions in which unpaid care work is performed, and may have positive impacts on the nature and extent of the work itself.(49,52) There are important international human rights frameworks that establish the right to care and the gender dimensions of unpaid care. The European Pillar of Social Rights, which outlines 20 principles of social rights across the full care spectrum, represents an example of a rights-focused approach to social care policies. (219) At the level of national policy, Uruguay has

also developed a rights-based approach to its care policies: under the 2016 Care Act, Uruguay recognizes the legal right to care and be cared for, and its Integrated National Care System (*Sistema Nacional de Cuidados*) explicitly respects the rights of paid and unpaid caregivers.(220–222)

### 5.1.2 Recognition, reduction, redistribution, representation and reward: the 5Rs

The 5R approach, outlined in Table 1, is central to promoting decent care work across paid and unpaid settings.(124,218,220,223) Policy approaches to decent care work focus on recognizing, reducing and redistributing unpaid care work, increasing the representation of care workers and those with caregiving responsibilities in decision-making, and properly valuing (rewarding) care workers and upholding their rights regardless of migration or contract status. Governments can apply the 5R approach to both domestic and international policies. For example,

the Canadian Government's Feminist International Assistance Policy has embedded the 5R approach into its international strategy, with a focus on developing care programming anchored in a feminist, gender-transformative approach.(224) A range of practical tools have also been developed to support the creation of decent care work environments and the equitable redistribution of caregiving work, including UN Women's Toolkit on Paid and Unpaid Care Work (225) and Oxfam's Care Policy Scorecard.(218)

### 5.1.3 Universal social protection

Social protection policies are designed to reduce the impact of poverty, vulnerability and social exclusion throughout a person's lifetime and can help recognize, reduce and redistribute unpaid care work.(220) For example, health and social insurance programs, such as Rwanda's *Mutuelle de Santé*, can extend coverage to unpaid and informal workers.(220) Cash for care programmes, such as Argentina's *Asignación Universal por Hijo*, can provide financial benefits to households with caregiving responsibilities.(220) Pension reforms, such as those that occurred in the Plurinational State of Bolivia (*Renta Dignidad*), can ensure that women are compensated for time spent in unpaid childcare.(220,226) Social protection policies can align national priorities with addressing unpaid care and creating quality care work environments, and can help directly reduce the unpaid care work

primarily performed by women.(220) While cash and tax supports are beneficial in the short term, in reality they may work to reinforce the low value attached to particular forms of unpaid work or may unwittingly reinforce gender inequalities by presupposing a maternal model of care.(49,52,227)

### 5.1.4 Strengthen care infrastructure

In the short term, investments in social care infrastructure stimulate the economy, remove barriers to labour force participation and provide an important source of jobs, particularly for women.(228,229) In the long term, investments in social care infrastructure support education, gender equality, decent work, economic progress and health gains.(134,229,230) Social infrastructure policies should prioritize the recruitment, training and retention of care workers while ensuring their quality of work through better pay, workplace benefits and guaranteeing collective bargaining power.(229) Guidance on strengthening care infrastructure is available from the UN Women Regional Office for the Americas and the Caribbean and the Economic Commission for Latin America and the Caribbean, who have developed guidance for the development of comprehensive national care systems as a pillar of social protection in the region.(231)

## 5.2 Closing the Gender Gap in Participation

<b>Policy levers to close the Gender Gap in Participation</b>	Education and career progression	Promoting access to gender equitable higher education Educational curriculum reform to support gender equality and life skills for girls Health and care workforce education
	Strengthening labour rights and anti-discrimination laws	Enacting/ strengthening legislation against discrimination Zero tolerance policies for health and care worker discrimination, establishing or strengthening monitoring and enforcement mechanisms, ensuring health and care worker recruitment practices prohibit discrimination, and promoting inclusive health and care work environments
	Ensuring access to safe and free family planning	Policies to address the legality, accessibility and quality of family planning services
	Gender balanced parental and family leave and flexible working arrangements	Legislated gender equitable maternity, paternity and family leave Flexible working arrangement: flexible work hours, carer and family leave, carer pensions, flexitime and teleworking
	Rectifying economic disincentives to labour force participation	Gender-equitable tax-benefit systems (addressing joint taxation for married couples, transferable tax credits and dependent spouse allowances) Rectifying the gender pay gap
	Improve leadership and representation of women in decision-making	Gender-sensitive budgeting Professional networks and mentorships Quotas for political representation and corporate boards
	Inclusive infrastructure to support equitable labour force participation	Transport Urban planning Environmental policies Information technology

### 5.2.1 Education and career progression

Access to education, particularly higher education, is a key policy objective for promoting women's entry into the labour force, more equitable representation of women in higher-status occupational roles and intergenerational gender equality. Education, and particularly the completion of secondary education, significantly reduces the probability of unemployment or informal or precarious forms of work, and translates to higher salaries and better living standards for women and their families.(232)

In the health and care sector, policies that support the education and gender-equitable training of health and care workers encourage the recognition and progression of women's careers and gender-responsive work environments.(233,234) Such policies include occupational regulation mechanisms, human resource information systems and technology-enabled vocational education.(233)

### 5.2.2 Strengthening labour rights and anti-discrimination laws

National legislation can address discrimination in the labour market, particularly through laws that penalise gender discrimination in employment.(232) Other legal impediments to women's labour force participation include restrictions on inheritance and property rights, opening a bank account and freely pursuing a profession.(235) Removing such discriminatory barriers from the national legal framework is a priority. Iceland provides a strong example of embedding gender equality in its national legislative framework, with one of the highest rates of women's labour force participation in Europe.(236) ILO's International Labour Standards are legal instruments setting out basic principles and rights at work, and can be used by policymakers to actively address and support gender equality in labour force participation and working conditions.(211)

The WHO Global Health and Care Worker Compact calls for the equal treatment and non-discrimination of all health and care workers and lays out management and policy actions structured around four domains, namely: preventing harm; providing support; inclusivity; and safeguarding rights.(186) Such measures should adhere to labour and human rights, ensuring the right to freedom of association, and should guarantee that hiring is based on objective criteria, and that conditions of work are just, safe and healthy. They should also ensure equal pay for equal work, timely remuneration, job security, opportunities for career progression and professional development, adequate leave, reasonable limits on working hours and social security benefits.(186)

### **5.2.3 Ensuring access to safe and free family planning**

Safe and free family planning supports women's labour force participation by reducing the amount of unpaid care they perform, while helping keep women and girls in education. Policies that address the legality, accessibility and quality of family planning services, alongside targeted education campaigns, can help create an environment where women and their families can make informed reproductive choices.(232) Thailand provides an excellent example of sustained, effective national family planning policies that attempt to understand and address the economic and social drivers of reproduction.(237)

### **5.2.4 Gender balanced parental and family leave and flexible working arrangements**

Parental leave mandated by the state is a key policy area for addressing unequal opportunities and labour force participation for women. While maternity leave provisions are essential, equal paid parental leave (that is, maternity, paternity or carer leave) can positively impact the distribution of household unpaid care and female labour market outcomes.(160) In 1974 Sweden became the first country to introduce a gender-neutral paid parental leave benefit, and since then various reforms have continued to mandate equal paid leave for dual-earner households in order to support gender equality and women's labour force participation.(238)

Flexible working arrangements can also help support people with caring responsibilities. Other employment supports may include carer and family leave, carer pensions, flexitime or teleworking.(52,160) However, these may mean that women end up taking on double workloads of caring and paid work.(52)

### **5.2.5 Rectifying economic disincentives to labour force participation**

Two key economic disincentives to women's labour force participation are gender-unequal tax-benefit systems and gender wage gaps. The tax-benefit system may impact work incentives for second earners in cases that involve joint taxation of married couples, transferable tax credits or dependent spouse allowances.(160,239) In particular, joint taxation increases the marginal tax rate of secondary earners and lowers that of primary earnings, thus creating an economic disincentive for women, who tend to be secondary earners. Tax policies that shift to individual taxation systems, such as in the United Kingdom, can help address this.(160,239,240)

### **5.2.6 Improving leadership and representation of women in decision-making**

The under-representation of women in leadership positions within and beyond the health workforce is a result of exclusionary structures and laws, relating to family planning, child marriage, unpaid care and inheritance, that preclude women from gaining essential skills and training for leadership roles.(241,242) Addressing these as priority policy areas boosts women's rights and bolsters women's leadership opportunities.(241,242) Gender-sensitive budgeting initiatives, such as Tanzania's Gender Budgeting Initiative, can direct targeted government spending towards programmes supporting women and girls' leadership.(242–244)

Quotas have been utilized to advance women's leadership in politics and the private sector. Research on the impact of political quotas found they can increase female leadership and influence gender attitudes in the long term.(242,245) The presence of national leadership positions (such as government chief nursing officer) and programmes (such as nursing leadership programmes) for woman-majority occupations are associated with a stronger regulatory environment.(246) However,

this must be coupled with access to resources, a mandate and a clear area of work.

### 5.2.7 Infrastructure to support equitable labour force participation

Gender-equitable labour force participation should be supported by transport, environmental and urban planning policies. These policies have the potential to be transformative for everyone, and enable safe and efficient access to workplaces, particularly for women. For example, networked public transport and cycling initiatives can help ensure safety and accessibility in accessing workplaces, as well as support caregiving that occurs outside of the labour force. Through UN Women’s Safe Cities and Safe Public Spaces for Women and Girls initiative, countries

such as Morocco and Papua New Guinea have undertaken gender-responsive planning for urban spaces and public transport.(247) The World Bank also recently released a toolkit to make transport and public spaces more gender inclusive in India.(248)

Additionally, ensuring gender equitable access to relevant information technology infrastructure can support women develop the education, skills and networks they require to advance through their career. This includes access to mobile and computer technologies. High quality and continuous access to information technology training for women improves their employment prospects as well as enhances living conditions for their families.(249)

## 5.3 Closing the Gender Gap in Earnings

<b>Policy levers to close the Gender Gap in Earnings</b>	Legislating for equal pay for work of equal value	Equal pay laws mandating equal pay for equal work
	Increasing pay transparency	Legal protections against pay secrecy, pay data collection, pay data reporting, and gender audits
	Freedom of Association and Collective Bargaining	Ensuring the freedom of association to join organisations of one’s own choosing, and the right to collectively bargain for better employment terms
	Promoting diversity and inclusion in the workplace	Diversity, equity and inclusion organisational strategies across spectrum of recruitment, retention, staff development Diversity in management Accountability for leadership
	Compensate for the impact of unpaid care on paid work	Social security programmes and pensions to provide caregiving credits

### 5.3.1 Legislation to address gender discrimination in remuneration

Legislation that mandates equal pay for equal work of equal value is an important step towards closing gender pay gaps. While many countries are implementing national legislation which prohibits gender discrimination in remuneration, fewer countries have embodied the full principle of equal pay for work of equal value. One such example is the Icelandic Equal Pay Standard, based on job evaluation tools, adopted by the Icelandic government to ensure equal pay for equal work of equal value.(236) The Equal Remuneration Convention (No. 100) of the ILO provides an international reference framework.

### 5.3.2 Increasing pay transparency

Policy instruments that foster pay transparency represent another important contribution to closing gender pay gaps.(1) Businesses and institutions can be encouraged to improve pay transparency through pay data policies that incentivise or require employers to collect and provide information to national authorities.(250,251) Employers can also be held accountable through mandatory or voluntary gender audits.(250,251) Institutions can help foster accountability through imposing fines on businesses that don’t comply with gender audits, or through encouraging public scrutiny.(250)



### 5.3.3 Freedom of association and collective bargaining

The freedom of association to join organisations of one’s own choosing, and the right to collectively bargain for better working conditions, can help close gender wage gaps. This can be achieved through four key mechanisms: advocating for targeted raises that compensate for the concentration of women in low-paid industries; correcting the undervaluation of female-dominated occupations through developing

gender-neutral occupational classification schemes; promoting pay transparency and addressing wage discrimination; and supporting career progression through gender-neutral evaluation criteria.(252) In the USA, union membership was associated with a significant reduction in the gender pay gap: the earnings ratio between women and men was 90% for union workers, compared to 82% for those not covered by union contracts.(253)

## 5.4 Closing the Gender Gap in Working Conditions

<b>Policy levers to close the Gender Gap in Working Conditions</b>	Ensure decent work for all	Ensure safe work, adequate earnings, decent working time, stability and security of work, social dialogue, employers’ and workers’ representation, employment opportunities, social security, work, family and personal life balance, abolishing child and forced labour, and equal opportunity treatment
	Preventing violence and harassment	National legislation preventing violence against women Effective enforcement mechanisms Zero-tolerance harassment and discrimination in the workplace
	Address informality and nonstandard employment	Support the transition to formality and regularisation of contracts Simultaneously improve the quality of informal and non-standard work conditions Extend social protection to all workers, regardless of contract or migration status Legislative approaches to help plug regulatory gaps Safeguards or restrictions on certain types of employment

### 5.4.1 Ensuring decent work for all

Decent work is an umbrella term that refers to “the aspirations of people in their working lives. It involves opportunities for work that are productive and deliver a fair income, security in the workplace and social protection for all, better prospects for personal development and social integration, freedom for people to express their concerns, organise and participate in the decisions that affect their lives and equality of opportunity and treatment for all women and men”.(254) There are a number of policy components and global conventions designed to support decent work.(3,33) Decent working conditions are also of particular concern to those in more precarious forms of employment.

Decent work country programmes such as in Fiji “promote decent work as a key component of development policies and at the same time as a national policy objective of governments and social partners.”(255) The WHO Global Health and

Care Worker Compact provides technical guidance for Member States and relevant stakeholders on how to protect the health, safety and human rights of health and care workers everywhere, and how to ensure they have work environments that are safe, supportive and enabling.(186)

An important component of decent working conditions is a safe and healthy working environment. Actions that can be taken at national level to address “the prevention of work-related injuries and diseases, as well as the protection and promotion of the health of workers”(256) include legislation and the enforcement of occupational safety and health measures, including infection prevention and control, as well as employer requirements to adapt the working environment to the physical and mental health needs of workers.(186,257)

### 5.4.2 Preventing violence and harassment

National legislation preventing violence against women or other forms of gender bias should be

either adopted or strengthened and followed up with effective enforcement mechanisms. In Rwanda, for example, the Indashyikirwa program aims to reduce intimate partner violence by combatting harmful gender norms, particularly around domestic and care labour, and by securing women’s roles as equal partners in the formal economy.(258) Relevant international frameworks are outlined in Table 1.

At an institutional level, health and care institutions must take a zero-tolerance attitude to both sexual harassment and other forms of harassment and discrimination.(186,187,233) This can be addressed across the spectrum of recruitment, training and development of the health and care workforce through education and training that tackle harmful gender norms.(259)

### 5.4.3 Addressing informality and nonstandard employment

Supporting workers in the informal economy and in nonstandard employment requires a policy approach that simultaneously improves the quality of working conditions, supports all workers regardless of their employment status and encourages a transition to formal, regularised working contracts. Policy approaches to address

informal employment are outlined in Table 1.(260,261)

Policy options that support workers in nonstandard employment should also have a dual focus on improving job quality while providing social protection and support regardless of employment status.(167) Such legislative approaches can help plug regulatory gaps, fostering equality of treatment, fairer working conditions and inclusive labour market practices. (167) The Republic of Korea, for example, has introduced and strengthened legislation that prohibits discrimination against workers on nonstandard contracts on the basis of to their employment status.(167) Countries may also enforce minimum hours requirements and other safeguards for part-time, on-call and casual workers, or may alternatively restrict, limit or prohibit certain types of nonstandard employment to avoid situations of exploitation. Other policy initiatives focus on encouraging collective agreements and improving the quality of working environments through establishing shared liability for occupational health and safety in contractual arrangements.(167)

## 5.5 Closing the Gender Gap in Data

<b>Policy levers to close the Gender Gap in Data</b>	Strengthen health and care workforce statistics	Reviewing and strengthening labour statistics and ensuring information on informal, domestic, migrant and unpaid work is included in national accounts
	Sex-disaggregated data	Ensuring sex-disaggregation of data on health and care work across all settings and in all occupations
	Identify evidence gaps	Articulate evidence gaps, invest in research and collaboration with academia and civil society
	Gender-sensitive monitoring and evaluation, and public accountability mechanisms	Establish public accountability mechanisms and gender-responsive monitoring and evaluation frameworks

### 5.5.1 Identify evidence gaps

Missing data, heterogeneity in measures of unpaid work, and a lack of sex and gender-disaggregated information are key contributors to information and evidence gaps. Governments have the opportunity to work with academia, social partners and civil society to identify national evidence gaps and develop a more context-specific evidence base.

There is also a strong case for introducing a standardized accounting framework for all forms health and care work that captures different types of nonstandard and unpaid work.(48) In 2013, the 19th session of the ICLS defined the concept of work as “any activity performed by persons of any sex and age to produce goods or to provide services for use by others or for own use”.(48) This typology is important because it encompasses the



diverse ways that individuals engage with labour markets and contribute to the broader economy through paid and unpaid activities.(48) The ICLS19 definition facilitates the formal recognition of unpaid care work as work, and recognizes that individuals may be involved in more than one form of work at a time.(262)

### **5.5.2 Strengthen health and care workforce statistics**

Strengthening national accounting frameworks to ensure the recognition of the full spectrum of health and care work is central to advocating for the value of health and care work. Information on the health and care workforce comes from five main sources: population censuses, labour force and employment surveys, health facility assessments, time-use surveys (particularly for unpaid care), and administrative information systems – such as registries of public expenditure, payroll, and professional registration bodies.(263) NHWA and Systems of Health Accounts provide an integrated approach to collecting information on health and care workers and relevant expenditure. However, the availability of data disaggregated by sex and gender, and other factors such as disability, is still limited.(264–266) Estimates on the volume and cost of human resources derived from Systems of Health Accounts and Systems of National Accounts form the basis of national wage bills.(266) Care work is only partially accounted for through Systems of National Accounts and may be better captured by Household Satellite Accounts, which include unpaid care work in measuring and valuing the outputs produced by households using time-use surveys and other innovative forms of data.(159,267–269)

Closing data gaps also means developing new approaches and methodologies, encouraging data collection (particularly in under-represented areas) and valuing diverse forms of evidence, including qualitative data.(22)

### **5.5.3 Gender and sex-disaggregated data**

Without gender or sex-disaggregated information on the experiences of all health and care workers, as well information on the economic, health and social impacts of their work, decision-making remains limited. Gathering sex or gender-disaggregated data supports the monitoring of

SDG targets and more effectively captures gender imbalances in health and care work.

Beyond this, an intersectional approach to data is critical to understanding the full spectrum of experiences in health and care work, and to ensuring that the experiences of those who are at greatest risk of marginalization are centred. An intersectional approach to data involves engaging directly with and centring the experiences of those most impacted by an issue, policy or programme, promoting equity across the full data value chain and ensuring institutional data systems are inclusive.(270) Ideally, disaggregated data should be available to examine multiple axes of privilege or oppression across both outcome and process indicators.(22)

### **5.5.4 Gender-responsive monitoring and evaluation, and public accountability mechanisms**

Gender-responsive public accountability mechanisms and monitoring and evaluation frameworks may help to ensure that any health system policy initiative is transparent and responsive to the needs of the population. Promising accountability mechanisms are outlined in Table 1.(271) These mechanisms need to ensure appropriate gender balance and representation for marginalized workers – informal or unpaid workers, for example. Gender-sensitive monitoring and evaluation frameworks build on national sex-disaggregated data and allow governments to monitor their policy interventions, ensuring that any impact – intended or unintended – on health, gender or socioeconomic outcomes can be captured.

## 5.6 Closing the Gender Gap in Investment

<b>Policy levers to close the Gender Gap in Investment</b>	Align with the sustainable development agenda	SDGs 3,4,5,8 and 17 Addis Ababa Action Agenda
	Domestic resource mobilisation for health	Progressive taxation Effective public financial management
	Strengthening universal health coverage	National budgetary commitments Ensuring financial risk protection Strengthening primary health care
	Invest in human resources for health and care	Targeting the recruitment, development, training and retention of health and care workers

### 5.6.1 Align investments with the Sustainable Development Agenda

Aligning investments and policy efforts with the Sustainable Development Agenda makes political sense as it enables a set of approaches to cohere under the banner of the SDGs. Women’s health and care work is central to multiple SDGs relating to gender, labour, poverty, education and health, including: SDG 3 (Ensure healthy lives and promote well-being for all at all ages), SDG 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), SDG 5 (Achieve gender equality and empower all women and girls, and SDG 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all).

The Addis Ababa Action Agenda sets out a global framework for financing sustainable development and achieving the SDGs, and recognizes the importance of delivering social protection and essential public services for all, investing in sustainable and resilient infrastructure, domestic resource mobilisation, generating full and productive employment and decent work and unlocking the transformative potential of people. (214) It also underlines the importance of gender equality and the empowerment of women and girls to achieve sustained, inclusive and equitable economic development.

### 5.6.2 Expand the fiscal space for health and care

Expanding the national fiscal space for health and care may be achieved through reprioritizing expenditure, raising domestic revenue, boosting efficiency of public expenditure, increasing foreign

borrowing and providing debt relief through various mechanisms.(272–274) In particular, progressive taxation paired with effective public financial management has the potential to effectively mobilise domestic resources that can be reinvested to strengthen health systems. (275,276) Progressive tax revenues derived from profits, capital and income were found to be significantly and strongly associated with increased government health spending while consumption taxes on essential goods were not. (275,276) However, health taxes imposed on consumption goods associated with negative impacts on public health (such as tobacco, alcohol, sugar sweetened beverages and fossil fuels) have the added benefits of improving population health and generating revenues for the budget.(277)

### 5.6.3 Invest in UHC and primary health care

UHC “means that all individuals and communities receive the health services they need without suffering financial hardship”.(278) It is recognized that primary health care is “a key component of all high-performing health systems and is an essential foundation of universal health coverage”. (279) Improving health service coverage goes hand in hand with investment in the health workforce: improved population health and progressing towards UHC “depends on the availability, accessibility, and capacity of health and care workers to deliver quality people-centred integrated care”.(278)

Political commitment is required to progress towards UHC and primary health care, and should be supported by policies that promote equity in access to quality health services, increased

financial protection, an enabling regulatory and legal environment, improved health systems infrastructure, sustained public financing, the harmonization of health investments, and robust accountability mechanisms.(280) Governments should also establish national spending targets for health that are consistent with national sustainable development strategies, tackle debt sustainability challenges, ensure sufficient domestic public spending on health, and pool health funds.(281) Where possible, financing mechanisms should be supported by a coalition of political support and responsive to people's needs.(281)

#### **5.6.4 Invest in human resources for health and care**

The WHO Global Strategy on Human Resources for Health: Workforce 2030 recommends that countries “align investment in human resources for health with the current and future needs of the population and health systems, taking account of labour market dynamics and education policies, to address shortages and improve decent working conditions as well as distribution of health and care workers, so as to enable maximum improvements in health outcomes, social welfare, employment creation and economic growth”. (197) Policy options to improve investments in human resources for health are outlined in Table 1.(197,282)

The High-Level Commission on Health Employment and Economic Growth makes six recommendations for transforming the health workforce in line with the SDGs, including investing in decent health sector jobs, addressing gender inequalities in participation, leadership and education, scaling up quality education and skill building, reforming service models towards integrated, community-based, people-centred primary and ambulatory care, harnessing information and communication technologies, and investment in International Health Regulations core capacities as well as ensuring the protection and security of all health and care workers and health facilities.(23)

## References

1. World Health Organization and International Labour Organization. The gender pay gap in the health and care sector: A global analysis in the time of COVID-19. Geneva: WHO and ILO; 2022. Available from: <https://www.who.int/publications/i/item/9789240052895>
2. Boniol M, Mclsaac M, Xu L, Wuliji T, Diallo K. Gender equity in the health workforce: analysis of 104 countries. Geneva: World Health Organization; 2019.
3. Addati L, Cattaneo U, Esquivel V, Valarino I. Care work and care jobs for the future of decent work [Internet]. Geneva: ILO; 2018. Available from: [https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms\\_633135.pdf](https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_633135.pdf)
4. Flor LS, Friedman J, Spencer CN, Cagney J, Arrieta A, Herbert ME, et al. Quantifying the effects of the COVID-19 pandemic on gender equality on health, social, and economic indicators: a comprehensive review of data from March, 2020, to September, 2021. *Lancet*. 2022 Jun 25;399(10344):2381–97.
5. Wenham C. The gendered impact of the COVID-19 crisis and post-crisis period. Strasbourg: European Parliament; 2020.
6. Morgan R, Tan HL, Oveisi N, Memmott C, Korzuchowski A, Hawkins K, et al. Women healthcare workers' experiences during COVID-19 and other crises: A scoping review. *International Journal of Nursing Studies Advances*. 2022; 4(100066).
7. Jones Y, Durand V, Morton K, Ottolini M, Shaughnessy E, Spector ND, et al. Collateral Damage: How COVID-19 Is Adversely Impacting Women Physicians. *J Hosp Med*. 2020 Aug;15(8):507–9.
8. Felice C, Di Tanna GL, Zanus G, Grossi U. Impact of COVID-19 Outbreak on Healthcare Workers in Italy: Results from a National E-Survey. *J Community Health*. 2020 Aug;45(4):675–83.
9. Policy Brief: The Impact of COVID-19 on Women. New York: UN Women; 2020. 21 p.
10. Langer A, Meleis A, Knaul FM, Atun R, Aran M, Arreola-Ornelas H, et al. Women and Health: the key for sustainable development. *Lancet*. 2015 Sep 19;386(9999):1165–210.
11. Beneria L. Reproduction, production and the sexual division of labour. *Cambridge J Econ*. 1979 Sep;3(3):203–25.
12. Morgan R, George A, Ssali S, Hawkins K, Molyneux S, Theobald S. How to do (or not to do)... gender analysis in health systems research. *Health Policy Plan*. 2016 Oct;31(8):1069–78.
13. Dugarova E. Unpaid care work in times of the COVID-19 crisis: Gendered impacts, emerging evidence and promising policy responses. In: Proceedings of the UN Expert Group Meeting “Families in development: Assessing progress, challenges and emerging issues Focus on modalities for IYF +30” [Internet]. 2020. Available from: [https://www.un.org/development/desa/family/wp-content/uploads/sites/23/2020/09/Dugarova.Paper\\_.pdf](https://www.un.org/development/desa/family/wp-content/uploads/sites/23/2020/09/Dugarova.Paper_.pdf)
14. Rethinking policy priorities in the light of pandemics: a call to action. [Internet]. Copenhagen: WHO EURO; 2021 [cited 2022 Dec 2]. Available from: <https://www.who.int/europe/publications/m/item/rethinking-policy-priorities-in-the-light-of-pandemics--a-call-to-action>
15. Ferrant G, Pesando LM, Nowacka K. Unpaid Care Work: The missing link in the analysis of gender gaps in labour outcomes. [Internet] Paris: OECD Development Centre; 2014. Available from: [https://www.oecd.org/dev/development-gender/Unpaid\\_care\\_work.pdf](https://www.oecd.org/dev/development-gender/Unpaid_care_work.pdf)

16. Coffey C, Espinoza Revollo P, Harvey R, Lawson M, Butt AP, Piaget K, Sarosi D, Thekkudan J. Time to care: Unpaid and underpaid care work and the global inequality crisis. [Internet]. Oxford (UK): Oxfam; 2020. Available from: <https://oxfamlibrary.openrepository.com/bitstream/handle/10546/620928/bp-time-to-care-inequality-200120-en.pdf>
17. WHO Global Health Workforce Network's Gender Equity Hub. Delivered by women, led by men: A gender and equity analysis of the global health and social workforce (Human Resources for Health Observer Series No. 24). [Internet]. Geneva: World Health Organization; 2019 [cited 2022 Dec 2]. Available from: <https://www.who.int/publications/i/item/978-92-4-151546-7>
18. Heintz J, Staab S, Turquet L. Don't Let Another Crisis Go to Waste: The COVID-19 Pandemic and the Imperative for a Paradigm shift. *Feminist Economics* [Internet]. 2021 Mar;27(1–2):470–85. Available from: <http://dx.doi.org/10.1080/13545701.2020.1867762>
19. Shannon G, Minckas N, Tan D, Haghparast-Bidgoli H, Batura N, Mannell J. Feminisation of the health workforce and wage conditions of health professions: an exploratory analysis. *Hum Resour Health*. 2019 Oct 17;17(1):72.
20. Knaul FM, Essue BM, Arreola-Ornelas H, Watkins D, Langer A. Universal health coverage must become a best buy for women. *Lancet*. 2021 Dec 18;398(10318):2215–7.
21. Heintz J. *The economy's other half*. Newcastle upon Tyne, England: Agenda Publishing; 2018.
22. United Nations Women. *Beyond COVID-19: A Feminist Plan for Sustainability and Social Justice*. [Internet]. New York: United Nations.; 2021. 96 p. Available from: <https://www.unwomen.org/en/digital-library/publications/2021/09/beyond-covid-19-a-feminist-plan-for-sustainability-and-social-justice>
23. High-Level Commission on Health Employment and Economic Growth. *Working for health and growth: investing in the health workforce*. [Internet]. Geneva: World Health Organization; 2016. Available from: <https://www.who.int/publications/i/item/9789241511308>
24. Lauer J, Soucat A, Araujo E, Weakliam D. Pathways: the health system, health employment, and economic growth. In: Buchan J, Dhillon IS, Campbell J, editors. *Health Employment and Economic Growth: An Evidence Base*. Geneva: World Health Organization; 2017:173–94.
25. Boniol M, Kunjumen T, Nair TS, Siyam A, Campbell J, Diallo K. The global health workforce stock and distribution in 2020 and 2030: a threat to equity and “universal” health coverage? *BMJ Glob Health*. 2022 Jun;7(6).
26. Mazzucato M. Health for All: Transforming economies to deliver what matters. *BMJ*. 2023 May 23;381:1175.
27. WHO Council on the Economics of Health for All. *Health for All: Transforming economies to deliver what matters - Final report*. [Internet]. Geneva: World Health Organization; 2023. Available from: [https://cdn.who.int/media/docs/default-source/council-on-the-economics-of-health-for-all/council-eh4a\\_finalreport\\_web.pdf?sfvrsn=a6505c22\\_5&download=true](https://cdn.who.int/media/docs/default-source/council-on-the-economics-of-health-for-all/council-eh4a_finalreport_web.pdf?sfvrsn=a6505c22_5&download=true)
28. The value of investing in social care What are the benefits of further funding for reform to adult social care in England? [Internet]. London: The King's Fund; 2021. Available from: <https://www.kingsfund.org.uk/sites/default/files/2021-10/value-investing-social-care-briefing.pdf>
29. Antonopoulos R, Kim K. *Public Job-Creation Programs: The Economic Benefits of Investing in Social Care? Case Studies in South Africa and the USA* (Levy Economics Institute Working Paper No. 671). [Internet]. Annandale-on-Hudon (NY): Levy Economics Institute of Bard College; 2011 [cited 2022 Dec 3]. Available from: <https://papers.ssrn.com/abstract=1846741>
30. Buchan J, Dhillon IS, Campbell J. *Health Employment and Economic Growth: An Evidence Base*. [Internet]. Geneva: World Health Organization; 2017. Available from: <https://apps.who.int/iris/bitstream/handle/10665/326411/9789241512404-eng.pdf>



31. Magar V, Gereke M, Dhillon I, Campbell J. Women's contribution to sustainable development through work in health: using a gender lens to advance a transformative 2030 agenda. In: Buchan J, Dhillon IS, Campbell J, editors. *Health Employment and Economic Growth: An Evidence Base*. Geneva: World Health Organization; 2016:27–50.
32. James C. Health and inclusive growth: Changing the dialogue. In: In: Buchan J, Dhillon IS, Campbell J, editors. *Health Employment and Economic Growth: An Evidence Base*. Geneva: World Health Organization; 2016:195–212.
33. The road to decent work for domestic workers. [Internet]. Geneva: ILO; 2023 [cited 2023 Jul 10]. Available from: [https://www.ilo.org/global/topics/domestic-workers/publications/WCMS\\_883181/lang--en/index.htm](https://www.ilo.org/global/topics/domestic-workers/publications/WCMS_883181/lang--en/index.htm)
34. The General Conference of the International Labour Organization. Resolution concerning decent work and the informal economy. ILO; 2002. Available from: <https://www.ilo.org/public/english/standards/relm/ilc/ilc90/pdf/pr-25res.pdf>
35. How fragile contexts affect the well-being and potential of women and girls. OECD Development Co-operation Directorate. Paris: OECD Publishing; 2022.
36. Centre for Sustainable Healthcare. Climate change adaptation: a guide for health and care professionals. [Internet]. 2022 [cited 2023 Aug 15]. Available from: <https://sustainablehealthcare.org.uk/blog/climate-change-adaptation>
37. Pörtner H-O, Roberts DC, Adams H, Adler C, Aldunce P, Ali E, et al. Climate change 2022: Impacts, adaptation and vulnerability. IPCC Sixth Assessment Report. [Internet]. Geneva: The Intergovernmental Panel on Climate Change (IPCC); 2022; Available from: <https://www.ipcc.ch/report/ar6/wg2/>
38. Victor CR. *Ageing, Health and Care*. Bristol: Policy Press; 2010. 224 p.
39. Caregiving in Crisis: Gender inequality in paid and unpaid work during COVID-19. OECD Policy Responses to Coronavirus (COVID-19) [Internet]. Paris: OECD Publishing; 2021. Available from: <http://dx.doi.org/10.1787/3555d164-en>
40. UN Women Data Hub. Three ways to contain COVID-19's impact on informal women workers. [Internet]. New York: UN Women; 2022 [cited 2022 Dec 2]. Available from: <https://data.unwomen.org/features/three-ways-contain-covid-19s-impact-informal-women-workers>
41. Regenold N, Vindrola-Padros C. Gender matters: A gender analysis of healthcare workers' experiences during the first COVID-19 pandemic peak in England. *Soc Sci*. 2021 Jan 27;10(2):43.
42. Horton R, Ceschia A. Making women count. *Lancet*. 2015 Sep 19;386(9999):1112–4.
43. Nguyen MP, Mirzoev T, Le TM. Contribution of health workforce to health outcomes: empirical evidence from Vietnam. *Hum Resour Health*. 2016 Nov;14(1):68.
44. Jin Y, Zhu W, Yuan B, Meng Q. Impact of health workforce availability on health care seeking behavior of patients with diabetes mellitus in China. *Int J Equity Health*. 2017 Jul 1;16(1):80.
45. Pittman P, Chen C, Erikson C, Salsberg E, Luo Q, Vichare A, et al. Health Workforce for Health Equity. *Med Care*. 2021 Oct 1;59(Suppl 5):S405–8.
46. Knaul FM, Arreola-Ornelas H, Aran M, Atun R, Méndez O, Pleic M, et al. Valuing the Gender differentials and the value of health care and caregiving contributions. [PowerPoint presentation]. Fifth Global Forum on Human Resources for Health, World Health Organization 3-5 April 2023.
47. International Health Conference. Constitution of the World Health Organization, 1946. *Bull World Health Organ*. 2002;80(12):983–4.

48. ILOSTAT. Work statistics - 19th ICLS (WORK). [Internet]. Geneva: ILO; 2022 [cited 2022 Dec 2]. Available from: <https://ilostat.ilo.org/resources/concepts-and-definitions/description-work-statistics-icls19/>
49. Pan American Health Organization. Unpaid health care work: A gender equality perspective. [Internet]. Washington D.C.:PAHO; 2021 [cited 2022 Dec 2]. Available from: [https://iris.paho.org/bitstream/handle/10665.2/54847/9789275122310\\_eng.pdf?sequence=1&isAllowed=y](https://iris.paho.org/bitstream/handle/10665.2/54847/9789275122310_eng.pdf?sequence=1&isAllowed=y)
50. UNESCO. The Implications of HIV and AIDS on women's unpaid labour burden. [Internet]. Paris: UNESCO; 2010 [cited 2023 Jul 10]. Report No.: Gender Equality Series 1. Available from: <https://unesdoc.unesco.org/ark:/48223/pf0000191470>
51. Mark M. Ebola crisis: how health workers on west African frontline are paying with their lives. The Guardian [Internet]. 2014 Oct 8 [cited 2023 Jul 10]; Available from: <https://www.theguardian.com/world/2014/oct/08/-sp-ebola-west-africa-health-workers>
52. Armstrong P by P. Unpaid Health Care: An Indicator of Equity. In: Armstrong P, Pederson A. Women's Health: Intersections of Policy, Research, and Practice. Toronto: Women's Press; 2015.
53. Elson D. Recognize, Reduce, and Redistribute Unpaid Care Work: How to Close the Gender Gap. New Labor Forum. 2017 May 1;26(2):52–61.
54. Women's Budget Group. Women's and children's poverty: making the links [Internet]. London: WBG; 2005 [cited 2023 Jul 10]. Available from: <https://wbg.org.uk/analysis/womens-and-childrens-poverty-making-the-links/>
55. Folbre N. The homemade value-added stabilizer [Internet]. Care Talk. 2020 [cited 2022 Dec 3]. Available from: <https://blogs.umass.edu/folbre/2020/05/19/the-homemade-value-added-stabilizer>
56. Lacey N, Bricker D. The COVID-19 effect on the global gender gap: Measuring it is the first step towards closing it. World Economic Forum [Internet]. Geneva: World Economic Forum; 2021 [cited 2022 Dec 2]. Available from: <https://www.weforum.org/agenda/2021/03/the-covid-19-effect-on-the-global-gender-gap-measuring-it-is-the-first-step-towards-closing-it/>
57. COVID-19 cost women globally over \$800 billion in lost income in one year. [Internet]. Oxford (UK): Oxfam International; 2021 [cited 2023 Jul 10]. Available from: <https://www.oxfam.org/en/press-releases/covid-19-cost-women-globally-over-800-billion-lost-income-one-year>
58. Garraza LG, Tobar F, Rodríguez Bernate I. Out-of-pocket spending for contraceptives in Latin America. Sex Reprod Health Matters. 2020 Dec;28(2):1833429.
59. Gender and Development Network. The impact of economic reforms and austerity measures on women's human rights. [Internet]. 2018 [cited 2023 Jul 10]. Available from: <https://gadnetwork.org/gadn-resources/2018/4/4/the-impact-of-economic-reforms-and-austerity-measures-on-womens-human-rights-gadn-submission>
60. United Nations Human Rights: Office of the High Commissioner. Report on austerity measures and economic and social rights. [Internet]. Geneva: OHCHR; 2013. Available from: <https://www.ohchr.org/en/social-security/austerity-measures-and-right-social-security>
61. Women working for recovery: The impact of female employment on family and community welfare after conflict. [Internet]. New York: UN women; 2012 [cited 2023 Jul 10]. Available from: <https://www.un.org/shestandsforpeace/content/women-working-recovery-impact-female-employment-family-and-community-welfare-after-conflict>
62. Osman-Elasha B. Women...In the Shadow of Climate Change. UN Chronicle (Special Climate Change Issue). 2009;XLVI(3&4) [cited 2023 Aug 12]. Available from: <https://www.un.org/en/chronicle/article/womenin-shadow-climate-change>

63. ILOSTAT. These occupations are dominated by women. [Internet]. Geneva: ILO; 2020 [cited 2022 Dec 2]. Available from: <https://ilostat.ilo.org/these-occupations-are-dominated-by-women/>
64. Who are domestic workers [Internet]. Geneva: ILO; 2022 [cited 2022 Dec 2]. Available from: <https://www.ilo.org/global/topics/domestic-workers/who/lang--en/index.htm>
65. Smith J, Davies SE, Feng H, Gan CCR, Grépin KA, Harman S, et al. More than a public health crisis: A feminist political economic analysis of COVID-19. *Glob Public Health*. 2021 Mar 11;16(8–9):1364–80.
66. Chaklader A, Ascott A. Personal protective equipment is sexist. [Internet]. *The BMJ Opinion*; 2021 Mar 9 [cited 2022 Dec 2]. Available from: <http://blogs.bmj.com/bmj/2021/03/09/personal-protective-equipment-is-sexist>
67. Hoernke K, Djellouli N, Andrews L, Lewis-Jackson S, Manby L, Martin S, et al. Frontline healthcare workers' experiences with personal protective equipment during the COVID-19 pandemic in the UK: a rapid qualitative appraisal. *BMJ Open*. 2021 Jan 20;11(1):e046199.
68. Ryan NE, El Ayadi AM. A call for a gender-responsive, intersectional approach to address COVID-19. *Glob Public Health*. 2020 Sep;15(9):1404–12.
69. UN Women Data Hub. COVID-19: Emerging gender data and why it matters [Internet]. Geneva: World Economic Forum; 2021 [cited 2022 Dec 2]. Available from: <https://data.unwomen.org/resources/covid-19-emerging-gender-data-and-why-it-matters>
70. Mothupi M, Dasgupta J, Hosseini Jebeli SS, Stevenson J, Berdichevsky K, Vong S, et al. Using an intersectionality approach to transform health services for overlooked healthcare users and workers after covid-19. *BMJ*. 2023 Jun;381:e072243.
71. Gender-based violence and harassment against domestic workers: Case stories from Asia. [Internet]. Hong Kong: International Domestic Workers Federation; 2022 [cited 2023 Jul 10]. Available from: [https://idwfed.org/wp-content/uploads/2022/07/gender\\_based\\_violence\\_and\\_harassment\\_against\\_domestic\\_workers\\_en.pdf](https://idwfed.org/wp-content/uploads/2022/07/gender_based_violence_and_harassment_against_domestic_workers_en.pdf)
72. Jamison DT, Summers LH, Alleyne G, Arrow KJ, Berkley S, Binagwaho A, et al. Global health 2035: a world converging within a generation. *Lancet*. 2013 Dec 7;382(9908):1898–955.
73. World Health Organization. Global spending on health: Weathering the storm. Geneva: World Health Organization; 2020 [cited 2022 Dec 4]. Available from: <https://www.who.int/publications/item/9789240017788>
74. Aghion P, Howitt P, Murtin F. The Relationship Between Health and Growth: When Lucas Meets Nelson-Phelps. [Internet]. National Bureau of Economic Research; 2010. (Working Paper Series). Available from: <http://www.nber.org/papers/w15813>
75. Watkins DA, Yamey G, Schäferhoff M, Adeyi O, Alleyne G, Alwan A, et al. Alma-Ata at 40 years: reflections from the Lancet Commission on Investing in Health. *Lancet*. 2018 Oct 20;392(10156):1434–60.
76. Onarheim KH, Iversen JH, Bloom DE. Economic Benefits of Investing in Women's Health: A Systematic Review. *PLoS One*. 2016 Mar 30;11(3):e0150120.
77. de Paula N, Jung L, Mar K, Bowen K, Maglakelidze M, Funderich M, et al. A planetary health blind spot: the untapped potential of women to safeguard nature and human resilience in LMICs. *Lancet Planet Health*. 2021 Mar;5(3):e109–10.
78. Gan CCR, McNamara C, Gunasiri H, Oliva P, Sebar B. Women and planetary health in Asia-Pacific. *Front Clim*. 2023 Mar 28;5. Available from: <https://www.frontiersin.org/articles/10.3389/fclim.2023.1058432/full>



79. Trebeck BK. A wellbeing economy agenda to help shape the post- Coronavirus economy. *Eurohealth*. 2020;26(3):6–9 [cited 2023 Aug 16]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/338915/Eurohealth-26-3-6-9-eng.pdf>
80. Hutchinson B, Small R, Acquah K, Sandoval R, Nugent R, Davidson T, et al. The investment case as a mechanism for addressing the NCD burden: Evaluating the NCD institutional context in Jamaica, and the return on investment of select interventions. *PLOS ONE*. 2019;14:p. e0223412. Available from: <http://dx.doi.org/10.1371/journal.pone.0223412>
81. Heise L, Greene ME, Opper N, Stavropoulou M, Harper C, Nascimento M, et al. Gender inequality and restrictive gender norms: framing the challenges to health. *Lancet*. 2019 Jun 15;393(10189):2440–54.
82. Ridgeway CL, Correll SJ. Unpacking the Gender System: A Theoretical Perspective on Gender Beliefs and Social Relations. *Gend Soc*. 2004 Aug 1;18(4):510–31.
83. World Health Assembly. Integrating gender analysis and actions into the work of WHO: draft strategy (WHA60.25). [Internet]. 2007. Available from: [https://apps.who.int/gb/ebwha/pdf\\_files/WHA60/A60\\_R25-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA60/A60_R25-en.pdf)
84. Gender mainstreaming for health managers: a practical approach [Internet]. Geneva: World Health Organization; 2011 [cited 2022 Dec 3]. Available from: <https://www.who.int/publications/item/9789241501057>
85. Larson E, George A, Morgan R, Poteat T. 10 Best resources on... intersectionality with an emphasis on low- and middle-income countries. *Health Policy Plan*. 2016 Oct;31(8):964–9.
86. UN Women and World Health Organization. Respect Women: Strategy Summary. Transformed attitudes, beliefs and norms. [Internet]. New York: UN Women; 2020. Available from: <https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/RESPECT-implementation-guide-Strategy-summary-Transformed-attitudes-beliefs-and-norms-en.pdf>
87. Gender norms. [Internet]. Vilnius: European Institute for Gender Equality; 2023 [cited 2023 Jul 10]. Available from: [https://eige.europa.eu/publications-resources/thesaurus/terms/1288?language\\_content\\_entity=en](https://eige.europa.eu/publications-resources/thesaurus/terms/1288?language_content_entity=en)
88. Gender and health [Internet]. Geneva: World Health Organization; 2023 [cited 2023 Jul 10]. Available from: <https://www.who.int/health-topics/gender>
89. Survey on the role of women in development 2009. [Internet]. New York: UN Women; 2023 [cited 2023 Jul 10]. Available from: <https://www.un.org/womenwatch/daw/ws2009/>
90. United Nations Economic and Social Commission for Western Asia. Gender division of labour. [Internet]. 2014 [cited 2023 Jul 10]. Available from: <https://archive.unescwa.org/gender-division-labour>
91. March C, Smyth IA, Mukhopadhyay M. *A Guide to Gender-analysis Frameworks*. Oxford (UK): Oxfam; 1999. 144 p.
92. Gender division of labour. [Internet]. Vilnius: European Institute for Gender Equality; 2023 [cited 2023 Jul 10]. Available from: [https://eige.europa.eu/publications-resources/thesaurus/terms/1226?language\\_content\\_entity=en](https://eige.europa.eu/publications-resources/thesaurus/terms/1226?language_content_entity=en)
93. Crompton R. Gender inequality and the gendered division of labour. In: Browne, J. *The Future of Gender*. Cambridge; Cambridge University Press; 2007.
94. Reproductive work. [Internet]. Vilnius: European Institute for Gender Equality; 2022 [cited 2022 Dec 3]. Available from: <https://eige.europa.eu/thesaurus/terms/1352>

95. Gross E. Plus ça change...? The sexual structure of occupations over time. *Soc Probl.* 1968;16(2):198–208.
96. Gender segregation in education, training and the labour market: review of the implementation of the Beijing Platform for Action in the EU Member States. Strasbourg: Council of the European Union; 2017.
97. Meulders D, Plasman R, Rigo A, O'dorchai S. Horizontal and vertical segregation. Meta-analysis of gender and science research – Topic report. European Union; 2010. Available from: [http://www.genderportal.eu/sites/default/files/resource\\_pool/TR1\\_Segregation.pdf](http://www.genderportal.eu/sites/default/files/resource_pool/TR1_Segregation.pdf)
98. Irvine L. Feminization of Work. In: Smith V, editor. *Sociology of Work: An Encyclopedia*. Sage Publications, Inc; 2013.
99. Murphy E, Oesch D. The Feminization of Occupations and Change in Wages: A Panel Analysis of Britain, Germany, and Switzerland. *Soc Forces.* 2015 Aug 17;94(3):1221–55.
100. ILO Press Release. Women work more, but are still paid less [Internet]. ILO; 2022 [cited 2022 Dec 2]. Available from: [https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS\\_008091/lang-en/index.htm](https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_008091/lang-en/index.htm)
101. Grimshaw D, Rubery J. Undervaluing women's work [Internet]. Equal Opportunities Commission; 2007 [cited 2023 Oct 18]. Available from: [https://www.njl.nu/uploads/Paper\\_2007\\_Jill\\_Rubery.pdf](https://www.njl.nu/uploads/Paper_2007_Jill_Rubery.pdf)
102. Jayachandran S. Social Norms as a Barrier to Women's Employment in Developing Countries. *IMF Economic Review.* 2021 Sep;69(3):576–95.
103. Marcus R. Gender, Social Norms, and Women's Economic Empowerment. In: *Women's Economic Empowerment*, 1st Edition. Routledge; 2021:126–53.
104. Gender equality glossary [Internet]. New York: UN Women; 2023 [cited 2023 Jul 10]. Available from: <https://trainingcentre.unwomen.org/mod/glossary/view.php?id=36>
105. Moser CON, Tornqvist A, van Bronkhorst B. *Mainstreaming Gender and Development in the World Bank: Progress and Recommendations*. Washington D.C.: World Bank Publications; 1999. 38 p.
106. Maestre M, Thorpe J. Understanding unpaid care work to empower women in market systems approaches: policy brief. Brighton (UK): Institute of Development Studies; 2016.
107. A Guide for the Analysis and Monitoring of Gender Equity in Health Policies. [Internet]. Washington D.C.: PAHO; 2009 [cited 2022 Dec 3]. Available from: <https://www.paho.org/en/documents/guide-analysis-and-monitoring-gender-equity-health-policies-0>
108. Elias M, Meinzen-Dick R. Assessing women's empowerment initiatives collaboratively can create positive change. CGIAR Gender Platform Evidence Explainer [Internet]. Washington D.C.: International Food Policy Research Institute; 2021 [cited 2022 Dec 3]. Available from: <https://www.ifpri.org/publication/assessing-womens-empowerment-initiatives-collaboratively-can-create-positive-change>
109. UN Women – Asia Pacific. Women in power and decision-making. [Internet]. UN Women; n.d. [cited 2023 Jul 10]. Available from: <https://asiapacific.unwomen.org/en/beijing20/in-focus/women-in-power-and-decision-making>
110. Alliance for Health Policy and Systems Research. Rapid reviews to strengthen health policy and systems: a practical guide [Internet]. 2017 [cited 2022 Dec 3]. Available from: <https://ahpsr.who.int/publications/i/item/2017-08-10-rapid-reviews-to-strengthen-health-policy-and-systems-a-practical-guide>

111. Marphatia AA, Moussié R. A question of gender justice: Exploring the linkages between women's unpaid care work, education, and gender equality. *Int J Educ Dev*. 2013 Nov 1;33(6):585–94.
112. The status of nursing and midwifery in the world. *Lancet*. 2020 Apr 11;395(10231):1167.
113. Lokot M, Bhatia A. Unequal and Invisible: A Feminist Political Economy Approach to Valuing Women's Care Labor in the COVID-19 Response. *Front Sociol*. 2020 Nov 6;5:588279.
114. Seedat S, Rondon M. Women's wellbeing and the burden of unpaid work. *BMJ*. 2021 Aug 31;374:n1972.
115. UN Women Data Hub. Surveys show that COVID-19 has gendered effects in Asia and the Pacific. UN Women Data Hub [Internet]. New York: UN Women; 2020 [cited 2023 Jul 10]. Available from: <https://data.unwomen.org/resources/surveys-show-covid-19-has-gendered-effects-asia-and-pacific>
116. Ervin J, Taouk Y, Alfonzo LF, Hewitt B, King T. Gender differences in the association between unpaid labour and mental health in employed adults: a systematic review. *Lancet Public Health*. 2022 Sep;7(9):e775–86.
117. Facts and figures. [Internet]. London: Carers UK; n.d. [cited 2022 Dec 3]. Available from: <https://www.carersuk.org/news-and-campaigns/press-releases/facts-and-figures>
118. McMunn A. Unpaid labour is a neglected social determinant of health. *Lancet Public Health*. 2023 Apr;8(4):e250–1.
119. Global Health Observatory. Community health workers. [Internet]. Geneva: World Health Organization; 2023 [cited 2023 Jul 10]. Available from: [https://www.who.int/data/gho/data/indicators/indicator-details/GHO/community-health-workers-\(number\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/community-health-workers-(number))
120. Colvin CJ, Hodgins S, Perry HB. Community health workers at the dawn of a new era: 8. Incentives and remuneration. *Health Res Policy Syst*. 2021 Oct 12;19(Suppl 3):106.
121. Budlender D. Compensation for contributions: report on interviews with volunteer care-givers in six African countries. New York: The Huairou Commission; 2009.
122. WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes. Geneva: World Health Organization; 2018. Available from: <https://www.who.int/publications/i/item/9789241550369>
123. Ballard M, Westgate C, Alban R, Choudhury N, Adamjee R, Schwarz R, et al. Compensation models for community health workers: Comparison of legal frameworks across five countries. *J Glob Health*. 2021 Feb 15;11:04010.
124. Elson D. Recognize, Reduce, and Redistribute Unpaid Care Work: How to Close the Gender Gap. *New Labor Forum*. 2017 May 1;26(2):52–61.
125. Women Count Data Hub. Whose time to care: Unpaid care and domestic work during COVID-19. [Internet]. New York: UN Women; 2020 [cited 2022 Dec 3]. Available from: <https://data.unwomen.org/publications/whose-time-care-unpaid-care-and-domestic-work-during-covid-19>
126. COVID-19 and its economic toll on women: The story behind the numbers. [Internet]. New York: UN Women; 2020 [cited 2022 Dec 3]. Available from: <https://www.unwomen.org/en/news/stories/2020/9/feature-covid-19-economic-impacts-on-women>
127. Pan-European commission on health and sustainable development [Internet]. Geneva: World Health Organization; n.d. [cited 2023 Jul 10]. Available from: <https://www.who.int/europe/groups/pan-european-commission-on-health-and-sustainable-development>

128. Peng I. What is the care economy and why should we care? [Internet]. Washington D.C.: Care Work and the Economy Project; 2021 [cited 2022 Dec 2]. Available from: <https://research.american.edu/careworkeconomy/blog/2021/04/02/what-is-the-care-economy-and-why-we-should-know-more-about-it-particularly-now/>
129. Giannelli GC, Mangiavacchi L, Piccoli L. GDP and the value of family caretaking: how much does Europe care? *Appl Econ*. 2012 Jun 1;44(16):2111–31.
130. Miranda V. Cooking, caring and volunteering: Unpaid work around the world. [Internet]. Paris: OECD; 2011. Available from: [https://www.oecd-ilibrary.org/social-issues-migration-health/cooking-caring-and-volunteering-unpaid-work-around-the-world\\_5kghrjm8s142-en](https://www.oecd-ilibrary.org/social-issues-migration-health/cooking-caring-and-volunteering-unpaid-work-around-the-world_5kghrjm8s142-en)
131. Information systems: transforming data into information, information into knowledge and knowledge into political decisions (Repository of information on time use in Latin America and the Caribbean). [Internet]. Santiago: Economic Commission for Latin America and the Caribbean; 2021. Available from: [https://oig.cepal.org/sites/default/files/c2100832\\_web.pdf](https://oig.cepal.org/sites/default/files/c2100832_web.pdf)
132. Payne CS, Vassilev G. Household satellite account, UK: 2015 and 2016. [Internet]. Newport (UK): Office for National Statistics; 2018. Available at: <https://www.ons.gov.uk/economy/nationalaccounts/satelliteaccounts/articles/householdsatelliteaccounts/2015and2016estimates>
133. Soupourmas F, Ironmonger D. Calculating Australia's Gross Household Product: Measuring The Economic Value Of The Household Economy 1970-2000 (Department of Economics - Working Papers Series 833). [Internet]. Melbourne: University of Melbourne; 2002 [cited 2022 Dec 4]. Available from: [https://fbe.unimelb.edu.au/\\_\\_data/assets/pdf\\_file/0010/805834/833.pdf](https://fbe.unimelb.edu.au/__data/assets/pdf_file/0010/805834/833.pdf)
134. Addati L, Cattaneo U, Pozzan E. Care at work: Investing in care leave and services for a more gender equal world of work. Geneva: International Labour Organization; 2022 [cited 2022 Dec 4]. Available from: [https://www.ilo.org/global/topics/care-economy/WCMS\\_838653/lang--en/index.htm](https://www.ilo.org/global/topics/care-economy/WCMS_838653/lang--en/index.htm)
135. Investing in the care economy – A gender analysis of employment stimulus in seven OECD countries. [Internet]. Brussels: International Trade Union Confederation; 2016 [cited 2022 Dec 4]. Available from: <https://www.ituc-csi.org/investing-in-the-care-economy>
136. World Employment and Social Outlook: Trends. [Internet]. Geneva: ILO; 2023. Available from: [https://www.ilo.org/wcmsp5/groups/public/---dgreports/---inst/documents/publication/wcms\\_865332.pdf](https://www.ilo.org/wcmsp5/groups/public/---dgreports/---inst/documents/publication/wcms_865332.pdf)
137. The G20 Health and Development Partnership. The overlooked pandemic: How to transform patient safety and save healthcare systems. [Internet]. London: Sovereign Sustainability & Development Hub; n.d. [cited 2023 Jul 10]. Available from: <https://www.ssdhub.org/the-overlooked-pandemic/>
138. Reich M. What are the likely effects of a \$15 federal minimum wage by 2024? [Internet]. Berkley (US): Institute for Research on Labour and Employment; 2019. Available from: <https://irle.berkeley.edu/publications/brief/likely-effects-of-a-15-federal-minimum-wage-by-2024/>
139. Simhoni S. Occupational segregation in America. [Internet]. Center for American Progress; 2022 [cited 2023 Jul 10]. Available from: <https://www.americanprogress.org/article/occupational-segregation-in-america/>
140. Global Gender Gap Report 2015. [Internet]. Cologny: World Economic Forum; 2015 [cited 2022 Dec 3]. Available from: <https://www.weforum.org/reports/global-gender-gap-report-2015>
141. Elborgh-Woytek K, Newiak M, Kochhar K, Fabrizio S, Kpodar K, Wingender P, Clements B, Schwartz G. Women, Work, and the Economy: Macroeconomic Gains From Gender Equity. Washington D.C.; International Monetary Fund; 2013.

142. Woetzel J, Ellingrud K, Labaye E, Devillard S, Kutcher E, Manyika J, et al. The Power of Parity: How Advancing Women’s Equality can add \$12 trillion to global growth. [Internet]. New York (US): McKinsey & Company; 2015. Available from: <https://www.mckinsey.com/featured-insights/employment-and-growth/how-advancing-womens-equality-can-add-12-trillion-to-global-growth>
143. Thévenon O, Ali N, Adema W, del Pero AS. Effects of reducing gender gaps in education and labour force participation on economic growth in the OECD. OECD Social, Employment and Migration Working Papers [Internet]. Paris: Organisation for Economic Co-Operation and Development; 2012 [cited 2022 Dec 3]. Available from: [https://www.oecd-ilibrary.org/social-issues-migration-health/effects-of-reducing-gender-gaps-in-education-and-labour-force-participation-on-economic-growth-in-the-oecd\\_5k8xb722w928-en](https://www.oecd-ilibrary.org/social-issues-migration-health/effects-of-reducing-gender-gaps-in-education-and-labour-force-participation-on-economic-growth-in-the-oecd_5k8xb722w928-en)
144. Silva MS, Klasen S. Gender inequality as a barrier to economic growth: a review of the theoretical literature. *Review of Economics of the Household*. 2021;19: 581–614. Available from: <http://dx.doi.org/10.1007/s11150-020-09535-6>
145. UN Women Arab States. Women as drivers of economic recovery and resilience during COVID-19 and beyond. [Internet]. New York: UN Women; 2020. Available from: <https://arabstates.unwomen.org/en/news/stories/2020/07/statement-joint-w20-women-during-covid-19-and-beyond>
146. Liu JX, Goryakin Y, Maeda A, Bruckner T, Scheffler R. Global Health Workforce Labor Market Projections for 2030. *Hum Resour Health*. 2017 Feb 3;15(1):11.
147. Scheil-Adlung X, Nove A. Global estimates of the size of the health workforce contributing to the health economy: the potential for creating decent work in achieving universal health coverage. In: Buchan J, Dhillon IS, Campbell J, editors. *Health Employment and Economic Growth: An Evidence Base*. Geneva: World Health Organization; 2017:139–72.
148. United Nations Statistics Division. Classification detail (ISIC, Rev. 4) [Internet]. [cited 2023 Aug 16]. Available from: <https://unstats.un.org/unsd/classifications/Econ/Detail/EN/27/7490>
149. Equal pay for work of equal value. [Internet]. New York: UN Women CSW61; 2017. Available from: <https://www.unwomen.org/en/news/in-focus/csw61/equal-pay>
150. Ñopo HR. New century, Old Disparities: Gender and Ethnic Earnings Gaps in Latin America and The Caribbean. [Internet]. Washington D.C.: Inter-American Development Bank; 2012 [cited 2023 Jul 10]. Available from: <https://publications.iadb.org/publications/english/document/New-century-Old-Disparities-Gender-and-Ethnic-Earnings-Gaps-in-Latin-America-and-The-Caribbean.pdf>
151. The Institute for Women’s Policy Research. Same Gap, Different Year. The Gender Wage Gap: 2019 Earnings Differences by Gender, Race, and Ethnicity. [Internet]. Washington D.C.: The Institute for Women’s Policy Research; 2020. Available from: <https://iwpr.org/wp-content/uploads/2020/07/2020-Weekly-Wage-Gap-2020-FINAL.pdf>
152. US Census Bureau. Women represent majority of workers in several essential occupations. 2022 Jun 10 [cited 2022 Dec 3]; Available from: <https://www.census.gov/library/stories/2021/03/unequally-essential-women-and-gender-pay-gap-during-covid-19.html>
153. Muench U, Sindelar J, Busch SH, Buerhaus PI. Salary differences between male and female registered nurses in the USA. *JAMA*. 2015;313(12):1265–7.
154. Enda G, Gale WG. How does gender equality affect women in retirement? [Internet]. Washington D.C.: Brookings Institute; 2020 [cited 2023 Jul 30]. Available from: <https://www.brookings.edu/articles/how-does-gender-equality-affect-women-in-retirement/>
155. Understanding the gender pay gap. [Internet]. Geneva: ILO; 2020. Available from: [https://www.ilo.org/wcmsp5/groups/public/---ed\\_dialogue/---act\\_emp/documents/publication/wcms\\_735949.pdf](https://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---act_emp/documents/publication/wcms_735949.pdf)



156. Buvinic M, Lunde T, Sinha N. Investing in gender equality: Looking ahead (Economic Premise; No. 22). [Internet]. Washington D.C.: World Bank; 2010 [cited 2023 Jul 10]. Available from: <https://openknowledge.worldbank.org/handle/10986/10168>
157. Wolszczak-Derlacz J. The Impact of Gender Wage Gap on Sectoral Economic Growth – Cross-country Approach Equilibrium. 2013;8: 103–22. Available from: <http://dx.doi.org/10.12775/equil.2013.022>
158. Shaw E, Mariano H. Narrow The Gender Pay Gap, Reduce Poverty for Families: The Economic Impact of Equal Pay by State (Policy brief, IWPR). [Internet]. Washington D.C.: The Institute for Women’s Policy Research; 2021. Available from: [https://iwpr.org/wp-content/uploads/2021/05/Economic-Impact-of-Equal-Pay-by-State\\_FINAL.pdf](https://iwpr.org/wp-content/uploads/2021/05/Economic-Impact-of-Equal-Pay-by-State_FINAL.pdf)
159. Hernandez P, Dräger S, Evans DB, Tan-Torres T, Dal Poz MR. Measuring expenditure for the health workforce: challenges and evidence. Geneva: World Health Organization; 2006.
160. Women’s situation in the labour market. [Internet]. Brussels: European Commission; 2019 [cited 2022 Dec 5]. Available from: [https://ec.europa.eu/info/policies/justice-and-fundamental-rights/gender-equality/women-labour-market-work-life-balance/womens-situation-labour-market\\_en](https://ec.europa.eu/info/policies/justice-and-fundamental-rights/gender-equality/women-labour-market-work-life-balance/womens-situation-labour-market_en)
161. The cost of inequality in women’s work. [Internet]. Chard (UK): ActionAid UK; 2015 [cited 2022 Dec 3]. Available from: <https://www.actionaid.org.uk/close-the-gap-the-cost-of-inequality-in-womens-work>
162. Boost Women’s Economic Empowerment: Facts, Solutions, Case Studies, and Calls to Action. [Internet]. Women Deliver; 2019. Available from: [https://womendeliver.org/wp-content/uploads/2017/09/2019-7-D4G\\_Brief\\_Economic.pdf](https://womendeliver.org/wp-content/uploads/2017/09/2019-7-D4G_Brief_Economic.pdf)
163. George AS, McConville FE, de Vries S, Nigenda G, Sarfraz S, Mclsaac M. Violence against female health workers is tip of iceberg of gender power imbalances. *BMJ*. 2020;371:m3546 Available from: <https://www.bmj.com/content/371/bmj.m3546>
164. Violence at Work. [Internet]. Geneva: ILO; 2004. Report No.: Labour Education 2003/4 No. 133. Available from: [https://www.ilo.org/wcmsp5/groups/public/---ed\\_dialogue/---actrav/documents/publication/wcms\\_111456.pdf](https://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---actrav/documents/publication/wcms_111456.pdf)
165. Joint programme launches new initiative against workplace violence in the health sector. [Internet]. Geneva: ILO; 2002 [cited 2023 Jul 10]; Available from: [https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS\\_007817/lang--en/index.htm](https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_007817/lang--en/index.htm)
166. Violence against women. [Internet]. Geneva: World Health Organization; 2021 [cited 2023 Jul 12]. Available from: <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>
167. Non-standard employment around the world: Understanding challenges, shaping prospects. [Internet] Geneva: ILO; 2016 [cited 2023 Jul 11]. Available from: [https://www.ilo.org/global/publications/books/WCMS\\_534326/lang--en/index.htm](https://www.ilo.org/global/publications/books/WCMS_534326/lang--en/index.htm)
168. Campbell I. Australia: institutional changes and workforce fragmentation. In: Lee S, Eyraud F, editors. *Globalization, Flexibilization and Working Conditions in Asia and the Pacific*. Chandos Publishing; 2008:115–52.
169. Gheith N. Developing a Proactive Protocol for Addressing Casualization of Nursing Workforce at Mansoura City, Egypt. *Aust J Basic Appl Sci*. 2014; 8(13): 642–656.
170. Rispel LC, Blaauw D. The health system consequences of agency nursing and moonlighting in South Africa. *Glob Health Action*. 2015 May 11;8:26683.
171. More than 60 per cent of the world’s employed population are in the informal economy. Geneva: ILO; 2018 [cited 2023 Jul 10]. Available from: [https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS\\_627189/lang--en/index.htm](https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_627189/lang--en/index.htm)

172. ILO launches new strategy to achieve decent work for domestic workers. [Internet] Geneva: ILO; 2023 [cited 2023 Jul 10]; Available from: [https://www.ilo.org/global/topics/domestic-workers/news/WCMS\\_885135/lang--en/index.htm](https://www.ilo.org/global/topics/domestic-workers/news/WCMS_885135/lang--en/index.htm)
173. Migrant and Domestic Workers. [Internet]. Geneva: ILO; 2023 [cited 2023 Jul]. Available from: <https://www.ilo.org/global/topics/labour-migration/policy-areas/migrant-domestic-workers/lang--en/index.htm>
174. Briefing paper: Growing need for long-term care: Assumptions and realities. [Internet]. New York: UN Department of Economic and Social Affairs; 2016 [cited 2023 Aug 16]. Available from: <https://www.un.org/development/desa/ageing/news/2016/09/briefing-paper-growing-need-for-long-term-care-assumptions-and-realities/>
175. Leichsenring K, Kadi S, Simmons C. Making the Invisible Visible: The Pandemic and Migrant Care Work in Long-Term Care. *Soc Sci.* 2022 Jul 25;11(8):326.
176. Integrated continuum of long-term care. [Internet]. [cited 2023 Aug 15]. Available from: <https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/ageing-and-health/integrated-continuum-of-long-term-care>
177. ILO global estimates on international migrant workers – results and methodology. Geneva: ILO; 2021 [cited 2023 Jul 10]; Available from: [https://www.ilo.org/global/topics/labour-migration/publications/WCMS\\_808935/lang--en/index.htm](https://www.ilo.org/global/topics/labour-migration/publications/WCMS_808935/lang--en/index.htm)
178. Global Health Workforce statistics database [Internet]. Geneva: WHO; 2022 [cited 2022 Dec 3]. Available from: <https://www.who.int/data/gho/data/themes/topics/health-workforce>
179. Recent trends in international migration of doctors, nurses and medical students. Paris: OECD; 2019. Available from: <https://www.oecd.org/health/recent-trends-in-international-migration-of-doctors-nurses-and-medical-students-5571ef48-en.htm>
180. Briggs B. International migration and the healthcare workforce [Internet]. Newport (UK): Office for National Statistics; 2019 [cited 2023 Jul 10]. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/articles/internationalmigrationandthehealthcareworkforce/2019-08-15>
181. Batalova J. Immigrant health-care workers in the USA. [Internet]. Washington D.C.: Migration Policy Institute; 2023 [cited 2023 Jul 10]. Available from: <https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states>
182. Dempster H, Smith R. Migrant health workers are on the COVID-19 frontline. We need more of them. [Internet]. London: Center For Global Development; 2020 [cited 2023 Jul 10]. Available from: <https://www.cgdev.org/blog/migrant-health-workers-are-covid-19-frontline-we-need-more-them>
183. The international platform on health worker mobility. [Internet]. Geneva: World Health Organization; 2017 [cited 2023 Jul 10]. Available from: <https://www.who.int/publications/m/item/the-international-platform-onhealth-worker-mobility>
184. Bourgeault IL, Runnels V, Atanackovic J, Spitzer D, Walton-Roberts M. Hiding in plain sight: the absence of consideration of the gendered dimensions in ‘source’ country perspectives on health worker migration. *Human Resources for Health.* 2021;19. Available from: <http://dx.doi.org/10.1186/s12960-021-00571-6>
185. Vahí AO. On the intersection of gender, care, and migration in the COVID-19 pandemic. [Internet]. Human Rights Pulse; 2021 [cited 2022 Dec 2]. Available from: <https://www.humanrightspulse.com/mastercontentblog/on-the-intersection-of-gender-care-and-migration-in-the-covid-19-pandemic>
186. Global health and care worker compact. [Internet]. Geneva: World Health Organization; 2023 [cited 2023 Aug 8]. Available from: <https://www.who.int/publications/m/item/carecompact>

187. Zgheib N. New guidance for private sector on gender-based violence and harassment. [Internet]. London: European Bank for Reconstruction and Development (EBRD); 2020 [cited 2023 Jul 12]. Available from: <https://www.ebrd.com/news/2020/new-guidance-for-private-sector-on-addressing-risks-of-genderbased-violence-and-harassment.html>
188. Amarante V. Informality and the achievement of SDGs. Background paper for United Nations Department of Economic and Social Affairs. New York: UNDESA; 2021.
189. Five Things to Know about the Informal Economy. [Internet]. Washington D.C.: IMF; 2021 [cited 2023 Jul 10]. Available from: <https://www.imf.org/en/News/Articles/2021/07/28/na-072821-five-things-to-know-about-the-informal-economy>
190. Qiang CZ, Ghossein T. Out of the shadows: Unlocking the economic potential of informal businesses. World Bank Blogs [Internet]. World Bank Group; 2020 [cited 2023 Jul 10]. Available from: <https://blogs.worldbank.org/psd/out-shadows-unlocking-economic-potential-informal-businesses>
191. Packer C, Runnels V, Labonté R. Does the Migration of Health Workers Bring Benefits to the Countries They Leave Behind? In: Shah RS, editor. *The International Migration of Health Workers: Ethics, Rights and Justice*. London: Palgrave Macmillan UK; 2010:44–61.
192. At what cost? Women migrant workers, remittances and development. [Internet]. New York: UN Women; 2017 [cited 2023 Jul 11]. Available from: <https://www.unwomen.org/en/digital-library/publications/2017/2/women-migrant-workers-remittances-and-development>
193. Working for Health Five-year action plan for health employment and inclusive economic growth (2017–2021). [Internet]. Geneva: World Health Organization; 2018 [cited 2022 Dec 3]. Available from: <https://www.who.int/publications/i/item/9789241514149>
194. Closing data gaps in gender. [Internet]. Geneva: World Health Organization; 2023 [cited 2023 Aug 15]. Available from: <https://www.who.int/activities/closing-data-gaps-in-gender>
195. World Health Organization. Health workforce [Internet]. [cited 2022 Dec 2]. Available from: <https://www.who.int/teams/health-workforce/about>
196. Stenberg K, Hanssen O, Edejer TT-T, Bertram M, Brindley C, Meshreky A, et al. Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries. *The Lancet Global Health*. 2017;5: p. e875–87. Available from: [http://dx.doi.org/10.1016/s2214-109x\(17\)30263-2](http://dx.doi.org/10.1016/s2214-109x(17)30263-2)
197. Global strategy on human resources for health: workforce 2030. [Internet]. Geneva: World Health Organization; 2016 [cited 2022 Dec 3]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/250368/?sequence=1>
198. Dieleman JL, Templin T, Sadat N, Reidy P, Chapin A, Foreman K, et al. National spending on health by source for 184 countries between 2013 and 2040. *Lancet*. 2016 Jun 18;387(10037):2521–35.
199. OECD. Health expenditure and financing: Human resources cost (Edition 2015). [Internet]. Paris: OECD Health Statistics; 2016. Available from: <http://dx.doi.org/10.1787/754533c6-en>
200. Micah AE, Zlavog BS, Chen CS, Chapin A. Donor financing of human resources for health, 1990–2016: an examination of trends, sources of funds, and recipients. *Global Health*. 2018;14(98). Available from: <https://doi.org/10.1186/s12992-018-0416-z>
201. Iacobucci G. Covid-19: Underfunding of health workforce left many European nations vulnerable, says commission. *BMJ*. 2021 Mar 16;372:n724.
202. Commission on a Global Health Risk Framework for the Future, National Academy of Medicine, Secretariat. *The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises*. Washington D.C.: National Academies Press (US); 2016.



203. IMF sees cost of COVID pandemic rising beyond \$12.5 trillion estimate. Reuters [Internet]. 2022 Jan 20 [cited 2022 Dec 3]; Available from: <https://www.reuters.com/business/imf-sees-cost-covid-pandemic-rising-beyond-125-trillion-estimate-2022-01-20/>
204. Global Outlook on Financing for Sustainable Development 2021 A New Way to Invest for People and Planet: A New Way to Invest for People and Planet. Paris: OECD Publishing; 2020.
205. Dodd A, Knox D, Breed D. Aid data 2019–2020: analysis of trends before and during Covid. [Internet]. Bristol (UK): Development Initiatives; 2021. Available at: <https://devinit.org/resources/aid-data-2019-2020-analysis-trends-before-during-covid/>
206. Global Burden of Disease 2020 Health Financing Collaborator Network. Tracking development assistance for health and for COVID-19: a review of development assistance, government, out-of-pocket, and other private spending on health for 204 countries and territories, 1990-2050. *Lancet*. 2021 Oct 9;398(10308):1317–43.
207. World Health Organization. Global health expenditure database [Internet]. [cited 2023 Oct 18]. Available from: <https://apps.who.int/nha/database>
208. Arcand JL, Araujo EC, Menkulasic G, Weber M. Health sector employment, health care expenditure and economic growth: what are the associations? Washington D.C.: World Bank; Forthcoming.
209. Veas C, Crispi F, Cuadrado C. Association between gender inequality and population-level health outcomes: Panel data analysis of organization for Economic Co-operation and Development (OECD) countries. *EClinicalMedicine*. 2021 Sep;39:101051.
210. Haddad CR, Nakić V, Bergek A, Hellsmark H. Transformative innovation policy: A systematic review. *Environmental Innovation and Societal Transitions*. 2022 Jun 1;43:14–40.
211. Labour Standards. [Internet]. ILO; 2023 [cited 2023 Jul]. Available from: <https://www.ilo.org/global/standards/lang--en/index.htm>
212. United Nations Department of Economic and Social Affairs. The 17 goals. [Internet]. [cited 2023 Oct 18]. Available from: <https://sdgs.un.org/goals>
213. Beijing Declaration and Platform for Action, Beijing +5 political declaration and outcome [Internet]. UN Women. [cited 2023 Oct 18]. Available from: <https://www.unwomen.org/en/digital-library/publications/2015/01/beijing-declaration>
214. 3rd international conference on financing for development. [Internet]. UNDESA; 2016 [cited 2023 Aug 15]. Available from: <https://sdgs.un.org/publications/3rd-international-conference-financing-development-18042>
215. UN Climate Change. The Paris Agreement. [Internet]. UNFCCC; 2015. Available from: [https://heinonline.org/hol-cgi-bin/get\\_pdf.cgi?handle=hein.journals/intlm55&section=46](https://heinonline.org/hol-cgi-bin/get_pdf.cgi?handle=hein.journals/intlm55&section=46)
216. Convention C155 - occupational safety and health convention, 1981 (no. 155). [Internet]. Geneva; ILO [cited 2023 Aug 9]. Available from: [https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100\\_ILO\\_CODE:C155](https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C155)
217. Paes F, Geraldine A. Convention on the elimination of all forms of discrimination against women. In: *Encyclopedia of the UN Sustainable Development Goals*. Cham: Springer International Publishing; 2021.124–34.
218. Butt AP, Parkes A, Castro Bernardini MDR, Paz Arauco V, Sharmishtha N, Seghaier R. Care Policy Scorecard: A tool for assessing country progress towards an enabling policy environment on care. [Internet]. Oxfam; 2021 Sep 20 [cited 2022 Dec 5]. Available from: <https://policycommons.net/artifacts/1820906/care-policy-scorecard/2559042/>

219. The European Pillar of Social Rights in 20 principles. [Internet]. Brussels: European Commission; n.d. [cited 2023 Jul 30]. Available from: <https://ec.europa.eu/social/main.jsp?catId=1606&langId=en>
220. OECD. Enabling Women's Economic Empowerment New Approaches to Unpaid Care Work in Developing Countries. Paris: OECD Publishing; 2019.
221. How a new law in Uruguay boosted care services while breaking gender stereotypes. Geneva: ILO; 2018 [cited 2023 Jul 30]. Available from: [https://www.ilo.org/global/about-the-ilo/mission-and-objectives/features/WCMS\\_643905/lang--en/index.htm](https://www.ilo.org/global/about-the-ilo/mission-and-objectives/features/WCMS_643905/lang--en/index.htm)
222. Esquivel V. The rights-based approach to care policies: Latin American experience. *Int Soc Secur Rev.* 2017 Oct;70(4):87–103.
223. Unpaid Care Work: Practical Guidance on Analysis and Intervention Design. [Internet]. Zurich: Helvetas; 2017. Available from: [https://www.shareweb.ch/site/Gender/Documents/Topics/Economic%20Empowerment/Unpaid%20Care%20Work/2017-Unpaid%20Care%20Work\\_Practical%20Analysis.PDF](https://www.shareweb.ch/site/Gender/Documents/Topics/Economic%20Empowerment/Unpaid%20Care%20Work/2017-Unpaid%20Care%20Work_Practical%20Analysis.PDF)
224. Government of Canada. Canada's feminist approach to addressing unpaid and paid care work through international assistance. [Internet]. 2017 [cited 2023 Jul 30]. Available from: [https://www.international.gc.ca/world-monde/issues\\_development-enjeux\\_developpement/priorities-priorites/fiap\\_care\\_work-paif\\_prestation\\_soins.aspx?lang=eng](https://www.international.gc.ca/world-monde/issues_development-enjeux_developpement/priorities-priorites/fiap_care_work-paif_prestation_soins.aspx?lang=eng)
225. A toolkit on paid and unpaid care work: From 3Rs to 5Rs. [Internet]. New York: UN Women; 2022. [cited 2023 Jul 30]. Available from: <https://www.unwomen.org/en/digital-library/publications/2022/07/a-toolkit-on-paid-and-unpaid-care-work>
226. From beneficiaries to citizens: Access by and treatment of women in Latin American pension systems. [Internet]. Santiago: Economic Commission for Latin America and the Caribbean; 2019. Available from: [https://oig.cepal.org/sites/default/files/c1900076\\_web.pdf](https://oig.cepal.org/sites/default/files/c1900076_web.pdf)
227. Molyneux M, Thomson M. Cash transfers, gender equity and women's empowerment in Peru, Ecuador and Bolivia. *Gend Dev.* 2011 Jul;19(2):195–212.
228. Investing in the Care economy to boost employment and gender equality. [Internet]. London: Women's Budget Group; 2016 [cited 2022 Dec 5]. Available from: <https://wbg.org.uk/analysis/investing-in-the-care-economy-to-boost-employment-and-gender-equality/>
229. Gibson & Sims MD. Building an Infrastructure of Care. [Internet]. The Aspen Institute. Denver (US): Aspen Institute; 2021 [cited 2022 Dec 5]. Available from: <https://www.aspeninstitute.org/blog-posts/building-an-infrastructure-of-care/>
230. De Henau J, Himmelweit S. A Care-Led Recovery From Covid-19: Investing in High-Quality Care to Stimulate And Rebalance The Economy. *Fem Econ.* 2021 Apr 3;27(1–2):453–69.
231. Towards construction of comprehensive care systems in Latin America and the Caribbean: Elements for their implementation. [Internet]. Santiago: CEPAL; 2022 [cited 2023 Aug 16]; Available from: <https://repositorio.cepal.org/handle/11362/47899>
232. Malta V, Kolovich MLL, Martinez A, Tavares MMM. Informality and Gender Gaps Going Hand in Hand. New York: International Monetary Fund; 2019.
233. Ellery J. Training the public health education workforce. *Am J Public Health.* 2002 Jul;92(7):1053; author reply 1053-4.
234. B Brody A, Ali Ahmed R, Mohammed Yusuf F, Hashi S, Kitembo D, Eoju W. Exploring Gender Equality In The Health Workforce: A Study In Uganda And Somaliland. [Internet]. London: THET; 2019. Available from: [https://ir.umu.ac.ug/bitstream/handle/20.500.12280/2470/Namatende\\_ResearchReport\\_iLacs\\_2019\\_Exploring-1.pdf?sequence=1](https://ir.umu.ac.ug/bitstream/handle/20.500.12280/2470/Namatende_ResearchReport_iLacs_2019_Exploring-1.pdf?sequence=1)

235. Gonzales C, Jain-Chandra S, Kochhar K, Newiak M. Fair Play: More Equal Laws Boost Female Labor Force Participation. [Internet]. New York: IMF; 2015 [cited 2022 Dec 5]. Available from: <https://www.imf.org/en/Publications/Staff-Discussion-Notes/Issues/2016/12/31/Fair-Play-More-Equal-Laws-Boost-Female-Labor-Force-Participation-42721>
236. Wagner I. Equal Pay for Work of Equal Value? Iceland and the Equal Pay Standard. *Soc Polit.* 2020 Dec 14;29(2):477–96.
237. Nepomuceno T. The “anatomy” of Thailand’s successful family planning program. *ICMH Newsl.* 1991 Jan-Feb;18(189):1.
238. Ministry of Employment, Sweden. Three important welfare reforms to promote gender equality in Sweden. [Internet]. 2020 [cited 2023 Aug 16]. Available from: <https://www.government.se/articles/2020/11/three-important-welfare-reforms-to-promote-gender-equality-in-sweden/>
239. Pignatti N. Encouraging women’s labor force participation in transition countries. IZA World Labor [Internet]. Tbilisi State University, Georgia; 2020. Available from: <https://wol.iza.org/articles/encouraging-womens-labor-force-participation-in-transition-countries/long>
240. Individual income taxation and social benefits in Sweden, the United Kingdom and the USA. [Internet]. Vilnius: European Institute for Gender Equality; n.d. [cited 2023 Aug 8]. Available from: <https://old.eige.europa.eu/library/resource/eige.000279590>
241. Barriers & bias: The status of women in leadership [Internet]. Washington D.C.: AAUW: Empowering Women Since 1881; 2020 [cited 2022 Dec 5]. Available from: <https://www.aauw.org/resources/research/barrier-bias/>
242. Women’s leadership. [Internet]. New York: Women Deliver; 2018 [cited 2022 Dec 5]. Available from: <https://womendeliver.org/womensleadership/>
243. Turning promises into action: Gender equality in the 2030 Agenda for Sustainable Development. [Internet]. New York: UN Women; 2018 [cited 2022 Dec 5]. Available from: <https://www.unwomen.org/en/digital-library/publications/2018/2/gender-equality-in-the-2030-agenda-for-sustainable-development-2018>
244. Gender Budget Initiatives: Strategies, concepts and experiences. [Internet]. New York: UN Women; 2002 [cited 2023 Aug 8]. Available from: <https://www.unwomen.org/en/digital-library/publications/2002/1/gender-budget-initiatives-strategies-concepts-and-experiences>
245. Pande R, Ford D. Gender quotas and female leadership. [Internet]. Washington D.C.: World Bank; 2012 [cited 2022 Dec 5]. Available from: <https://openknowledge.worldbank.org/handle/10986/9120>
246. State of the world’s nursing 2020: investing in education, jobs and leadership. [Internet]. Geneva: World Health Organization; 2020 [cited 2023 Jul 31]. Available from: <https://www.who.int/publications/i/item/9789240003279>
247. United Nations Women. Safe Cities and Safe Public Spaces. [Internet] UN Women; 2023 [cited 2023 October 1] Available from: <https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/How%20We%20Work/flagship%20programmes/UN-Women-Flagship-programme-Safe-cities-public-spaces-en.pdf>
248. World Bank Group. New World Bank Toolkit to make transport and Public Spaces more gender inclusive. [Internet]. Washington D.C.: World Bank Group; 2022 [cited 2023 Aug 16]. Available from: <https://www.worldbank.org/en/news/press-release/2022/12/08/new-world-bank-toolkit-to-make-transport-and-public-spaces-in-india-more-gender-inclusive>

249. Increased women's, girls' participation in digital technology crucial to economies, global sustainability, speakers tell commission, as session continues. [Internet]. United Nations 2023 [cited 2023 Aug 16]. Available from: <https://press.un.org/en/2023/wom2224.doc.htm>
250. Holmes K, Corley D. International approaches to closing the gender wage gap. [Internet]. Washington D.C.: Center for American Progress; 2017 [cited 2022 Dec 5]. Available from: <https://www.americanprogress.org/article/international-approaches-closing-gender-wage-gap/>
251. Gender audit. [Internet]. Vilnius: European Institute for Gender Equality; n.d. [cited 2022 Dec 5]. Available from: <http://eige.europa.eu/gender-mainstreaming/tools-and-methods/gender-audit>
252. Can collective bargaining help close the gender wage gap for women in non-standard jobs? Paris: OECD; 2020 [cited 2023 Aug 16]; Available from: <https://policycommons.net/artifacts/3820760/can-collective-bargaining-help-close-the-gender-wage-gap-for-women-in-non-standard-jobs/4626676/>
253. The Facts Are Clear: Unions Help Women Close the Pay Gap. [Internet]. Washington D.C.: Institute for Women's Policy Research; 2023 [cited 2023 Aug 15]. Available from: <https://iwpr.org/the-facts-are-clear-unions-help-women-close-the-pay-gap/>
254. Decent work [Internet]. Geneva: International Labour Organization; 2023 [cited 2023 Jul]. Available from: <https://www.ilo.org/global/topics/decent-work/lang--en/index.htm>
255. Decent Work Country Programme: Fiji (2010-2012). [Internet]. Geneva: ILO; 2012. Available from: [https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-suva/documents/publication/wcms\\_155749.pdf](https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-suva/documents/publication/wcms_155749.pdf)
256. ILO research guides: Occupational Safety and Health. Geneva: ILO; 2017 [cited 2023 Aug 8]. Available from: <https://libguides.ilo.org/occupational-safety-and-health-en>
257. UN Global Compact on Health and Care Work. Occupational safety and health. [Internet]. New York: UN Global Compact; n.d. [cited 2023 Aug 8]. Available from: <https://unglobalcompact.org/take-action/safety-andhealth>
258. Programme Summary: The Indashyikirwa Programme, Rwanda. [Internet]. The Prevention Collaborative; 2019. Available from: <https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2020/RESPECT-implementation-guide-Programme-summary-Indashyikirwa-en.pdf>
259. Hearle C, Baden S, Kalsi K. Promoting economic empowerment for women in the informal economy. UK: DFID; 2019.
260. OECD Development Centre. Tackling vulnerability in the informal economy. Paris: Organization for Economic Co-operation and Development (OECD); 2019.
261. International Labour Organization. Policies, Strategies and Practices for the Formalisation of Micro and Small Enterprises [Internet]. Geneva: ILO; 2016. Available from: [https://www.ilo.org/wcmsp5/groups/public/---ed\\_emp/---emp\\_ent/---ifp\\_seed/documents/publication/wcms\\_533204.pdf](https://www.ilo.org/wcmsp5/groups/public/---ed_emp/---emp_ent/---ifp_seed/documents/publication/wcms_533204.pdf)
262. Making women's work visible: The 19th ICLS standards, purpose, and progress. [Internet]. Washington D.C.: Data2X; 2020 [cited 2023 Aug 15]. Available from: <https://data2x.org/resource-center/making-womens-work-visible-the-19th-icls-standards-purpose-and-progress/>
263. Global Health Observatory Data Repository. [Internet]. Geneva: World Health Organization; n.d. [cited 2022 Dec 5]; Available from: <https://apps.who.int/gho/data/node.main.HWFGRP>
264. National Health Workforce Accounts. [Internet]. Geneva: World Health Organization; 2019 [cited 2022 Dec 3]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/311853/WHO-HIS-HWF-NHWA-2019.1-eng.pdf>

265. National health workforce accounts: better data and evidence on health workforce [Internet]. Geneva: World Health Organization; 2019 [cited 2022 Dec 5]. Available from: <https://www.who.int/publications/i/item/who-his-hwf-nhwa-2019-1>
266. OECD. A System of Health Accounts. Paris: OECD Publishing; 2000.
267. Folbre N. Developing Care: The care economy and economic development. Women's Economic Empowerment [Internet]. 2021; Available from: <https://www.taylorfrancis.com/chapters/edit/10.4324/9781003141938-7/developing-care-nancy-folbre>
268. Folbre N. Developing Care: The care economy and economic development. Women's Economic Empowerment. In: Grantham K, Dowie G, de Haan A. Women's Economic Empowerment. London: Routledge; 2021.
269. Vaca I, Scuro L. Analysis and use of time-use data. [Internet]. Santiago: CEPAL; 2014. Available from: [https://www.cepal.org/sites/default/files/courses/files/8.\\_analysis\\_and\\_use\\_of\\_time-use\\_data.pdf](https://www.cepal.org/sites/default/files/courses/files/8._analysis_and_use_of_time-use_data.pdf)
270. Global Partnership for Sustainable Development. Unpacking intersectional approaches to data. [Internet]. Data4SDGs; 2022 [cited 2023 Aug 9]. Available from: <https://www.data4sdgs.org/resources/unpacking-intersectional-approaches-data>
271. Molyneux S, Atela M, Angwenyi V, Goodman C. Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework. Health Policy Plan. 2012 Oct;27(7):541–54.
272. Fiscal space for health. [Internet]. Geneva: World Health Organization; n.d. [cited 2022 Dec 4]. Available from: <https://www.who.int/teams/health-systems-governance-and-financing/health-financing/policy/fiscal-space-for-health>
273. Segal S. Creating Fiscal Space in the Covid-19 Era (CSIS Commission on Strengthening America's Health Security). [Internet]. Center for Strategic and International Studies; 2021 [cited 2022 Dec 4]. Available from: <https://www.jstor.org/stable/pdf/resrep31113.pdf>
274. Sustainable Recovery 2020. [Internet]. Winnipeg (Canada): International Institute for Sustainable Development; 2020. Available from: <https://www.iisd.org/sustainable-recovery/debt-to-health-swaps-financing-health-system-resilience-beyond-the-covid-19-pandemic/>
275. Reeves A, Gourtsoyannis Y, Basu S, McCoy D, McKee M, Stuckler D. Financing universal health coverage—effects of alternative tax structures on public health systems: cross-national modelling in 89 low-income and middle-income countries. The Lancet. 2015;386:274–80. Available from: [http://dx.doi.org/10.1016/s0140-6736\(15\)60574-8](http://dx.doi.org/10.1016/s0140-6736(15)60574-8)
276. Yates R. Universal health coverage: progressive taxes are key. Lancet. 2015 Jul 18;386(9990):227–9.
277. Health taxes: a primer. [Internet]. Geneva: World Health Organization; 2019 [cited 2022 Dec 4]. Available from: <https://www.who.int/publications/i/item/health-taxes-a-primer>
278. Universal health coverage. [Internet]. Geneva: World Health Organization; 2022 [cited 2022 Dec 4]. Available from: <https://www.who.int/publications-detail-redirect/universal-health-coverage>
279. Hanson K, Brikci N, Erlangga D, Alebachew A, De Allegri M, Balabanova D, et al. The Lancet Global Health Commission on financing primary health care: putting people at the centre. Lancet Glob Health. 2022 May;10(5):e715–72.
280. The world health report: health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010.
281. UHC2030. Parliamentarian guide: 6 action steps to achieve UHC. [Internet]. Geneva: World Health Organization; n.d. [cited 2022 Dec 4]. Available from: <https://www.uhc2030.org/what-we-do/voices/advocacy/parliamentarian-guide/>

282. Cashin C, Sparkes S, Bloom D. Earmarking for health: from theory to practice [Internet]. Geneva: World Health Organization; 2017 [cited 2022 Dec 4]. Report No.: WHO/HIS/HGF/HFWorkingPaper/17.5. Available from: <https://apps.who.int/iris/handle/10665/255004>



# Annex 1: The Gender Value Gaps data

## Annex 1.1: Gender Value Gaps database sources

The Gender Value Gaps database was compiled using sex and/or gender-disaggregated data for the period 2000–2020, extracted from the GHO, ILO, NHWA, OECD, UNDP, United Nations Industrial Development Organization and the World Bank.

### Annex 1.1.1: Exploring unpaid work

To explore the gender balance in unpaid work between women and men, the Gender Value Gaps dataset utilized data for 2019 from the OECD Employment Database for OECD countries, as well as China, India and South Africa, which reported sex-disaggregated information taken from national time use surveys for time spent in all forms of unpaid work. Unpaid work includes: “routine housework; shopping; care for household members; child care; adult care; care for non-household members; volunteering; travel related to household activities; other unpaid activities”. Unpaid care and unpaid health care activities constitute a subset of unpaid work but were not distinguishable from the aggregated data.

Data from the OECD dataset were compiled from estimates of daily working time based on national time use surveys. The data on time use were normalized to 1440 minutes per day. Time-use estimates for some countries contain methodological differences, or represent weighted averages for age brackets 15–19, 20–24, 25–44 and 45–64, while data for other countries refer to all individuals aged 15 and above. Data were collected prior to COVID-19.

### Annex 1.1.2: Exploring national-level gender inequality

Two well recognized indexes were used to reflect two complementary aspects of gender inequality at the national level. The UNDP Gender Inequality Index represents gender equality outcomes across reproductive health, education, employment and empowerment. The SIGI represents the wider social, legal, and institutional environment of gender (in)equality at the national level.

The Gender Inequality Index reports information across three dimensions – reproductive health, empowerment and the labour market – for as many countries as data of reasonable quality allow. Data are scaled from 0 (representing equality between women and men across the indicators) to 1 (representing complete inequality between women and men across the indicators). Specific indicators include maternal mortality ratio, adolescent birth rate, female and male population with at least secondary education, female and male shares of parliamentary seats, and female and male labour force participation rates.

The SIGI reports information on the dimensions of discrimination in the family, restricted physical integrity, restricted access to productive financial resources, and restricted civil liberties. Data were gathered and reported for 179 countries. The SIGI compiles 16 indicators across four key dimensions: child marriage, household responsibilities and inheritance and divorce laws (discrimination in the family); violence against women, female genital mutilation, missing women and reproductive autonomy (restricted physical integrity); secure access to land and non-land assets, access to formal financial services, and workplace rights (restricted access to productive and financial resources); and citizenship rights, freedom of movement, political voice and access to justice (restricted civil liberties).

### Annex 1.1.3: Exploring health system performance

Health system performance was captured through global data on SDG target 3.8: “achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”. Data on UHC comprise two indicators: 3.8.1 on health service coverage and 3.8.2 on health expenditures relative to a household’s budget to identify financial hardship caused by direct health care payments. Coverage of essential health services represents the average coverage

of essential services based on tracer interventions across reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access. The indicator for health system performance is scaled from 0 to 100, computed as the geometric mean of 14 tracer indicators of health service coverage.

The second aspect of assessing UHC involves financial protection. This was represented by a data series on households impoverished by out of pocket payments. The data gathered included: population with household out of pocket spending on health as >10% or >25% of total household income; population pushed below the poverty line by out of pocket household health expenditure, represented by US\$ 1.90/day and US\$ 3.10/day 2011 PPPs; and population pushed below the poverty line, represented by > 60% median daily household income. Data on the proportion of households pushed below the US\$ 3.10/day 2011 PPP poverty line due to catastrophic health expenditure were compiled from household budget, income, and expenditure surveys, and household socioeconomic and living standards surveys. Data came from SDG target 3.8 indicators reported by countries for global monitoring of the SDGs.

#### **Annex 1.1.4: Exploring spending on health**

Data on health spending cover individual and population health care and a range of health financing schemes, including government health schemes, compulsory insurance (public or private), voluntary arrangements such as private voluntary health insurance or direct payments, and out of pocket payments by households. Data on health spending were reported in US dollars per capita for 2019 or latest year. These data were derived from the WHO Global Health Expenditure Database and accessed via the OECD library of Health at a Glance 2021.

#### **Annex 1.1.5: Exploring health and care work in the informal economy**

Sex-disaggregated information on employment in the informal economy was derived from ILO Labour Force Statistics data on employment outside the formal sector by sex and economic activity. The ILO data series was based on definitions from the 13th ICLS and includes

countries that have implemented the standards from the 19th ICLS. The series was derived using the same set of criteria for all countries on what constitutes informal employment or an informal enterprise, such as: employment status, institutional sector, destination of production, registration, social security contribution and size of enterprise.<sup>(1)</sup> The Gender Value Gaps analysis used this data series to compare sex-disaggregated information on the health and care labour force with all-sector labour force participation by country and national income levels.

#### **Annex 1.1.6: Exploring health and care employment**

Data from the ILO dataset on employment by sex and economic activity were used to report on women's and men's labour force participation in the health care sector compared to other sectors. Employed persons "comprise all persons of working age who, during a specified brief period, were in one of the following categories: a) paid employment (whether at work or with a job but not at work); or b) self-employment (whether at work or with an enterprise but not at work)". Data were available for 2019 and were disaggregated by economic activity according to the 13th ISIC.

Sex-disaggregated health workforce information was only available for doctors and nurses. Health and care worker density (doctors and nurses per 10 000 of the population) by sex and country was derived from the WHO National Health Workforce Accounts platform. Health workers were classified using ILO ISCO-08 categories. Data for the denominator (population) were obtained from the UNDP's World Population Prospects database.

#### **Annex 1.1.7: Exploring gender gaps in earnings**

The Gender Value Gaps dataset compiled sex-disaggregated data on monthly earnings from all sectors and for the health care sector specifically. Earnings relate to "the gross remuneration in cash and in kind paid to employees, as a rule at regular intervals, for time worked or work done together with remuneration for time not worked, such as annual vacation, other type of paid leave or holidays".<sup>(1)</sup> These data came from the ILO Wages and Working Time Statistics database.



Data on earnings were converted to US dollars as the common currency. Information on sectoral activities were defined by ISIC categories. First, to understand the gender pay gap in health and care work, monthly earnings of women were compared with monthly earnings of men in the health care sector. Second, to understand the sectoral pay penalty, monthly earnings in health and care work (for men and women combined) were compared with monthly earnings in education, scientific/professional and other service activities.

### **Annex 1.1.8: Exploring health system performance**

UHC indicators were used as a proxy for health system performance. Data on SDG Target 3.8 (“achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”) were downloaded from the GHO database. There were two indicator groups for this target: indicator 3.8.1 (health service coverage) and indicator 3.8.2 (financial hardship through direct health care payments captured by health expenditures in relation to a household’s budget). Coverage of essential health services (3.8.1) is defined as “the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access, among both the general population and the most disadvantaged groups.”(2) This indicator is represented by an index measured on a scale of 0 to 100, and was derived from national household surveys, administrative data and special facility surveys. Financial protection (3.8.2) was captured by the proportion of the population with household spending on health at > 10% or > 25% of household budget, the population pushed below poverty line at the US\$ 1.90 and US\$ 3.20 marks, and the population pushed below the poverty line (measured as > 60% of median daily income) by direct health care spending.

### **Annex 1.1.9: Economic and societal impact of the Gender Value Gaps**

Cross-sectional data on each aspect of the Gender Value Gaps were compared to other relevant societal outcomes, namely economic indicators.

Whilst a range of other social, environmental and economic indicators are relevant, gross domestic product (GDP, 2011 PPP) and annual GDP growth measured as a percentage were used because they are both actionable and widely recognized. The report notes the need to move away from narrow indicators, such as GDP, towards metrics that value fuller societal objectives.

## **Annex 1.2: Data limitations**

The Gender Value Gaps dataset was limited in a number of ways. First, methodology in data collection methods can vary significantly from country to country, affecting the accuracy of estimates and cross-country comparisons. Next, many countries still do not collect standardized, gender or sex-disaggregated data on key areas relative to the health and care workforce, leading to a limited understanding of the true picture of gender equality in health and care work across the world. Additionally, unpaid work, nonstandard employment and work in the informal economy are not routinely measured in many countries, meaning the extent of these types of work is unclear or underestimated.

Many countries also have missing or incomplete data, meaning that they are excluded when a complete case analysis is adopted. This is particularly true for LMICs, where data availability and quality are a particular concern, and reflect challenges in data collection, access and use. Lack of data in LMICs, compared to high income countries, can lead to analyses and results disproportionately focused on high income countries and risks generating action out of sync with LMIC realities.

## **Annex 1 References**

1. ILO Data Explorer. [Internet]. Geneva: ILO; 2023 [cited 2023 Aug 16]. Available from: <https://www.ilo.org/shinyapps/bulkexplorer1/>
2. Universal health coverage. [Internet]. Geneva: World Health Organization; 2022 [cited 2022 Dec 4]. Available from: <https://www.who.int/publications-detail-redirect/universal-health-coverage>





**Health Workforce Department**

World Health Organization

20 Avenue Appia

1211 Geneva 27

Switzerland

who.int

9789240082854

