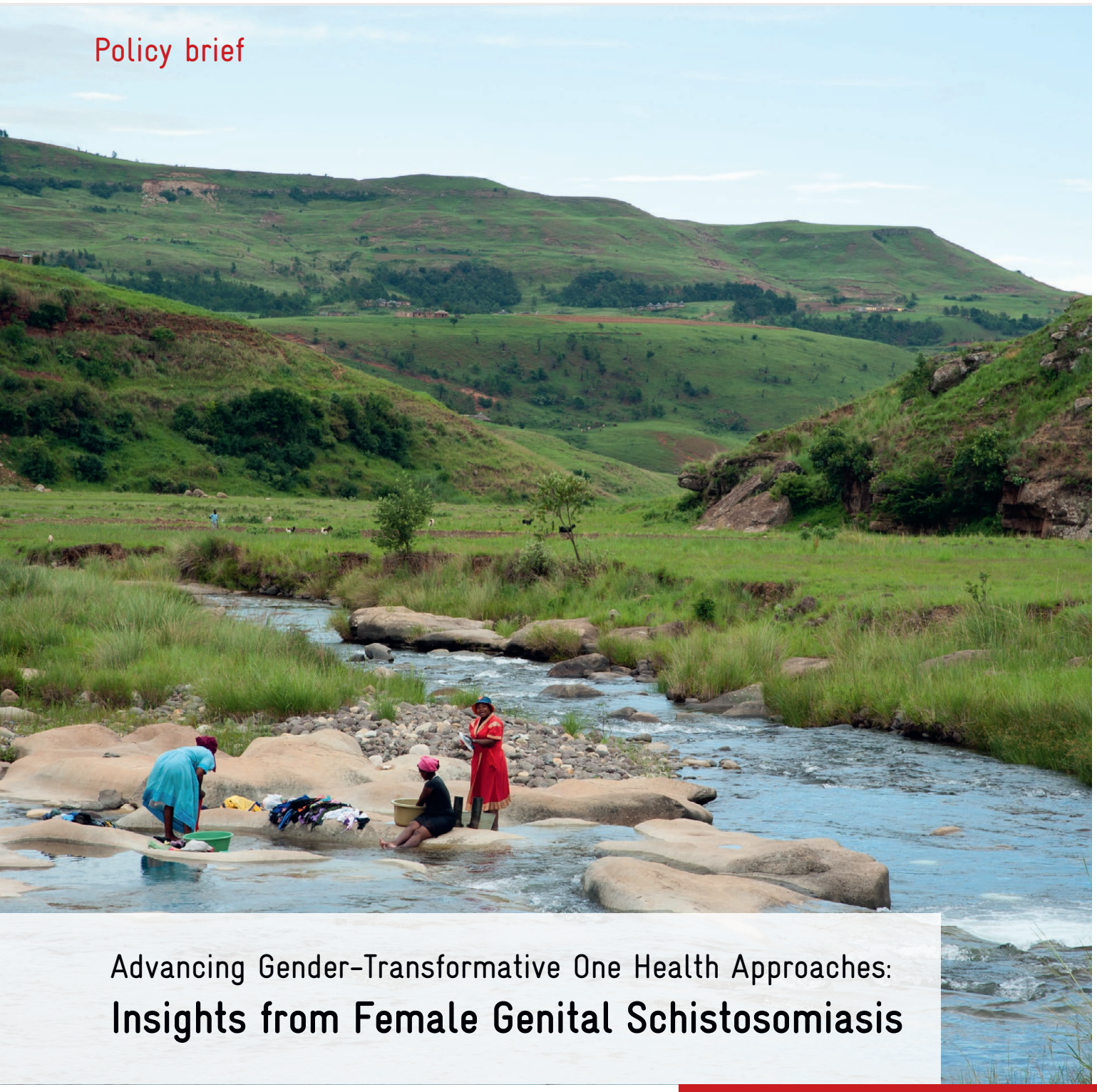
Policy brief



Advancing Gender-Transformative One Health Approaches: Insights from Female Genital Schistosomiasis

»Integrating gender and diversity strengthens One Health implementation by improving equity and overall effectiveness, demonstrating that inclusive approaches are essential, not optional, for the success of One Health systems.«

Dr Victoria Gamba

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Why Diversity, Equity and Inclusion matters

The One Health approach seeks to optimize the health of people, animals, environment and ecosystems through integrated action. Its principles – equity, parity and inclusion, socioecological equilibrium, stewardship and transdisciplinarity – recognize that health priorities are shaped by interconnected systems.[a] The definition underlying this approach was developed by the *One Health High-Level Expert Panel's* (OHHLEP) adopted by the One Health Quadripartite. Yet in practice, the One Health approach implementation often remains too narrow: focused on biomedical risks, while the social conditions that determine who is exposed and who reaches care remain unaddressed.

In this policy brief, Diversity, Equity and Inclusion (DEI) means recognizing how intersecting social, ecological and structural conditions shape unequal risks, resources and outcomes, while ensuring meaningful participation in decision-making so that One Health policies and programmes are equitable, inclusive and responsive across human, animal and environmental systems. One Health core principles align closely with DEI concepts, and the definition holds that One Health is only partly applied if they are left out.[b] This brief uses Female Genital Schistosomiasis (FGS)[c] as a case study to exemplify pathways to effective integration of DEI into One Health.

Up to 56 million women and girls worldwide are affected by Female Genital Schistosomiasis, most of them on the African continent.[c]

Integrating DEI into One Health: Key recommendations at a glance across the Four C's

What Female Genital Schistosomiasis reveals about One Health

Collecting water, washing clothes, irrigating fields, watering livestock: the tasks that expose women and girls to freshwater carrying *Schistosoma haematobium* are shaped by socially assigned roles.[d] The same water bodies serve households and herds, meaning that exposure sits across water, agriculture and health mandates at once. What follows is a chain of missed opportunities:

Because FGS affects the genital tract and presents much like a sexually transmitted infection (STI), women often conceal symptoms rather than seeking care. When they do seek care, providers may fail to recognize the condition and treat it as an STI instead; since the treatment is hence ineffective, therefore the symptoms persist, resulting in social problems that are often overlooked in addressing FGS as only a medical problem affecting an individual. Women pass through sexual and reproductive health, Human Immunodeficiency Virus (HIV) and maternal health services without being screened, because no service clearly holds that mandate. The result can be chronic pain, infertility, adverse pregnancy outcomes and heightened susceptibility to HIV and Human Papillomavirus. No link in this chain can be addressed through a purely biological lens: each is shaped by social, environmental and institutional factors, and each can fall into the gaps between sectors – precisely what a gender-blind One Health approach fails to see.

This brief uses FGS as an example to show how DEI can strengthen One Health policy and programming, with important lessons for schistosomiasis specialists. According to OHHLEP's **four Cs** definition as operational dimensions of the One Health approach, this brief structures around **Collaboration, Communication, Coordination and Capacity building,** drawing on a grey literature review and consultations with twelve experts, mostly from FGS endemic countries, informing the recommendations put forward by the authors.

1. Collaboration: Make community ownership a core implementation principle

» Don't let it be discussed only by women. Inclusivity is key.» – Dr Pauline Mwinzi

According to findings from the expert consultations and literature review, community engagement approaches often do not strategically embed DEI and gendered knowledge. Because communities are not homogeneous, participation without a DEI lens reproduces existing hierarchies. Meaningful community participation should be treated as a core pillar of One Health implementation and should include participatory design, community-led monitoring and dedicated resources for local organizations. This speaks directly to parity as one core One Health principle: communities should not merely be consulted but should shape decisions, priorities and implementation. One expert described rainforest communities designing interventions entirely themselves, with the civil society organization's role to convening a demographically representative group.

Female Genital Schistosomiasis shows that interventions fail when behaviour change is expected without feasible alternatives: advising women to avoid unsafe water sources does not result in change if the women do not perceive it to be unsafe and no safe alternatives are known, accepted or exist. Interventions matching community priorities have been reported to be taken up and sustained better. Consulted experts reported that male allyship approaches turned out to make a crucial difference in reaching women more effectively in an all-of-community approach.[e] Community-based organizations play a crucial role as a two-way bridge between lay people and policy-makers.

COLLABORATION – KEY RECOMMENDATIONS:

1.1. Give local actors a resourced seat

Give community-based organizations, traditional leaders and other key local actors a formal, resourced role in coordination and monitoring structures within the next programme cycle, and earmark a defined share of programme budgets for them while routinely assessing their reach.

1.2. Engage everyone, not only those obviously affected

Participation should be inclusive across gender and social groups, as engaging only the affected group can unintentionally reinforce the very stigma that keeps a health priority hidden.

1.3. Build allyship into programme design

For schistosomiasis and other Neglected Tropical Diseases (NTDs), build (male) allyship components into programme design, and involve local knowledge-holders outside the health sectorf, including community animal health workers, ecoguards, respected herbalists and traditional birth attendants, who are often the first point of contact for local people.

In a project **in Kenya**, training materials were revised to include men, who subsequently became advocates for FGS screening and treatment within their own households. A similar approach was used in a **Cameroonian** project, where separate materials and messaging were designed for men and women according to their household roles.

2. Communication: Invest in equity-focused data systems and locally meaningful evidence, and reposition One Health priorities as equity issues

» Data may only capture demographic information on men and women but does not break it down into the nitty-gritty. For people working in the gender space – for example those focusing on female-headed or male-headed households – this detail, these metrics are important: how should they be included, how can we handle them?» – Prof. Salome Bukachi

Data blind spots keep inequities invisible, and what remains invisible remains unfunded. One Health surveillance and data systems must capture how different determinants and socio-economic factors intersect to shape risk and access. Such clear evidence can then be used to credibly reframe One Health issues as equity issues.

Female Genital Schistosomiasis illustrates the gap: it remains underreported because data are usually disaggregated (if at all) by sex only.[g] Most consulted experts highlighted that weak and non-intersectional[1] data obscure who is affected and who remains excluded. Environmental surveillance, including water contamination and snail habitat data, is rarely linked to service access and uptake data, obscuring where interventions are needed and who is not accessing care.

With clearer equity data, a broader DEI framing beyond biomedical aspects becomes possible – with tangible benefits for programme resources: In **Tanzania**, domestic budget allocations for NTD programming rose from approximately 1.8 billion to 16.9 billion Tanzanian shilling between 2021 and 2024; a consulted expert attributed this increase to the shift from a mere health framing to a gender-equality framing of the interventions, unlocking more partners and funding streams.

[1] Intersectional data refers to data that shows how different factors – such as gender, age, disability, livelihood, poverty, geography, migration status or social position – overlap to shape people's exposure, access to services, participation and health outcomes.

COMMUNICATION – KEY RECOMMENDATIONS:

2.1. Disaggregate beyond sex

Adopt intersectional data standards, capturing at least sex and gender, age, disability, geography, poverty, livelihood and household roles alongside environmental exposure and migration.

2.2. Measure access, not only coverage

Include community wellbeing and service access indicators in One Health monitoring frameworks. Engage national statistics agencies and support data standards[h] and sovereignty at global level.

2.3. Link environmental health and service data

Apply these standards operationally by linking surveillance systems beyond human health, e.g. in schistosomiasis programmes, link with environmental surveillance, including water contact sites, snail habitats and livestock keeping data with service uptake data at programme level, to identify who is being reached and excluded.

2.4. Speak other sectors' language

Systematically translate disaggregated evidence on who is exposed, excluded or underserved into gender-equity, water sanitation and hygiene (WASH), livelihood and development arguments, so that more sectors can take ownership and additional funding streams can be mobilized.

3. Coordination: Institutionalize DEI and multisectoral responsibility within One Health governance

» If gender is not included at a 'higher level', there is no funding [...]. Policy guides both implementation and funding, and if gender is not explicitly stated, it will easily be forgotten.« – Prof. Salome Bukachi

National and global One Health strategies, action plans and frameworks are often inconsistently integrating explicit DEI and gender objectives and indicators, dedicated budgets and accountability mechanisms. Diversity, Equity and Inclusion often appear as a standalone paragraph instead of being mainstreamed across governance, planning, implementation and monitoring.

Female Genital Schistosomiasis shows why this matters: Consulted experts stress that exposure arises from water use serving households and livestock alike and thus it sits across water, agriculture and health mandates – and therefore within none of them. Fragmented services between maternal health, sexual and reproductive health, and HIV services result in a lack of screening for FGS.[i]

National schistosomiasis strategies address treatment coverage while the structural drivers of exposure fall outside their scope, and outside everyone else's. Without global normative guidance, DEI integration depends on individual champions rather than on mandate.

FGS is a useful model for integrated service delivery: it sits across sexual and reproductive health, HIV, maternal health, NTD control, WASH and environmental management, making visible how risk falls between institutional mandates rather than any single sector's neglect. Countries could pilot FGS-based cross-sectoral coordination before extending it to other NTDs with similarly overlapping determinants.

COORDINATION – KEY RECOMMENDATIONS:

3.1. Mainstream DEI across policy documents

Ministries responsible for national One Health strategies and coordination mechanisms should revise and embed DEI objectives, indicators and budget lines, mainstream gender across policy documents rather than standalone sections, and formally clarify cross-sectoral roles and responsibilities – including water, gender, social welfare, education and civil society.

3.2. Anchor DEI through global guidance

Global, multilateral institutions should strengthen normative guidance on DEI and anchor it in strategic frameworks such as the WHO NTD Roadmap 2030 and the Quadripartite's *One Health Joint Plan of Action* in its extension to 2029.

3.3. Recruit beyond the disease silo

NTD programmes under a One Health lens should seek relevant expertise beyond the disease silo; for schistosomiasis control programmes that would mean to formally include DEI and gender expertise as well as animal health and environmental specialists, given the environmental and potential zoonotic dimensions of transmission.

In **The Gambia**, the Ministry of Gender, Children and Social Welfare co-developed a One Health Governance Manual that embedded gender-sensitive community engagement and health promotion approaches.

In **Cameroon**, a policy brief on gender and zoonotic diseases helped improve national stakeholders' understanding of DEI issues within One Health sectors and their multisectoral governance mechanism.

4. Capacity building: Build a workforce capable of addressing social determinants, resourced through flexible financing

» Gender and intersectional aspects are frequently perceived as social or political issues rather than technical determinants of health outcomes.» – Dr Kuduishe Kisowile

Diversity, Equity, Inclusion competencies are skills which need more strategic capacity building: One Health training curricula for public health workers, veterinarians, environmental professionals and programme managers should include mandatory competencies in gender-transformative programming, equity and inclusion, community engagement, stigma-sensitive communication and intersectional analysis. Approaches such as radical listening[2] can help reduce power imbalances between institutions and affected communities.

Female Genital Schistosomiasis shows what this looks like in practice. It is routinely missed or misdiagnosed as an STI because clinical providers are rarely trained to recognize its distinct symptoms thus reinforcing stigma.[j]

This is a professional competency gap: it requires embedding FGS-specific clinical recognition and stigma-sensitive counselling into standard medical curricula, not as isolated workshops.[k]

Short, vertical funding cycles undermine the trust-building this approach needs to induce actual change. Further, transmission itself persists when structural drivers, such as safe water access, remain unfunded based on lack of strategic, cross-sectoral, DEI-informed coordination.

[2] Radical listening approach: listening with the intent to understand, learn from lived experiences and centre marginalized voices in decision-making.

CAPACITY BUILDING – KEY RECOMMENDATIONS:

4.1. Make DEI competencies mandatory

Training institutions should embed and standardize DEI and gender competencies into curricula.

4.2. Draw on gender expertise in global learning

Include gender and DEI actors and networks such as *Women for One Health* in global learning initiatives such as the *Joint One Health Learning Taskforce*.

4.3. Fund beyond the project cycle

Donors should shift funding instruments to multi-year, flexible, non-disease-specific financing to allow for sufficient community analysis as well as addressing structural drivers.

4.4. Budget social expertise from day one

Include social scientists or gender specialists alongside community knowledge from the project inception phase onwards with dedicated budget lines, ensuring sufficient time to gather relevant DEI and gender data and design meaningful community engagement approaches throughout programme cycles.

In **Kenya**, training programmes expanded awareness of gender and human health dimensions among livestock officers.

Call to action

Female Genital Schistosomiasis shows that gender and DEI are not peripheral concerns; they are central to effective risk analysis, governance, service delivery, workforce development across different sectors for sustainable prevention. The four Cs are not four silos: community input shapes which evidence is needed; evidence justifies mandates; mandates require a resourced workforce – and that workforce is what sustains community-led work in turn.

To strengthen One Health systems, DEI including gender must be treated as core implementation architecture, not optional add-ons.

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