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RESEARCH ARTICLE

Comparative Study of Gender-Based Health Policies in Indonesia and the Philippines: Strategies and Equity Impact

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ABSTRACT

Introduction: Gender equality remains a central challenge in achieving the Sustainable Development Goals (SDGs), particularly SDGs 3 and 5, in Southeast Asia. This study compares gender-based health policies in Indonesia and the Philippines, focusing on how policy strategies and implementation affect health equity.

Methods: This study employed a qualitative comparative design (Mill's Method of Difference), analysing national policy documents from 2015 to 2025. The study is grounded in Sabatier and Mazmanian's policy implementation framework and intersectionality theory to provide a comprehensive evaluation of both countries' approaches.

Results: The Philippines demonstrates a relatively explicit rights-based policy architecture, with clearer legal mandates, institutional responsibilities, and documented implementation mechanisms. Indonesia relies more heavily on gender mainstreaming across broader development and health-planning instruments, with implementation responsibilities distributed across existing institutions. The comparison identifies differences in health-worker training, community participation, monitoring arrangements, and access-related patterns. However, population-level health indicators are interpreted as contextual and corroborative evidence rather than as direct measures of policy effectiveness, because the study design cannot establish causal effects.

Conclusion: The comparison suggests that gender-responsive health policy implementation is associated with the configuration of legal mandates, institutional capacity, contextual conditions, and equity-oriented community participation. Policy learning from the Philippine case may inform Indonesia, but implementation would require adaptation to Indonesia's decentralised governance and sociocultural context.

Keywords: Public Policy; ASEAN; Equitable Access; Maternal Mortality

INTRODUCTION

Gender equality in health is a key indicator of human development and a crucial pillar in achieving the Sustainable Development Goals (SDGs), particularly SDG 3 on good health and SDG 5 on gender equality (1). Efforts to achieve this equality encompass not only access to health services but also the quality of services, the sensitivity of healthcare workers, and regulations that support the rights of women and vulnerable groups. Globally, widening health disparities remain a significant challenge. The World Health Organisation (WHO) reports that women in low- and middle-income countries face a 33-fold higher risk of maternal death than in developed countries (1-3). This disparity reflects not only economic inequality but also structural injustices in health systems that fail to respond to women's specific needs. Furthermore, UN Women emphasizes that gender equality in health is not merely a medical issue but a human rights issue that requires comprehensive, sustainable policy interventions.

Gender mainstreaming in health has been on the global agenda since the World Conference on Women in Beijing (1995), which emphasized integrating a gender perspective into all aspects of public policy, including health (4). However, the implementation of this principle varies widely across countries, depending on political commitment, institutional capacity, and socio-cultural context. In Southeast Asia, gender disparities in health remain evident, with high maternal mortality rates, limited access to reproductive health services, and low participation of women in health decision-making (2). Gender mainstreaming in health is defined as a systematic process for integrating a gender perspective into the planning, implementation, monitoring, and evaluation of health policies and programmes (5). This theoretical framework is based on three main pillars: the recognition that gender is a social determinant of health that influences access, utilisation, and outcomes of health services; a commitment to addressing structural inequalities that prevent women and marginalised groups from accessing their right to health; and the application of a rights-based approach that places gender equality as a prerequisite for achieving universal health (5).

This study uses a complementary analytical framework, in which Sabatier and Mazmanian's policy implementation framework serves as the primary framework for analysing how policy design translates into implementation. The framework directs attention to the clarity of policy objectives and legal mandates, the institutional and resource capacity available for implementation, and the political and social conditions that may facilitate or constrain implementation (6). Gender mainstreaming is treated as a policy-design perspective that examines whether gender considerations are incorporated into policy objectives, institutional responsibilities, planning instruments, and implementation arrangements.

Lipsky's concept of street-level bureaucracy is used as a secondary implementation lens rather than as a separate overarching framework. It is applied to examine how frontline health workers interpret and exercise discretion in translating formal policy requirements into service practices, particularly where policy guidance, organisational resources, and local implementation conditions vary. This application is consistent with evidence that street-level discretion can influence policy implementation and frontline health professionals' responses to policy demands (6,7). Research applying street-level bureaucracy theory to health policy implementation in low- and middle-income countries further demonstrates the relevance of frontline discretion to decisions about which services are provided, how services are delivered, and how citizens experience policy implementation (8). Intersectionality is used as an equity lens to examine how gender intersects with socioeconomic position, geographic location, and other relevant social positions to shape access to health services and exposure to implementation barriers. Rather than treating women as a homogeneous population, an intersectional approach recognises that health inequalities may arise through the interaction of multiple social positions, institutional practices, and structures of power (9). This approach is particularly relevant to health equity analysis because intersectional research can reveal heterogeneity in experiences and mechanisms that may be obscured when gender is examined as a single analytical category (9).

Accordingly, the frameworks serve distinct but complementary purposes. Gender mainstreaming informs the assessment of policy architecture; Sabatier and Mazmanian's framework guides the assessment of implementation conditions; Lipsky's street-level bureaucracy informs the analysis of frontline implementation; and intersectionality guides the assessment of distributional and access-related consequences. The frameworks were therefore not treated as competing theories but were translated into predefined analytical domains that structured the cross-country comparison.

In the ASEAN region, each country has adopted different strategies for integrating a gender perspective into its health system. The legal framework, institutional capacity, socio-cultural conditions, and political commitment of each government influence these differences. Indonesia and the Philippines are two interesting examples because they have contrasting policy backgrounds: Indonesia emphasizes gender mainstreaming in development planning documents, while the Philippines has developed an explicit legal framework that guarantees women's reproductive health rights (10,11).

The selection of Indonesia and the Philippines as comparative cases was based on their similar demographic characteristics as archipelagic nations with large populations and high cultural diversity, and on the fact that their policy architectures and selected health indicators provide useful contrasts (2,12). Both are active members of ASEAN that have committed to the ASEAN Gender Mainstreaming Strategic Framework 2021–2025 (12). The comparison, therefore, provides an opportunity to examine how different configurations of gender-responsive policy architecture and implementation conditions are associated with health-equity patterns, without assuming that policy differences alone explain population-level outcomes. For descriptive context, internationally harmonized 2023 estimates report maternal mortality ratios of 140.5 per 100,000 live births in Indonesia and 83.8 per 100,000 live births in the Philippines. Modelled modern contraceptive prevalence among currently married women aged 15–49 was 59.9% in Indonesia and 42.8% in the Philippines in 2023. These indicators are used as contextual evidence rather than direct measures of policy effectiveness.

Recent evidence indicates differences between Indonesia and the Philippines in selected gender and health indicators, although these indicators are affected by variations in data production, estimation, and reference periods. For cross-country comparison, this study therefore uses harmonized 2023 estimates where available. The WHO/UNICEF/UNFPA/World Bank/UN DESA Maternal Mortality Estimation Inter-Agency Group estimates maternal mortality ratios of 140.5 per 100,000 live births for Indonesia and 83.8 per 100,000 live births for the Philippines in 2023. Similarly, the 2023 modelled modern contraceptive prevalence rate among currently married women aged 15–49 was 59.9% in Indonesia and 42.8% in the Philippines. These population-level indicators are used as contextual and corroborative evidence rather than as direct measures of policy effectiveness. Differences in service access and equity are further examined through documentary evidence concerning geographic, socioeconomic, institutional, and gender-related barriers.

Furthermore, gender-disaggregated evidence indicates that financial, geographic, and autonomy-related barriers to health-care access are greater for some disadvantaged groups of women in Indonesia (10). In the Philippines, although similar disparities persist, the implementation of community-based programmes such as the Social Innovation in Health Initiative (SIHI) has helped address them. Selected SIHI initiatives have documented community-based approaches to adapting health services to local needs; these programme-level examples are interpreted as illustrative rather than nationally representative evidence (13).

Although previous research has examined gender and health inequalities in Southeast Asia, much of the available evidence focuses on individual countries, specific programmes, or particular dimensions of gender inequality. For example, regional reviews document the scale and persistence of gender-related health disparities across Southeast Asia (3,10), and regional policy frameworks outline shared gender-mainstreaming commitments across ASEAN member states (13); other implementation-focused work examines multisectoral governance challenges in implementing reproductive-health law in the Philippines (14). None of these sources undertakes a structured, country-paired comparison that jointly examines policy architecture, implementation capacity, frontline practice, and equity-related consequences within a single analytic framework. Existing comparative work provides important information on differences in policy commitments and health outcomes, but less attention has been given to how differences in policy architecture interact with implementation capacity, frontline practices, contextual conditions, and the distribution of access across socially differentiated groups. Consequently, the relationship between formal policy design and implementation has often remained analytically separated from the equity consequences experienced by populations facing overlapping socioeconomic and geographic disadvantages. This study addresses this gap through a structured comparison of Indonesia and the Philippines. Its contribution is not to establish that a single national policy model yields superior health outcomes, but to identify how different configurations of legal explicitness, institutional responsibility, implementation capacity, frontline practice, community participation, and contextual conditions are associated with distinct patterns of policy implementation and health-service equity. The comparison, therefore, contributes a policy-learning perspective by distinguishing potentially transferable implementation mechanisms from country-specific institutional arrangements.

This study compares gender-responsive health policy architectures in Indonesia and the Philippines, with particular attention to how policy design translates into implementation and how implementation configurations are associated with patterns of health service access and equity. Rather than testing whether one policy model directly causes better population-level outcomes, the study examines the institutional and contextual mechanisms that may help explain differences in implementation and equity-related patterns between the two cases. The study addresses three questions: (1) How do the policy and regulatory architectures of Indonesia and the Philippines differ in the explicitness, institutional responsibilities, implementation provisions, and accountability mechanisms related to gender and health? (2) What implementation mechanisms and contextual conditions are associated with differences in health-service access and equity across the two cases? and (3) What policy-learning mechanisms appear potentially transferable to Indonesia, and what contextual adaptations would be required?

METHODS

This study employs a comparative qualitative approach to examine the differences and similarities in gender-based health policies in Indonesia and the Philippines. The choice of a qualitative approach was based on the need to understand the complexity of the policy process, the sociocultural context, and the implementation dynamics that quantitative methods cannot fully capture (15,16). The comparative approach enables the identification of patterns, causal mechanisms, and contextual factors that explain why policies with similar objectives yield different impacts in the two countries (16). Below are the components of the methodology:

Research Type

This study adopts a qualitative comparative case-study design. The comparative logic draws on the heuristic of Mill's Method of Difference, but it is not used to establish definitive causal effects (17). Instead, the method provides a structured basis for comparing two countries that share several relevant characteristics yet differ in their policy architectures and implementation configurations. Comparative case-study approaches are particularly useful for examining how institutional and contextual conditions interact with policy processes, although cross-national comparisons should not be interpreted as equivalent to experimental causal identification.

For the purposes of this study, policy explicitness refers to the extent to which gender and reproductive health objectives are translated into identifiable legal mandates, institutional responsibilities, implementation requirements, and accountability mechanisms. An explicit rights-based policy architecture is operationalized as one in which gender-related health rights or

entitlements are articulated in dedicated or clearly identifiable legal instruments and accompanied by specified implementation responsibilities and accountability arrangements. A predominantly mainstreamed policy architecture refers to an arrangement in which gender objectives are primarily incorporated across broader development or health-planning instruments, with implementation responsibilities and accountability distributed across existing institutions rather than concentrated in a dedicated gender-health legal mandate.

This distinction is analytical rather than binary. A country classified as having a predominantly mainstreamed architecture may still possess explicit gender-related laws, regulations, or programmes. Conversely, the presence of dedicated legislation does not by itself demonstrate effective implementation. Classification was therefore based on the overall configuration of policy instruments rather than on the presence or absence of a single law.

The comparison assessed policy architecture across five dimensions: (1) explicitness of gender and reproductive-health objectives; (2) legal or regulatory authority; (3) allocation of institutional responsibility; (4) implementation and resource provisions; and (5) monitoring, reporting, and accountability mechanisms. These dimensions were subsequently compared with implementation conditions and equity-related evidence.

The selection of Indonesia and the Philippines was based on a structured comparative logic rather than an assumption that the cases were equivalent (16). The countries share several broadly comparable characteristics relevant to the study, including ASEAN membership, archipelagic geography, large and heterogeneous populations, substantial cultural and socioeconomic diversity, commitments to the Sustainable Development Goals, and participation in regional gender-mainstreaming initiatives. These similarities provide a contextual basis for comparison, but they do not constitute statistical matching or experimental control. The principal analytical contrast concerns the configuration of gender-related policy architecture, particularly the relative concentration of gender and reproductive-health objectives within dedicated legal mandates versus broader mainstreaming instruments. Because the cases also differ in health-system financing, decentralization, political institutions, civil-society mobilization, baseline service coverage, health-worker availability, and other contextual conditions, Mill's Method of Difference is used only as a comparative heuristic. These rival explanations are therefore retained throughout the analysis rather than assumed away.

Consequently, differences in observed health indicators are interpreted cautiously. The comparison identifies plausible mechanisms and configurational differences associated with implementation and equity, but does not claim that policy explicitness alone caused differences in national health outcomes. Where evidence was insufficient to distinguish between competing explanations, the interpretation was reported as uncertain rather than attributed to a single policy factor.

Document Identification and Screening

Rather than a systematic, PRISMA-style database search, document identification followed an approach appropriate to a qualitative, theory-informed comparison of policy architecture: documents were purposively identified from primary legal and regulatory sources (national legislation, presidential instructions, and official development-planning instruments) and from official institutional and international-agency sources (relevant ministries, national statistical and family-planning monitoring bodies, and ASEAN/UN agency reports), because these source types directly define the policy architecture and population indicators under comparison. Identification continued iteratively as the analytical domains in Table 1 were refined, rather than through a single fixed search conducted at one point in time. Documents were included where they constituted primary legal or regulatory instruments, or official institutional/international-agency reports, directly relevant to gender-responsive health policy or to the population indicators compared in Table 1, and where they were in force or reported during the 2015–2025 observation period; instruments issued before 2015 were eligible for inclusion where they remained legally in force during this period. Documents were excluded where they were draft or unenforced instruments, internal or non-public materials that could not be independently verified, or secondary commentary without independent evidentiary value. Because the comparison relies on a relatively small set of primary legal instruments and official reports per country rather than a large heterogeneous literature, document counts at each stage of identification and screening were not separately tracked and are not reported; this is noted here as a limitation of the documentation process rather than of the underlying source material. All documents were retrieved in their original English, Indonesian, or Filipino-language official versions; no documents required translation or were excluded for language reasons.

Data Collection Procedures

Document analysis followed a structured, theory-informed coding procedure conducted in four stages. First, relevant sections of each eligible document were extracted and organised according to the predefined analytical domains. Second, a deductive codebook was developed from the study's analytical framework. The initial deductive codes covered policy explicitness, legal and regulatory authority, institutional responsibility, implementation resources, monitoring and accountability, frontline implementation, community participation and empowerment, and intersectional equity. Third, inductive coding was undertaken alongside deductive coding to capture concepts, implementation mechanisms, barriers, or contextual conditions that were not adequately represented by the initial framework. This allowed the analysis to remain theoretically informed while permitting country-specific themes to emerge from the documentary material.

Fourth, coded evidence was organised into a country-by-domain comparison matrix. Each domain was first examined within each country to identify internally coherent patterns and contradictions before cross-case comparison was undertaken. Evidence was then synthesized across countries to identify convergent patterns, contrasting configurations, and plausible implementation mechanisms. Population-level indicators, including maternal mortality, contraceptive use, and service

coverage, were not coded as direct evidence of policy effectiveness; instead, they were treated as contextual or corroborative evidence that could be considered alongside documented policy and implementation mechanisms.

Analytic decisions were reviewed through repeated comparisons among the extracted text, assigned codes, the analytical framework, and the original source document. Where evidence could support more than one interpretation, the relevant passage was revisited and the broader documentary context considered before classification. Claims that could not be directly supported by the documentary corpus were either removed, qualified as interpretive inference, or reported as uncertain. This procedure was intended to improve the auditability and reproducibility of the qualitative comparison.

To improve analytic transparency, interpretive claims were linked to the underlying policy documents or secondary sources from which they were derived. Coding decisions were reviewed against the analytical framework to identify inconsistencies, overlapping categories, and unsupported causal interpretations. Where documentary evidence was incomplete, inconsistent, or not directly comparable across countries, the finding was classified as limited or uncertain rather than treated as definitive. Where multiple source types addressed the same claim, national legal and policy instruments were treated as the authoritative source for policy architecture and institutional responsibility; international agency indicator reports (e.g., the WHO/UNICEF/UNFPA/World Bank/UNDESA Maternal Mortality Estimation Inter-Agency Group and the FP2030/Track20 Measurement Reports) were treated as the authoritative source for population-level indicators; and secondary academic and grey literature were used to corroborate or contextualise implementation claims rather than as a primary evidentiary source for policy architecture or population indicators. Document authenticity was checked by confirming that each legal or regulatory instrument was published on, or consistent with, the corresponding official government or ministry website and its stated promulgation or gazette number; international agency reports were checked against the publishing agency's own official release. Where sources conflicted – for example, where an international indicator estimate differed from a figure reported in a national instrument – the more recent, internationally harmonised estimate was given precedence for cross-country comparison, and the discrepancy was reported explicitly in the text (as for the maternal mortality ratio, above) rather than silently reconciled.

Intersectional Equity Analysis

Intersectionality was applied as an analytical lens to examine how gender-related barriers interact with other dimensions of social position rather than treating women as a homogeneous population. The analysis specifically examined combinations of gender with socioeconomic position and geographic location, as well as other dimensions where documentary evidence was available. Particular attention was given to situations in which overlapping disadvantages could shape access to health services, such as the experiences of women living in geographically remote areas while also experiencing socioeconomic disadvantage.

The analysis distinguished between multidimensional disparities and intersectional mechanisms. A multidimensional disparity refers to separate differences associated with more than one social dimension, whereas an intersectional interpretation requires evidence that overlapping social positions jointly shape the nature, severity, or consequences of a health-service barrier. This distinction follows intersectionality scholarship in population health, which emphasizes that health inequalities cannot always be understood by examining social categories in isolation, as their interactions can produce distinct patterns of disadvantage and influence institutional processes (10).

Where documentary evidence did not permit an assessment of such interaction, the finding was reported as a multidimensional disparity rather than as definitive evidence of intersectionality.

For the purposes of this study, intersectional analysis was considered present only when documentary evidence indicated that two or more social positions jointly shaped access to, utilisation of, or responsiveness of health services. The analysis, therefore, did not treat socioeconomic disadvantage, geographic remoteness, or gender as independent explanatory variables by default. Instead, attention was given to configurations in which these positions interacted to produce compounded or qualitatively different barriers. For example, evidence concerning women who were simultaneously socioeconomically disadvantaged and geographically remote was examined for indications that the combination of limited financial resources, distance from health facilities, restricted availability of health workers, and gender-related constraints affected their ability to obtain reproductive or maternal health services. When the documents demonstrated only separate socioeconomic or geographic disparities without evidence of interaction, these findings were classified as multidimensional disparities rather than intersectional effects. This distinction was applied consistently across the two country cases.

Health-Promotion Lens

Because the study is situated within health-promotion research, community participation and empowerment were analysed as potential mechanisms linking policy implementation to equity. The Ottawa Charter defines health promotion as a process of enabling people to increase control over and improve their health and identifies strengthening community action, developing personal skills, creating supportive environments, building healthy public policy, and reorienting health services as key areas for action. Accordingly, community engagement was not treated merely as an implementation activity but was examined in relation to participation, empowerment, service responsiveness, and communities' capacity to influence health-related decisions.

However, the presence of community-engagement initiatives was not interpreted as evidence of improved population-level health outcomes unless such an association was directly supported by the available evidence. This distinction allowed the study to assess the health-promotion relevance of policy mechanisms while avoiding unsupported causal attribution.

Analytical Comparison Matrix

The analytical comparison matrix was structured around seven domains: (1) policy architecture and legal explicitness; (2) institutional implementation capacity; (3) frontline health-worker implementation; (4) community participation and health-promotion mechanisms; (5) intersectional barriers and equity; (6) health-system and population-level indicators; and (7) contextual and rival explanations. For each domain, evidence from the two countries was assessed for policy provisions, implementation mechanisms, documented barriers, and observed equity patterns. This structure enabled the analysis to move from policy content to implementation processes and distributional implications without assuming a direct causal relationship between policy design and population-level outcomes.

The analytical domains were informed by the study's theoretical framework. Policy architecture and implementation capacity were examined primarily through Sabatier and Mazmanian's framework; frontline implementation through the street-level bureaucracy perspective; intersectional barriers through intersectionality theory; and community participation through the health-promotion principles of the Ottawa Charter (18).

Interpretive Scope

Because the study uses two national cases and documentary evidence, Mill's Method of Difference is used as a comparative heuristic rather than as a formal causal identification strategy. The analysis is therefore intended to generate theoretically informed explanations of policy and implementation differences while recognising that cross-country differences cannot be attributed to policy architecture alone. This interpretive boundary was maintained throughout the analysis and discussion. The approach is consistent with implementation research that conceptualizes policy outcomes as the product of interactions among policy characteristics, implementing structures, resources, and broader political and social conditions (16).

Ethical Approval

This study was based exclusively on publicly accessible national policy documents, official government reports, and publicly available secondary health indicators. No human participants were recruited, interviewed, observed, or directly involved in generating the study data, and no non-public individual-level data were used. The study, therefore, involved documentary and secondary data analysis rather than primary research involving human subjects. All documentary and secondary sources used in the analysis are identified in the manuscript to support transparency and source traceability.

RESULTS

Policy Strategy

Indonesia has incorporated gender mainstreaming principles into the 2020-2024 National Medium-Term Development Plan (RPJMN) and several other sectoral policies (1,19). This step demonstrates the government's formal commitment to incorporating gender equality issues into the national development agenda. However, implementing these policies still faces significant challenges, primarily due to uneven implementation across regions. Differences in institutional capacity, limited resources, and variations in cultural sensitivities often lead to inconsistent policy implementation.

Indonesia's policy architecture was classified as predominantly mainstreamed rather than wholly implicit. Gender-related objectives are incorporated into broader national development and health-planning instruments, while implementation responsibilities and accountability are distributed across existing institutions. The documentary evidence indicates that this configuration provides a formal basis for gender mainstreaming but does not concentrate gender-related health entitlements, implementation duties, and accountability within a single dedicated rights-based health mandate. The implication is not that Indonesia lacks explicit gender-related laws or programmes, but that the overall policy architecture relies more heavily on mainstreaming across existing planning and institutional arrangements. The comparative classification should therefore be understood as a difference in the configuration and concentration of policy instruments rather than as a binary distinction between the presence and absence of gender-related regulation.

In contrast, the Philippines has a more explicit and structured legal framework. Through the Magna Carta of Women and the Responsible Parenthood and Reproductive Health Act, the country explicitly guarantees women's rights to reproductive health services, including access to modern contraception (11,12,20). These regulations not only provide a strong legal basis but also affirm the state's commitment to ensuring that reproductive health services are widely available and accessible to all women, regardless of social status or geographic location.

The strengths of the Philippines' explicit approach lie in several aspects. First, specific regulations create a binding legal mandate for all levels of government to allocate resources and implement gender-based health programmes. Second, a clear legal framework facilitates advocacy and accountability, enabling civil society and women's groups to demand the fulfilment of their health rights. Third, explicit regulations strengthen the position of gender issues within national policy priorities, preventing them from being easily marginalised by other development agendas. The explicit legal framework provides documented mandates for reproductive-health provision, institutional responsibilities, and accountability. These provisions may facilitate implementation by clarifying institutional roles and entitlements, although the comparative design does not permit estimation of the independent effect of legal explicitness on health outcomes.

Program and Service Implementation

The National Health Insurance (JKN) and Family Hope Program (PKH) in Indonesia have reached millions of women, particularly those living in poor and remote areas (21). The existence of these two programmes demonstrates the country's commitment to expanding access to health services and social protection. However, their effectiveness remains limited because they are not fully responsive to specific gender-based needs. For example, reproductive and maternal health services

are often not optimally integrated into the JKN scheme, while PKH mentoring mechanisms do not always address the gender equality dimension in practice.

Structural barriers to JKN implementation include limited health facilities in remote areas, uneven distribution of health workers, and low-quality reproductive health services. Furthermore, a weak referral system often prevents women with pregnancy complications or severe reproductive health conditions from receiving timely follow-up care. PKH, while successful in increasing utilisation of maternal and child health services, has not fully addressed cultural and social barriers that limit women's autonomy in health decision-making.

In contrast, the Philippines has a more explicit implementation framework for reproductive health. Republic Act No. 10354 assigns the Department of Health and local governments responsibilities for reproductive-health capacity building, while its implementing rules require gender-sensitive handling of clients and training for relevant health professionals and community health workers (12,22). These provisions create a formal basis for strengthening gender-responsive service delivery, although the documentary evidence reviewed here does not establish uniform implementation across all facilities or professional curricula.

The Philippine reproductive-health framework also establishes implementation, coordination, and reporting responsibilities across the Department of Health, local governments, and other implementing bodies (12,20,22). These arrangements can support continuity and accountability, but the present documentary comparison does not establish that referral or information systems operate uniformly across all localities.

Community-based initiatives, such as the Social Innovation in Health Initiative (SIHI), further strengthen the effectiveness of services in the Philippines (23,24). These programmes not only improve access but also foster community ownership of health care services. By involving local communities, selected SIHI initiatives illustrate a service model designed to be responsive to gender needs and to address socio-cultural challenges that often hinder the use of health services. These programme-level examples suggest that a bottom-up approach involving active community participation may strengthen the sustainability and scalability of gender-based health programmes, although the available documentary evidence does not permit generalisation of this claim to the Philippine health system as a whole.

Impact on Access and Quality

The Philippines has demonstrated improvement in several reported women's health indicators during the study period. These temporal changes coincide with the implementation and institutionalization of reproductive health policies, including the Responsible Parenthood and Reproductive Health Act, as well as broader investments in health service delivery and implementation capacity. However, the present qualitative design does not permit these changes to be attributed causally to any single policy instrument. The documentary evidence instead identifies several mechanisms that may have contributed to improved access, including clearer legal mandates, institutional responsibilities, health-worker capacity building, referral arrangements, and community-level initiatives. These mechanisms operated within a broader health-system and political context, and their relative contribution to observed population-level changes cannot be estimated from the present study.

Descriptive evidence indicates temporal changes in maternal mortality, contraceptive use, and service coverage in the Philippines during and around the study period. For the harmonized cross-country comparison, the 2023 MMEIG estimate of the maternal mortality ratio was 83.8 per 100,000 live births (80% UI: 64.0–119.3), while the 2023 modelled modern contraceptive prevalence rate among currently married women aged 15–49 was 42.8%. These indicators are interpreted as contextual evidence of the health environment in which reproductive-health policies were implemented, rather than as direct evidence of the causal effect of the Responsible Parenthood and Reproductive Health Act. The documentary evidence instead identifies clearer legal mandates, institutional responsibilities, health-worker capacity building, referral arrangements, and community-level initiatives as plausible implementation mechanisms.

In Indonesia, the available evidence indicates that barriers to reproductive and maternal health access are not distributed uniformly among women. Geographic remoteness and socioeconomic disadvantage can overlap, creating compounded constraints for women who simultaneously have limited financial resources and live far from adequately equipped health facilities (25). In such settings, economic constraints may limit access to care, while geographic distance, limited availability of health workers, and weak referral pathways further reduce the feasibility of obtaining timely and appropriate services. Gender-related constraints, including limited autonomy in health decision-making and insufficient gender-responsive communication, may further shape how these structural barriers are experienced. The evidence, therefore, suggests an intersection between socioeconomic position, geographic location, and gender-related power relations for some groups of women, rather than a single, uniform “women” category. However, because the documentary corpus does not provide systematically comparable intersectional estimates across both countries, these findings are interpreted as evidence of intersectional mechanisms in specific contexts rather than as population-level estimates of intersectional inequality.

The Indonesian Long Form 2020 Population Census reported an MMR estimate of 189 per 100,000 live births. Because this estimate refers to the 2020 census period, rather than a 2023 observation, it was not used for the harmonized 2023 cross-country comparison presented in Table 1, which instead reports the 2023 MMEIG estimate of 140.5 per 100,000 live births.

The comparison suggests that the success of gender-based health policies is associated not only with the existence of regulations but also with the health system's capacity to translate policies into inclusive practices. The Philippines provides documented examples in which explicit regulations, health-worker training, and community engagement serve as complementary implementation mechanisms. Their contribution to population-level health outcomes, however, cannot be isolated from broader health-system, political, and socioeconomic conditions within the present study design. Meanwhile,

Indonesia may benefit from strengthened implementation so that formulated policies are more likely to improve the quality of life for women, especially those in vulnerable groups (Table 1).

Table 1. Comparison of strategic gender and health aspects: Indonesia and the Philippines

Domain	Indonesia	Philippines	Reference year / period	Definition / basis of comparison	Source
Gender policy architecture	Predominantly mainstreamed through national development planning and gender-mainstreaming regulations; gender objectives are integrated across sectoral policies rather than concentrated in a single reproductive-health statute.	Predominantly explicit rights-based architecture, including dedicated legislation addressing women's rights and reproductive health.	Policy instruments in force during study period	Classification based on legal mandates, institutional responsibilities, implementation requirements, and accountability mechanisms defined in the study.	Presidential Instruction No. 9/2000; RPJMN 2020–2024; Republic Act No. 9710; Republic Act No. 10354
Gender-disaggregated and equity-oriented data	Gender and geographic disaggregation are incorporated in national health and development monitoring, but the availability and use of disaggregated evidence vary across indicators and settings.	Gender- and geographically disaggregated evidence is incorporated in national demographic and health monitoring, including rural–urban and socioeconomic analyses.	2022–2024 / latest available	Evidence assessed from national monitoring and survey systems; not interpreted as a direct measure of policy effectiveness.	ASEAN Gender Outlook 2024; Indonesia/Philippines national health and demographic data
Gender-responsive health-worker capacity building	Gender mainstreaming training is institutionalised through Ministry of Health training programmes, although implementation is not necessarily uniform across regions and programmes.	RA 10354 explicitly provides for capacity building of barangay health workers and other community volunteers for reproductive-health promotion.	2021–2025 / policy period	Presence of formal training/capacity-building provisions rather than percentage of workers trained.	Ministry of Health Indonesia; Republic Act No. 10354
Reproductive-health service access	Access remains geographically and socioeconomically differentiated, particularly in remote and underserved areas.	Legal framework explicitly requires accessible, affordable and quality reproductive-health services, including provisions for poor and marginalised populations.	Study period	Qualitative policy/access evidence; country-level service availability should not be interpreted as uniform national coverage.	ASEAN Gender Outlook 2024; RA 10354; RA 9710
Community participation and empowerment	Community participation is present through primary-health-care and community programmes, but its integration into gender-responsive policy implementation varies by programme and locality.	Community participation is explicitly recognised in reproductive-health policy, with roles for NGOs, women's organisations, civil society, faith-based organisations and communities; programme-level social innovations provide additional examples.	Study period	Programme/policy evidence of participation, consultation, mobilisation or community decision-making.	RA 10354; SIHI programme literature
Maternal mortality ratio (MMR)	140.5 per 100,000 live births (80% UI: 93.4–235.1) (26)	83.8 per 100,000 live births (80% UI: 64.0–119.3) (26)	2023	Number of maternal deaths per 100,000 live births. Values are internationally comparable modelled estimates, not national administrative estimates.	WHO/UNICEF/UNFPA/World Bank/UNDESA MMEIG, 2025
Modern contraceptive prevalence rate (mCPR)	59.9% among currently married women aged 15–49 (27)	42.8% among currently married women aged 15–49 (28)	2023	Modelled modern contraceptive prevalence among currently married women aged 15–49 using the FP2030 Family Planning Estimation Tool (FPET).	FP2030/Track20, 2023 Measurement Report

Domain	Indonesia	Philippines	Reference year / period	Definition / basis of comparison	Source
Births attended by skilled health personnel	97% (latest WHO-reported value)	89.6% (2022)	Latest available; years differ	Proportion of births attended by skilled health personnel; definition follows SDG indicator 3.1.2.	WHO Global Health Observatory / WHO Data
Gender/equity context	Substantial geographic and socioeconomic inequalities remain, including barriers affecting women in remote and poorer settings.	Inequalities also persist, including geographic and socioeconomic barriers, despite improvements in selected service indicators.	Latest available evidence	Contextual evidence used to interpret implementation and equity mechanisms, not as a causal outcome of policy architecture.	ASEAN Gender Outlook 2024; national DHS/health sources

DISCUSSION

The comparison indicates that differences in gender-responsive health policy implementation are associated with the configuration of regulatory clarity, institutional capacity, frontline implementation, and community involvement. From a policy implementation theory perspective, this finding aligns with Sabatier and Mazmanian's framework, which emphasizes that policy effectiveness is determined not only by the quality of formulation, but also by three key factors: clarity of objectives and legal mandates, resource capacity (financial, human, and institutional), and political and social support (6).

Indonesia has great potential by integrating mainstream gender principles into national development planning documents (1). However, this potential has not been fully realized due to structural and cultural barriers. Strong patriarchal norms, limited gender-disaggregated data, and unsystematic training of health workers are key inhibiting factors. These conditions often result in formulated policies failing to address the specific needs of women, particularly those living in remote areas and from economically disadvantaged groups.

From the perspective of Lipsky's "street-level bureaucracy" theory, health workers, as frontline implementers, play a crucial role in translating policies into gender-responsive practices (8). In Indonesia, low gender sensitivity of health workers and minimal structured training have led to a gap between policy intentions and the reality of services on the ground. In contrast, the Philippines has shown that investment in ongoing training and capacity building of health workers can significantly improve the quality and responsiveness of services (22).

The success or failure of gender-based health policies cannot be separated from the social, cultural, political, and economic context in which they are implemented. In the Philippines, implementation has involved government institutions, civil-society actors, and international partners, while governance studies document continuing political and multisectoral contestation around reproductive-health policy (14,20,29). These contextual conditions shape how formal legal mandates are translated into practice.

In contrast, the Philippines exhibits more explicit and targeted policy practices. The Magna Carta of Women and the Responsible Parenthood and Reproductive Health Act provide a statutory basis for reproductive-health rights and implementation responsibilities (11,12,20). Their implementation is supported by formal capacity-building and gender-sensitive service requirements (12,22). At the programme level, selected Social Innovation in Health Initiative (SIHI) cases illustrate how community participation can support local ownership and service adaptation; these examples are illustrative rather than nationally representative (29,30).

In Indonesia, contextual factors that hinder policy effectiveness include: first, persistent patriarchal norms in society, which limit women's autonomy in health decision-making and create stigma against reproductive health services (30); second, decentralization, which has not been accompanied by strengthening regional capacity, has led to significant disparities in policy implementation between regions; and third, limited funding and political priorities that frequently shift with leadership changes.

However, the Philippines also faces challenges, particularly related to limited funding and resistance from conservative groups who reject some reproductive health policies. This demonstrates that, despite clear regulations and a relatively responsive health system, social and political factors continue to influence policy success. Resistance from conservative religious groups to comprehensive contraception and sexual education programmes demonstrates that the implementation of gender-based health policies is never free from political and ideological contestation.

Implementing gender-based health policies involves multiple stakeholders with diverse interests, capacities, and roles. In the Philippines, implementation involves government agencies, local governments, civil-society organisations, and communities. The Philippine Commission on Women has a formal role in advancing gender mainstreaming across government, while implementation of reproductive-health policy also requires multisectoral coordination (11,14,20).

Community-based approaches, such as SIHI, demonstrate the importance of engaging local communities as agents of change, rather than simply as passive recipients of services (23,24). This model enhances programme ownership and sustainability, enabling services to be adapted to meet specific local needs and contexts. The involvement of community health workers and local health cadres has proven effective in overcoming cultural barriers and increasing public trust in reproductive health services.

In Indonesia, coordination between stakeholders remains weak, with fragmented responsibilities across various ministries and agencies, and ineffective coordination mechanisms. The involvement of civil society and women's organisations in policy formulation and monitoring remains limited, which reduces the accountability and responsiveness of policies to women's

needs. Furthermore, the dominant top-down approach to health programme implementation often ignores local knowledge and community participation, reducing programme effectiveness and sustainability.

Structural barriers in Indonesia encompass several interrelated dimensions. First, a decentralized system that has not been accompanied by strengthening regional capacity has led to significant disparities in the implementation of gender-based health policies. Local governments have autonomy in health planning and budgeting, but many lack the technical capacity and political commitment to prioritise gender equality. As a result, budget allocations for reproductive and maternal health programmes vary widely across regions, with poor and remote areas often allocated minimal resources. Second, limited health infrastructure and uneven distribution of health workers create significant geographic barriers. In remote areas, health facilities often lack adequate equipment, medicines, and trained health workers to provide quality reproductive health services. Weak referral systems exacerbate this situation, preventing women with pregnancy complications or severe reproductive health conditions from receiving timely follow-up care. Third, a gender-disaggregated health data system hinders evidence-based policy planning and evaluation. Without accurate and disaggregated data, policymakers cannot identify specific disparities, target interventions effectively, or measure the impact of programmes on gender equality. The Philippines demonstrates that investing in an integrated, gender-disaggregated health information system is a prerequisite for responsive, accountable policies (16,22).

Cultural barriers in Indonesia include patriarchal norms that limit women's autonomy in health decision-making, social stigma against reproductive health services, and low reproductive health literacy. In many communities, decisions about women's health—including contraceptive use, prenatal care, and place of delivery—are still dominated by husbands or other male family members. The stigma against women accessing reproductive health services, especially contraception, creates a significant psychosocial barrier (30). Furthermore, low gender sensitivity among health workers reflects the internalization of patriarchal norms within the health system itself. Health workers who are not trained in gender-responsive communication often provide judgmental services, disrespect patients' privacy and autonomy, or even reinforce harmful gender stereotypes. This situation reduces women's trust in the health system and hinders service utilisation.

The Philippine experience offers several lessons relevant to Indonesia. First, explicit legislation can strengthen legal mandates and accountability for reproductive-health rights (11,12,20). Second, formal requirements for gender-sensitive handling and capacity building provide a basis for strengthening health-worker responsiveness (22). Third, selected SIHI cases illustrate how community participation and locally adapted implementation can support ownership and service responsiveness (30), (29).

Documented SIHI cases suggest that community ownership and local adaptation may strengthen the relevance and continuity of community-based programmes, although these examples should not be generalised to the national health system (30), (29). Fourth, gender-disaggregated monitoring and formal reporting arrangements can support equity-oriented planning and accountability (11,20,22). Institutional continuity is also supported by statutory and local gender-mainstreaming mechanisms, although legislation alone does not guarantee programme sustainability (28).

The scalability of gender-responsive health programmes depends on implementation guidance, training, monitoring, and adaptation mechanisms rather than on legal mandates alone (20,22). SIHI cases illustrate how locally developed social innovations can be documented, adapted, and studied across settings; however, the available evidence does not establish that SIHI operates as a fully national programme (29,30). In Indonesia, sustainability and scalability remain context-dependent and require integration with routine governance, financing, implementation capacity, and learning systems.

To enhance sustainability and scalability, Indonesia should: first, integrate gender-based health programmes into the mainstream health system with consistent budget allocations from both national and regional sources; second, establish learning and knowledge management mechanisms to support the replication of best practices; third, build regional capacity to adapt and implement programmes tailored to local contexts; and fourth, implement monitoring and evaluation systems that identify factors contributing to programme success or failure. Comparative analysis of the two countries demonstrates that gender-based health policy should not be regarded solely as a regulatory outcome, but rather as an ongoing process requiring institutional support, adequate human resources, and broad social acceptance. Indonesia may draw lessons from the Philippines by reinforcing explicit regulations, developing a comprehensive gender-disaggregated data system, and fostering greater community participation in the planning and implementation of health programmes. These measures can enhance the effectiveness of gender-based health policies in Indonesia, improving both access to and quality of services, and accelerating progress toward SDGs 3 and 5.

SDG 3 (good health and well-being) and SDG 5 (gender equality) are closely interconnected and require an integrated approach (10). Gender equality and health outcomes are conceptually and empirically interconnected, but the present study does not estimate the causal contribution of gender-responsive policy implementation to changes in population-level health indicators. The comparison instead identifies implementation and equity mechanisms that may shape women's experiences of health services, particularly where socioeconomic disadvantage, geographic remoteness, and gender-related power relations overlap. The findings indicate that Indonesia should prioritise gender equality as a central component of the national health agenda, rather than treating it as a marginal cross-reform to establish an explicit legal mandate for women's reproductive health rights, provision of adequate and sustainable budget allocations for gender-based health programmes, enhancement of institutional and human resource capacity across all levels of the health system, and development of data and monitoring systems capable of tracking progress toward sustainable development goal (SDG) targets disaggregated by gender, geographic location, and socioeconomic status.

This study presents several limitations that affect the interpretation and transferability of its findings. First, the analysis relies on two national cases, which does not permit statistical generalisation to other Southeast Asian countries. The findings should

be regarded as analytically informed comparisons that may inform hypothesis generation and policy-learning propositions. Second, the use of national-level policy and health indicators introduces the risk of ecological inference, as population-level patterns may not accurately reflect the experiences of all women or specific intersectional groups. Third, Indonesia and the Philippines differ in health-system financing, decentralization, political institutions, demographic conditions, civil society mobilization, service coverage, and other contextual factors that cannot be fully controlled in a two-case qualitative design. These differences constrain the extent to which observed contrasts can be attributed solely to policy architecture.

Fourth, health indicators may differ in their definitions, reference periods, estimation procedures, and data-production systems across countries. The analysis, therefore, prioritised comparable indicators and treated differences with caution where methodological comparability could not be established. Fifth, the documentary corpus may be affected by selective availability and differences in the accessibility and quality of official policy and implementation documents. Sixth, some claims concerning implementation practices relied on secondary literature because comparable primary implementation documentation was not consistently available for both countries. Finally, the study cannot estimate the causal effect of specific policies on population-level health outcomes. Temporal changes in maternal mortality, contraceptive use, or service coverage are therefore interpreted descriptively and in relation to plausible implementation mechanisms rather than as evidence of attributable policy effects. These limitations require the policy implications to be interpreted as context-sensitive policy-learning propositions rather than direct prescriptions for policy replication.

Not all Philippine policy instruments are directly transferable to Indonesia. Accountability mechanisms, gender-responsive training, and gender-disaggregated monitoring represent relatively transferable implementation functions, whereas the Philippine rights-based legislative architecture and specific institutional arrangements are more context-dependent. In Indonesia, these elements would need to be adapted to the decentralized distribution of authority, variation in subnational capacity, existing health-system governance, and sociocultural conditions.

CONCLUSION

This comparative analysis indicates that Indonesia and the Philippines have developed distinct configurations of gender-responsive health policy architecture and implementation. The Philippines exhibits a more explicit rights-based legal framework, with clearly defined institutional responsibilities and documented implementation mechanisms, including health-worker capacity building, monitoring, and community-level initiatives. In contrast, Indonesia emphasizes gender mainstreaming within broader development and health-planning instruments, distributing implementation responsibilities across existing institutions. These differences in policy configuration are associated with varying patterns of implementation capacity and health-service equity. However, the study does not establish that regulatory explicitness alone accounts for differences in population-level health outcomes.

The analysis further indicates that policy implementation is influenced by the interaction of institutional and contextual factors, such as financing, decentralization, health worker capacity, service availability, political and civil society support, and sociocultural dynamics. From a health-promotion perspective, community participation and empowerment may serve as an important mechanism for enhancing the responsiveness of policy implementation to the needs of socially disadvantaged groups. Nevertheless, the evidence regarding these mechanisms is not uniformly comparable between the two countries, and programme-level examples, such as community innovations, should not be generalized to the national health system without careful consideration.

For Indonesia, the comparison suggests that policy learning is more appropriate than direct policy replication. Elements that may be transferable include clearer accountability arrangements, systematic gender-responsive training, enhanced gender-disaggregated monitoring, and mechanisms for meaningful community participation. However, implementing these elements would require adaptation to Indonesia's decentralized governance structure, regional variations in institutional capacity, financing arrangements, and sociocultural conditions. The principal contribution of this study is to demonstrate that the effectiveness of gender-responsive health policy should be understood as a configuration of policy design, implementation capacity, contextual conditions, and equity-oriented participation, rather than as a simple consequence of regulatory explicitness.

DECLARATIONS

Author contributions: All authors contributed to the research design, data collection, analysis, and manuscript preparation. The first author led the conceptualization, analysis, and drafting of the manuscript. The second author was responsible for methodology, supervision, and validation. The third author developed the theoretical framework, conducted the literature review, and validated findings. The fourth author refined the discussion. All authors approved the final manuscript.

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