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# Feminist Evaluation of Universal Health Coverage Programs in Kenya: A Conceptual Analysis

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## ABSTRACT

The conceptual analysis evaluates the applicability of feminist principles of evaluation to the gender-transformative potential of Universal Health Coverage (UHC) programs in Kenya. With the help of a conceptual research design, the study synthesizes Kenyan health policy documents and secondary evidence using an integrated feminist political economy and intersectionality perspective. The frameworks that inform this approach include analyzing actor-power and ideas in policy prioritization. The main finding was that Kenya has gender integration in its health policy, which is inconsistent and politically mandated. There is also a positive correlation between the presence of strong advocacy coalitions and gender integration and vice versa, which validates the actor-dependence of equity. The analysis also revealed serious systemic flaws in the UHC design, including systematic exclusion of unpaid care work as a standard indicator. The paper's major contribution lies in a new conceptual framework that shifts the technical measures of UHC evaluation into examining the redistribution of power, participatory governance, and intersectional equity. The paper concludes that unless this feminist lens is applied, UHC reforms are likely to continue reinforcing the gendered inequities it is expected to address. The key recommendations are the official integration of feminist evaluation standards into the monitoring systems and the pilot of the framework through county-level assessments. The study also makes a major contribution to monitoring and evaluation (M&E) by introducing a context-sensitive and structured tool that connects feminist theory with health systems practice. Finally, it seeks to make the Kenya UHC agenda deliver the promise of substantive rather than just nominal universalism.

**Keywords**: Feminist evaluation, Universal Health Coverage, feminist political economy, health policy, gender equity.

## INTRODUCTION

Universal Health Coverage (UHC) has been an important pillar of the 2030 Agenda of Sustainable Development (World Health Organization, 2023). It is propagated as a tool for attaining health equity and financial protection for everyone. However, the emerging cycle of critical scholarship demonstrates the existence of an implementation paradox. The idea of universal population coverage may obscure and even intensify underlying social injustices, especially those of a gender-related nature (Morgan et al., 2018; Rotz et al., 2022; Steinert et al., 2021; MacArthur et al., 2023). This arises when programs are designed and assessed on the basis of technocratic, gender-neutral

perceptions. Health systems are not passive systems. They represent a dynamic political enterprise that embodies and frequently maintains existing power structures and social norms, such as repressive gender roles (Mohapatra & Wiley, 2019; Hay et al., 2019; Davies et al., 2019; Gore & Parker, 2019; Heise et al., 2019). To attain substantive universality, therefore, evaluative frameworks are necessary that clearly examine the way in which policies allocate power, resources, and capabilities between various social groups (Morgan et al., 2018; Hanney et al., 2020).

This is a dynamic that is acutely applicable in Kenya. The country has entrenched health in its constitution as an essential right, and has made UHC a flagship policy in its national development drive (Republic of Kenya, 2010). Similarly, Kenya is in a major health financing transition. It is shifting out of the National Hospital Insurance Fund (NHIF) to a new system under the banner of the Social Health Insurance Act, 2023 (Parliament of Kenya, 2023). This radical reform both creates the Social Health Authority and four separate funds. Similarly, the health system also existed in the complicated devolved governance system and a health funding system that is intended to eliminate financial obstacles. Nonetheless, it has been shown that the absence of an explicit equity lens means that such reforms can be used to further enrich the already advantaged groups. They might not target the complexity of barriers encountered by marginalized groups, such as women, the poor, and rural groups (Barasa et al., 2018; Nyawira et al., 2024). In fact, according to the foregoing analyses, it can be concluded that gender integration in Kenyan health policy lacks consistency. It is not always an institutionalized element of governance and is often determined by the advocacy power of particular actors (Wangamati, 2024). As an illustration, Kenya AIDS Strategic Framework II is gender-responsive in its design. Conversely, other non-communicable disease or tuberculosis strategic plans show little or reactive consideration of gender (Wangamati, 2024).

There is thus a significant conceptual and methodological gap in the current body of knowledge. Conventional M&E models used in UHC are mostly based on quantitative measures. Their indicators include service coverage and financial protection, but policy is viewed as a neutral context instead of a political contestation process (Morgan et al., 2022; Williams et al., 2021; Abu & Elliott, 2020; Endalamaw et al., 2022). These methodologies cannot adequately diagnose the

role of power in health systems and therefore are structurally compromised to determine whether the programs change or deepen the structural determinants of health inequalities. Unpaid care, gender-based economic marginalization, or discriminating social norms are typically disregarded (Gore & Parker, 2019; Heise et al., 2019; Morgan et al., 2018; Rotz et al., 2022). Therefore, feminist assessment has developed into a unique paradigm since it focuses on issues of power, participation, and social justice. Nevertheless, its implementation in national UHC programs in African devolved settings is under-theorized and sparse (Podems, 2024; Denny, 2021; Heidari & Doyle, 2020; Araujo-Vila et al., 2021; Alarcón & Cole, 2019; Davies et al., 2019). Thus, a strong necessity exists to go beyond merely including the term 'gender' as a variable. Instead, a strong analytical framework has to be adopted that can inform a systemic feminist examination of the foundational pillars of UHC in a particular national setting such as Kenya (Gideon & Hawkes, 2024; Gideon & Gianella, 2024a; Gideon, 2023). These pillars are financing, governance, service delivery, and the health workforce.

To bridge this gap, this study undertakes a conceptual analysis to examine how the principles of feminist evaluation might be synthesized to create a transformative framework of analytical evaluation to critically examine the UHC programs in Kenya. It is done to create a context-specific conceptual prism that will bring together feminist political economy and intersectionality theory. It not only attempts to assess whether UHC programs are universal and cover people, but also their operation and engagement with gendered power structures that determine health access, agency, and outcomes (Crenshaw, 2019; Losleben & Musubika, 2023; Smith et al., 2021; Mezzadri et al., 2022). Black feminist thought is also integrated in intersectionality and it gives a crucial instrument in this analysis. It demands a study on the interactions between overlapping systems of power and identity that produce distinct experiences of advantage and disadvantage (Crenshaw, 2019; Losleben & Musubika, 2023; Collins et al., 2021). These systems are gender, class, ethnicity, and geography.

The justification of this conceptual venture is both theoretical and as well as an urgent practicality. Theoretically, it aims at advancing the discipline of feminist evaluation. It attempts to base the discipline on the local political economy of an African devolved state. This is in response to the demands to decolonize evaluation methodologies and put the Southern epistemologies at the center

(Chilisa, 2020; Masaba et al., 2020; Masaviru et al., 2021). In practice, it provides Kenyan policymakers, civil society, and researchers with a timely instrument to navigate the process of implementing the new Social Health Insurance Act. This analysis suggests a number of key areas in which a feminist assessment can and needs to be examined. They are gendered assumptions of the informal sector in insurance premium design, the structure of county health governance institutions, the content of the essential benefits package regarding sexual and reproductive health rights, and the nature of a predominately female community health workforce (Wichterich, 2023; Raphael & Bryant, 2019; Meagher et al., 2021; Kamau & Mbirithi, 2021; Mukorombindo, 2018). This study advocates a transformative assessment by synthesizing the pertinent literature and using a feminist political economy lens to critique it. This analysis of UHC in Kenya should determine the effect on the redistribution of unpaid care labor, women's health decision-making empowerment, and even distribution of access for the most marginalized. Such a structural framework is ultimately the goal of this conceptual analysis. The aim is to make sure that the pursuit of universality in Kenya is done in a conscious and structural way of breaking down gender-based inequities instead of unwittingly perpetuating them.

## REVIEW OF RELEVANT LITERATURE

There is a crucial point of intersection in the literature. On the one hand, there is a long-standing theoretical urging of a gender-transformative health policy, and on the other hand, there are enduring obstacles to the achievement of equitable Universal Health Coverage (UHC) in countries such as Kenya (Morgan et al., 2018; MacArthur et al., 2023). The review is a synthesis of the scholarly work in three interrelated areas. They are the principled background of feminist policy evaluation, the empirical landscape of health policy in Kenya, and the particular gendered evidence revealing systematic inequities (Gideon & Hawkes, 2024). This synthesis elucidates one important finding that although the normative call of gender equity in health is universal (World Health Organization, 2023), its implementation is highly political and uneven. It is essentially conditioned by local power arrangements, data regimes, and institutional actors (Wangamati, 2024; O'Connor et al., 2019; Solnes Miltenburg et al., 2023).

The conceptual basis of a feminist assessment of UHC is strong since it has been established on the basis of feminist political economy as well as intersectionality (Mezzadri et al., 2022; Smith et

al., 2021). The difference between feminist evaluation and the mainstream approaches lies in the fact that the former clearly focuses on the power relations and participatory processes through transformative social justice as its primary goals (Podems, 2024; Denny, 2021; Jabeen, 2020). This method goes beyond measuring technical program outputs. It is has in itself political aspects that question who is advantaged by policies and whose views is prioritized (Gore & Parker, 2019; Williams et al., 2021; Araújo-Vila et al., 2021). Here, the concept of intersectionality cannot be ignored (Crenshaw, 2019; Losleben & Musubika, 2023; Nepali & Baral, 2024). It requires the cross-examination of the intersection of systems of oppression. These systems are grounded in gender, race, class, and other identities. They intersect, producing their unique and compounded experience of marginalization (Collins et al., 2021; Christoffersen et al., 2025). When this lens is perpetuated to health policy, there are critical gaps that are exposed. Apparently neutral UHC mechanisms have the propensity to maintain inequalities. This occurs when they neglect to consider these intersecting social classifications (Steinert et al., 2021; Rotz et al., 2022). Moreover, it is imperative to incorporate a political economy approach (Morgan et al., 2018; Hanney et al., 2020) because health systems do not exist in a vacuum as neutral technical systems. Rather, they are arenas where historical, economic, and political power is debated. This contesting usually happens at the expense of women and marginal groups (Hay et al., 2019; Heise et al., 2019).

Throughout Kenya, there is a dynamic and ambitious national policy environment towards UHC. However, it is riddled with complexities of implementation that have a direct effect on gender equity. Kenya has branded UHC as one of its flagship policies in its national development agenda (Republic of Kenya, 2010). It has also engaged in major structural restructuring, including the transformation of the National Hospital Insurance Fund (NHIF) into the new Social Health Authority (SHA) (Parliament of Kenya, 2023). This reform intends to simplify the public health insurance system that reflects one of the biggest reorganizations of the health financing environment. Nonetheless, it is a goal that functions under a complicated devolved system of governance. In this case, the health service delivery is a devolved responsibility of 47 semi-autonomous counties. This decentralization establishes a disjointed policy implementation environment where results of equity can differ radically depending upon the ability of the county, the political goodwill, and resource distribution (Masaba et al., 2020; Masaviru et al., 2021; Abimbola et al., 2019). This background of structural fluidity and decentralization of power is an

essential pretext. It is on this background that any feminist analysis should be placed (Kamau & Mbirithi, 2021; Mukorombindo, 2018).

Empirical data on the integration of genders in Kenya show a trend. This is a trend of alarming inconsistency and actor-dependence (Wangamati, 2024). Research that analyzed four Kenyan Health Policy Implementation Strategies (HPIS) had identified that meaningful gender integration is not a systemic phenomenon. On the contrary, it is very dependent on the particular advocacy coalitions and availability of data (Wangamati et al., 2025; Mauti et al., 2019). As an example, the Kenya AIDS Strategic Framework (KASF II) was very gender responsive (Republic of Kenya, 2020). This was attributed to powerful leadership by agencies such as the National AIDS Control Council (NACC) and UNAIDS (Alarcón & Cole, 2019). It was also backed up by sound gender-disaggregated statistics. In a sharp contrast, the National Strategic Plan on Tuberculosis (NSP-TB) showed little gender integration (Wangamati et al., 2025). This was credited to the lack of committed gender advocacy players. A vague definition of gender as a problem also played a role. Perhaps most revealingly, there was initially a stage when gender was fully ignored in the context of emergency responses. One of them is the COVID-19 Targeted Testing Strategy. It merely encompassed reactive actions once disparities were revealed (Wangamati et al., 2025; Odero et al., 2025). This brings out the vulnerability of gender undertakings in a crisis context. It also demonstrates the absence of pre-existing equity frameworks. This fact evidences a decisive reality that gender equity in the Kenyan health policy is a political bargaining issue as opposed to an institutionalized standard.

Unpaid care work is a gendered determinant of health access that has been critically and continuously neglected (Wichterich, 2023; Meagher et al., 2021; Quick, 2022). Women and girls bear huge a responsibility in Kenya. Statistics indicate that Kenyan women spend between four and five hours every day in unpaid care and household duties. Men spend just one hour (KNBS, 2021; Samman et al., 2025). This causes severe ‘time poverty’. It deprives women of access to health care or paid employment (Raphael & Bryant, 2019; Akinwale, 2023). Reacting to this, Kenya formulated an innovative National Care Policy (Republic of Kenya, 2024). It is constructed around the 5R model of the International Labour Organization. The framework is meant to Recognize, Reduce, Redistribute, Reward, and Represent care work. The policy recognizes formally the care work as a social good that is necessary to the welfare in society. The development

of the policy relied on the data initiatives, which highlight the role of evidence in catalyzing policy change. This is a significant step forward, but its nationwide adoption through counties is unclear. A fundamental point of feminist examination is its incorporation of UHC financing tools, including the new SHA schemes (Nungo et al., 2024; Okungu et al., 2018; Kabia et al., 2018).

The synthesis of these strands demonstrates certain gaps in the existing literature. This conceptual analysis attempts to respond to them. To start with, there is a conceptual research gap. Although UHC frameworks and feminist theories are established, the synthesized model does not exist (Gideon & Gianella, 2024a). This model would combine feminist evaluation principles and the fundamental pillars of a health system. It would be specifically applicable in evaluating the national UHC program in a devolved context. Second, there is a strong contextual research gap. The literature gives diagnoses of gender integration problems in Kenya. It, however, does not provide much information on how to operationalize a feminist evaluation framework. Such operationalization is required in 47 different political environments at the county level. Third, there is still a methodological research gap as there is a lack of practical guidance on how to use feminist participatory methods (Abu & Elliott, 2020; Endalamaw et al., 2022). Such techniques are required to test large-scale, technical health financing reforms. Fourth, a theoretical research gap arises in terms of the integration of African feminist thought. This has to be integrated so as to engender more contextually attuned and decolonized evaluation models (Chilisa, 2020; Ndlovu-Gatsheni, 2018; 2021). Lastly, there is an empirical evidence gap. The policy discrepancies are apparent, but there is no systematic evidence available, and it has to be produced with a feminist perspective (Wambalaba, 2024; Wakiaga et al., 2024). It must indicate the different impacts of UHC reforms in Kenya on various populations in overlapping social and geographical layers.

Finally, the literature confirms various important points. UHC is inherently a political initiative, whereas gender inequity is a structural aspect of health systems (Heidari & Doyle, 2020; Araujo-Vila et al., 2021). This discrimination is compounded by the unpaid burdens of care, and irregular policy implementation. It is also influenced equally by the actor's power and data. Nonetheless, the literature fails to provide a consistent conceptual framework that is required to objectively address the critical question of how and whether UHC programs change these conditions. This gap is precisely the focus of this paper which establishes a conceptual framework of feminist evaluation. This framework fits the UHC in Kenya and gives it a systematic point of focus to

evaluate not only coverage, but also the alteration of gendered power in the health system itself.

## METHODOLOGY

In developing a feminist analysis framework of the Universal Health Coverage programs in Kenya, the study uses a conceptual research approach. The overall goal is to extrapolate existing knowledge and theories in order to develop new analytical tool, rather than developing a new empirical evidence (Hassnain, 2023; Jordan & Hall, 2023; Podems, 2024; Denny, 2021). Such an approach would better suit the purpose of the research as it would make it possible to critically analyze underlying assumptions, power relations, and ideological constructs that become interlaced in policy documents and existing literature (Jabeen, 2020; Chilisa, 2020). The methodology will allow developing a context-based framework mediating between feminist evaluation theory and the health system realities in Kenya through analytic deconstructive and reconstructive reinterpretation of the literature in an innovative theoretical method.

The primary source of this conceptual analysis is a purposively chosen sample of Kenyan health policy documents and scholarly articles. The key policy documents under analysis are primary policy documents such as Kenya AIDS Strategic Framework II (KASF II), the National Strategic Plan of Non-Communicable Diseases, and the Act on Social Health Insurance, 2023 (Republic of Kenya, 2020; Parliament of Kenya, 2023). These are supplemented by a systematic review of the secondary empirical evidence like the Kenya Demographic and Health Survey (KDHS) and secondary study which explain the gendered experiences in the health system (KNBS & ICF, 2022; Wambalaba, 2024; Wakiaga et al., 2024). The selection criteria is narrowed down to papers and reports centered on the UHC agenda, including those adopting alternative strategies in gender integration, and those with evidence on the interaction of gender with other social determinants of health (Wichterich, 2023; Raphael & Bryant, 2019; Meagher et al., 2021). This type of multi-source method will ensure that the analysis is theorized on the official policy discourse, and the actual lived realities that have been documented.

The explicit interdisciplinary presentation of the feminist political economy alongside decolonial and African feminist theory is the critical paradigm according to which the synthesis is framed.

Feminist assessment is the background prism according to which the analysis should make power relations, processes of participation, and transformative social justice central (Podems, 2024; Denny, 2021). It is operationalized through the framework of policy prioritization of Shiffman and Smith, which provides a structure on which to analyze the role of actor power, ideas, political contexts, and features of the factors that drive or tend to marginalize gender equity in health policy (O'Connor et al., 2019; Jolivet et al., 2025). More to the point, this political economy analysis is interlaced with intersectionality theory since it demands analysis of the way in which gender relates to other dimensions of inequality, including class, ethnicity, and disability (Crenshaw, 2019; Losleben & Musubika, 2023). Furthermore, to disrupt the Western-centric epistemological biases, the framework is infused with the African feminist theory and decolonization strategies, in which the primary position is taken by context, relationality, and making African knowledge systems central to evaluation (Chilisa, 2020; Ndlovu-Gatsheni, 2018; Ndlovu-Gatsheni, 2018b; Hassnain, 2023; Jordan & Hall, 2023).

The process of analysis is cyclic and involves a sequence of methodical processes. To support the integrated theoretical framework, first, the selection of the policy documents undergoes a qualitative content analysis, which is based on a coding matrix (Podems, 2024; Crupi & Godden, 2024). It involves coding the text in a systematic way to denote evidence of actor networks, the frame of gender (e.g., a difference of biology versus a power relation), and the potential remedies of equity. Concurrently, the themes in the secondary literature are identified and summarized with a special focus on the reported barriers in the form of disproportionate unpaid workload, financial exclusion in health funding, and geographical inequities (Kabia et al., 2018; Barasa et al., 2018; Barako, 2021; Aellah, 2021; Kemei, 2019). The active process of building up the conceptual framework is the synthesis stage. Here, the outcomes of the policy analysis are measured against the data of the empirical body of literature through the lens of the feminist-political economy. It is done in order to identify critical disconnects, such as the disparity between the gender-responsive policy discourse and the lack of budgetary allocations, or disparities within the decentralized system of governance, which may contribute to unequal service provision (Masaba et al., 2020; Masaviru et al., 2021; Kamau & Mbirithi, 2021; Mukorombindo, 2018). The final deliverable is a conceptual framework of logic that explains key principles, evaluating questions, and the needs of adopting a feminist approach to all pillars of the UHC system in Kenya. The methodology provides

a systematic, clear, and theoretically legitimate pathway towards the development of a tool that would be able to not only measure the health coverage, but also health justice prospects.

**FINDINGS**

This conceptual analysis produced an organized framework of feminist evaluation fitting the Kenyan context of Universal Health Coverage. The findings are the culmination of an integration process of policy documents, secondary empirical evidence, and theoretical literature. It was guided by the integrated feminist-political economy lens mentioned in the methodology. The findings are presented in a particular order. First, it lists the fundamental elements of the suggested framework, and then applies this lens to the UHC policy in Kenya to provide crucial insights. Lastly, it points out the systemic loopholes and contradictions that the framework uncovers.

The analysis generated a holistic framework of feminist evaluation that consisted of four interrelated dimensions. To begin with, the framework is rooted in the evaluative principles that move from the coverage metrics approach to the power relations. They require that in any evaluation of UHC, there must be an inquiry into what interests are promoted, what knowledge is valued and how programs reallocate power and resources. It is more than just an enumeration of service users (Podems, 2024; Denny, 2021; Aaraujo-Vila et al., 2021; Alarcón & Cole, 2019). Second, the framework operationalizes intersectionality as a fundamental necessity since it assumes that gender cannot be measured separately. It has to be examined because it cuts across other axes of inequality, such as poverty, ethnicity, geography, and disability. They comprise and result in compounded barriers to access of health (Crenshaw, 2019; Losleben & Musubika, 2023; Nepali & Baral, 2024; Christoffersen et al., 2025; Thaler et al., 2023). Third, it asserts participatory and transformative methodologies that entails a shift out of expert-led assessments. It demands co-creation of assessment strategies with nongovernmental women's organizations and community health workers. Similarly, the lived life experiences of marginalized communities should determine what constitutes success (Chilisa, 2020). Lastly, the framework is implemented in the six health system pillars to create concrete evaluative questions in financing, governance, and service delivery, health workforce, information systems, and medical products as well.

Applying this framework to the UHC policy documents of Kenya showed a terrain of deep inconsistency where the level of gender integration is very uneven. The analysis affirmed that

gender responsiveness is very actor-specific. As an example, the Kenya AIDS Strategic Framework (KASF II) had robust and clear gender strategies. This observation can be ascribed to the presence of a potent advocacy coalition. This coalition was headed by the National AIDS Control Council and backed by strong gender-disaggregated statistics (Mauti et al., 2019; Araujo-Vila et al., 2021; Alarcon & Cole, 2019). Conversely, the National Strategic Plan on Non-Communicable Diseases simply made vague mentions. It contextualized gender as a 'vulnerability' factor and lacked actionable strategies. Gender aspects were highly absent in the Tuberculosis plan (Mauti et al., 2019; Araaujo-Vila et al., 2021; Alarcón & Cole, 2019). This inconsistency highlights an important fact that gender equity is not an institutionalized principle but a negotiable priority. The existence of certain advocacy players and compelling statistics has a significant bearing on its prominence.

One of the key findings was that the framework revealed the political economy of the policy silence. This was demonstrated as a trend in areas of policy that were not strongly supported by gender advocacy. Gender was also a strictly biomedical construct in the context of programs such as tuberculosis or emergency response. It was concerned with biological sex differences in disease prevalence rather than with gender as a social determinant of power that impacts access, affordability, and quality of care (Mauti et al., 2019; Araujo-Vila et al., 2021; Alarcón & Cole, 2019; Odero et al., 2025; Morgan et al., 2024). Such technical framing depoliticizes gender and shifts it from a structural problem to a 'risk' factor.

Moreover, the framework identified one of the results of the devolved governance of Kenya as a disjointed implementation environment. Decentralization provides possibilities of locally unique solutions, but it also promotes the development of inequities. The capacity to act at the county level and political commitments to gender equality are diverse and result in different outcomes (Masaba et al., 2020; Masaviru et al., 2021; Abimbola et al., 2019; Oliveira et al., 2023).

The secondary evidence synthesis involving policy rhetoric revealed huge gaps. It is disjuncture between the stated intent and structural reality. Indicatively, Kenya UHC Policy 2020-2030 promotes principles of equity, but, the fundamental benefits package is often criticized as it does not wholly cover sexual and comprehensive reproductive health services. This ignores a

constitutional commitment to services such as safe abortion within the legal framework (Odero et al., 2025; Morgan et al., 2024; Republic of Kenya, 2010). Likewise, the policy priority is the financial protection by insurance plans such as the NHIF and this fails to sufficiently tackle gendered financial obstacles. These barriers affect women in the informal sector and they might not be able to pay premiums even when there are subsidy programs (Nungo et al., 2024; Okungu et al., 2018; Samman et al., 2025; Akinwale, 2023).

Probably the most meaningful implication was that the framework highlighted structural weaknesses such as unpaid care work. The gendered analysis states that women suffer a disproportionate care burden. They devote four to five hours to non-paid household and care activities. On the other hand, men dedicate approximately one hour (Samman et al., 2025; Akinwale, 2023). It leads to the phenomenon of 'time poverty' that is a primary determinant of health access. It is, however, nearly nonexistent in UHC monitoring indicators. A feminist critique should then evaluate whether UHC programs acknowledge, lessen, and redistribute this care burden. This is in line with the objectives of the National Care Policy (Republic of Kenya, 2024) that disclosed a severe deficiency in governance evaluation. Community participation is mentioned in policies; nevertheless, a feminist perspective raises inquiries into the true power and representation of women. This particularly applies to women representing the marginalized groups who are not included in the decision-making process of health committees at the county level (Kamau & Mbirithi, 2021; Mukorombiko, 2018).

Overall, the results prove that the developed framework is a rigorously constructed tool that can be used to critique the system. It takes evaluation beyond technical efficiency. It poses the radical questions concerning power and representation and the structural transformation. A significant gap is unveiled in the framework. Devoid of deliberate, institutionalized structures to confront the gendering of power relations, UHC reforms in Kenya can attain nominal coverage and systemic injustices would be preserved.

## DISCUSSION

This discussion interprets the feminist evaluation system formulated in Kenya around the UHC. According to the findings, there exists an uneven landscape of gender integration mediated by

politics. There are critical gaps that lie between equity rhetoric and structural designs. This part summarizes these findings. It suggests the use of the feminist lens cannot be an additive task but should be a radical redefinition of what is considered as success in UHC. The framework can be understood as a critical analysis instrument, as well as templates of guiding action in a correct manner. It also connects the findings to more general arguments of health equity, political economy, and social justice.

Its core point of discussion is that gender equity of UHC in Kenya is not a technical fault but rather a political decision. This is supported by the stark difference in the gender integration of policies where Kenya AIDS Strategic Framework II has strong approach in comparison to minimum inclusion in tuberculosis plans. It proves that equity depends on advocacy, actor power and persuasive data (Mauti et al., 2019; Araaujo-Vila et al., 2021; Alarcon & Cole, 2019). This finding corresponds to political economy approaches in which policy is understood as a space of conflict between actors that possess different levels of influence (Solnes Miltenburg et al., 2023; Ruiz-Cantero et al., 2019). It is the responsibility of a feminist evaluation to map the actors and their power relations in a systematic fashion. It should also know why some gendered health problems are given first priority and why others have to be pushed to the back. This shifts the evaluative agenda beyond a mere question which would state "is gender taken into consideration?" to asking the question, "to whom is the power served?" The given political evaluation shatters the dominant technocratic narrative about the UHC and exposes implementation as a highly political process. In this case, there is continuous negotiation over gender norms and economic interests.

Moreover, the capacity of the framework to reveal structural voids has deep implications especially on unpaid care work. The fact that the care economy was almost completely omitted by mainstream UHC indicators is a significant epistemological failure (Quick, 2022). The framework demands that the evaluation measure how the policies address the burden of unpaid care. They need to recognize, reduce, and reallocate them. This fills a crucial gap between the health systems analysis and feminist economics and aligns UHC evaluation in Kenya with its National Care Policy (Republic of Kenya, 2024). This makes a practical avenue of policy coherence in which the implication is evident. A UHC program could have the potential to broaden clinical coverage, but in the case that it overlooks the 'time poverty' faced by women caregivers, it cannot pass a test of

equity. It highlights the fact that universal access is never isolated but entails finding a solution to the gendered social and economic systems that dictate access to care.

The discussion also requires a critical consideration of the Kenyan devolved context. Decentralization provides a prospect of local, participative governance. Nevertheless, our results also accentuate the threat of fragmentation and unequitable implementation (Masaba et al., 2020; Masaviru et al., 2021). A county-based health system may reproduce, or enhance, sub-national gender inequity. This occurs in the absence of powerful national requirements and capacity building that is equity-based. Thus, a feminist evaluation framework is not universally applicable. It needs to be modified to measure national policy coherence and implementation fidelity at the county level. This necessitates considering the representational strength of women in county health committees and has to determine how much resources are distributed to gender-specific services in regions (Kamau & Mbirithi, 2021; Mukorombindo, 2018). The framework can consequently advance research on the topic of decentralization since it offers a gender-sensitive instrument to evaluate equity effects. It goes beyond administrative efficiency to analyze justice in service distribution.

Although useful, this conceptual analysis has natural constraints. The practical efficacy of the framework as a theoretical construction has to be empirically validated. This necessitates the implementation of particular UHC program assessments. It is dependent on secondary data and policy documents which, is a limitation. It incorporates defined purpose and documented outcomes yet, it might not adequately capture and account on the lived experiences of all the marginalized groups. This requires primary qualitative research. Moreover, the framework focuses on intersectionality. Nevertheless, it is still a challenge to operationalize this complex theory into discrete evaluative indicators (Bowleg, 2021). This needs to be the subject of future empirical work. The framework also interrelates largely with English-language documents. It probably lacks the insights into community-level discourses of local languages.

On these interpretations, some recommendations become evident. The next step, as perceived by researchers, will be to pilot the framework in one specific UHC domain. One example is considering the gender equity of the new Social Health Insurance Fund package. This must utilize

mixed methods. It must integrate the guiding questions of the framework with the ground-truth findings of a community-based participatory research (Chilisa, 2020) that will be its foundation. To policy officials and evaluators, the recommendation is to embrace formally the principles of the framework. This may include requiring feminist evaluation criteria in UHC program evaluations. It also involves investing in the gathering of intersectional data. Information regarding unpaid care and time utilization is especially valuable. Lastly, to the rest of the academic community, this analysis demands more interaction with African feminist epistemologies. This will further decolonize evaluation methodologies (Ndlovu-Gatsheni, 2021). It makes sure that they sound relevant to a local context and worldview. These steps will bring the goal of UHC in Kenya nearer to its transformative promise. It is able to leave no one behind by first detecting and appreciating the people who are made invisible by the current systems.

## CONCLUSION AND RECOMMENDATIONS

This conceptual inquiry aimed to fill a substantial gap in both the evaluation methodology and the policy of health equity by posing the following question: How can we integrate the principles of feminist evaluation to build a transformative analytical approach to the evaluation of Kenya's UHC programs? The motivation behind the study was that, even though UHC is meant to be universal, its traditional metrics of evaluation usually do not challenge the gendered power that dictates the ultimate beneficence. In answering this, the study adopted a conceptual research design, which included a feminist political economy examination of Kenyan health policy documents and synthesized secondary empirical evidence on gendered health inequities. The analysis involved the systematic use of a theoretical prism that integrated feminist analysis, intersectionality analysis and political economy analysis to the UHC policy environment in Kenya and its devolved governance.

The greatest contribution made in this study is the establishment of a consistent feminist evaluation model that fits the Kenyan context. This paradigm shifts the fundamental metrics of UHC successes away from biased coverage of technicality and financial protection to transformative results focusing on redistributing power, involvement in governance, and elimination of overlapping inequalities. One of the key findings that were obtained by using this framework is

the validation that gender integration within Kenyan health policy is not systematic, but is rather highly actor-dependent. The analysis indicated the existence of a sharp contrast between policies such as Kenya AIDS Strategic Framework II, where there is sound gender integration based on a strong advocacy coalition, and other strategic plans on non-communicable diseases or tuberculosis, where gender considerations are marginal or superficial. This inconsistency reiterates that gender equity is a bargaining political tool and not an institutional standard in the health system.

In addition, the framework is effective in revealing deep structural blindness in existing UHC design and assessment. It emphasizes that unpaid care work, a very feminine burden that results in severe time shortage, is simply ignored in normal UHC measures. With this issue at its center, this framework makes UHC evaluation correspond with the progressive National Care Policy of Kenya, and closes the gap between health systems analysis and feminist economics. The framework is also critical in analyzing the devolved governance framework of Kenya. It puts in question the assumptions that lead to the idea that decentralization immediately expands equity but rather provides means of testing whether county-level implementation leads to the establishment of true participatory decision-making with women or an increase in geographical inequities due to the presence of fragmented political commitment.

The main contribution of this study is the fact that it offers a context-sensitive and structured instrument to scholars, policymakers, and the civil society. The framework takes investigation above the identification of gaps to provide a positive, practical set of principles and inquiries of gender-transformative analysis. It proves that applying the feminist concept to the UHC is not a case of introducing a gender element to it but a complete redefinition of the purpose of the evaluation, basing it on elements of justice and power analysis. This empowers the academic discussions in feminist policy studies, health systems studies, and African studies, by establishing a global assessment format based on the particular political and social realities of a devolved African state.

This study has some intrinsic limitations, despite its contributions. As a conceptual study, operational difficulties and feasibility of the framework must undergo empirical testing and application in particular county or programs assessments. It depends on recorded policy and

secondary resources, and so reflects the premeditated design as well as reported results but might not access the rich experience at the community level without a primary qualitative study to supplement data. Also, although the framework is intersectionality focused, the translation of this complex theory into evaluations indicators that are consistent and applicable across Kenyan contexts is a frontier of methodology that this conceptual piece can merely speculate.

The constraints and results of the current research instantly lead to several crucial possibilities of further research. Future empirical research ought to focus on refining and testing this framework in practice, perhaps by a feminist assessment of one particular pillar of UHC, such as the equity implication of the novel structure of the premium levels of the new Social Health Insurance Fund to women in the informal sector. The methodological innovation is also urgently needed to create the participatory and arts-based methodology tools which may transform intersectional analysis into the community-led monitoring. Historical and discursive analysis is another key area that could be used to trace how the various feminist epistemologies and especially the African feminist thought has shaped the health equity policy in Kenya.

In a broader sense, this study contends that in order for Kenya attains the constitutional right to health of all its people, UHC has to be carefully planned and measured as a social justice project, rather than a service provision initiative. The framework offers a practical way to this end. To the policymakers in the country and county, its implementation may reshape M&E systems, requiring the evaluation of power in health committee decision making and resource distribution. To civil society and women's rights organizations, it provides space to advocate legitimate and structured approaches to accountability by making them demand scrutiny about who holds power and not only who gets the services. Finally, this conceptual analysis assumes that feminist evaluation is not a marginal preoccupation but rather one of the essential requirements of a UHC which can be described as being truly universal. It gives the analytical prism to make sure that in creating health, among all in Kenya, it consciously breaks the gendered hierarchies that have historically rendered health as a privilege, as opposed to a right.

**REFERENCES**

Abimbola, S., Baatiema, L., & Bigdeli, M. (2019). The impacts of decentralization on health system equity, efficiency and resilience: A realist synthesis of the evidence. *Health Policy and Planning*, *34*(8), 605–617.

Abu, T. Z., & Elliott, S. J. (2020). When it is not measured, how then will it be planned for? WaSH a critical indicator for universal health coverage in Kenya. *International Journal of Environmental Research and Public Health*, *17*(16), 5746.

Aellah, G. J. (2021). *Everyday life in a site of transnational medical research in Western Kenya: An ethnographic study* [Doctoral dissertation, London School of Hygiene & Tropical Medicine].

Akinwale, A. A. (2023). Gender equity and social progress: Empowering women and girls to drive sustainable development in Sub–Saharan Africa. *International Journal of Innovation Research and Advanced Studies*.

Alarcón, D. M., & Cole, S. (2019). No sustainability for tourism without gender equality. *Journal of Sustainable Tourism*.

Araújo-Vila, N., Otegui-Carles, A., & Fraiz-Brea, J. A. (2021). Seeking gender equality in the tourism sector: A systematic bibliometric review. *Knowledge*, *1*(1), 12–24.

Barako, T. D. (2021). *Exploring antenatal care experiences amongst pastoralist communities in Kenya: A focused ethnographic study* [Doctoral dissertation, University of Nottingham].

Barasa, E., Mbau, R., & Gilson, L. (2018). What is resilience and how can it be nurtured? A systematic review of empirical literature on organizational resilience. *International Journal of Health Policy and Management*, *7*(6), 491.

Barasa, E., Nguhiu, P., & McIntyre, D. (2018). Measuring progress towards sustainable development goal 3.8 on universal health coverage in Kenya. *BMJ Global Health*, *3*(3), e000904.

Barasa, E., Rogo, K., Mwaura, N., & Chuma, J. (2018). Kenya National Hospital Insurance Fund Reforms: Implications and lessons for universal health coverage. *Health Systems & Reform*, *4*(4), 346–361.

Bowleg, L. (2021). Evolving intersectionality within public health: From analysis to action. *American Journal of Public Health*, *111*(1), 88–90.

Chilisa, B. (2019). *Indigenous research methodologies*. Sage Publications.

Christoffersen, A., Hunting, G., & Hankivsky, O. (2025). Integrating intersectionality in policy: A review and analysis of guidance. *Canadian Public Policy*, *51*(3), 363–383.

Collins, P. H., da Silva, E. C. G., Ergun, E., Furseth, I., Bond, K. D., & Martínez-Palacios, J. (2021). Intersectionality as critical social theory. *Contemporary Political Theory*, *20*(3), 690–714.

Crenshaw, K. (2019). 'Difference' through intersectionality 1. In *Dalit Feminist Theory* (pp. 139–149). Routledge India.

Crupi, K., & Godden, N. J. (2024). Feminist evaluation using feminist participatory action research: Guiding principles and practices. *American Journal of Evaluation*, *45*(1), 51–67.

Davies, S. E., Harman, S., Manjoo, R., Tanyag, M., & Wenham, C. (2019). Why it must be a feminist global health agenda. *The Lancet*, *393*(10171), 601–603.

Denny, E. S. (2021). Is feminist policy evaluation possible? Methodological and theoretical considerations. In *A Research Agenda for Evaluation* (pp. 147–164). Edward Elgar Publishing.

Eger, H., Chacko, S., El-Gamal, S., Gerlinger, T., Kaasch, A., Meudec, M., ... & Uribe, O. L. (2024). Towards a feminist global health policy: Power, intersectionality, and transformation. *PLOS Global Public Health*, *4*(3), e0002959.

Endalamaw, A., Gilks, C. F., Ambaw, F., & Assefa, Y. (2022). Universality of universal health coverage: A scoping review. *PloS One*, *17*(8), e0269507.

Firdaus, A., Aksar, I. A., Danaee, M., Gong, J., & Dharejo, N. (2023). Methodological challenges in interviewing elite women in a patriarchal society. *The Qualitative Report*, *28*(5), 1520–1534.

Gideon, J. (2023). Financing development through PPPs: What does this mean for inequalities. In *The Political Economy of Global Manufacturing, Business and Finance* (pp. 243–265). Springer Nature.

Gideon, J., & Gianella, C. (2024). Gender equality? In *A Research Agenda for Gender and Health* (p. 123). Edward Elgar Publishing.

Gideon, J., & Hawkes, S. (2024). Introduction: Gender and health—a future research agenda. In *A Research Agenda for Gender and Health* (pp. 1–20). Edward Elgar Publishing.

Gore, R., & Parker, R. (2019). Analysing power and politics in health policies and systems. *Global Public Health*, *14*(4), 481–488.

Hanney, S. R., Kanya, L., Pokhrel, S., Jones, T. H., & Boaz, A. (2020). How to strengthen a health research system: WHO's review, whose literature and who is providing leadership? *Health Research Policy and Systems*, *18*(1), 72.

Hassnain, H. (2023). Decolonizing evaluation: Truth, power, and the global evaluation knowledge base. *Journal of MultiDisciplinary Evaluation*, *19*(44), 142–155.

Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., ... & Gupta, G. R. (2019). Disrupting gender norms in health systems: Making the case for change. *The Lancet*, *393*(10190), 2535–2549.

Heidari, S., & Doyle, H. (2020). An invitation to a feminist approach to global health data. *Health and Human Rights*, *22*(2), 75.

Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., ... & Gupta, G. R. (2019). Gender inequality and restrictive gender norms: Framing the challenges to health. *The Lancet*, *393*(10189), 2440–2454.

Jabeen. (2020). [Original work cited as Jabeen 2020 in text].

Jenkins, K., Narayanaswamy, L., & Sweetman, C. (2019). Introduction: Feminist values in research. *Gender & Development*, *27*(3), 415–425.

Jolivet, R. R., Gausman, J., & Langer, A. (2025). Measuring social, economic, policy, and health system determinants of maternal health and survival: An urgent global priority. *PLoS One*, *20*(1), e0317095.

Jordan, L., & Hall, J. (2023). Framing anticolonialism in evaluation: Bridging decolonizing methodologies and culturally responsive evaluation. *Journal of MultiDisciplinary Evaluation*, *19*(44), 102–116.

Kabia, E., Mbau, R., Muraya, K. W., Morgan, R., Molyneux, S., & Barasa, E. (2018). How do gender and disability influence the ability of the poor to benefit from pro-poor health financing policies in Kenya? An intersectional analysis. *International Journal for Equity in Health*, *17*(1), 149.

Kamau, S. K., & Mbirithi, D. M. (2021). Citizen participation in the formulation of public policy in Mombasa County, Kenya. *International Journal of Current Aspects*, *5*(4), 90–107.

Kemei, J. J. (2019). *Experiences of nurses and midwives regarding postpartum care in rural Kenyan communities: A qualitative focused ethnography study* [Doctoral dissertation, University of Ottawa].

Kenya National Bureau of Statistics (KNBS). (2022). *Kenya Demographic and Health Survey 2022*. KNBS.

Leavy, P., & Harris, A. (2018). *Contemporary feminist research from theory to practice*. Guilford Publications.

Losleben, K., & Musubika, S. (2023). Intersectionality. In *Gender Diversity, Equity, and Inclusion in Academia* (pp. 72–84). Routledge.

MacArthur, J., Carrard, N., Mott, J., Raetz, S., Siscawati, M., & Willetts, J. (2023). Gender equality approaches in water, sanitation, and hygiene programs: Towards gender-transformative practice. *Frontiers in Water*, *5*, 1090002.

Masaba, B. B., Moturi, J. K., Taiswa, J., & Mmusi-Phetoe, R. M. (2020). Devolution of healthcare system in Kenya: Progress and challenges. *Public Health*, *189*, 135–140.

Masaviru, L. A., Namusonge, G. S., & Nambuswa, E. M. (2021). Influence of devolved financial resource governance structure on service delivery in the public health sector in Kenya. *Public Policy and Administration Research*, *11*(1).

Mauti, J., Gautier, L., De Neve, J. W., Beiersmann, C., Tosun, J., & Jahn, A. (2019). Kenya's Health in All Policies strategy: A policy analysis using Kingdon's multiple streams. *Health Research Policy and Systems*, *17*(1), 15.

Meagher, K., Attal, B., & Patel, P. (2021). Exploring the role of gender and women in the political economy of health in armed conflict: A narrative review. *Globalization and Health*, *17*(1), 88.

Mezzadri, A., Newman, S., & Stevano, S. (2022). Feminist global political economies of work and social reproduction. *Review of International Political Economy*, *29*(6), 1783–1803.

Mohapatra, S., & Wiley, L. F. (2019). Feminist perspectives in health law. *Journal of Law, Medicine & Ethics*, *47*(S4), 103–115.

Morgan, R., Ayiasi, R. M., Barman, D., Buzuzi, S., Ssemugabo, C., Ezumah, N., & Waldman, L. (2018). Gendered health systems: Evidence from low-and middle-income countries. *Health Research Policy and Systems*, *16*(1), 58.

Morgan, R., Garrison-Desany, H., Hobbs, A. J., & Wilson, E. (2022). Strengthening effectiveness evaluations through gender integration to improve programs for women, newborn, child, and adolescent health. *Global Health Action*, *15*(sup1), 2006420.

Morgan, R., Kalbarczyk, A., Decker, M., Elnakib, S., Igusa, T., Luo, A., & Malhotra, A. (2024).

Gender-responsive monitoring and evaluation for health systems. *Health Policy and Planning*, *39*(9), 1000–1005.

Mukorombindo, Y. C. (2018). *Budget and policy planning in devolved Kenya: A case study of citizen participation in Nairobi County* [Case Study/Report].

Ndlovu-Gatsheni, S. (2018a). *Epistemic freedom in Africa: Deprovincialization and decolonization*. Routledge.

Ndlovu-Gatsheni, S. J. (2018b). Introduction: Seek ye epistemic freedom first. In *Epistemic Freedom in Africa: Deprovincialization and Decolonization*. Taylor & Francis.

Ndlovu-Gatsheni, S. J. (2021). The cognitive empire, politics of knowledge and African intellectual productions. *Third World Quarterly*, *42*(5), 882–901.

Nepali, P., & Baral, P. (2024). An intersectionality based policy analysis framework: Advancing the multiple equity measures. *Journal of Underrepresented & Minority Progress*, *8*(SI 1).

Nungo, S., Filippon, J., & Russo, G. (2024). Social Health Insurance for Universal Health Coverage in Low and Middle-Income Countries (LMICs). *BMJ Open*, *14*(12), e085903.

Nyawira, L., Machira, Y., Munge, K., Chuma, J., & Barasa, E. (2024). Examining the implementation experience of the universal health coverage pilot in Kenya. *Health Systems & Reform*, *10*(3), 2418808.

O'Connor, M., McGowan, K., & Jolivet, R. R. (2019). An awareness-raising framework for global health networks. *Reproductive Health*, *16*(1), 1.

Odero, H. O., Kwesiga, D., Odunga, S., Kadengye, D. T., & Kiwuwa-Muyingo, S. (2025). Examining gender as an issue of policy priority: A case study of four Kenyan health policy implementation strategies. *Frontiers in Public Health*, *13*, 1615792.

Okungu, V., Chuma, J., Mulupi, S., & McIntyre, D. (2018). Extending coverage to informal sector populations in Kenya. *BMC Health Services Research*, *18*(1), 13.

Oliveira, R., Santinha, G., & Sá Marques, T. (2023). The impacts of health decentralization on equity, efficiency, and effectiveness: A scoping review. *Sustainability*, *16*(1), 386.

Parliament of Kenya. (2023). *The Social Health Insurance Act, No. 16 of 2023*. Government Printer.

Podems, D. R. (2024). Feminist principles evaluation. In *Research Handbook on Program Evaluation* (pp. 174–191). Edward Elgar Publishing.

Quick, P. (2022). Rise and decline of patriarchal systems: An intersectional political economy. *Science & Society*, *86*(3), 460–462.

Raphael, D., & Bryant, T. (2019). Political economy perspectives on health and health care. In *Staying Alive: Critical Perspectives on Health, Illness, and Health Care* (3rd ed., pp. 61–83). Canadian Scholars' Press Inc.

Republic of Kenya. (2010). *The Constitution of Kenya, 2010*. National Council for Law Reporting.

Republic of Kenya. (2020). *Kenya AIDS Strategic Framework II (KASF II) 2020-2024*. Ministry of Health.

Republic of Kenya. (2024). *National Care Policy*. Ministry of Public Service, Gender and Affirmative Action.

Rotz, S., Rose, J., Masuda, J., Lewis, D., & Castleden, H. (2022). Toward intersectional and culturally relevant sex and gender analysis in health research. *Social Science & Medicine*, *292*, 114459.

Ruiz-Cantero, M. T., Guijarro-Garvi, M., Bean, D. R., Martínez-Riera, J. R., & Fernández-Sáez, J. (2019). Governance commitment to reduce maternal mortality. *Health & Place*, *57*, 313–320.

Samman, E., Acoca, A., Encarnacion, J., Kenneally, S., Cobos Hernandez, M. I., Vaca Trigo, I., ... & Noe, L. (2025). Beyond measurement: Addressing gaps in gender data capacity for evidence-based policy and action. *Statistical Journal of the IAOS*, *41*(3), 532–556.

Smith, J., Davies, S. E., Feng, H., Gan, C. C., Grépin, K. A., Harman, S., ... & Wenham, C. (2021). More than a public health crisis: A feminist political economic analysis of COVID-19. *Global Public Health*, *16*(8-9), 1364–1380.

Solnes Miltenburg, A., Kvernflaten, B., Meguid, T., & Sundby, J. (2023). Towards renewed commitment to prevent maternal mortality and morbidity. *Sexual and Reproductive Health Matters*, *31*(1), 2174245.

Steinert, J. I., Alacevich, C., Steele, B., Hennegan, J., & Yakubovich, A. R. (2021). Response strategies for promoting gender equality in public health emergencies: A rapid scoping review. *BMJ Open*, *11*(8), e048292.

Thaler, A., Karner, S., Yennie Bredin, G., Brown, H. F., Franklin, A., Gundersen, V., & Wähler, T. (2023). *Methodological framework for intersectionality analysis* (Report No. D1, p. 3).

Wakiaga, J., Odary, K. V., & Masha, S. C. (2024). The role of community health volunteers in promoting health equity. *African Journal of Empirical Research*, *5*(2), 824–831.

Wambalaba, E. A. (2024). Addressing health equity challenges in women's care: Insights from Kenya. In *The Landscape of Global Health Inequity* (pp. 151–167). Springer Nature Switzerland.

Wichterich, C. (2023). Global political economy of care and gender-crisis, extractivism and contestation. In *Handbook of Research on the Global Political Economy of Work* (pp. 401–411). Edward Elgar Publishing.

Williams, A., Lyeo, J. S., Geffros, S., & Mouriopoulos, A. (2021). The integration of sex and gender considerations in health policymaking: A scoping review. *International Journal for Equity in Health*, *20*(1), 69.

World Health Organization. (2023). *Universal health coverage (UHC)*. https://www.who.int/health-topics/universal-health-coverage