

Gender and Health

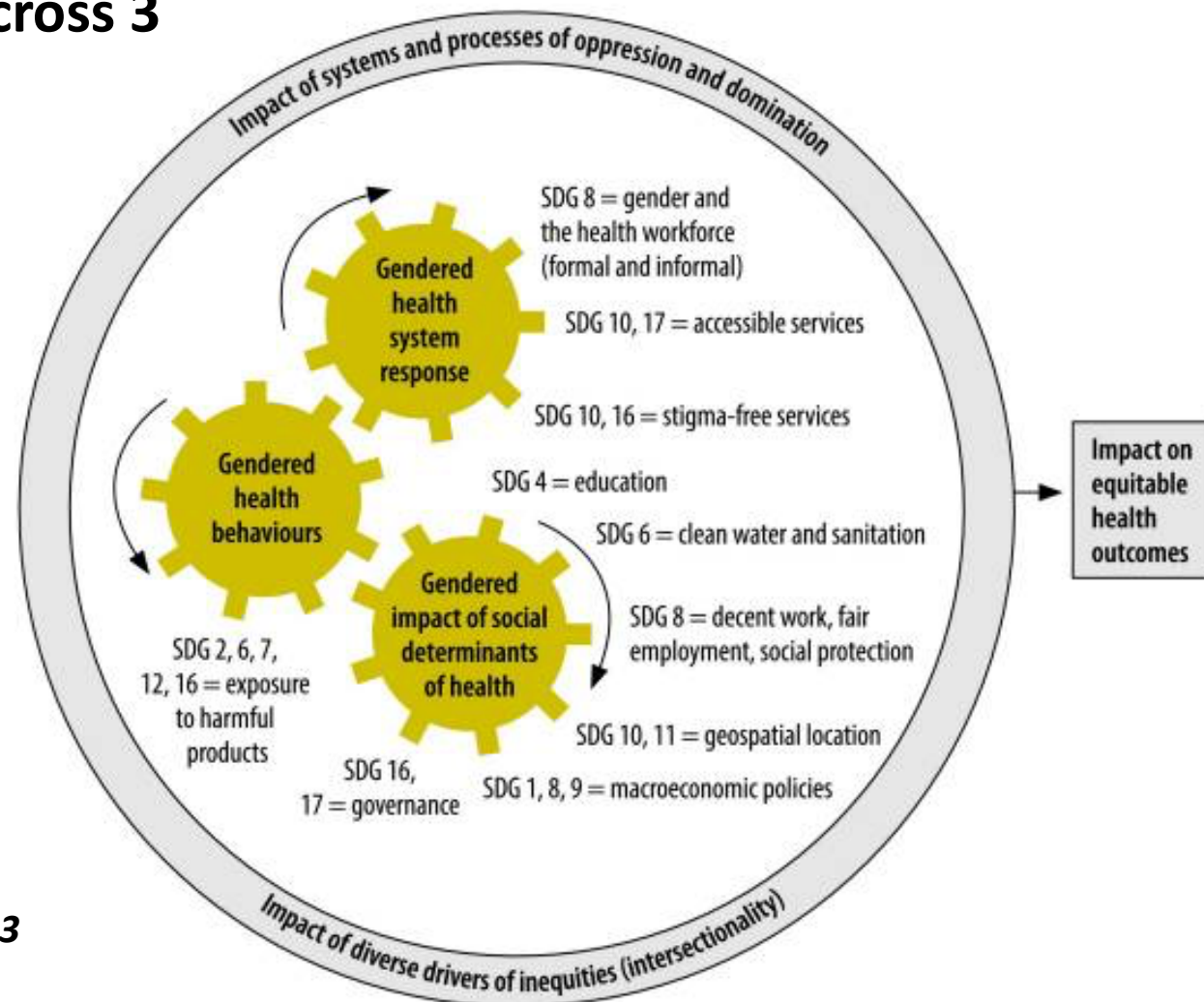
**Tasnim Azim
Naripokkho**

**Action for Equitable Health Systems – Advancing Universal
Comprehensive Primary Health care in Pandemic Times
PHM and IPHU
9 December 2022**

Beyond SDGs 3 and 5, gender equality is a cross-cutting feature of *“Transforming our world: the 2030 agenda for sustainable development”*

Gender influences health and well-being across 3 domains

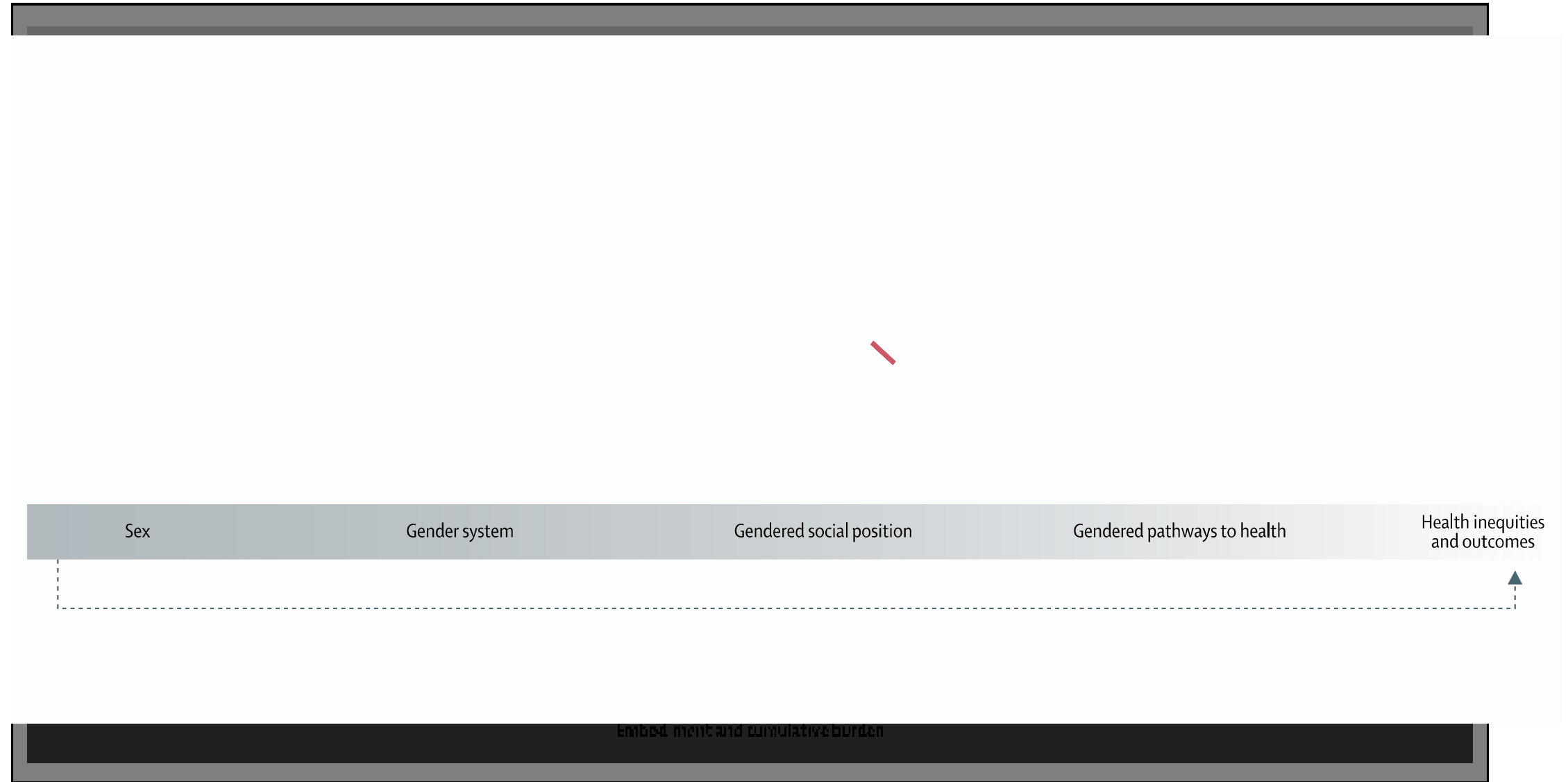
- (i) through its interaction with the social, economic and commercial determinants of health;
- (ii) via health behaviours that are protective of, or detrimental to, health outcomes;
- (iii) in terms of how the health system responds to gender, including how it affects the financing of and access to quality health care

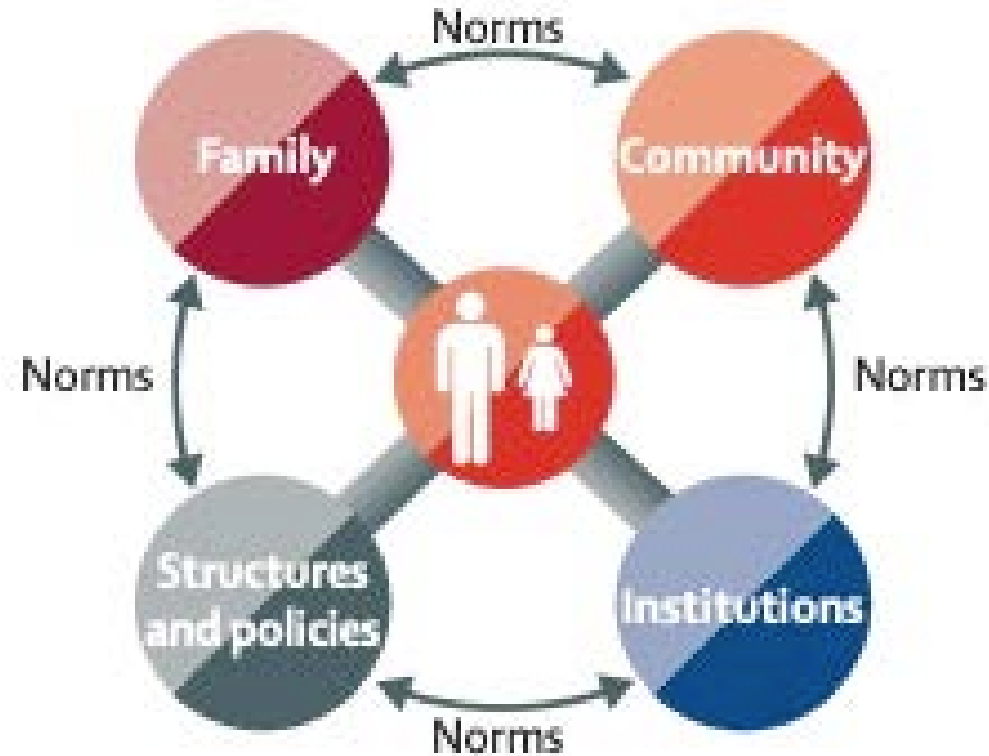


Source: Manandhar et al Bull World Health Organ 2018;96:644–653

Pathways through which gender impacts health¹

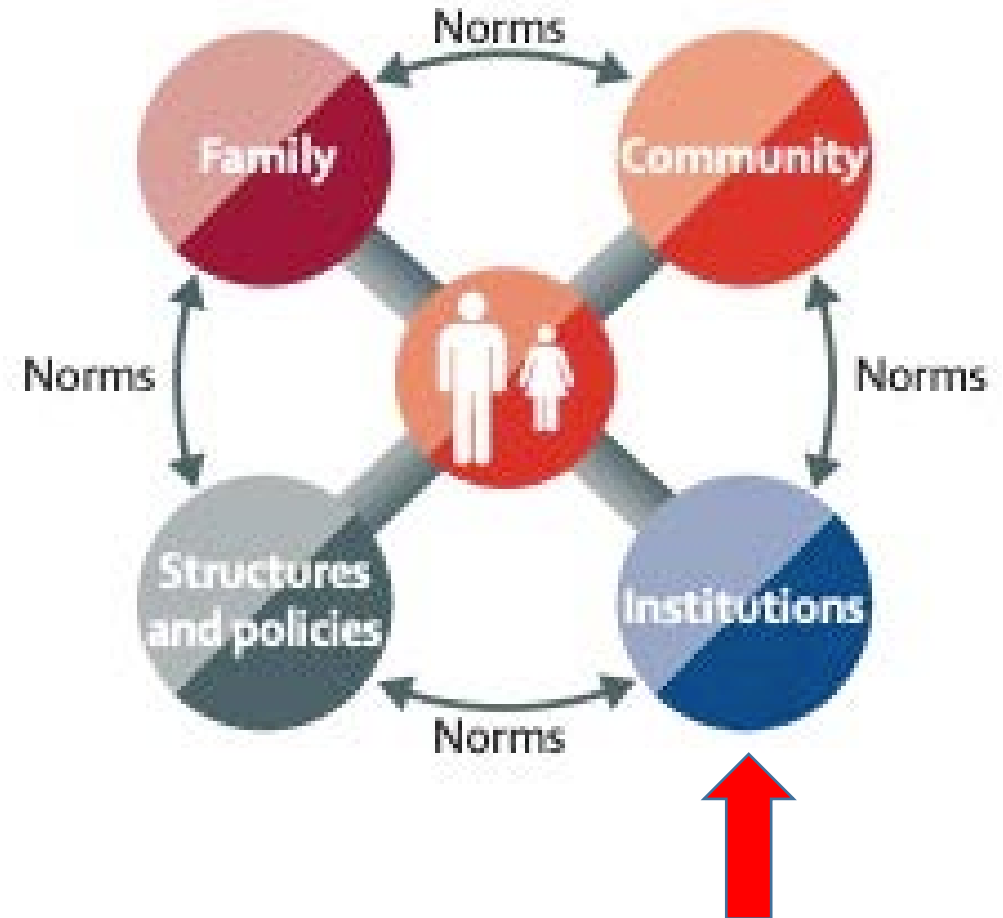
¹. Heise L et al. Gender inequality and restrictive gender norms: framing the challenges to health. *Lancet* 2019; 393: 2440–54





- 1. Differences in Exposure**
- 2. Health behaviours**
- 3. Access to health services**
- 4. Gender biased health systems**
- 5. Gender biased health research, institutions & policies**

How gender-responsive are the world's most influential global health organisations?



2021 Global Health 50/50 report



Reviews gender-related policies and practices of global organisations that are operational in more than 3 countries promoting health and/or influencing global health policy.

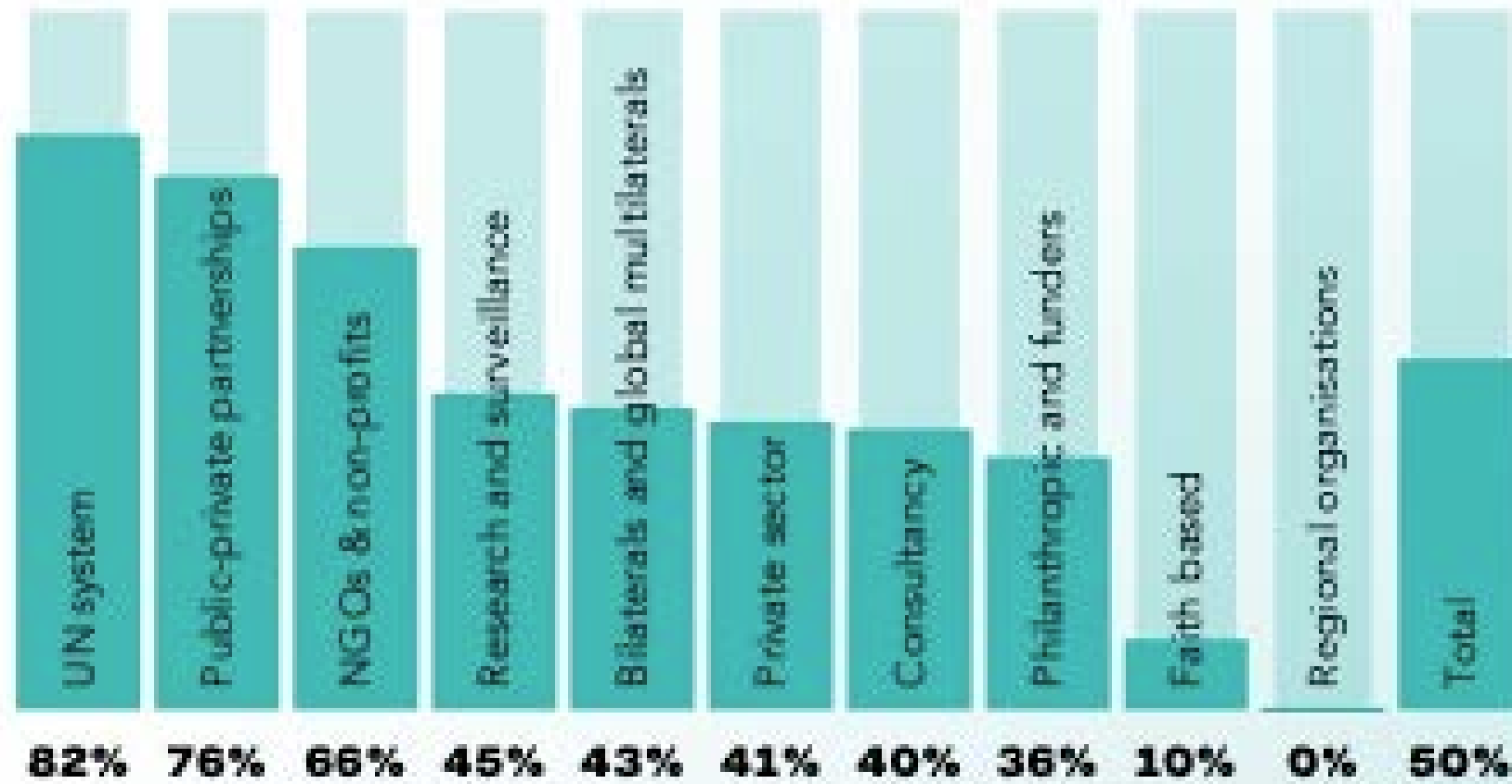
Assessment on 14 variables across four dimensions.

Gender-blind

Ignores gender norms, roles and relations and very often reinforces gender-based discrimination. By ignoring differences in opportunities and resource allocation for women and men, such policies are often assumed to be “fair” as they claim to treat everyone the same.

201 global organisations

% organisations that validated data published in the 2021 report



VARIABLES IN THE 2021 REPORT

COMMITMENTS TO REDISTRIBUTE POWER

1. Stated commitment to gender equality
2. Definition of gender

EQUITABLE OUTCOMES IN POWER AND PAY

1. Gender parity in senior management and governing bodies
2. Gender and geography of global health leadership
3. Gender pay gap

TACKLING POWER AND PRIVILEGE IMBALANCES IN THE WORKPLACE

1. Workplace gender equality policies
2. Workplace diversity and inclusion policies
3. Anti-sexual harassment policies
4. Parental leave and support to new parents
5. Flexible working arrangements



COVID-19: HOW IS THE SECTOR RESPONDING IN THE WORKPLACE?

TAKING A GENDER-RESPONSIVE APPROACH TO IMPROVING HEALTH

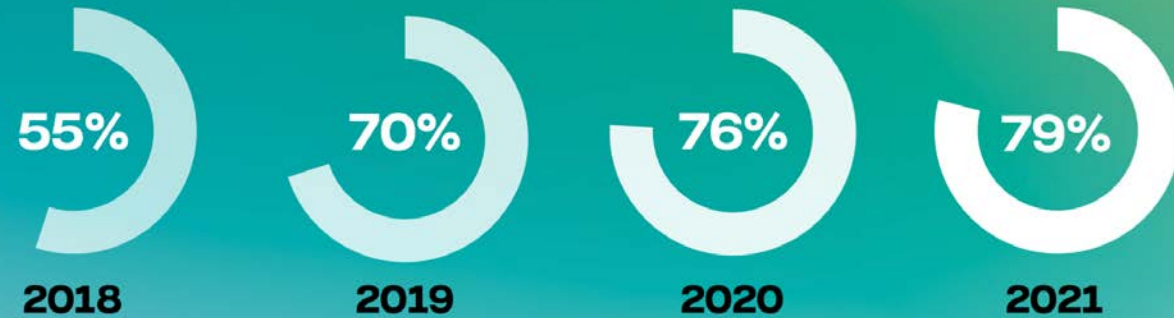
1. Gender-responsiveness of global health programmes
2. Sex-disaggregated monitoring and evaluation data



COVID-19: EXAMINING THE GENDER-RESPONSIVENESS OF ORGANIZATIONS' COVID-19 ACTIVITIES

COMMITMENT IS RISING:

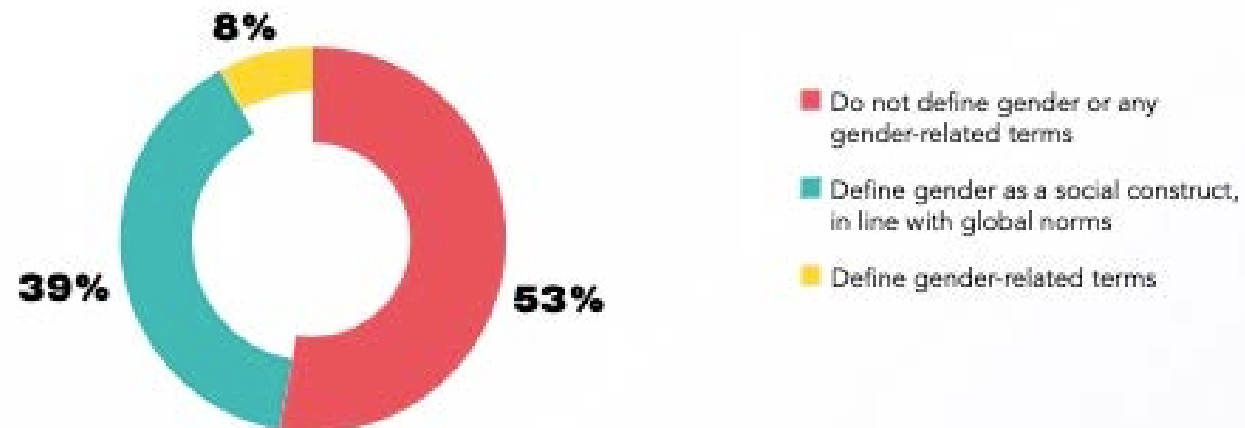
8 IN 10 ORGANISATIONS STATE A COMMITMENT TO GENDER EQUALITY



GH5050 2021 REPORT: FLYING BLIND IN A TIME OF CRISIS

GLOBAL HEALTH 5050
TOWARDS GENDER EQUALITY IN GLOBAL HEALTH

Figure 16. Defining gender in line with global norms



WORKPLACE POLICIES TO TACKLE IMBALANCES IN POWER AND PRIVILEGE: ARE ORGANISATIONS DOING ENOUGH?

61%

**HAVE WORKPLACE
GENDER EQUALITY
POLICIES AVAILABLE**

51%

**HAVE DIVERSITY AND
INCLUSION POLICIES
AVAILABLE**

44%

**ARE TRANSPARENT
ABOUT THEIR ANTI-
SEXUAL HARASSMENT
POLICIES**

20%

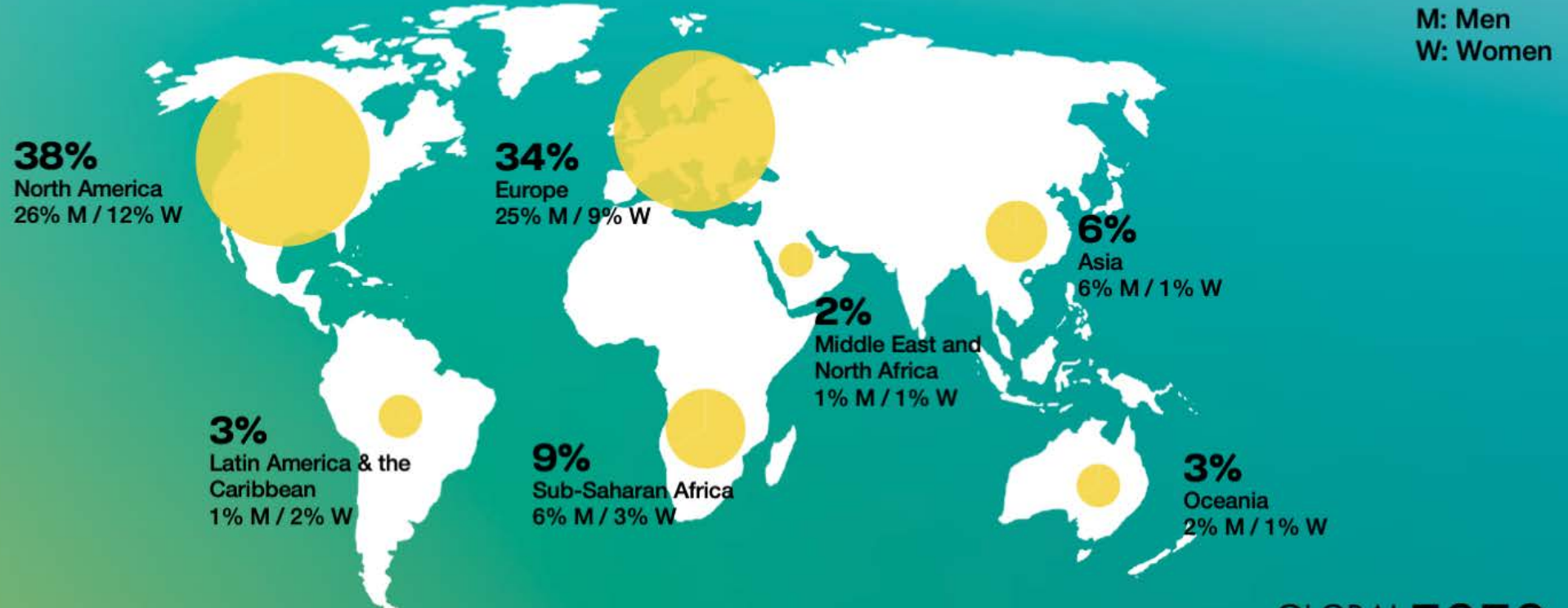
**HAVE BOARD
DIVERSITY POLICIES
AVAILABLE**

Men continued to hold 70% of leadership positions and nationals of high-income countries held 84%

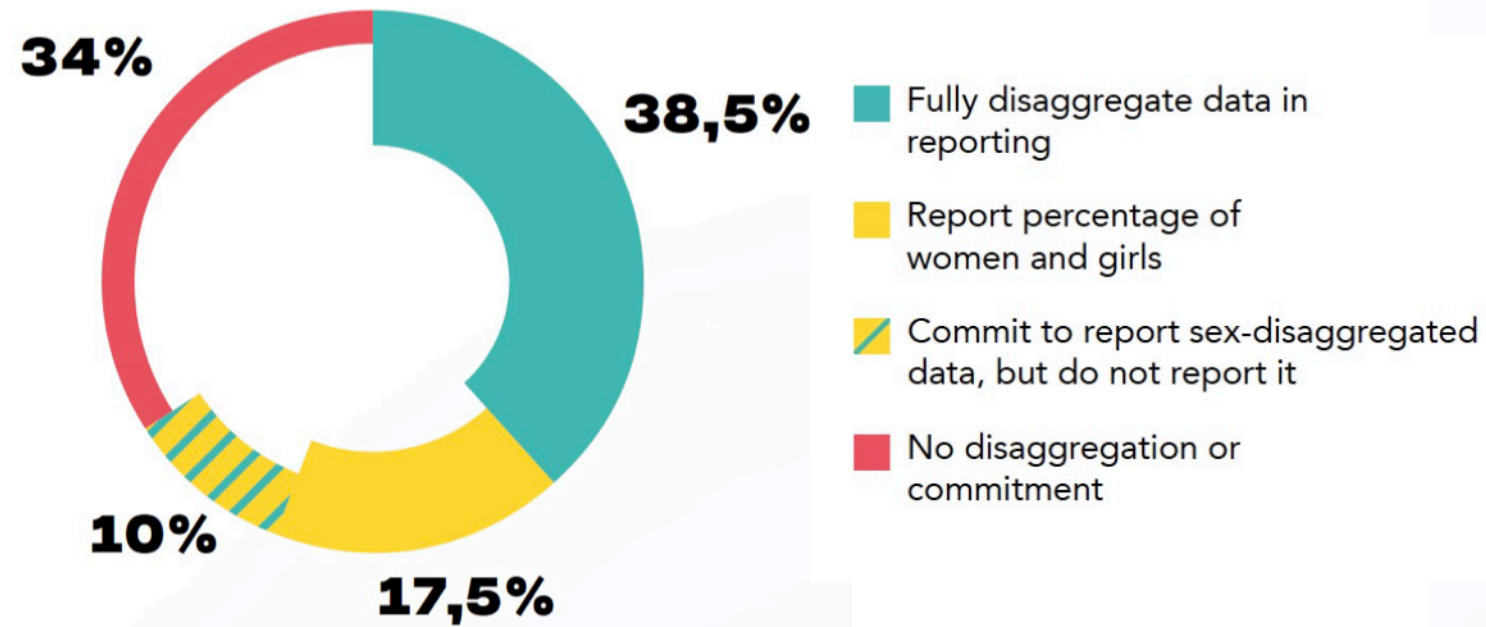
GENDER AND GEOGRAPHY OF LEADERSHIP:

70% MEN & 72% NATIONALS OF NORTH AMERICA AND EUROPE

% CEOS AND BOARD CHAIRS, BY NATIONALITY



39% OF ORGANISATIONS PUBLISH SEX-DISAGGREGATED PROGRAMMATIC DATA

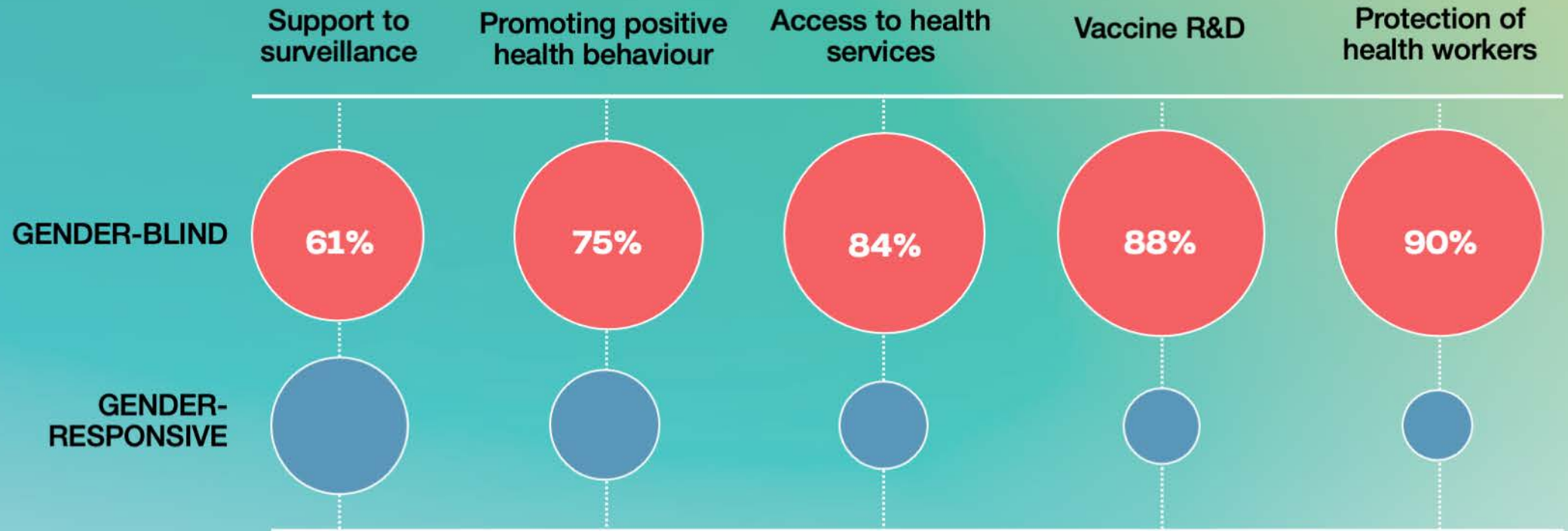


**NO PROGRESS ON THIS VARIABLE
SINCE 2018**

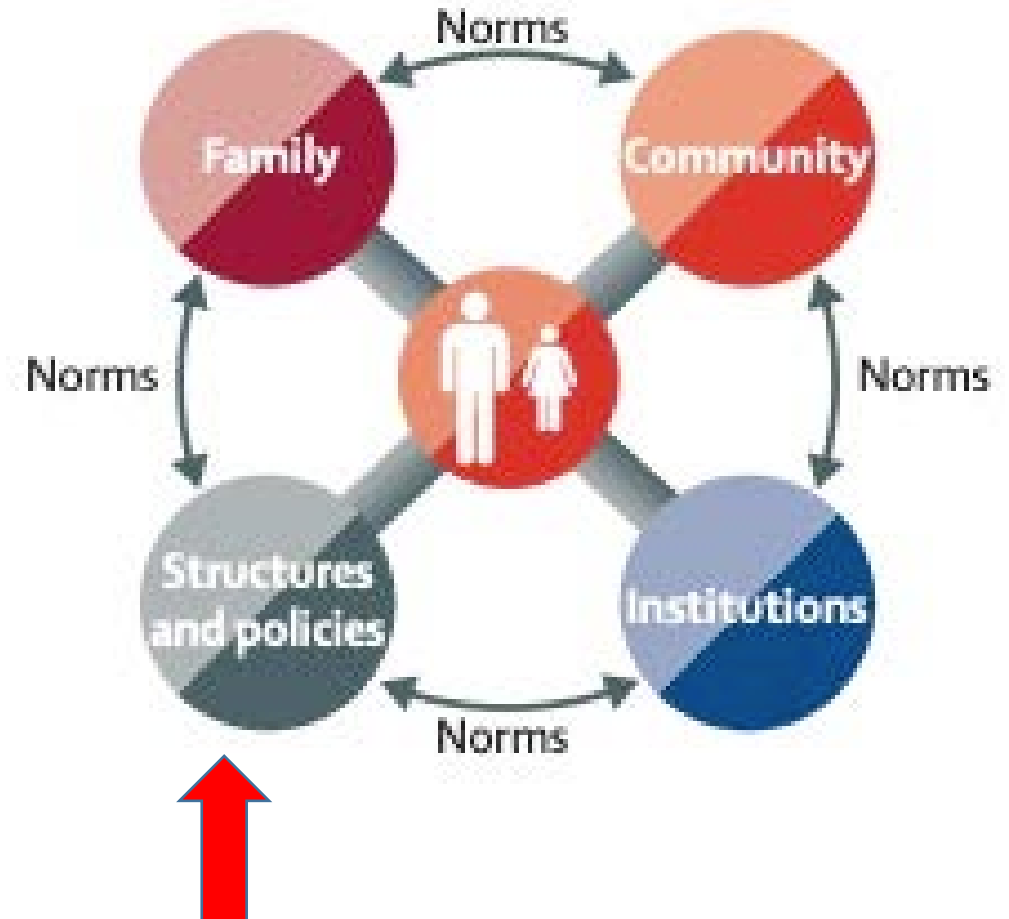
COVID-19 responses

GENDER & COVID-19:

OVER 80% OF ORGANISATIONS' COVID-19 HEALTH ACTIVITIES APPEAR TO BE GENDER-BLIND



LAWS AND POLICIES



ROLE OF LAWS AND POLICIES

Tuition-free primary education laws and policies:

- Treatment countries: Armenia, Cambodia, Dominican Republic, Egypt, Ghana, Lesotho, Malawi, Mali, Nepal, Senegal, Tanzania, Uganda, Zambia
- Control countries: Benin, Colombia, Haiti, Indonesia, Kenya, Namibia, Nigeria, Philippines, Rwanda, Zimbabwe

Paid maternity and parental leave laws and policies:

- Treatment countries: Bangladesh, Colombia, Lesotho, Malawi, Uganda, Zambia, Zimbabwe
- Control countries: Benin, Egypt, Ethiopia, Ghana, Haiti, Indonesia, Jordan, Mali, Nepal, Nigeria, Peru, Philippines, Rwanda, Senegal, Tanzania

Health indicators for women:

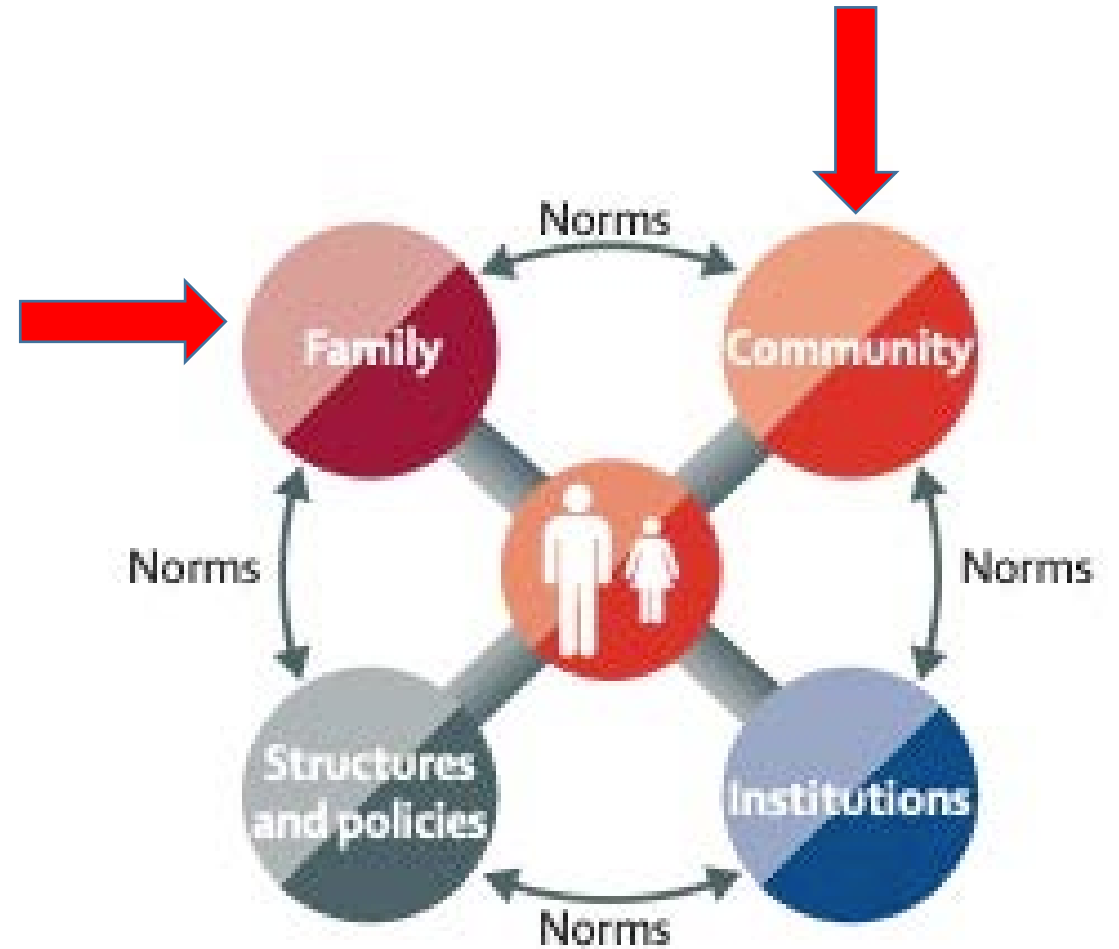
- (1) women's met need for family planning
- (2) women's use of modern contraceptives

Health indicators for children:

- (1) a skilled health provider's attendance at the delivery of the last child, born within 12 months before the survey
- (2) children's full, age-appropriate immunisation status

	Model 1: met need for family planning	Model 2: modern contraceptive use	Model 3: skilled attendant at birth	Model 4: up-to-date child immunisation	Model 5: proxy for gender norms
Tuition-free primary education					
Sample size	414 689	287 622	115 648	111 690	598 598
OR (95% CI)	1.58 (1.42–1.75)	1.62 (1.30–2.01)	1.22 (1.02–1.47)	1.16 (0.99–1.34)	1.46 (1.34–1.58)
p value	<0.0001	<0.0001	0.032	0.059	<0.0001
10-week increase of paid maternity and parental leave					
Sample size	472 328	338 118	150 163	145 110	683 389
OR (95% CI)	1.34 (1.23–1.46)	2.10 (1.82–2.42)	1.42 (1.22–1.65)	1.69 (1.49–1.93)	1.45 (1.35–1.56)
p value	<0.0001	<0.0001	<0.0001	<0.0001	<0.0001
All models are weighted and adjusted for area of residence, women’s marital status and age, partners’ age, survey year fixed effects, and country fixed effects. Models also control for topic-specific factors including partners’ education, household assets, public health expenditure, women’s birth month and year fixed effects, children’s year of birth fixed effects, per capita growth of gross domestic product, and child’s age, gender, and birth order when relevant (appendix). OR=odds ratio.					
Table 1: Effects of laws and policies in two areas on selected health outcomes and proxy for gender norms					

Community and family Gender roles



Women are the primary water collectors worldwide

- **While water fetching, women have increased risks of infection from faecally transmitted diseases, such as ascariasis, trichuriasis, diarrhoea, and trachoma.**
- **Chronic or persistent infection, in addition to the physical effort of carrying water, causes fatigue**
- **Navigation of uneven terrain with substantial water loads can cause injury, especially if women are pregnant, carrying babies, or have recently given birth.**
- **Water fetching, bathing, and defecation in the open expose women and girls to sexual harassment.**

CARE GIVING ROLE: Mental Health

- **Women meet more of the 'costs of caring' than men by spending more time helping and providing care to others in their social networks**
- **In 2017 in the USA, ~2/3 of the caregivers for people with dementia were women.**
- **Caregivers of patients with dementia tend to experience higher levels of stress and mental problems than other types of caregivers, with at least a third experiencing symptoms of depression.**
- **In sub-Saharan Africa, women and girls are responsible for two-thirds of HIV-related care and experience heavy physical and mental health burdens, social isolation, and stigma.**

WOMEN WORKING OUTSIDE THE HOME AND INTIMATE PARTNER VIOLENCE: EVIDENCE FROM NIGERIA

Communities were classified on the basis of female labour-force participation as

- high (assumed absence of restrictive norms)**
- low (assumed presence of norms sanctioning working outside the home)**

Women who worked in communities where female employment was uncommon had significantly higher odds of experiencing intimate partner violence in the year before the survey compared with non-working women [OR=2.38, 95% CI 1.29–4.39, p=0.006].

However, in communities where female employment was common, women's risk of intimate partner violence did not differ by working status

Depression: “Self in relation”, “silencing the self”

- **The level of psychological investment in relationships is pivotal in determining women’s sense of self and self regard or esteem**
- **Women with low self esteem who seek reassurance from partners but receive rejection and devaluation are particularly likely to experience emotional distress and depression**
- **The degree of importance women place on their personal relationships with husbands and partners tends to cause them to make efforts to avoid conflict and suppress anger in order to preserve these relationships. The result, is a form of self censorship described as ‘silencing the self’. This self silencing, causes depression.**
- **Feelings of inferiority, low self esteem, shame and being of low rank have commonly been found amongst depressed people. Submissive, dependent and non assertive behaviour is stereotypically feminine behaviour which is still considered desirable in many countries, has also been documented in relation to depression.**

FEMALE APPEARANCE AND BODY DISSATISFACTION

- **Female appearance is strongly emphasised socially.**
- **Body dissatisfaction is often associated with low self- esteem, especially in girls.**
- **Toxic beauty products - skin-lightening creams that contain mercury, vaginal douches containing phthalates, and talcum powder.**
- **Eating disorders - in adolescent girls in Nicaragua rose dramatically at a time of the introduction of television, with self-induced vomiting to control weight rising from 0% in 1995 to 11.3% in 1998.**

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- 5. Gender biased health research,
institutions & policies**

AIR POLLUTION AND STILL BIRTHS

39.7% of stillbirths in low- and middle-income countries (n=137 countries)

Source: Xue et al *Nature Communications* (2022)13:6950

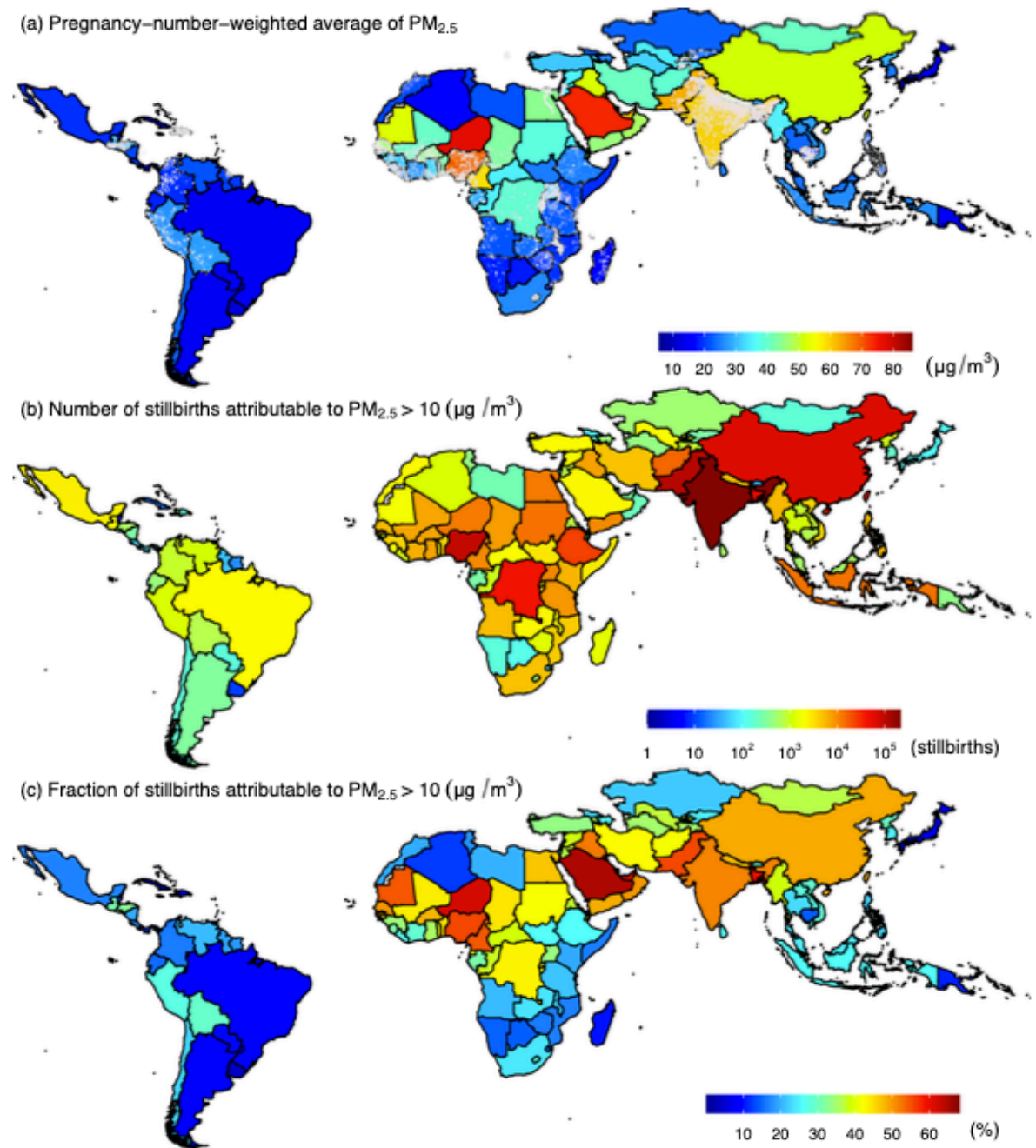


Fig. 1 | Maps of stillbirths attributable to PM_{2.5} exposure in the 137 countries. PM_{2.5} exposure (a), number (b), and fraction (c) of stillbirths attributable to exposure in 2015 in the 137 countries. Gray dots in panel (a) are the surveyed

locations for the samples from 54 low- and middle-income countries used to derive the exposure-response curves.

HOUSEHOLD AIR POLLUTION

- **Around 2.4 billion people worldwide (around a third of the global population) cook using open fires or inefficient stoves fuelled by kerosene, biomass (wood, animal dung and crop waste) and coal, which generates harmful household air pollution.**
- **Women and children, typically responsible for household chores such as cooking collecting firewood, bear the greatest health burden from the use of polluting fuels and technologies in homes.**
- **Household air pollution increases the risk of**
 - **stroke,**
 - **heart disease,**
 - **chronic obstructive pulmonary disease,**
 - **lung cancer**

The Lancet women and cardiovascular disease Commission: reducing the global burden by 2030. Vogel et al 2021

- In 2019, there were an estimated 275.2 million cases of cardiovascular disease in women worldwide.
- Cardiovascular disease is the leading cause of death in women worldwide and was responsible for 35% of total deaths in women in 2019
- Since 1990, most regions have had a decline in the age-standardised prevalence, representing an overall decrease of 4.3%
- But some countries showed an increase in cardiovascular disease prevalence including
 - China (7.5%, 95% UI 6.2% to 8.8%),
 - Indonesia (4.8%, 95% UI 3.6 to 6.0%),
 - India (2.4%, 95% UI 1.6% to 3.2%).
- Large gaps in the knowledge of and care for women with cardiovascular disease persist. These gaps in clinical data are accompanied by insufficient epidemiological data, particularly for women in low-income and middle-income countries.

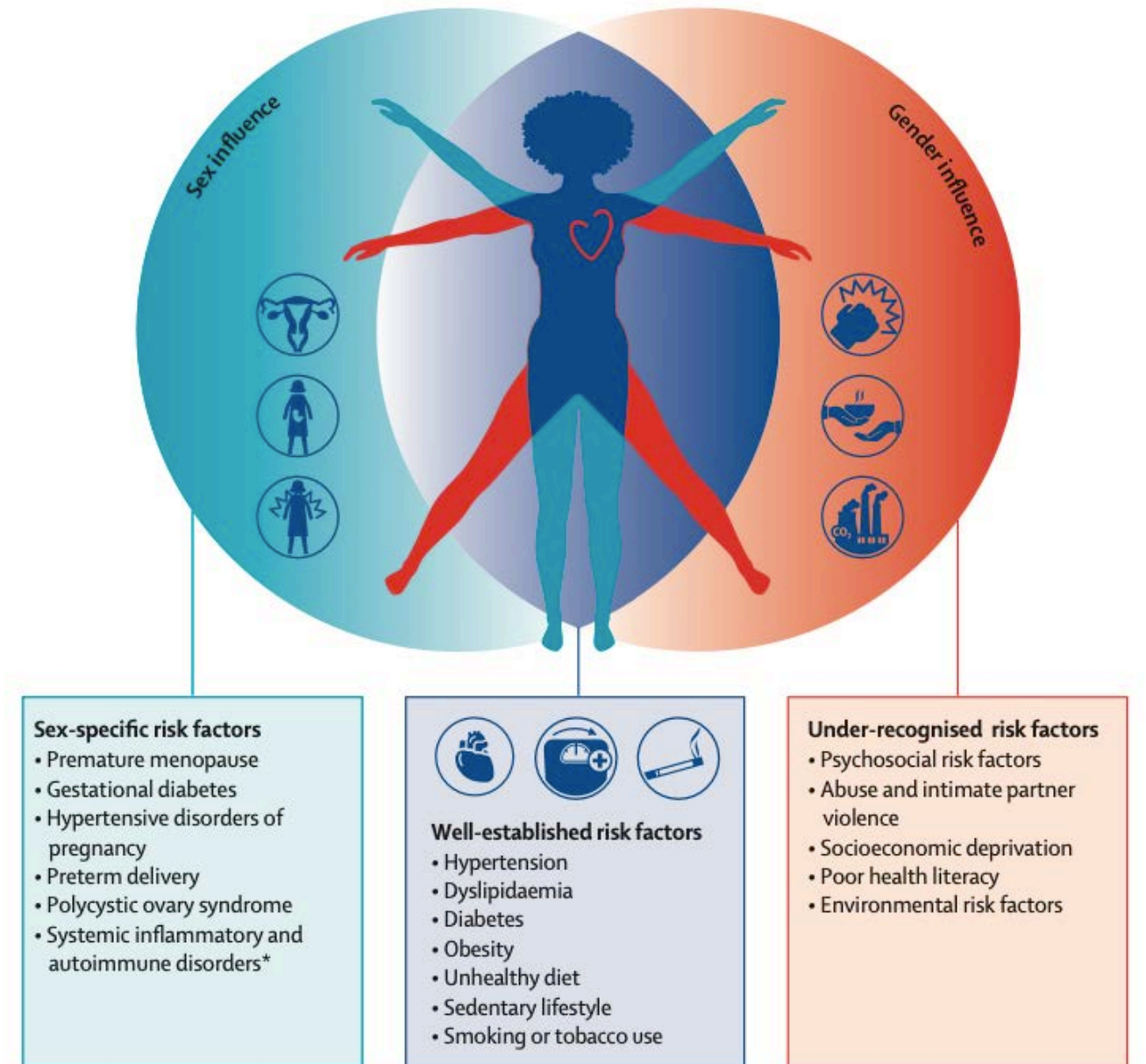
Three categories of risk factors for cardiovascular disease in women

1. Well-established and affecting both sexes but which might affect women differently to men (eg, hypertension, dyslipidaemia, and diabetes)

2. Sex-specific (eg, premature menopause and pregnancy-related disorders); and those that are under-recognised (eg, intimate partner violence or poverty)

3. Related to gender and interaction with a woman's social and physical environment.

***Systemic inflammatory and autoimmune disorders are not sex-specific risk factors, but women are disproportionately affected by these conditions.**



Data: Sex related reporting in medical research

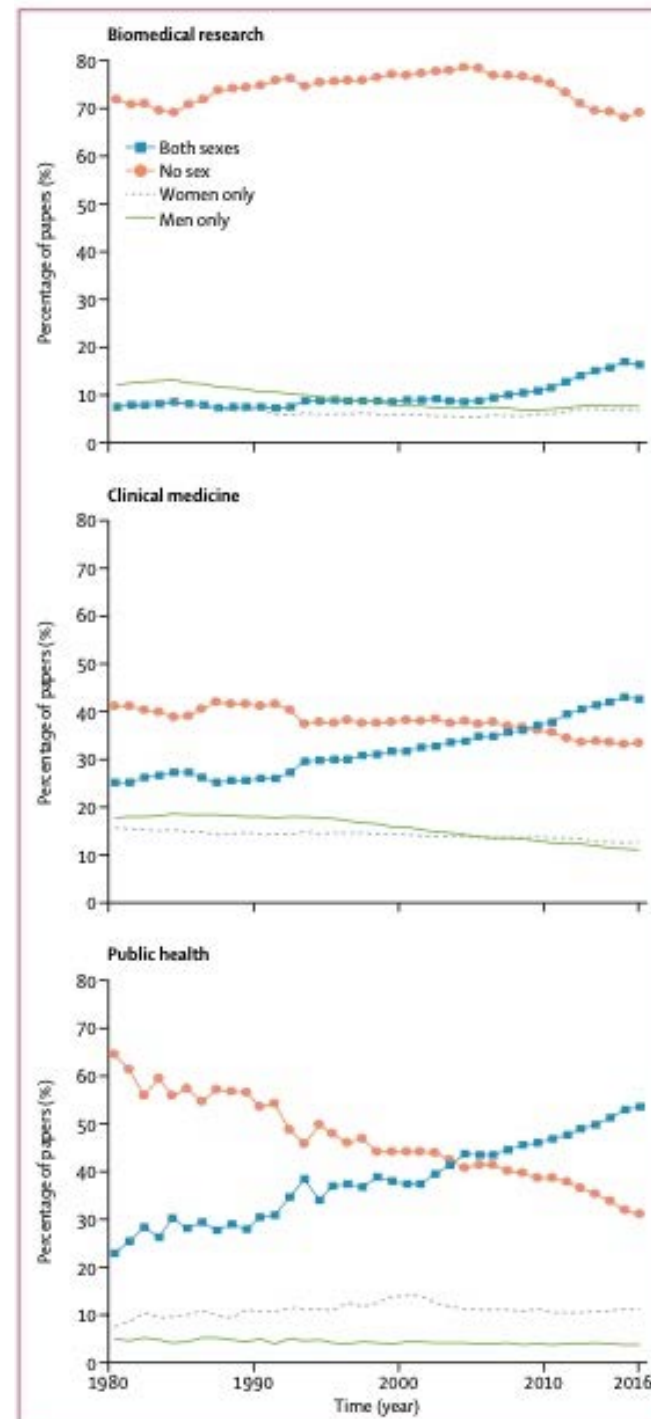
In 2016, types of studies reporting both female and male populations:

Biomedical (laboratory) research – 30%

Clinical medicine studies - 43%

Public health studies - 54%

Source: Sugimoto et al Lancet 2019; 393: 550–59



Quantifying the effects of the COVID-19 pandemic on gender equality on health, social, and economic indicators: a comprehensive review of data; *Flor et al Lancet 2022*

Between March, 2020, and September, 2021

- women were more likely to report employment loss (26·0%) than men (20·4%)
- women were more likely to report forgoing work to care for others (ratio of women to men: 2·4)
- Women and girls were 1·21 times (1·20–1·21) more likely than men and boys to report dropping out of school for reasons other than school closures
- Women were 1·23 (1·22–1·23) times more likely than men to report that gender-based violence had increased during the pandemic.

Interpretation The most significant gender gaps identified show intensified levels of pre-existing widespread inequalities between women and men during the COVID-19 pandemic.

CONCLUSIONS

- **Gender inequality remains one of the most pervasive inequalities in health and one of the most insidious.**
- **We need to re-think the interconnection between women, gender, and global health.**
- **Women are disadvantaged structurally, being over-represented in informal care roles and under- represented in leadership, decision making, and senior research roles.**
- **Global health policy and programmes are often blind to the differences between women's needs and men's needs (gender equity), and to women's unequal position in society (gender equality), rendering women “conspicuously invisible”**
- **Addressing gender inequality and restrictive gender norms holds the potential to yield multiple downstream benefits for health and development and is essential for achieving the UN's Sustainable Development Goals**