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Gender and Health Background Document

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1 Introduction and definition

Health is significantly influenced by the biological sex and by gender. Many of the health outcomes and mortality patterns are due in part to the impact of biological sex and differences between males and females in growth, metabolism, throughout the life cycle, etc.[1] Through the use of gender analyses of health data it is apparent that explanations for differences in morbidity and mortality between men and women alone are limited and many of the differences are due to the social phenomenon of gender.[2] Health outcomes also depend upon social and economic factors that, in turn, are influenced by prevailing socio-cultural, economic and political factors. To understand health and illness, both sex and gender must be taken into account, which is not always the case. Globally, the average life expectancy gap between men and women is 4.6 years, with women outliving men in all countries, and a gap of over 10 years in some cases.[3]The global burden of disease disproportionately affects men in terms of disability-adjusted life years,[4] while women are more likely to spend a longer time living with a disability.[5] Women and girls, however, have to contend with health vulnerabilities linked to their reproductive role and some 830 women are estimated to die every day from preventable causes related to pregnancy and childbirth.[6]

Gender refers to the expected and acceptable roles, behaviours, activities, attributes and opportunities that society considers appropriate for boys and girls, and men and women. Underling gender expectations and norms are complex social processes through which people are defined to fit into acceptable social structures and relationships. These boundaries are closely entwined with access to resources and opportunities, decision-making, and ultimately patterns of power, underpinned by complex social processes across all domains of society including between people, as well as at the levels of institutions, government and the state. It is important to keep in mind that although social and religious elements that define and maintain gender inequalities are strong and enduring, they can be modified by social change, education and at different points within individuals' lifetimes. Institutions such as government, academia, the development sector, and religious organisations have the power to initiate change and can be very effective partners for gender-transformative action.

This Background document has been commissioned as an internal instrument to support SDC in incorporating issues relating to the interplay between gender and health in processes of health policy, programming, implementation, design and outcome analysis to ensure that it is responsive to the needs of all people, in all their diversity. One of the key messages is that gender is not just about women and girls, who tend to receive more attention under the banner

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[1] Colchero F, Rau R, Jones OR, Barthold JA, Conde DA, Lenart A, et al. The emergence of longevous populations. Proc Natl Acad Sci USA. 2016 11 29; 113(48):E7681–90. http://dx.doi.org/10.1073/pnas.1612191113 pmid: 27872299

[2] Vlassoff C, Garcia Moreno C. Placing gender at the centre of health programming: challenges and limitations. Soc Sci Med. 2002;54:1713–23

[3] Life expectancy. Global Health Observatory. http://www.who.int/gho/mortality_burden_disease/life_tables/situation_trends_text/en/

[4] GBD Compare. Data visualization hub Seattle: Institute for Health Metrics and Evaluation, University of Washington, 2016. Available from: http://vizhub.healthdata.org/gbd-compare

[5] Gender and blindness. Gender and health information sheet [internet]. Geneva: World Health Organization; 2002. Available from: http://www.who.int/gender-equity-rights/knowledge/a85574/en

[6] UN Women 2018. Infographic: Why gender equality matters to achieving all 17 SDGs. http://www.unwomen.org/en/digital-library/multimedia/2018/7/infographic-why-gender-equality-matters-to-achieving-all-17-sdgs

of gender programming, but that there is a need to redresses the balance by considering also male health issues and aspects of masculinity that not only impact on women, but compound health risks and risk taking and inhibit men from timely health seeking. **This document highlights the pivotal role of gender *dynamics* that determine health inequalities at all levels from the household to international development organisational decision-making and leadership.**

1.1 What is "Gender"?

Is gender in health issues about women's health only? Or have we been missing men? The term "gender" refers to the learned, socially-constructed yet changeable characteristics of women and men, boys and girls, while "sex" refers to purely biological differences. The World Health Organisation (WHO) elaborates this:

"Gender refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities and work places. When individuals or groups do not "fit" established gender norms they often face stigma, discriminatory practices or social exclusion – all of which adversely affect health. It is important to be sensitive to different identities that do not necessarily fit into binary male or female sex categories."[7]

A key issue that is often overlooked as the term "gender" is used and misused in everyday discourse is that it is a socio-cultural construct that shapes the empowerment, autonomy, roles, behaviours, actions, characteristics and opportunities that a society considers to be appropriate or inappropriate for women and men, and boys and girls. Gender also determines the relationships between people and the distribution of power within those relationships, however, these can be changed through gender-responsive and gender-transformative approaches. Gradually, organisations are acknowledging that the exclusion of males from "gender" interventions has not yielded the most effective or efficient results. Recent examples of a growing trend to include male health can be seen in the 2018 report "The health and well-being of men in the WHO European Region: better health through a gender approach"[8] and the 2017 UNAIDS report on addressing the unmet HIV and AIDS needs of males entitled "Blind Spot. UNAIDS (2017). Reaching out to men and boys."[9]

In the past, in attempting to redress the negative balance of gender inequalities experienced by females, the term "gender" was used to imply women and girls and much gender concerned programming was solely about them, rather than the realities of gender dynamics and relations that impact of the health, well-being and the wider development process.

Although, semantically, the term "sex" refers only to biological or genetic sex, the World Health Organisation combines sex and gender when considering different disease patterns and their determinants, therefore, this paper will include biological sex as it relates to health and well-being.

A number of terms have come into use to describe issues relating to gender and ways in which we do or do not approach them. Some of these are commonly misused, therefore to clarify, listed in box 1 are some key terms and definitions that are relevant to health in the

[7] https://www.who.int/gender-equity-rights/understanding/gender-definition/en/

[8] http://www.euro.who.int/en/publications/abstracts/the-health-and-well-being-of-men-in-the-who-european-region-better-health-through-a-gender-approach-2018

[9] http://www.unaids.org/en/resources/campaigns/blind_spot

development context. They have been defined by the 2017 UNICEF Gender Equality: Glossary of Terms and Concepts[10] that provides a more exhaustive list of definitions.

Gender equality is the concept that women and men, girls and boys have equal conditions, treatment and opportunities for realizing their full potential, human rights and dignity, and for contributing to and benefitting from economic, social, cultural and political development. Equality implies that the interests, needs and priorities of both women and men and girls and boys are taken into consideration, without the limitations set by stereotypes and prejudices about gender roles. An example of gender equality is equal access and treatment by health service staff; or equal pay and conditions for both male and female health care workers. Gender equality is a matter of human rights and is considered a precondition for, and indicator of, sustainable people-centred development.

Gender equity refers to the process of being fair to men and women, boys and girls, and importantly the equality of outcomes and results. An approach to achieve gender equity may involve the use of temporary special measures to compensate for historical or systemic bias or discrimination. It refers to differential treatment that is fair and positively addresses a bias or disadvantage that is due to gender roles or norms or differences between the sexes. Equity ensures that women and men and girls and boys have an equal chance, not only at the starting point, but also when reaching the finishing line. It is about the fair and just treatment of both sexes that takes into account the different needs of the men and women, cultural barriers and (past) discrimination or disadvantages.

Gender balance refers a human resource issue calling for equal participation of women and men in all areas of work (international and national staff at all levels, including at senior positions) and in programmes that agencies initiate or support (e.g. food distribution programmes). Achieving a balance in staffing patterns and creating a working environment that is conducive to a diverse workforce improves the overall effectiveness of our policies and programmes, and will enhance agencies' capacity to better serve the entire population.

Gender disparities or gaps are the statistical differences between men and women, boys and girls that reflect inequalities.

Gender bias refers to making decisions based on gender that result in favouring one gender over the other which often results in contexts that are favouring men and/or boys over women and/or girls. For example sons receive preferential treatment with regard to food and medical care over daughters in a number of countries in South Asia.[11] Another evident in the gender bias occurs in the treatment of psychological disorders. According to WHO[12] doctors are more likely to diagnose depression in women compared with men, even though they have similar scores on standardized measures of depression or present with identical symptoms.

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Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between females and males. The nature and extent of specific types of GBV vary across cultures, countries and regions. Examples include sexual violence, including sexual exploitation/abuse and forced prostitution, domestic violence, trafficking, forced/early marriage, harmful traditional practices such as female genital mutilation, honour killings and widow inheritance.

Gender blindness refers to the failure to recognize that the roles and responsibilities of men/boys and women/girls are given to them in specific social, cultural, economic and political contexts and backgrounds. Projects, programmes, policies and attitudes which are gender blind do not take into account these different roles and diverse needs, maintain status quo, and will not help transform the unequal structure of gender relations or the impact they have on global health and development.

[10] UNICEF 2017 Gender Equality: Glossary of Terms and Concepts. UNICEF Regional Office for South Asia November 2017. https://www.unicef.org/rosa/sites/unicef.org.rosa/files/2018-06/Glossary%20of%20Gender%20Terms%20and%20Concepts%20UNICEF%20ROSA%20Nov%202017.pdf

[11] Shah, M. 2005. Son Preference and Its Consequences (A Review). Gender and Behaviour. Vol 3.(1).http://dx.doi.org/10.4314/gab.v3i1.23325

[12] https://www.who.int/mental_health/prevention/genderwomen/en/

Gender neutral refers to elements such as concepts, style of language etc. that is unassociated with either the male or female gender.

Gender-transformative refers to programming and policies that actively transform gender relations to achieve gender equity.

Gender-responsive programming and policies intentionally use gender considerations to shape the design, implementation and results. These reflect the realities and needs of women, men, girls and boys, in elements such as site, project staff selection, approaches, content, monitoring and reporting.

Femininity refers to a set of socially constructed attributes, behaviours, and roles generally associated with girls and women. It refers to socially-defined factors and both males and females can be deemed to exhibit feminine traits.

Masculinity refers to a set of attributes, behaviours, and roles associated with boys and men. As a social construct, it is distinct from the definition of the male biological sex. Standards of manliness or masculinity vary across different cultures and historical periods and both males and females can exhibit masculine traits and behaviour.

Box 1. Terms and definitions defined by the 2017 UNICEF Gender Equality: Glossary of Terms and Concepts[13]

1.2 Does the term "health" mean just "the absence of illness"?

It is also important to consider what is meant by the term "health". The WHO Constitution makes a clear statement of its holistic nature: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" as well as the risk to health posed by inequalities: "Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger."[14] For more than a decade there has been debate on how health might be better defined,[15] [16] and argument continues as to how to better include the multiple and complex biological and non-biological factors - including gender - at play in health, illness, care seeking and outcomes.

This document discusses some of the known consequences of gender inequalities on health and how these are further amplified by other socio-economic disparities.

1.3 Is gender relevant to current health and development agendas?

The Rio Political Declaration on Social Determinants of Health[17] adopted during the World Conference on Social Determinants of Health on 21 October 2011 underscores the importance of gender in public policies as well within social and health services in order to adopt better governance for health and development. Gender norms, roles and relations influence people's susceptibility to different health conditions and diseases and affect their enjoyment of good mental, physical health and wellbeing. They also have a bearing on people's access to and

[13] UNICEF 2017 Gender Equality: Glossary of Terms and Concepts. UNICEF Regional Office for South Asia November 2017. https://www.unicef.org/rosa/sites/unicef.org.rosa/files/2018-06/Glossary%20of%20Gender%20Terms%20and%20Concepts%20UNICEF%20ROSA%20Nov%202017.pdf

[14] Constitution of the WHO (1946). http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1

[15] Jadad AR, O'Grady L: How should health be defined? (2008). "How should health be defined?" BMJ (Clinical Research Ed.). 337: a2900.

[16] Taylor S, Marandi A (2008). "How should health be defined?". BMJ. 337: a290. doi:10.1136/bmj.a290. PMID 18614520.

[17] Rio Political Declaration on Social Determinants of Health Rio de Janeiro, Brazil, 21 October 2011 https://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf

uptake of health services and on the health outcomes they experience throughout the life-course, particularly in low- and middle-income countries (LMICs).

The Sustainable Development Goals (SDGs) highlight the importance of gender and health. Notably, SDG 3 ”Good Health and Well-being” includes six gender-specific indicators, these are: (i) maternal mortality ratio; (ii) births attended by skilled health personnel; (iii) new human immunodeficiency virus (HIV) infections, by sex; (iv) satisfactory family planning with modern methods; (v) adolescent birth rate; and (vi) coverage of essential health services, including reproductive and maternal health. Additionally, SDG 5 “Gender Equality”, itself highlights the importance of injury and ill health associated with gender based violence and includes the elimination of violence against women and girls.

However, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) highlights the importance of seeing the SDG framework through a gender lens. Its examination of the other SDGs revealed them to be a combination of gender-sensitive or gender-sparse.[18] WHO argues that a wider gender perspective is key to improving the understanding of and to inform action on health.[19]

1.4 Is gender considered to be a determinant of health?

Biological sex accounts to a certain extent for the differences in health conditions, breast cancer for example, and health outcomes between women and men. However, socio-cultural issues relating to gender roles and norms enable or hinder women and girls differently to men and boys in terms of access to information, services, resources and decision making (see next chapter). These in turn have created inequalities in health. Therefore, gender is an important determinant for health.

> *“….a strategic shift away from purely a disease focus to a broader conceptualization of health to include its determinants such as income, education or gender is crucial. Such a comprehensive approach to address health issues requires intersectoral collaboration or what is called the “health in all policies” approach.”*
>
> Strategic Framework 2015–2019 SDC Global Programme Health

Although gender as has not been defined by SDC as a determinant of health, the Strategic Framework 2015–2019 SDC Global Programme Health cites social inequalities, including those related to gender as continuing to pose major challenges to health globally and its expresses concern that these are becoming even more pronounced, especially in middle-income countries that today have the highest number of poor people.

It has long been argued that gender interacts with the social, economic and biological determinants and consequences of diseases to create different health outcomes for males and females. According to the 2018 Global Health 50/50 Report[20]gender is among the most significant determinants of health and WHO lists gender to be a health determinant, not least because men and women suffer from different types of diseases at different points in their life course.

Where analyses have disaggregated data, the relationship between sex, gender and health is visible globally in hard statistics, such as the average life expectancy gap of 4.6 years between men and women, with women outliving men in many country contexts. Figure 1 illustrates that

[18] Turning promises into action: gender equality in the 2030 agenda for sustainable development. New York: UN Women; 2018. Available from: http://www.unwomen.org/en/digital-library/sdg-report

[19] Mary Manandhar a, Sarah Hawkes b, Kent Buse c, Elias Nosrati d & Veronica Magar (2018) Gender, health and the 2030 agenda for sustainable development. Bulletin of the World Health Organization 2018;96:644-653. doi: http://dx.doi.org/10.2471/BLT.18.211607

[20] Global Health 50/50: Towards accountability for gender equality in global health. https://globalhealth5050.org/wp-content/uploads/2018/03/GH5050-Report-2018_Final.pdf

in some countries this disparity is as high as 11.6 years, indicating that combined gender and biological issues can have a substantial impact on mortality.

Country	Male	Female	Difference
Russia	64.7	76.3	11.6
Belarus	66.5	78.0	11.5
Lithuania	68.1	79.1	11.0
Rwanda	60.9	71.1	10.2
Syria	59.9	69.9	10.0
Ukraine	66.3	76.1	9.8
Latvia	69.6	79.2	9.6
Vietnam	71.3	80.7	9.4
Estonia	72.7	82.0	9.3
El Salvador	68.8	77.9	9.1

Table 1: Life expectancy gender gap – countries with the greatest disparity[21]

Gender disparities in health are apparent across all regions of the world as shown in figure 1. This illustrates the sex difference in life expectancy at birth between females and males over the last 60 years.

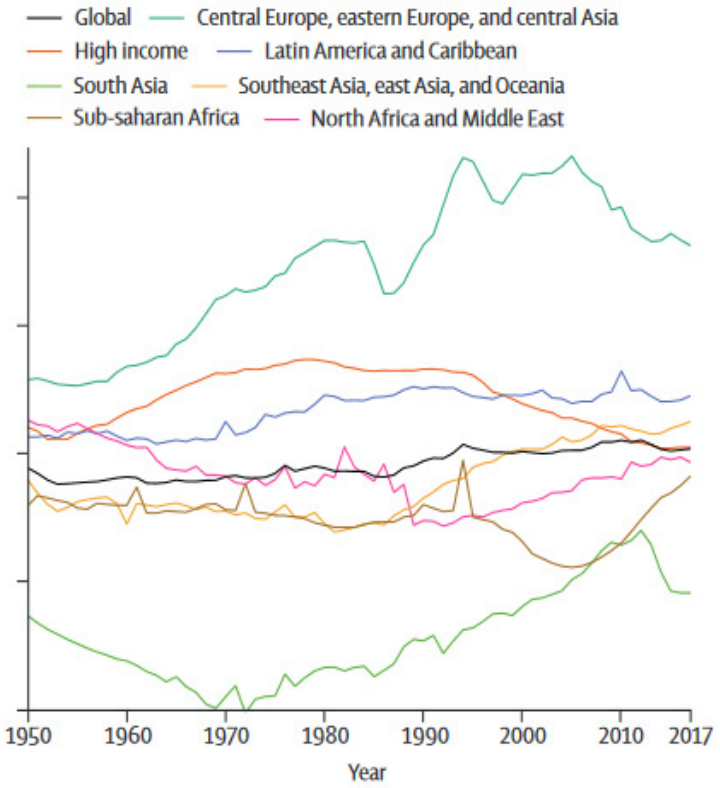

Figure 1: Difference in life expectancy at birth between females and males 1950-2017. Source GBD 2018)[22]

Looking at the Global Burden of Disease[21] (GBD) men are disproportionately affected in terms of disability-adjusted life years, although women are more likely to spend a longer time living with a disability such as blindness than their male counterparts.

Some of the epidemiological differences between disease patterns and gender reflected in the illustrations above may be due in part to differences between male and female hormones, biochemical and metabolic processes. This is indicated in the gender disparity in the health impacts of tobacco smoking, for example, as female smokers tend to develop severe chronic obstructive pulmonary disease at younger ages than men.[22] Biological factors, however, only account for some of the disparities in the health consequences of risk exposure, and gender is considered to influence health and well-being across three domains:

1. Through its interaction with the social, economic and commercial determinants of health;

2. Through health behaviours that are protective of, or detrimental to health outcomes;

3. In the modes by which health systems and services responds to gender, including how it affects the financing of and access to quality health care, including treatment by health care providers.[23]

All of these domains can be addressed through intervention design and programming – not only within health and health systems strengthening initiatives, but across multiple sectors.

2 How does gender influence health?

The interaction between gender and health is complex especially as it intersects with and amplifies other drivers of inequities that compound effects on health and well-being. These include poverty, ethnicity, social and economic status, age, disability, sexual orientation and identity, geographical location, distance to services, lack of control over resources and social exclusion.[11]

Apart from sex-specific causes of ill-health, disability and premature death such as prostate and testicular cancers in men and cervical and ovarian cancers in women, there are clear gendered factors at play, underlying inequities in the rates, treatment and survival of illnesses than are non-sex specific. These often relate to male reluctance to seek medical assistance, linked with concepts of strength and weakness in relation to masculinity in addition to embarrassment concerning intimate issues. Women on the other hand, do not have to contend with care-seeking as a threat to their femininity and develop experience of intimate examination in the course of child-bearing. These influences can be seen in the significant gender differences following curative rectal cancer surgery, with women enjoying overall significantly longer survival.[24] This may relate to better post-surgery self-care in women, who are more likely to voice intimate problems at an early stage with health care professionals. Men on the other hand, are less likely and later to seek additional care for intimate problems and as a result, their health outcomes can be compromised. Conversely, in a large comparative study of gender differences in mitral valve cardiac operations, a condition without the embarrassment issues of rectal cancer, elderly women in the United States of America had higher operative mortality and lower long-term survival. This form of heart repair, in this

[21] http://www.healthdata.org/gbd

[22] The health consequences of smoking: 50 years of progress. A report of the Surgeon General. Atlanta: Centers for Disease Control and Prevention; 2014. Accessible from: https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf

[23] Hawkes S, Buse K. Gender and global health: evidence, policy, and inconvenient truths. Lancet. 2013 May 18;381(9879):1783–7. http://dx.doi.org/10.1016/S0140-6736(13)60253-6

[24] Wichmann et al (2001) Gender differences in long-term survival of patients with colorectal cancer. Br J. Surg 88(8):1092-8.

particular country setting appears to restore normal life expectancy for men, but not for women,[25] reflecting biological issues of recovery, rather than confounding socio-cultural issues of gender.

The causal factors underlying the interplay between gender and health are often subtle, complex and work in concert with multiple social, cultural, psychological, economic, location and ethnic issues. The following are a few examples of key gender issues that have been identified to have impacts on health:

2.1 Gendered spheres of action and education

The extent to which cultural context restricts or excludes girls from school, travel outside the household and participation in wider public life, **affects female knowledge about health issues, illness prevention and where to obtain treatment and care**. It is estimated that today, 63% of illiterate adults are women and that a gender bias persists in access to education, whereby girls are 1.5 times more likely than boys to be denied their right to primary school education.[26] Female education has multiple direct and indirect impacts on health: women with secondary education earn twice as much as those without it, enabling them to better provide for their children; and, better educated women marry later, when they are better able to support pregnancy, child birth and motherhood. They also have fewer unplanned pregnancies, which is associated with child better care, nutrition and health for fewer children.

The common subordination of women in many societies results in a distinction between roles of men and women and their separate assignment to **domestic and public spheres**. This has a negative impact not only on girls and women, but **on their abilities as mothers to optimally care for their children** as there is positive relationship between female school attendance, the empowerment of women in the household and the nutritional status of their children.[27]

SDC's Thematic Guidance Sheet on Gender and Vocational Skills Development[28] highlights some of the gendered issues in access to education as well of ways of addressing these.

2.2 Gendered investment in children

In many poor and disadvantaged communities, investment in a child is determined by the economic return expected in later life and particularly in subsistence societies, **male offspring are crucial to maintaining family land and household food production.** The complex interplay between gendered roles in household economies and the welfare of parents in old age heightens the need for ensured male survival and shapes favourable investment in boys. In some patrilineal communities, for example in rural Nepal, where daughters marry into their husbands' households and sons bring wives (and their labour and children) into the household, the **investment-return** benefit is clearly with sons. Consequently, the poorest households tend to focus their limited resources on investing in boys in terms of the **opportunity and actual costs** of schooling, **health expenditure** and even **food,** as they will support their

[25] Vassileva et al (2913) Gender Differences in Long-Term Survival of Medicare Beneficiaries Undergoing Mitral Valve Operations. nn Thorac Surg 96:1367–73 https://www.annalsthoracicsurgery.org/article/S0003-4975(13)00875-8/pdf

[26] https://womendeliver.org/investment/ensure-equitable-quality-education-levels/

[27] Borooah VK. Gender bias among children in India in their diet and immunization against disease. Soc Sci Med. 2004;59:1719–31

[28] https://www.shareweb.ch/site/Gender/en/Topics/Pages/Gender-and-Skills-Development,-Vocational-Training.aspx

parents' household and farm production into the future.[29] Differential care and nutrition of girls and boys may have **life-long health consequences**, as does the gender gap in access to education. Given the preferential schooling of boys, many girls are unable to access the basic education they need to better care for their own families and children in the future.

2.3 Access to cash and control over financial resources

In many societies gender norms dictate that men handle the **household income**. In rural southern Tajikistan, for example, the low status of daughters-in-law within their patrilineal households means that they have little access to cash, as paid work outside the household is deemed culturally inappropriate. As their husbands have become reliant on migrant labour in Russia in recent years, newly-married women and young mothers have been placed in a position where they have to seek both the **permission and cash support** from their parents-in-law. This proves to be prohibitive for women seeking gynaecological, family planning and other health information or care and at the same time constrains them in seeking timely care for their children.[30] Because of gendered elements surrounding women, they have **no autonomy** or **decision-making power over their own health** or that of their children. This can lead to them **accessing care at a late stage** that is associated with **poor health outcomes**.

SDC's Thematic Guidance Sheet on Mainstreaming Women's Economic Empowerment in Market Systems Development[31] elaborates some of these issues together with programmatic responses.

2.4 Gendered work spheres

While cultural norms of male and female sanctioned spheres of action contain female access to cash, men in certain settings are more likely to be **exposed to infectious disease**, for example malaria transmitted by mosquitoes in certain work environments such as forestry or mining in the tropics.[32] As gender bias exists in many industrial settings and women are **excluded from factory work**, there is **gender disparity in non-communicable diseases** and men have higher risk of **exposure to industrial pollutants and toxins**, leading to higher rates of associated cancers.[33]

2.5 Insecurity and migration

Disparities in gender and health are exacerbated overall in times of **instability, emergency and crisis**. In Nepal during the civil war (1996 to 2006) some of the most empowered and advantaged young women in urban areas were shamed and abused at security checkpoints if they were discovered to have contraception or condoms in their handbags[34] which led to a

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[29] Molesworth, K. (2006) Development Interventions, Gender Dynamics and Fertility in Rural Nepal. In Smita Premchander and Christine Müller *Gender and Sustainable Development*. NCCR North-South, Geographica Bernensia.

[30] Molesworth, K. et al (2017) Impact of group formation on women's empowerment and economic resilience in rural Tajikistan. Journal of Rural and Community Development, 12(1), 1-22. http://journals.brandonu.ca/jrcd/article/view/1336/306

[31] https://www.enterprise-development.org/wp-content/uploads/SDCWEEinMSD.pdf

[32] Rathgeber E, Vlassoff C. Gender and tropical diseases: a new research focus. Soc Sci Med. 1993; 37:513–20.

[33] Charmaz K. Identity dilemmas of chronically ill men. In: Sabo D, Gordon D, editors. Men's health and illness: gender, power and the body, v. 8. London: Sage; 1995. pp. 266–91.

[34] Molesworth, K. (2007) Gender and political dynamics mediating mobility and access to health services and female reproductive health in rural Nepal 89 – 106.Transport and Communications Bulletin for Asia and the Pacific, No. 76

fall in them carrying what they needed to prevent unwanted pregnancy or sexually transmitted infections. This **interplay between politics gender norms and social change** illustrated the change in female autonomy and pre-marital sex, but also highlighted the constraints placed by insecurity.[35] In the same way, female rights are frequently compromised during the **process of migration**. As the state of crisis surrounding human movement increases, so does the **infringement of the right to health**, access to services and the risk of **bodily harm**. In heightened conflict **sexual assault** is frequently used as a **weapon and method of intimidation**. While perpetrators are in the main men against women, males may also be assaulted and because of **embedded psycho-social aspects of masculinities**, they are less able to seek help and services are less enabled to provide appropriate care and treatment. The SDC Gender, Migration and Development Guidance Sheet[36] discusses the interplay of gender and rights in migration and provides some examples of gender-responsive interventions and the IASC Gender Handbook in Humanitarian Action[37] and Guidelines for Gender-based Violence Interventions in Humanitarian Settings[38] discuss issues and approaches to GBV in humanitarian situations.

3 What is known of selected gender-related health vulnerabilities?

The disaggregation of health data and analysis has thrown light on gender-related vulnerabilities to disease, risk factors and outcomes. Some analyses have been conducted by differentiating by sex using recent Global Burden of Disease data, [39] although overall sex-disaggregated analyses were not routinely conducted and information on many gendered aspects of health remain unreported. Some of the key gender-related findings in the health area in which SDC works are highlighted in this section.

3.1 NCDs and risk factors

3.1.1 Gendered risk by consumption

Earlier in this Background Document some examples were set out of gendered disease and mortality patterns relating to cancers and gender-based difference in care seeking and health outcomes. It was apparent when men and women are equally exposed to a risk or disease, health consequences can vary by sex. For example, among men and women who smoke tobacco, women appear to develop severe chronic obstructive pulmonary disease at younger ages than men, even with lower cumulative cigarette smoke exposure.[40]

Many NCDs are known to be caused by or contributed to by certain substances or behaviours related to livelihoods, foods or other substances such as alcohol and tobacco. The use of some of these substances is embedded in socio-culturally defined concepts of masculinity and

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[35] Haour-Knipe, M., de Zalduondo, B., Samuels, F., Molesworth, K. and Sehgal, S. (2014) HIV and "People on the Move": Six Strategies to Reduce Risk and Vulnerability during the Migration Process. Int Migr, 52: 9–25.

[36] www.shareweb.ch/site/Migration/Documents/Gender and Migration_final.pdf

[37] IASC (2006) Women, girls, boys and men. Different needs – equal opportunities. Gender Handbook in Humanitarian Action

[38] http://www.humanitarianinfo.org/iasc/gender

[39] GBD 2017 Causes of Death Collaborators (2018) Global, regional, and national age-sex-specific mortality for 282 causes of death in 195 countries and territories, 1980–2017: a systematic analysis for the Global Burden of Disease Study 2017. The Lancet, Vol. 392, No. 10159 Published: November 10, 2018 https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)32225-6.pdf

[40] The health consequences of smoking: 50 years of progress. A report of the Surgeon General. Atlanta: Centers for Disease Control and Prevention; 2014. Accessible from: https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf

femininity as well as gender-related behaviours, which is reflected in gendered differences in global age-standardised summary exposure values for many risk factors.

Table 2 illustrates the global disparity in consumption of known NCD risk substances. This shows that tobacco smoking, alcohol consumption, drug use, red meat and sugar consumption are all higher in men overall. The data on tobacco smoke shows that while men are at high risk associated with active tobacco smoking, women are at greater risk than men for damage to health caused by passive inhalation. This reflects the gendered power dynamics within many households whereby men feel free to smoke in the same space as women, who do not have the status of men to enable them to object.

Risk factor	Males	Females
Tobacco		
Active smoking	8.7	1.76
Passive smoke inhalation	30.28	43.06
Alcohol consumption	16.23	4.65
Drug use	0.86	0.42
Diet		
High in red meat	15.11	6.81
High in sugary drinks	6.58	4.74

Table 2: Global age-standardised summary exposure values for selected consumption risk factors, by sex in 2017. Adapted from GBD 2017[41] study.

According to WHO the lifetime prevalence rate for alcohol dependence, is more than twice as high in men as women. In industrialised countries, approximately 1 in 5 men and 1 in 12 women develop alcohol dependence during their lives.[42] Studies have consistently shown that adult males consume more alcohol and have more alcohol-related health and social problems than females, reflecting the male stereotypes relating to alcohol consumption and risk-taking. Although women's physiological sensitivity to lower doses of alcohol places them at greater risk of dependence, social sanctions against female drinking-related behaviours, and increased risk of physical and sexual assault resulting from inebriation, act as factors to prevent female drinkers from engaging in heavier alcohol use.[43]

3.1.2 Gendered risk by pollution exposure

Data analysis of the GBD data reflects gender disparities in spheres of action and livelihood roles. As discussed earlier, women in many countries, especially in rural areas, tend to be confined to their households, where they have the responsibility for domestic tasks such as cooking. Men on the other hand, are enabled by gendered roles in society to take up waged labour. In both the domestic and industrial settings women and men are exposed differently to pollutants. Table 3 shows that world-wide women are slightly more exposed to domestic solid fuel pollutants to which they are exposed to a greater extent than men in their role of cooking for families.

[41] GBD 2017 ibid.

[42] https://www.who.int/mental_health/prevention/genderwomen/en/

[43] Schulte MT, Ramo D, and Brown SA.(2009) Gender differences in factors influencing alcohol use and drinking progression among adolescents. Clin Psychol Rev. 2009 Aug; 29(6): 535–547. doi: 10.1016/j.cpr.2009.06.003

Risk factor	Males	Females
Domestic pollutants		
Solid fuel pollution	23.90	25.67
Occupational pollutants		
Particles, fumes, gas	8·48	5.20
Asthmagens	15.39	8.04

Table 3: Global age-standardised summary exposure values for selected environmental risk factors, by sex in 2017. Adapted from GBD 2017[44] study.

Male health, however, is also impacted by the gender bias that enables them to engage in waged labour. Table 3 shows that as a consequence, men are far more at risk of occupational pollutants in many of the poorest countries of the world.

3.2 Mental health

According to WHO, gender and the disparities in power and control that men and women have over their lives are critical determinants of mental health and mental illness. Unfortunately, the sex-patterns in morbidity associated with mental illness have received substantially more attention than the gender specific determinants and mechanisms that promote and protect mental health and foster resilience to stress and adversity. As men, due to constructs of masculinity, are much less likely to seek assistance for mental health issues, data on gendered aspects of mental distress and ill-health are not fully recorded. However, WHO reports that depressive disorders account for 41.9% of the disability from neuropsychiatric disorders among women compared to 29.3% among men. Women are thought to be more affected by depression and anxiety, associated with gendered factors relating to gender based roles, stressors and negative life experiences and events, while men are more than three times more likely to be diagnosed with antisocial personality disorder than women. However, issues of gender-related care seeking may underestimate male psychological suffering and ill-health, given the patterns observed in the sex-disaggregated data on suicide. Figure 2 shows that in all WHO regions of the world and globally overall, suicide is significantly higher in men than women. As suicide is a strong indicator of mental distress, this highlights the gender bias in acknowledging and timely care seeking among males and reflects constructs of masculinity surrounding concepts of male strength and self-reliance that disadvantage men from gaining the care they need to prevent suicide.

[44] GBD 2017 ibid.

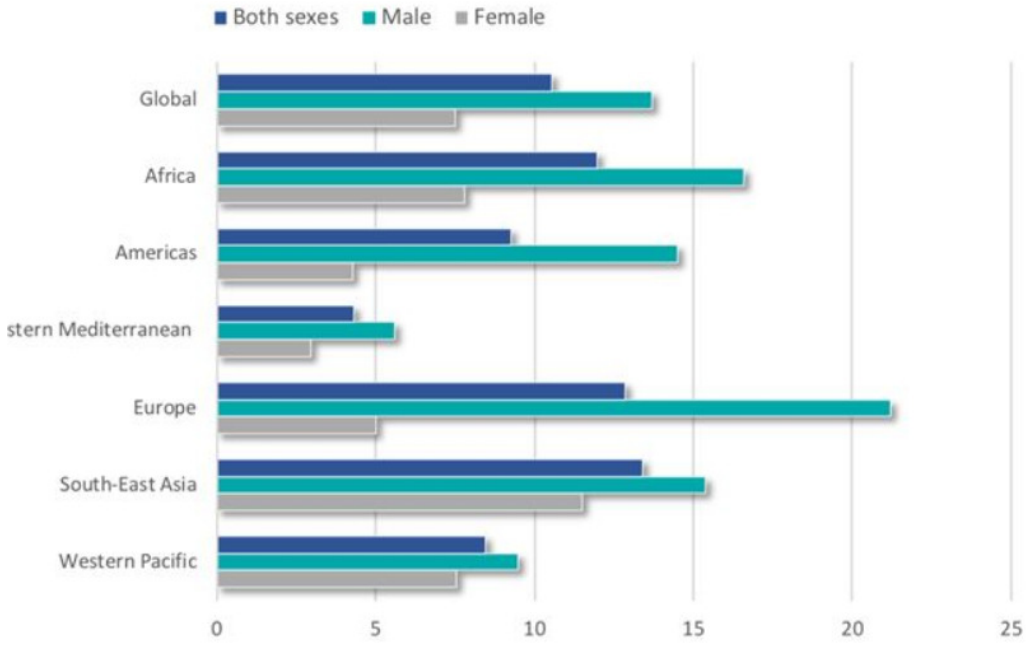

Figure 2: Suicide rate per 100,000 population by WHO region in 2016[45]

3.3 Accident, injury and violence

Figure 3 illustrates the leading causes world-wide of death among 15-29 year olds, all of which are preventable. Here, the overall gendered importance of suicide is evident as it is the second leading cause of death in male youth, compared with the third leading cause among females. Maternal conditions, a combination of biological and gendered issues are the leading cause of death among female youth, while road injury is the main cause of death among their male counterparts. The gender disparity in death by road injury likely reflects the fact that more men than women drive globally, in combination with elements of risk-taking inherent in constructs of masculinity in many cultures. Elements of masculinity and femininity also lie at the heart of the disparity in male death caused by interpersonal violence – the second leading cause of mortality among male youth, but not among their female counterparts.

[45] https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

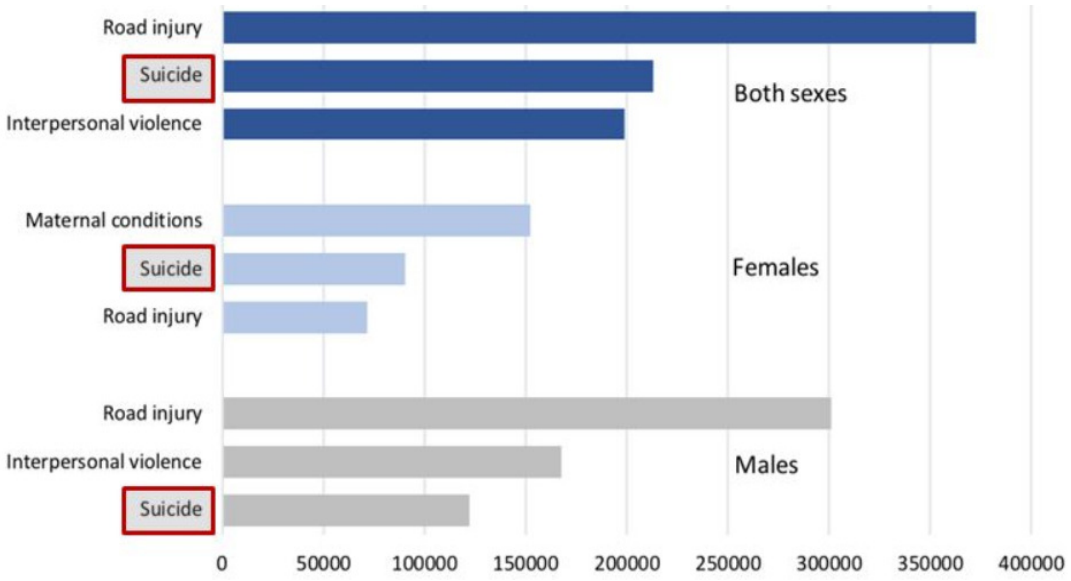

Figure 3: Leading causes of death for 15-29 year olds in 2016[46]

3.4 Sexual and gender-based violence

The SDC Guidance Sheet Addressing Sexual and Gender-Based Violence in SDC Programmes defines sexual and gender-based violence (SGBV) to be:

> "…any harm perpetrated against a person's will that is based on gender-related power inequalities. Forms of SGBV include harmful cultural and traditional practices such as child, early, and forced marriages; sexual trafficking of women and children; rape; sexual slavery; honour killing, female genital mutilation and economic abuse..."

SGBV be perpetrated by intimate partners, within the family, by known and unknown individuals and by groups in peace-time, conflict, and in post-conflict settings. As such it may be covert, or visible and known to others, which can have social implications for survivors such as stigma and exclusion. The **risk of SGBV is very much determined by societies**, which govern the extent to which violence against women and girls is sanctioned, tolerated or even encouraged by concepts of masculinity and femininity and expectations surrounding family reputation. Females are far more affected than males by SGBV and according to WHO, over 35% of women globally face sexual and/or intimate partner violence in their lifetime: In humanitarian situations and conflict, the incidence of violence based on gender inequality becomes more severe.[47]

SGBV can have wide-ranging, short- and long-term impacts on physical, mental, sexual and reproductive and health. The health consequences of SGBV against women include, apart from generalised injuries, unwanted pregnancy, sexually transmitted infections (STIs) including HIV, hepatitis B and C, chronic pelvic pain and urinary tract infections, fistula, genital injuries, and conception and pregnancy complications. People who have survived SGBV often have to contend with social impacts including stigma. Mental health consequences include post-traumatic stress disorder, depression and anxiety, which in turn can cause sleep

[46] https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/
[47] https://www.who.int/health-cluster/about/work/task-teams/genderbasedviolence/en/

disturbances, substance misuse, self-harm and suicidal behaviour. Timely access to appropriate, gender-sensitive health services is crucial following SGBV as these can provide time-bound care for sexual assault and rape, such as emergency contraception and post–exposure prophylaxis (PEP) to prevent HIV infection and presumptive treatment of other STIs. Health services can also be pivotal in offering psycho-social care and referral to specialist services.

Although SGBV is perpetrated mostly against women and girls it is also committed against men and boys, particularly during conflict. Sexual violence is also perpetuated in peace-time by some women against males: Although the incidence of female intimate partner violence against men is much lower than male to female SGBV, and there is an absence of research in low- and middle-income countries, the United States Coalition Against Domestic Violence for example, reports that that 1 in 9[48] men experience intimate partner sexual violence. Gender constructs around masculinities discourage many men from reporting female-perpetuated violence and in many cultures, sexual violence, whether perpetrated by other men or women, presents a more threatening taboo for male survivors for whom specialist services are non-existent.

3.5 Neglected Tropical Diseases (NTDs)

Gender-determined norms and values that influence the division of labour, leisure patterns and spheres of action interact with NTDs and their vectors in many different ways that result in gender disparities in health. In some cases NTDs incur added burdens due to stigma, isolation and other negative consequences. These factors may also reduce the acceptability and access to health services, leading to further disparities in health care and outcomes. Some examples are discussed below:

3.5.1 Malaria

Research suggests that when equally exposed, adult men and women are also equally vulnerable to malaria infection, except for pregnant women, who are at greater risk of severe malaria in most endemic areas[49] due to immunological changes. Although malaria affects both men and women, gender roles and dynamics give rise to different exposure patterns. For example, traditional gender roles may involve men working in the fields at dusk or women gathering water early in the morning, exposing them at peak mosquito-biting times. Socially marginalized populations, such as sex workers and people who do not conform to gender norms such as those who are homosexual or transgender, may also be more vulnerable to infection because they are more likely than others to be homeless and sleep outside and less likely to access health care, due to stigma related to gender expectations.[50]

Prevention and treatment of malaria are also influenced by gender. Women may be more willing than men to invest in malaria-prevention measures, such as insecticide-treated bed nets (ITN), but may lack the financial and decision making power to do so.[51] Gender norms around sleeping arrangements can also determine who is protected by sleeping under ITNs

[48] https://ncadv.org/statistics

[49] Reuben R. Women and Malaria. Special Risks and Appropriate Control Strategy. Social Science and Medicine, 1993, 37(4):473-480.

[50] Walters, V. & Gaillard, J. (2014). Disaster risk at the margins: Homelessness, vulnerability and hazards. *Habitat International, 44*, 211–219. http://www.sciencedirect.com/science/article/pii/S0197397514000824

[51] Lampietti, J. A., Poulos, C., Cropper, M. L., Mitiku, H., & Whittington, D. (1999). Gender and preferences for malaria prevention in Tigray, Ethiopia. Policy report on gender and development working paper series, No. 3. World Bank. http://siteresources.worldbank.org/ INTGENDER/Resources/wp3.pdf

within a household - and it may not be pregnant women who are most vulnerable to infection.[52] Gender norms and dynamics, apart from influencing exposure to pathogens can also determine the efficacy of health interventions. This was highlighted in a study of insecticide treated bed nets use to prevent malaria in Tanzania, commissioned by SDC in 2011.[53] This found that gender blindness in programming ignored gender norms, roles and relations governing household sleeping arrangements to effectively exclude men from behaviour change communication campaigns.

3.5.2 Schistosomiasis

Research in Sudan[54] and Egypt[55] show a complex relationship between schistosomiasis and gender roles in relation to domestic activities and farming, reflecting current GBD data on higher female ill-health as a result of unsafe sanitation, illustrated in Table 4. Female genital schistosomiasis has recently been found to constitute a neglected and underestimated public health problem.

Risk factor	Males	Females
Domestic pollutants		
Unsafe sanitation	**29.88**	**32.28**

Table 4. Global age-standardised summary water exposure values, by sex in 2017. Adapted from GBD study.

3.5.3 Leishmaniasis

Leishmaniosis, is transmitted by the bite of infected sand flies and research has shown that it is more frequently contracted by men than women[56] and that the vector habitat is enlarging with deforestation. This difference could be due to different risks of exposure of males and females. Gender-related differences in the host response to infection may also play a role in the higher infection rates among men, but male occupational exposure is an important factor in agricultural and forestry work in endemic areas as well as deforestation work for building roads and military training.

3.5.4 Leprosy

A review of leprosy from a gender perspective in 1997 revealed the complex gender dynamics of the disease. There was found to be lower case detection among women, perhaps linked to their greater experience of stigma than their male counterparts, while males had a higher

[52] Garley, A. E., Ivanovich, E., Eckert, E., Negroustoueva, S.,& Ye, Y. (2013). Gender differences in the use of insecticide treated nets after a universal free distribution campaign in Kano State, Nigeria: Post-campaign survey results. Malaria Journal, 12(1), 1–7. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/23574987

[53] Kessy, F. (2011). Study on gender dimensions of the distribution and use of mosquito nets in Dodoma Region, Tanzania. https://www.shareweb.ch/site/Health/publiclibrary/Public%20Library/A%20study%20on%20gender%20dimensions%20in%20the%20distribution%20and%20use%20of%20mosquito%20nets%20Dodoma%20region,%20Tanzania.pdf

[54] Feldmeier H et al. (1995) Female genital schistosomiasis: new challenges from a gender perspective. Tropical and Geographical Medicine, 1995, 47(Suppl. 2):S2–S15

[55] El Katsha S, Watts S. (2002)Gender, behavior, and health: schistosomiasis transmission and control in rural Egypt. Cairo, American University in Cairo Press, 2002

[56] Cattand P et al. Tropical diseases lacking adequate control measures: dengue, leishmaniasis, and African trypanosomiasis. In: Disease Control Priorities Project. Washington, DC, International Bank for Reconstruction and Development/World Bank, 2006:451–466

incidence of leprosy-determined deformities[57]. After diagnosis, women were found to better adhere to treatment than men (70% versus 60%) in spite of the cost of travel to treatment centres that frequently places women at a disadvantage in accessing health care. Male failure to comply with medical appointments and treatment was linked with disbelief in the diagnosis, fear of losing paid employment and perceived effects of medication combined with alcohol use. Women's concerns, on the other hand, focussed upon the potential deterioration in their skin and appearance, which motivated them to better comply with care and treatment schedules.

3.6 Sexual and reproductive health (SRH)

The intersection of biological vulnerability, human rights and gendered aspects of power, autonomy, socio-economic assets and cultural expectations has perhaps the greatest impact on sexual and reproductive health. There are multiple pathways through which gender inequalities affect the sexual and reproductive health and wellbeing of women and according to the United Nations[58] only 52% of women married or in a union freely make their own decisions about sexual relations, contraceptive use and health care. In many countries, indicators of contraceptive use only include married women of reproductive age, leaving aside the unmet need of unmarried women. Gender norms that licence men's control over women and violence against women constrain women's ability to negotiate sex and marriage, practice safer sex, make reproductive decisions and disclose issues relating to their SRH such as their HIV status. Just a few of these are discussed here:

> *Slow progress in some areas of SRHR is due to the fact that SRHR is directly or indirectly influenced by factors outside the health system, such as education, gender equality and more broadly poverty. The core area of SRHR is therefore closely linked to "universal health coverage" and "determinants of health", two other core areas of the GPH.*
>
> Strategic Framework 2015–2019 SDC Global Programme Health (GPH)

3.6.1 Child marriage

Figure 4: Child marriage in Asia.

Approximately 650 million girls and women alive today were married before their 18th birthday and a further 12 million girls marry before the age of 18 each year[59] in spite of the practice being prohibited by law in many nation states.

As figure 5 illustrates the greatest majority of child marriage takes place in South Asia and sub-Saharan Africa, but it also occurs within the Balkan Peninsular in countries such as Serbia and within ethnic groups such as the Roma.

[57] De Oliveira, M. (1997) The effects of leprosy on men and women: a gender study. WHO/Nursing School of Ribeirão Preto, University of São Paolo, Brazil. http://origin.who.int/tdr/publications/documents/leprosy-gender.pdf

[58] https://www.un.org/sustainabledevelopment/gender-equality/

[59] https://plan-international.org/sexual-health/child-early-forced-marriage

Figure 5: Child marriage by region [60]

Although the practice of child marriage has continued to decline globally according to UNICEF,[61] no region is on track to meet the Sustainable Development Goal target of eliminating this harmful practice by 2030. As girls are much younger than the men they marry in some countries such as Afghanistan, they may become infected by sexually transmitted diseases accumulated during their husbands' previous sexual encounters. Some girls may also be married to men whose wives have died of HIV or cervical cancer triggered through sexual transmission of the human papilloma virus.

Girls Not Brides is a global partnership of more than 1,000 civil society organisations committed to ending child marriage. It reports that complications in pregnancy and childbirth are the leading cause of death in girls aged 15-19 globally (refer back to figure 3 which presents the WHO data for women aged 15-29 years) and that when a mother is under 20, her child is 50% more likely to be stillborn or die within its first weeks of life than a baby born to a more mature mother.[62] Child marriage is key in addressing maternal and neonatal mortality as well as maternal injuries such as fistula that results from tissue death during obstructed labour that is a common factor in child marriage.

3.6.2 Contraception

The ability to control one's own fertility and how many children to have and when is a **fundamental human right that underpins female empowerment, gender equality and engagement in the broader development process**. However, gender norms in many societies deny women and girls the knowledge and access to modern contraception, reproductive health and comprehensive sexuality education to the extent that 214 million continue to have unmet needs to control their fertility,[63] protect themselves from sexually transmitted diseases, access safe and legal abortion and post-abortion care, obtain infertility treatment and counselling, and maternal healthcare, regardless of their age, income and marital status. Not only are these essential rights of girls and women, as well as men and boys, but these elements form the basis of physical and sexual wellbeing.

In many countries, there is a lack of political commitment and budget support to address gender inequalities and that hamper female access, with the consequence that an estimated 43% of the 206 million pregnancies world-wide in 2017 were unintended,[64] and 84% of which

[60] UNICEF 2018 ibid.
[61] UNICEF 2018. Child Marriage: Latest trends and future prospects July 2018. https://data.unicef.org/resources/child-marriage-latest-trends-and-future-prospects/
[62] https://www.girlsnotbrides.org/themes/health/
[63] World Health Organization, (2017) Leading the realization of human rights to health and through health: report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents. Web. <http://apps.who.int/iris/bitstream/10665/255540/1/9789241512459-eng.pdf?ua=1>
[64] Guttmacher Institute (2917). Adding it up: Investing in contraception and maternal and newborn health, Fact Sheet, https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017

were due to unmet contraceptive needs. The **implications for female health are substantial due to the risks that pregnancy,** particularly unplanned pregnancy, places upon women's lives. In 2017, approximately 308,000 women died as a result of maternal or pregnancy-related complications in low-income countries[65] and complications from pregnancy and childbirth are leading causes of death among girls aged 15-19years. [66]

3.6.3 Circumcision and genital cutting

According to the United Nations[67] the rates of girls between 15-19, who are subjected to **female genital cutting** in the 30 countries where the practice is concentrated, have dropped from 1 in 2 girls in 2000 to 1 in 3 girls by 2017. International health and human rights organisations agree that this practice has **no health benefits whatsoever and is extremely harmful**. Apart from associated long term pain and the risk of acute and chronic infection, menstrual complications, birth obstruction and associated maternal and infant mortality, survivors often suffer from fistula, when damaged tissues fuse to form channels between the vagina and the walls of the urethra and rectum, causing infection, incontinence resulting in social exclusion and extreme stigma. In addition to this, natural female abilities to experience sexual pleasure are destroyed.

On the other hand, **male circumcision**, usually the removal of foreskin, is regarded to offer a number of health benefits from general hygiene to reduced sexual transmission of disease, most notably HIV. Like female circumcision, in almost all cultures that sanction the practice, circumcision is conducted by an individual of religious or cultural significance with few or no medical skills and there is no medical oversight or attention paid to quality of practice and care. As a consequence harm can be caused by the introduction of infection and both acute and chronic pain as a result of poor cutting technique and scarring. Culture determines a broad age range at which males are circumcised and the extent and process of tissue removal. In some societies such as the Masaai of south-eastern Africa, radical tissue removal, morphological and functional changes and scarring can impact on fertility.

However, the combination of certain health benefits intersecting the more general gendered acceptance of male circumcision has led to a situation whereby it is neglected as an issue for due attention to harm reduction.

3.6.4 Maternal health

Maternal health has already been discussed in a number of sections throughout this report, especially in terms of its impact on female mortality globally between the ages of 15 -29. It is important to underscore that the multiple gender disparities and biases related to decision-making power, freedom to travel, access to cash to pay for transport and care, education and access to health information, agency outside the domestic arena, to list just a few examples, all intersect with the biological vulnerabilities inherent in pregnancy and childbirth, together with practices of female genital cutting, and age at birth to impact in material and neonatal injury, morbidity and mortality. All socio-cultural, gender-based determinants are changeable through gender-responsive service provision and gender-transformative processes. Therefore focus is needed beyond programming for strengthening of hardware of maternal services.

One aspect of gender-blindness, overlooked in programming and service design is the inclusion of fathers in the maternity process. Often men are simply not considered and there is no physical space or protocol for them to attend the birth of their children and support

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[65] Ibid.

[66] World Health Organization, (2017). Adolescents: Health Risks and Solutions. http://www.who.int/mediacentre/factsheets/fs345/en/>.

[67] https://www.un.org/sustainabledevelopment/gender-equality/

mothers, both of which are recognised to support paternal bonding and responsibility-taking for infants and care of the mother.

3.6.5 HIV and AIDS

Biological and anatomical aspects of the female sex, increases vulnerability to infection. Added to this are social and cultural constructs of masculinity, femininity and gender-based violence discussed earlier, that hamper women in negotiating sex and safer sex to reduce HIV transmission. In combination, these multiple factors determine that young women are twice as likely to acquire HIV as their male peers.[68] As a result, some 18.8 million women and girls are living with HIV, which makes AIDS-related illness the leading cause of death among female between the ages 15-49 years as Figure 6 illustrates. The majority of these deaths are of women in south-eastern, western and central Africa and Asia and the Pacilific.

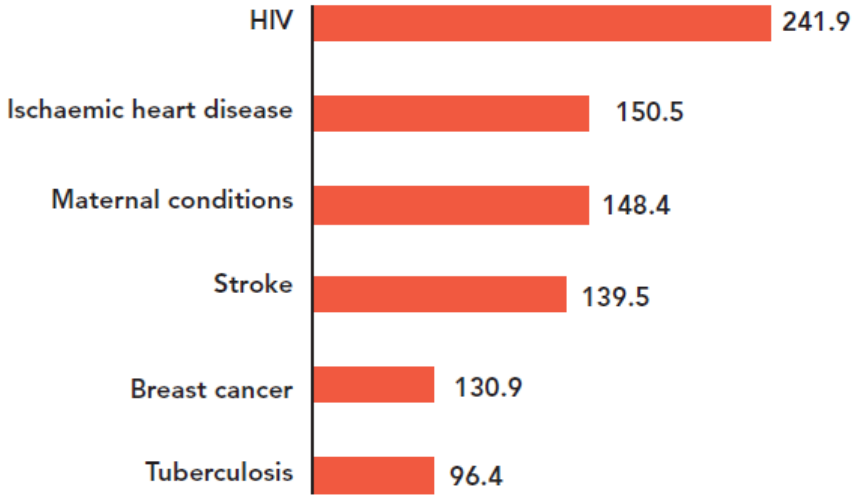

Figure 6: Cause of female death globally (in hundred thousands)[69]

Among women at greatest risk are sex workers who have an infection rate ten times higher than the general population, however, it is important to note that women are not the only high risk groups. The USA National Institute on Drug Abuse has collected and disaggregated data on most at risk populations by sex, as shown in figure 7. This illustrates the wide variation in transmission of the virus via heterosexual sex, from which 86% of females become infected and only 12% of their male counterparts. Indeed the majority of male vulnerability to HIV (77%) surrounds male-to-male sex.[70]

[68] UNAIDS Women, Girls and HIV.

[69] UNAIDS ibid

[70] National Institute on Drug Abuse 2010. www.drugabuse.gov/publications/research-reports/hivaids/who-risk-hiv-infection-which-populations-are-most-affected

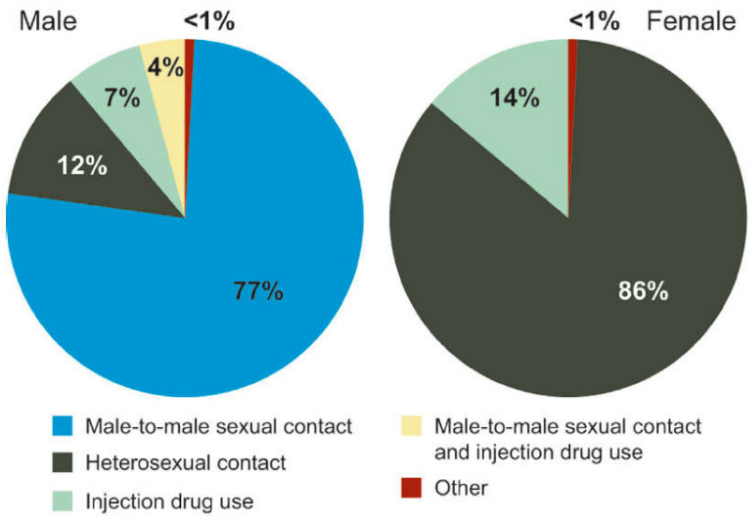

Figure 7: HIV rates among most at risk groups in the USA[71]

Figure 8 below sets out further data from the USA, disaggregated by sex, ethnicity and sexual orientation to provide an insight into the complex interplay on HIV infection dynamics. This illustrates a more complex interplay between ethnicity, transmission mode and gender.

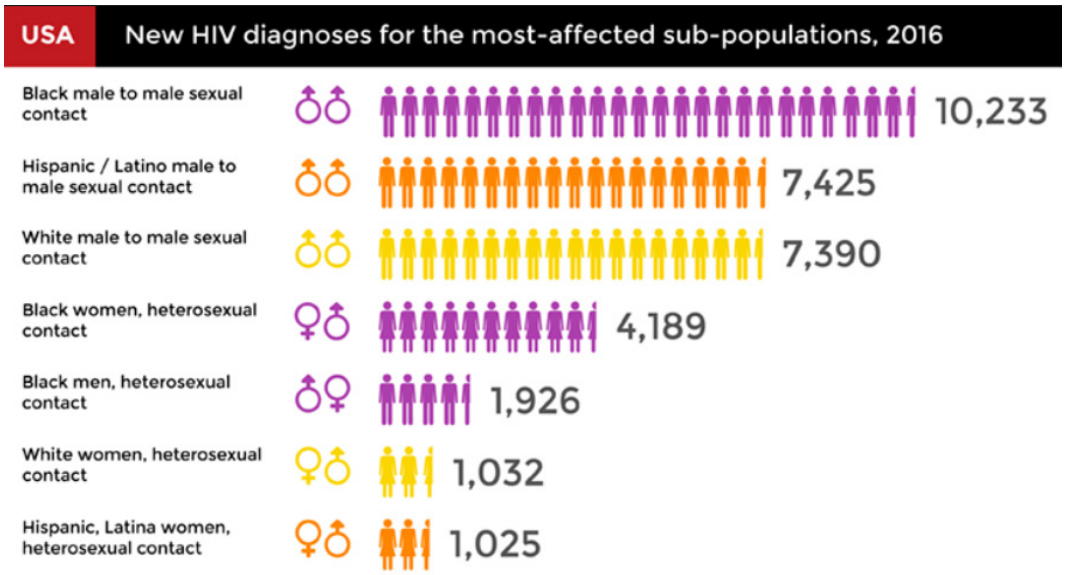

Figure 8: CDC 2017. HIV Surveillance Report

3.6.6 Burden of care.

The majority of people who develop AIDS are cared for at home. Providing care can be both rewarding and a heavy burden. For women and girls in particular, their gendered role as carers can constrain their sphere of action further to within the household arena and curtail opportunities to engage in education and waged labour. The relentless nature of home based

[71] National Institute on Drug Abuse 2010. www.drugabuse.gov/publications/research-reports/hivaids/who-risk-hiv-infection-which-populations-are-most-affected

care not only presents a source of stress but also poses a risk to opportunistic infectious diseases associated with AIDS. Providing full-time care to family members in itself is a barrier to women seeking health care. As a consequence, women and girls often "pay" for the health care they give to others with their own well-being[72] [73].

3.6.7 How gender equitable has the AIDS response been so far?

In response to female vulnerabilities both in terms of infection and the burden of care, interventions have been strongly female-focussed for many years and have failed to include males and work with the dynamics of gender as they play out in different geographical and socio-cultural settings. This is apparent in the gender bias in progress towards the 90-90-90 targets when data are sex-disaggregated, shown in figure 9.

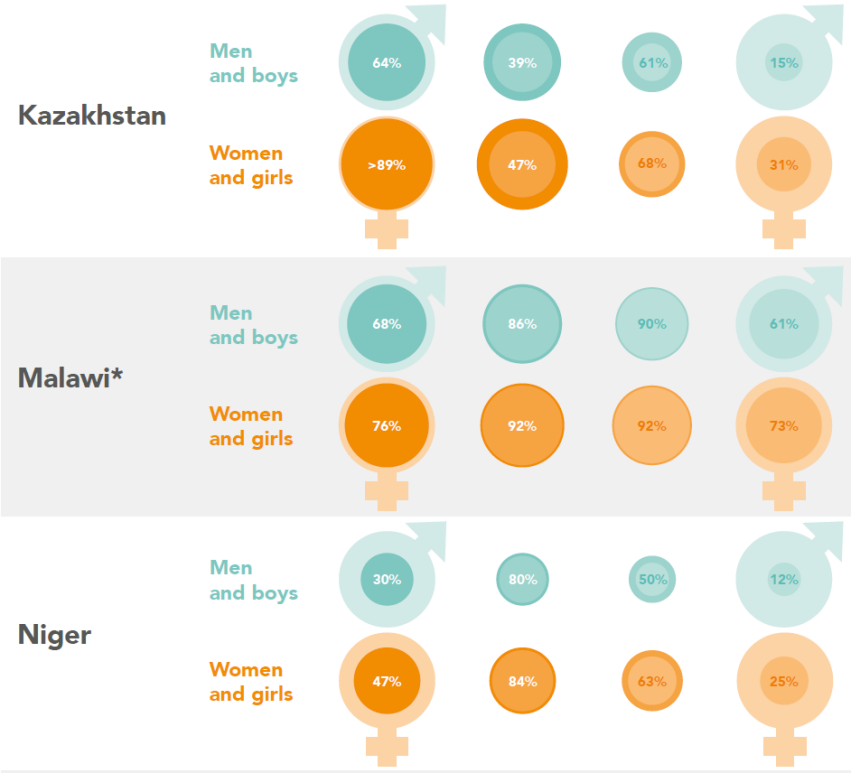

Figure 9: Gender gaps in progress towards the 90-90-90 targets in selected countries[74]

In response to the programming gap, UNAIDS recently launched its report entitled "Blind Spot" and it is worthy of note that in the forward, the UNAIDS Executive Director commented "In a world of gender inequalities that disadvantage women and girls, publishing a report on how men are not being reached by health services and are not exercising their right to health may seem counterintuitive." This echoes the long-standing misrepresentation of gender as being only about women and girls, rather than any disadvantage that might amass within prevailing gender norms, behaviours and dynamics. While women are disproportionately more affected than men by HIV, the focus of the AIDS response on women and girls, has left men and boys behind. As a consequence, men have been less likely than women to test and know their HIV

[72] Asuquoet al (2017) Assessing Women Caregiving Role to People Living With HIV/AIDS in Nigeria, West Africa SAGE Open January-March 2017: 1–10 https://journals.sagepub.com/doi/full/10.1177/2158244017692013.
[73] WHO 2009. Integrating Gender into HIV/AIDS Programmes in the Health Sector: Tool to Improve Responsiveness to Women's Needs. www.ncbi.nlm.nih.gov/books/NBK143043/
[74] UNAIDS (2017). Blind Spot. Reaching out to men and boys.

status and less likely to access and adhere to HIV treatment. As a result men are more likely to die of AIDS-related illnesses than HIV positive women.

The UNAIDS report responds to the reality that in many societies male behaviour linked to health and risk is influenced by many gender norms that discourage them from approaching health services. Prevailing concepts of masculinity and the stereotypes associated with it create conditions that make having safer sex, having conversations about sexual issues, testing, accessing and adhering to treatment, particularly challenging for men. Unhealthy eating habits and the use of alcohol, tobacco and drugs further exacerbate their situation. The report makes the case for progress along two related approaches: of reaching more men with health and HIV services in the short term, and enabling them to use and adhere to those services; and, introducing purposeful policies and practices that remove gender inequalities and promote more equitable gender norms and institutional arrangements to the benefit of both women and men.

4 How gender responsive are health systems and institutions?

4.1 Health systems and their components

Health systems and their components are not inherently gender neutral, [75] and can amplify gender inequalities, stereotypes, bias and gender-related stigma that drive inequalities in universal health coverage (UHC) and service quality. For example, health information systems often fail to provide meaningfully sex-disaggregated information, which in turn, does not enable analysis and interpretation of health realities for men and women, and boys and girls. For example, weak medicines management leading to drug stock-outs disproportionately affects women; within the health financing building block, out-of-pocket health expenditures at the household-level disproportionately affect women and girls; and, within the human resources component of health systems, there is a lack of prioritisation of gender issues and health worker shortages disproportionately impact women.[76]

Figure 10: The six building blocks of health systems[77]

Four key attributes of a gender-equitable health system are:

- Appropriately address the most urgent needs of females and males throughout the whole life course;

[75] Percival V, Richards E, MacLean T, Theobald S. Health systems and gender in post-conflict contexts: building back better? Confl Health. 2014; 8(1):19.

[76] Percival V, Dusabe-Richards E, Wurie H, Namakula J, Ssali, S. Theobald, S. (2018). Are health systems interventions gender blind? Examining health system reconstruction in conflict affected states Globalization and Health2018 14:90 https://doi.org/10.1186/s12992-018-0401-6

[77] WHO 2009. Systems thinking for health systems strengthening. https://apps.who.int/iris/bitstream/handle/10665/44204/9789241563895_eng.pdf;jsessionid=39EFFB6DA6134A8FDC4DD706FD82B1CD?sequence=1

- Ensure gender equality in access to and use of health services without financial, social and geographic barriers;
- Provide equitable opportunities for female and male health workers within the system;
- Generate relevant sex-disaggregated information to guide health systems policy and practice.

Figure 11 illustrates a framework that can be applied to integrate gender equity within health systems to enhance planning, research and monitoring and evaluation. It defines benchmarks for gender equity in each building block that describe how a gender equitable health system would perform. For example, within the governance building block, the benchmark would be to promote gender equity within the system in a way that reforms improve responsiveness to gendered health needs; and, within the human resources building block, equitable opportunities and career development for male and female health professionals would address existing gendered disparities.

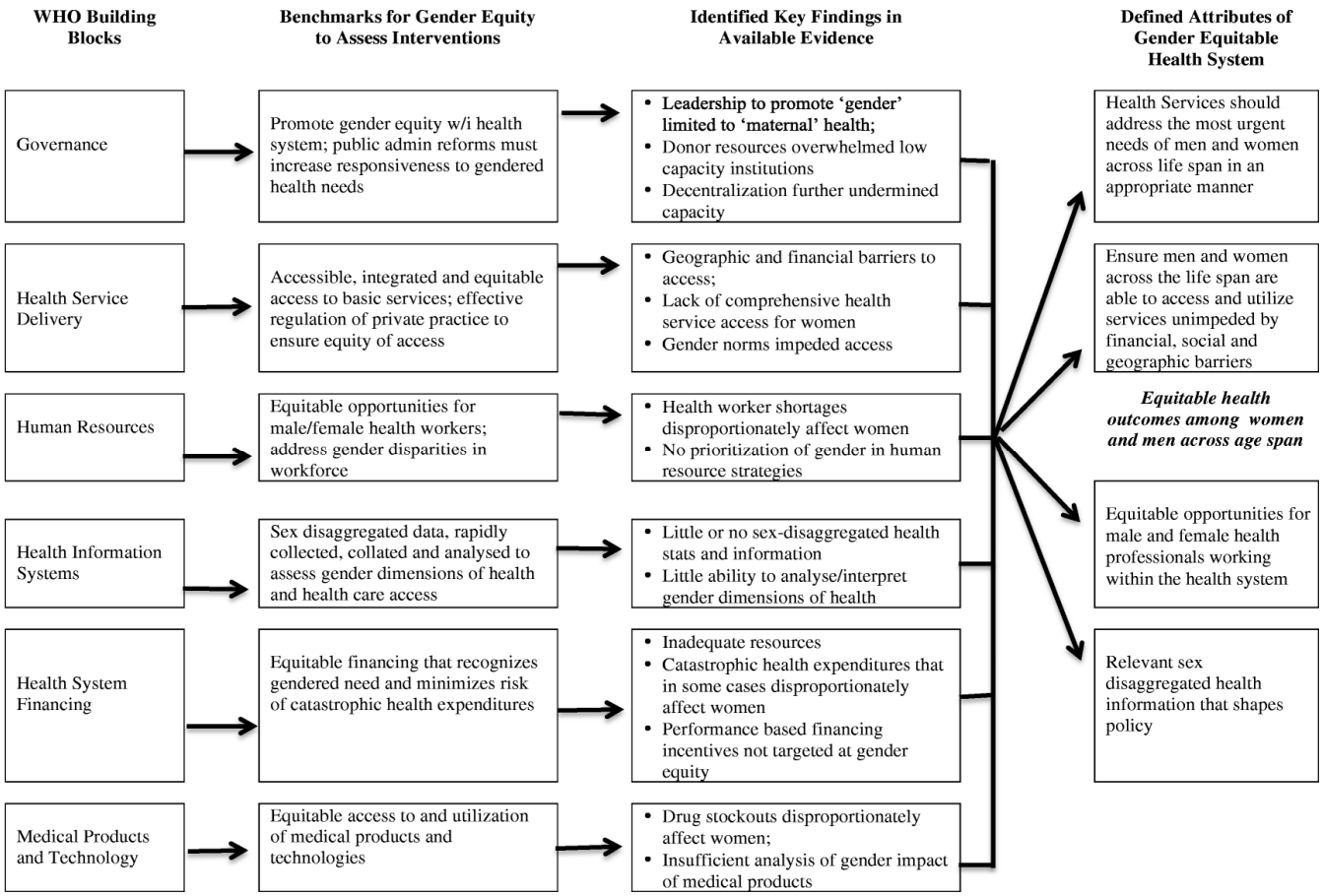

Figure 11: Framework to integrate gender equity within health systems [78]

[78] Percival V, Dusabe-Richards E, Wurie H, Namakula J, Ssali, S. Theobald, S. (2018). Are health systems interventions gender blind? Examining health system reconstruction in conflict affected states Globalization and Health2018 14:90 https://doi.org/10.1186/s12992-018-0401-6

4.2 How gender-equitable are global health organisations themselves?

In order to be effective in addressing inequalities in health, organisations and institutions bearing the duty to oversee and enact positive health change logically need to have the necessary gender awareness and responsiveness. It is, therefore, important to examine their gender approaches and commitment to determine and acknowledge just how gender-equitable they are themselves, as this will likely affect their leadership abilities in gender transformation and responsiveness within the global health arena.

4.2.1 Walking the talk: How effective are organisations in advancing of gender and health issues?

For some years, advocates of action for gender equality have been frustrated by the frequent peppering of reporting and public documents with the term "gender" accompanied by a lack of concrete action and results. There has been a growing concern that few global health organisations reflected their own gender-speak by defining, programming, resourcing or monitoring gender, either as a determinant of health, or as a driver of equality in their own organisations. Until recently, this phenomenon was unquantified and there was no effective accountability. Without this, there has been very little informed steerage to achieve meaningful and sustainable action to close the gender gaps in health, care seeking and related issues that result in the global disparity in life expectancy.

4.2.2 Do international health organisations suffer from gender-blindness?

The 2018 Global Health 50/50 Report for the first time delivers a comprehensive review of the gender-related policies of 140 major organisations working in and/or influencing the field of global health. The initiative is focused at the intersection of several SDGs, including health (SDG 3), gender equality (SDG 5), reduced inequalities (SDG 10) and inclusive societies and institutions (SDG 16). The report shows that, although gender is one of the most significant social determinants of health outcomes, the global health community itself remains largely gender-blind and there is a failure in gender-responsive programming as well as a failure to achieve gender parity in leadership across key public, private and civil society organisations engaged in health.

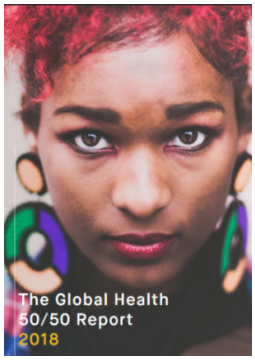

Figure 12 illustrates that analysis for the Gender 50/50 report revealed that a substantial proportion of organisations made no public commitment to gender equality and fewer than 2 out of 3 organisations did not define gender within their policies to be in line with global standards.

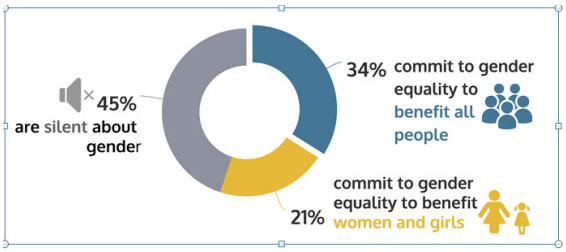

Figure 12: Proportion of organisations making a public commitment to gender equality[79]

[79] 'The Global Health 50/50 Report: How gender-responsive are the world's most influential global health organisations?', London, UK, 2018 https://globalhealth5050.org/wp-content/uploads/2018/03/GH5050-Report-2018_Final.pdf

Of particular concern is the finding that more than half of all organisations do not provide sex-disaggregated data, without which organisational monitoring, evaluation and reporting fail to provide alerts to gender inequalities relating to health programming and outcomes, which would otherwise guide gender responsive approaches and results. It is not surprising, therefore, that the Global Health 50/50 report found that 60% of organisations do not have programmatic policies in place to guide gender-responsive action

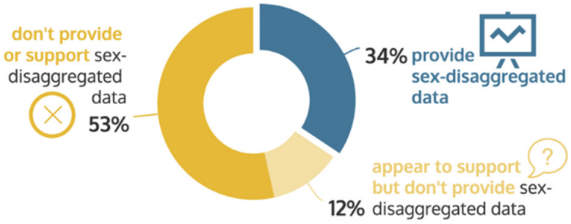

Figure 13 Proportion of organisations reporting sex-disaggregated data [80]

4.2.3 Is governance of our health organisations gender-balanced?

The finding of underachievement of gender parity in senior management and governance of health-related organisations, shown in figure 14, illustrates the under-representation of women in the leadership of global health.

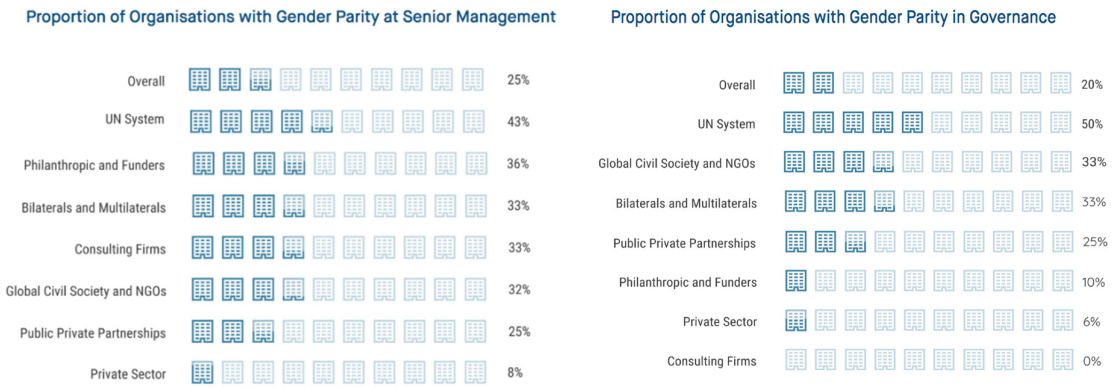

Figure 14. Extent to which health-related organisation has achieved gender parity in leadership.[81]

With only 31% of executive directors and 20% of board chairs held by women, it is apparent that global health decision-making power is male dominated. Perhaps this is why so few organisations have taken adequate concrete steps to ensure the visibility of gender-

[80] 'The Global Health 50/50 Report: How gender-responsive are the world's most influential global health organisations?', London, UK, 2018 https://globalhealth5050.org/wp-content/uploads/2018/03/GH5050-Report-2018_Final.pdf

[81] 2018 Global Health 50/50 report. Ibid.

determined inequalities in health through adequately disaggregated data and analyses to inform gender policy, strategy and programming to achieve gender parity in health outcomes.

Of more concern is that gender has been shown to influence how health policies are conceived and implemented, for example, how biomedical and contraceptive technologies are developed, and how the health system responds to male and female clients.[82] Our organisational policies and practice can be expected to have a substantial impact in maintaining gender-bias and gender-blindness in international health policy, programming and ultimately outcomes.

4.2.4 What about the GPPPH?

The Global Public Private Partnerships for Health (GPPPH) represent an increasingly influential element of the international health architecture and carry both financial and normative power. A recent gender analysis of 18 GPPPH - global institutions with a formal governance mechanism that includes both public and private for-profit sector actors – revealed gender to be poorly mainstreamed through the institutional functioning of the partnerships. Half made no mention of gender in their overall institutional strategy and only three partnerships had a specific gender strategy. Figure 15 illustrates the gender representation on 17 of the GPPPH governing boards, with only a minority reaching parity. Fifteen governing bodies comprised more men than women, some with a ratio of only one female board member for every male. Very few partnerships reported sex-disaggregated data in their annual reports or results. The majority of partnerships focused their work on maternal and child health and infectious diseases – none addressed non-communicable diseases (NCDs) directly, despite the strong role that gender plays in determining risk for the major NCD burdens.

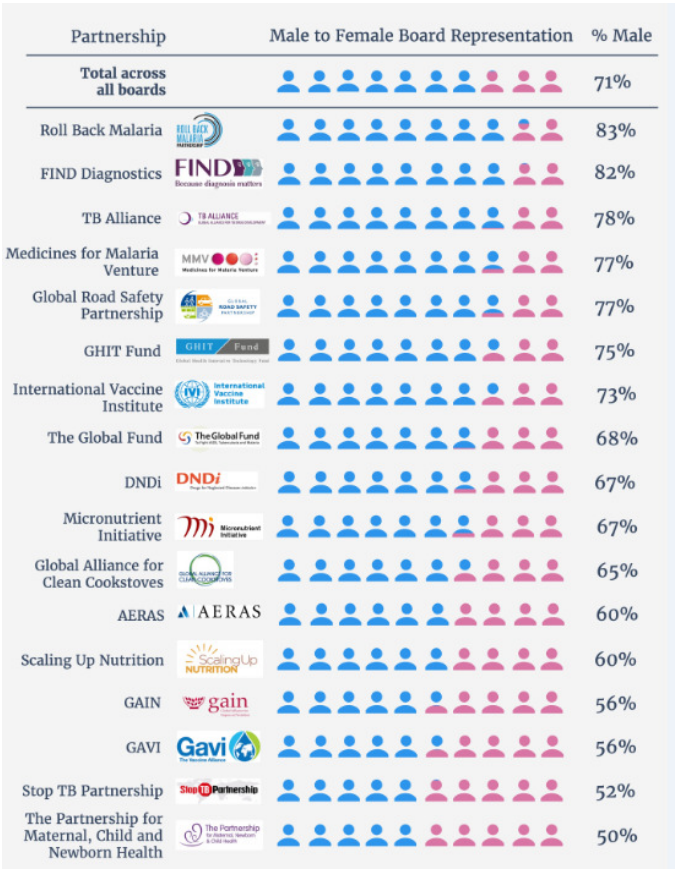

Figure 15: Gender representation on 17 of the GPPPH governing boards[83]

[82] Vlassoff C, Garcia Moreno C. Placing gender at the centre of health programming: challenges and limitations. Soc Sci Med. 2002;54:1713–23

[83] Hawkes, S, Buse, K & Kapilashrami, A. (2017). Gender blind? An analysis of global public-private partnerships for health. Globalization and Health 2017 13:26 https://doi.org/10.1186/s12992-017-0249-1

4.2.5 How far are organisations open to improving gender parity in governance and leadership?

In October 2017 the United Nations' System-wide Strategy on Gender Parity[84] was launched to address gender disparities and inequalities between male and female staff members at all levels. This followed the commitment made by the Secretary General during his oath of office, to address the UN's own institution gender disparities.

To date, the rate of appointing women to senior leadership posts, to redress the gender imbalance is on track to reach parity before the 2021 deadline.

Just a year after the introduction of the Gender Strategy, however, there have been reports that the gender parity effort is facing challenges from staff unions, structural blockages in the system and faltering political will. [85]

Enhanced political commitment will be needed from UN leaders beyond the Secretary-General and member states to ensure to ensure the success of the strategy.

> *"Management reform must ensure we reach gender parity sooner rather than later. The initial target for the equal representation of women and men among United Nations staff was the year 2000. Sixteen years later, we are far from that goal. I pledge to respect gender parity from the start in all my appointments to the Senior Management Group and the Chief Executives Board"*
>
> António Guterres: Extract from the Secretary-General's oath of office

4.2.6 #Us Too? How to move forward?

The world press in the second half of 2018,[86] has revealed that some of the organisations bearing the duty of health and social strengthening in both development and humanitarian contexts have not only failed in basic gender practice, but have been associated with the perpetration of gender-based exploitation and sexual misconduct.

Looking at its own house, the UN, for the first time in its history, conducted a system-wide survey on harassment, the report of which was released just a few weeks ago in January 2019. This revealed harassment within the UN system to be both prevalent and serious, with one in three respondents reporting being harassed in the previous two years. The survey findings have raised the profile of the issue of harassment to an important discussion point.

It is crucial that all organisations, especially those mandated to address health and well-being, get their own houses in order with regard to gender. Without meaningful gender approaches we will not only be unable to detect where problems, programmatic failures and inequities exist, but we will be ill-prepared to tackle health issues effectively and efficiently within the realities of the particular gender dynamics of people with unmet health needs.

Gender parity in governance and leadership of health organisations is a starting point, but our organisations and institutions need to go much further and at a faster pace to become more effective in in responding to the gender-related drivers of inequalities in health and well-being.

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[84] https://www.un.org/gender/sites/www.un.org.gender/files/gender_parity_strategy_october_2017.pdf

[85] Goetz, A and Arthur, P. (2019). The UN's Gender Parity Goals: The Backlash Begins. PassB lue Inependent Coverage of the UN. *Jan 23, 2019 03:28 pm.* https://us4.campaign-archive.com/?e=dda73500cd&u=5d5693a8f1af2d4b6cb3160e8&id=75a137d616.

[86] For example: https://www.thetimes.co.uk/article/oxfam-scandal-charities-were-verging-on-complicity-over-sexual-abuse-say-mps-px99llz98 and https://www.bbc.com/news/uk-43112200 and https://www.devex.com/news/oxfam-sexual-abuse-scandal-are-the-aid-sector-s-hr-systems-failing-92103.

5 Important aspects to inform effective gender-responsive approaches in health

Although shaped and maintained by social, cultural and religious institutions, gender concepts can be changed and shift over time. As practitioners, we can design our programming from the perspective of contributing to gender equality and equity. To do this we need to adopt a gender lens to ensure that our interventions are fully inclusive to ensure the best health outcomes by working with the dynamics between women, men, girls and boys. This will also enable a more effective, gender balance within intervention foci and optimise the roles that individuals, families and communities can play to reduce gender bias in access to the basic needs associated with health and disparities in the quality of care received.

To avoid gender blindness we need to routinely and meaningfully collect data and conduct disaggregated analyses. This will not only inform us on the extent to which project results are gender responsive, but by revealing the existence of previously unrecognised gender disparities, we will be informed to strengthen our planning and design to be better gender-responsive. Using gender-transformative approaches we can tackle health concerns more effectively and at the same time contribute to the achievement of equity and inclusion and health for all.

This Background Document has presented, based on existing evidence, the importance of applying a gender perspective to the conception, planning, design, implementation, M&E, data analysis and reporting in all health initiatives. While it has emphasised the complexity of gender dynamics within societies, as well as the health sector and its governance, certain elements have been presented that enable gender-responsive and -transformative approaches that not only enable more equal inclusion of all people in health initiatives and benefits, but are more likely to enable the achievement of health and broader development goals articulated in the SDG and aligned policies of nation states. A simple and concise list for consideration in guiding our activities is summarised here, to support efforts towards achieving health for all, efficiently and effectively.

Intervention conception and approach planning

- Consider gender determinants of health during intervention conception, situation analyses and design, making an explicit commitment to addressing gender equalities in health within our intervention documentation.
- Conduct gender-sensitive situation analyses that relate to health and wellbeing to inform effective programming and approaches.
- During the planning phase of an initiative, conduct analyses to determine the potential risk of creating a gendered burden within health interventions. Regularly assess whether gender inequalities have arisen as unintended side-effects of activities and rectify these.
- Define gender terms and approaches to intervention teams and partners in line with global norms to move beyond the reduction of the term “gender” to “females” to become more responsive to the health needs of women, men, girls and boys in all their diversity.
- Approach gender from an inclusive perspective, engaging and including males and females at all ages of their lives.
- Determine smart indictors to measure pertinent gender and health interventions.
- Budget for gender responsive programming and results evident in gender-disaggregated health data.

Mainstreaming in the workplace and in intervention activities

- Meaningfully mainstream gender to transform towards parity both our own organisations as a place of work, health decision-making and governance and within our interventions to promote and enable health for all.
- To reduce stress in the workplace and programme environment, make explicit statements on zero tolerance of gender-related and sexual harassment and define concretely what these are considered to be.
- Heighten sensitivity to gender and power dynamics at the community level, particularly to ensure gender balance in voices heard and representation in surveys, community conversations, health and social committees and local governance structures.
- Within core programming, plan gender balanced capacity building and decision-making to support strong approaches to address inequalities in health and gender-related drivers of ill-health.
- Plan action to address gender gaps in health service management and governance within a measurable time frame and accelerate the pace of change.
- Support gender-sensitive interventions beyond the health sector, to ensure that other gender influenced determinants of health (e.g. education, poverty, access to resources) are concurrently strengthened.
- Encourage health-related organisations and their duty-bearers to become serious in how they commit to and take action on gender as it mediates and determines aspects of health. As a basic approach it should be meaningfully mainstreamed through the day-to-day activities, deliverables and systems of accountability.
- In the current era of globally rising NCDs, greater attention needs to be placed on addressing the gendered nature of risk and devise informed and effective responses.

Monitoring and evaluation

- Conduct gender-based analyses and sex disaggregate data, analyses and reporting to monitor and evaluate the effectiveness of interventions from the perspective of male and female health throughout the life course and use this information to inform policy and programming.