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Gender and Health: an analysis of the influence of gender on healthcare and of social policies on women's health

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Introduction

"The complex construct of gender interacts with biological and genetic differences to create health conditions, situations and problems that are different for women and men as individuals and as population groups. This interaction, and how it plays out across different age, ethnic and income groups, should be understood by health providers and health policy makers."[1]

The objective of this dissertation is to analyze the complex influence that the concept of gender has on health, and in particular on women's health, with a focus on how national social policies differently impact people's lives and health based on their gender, and on how the situation has evolved in relation to the recent COVID-19 global pandemic.

In the first chapter, gender inequalities in health and the delivery of healthcare are discussed through the lens of biological and psychosocial factors. The phenomenon of gender segregation in the healthcare workforce is also analyzed. Gender impacts health in a variety of ways. Gender differences in health can be related to biological (i.e., sex-based) as well as social (i.e., gender-based) factors, but more commonly the interaction between the two account for health variability. Women and men are confronted with gender-specific health risks and diseases. Although life expectancy is generally lower for men, women's advantage does not translate into healthier years, and they usually suffer from a higher burden of non-fatal and debilitating conditions: in short, "women get sicker, men die quicker" (Macintyre, Hunt and Sweeting, 1996). This is partially due to biological differences, but several social factors also underpin differences in health and access to care. Gender stereotypes, norms and inequalities influence women's and men's behavior and life opportunities, and they usually translate into practices that affect the health and well-being of women. These include boys being valued over girls, beliefs that men have the right to control women, harmful traditional practices, limits placed on women's education and occupational choices and opportunities, and institutional biases that may perpetuate discriminatory values, norms and practices. Women are also the primary victims of violence and harassment, both at home and at the workplace, which significantly hurt both their mental and physical health and make them more susceptible to several disorders and diseases, such as depression or HIV/AIDS.

Furthermore, according to the theory of "constrained choice" (Bird, Rieker, 2008), the social context strongly influences one's preferences and priorities and, in turn, the perceived options individuals have for making everyday choices that cumulatively impact their lives and health. Misinformation and failure to account for evidence on how not only biological, but also social differences influence health can halt efforts to close gaps between men's and women's health and healthcare, by missing an opportunity to identify potential policy levers and processes that could be used to improve population health.

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[1] UN DAW, 1998. *Women and Health: Mainstreaming the Gender Perspective into the Health Sector*. [online] Un.org. Available at: https://www.un.org/womenwatch/daw/csw/healthr.htm [Accessed 20 April 2021].

The world of medicine and medical research, and its underlying philosophy, have equated, and sometimes still equate, male with normal, leaving women to be considered as "the other". The reality is that female bodies are simply not afforded the same level of medical attention as male bodies. Health services often view women only within their reproductive role and are blind to wider gender differences in health, leaving many women's problems untreated and ignored. And even regarding reproductive and maternal health, many women are often mistreated, both by health providers and by policymakers. Instead, a gender-responsive health system should ensure that the links between biology, gender and social determinants are addressed across their functions, to better understand the specific health needs of women and offer them a proper treatment. Health and care services also heavily depend on women, constituting the large majority of health workers worldwide, and contributing as unpaid, informal educators and carers, particularly for children, sick family members and older people. Women are overrepresented in the health and social sectors but rarely hold executive or management-level positions. Instead, they tend to be concentrated in lower-paid jobs where they are exposed to greater occupational health risks and economic difficulties. Key areas for attention for policymakers include gender balance in health management, in academic medicine, in public health and nursing, parental leave provision for both women and men, and childcare arrangements.

The second chapter explores all the different actions which should ideally be taken by national governments in order to achieve gender equality in health, and the international efforts made in the past to reach this goal. As far back as 1987, Verbrugge and Wingard started calling for researchers and clinicians to move beyond the focus on men toward a more nuanced view of gender differences in health patterns. They also suggested that non-health-related social policies such as universal day care, universal access to all levels of education, and retirement welfare have the potential to benefit individual and group health. Indeed, policy has a huge potential to affect public health in both negative and positive ways: from health-system-related policies to social welfare protections, they can all affect constrained agency and health in many ways. This is why it is so important that national governments and other actors promote an active and visible policy of mainstreaming a gender perspective in all policies and programs, also considering the interaction of gender with wider dimensions of inequality. The incorporation of the gender perspective into health interventions is considered an internationally accepted strategy which, according to the World Health Organization (WHO), aims to institutionalize gender equality in all sectors. In the latest years, the analysis of the distribution and causes of disease and mortality by gender has led to improvements in allocation of resources and in attention given to previously neglected health issues affecting women in particular. Many international organizations, including the European Union (EU), have joined WHO in its efforts to achieve a more gender-equal health treatment for everyone worldwide.

The third chapter reflects on how public policies act as macro-level determinants of gender inequalities which shape other social and economic factors, in turn influencing gender inequalities in health

and wellbeing. It concentrates specifically on the public policies implemented in countries of the European region and the effects they have on women's health. Different types of policy regimes formulate policies and regulations that directly and indirectly affect gender differences in health. Gendered roles and responsibilities interact with resources and barriers such as employment opportunities or security, the provision of childcare and elder care, and public safety. European countries have been leaders in family policy enacting various social investments focused on childcare, parental leave, active labour market programs, and long-term care policies. These are in part implemented to strengthen gender equity and reduce the gendered burden of family care work, which has a huge impact on women's health. A critical point here concerns the degree to which the state assumes responsibility for protective public health regulations and especially for family well-being and childcare, and how much remains the sole responsibility of individuals and families, and especially women. For example, in social democratic welfare regimes such as in the Nordic countries, where the state traditionally has had more responsibility, general health status seems to be better than in traditional southern, eastern or market-oriented countries. Some examples of policies in different regimes' countries are given in order to illustrate these differences.

Finally, the last chapter explores the intersection of gender inequalities with the recent COVID-19 global pandemic, from which women have been disproportionately suffering. From risk of exposure and biological susceptibility to infection to the social and economic implications, individuals' experience of the COVID-19 pandemic varies according to their biological and gender characteristics and their interaction with other social determinants. Yet the vast majority of activities to address health impacts of COVID-19 ignored the role of gender, also because there is a significant lack of sex-disaggregated data on COVID-19-related indexes, and so it is difficult to assess the disproportionate effect the pandemic has had on women and men. What is certain is that COVID-19 has put a halt to the progress in gender equality and that women are overrepresented in sectors that have been worst affected by the crisis, starting from the health and care sectors themselves. Thus, to be truly effective, global and national strategic responses to COVID-19 must be grounded in gender analysis and must ensure the participation of affected groups, including women, in decision-making and implementation.

Chapter I

"The influence of Gender in Health"

1.1 Gender and Health

Gender is defined as the socially constructed norms, roles, behavior, activities, and attributes that a particular society considers appropriate for men and women (WHO, 2021). Gender is relational, which means that gender roles and characteristics do not exist in isolation but are defined in relation to one another and through the relationships between women and men; they are also constructed historically and culturally. Gender interacts with sex, the biological and physical characteristics that define males and females (and intersex people) and is one of the main social determinants of health and a key driver of power to exercise the right to health. Health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity" (WHO, 1948).

The theory of social determinants of health (SDOH), defined by WHO as "the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life; these forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems", underlines that our health is indeed affected by diverse influences including work, ethnicity, food security, education, the environment, social relationships and, of course, gender. Historically, the design of health programs and medical research have placed much more emphasis on the differences between the sexes than on the complex interaction between sex, gender and health. But understanding that the different ways in which men and women fall ill cannot only be explained by genetic differences with a biological foundation, has made it necessary to introduce the concept of gender. Conceptually, gender has been described as influencing health and well-being across three domains: (i) through its interaction with the social, economic and commercial determinants of health; (ii) via health behaviors that are protective of, or detrimental to, health outcomes; and (iii) in terms of how the health system responds to gender, including how it affects the financing of and access to quality health care (WHO, 2018).

Gender plays a precise role in the incidence and prevalence of specific pathologies, and in their treatment and impact in terms of well-being and recovery. All of this is caused by the interrelations between sex-related biological differences and socioeconomic and cultural factors that affect the behavior of women and men and their access to health services. Health systems around the world are not gender neutral, instead we can say they are gendered, which means that male and female patients are treated differently and that male and female physicians behave differently. The role of gender within health systems relates to several concepts: universal health coverage, the impact of gender stereotypes and gender-related stigma on care, principles of accountability and inclusivity, and the gendered experience of the health workforce itself.

Inequalities and discriminations faced by women and girls put their health and well-being at risk. Women and girls often face greater barriers than men and boys to accessing health information and services. These barriers include restrictions on mobility; lack of access to decision-making power; lower literacy rates; discriminatory attitudes of communities and healthcare providers; and lack of training and awareness amongst healthcare providers and health systems of the specific health needs and challenges of women and girls. Indeed, women are often denied reproductive rights, whether legally or illegally. Nonetheless, harmful gender norms – especially those related to rigid notions of masculinity – can also affect boys and men's health and wellbeing negatively. Gender equality has been recognized as critical and led to a strong commitment to addressing unequal gender norms and gender stereotypes that influence health policy and services (EWEC, 2015, p.38).

Until recently, a male model of health was used almost exclusively for clinical research, and the findings were generalized to women, except for the reproductive period. Indeed, biomedical research focused on men's experiences of life-threatening chronic diseases, which are common in both sexes, while limiting the study of women's health problems primarily to sex-specific diseases and disorders. "Andronormativity" in medicine implies that masculinity and male values are regarded as normal to such an extent that femininity and female values are invisible and ignored; this has consequences for which conditions are prioritized or not in research and health care and may be reflected in status hierarchies of diagnoses. Researchers believed that men's and women's bodies functioned so similarly that findings from studies based exclusively on male bodies would be almost invariably applicable to women. At the same time, paradoxically, one prevalent argument for excluding women from clinical trials was that the study would have had more power if a homogeneous group was studied; however, if the rationale for excluding women was that they are different, it does not follow that the results from studies of exclusively male samples could be generalized to women. Clinical trials typically excluded women also to protect them and their unborn children from possible negative effects; at the same time, little if any attention was ever paid to the potential negative effects on men's fertility.

Gender issues conflict with this traditional biomedical health model that promotes a neutral approach to gender and fit better with a holistic health model. The women's health movement and their increasing representation among clinicians, researchers, and policymakers has led to the reconsideration of these assumptions and the recognition of the need for knowledge regarding the impact of particular treatment on women. In particular, questions about gender differences in heart disease, mental illness, and osteoporosis led to important recommendation that women be included in clinical studies to uncover gender differences and their impact on the prevention, diagnosis and treatment of disease. Furthermore, it was demonstrated that such a male model of health has had a significative negative impact for understanding the efficacy and safety of drugs for women, in particular the ones for the treatment of depression, which is ironically a disease which affects mostly women and makes them the highest consumers of antidepressants (Hamilton,

1995). Nowadays, despite increased inclusion of women in clinical trials, participation is still particularly low in studies in which safety, safe dosage range and side effects are determined, which results is a general lack of awareness among health care professionals about the importance of sex-specific differences in disease manifestation and response to treatment, considering that women are also 1.5 times more likely than men to develop adverse reaction to prescription drugs. Statistical data on health are often not systematically collected, disaggregated and analyzed by age, sex and socioeconomic status. Subjects of importance to women's health have not been adequately researched and women's health research often lacks funding. The advancement of human health and health-related knowledge requires research which includes both sexes and leads to a more integrated understanding of diseases and health problems that affect both men and women. Global health journals should encourage authors to include a gender analysis of sex-disaggregated data. This is to the benefit of both women and men: for example, a better understanding of biological differences which confer a health advantage to one sex could be used to develop pharmaceutical interventions to benefit members of the opposite sex.

The traditional biomedical model of disease assumes that medicine is a socially neutral science, ignoring the fact that the values underlying medical research, practice, theories and knowledge are deeply biased by the practice situations and social characteristics of the dominant group of medical professionals, who typically reflect societal values. Instead, the social and biomedical fields can and should be bridged through interdisciplinary research and supportive research policies to have a more holistic approach to health. Thus, an understanding of the interaction between sex and gender in the development and management of health and disease can benefit both sexes in terms of prevention, intervention and outcome: gender medicine, indeed, has made strong advances in explaining how the incorporation of gender issues into research can affect medical understanding, by recognizing differences in women and men's health patterns, and adapting the diagnosis and treatment to suit these differing needs. Gender medicine aims to improve the health condition of women and men by intervening both on the disease requiring multidimensional care and on lifestyles that can represent substantial risk factors. Anyhow, the term "gender", which has correctly replaced the term "sex" in healthcare research, is often misapplied to describe purely biological differences in sex organs and sex specific diseases.

Although different types of researchers study gender differences in health, there is usually little cross-disciplinary dialogue between the biomedical community and the social science community, they operate as two distinct paradigms. Because these two fields often compete for scarce resources in terms of research funding, researchers from both sciences tend to ignore and often disparage the other's perspective and work. Indeed, some researchers believe that the biomedical explanations of health disparities between men and women are so powerful that social aspects of gender are not an issue that needs explaining. Sociologists, in turn, may feel that biomedical explanations will never address the fundamental social cause of gender disparities in health created by inequality, or that inherent biological differences between men and

women are either minimal or largely irrelevant. The truth is that although biological differences may have no inherent consequences for men's and women's physical capabilities (aside from procreation), they have, together with social differences, significant consequences for men's and women's health and health care.

In their book "*Gender and Health – The Effects of Constrained Choice and Social Policies*"[2], Chloe E. Bird and Patricia P. Rieker have made a conceptualization of "constrained choice": men's and women's opportunities and choices are partially constrained by decision and actions taken by families, employers, communities, and governmental policies. Eventually, these choices can contribute to the observed patterns of gender-based health differences by creating, maintaining, or exacerbating underlying biological differences in health. So, gender differences in the constraints contribute to health disparities both directly and indirectly by affecting both men's and women's choices, their exposure to various risks (e.g., stress) and their access to protective resource (e.g., income). Such a perspective emphasizes the impact of constrained choices in the reproduction of gender roles and gendered behavior, but also how they are made in the face of unequal opportunities and expectations for success. Efforts to improve health and reduce gender disparities require that an understanding of the ways in which individual behaviors, family and social context, and social policies shape individuals' experiences. Current models of health behavior imply that people act irrationally when they make life choices that are not good for their health in the long run. However, recognizing the constraints and the context of everyday decisions made by individuals reveals how such choices and behaviors can be understood to be rational, even if they do not appear to be consistent with people's priorities. Under different circumstances, an individual may have fewer opportunities to choose health and thus to take responsibility for their own health because of more urgent needs, and this is often the case for women, and especially for mothers and those who care for other people. (Bird, Rieker, 2008).

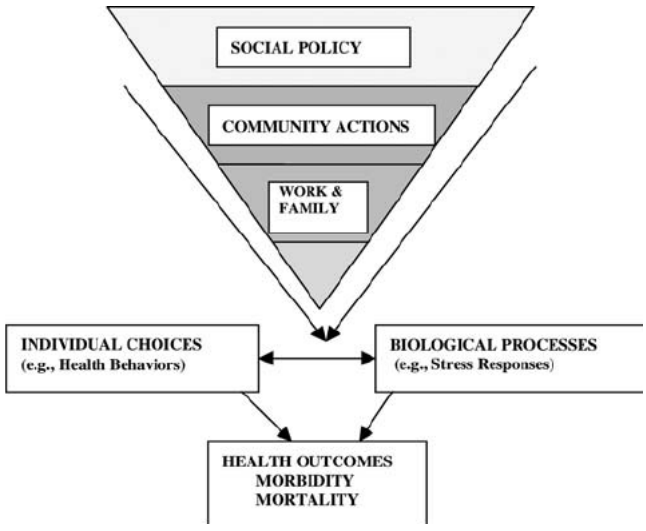

Figure 1: Bird, C. and Rieker, P., 2008. *Gender and health*. Cambridge: Cambridge Univ. Press.

[2] Bird, C. and Rieker, P., 2008. *Gender and health*. Cambridge: Cambridge Univ. Press.

Although many of the constraints and their consequences for individual choice are similar for men and women, their health impact will vary somewhat due to gender differences in biology and life experiences. The question of how corporeality can be brough back into the debate without biological reductionism is decisive for women's health research. At the same time, although biological factors, such as genetics and hormone exposure, may contribute to differences in men's and women's health, a wide range of social processes can also create, maintain or exacerbate underlying biological differences. It is difficult to disentangle biological from social or sociocultural influencing factors: human behavior, which influences mental health-being, is influenced by biologically determined sex-specific traits, but also by sex-specific cultural stereotypes; gender differences in life experiences might vice versa influence biological differences via epigenetics.

In conclusion, neither social nor biological theories alone offer substantial insight into the paradoxical complexities of gender differences in health. For example, by focusing only on the biological explanations for gender differences, most research implies that the best points for intervention are medical treatments at the individual level, overlooking the possibilities for more systematic social interventions to improve the health of the population and eliminate gender inequalities. Ultimately, at the research level, there is a need for integrated social and biological explanations of gender differences in health, while at the social level an understanding of the consequences of the choices and pathways that produce gender differences can inform individuals, families, communities, and societies about how to better integrate health implications into their decision and actions. Researches and policymakers have to critically analyze scientific "facts" about health and gender to rethink the traditional claims of medical practice to cure and care, taking into consideration how the living conditions of women in today's society and the burdens and discrimination they face influence their wellbeing and health behavior.

1.2 Gender inequalities in health: Women's Health

"Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life" (United Nations, 1995). Yet, unfortunately, this right is often not recognized to women, who encounter a major barrier to the achievement of the highest attainable standard of health in inequality. Women have different and unequal opportunities for the protection, promotion and maintenance of their health. Health policies and programs often perpetuate gender stereotypes and may not fully take account of the possible lack of autonomy of women regarding their health. Women's health is also affected by gender bias in health systems and by the provision of inadequate and inappropriate medical services to women. Broadly, health spending on men is often substantially higher than on women. The quality of women's health care is often deficient: women are frequently not treated with respect, nor are they guaranteed privacy and confidentiality, nor do they always receive full information about the options and services available. Gender stereotyping by health-care providers and gendered differences in the presentation

of diseases can affect diagnostic and treatment pathways, as, for example, is often the case with cardiovascular diseases. What most health systems are missing is gender sensitivity, which means that health professionals are competent to perceive existing gender differences and to incorporate these into their decisions and actions. To achieve full gender equity in health would not necessarily translate into equal rates of mortality and morbidity in women and men, but into the elimination of avoidable differences in opportunities to enjoy health and not to fall ill, suffer disabilities, or die from preventable causes. Likewise, gender equity in health does not necessarily imply equal quotas of resources and services for men and women, but a differential allocation and reception of resources, according to the particular needs of each person and in each specific socioeconomic context.

Women are affected by many of the same health conditions as men, but women experience them differently. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards them, the limited power they have over their sexual and reproductive lives and lack of influence in decision-making are all social realities which have an adverse impact on their health. Social factors, such as the degree to which women are excluded from schooling, or from participation in public life, and their general subordination by men, affect their knowledge about health problems and how to prevent and treat them. This type of treatment begins when they are young. Discrimination against girls, often resulting from son preference, in access to nutrition and health-care services endangers their current and future health and well-being. Conditions that force girls into early marriage, pregnancy and childbearing and subject them to harmful practices, such as female genital mutilation (FGM) and foot binding, pose severe health risks. Overall, adolescent girls are both biologically and psychosocially more vulnerable than boys to sexual abuse, violence and prostitution, and to the consequences of unprotected and premature sexual relations. For most of them, early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on the quality of their lives and the lives of their children. Young men, on the other hand, are often not educated to respect women's boundaries and self-determination and to share responsibility with them in matters of sexuality and reproduction. Women have the right to make decisions on matters relating to their sexuality, including sexual and reproductive health, being free of discrimination, coercion and violence. Social vulnerability and the unequal power relationships between women and men are obstacles to safe sex and to controlling the spread of sexually transmitted diseases, such as HIV/AIDS and Human papilloma virus (HPV), which is the most common sexually transmitted viral infection, with 10 per cent of all women in the world positive for at least one HPV genotype, and the main cause of cervical cancer and other genital cancers. Most high-income countries have introduced the HPV vaccine in their routine immunization programs for girls, but many low- and middle-income countries do not offer HPV vaccinations to adolescent girls, even if providing HPV vaccinations and screening could drastically reduce the incidence of and mortality from cervical cancer.

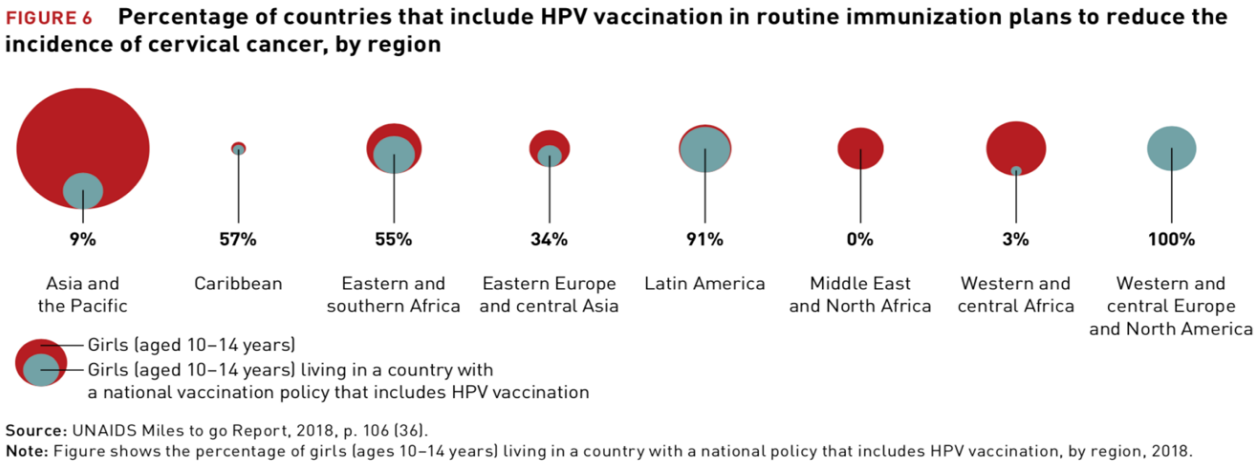

Figure 2: WHO, 2019. *Breaking barriers: Towards more gender-responsive and equitable health systems*.

So, women's vulnerability to HIV and STDs derives from a combination of biological predisposing factors and gender inequality conditions, such as limited women's knowledge, inability to negotiate safer sex, and, in certain situations sexual violence.

Another great obstacle is misinformation, which can only be solved with campaigns of sensibilization and efforts to improve health education. Literacy plays a precise role in determining a population's level of disease and mortality by affecting accessibility to health-related literature and information. Indeed, it is well documented that those who have access to literacy and education tend to adopt healthier behaviors in general and have a greater measure of control over their bodies. The International Council on Women's Health Issues (ICOWHI) seeks to support women in educational endeavors to promote empowerment and positively affect gender inequality in the educational sphere. The approach to sexuality education has also been changing from seeing learners as passive recipients of information about the risks associated with sex, to a focus on healthy sexual behavior and addressing gendered power relations.

Over the decades, there has been a correlated shift from health education to the multidisciplinary approach of health promotion: whereas health education was often focused on the individual health client and their needs in relation to health services, health promotion engages with the wider community to raise awareness and directly address the social determinants of health.

Health literacy is "the cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" (WHO, 2013). It is "a critical empowerment strategy to increase people's control over their health, their ability to seek out information and their ability to take responsibility" (Kickbusch et al., 2015).

Worldwide, 15 million girls of primary school age will never get the opportunity to learn to read or write in primary school, compared with 10 million boys. Education of girls and women has been shown to be one of the most cost-effective means of improving local health standards. Indeed, health and education are closely related in economic development. Education is a means to attain a higher income and status, which combine to produce greater opportunities and better health. Health, women's empowerment and

education are closely interlinked, and “women as informed health consumers are catalysts for social change” (OBOS, 2016). Recognizing women’s strong traditional role as caregivers, some programs have promoted women’s literacy in order to enhance health and nutrition, which is an important factor of well-being and a gendered dimension as well, in the wider community. Particularly in middle- and high-income countries, literacy has also been associated with enhancing social connectedness and providing an escape from depression or stress. From all of this, we can deduce that education is a lifesaving investment in health, both for women and men, as caregiver and care-receivers. But the beneficial effect of education can be affected by macro-level political and economic forces which result in contractions of welfare provisions (including health-system cuts), wage depression and insecurity.

The gender differences in the social consequences of health and illness include how illness affects men and women, including health-seeking behavior, the availability of support networks, and the stigma associated with illness and disease. Men and women respond differently when ill, in terms of time before acknowledging that they are ill, recovery time, and how women and men are treated by their families and society. Social explanations for gender inequalities in health stress the relevance of health behaviors, such as substances consumption, dietary habits, physical activity, and healthcare utilization, socio-economic factors, such as financial resources and working conditions, and psychosocial factors, such as critical life events and social network characteristics. From this point of view, gender differences in health arise from a gendered access to protective resources and a differential exposure to health risks. The biological differences can be amplified or suppressed by socialization and how society responds to sex-specific behavior. Social norms endorsing particular kinds of behavior may exacerbate negative tendencies, such as violence, or reinforce positive propensities, such as nurturing. By contrast, socialization can also suppress innate negative or positive tendencies. Some examples are women’s greater risk of depression compared to men, and men’s tendency toward more physically aggressive behavior compared to women. Although these differences may have some biological basis in sex hormones and are sometimes assumed to be “inherent” traits, they are reinforced (if not created entirely) through gender socialization whereby men and women are continuously judged for the gender appropriateness of their behavior, style of communication and expectation for their lives and social roles. This socialization process encourages women to accommodate others and allows men to express anger and frustration more readily and violently than women. Different roles and responsibilities assigned to a person as a function of being male or female can cause, for example, masculinity to be traditionally associated with force, resistance, and resilience. This can influence men who accept this masculine role to be reluctant to ask for help or consult health professionals, and to be more prone to take risks and have accidents. In contrast, traditional femininity is associated with delicacy and softness, which can cause women who accept this tule to consider it inappropriate for them to participate in physical activities, an attitude which can damage their health, both physically and mentally.

Gender is one of the critical factors influencing the experience of pain, its perception, description and expression. Women report more severe levels of pain and chronic pain than men. Women's pain responses are affected by hormones, menstrual cycle, pregnancy and oral contraceptive use. Despite that, women are less likely to receive an appropriate treatment and effective pain relief. The response to pain therapy also appears to be gender-related: for example, some evidence suggests gender differences in response to pharmacological treatments, but also different pain-coping strategies dictated by traditional gender roles. From an early age, boys are taught to be tough, tolerate pain, and sustain painful experiences, while girls are socialized to be sensitive, careful, and to verbalize discomfort. So, it is more socially accepted for women than for men to show pain and talk about it, but at the same time women with pain are often perceived as hysterical, too emotional and complaining. Furthermore, sometimes "medically unexplained" conditions go along with an unwillingness among healthcare professional to take seriously, believe in women's pain and further investigate into its causes. Feeling mistrusted or psychologized by healthcare professional can lead to even more distress. Instead, professionals should empower women by being wise, competent, caring, making women feel heard and building a trustful relationship with them.

Illnesses have a disproportionate effect on women, not only because of biological factors, but especially because of social determinants, so that the experience of illness is strongly related to gender identities. In the case of HIV-associated disease, for instance, the economic consequences may be worse for women who are left with families to support when husbands become infected and die, or they may not be able to earn income or support their families when they themselves are ill. Furthermore, the lower social status of women influences how society responds when they are affected by stigmatizing illnesses, such as HIV/AIDS, leprosy, tuberculosis, and mental illness. While both men and women suffer considerable discrimination, women are more marginalized by these health problems.

As pointed out by the UN Committee on the Elimination of Discrimination against Women (CEDAW), "gender-based violence is a critical health issue for women". Sexual and gender-based violence, including physical and psychological abuse, trafficking in women and girls, and other forms of abuse and sexual exploitation place girls and women at high risk of physical and mental trauma, disease and unwanted pregnancy. An estimated one in three women and girls experience physical or sexual violence by an intimate partner or non-partner sexual violence. According to the *World Report on Violence and Health*[3] by WHO, it can result in fatal health consequences, in physical consequences, psychological and behavioral consequences, and sexual and reproductive consequences. Women who experience such violence are 4.5 times more likely to attempt suicide than other women, and twice as likely to experience induced abortions, depression and alcohol use disorders.

[3] WHO, 2002. *World report on violence and health*. World Health Organization.

These women are also 1.5 times more likely to get a sexually transmitted infection. Indeed, women's greater biological susceptibility to HIV/AIDS and other sexually transmissible diseases is worsened by the increased vulnerability constituted by exposure to domestic violence and employment in unregulated and exploitative sex-based work. Such situations and restrictive laws and policies, including criminalization of sex work and age of consent laws, often deter women from using health and other service. Furthermore, women state that they feel unsafe more often than men, whether alone at home (9 per cent compared with 4 per cent) or outside (20 per cent compared with 9 per cent). The effects of feeling unsafe can be seen especially in higher rates of poor mental health, social isolation and depression. In some cases, this may have an impact on participation in social, economic and health-promoting activities and services. Mental disorders related to marginalization, powerlessness and poverty, along with overwork and stress and the growing incidence of domestic violence as well as substance abuse, are among other health issues of growing concern to women. For example, women experiencing intimate partner violence have double the risk of alcohol-use problems, and women develop higher blood alcohol concentrations than men for the same alcohol intake. In these cases, it is important for women to be vocal about such situations, not only to share experiences with each other, but also to gain a voice in the public domain and to construct identities that challenge negative representations of women in the media. Reducing domestic violence must include culturally sensitive strategies to educate and empower victims to speak out against offenders. Giving women a sense of control helps to create supportive environments.

Partner violence is mainly aggression by men against women and children, although men are also victims of domestic violence. This is also due to the fact that masculinity is often linked to the concepts of domination and aggression: the culture of patriarchy and violence includes the assumption of a hierarchy in gender roles and of male sexual entitlement to use some forms of violence as a legitimate and usual way to solve conflicts in interpersonal relationships. It is well-known that violent partners also frequently obstruct efforts of women to seek help for themselves and their children, and poor women have also little economic power and resources in such situations. Victims of domestic violence have more difficulty keeping a job because they often miss work due to physical injury.

Women also suffer disproportionately from stalking and harassment in the workplace. The fear and discomfort entailed affects their ability to perform, and they may also be forced to leave their job when the situation becomes unbearable or may be dismissed when they resist to harassment by male colleagues and superiors. Gender-based violence affects society as well as individuals; it has substantial effects on public health and is an obstacle to women's active participation in society. Some researches indicate that women's higher rates of health care utilization are in part due to the physical and psychological consequences of men's violent behavior (Koss et al., 1995). It is important also to note that violence and violation of women's health may also result either from State action, via harmful policies, or from State failure to meet its core obligations to promote the empowerment of women. Empowering women impacts positively on social and human capital and has a positive effect on economic growth and development.

Social scientists are investigating the impact of different kinds of work environment on health of men and women. Research in industrialized countries has shown that working outside the home is related to improved health for women, because of increased self-confidence and economic independence. Similarly, employment is associated with increased life expectancy. Work can be intrinsically and extrinsically rewarding in a way that promotes health, or unfulfilling and burdensome in a way that is detrimental to well-being. The effects of unemployment and work-related diseases on women are less well understood. It seems like musculoskeletal and lower-limb disorders, along with stress-related problems affect women more than men.

Gender stereotypes hamper both women and men's health behavior, making them think of being invulnerable to certain conditions (e.g., heart disease or HIV for women, negative effects of chemotherapy on fertility for men), and the quality of care, because of the difficulty in recognizing certain specific needs, such as the same degree of importance of psychosocial support for identity-threatening problems (e.g., breast cancer for women, prostate cancer for men) for both sexes. When confronted with illnesses, women are more prone to accept their condition as part of themselves, rather than to see it as a challenge to be overcome, as their male counterparts tended to do. This is because girls tend to be educated more toward passivity, helplessness, and low self-esteem, whereas boys are more encouraged to active coping. Anyway, men are often reluctant to seek help, due to a traditional "hegemonic" self-concept of masculinity, and less likely than women to directly ask physicians about their health problems. Instead, women report symptoms more willingly, seek help earlier, and demonstrate better compliance, also because they learn early on, in part through awkward clinical encounters such as gynecological visits, to persist in asking direct questions about their health conditions and possible treatments (Kaplan et al., 1995).

Globally, the average life expectancy gap between men and women is 4.6 years, so women universally live longer than men, but the gender gap is greatest in developed societies where women outlive men by about seven years on average. Despite women's greater longevity compared to men, women experience higher rates of morbidity and psychological distress, including anxiety, depression, worry and demoralization. This is called the "mortality/morbidity paradox": women live longer but have poorer health. This pattern of men's higher mortality and lower morbidity is often explained by gender differences in the patterns of disease: men have more life-threatening chronic diseases, including coronary heart disease, cancer, cerebrovascular disease, emphysema, cirrhosis of the liver, kidney disease and atherosclerosis; in contrast, women face higher rates of non-life-threatening chronic disorders such as anemia, thyroid conditions, gall bladder conditions, migraines, arthritis, colitis and eczema. Women also suffer from more acute conditions such as upper respiratory infections, gastroenteritis and other short-term infectious diseases, and they are disproportionally affected by obesity-related cancers.

Women's biological advantages consist in estrogen, which provides them a more flexible circulatory system that can carry a 20 per cent higher blood volume during pregnancy and thus produces less pressure on the vessels even at higher blood pressure resulting in less damage in premenopausal women than in men the same age, and in a stronger immune system that allows women to have higher levels of passive immunity during pregnancy and to pass on a substantial level of protective antibodies to infants during breast feeding (Grossman et al., 1991). On the downside, women's more robust immune systems expose them at a greater risk of autoimmune and genetic immune suppression disorders. Thus, for the most part women's advantage in longevity appears to be related to their ability to bear children and the physiological systems that permit pregnancy and childbearing, whereas men's health advantage in morbidity seems to be due to lower levels of role stress, role conflict, and lower societal demands.[4]

Although men suffer earlier onset of many life-threatening chronic diseases, women tend to experience these same health problems somewhat later in life. As they age, men and women suffer from similar types of illnesses, but men tend to suffer from acute illnesses for relatively short periods before they die. Women, by contrast, have a longer life, marked by many chronic non-life-threatening disabilities that can still greatly affect the quality of their lives. For example, osteoporosis, due to reduced levels of estrogens and a natural decline in bone density after menopause, affects mainly women. "Chronic and non-communicable diseases (NCDs) such as cardiovascular disorders, stroke, cancer, diabetes, chronic obstructive pulmonary disease and mental health disorders now the leading causes of death and disabilities for women in almost all countries" (Langer, 2015). Breast cancer is the most commonly diagnosed cancer and the leading cause of cancer death in women.

Even if women are less likely than men to be diagnosed and receive appropriate treatment for cardiovascular diseases (CVDs), among older people, deaths from CVDs are more prevalent among women than men. This is because women manifest different, "atypical" symptoms for CVDs that the established symptoms experienced by men. The gender bias in clinical guidelines stems from the historic gender bias in CVD research, which has resulted in a lack of evidence on CVD symptoms in women, lower awareness by female patients and poorer recognition by care providers, and thus delayed diagnosis, hospitalization and treatment. In the medical sector, this phenomenon is commonly called the "Yentl syndrome". Furthermore, women's increasing exposure to risk factors for non-communicable diseases (NCDs) in general increases the risk of developing diseases and disabilities earlier in life, and this risk may be increased by health system biases. An example of a health condition affecting women than often goes under-diagnosed and/or not treated is endometriosis, which is a chronic and disabling gynecological disease affecting 10 percent of women of reproductive age, associated with acute symptoms, mainly consisting of severe pelvic pain and infertility. In

[4] Bird C., Rieker P., 1999. *Gender matters: an integrated model for understanding men's and women's health.* Soc Sci Med.

endometriosis, women's symptoms are not always taken seriously and are often normalized or not recognized by doctors, which leads to delays in diagnosis and treatment.

The reality that female bodies are simply not afforded the same level of medical attention as male bodies is often dismissed with the reply that, on average, women enjoy more years of life than men. But as it has been previously said, longer longevity does not necessarily translate into an increase of the years of life spent in good health. The concept of life expectancy cannot efficiently account for the health of a population, so it should replace by that of health expectancy (HE), which expresses the average number of years that a person can expect to live in full health. Healthy life expectancy (HALE) is a form of HE that applies disability weightings to health states to compute the equivalent number of years of life expected to be lived in full health. Health life expectancy at birth was 63.1 years globally in 2015, and for females was hardly 4 years greater than that for males (Global Health Observatory GHO data, 2016). In 2019, the number of healthy life years (HLY) at birth was estimated at 65.1 years for women and 64.2 for men in the EU, which represented approximately 77.5 per cent and 81.8 per cent of the total life expectancy for women and men (Source: Eurostat). Also, when calculating the disability-free life expectancy and the chronic morbidity-free life expectancy, the female advantage disappears.

Several studies of the "will to live" have found that women have a weaker desire to prolong life than men, in terms of refusing life-sustaining care or a wish to die sooner if terminally ill.[5] Older women in both developing and industrialized countries are more likely to live alone than men, and isolation can severely affect the health of older people, and given the general lower economic status of women, they are less likely to be able to seek help. Gender and income inequity combine to increase the poverty risk of older women, which leads to women living longer but not in good health. The gender pay gap leads to a gender pension gap later in life.

Generally, earning an income brings greater autonomy, decision-making power and respect in society. In most societies, women have lower social status than men, producing unequal power relations, and experience higher rates of economic hardship, which makes them particularly vulnerable to human rights abuses and poor health conditions. The unemployment rate of women is 30 per cent, almost double that of men which is 17 per cent; a fifth of women living in poverty are not active in the labour market due to domestic and caretaking responsibilities. When they do work, women are subject to two different kinds of segregation:

- Vertical segregation, corresponding to the scarce presence of women at the top positions of organizations, institutions and workplaces in general, described through the metaphor of the "glass

[5] Carmel S., 2001. *The will to live: gender differences among elderly persons*. Soc Sci Med

ceiling phenomenon", an invisible obstacle inhibiting or blocking women to the access of power and decision-making roles.

- Horizontal segregation, which is the unbalanced distribution of women and men workers in certain sectors, such as the prevalence of women in the work fields related to care and their absence in STEM sectors.

These mechanisms of segregation explain why women have generally lower incomes than men. Furthermore, their financial resources have to go farther than men's because they are more likely to become single parents and caretakers to their elderly relatives, into the care of which women are far more likely to contribute their time and energy as well as their money. The proportion of time spent on unpaid domestic and care work by women is 2.6 times greater than for men. Parenthood and the unequal division of unpaid domestic work are recognized as the first cause of gender segregation in the labour market. Target 5.4 of SDGs is to "recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate." The so-called "reproductive labour", which includes work done within the household and is distinguished from productive labour performed outside, is not income-generating, but it is fundamental to reproducing the daily conditions of domestic survival and the reproduction of human values, attitudes and culture, and yet it is not appropriately recognized and compensated. Such economic strains can have direct and indirect health consequences. Interference between family and work responsibilities represent one of the main psychosocial factors leading to poorer health and reduced psychological well-being. The fact that women are often paid less for the same jobs as men, or they are not paid at all because of the unrecognized care labour, also means that they have fewer resources to fall back on when they become ill, and their control over their own earning is often limited. Because women living in poverty and working in informal employment have limited if any access to social health protection schemes, they may avoid accessing health services because of concerns that it will result in debt and further impoverishment. In general, non-standard workers (part-time, temporary, and daily labour), which are mostly women, are more likely to suffer from mental problems, in terms of depression and suicidal thoughts. Even if the gender pay gap still exists and so do traditional roles in society, gender relations and their impact on biological factors are changing, as women increasingly assume positions traditionally occupied by men and vice versa. Women with greater agency and social independence, including in relation to their male partners, have greater decision-making power and control over household resources than women with lower agency and independence.

Gender-related biological and social factors explain many differences in diseases between women and men. For example, studies on gender differences in diabetes in industrialized countries have focused on how men and women cope with the illness. The most common finding is that women and girls generally have a more negative way of dealing with diabetes than men and boys and they are more likely to develop anxiety, depression and eating disorders. As women in general tend to internalize problems more, girls may

internalize stress more than boys, who tend to externalize problems, choosing active coping strategy, and to deal with their stress by more positive behavior, such as practicing sports and following a controlled diet (even if sometimes this could lead to more aggressive coping strategies, such as the use of violence or substance abuse). Furthermore, some researchers have shown that men with diabetes generally receive more support from their partners than women, as demonstrated by the greater attendance of wives in education programs than husbands of diabetic women.[6]

Gender also plays an important role in determining risk factors for eating disorders, the most common being anorexia nervosa, bulimia nervosa, and binge eating (BED). Biomedical and psychological theories include hormonal imbalance, malfunctioning of serotonin in the brain, genetic explanations, and emotional problems expressed by abnormal relationship with food. Sociocultural explanations include the emphasis placed on the "ideal" female body shape, especially by media in western society. Research performed on health communication targeting women has shown that most studies concerning health information are somehow related to beauty and physical appearance; this is not the case for men, whose health seems to be a value in itself. Body weight is often considered as the main health indicator for women, and experts agree that a key factor is the internalized desire to please others. Dieting and bingeing may be used for improving body image and self-esteem, as well as resorting to cosmetic surgery, which sometimes is followed by complications and psychological consequences.

Results of research in industrialized countries consistently indicate that women have higher rates of anxiety, depression and posttraumatic stress than men. This goes against the biological reasoning that women should be protected by estrogens, which seem to have antipsychotic and stress protective properties, to improve affective symptoms, aggressive and suicidal behavior, and cognitive functioning. Nonetheless, some studies have suggested that the higher levels of depression among women may be partly genetic (Rusby et al., 2016). What is clear is that the impact of socioeconomic inequalities has a huge influence on women's mental health, both as patients and informal providers of care. Thus, the fact that men have greater control over resources, and decision-making power is one explanation, but there is considerable evidence that even when women have control over resources and income through employment anxiety and depression are not necessarily reduced. This is because the experience of a particular social or occupational position might be different for men and women. The gender differences in economic roles strongly influence mental health outcomes. Depression could be also caused by the higher burden of care work and responsibilities, but also by being subjected to different kinds of violence. In many settings women with mental health disorders and intellectual disabilities face mistreatment, abuse and coercion by health providers, including forced sterilization, involuntary abortions and forced institutionalization.

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[6] Gafvels C., Lithner F., Borjeson B., 1993. *Living with diabetes: relationship to gender, duration and complications. A survey in northern Sweden.* Daibet Med

Differences between men and women in sensitivity to toxic substances, combined with gender division of labour, may increase exposure and vulnerability of girls and women to chemicals and pollution. The division of labour prevalent in households and the unavailability of running water inside homes in some regions of the world, especially in rural areas, means that women and young girls may spend much of their time collecting drinking water, which could lead to missed learning opportunities. Lack of access to adequate water, sanitation and hygiene conditions in health facilities may also discourage or delay women seeking care. Furthermore, in areas where domestic heating and cooking needs are met by burning solid fuels on open fires or traditional stoves, women and young children who generally spend a significant amount of time indoors at home are disproportionally exposed to high levels of household air pollution, which includes a range of health-damaging pollutants such as fine particles and carbon monoxide. This is a clear example of the problems cause by the intersection of gender and economic inequalities.

Furthermore, workers' exposure to dangerous substances remains under-assessed in women-dominated sectors such as healthcare, service sectors, like cleaning, hairdressing and cosmetology and sectors where women make up the large proportion of the workforce, such as agriculture and waste management. Women are general less likely to be involved in accidents at work, but female-dominated sectors such as healthcare, social work, education, transport, public administration and retail are highly exposed to third-party violence and psycho-social risks. For example, violence against women in politics is widely reported, including physical attacks, intimidation, bullying and sexual harassment. This is why at the end more women than men report work-related ill-health.

Another important aspect that differentiates women's health from men's is maternal health. Maternal health refers to the health of women during pregnancy, childbirth and the postnatal period (WHO, 2021). Each stage of maternity should be a positive experience, ensuring women and their babies reach their full potential for health and well-being. Limited access to quality maternal health services must be identified and addressed at both health system and societal levels. Considering that birth is a period of high risk of morbidity and mortality, skilled health personnel should provide adequate care, and progress in the proportion of births attended by skilled health personnel, at country and global levels, needs an improvement in definitions and measurements. WHO, UNFPA, UNICEF, the International Confederation of Midwives (ICM), the International Council of Nurses (ICN), the International Federation of Gynecology and Obstetrics (FIGO) and the International Pediatric Association (IPA) have already tried to tackle this challenge by engaging in a broad Member States and stakeholders consultation in 2018, for developing a joint statement on an updated definition of "skilled health personnel"[7], which should always be present at birth to ensure the

[7] WHO, 2018. *Definition of skilled health personnel providing care during childbirth: the 2018 joint statement by WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPA*. [online] Apps.who.int. Available at: https://apps.who.int/iris/bitstream/handle/10665/272818/WHO-RHR-18.14-eng.pdf?ua=1 [Accessed 1 June 2021].

detection and management of possible complications. Many countries have abolished user fees for maternal and child health services, reducing some of the financial barriers to accessing maternal health care, but women, especially in low-income settings, still cite fear of mistreatment, disrespect and abuse as reasons for avoiding health facilities. Researchers have documented the mistreatment of women in childbirth for over three decades in all global regions and disrespect and abuse of women in childbirth have become critical to the discourse on maternal health in recent years. Obstetric violence can represent a violation of women's fundamental rights to human dignity and self-determination and can serve as a disincentive for women to seek care in facilities for their subsequent deliveries, or to have other children at all.

The number of women and girls who died each year from complications of pregnancy and childbirth declined by 38 per cent, from 451,000 to 295,000 in 2017. Still, over 800 women are dying each day from complications in pregnancy and childbirth, and for every woman who dies, approximately 20 others suffer serious injuries, infections or disabilities which could be prevented (WHO, 2017). The ambitious target set by SDG 3, to reduce the global Maternal Mortality Rate (MMR) to less than 70 per 100,000 births, with no country having a maternal mortality rate of more than twice the global average, is still far from being achieved.

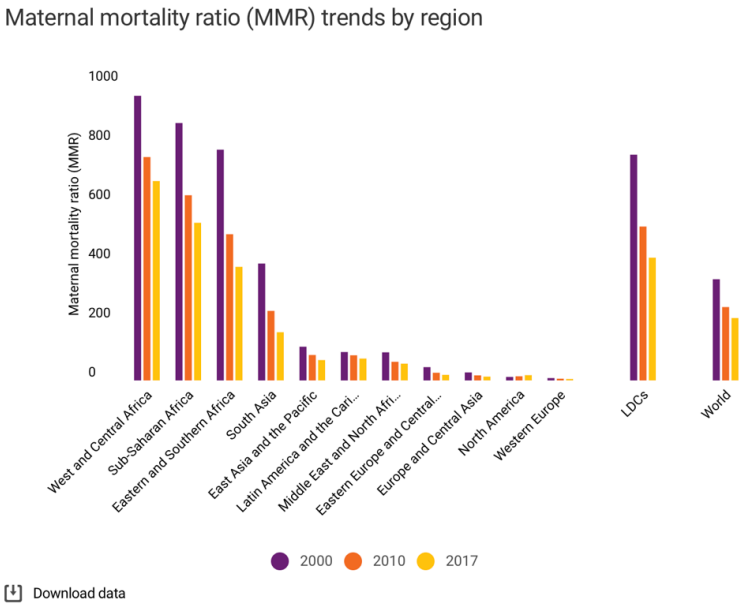

Figure 3: WHO, UNICEF, UNFPA, WB, 2019. *Trends in Maternal Mortality: 2000 to 2017.* WHO, Geneva

In many countries, the lack of progress in reducing maternal mortality often reflects the low value placed on the lives of women and their limited role in setting public priorities. Lack of access to antenatal and postnatal care services is commonly associated with social isolation, a lack of recognition of the importance of gestational care, or lack of resources. Women's agency and social independence can influence access to care. The lives of many women in developing countries could be saved by reproductive health interventions that in most rich countries are taken for granted. Most maternal deaths can be prevented if

births are attended by skilled health personnel – doctors, nurses or midwives –, regularly supervised, having the proper equipment and supplies, and able to refer women in a timely manner to emergency obstetric care when complications are diagnosed. Furthermore, intersectionality makes refugee, asylum seeker and migrant women seem to be at the greatest risk of worse health outcomes in the context of reproductive health: for example, the prevalence of postnatal depression among migrant women is twice that of women from host countries, and maternal mortality rates are also twofold among migrant women.

Lack of social health protection schemes, such as maternity benefits, create additional health risks and financial barriers for women. Globally, 41 percent of childbearing women received maternity benefits. Even in countries with maternity protection policies, only 52 percent met the standard set by the International Labour Organization of having at least 14 weeks of paid leave. The lack of maternity benefits, especially among women in the informal sectors, compels them to continue work very late into pregnancy and to return to work prematurely, exposing themselves and their children to increased health risks. Lack of maternity protection or short maternity leave can be a barrier to initiating and continuing breastfeeding exclusively for six months. A lack of transferable paternity leave compounds this problem, worsening women's access to employment and decreasing women's access to employment and decreasing women's pay relative to men, while also leaving women with disproportionate and unfair childcare responsibilities.

Paragraph 7.2 of the report of the International Conference on Population and Development defines reproductive and sexual health as follows: "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[8]

Reproductive health and gender issues are closely related, and there is also a deep connection between reproductive health and human rights and women's and men's empowerment, equity and dignity. Even if a large number of men would welcome the opportunity to use male contraceptive methods and recognize that sharing family planning should be an individual right other than responsibility, family planning continues to be demanded to women because options available for male contraception are still obsolete and affected by high failure rates. This could also be due to a historical legacy of government policy that promotes female sterilization to control population growth and to patriarchal norms that view

[8] United Nations, 1995. *Report of the International Conference on Population and Development*. [online] Un.org. Available at: https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/icpd_en.pdf [Accessed 1 June 2021].

vasectomy as a threat to masculinity. Furthermore, family planning demand is globally estimated only for women in union, because many countries with strong traditions do not collect information on contraceptive use by unpartnered women. Women are also still often stigmatized and blamed in case of infertility even if infertility can have also a male factor.

For many women and girls, even the most natural of reproductive cycle functions, menstruation, can equate to abuse (e.g., child marriage, sexual abuse, violations of bodily autonomy), stigma, missed opportunity and loss of dignity. There is also a lack of enough information about menstrual health, and stigma and discrimination associated with menstruation can result in many women and girls not receiving care for disorders related to menstruation, leaving them to suffer in silence. For example, premenstrual syndrome (PMS) is a collection of symptoms that can include among other things: mood swings, anxiety, breast tenderness, bloating, acne, headaches, stomach pain and sleep problems. PMS affects 90 percent of women, but is chronically under-studied: one research round-up found five times as many studies on erectile dysfunction than on PMS. Women also experiences difficulties in gaining access to feminine hygiene products. For example, today in Italy, feminine hygiene products, such as pads and tampons, as well as diapers for newborns, are subject to the ordinary tax rate of 22 percent because they are not considered essential goods. Precisely for this reason, the tampon tax is considered by many an unfair tax: tampons are taxed as luxury goods, the maximum provided by the Italian tax system. From this comes the famous slogan "the menstrual cycle is not a luxury" used to combat this system of taxation by many activists. The 22 percent rate is particularly burdensome for women with low incomes for whom, in some cases, it can even be a limitation to full and free participation in social and public life, with serious consequences on both physical and psychological health.

Legal and political factors may also affect women’s access to health services: for example, many countries legally restrict access to abortion services. Even where abortions are legal, access depends on the availability of services, including aftercare, and on the views and attitudes of health care providers and families. For example, 69 percent of Italian gynecologists are conscientious objectors, that is, they refuse to practice voluntary interruptions of pregnancy. In addition, 46.3 percent of anesthesiologists and 42.2 percent of non-medical healthcare personnel are also objectors. These percentages are the reason why in 35.1 percent of Italian facilities with a gynecology or obstetrics department it is not possible to access the voluntary interruption of pregnancy. This happens despite the fact that Law 194 of 1978, the one that affirms the right to abortion, prohibits "facility objection", that is, it establishes that the number of objecting physicians in a hospital must not prevent the practice of voluntary interruption of pregnancy. There are various reasons why physicians declare themselves objectors, and the most obvious, in a traditional Catholic country as Italy, is religious faith and the conviction that the embryo is a "form of life" to be safeguarded. However, there are also other reasons behind the choice of objection, which depend more on the functioning of the healthcare system and on the possibilities for physicians to make a career. Some physicians, for

example, become objectors to avoid being discriminated against by colleagues and primary objectors. Others do so because pregnancy termination interventions are uncomplicated, routine operations, and therefore are considered by physicians to be unrewarding practices. A vicious circle is thus nourished: many young gynecologists, out of fear of being relegated to practicing only interruptions of pregnancy and seeing their careers stranded in an outpatient clinic, declare themselves objectors. Another motivation is economic. In Italy, the voluntary interruption of pregnancy is one of the few practices that, according to the public health system, cannot be performed on a freelance basis within hospital outpatient clinics, charging patients for this practice. If voluntary interruptions of pregnancy were to be added to the list of paid health services, there would probably be further problems of access for women who want to use them; however, economic incentives could help to reduce objections.

Women who face barriers to accessing safe abortion services may resort to illegal, unsafe abortions, which are defined as procedures for terminating an unwanted pregnancy either by people without the necessary skills or in an environment lacking the minimal medical standards or both.[9] An estimated 8 to 11 per cent of maternal deaths worldwide are related to unsafe abortions.

As it has been highlighted in this chapter, the reasons why women are considered to be disadvantaged and often mistreated even in the field of health are multiple, thus the response to this problem has to be multi-faceted and multi-sectoral, involving many different actors, from health providers and medical researchers to policymakers and civil society in general.

1.3 Gender segregation in the healthcare workforce

Entrenched gender-based discrimination affects the global health workforce, which is predominantly female. Globally, around 70 per cent of people engaged and working in global health are women, but this proportion is not reflected at the top levels of leadership: more than 70 per cent of senior roles in health are held by men.[10] Discrimination in different areas of the health-care services is evidenced by gender pay gaps, lack of formal employment, physical and sexual violence, and lack of representation in leadership and decision-making.

[9] WHO, 1992. *The Prevention and management of unsafe abortion: report of a technical working group*. [online] Apps.who.int. Available at: https://apps.who.int/iris/bitstream/handle/10665/59705/WHO_MSM_92.5.pdf?sequence=1&isAllowed=y [Accessed 23 March 2021].

[10] HRH Global Resource Center, n.d. *Resource Spotlight: Gender and Health Workforce Statistics | HRH Global Resource Center*. [online] Hrhresourcecenter.org. Available at: https://www.hrhresourcecenter.org/gender_stats.html [Accessed 1 April 2021].

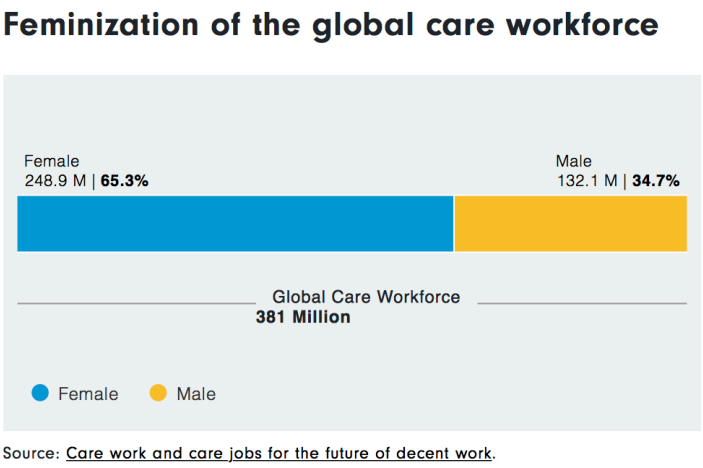

Figure 4: UN Women, 2020. *Women Count Data Hub*

The role of women has been largely neglected by historians of medicine, who have primarily focused on the great male university-trained physicians, and "official" Western medicine has been always widely dominated by men. This attitude has started to change only in the last decades, since the 1970s, when both the second wave feminist movement and the new study of social history contributed to the development of women's history of medicine.

Multiple layers of factors impact women's entry to leadership in the health and care workforce. The ecological model in health situates individuals in their social and public policy context and identifies factors at different levels that impact upon individual action. The model highlights public policy environments and systemic social factors that enable or constrain the entry of women into health and care leadership.

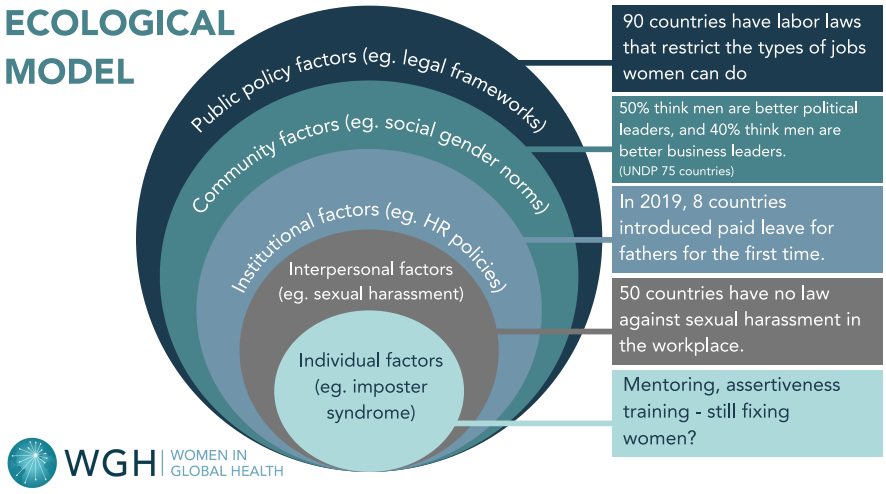

Figure 5: Women in Global Health, 2018. *Ecological Model*. World Medical Journal

In most countries, male workers make up the majority of physicians, dentists and pharmacists in the workforce, with female workers comprising the vast majority of the nursery and midwifery workforce. Nonetheless, in OECD countries, the share of female physicians between 2000 and 2017 increased by 13 per cent (an average by 0.58 per cent annually) (Source: Labour Force Surveys).

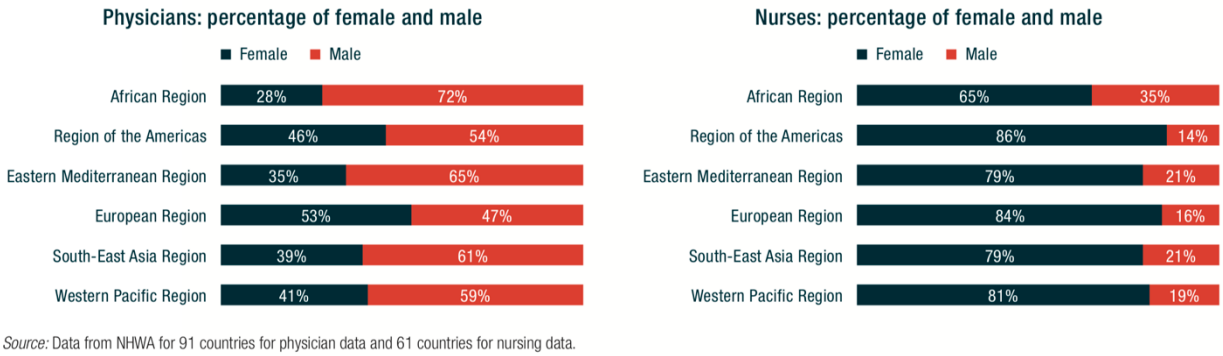

Figure 6: WHO, 2019. *Gender equity in the health workforce: Analysis of 104 countries*.

Women are more likely to choose specialties that are still conventionally seen as "feminine", such as family medicine, pediatrics, psychiatry, dermatology, and obstetrics/gynecology.

Even if women make up the vast majority of those working in the field of global health, they are underrepresented within top institutions, in global policy and governance forums, in though leadership panels, and across decision-making structures in the public and private sectors. For example, there are large discrepancies with the numbers at the top leadership positions in global health-funding agencies. 69 per cent of global health organizations are headed by men, and 80 per cent of board chairs are men. Only 20 per cent of global health organizations were found to have gender parity on their boards, and only 25 per cent had gender parity at senior management level (WHO, 2019). As for 2017, the percentage of women in the professional and higher categories of UAIDS and WHO were respectively 49.9 and 45.3 per cent.[11] Many organizations expect female health workers to fit into systems designed for male life patterns and gender roles (with, for example, no paid maternity leave), and many countries still lack laws on matters that underpin gender equality and dignity at work, such as sex discrimination, sexual harassment, equal pay and social protection. At the political level, only 27 percent of health ministers worldwide are women.

Given the important role of academia in shaping global health, it's notable that the vast majority of global health departments are chaired by male professors. Global health agencies along with universities, departments of global health, and associated consortia should consider commissioning a report to rigorously examine whether gender imbalances are occurring, and if they are, institutions should investigate the factors underlying those disparities and take practical steps to address them.

[11] UN Women, 2019. *Improvement in the status of women in the United Nations system: Report of the Secretary-General*. [online] Documents-dds-ny.un.org. Available at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/N19/229/95/PDF/N1922995.pdf?OpenElement [Accessed 1 April 2021].

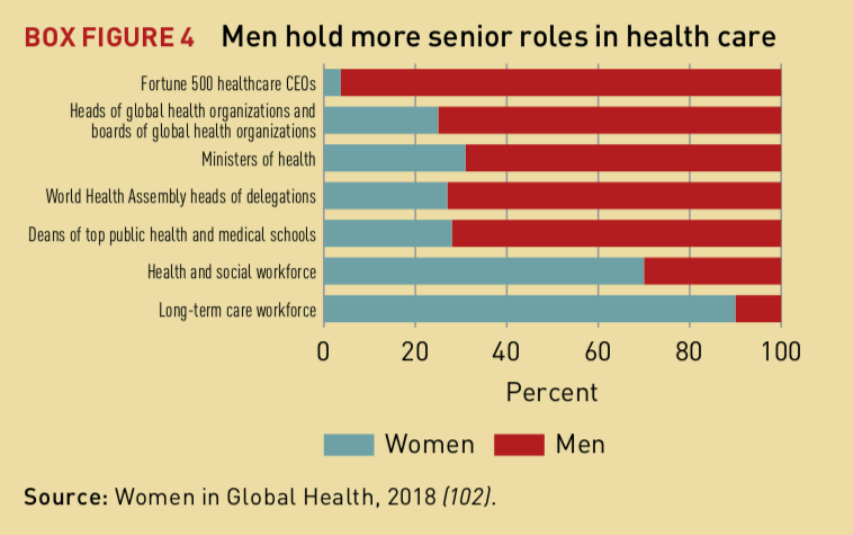

Figure 7: WHO, 2019. *Breaking barriers: Towards more gender-responsive and equitable health systems*.

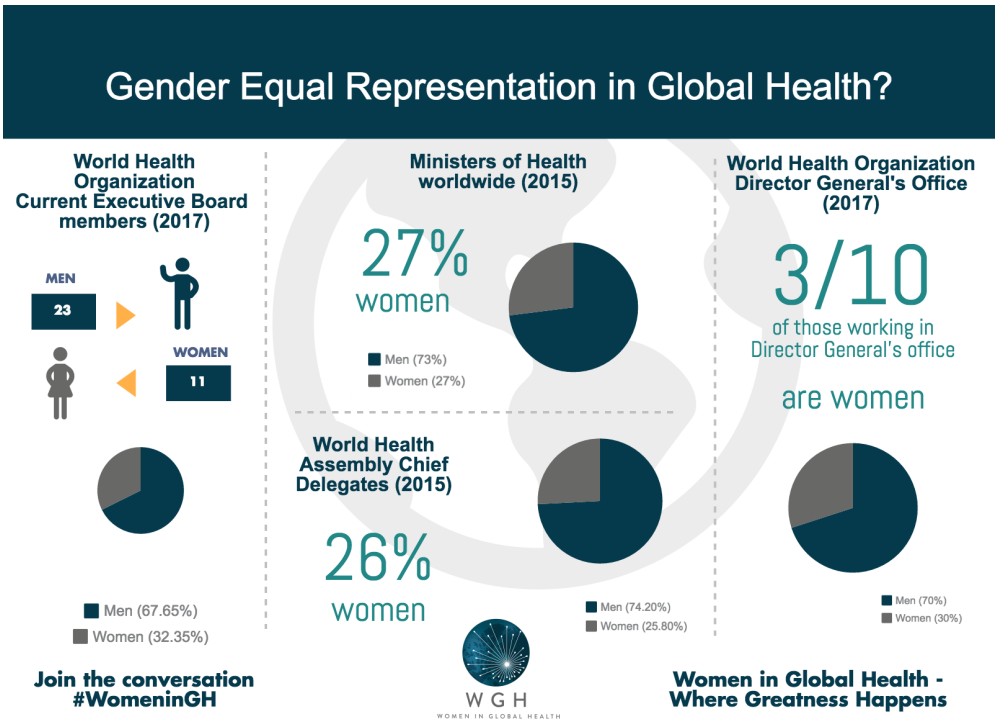

Figure 8: Women in Global Health, 2017. *Gender Equal Representation in Global Health?*

The gender pay gap, globally estimated at an average of over 20 per cent in the overall economy, appears even more marked in the human health and social work sectors. In many countries, this is also due to the absence of equal pay laws and collective bargaining. Nevertheless, the main cause remains the occupational segregation within the sector: women in the health and social work sectors tend to concentrate in lower-skilled jobs, with less pay and at the bottom end of the professional hierarchies.

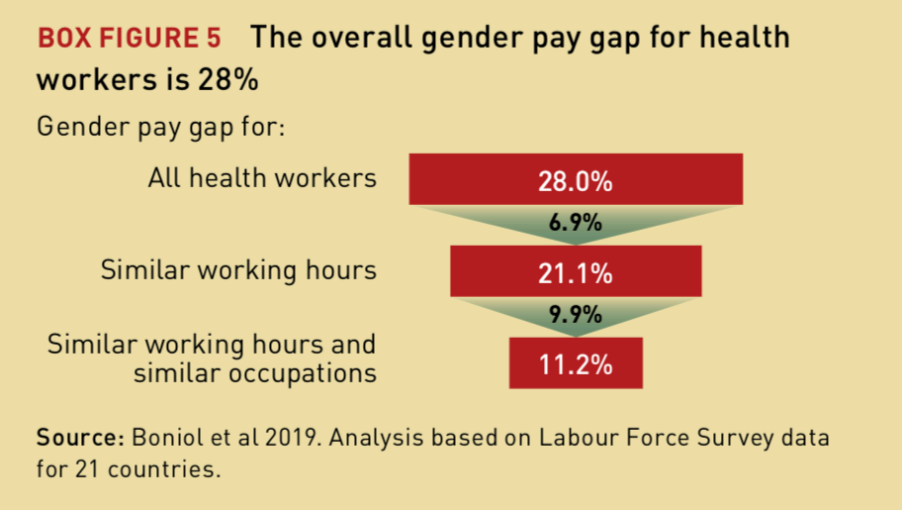

Figure 9: WHO, 2019. *Breaking barriers: Towards more gender-responsive and equitable health systems.*

Using data from 19 European countries, it has been shown that male physicians are more than twice as likely as female to be in the highest income category. LSF data from 56 countries showed higher average working hours per week for men than women, which likely reflects the different types of contracts, with more part-time jobs occupied by women. For highly paid occupations, such as physicians, men are more frequently employed in the private sector than women. However, the contrary is the case for low paid jobs, such as personal care workers, where women are more frequently employed by the private sector. This contrast illustrates a gender imbalance, with men more likely to obtain private sector jobs in occupations where public sector wage ceilings often exist, whereas women are more likely to obtain private sector jobs, which tend to offer a lower wage, less job security, and favor part-time employment.

Because care work involves tasks that women have traditionally performed without pay, the skills required for care provision are undervalued or overlooked in national measures of the economy (ILO, 2016). It has been argued that the labour market devalues so-called "female" tasks and skills, as shown by the fact that where women's share in the workforce or in an occupation increases, wages consequently often decline. Women's contribution to healthcare has been estimated to account for over US $3 trillion annually, nearly 5 per cent of global GDP, but nearly half of this (2.35 per cent of global GDP) is unpaid and unrecognized (Lancet Commission on Women and Health, 2015). The informal and volunteer work in families and communities is considered as a hidden subsidy to health systems and society that should be recognized and compensated. Still, care work remains characterized by poor working conditions, a void of benefits and protections, low wages or non-compensation, and exposure to physical, mental, and, in some cases, sexual harm.

Gender norms, expectations, roles and responsibilities at the individual level, within households, communities, and institutions affect entry and progression to the health sector, and the uptake of leadership opportunities. When offered leadership positions, women usually take a consensual approach to acceptance, seeking approval from families first. In the cases of women who have managed to reach leadership positions,

family and manager support has been very important for professional development. This type of positive change requires changes in personal and family attitudes and practices, while institutions in the health system must put in place supportive policies and practices, such as strategies to address violence, childcare and gender-sensitive training. This would be useful for men as well, who are constrained by gender stereotypes in entering some types of professions such as nursing.

For example, flexibility in the workplace is positively correlated with the enhanced engagement and retention of especially female, but also male, staff. It allows for a better work-life balance and integration of childcare and/or elder-care responsibilities. Without flexibility, staff are more likely to limit their career aspirations, or seek more favorable working conditions elsewhere.

In addition to gender stereotyping, female health workers also face the burden of sexual harassment from male colleagues, male patients and member of the community. It is often not recorded, and women may not report it due to stigma and fear of retaliation. Violence and harassment harms women limits their ability to do their job and causes ill health, attrition, lower morale and stress. Male health workers are more likely to be organized in trade unions than female ones. Women form the base of the pyramid on which global health rests and should be valued as change agents of health, not victims (WHO, 2019).

Health-system strengthening needs to better address how gender, power and social status can shape who is chosen as a health worker. Global health is evidently weakened by lost female talent, ideas and knowledge. Increasing women's leadership within global health is an opportunity to further health system resilience and system responsiveness, and it is particularly important in addressing problems that directly affect women's own lives. While a rights-based approach should be reason enough for achieving gender parity in global health leadership, the global health research community must also take into account the impact of gender parity on health outcomes.

In general, women deliver global health and men lead it. Indeed, the unequal men to women ratios in the decision-making positions within healthcare organizations perpetuate inequalities between men and women. In translating gender policies into practice, professionals are not neutral actors, but they help to constitute and maintain the status quo. This is connected to problem of the general lack of links between the levels of policymaking and service delivery and women's health research, due very often to time constraints and deficits in practical knowledge on the part of academic women. Women's leadership is particularly important in addressing problems that directly affect their own lives, and in addressing areas with increasing inequalities. At the very least, the health system should adopt good human rights practice to do no harm. It should ensure that it does not replicate or amplify local, often highly gendered, power dynamics that exclude or discriminate against certain population groups, including women.

Demographic changes and rising health care demands are projected to drive the creation of 40 million new jobs by 2030 in the global health and social sector, and this number will likely increase due to the effect of the COVID-19 pandemic. At the same time, there is an estimated shortfall of 18 million health workers, primarily in low- and middle-income countries. This global mismatch between health worker supply and demand is both a cause for concern and a potential opportunity, for addressing the gender dynamics of the health and social workforce which make women be segregated and disadvantaged.

Chapter II

"Social Policies for Gender Equality in Health at the International and EU Level"

2.1 Social Policies that Governments should implement to fight gender inequality in the health sector

To achieve universal health coverage, countries should develop equitable and gender-responsive health systems that consider the interaction of gender with wider dimensions of inequality, such as wealth, ethnicity, education, geographic location and sociocultural factors and implement them within a human rights framework.

In addressing inequalities in health status and unequal access to and inadequate health-care services between women and men, national governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programs, so that, before decisions are taken, an analysis is made of the effects for women and men, respectively. At the same time, decentralization is important, to support gender-specific capacity at the local level and tailoring gender issues to the local healthcare practice.

In this regard, national governments should:

- Review existing health legislations, as well as policies, to assess the impact on women's health of national strategies and action plans to identify critical actions and routinely conduct gender equity assessments of health policies.
- Identify and address institutional biases that may perpetuate intended or unintended gender-based discrimination in areas such as education, employment, social protection mechanisms, pension schemes and health insurance policies.
- Design, implement, and evaluate comprehensive strategies and public education programs aimed at bringing about a greater awareness about gender and a profound change in social and cultural attitudes.
- Improve the circumstances, environments and specific settings that influence women's health, with particular attention to housing, health care facilities, education facilities and workplaces.

- Collect and use disaggregated data to inform policies and programs, improving transparency and accountability on how priorities are set, data are collected, and research funding is allocated.
- Design and implement, in collaboration with women and community-based organizations, gender-sensitive health programs that address the specific needs of women and take into account their multiple roles and responsibilities and the demands on their time.
- Provide more accessible, available and affordable primary healthcare services of high quality for all, including sexual and reproductive health care, which includes family planning information and services, and giving particular attention to maternal and emergency obstetric care.
- Adopt legislation to safeguard people's right to make decisions concerning sexuality and reproduction free from discrimination, coercion and violence.
- Redesign health information, services and training for health workers so that they are gender-sensitive and reflect the user's perspectives.
- Take all appropriate measures to eliminate harmful, medically unnecessary or coercive medical interventions (e.g., FGM), that damage the health of girls and women and violate their human rights, through legislation, education and public awareness campaigns, and ensure that all women are fully informed of their options, including likely benefits and potential side-effects of medical interventions, by properly trained personnel.
- Integrate mental health services into primary health-care systems to care for girls and women, especially for those who have experiences any form of violence or sexual abuse.
- As recommended by WHO, implement in health systems a post-rape comprehensive care that includes first-line/psychological support, post-exposure prophylaxis for HIV and sexually transmitted infections, emergency contraception and safe abortion to the full extent of the law.
- Design tools to help prevent violence against women, such as population-based demographic and health surveys, as well as in surveillance and health information systems, and multisectoral responses to address interpersonal violence; the health sector has a crucial role in order to make violence against women unacceptable and felt as a public health problem with a focus on the prevention of recurrence.
- Integrate a gender perspective into health emergency response plans, such as the ones in relation to the COVID-19 crisis.
- Establish mechanism to support and involve non-governmental organizations working on women's health in government policymaking and program design, strengthening intersectoral mechanisms between the health and the social welfare and labour sector.

- Give priority to both formal and informal educational programs that support and enable women to develop self-esteem, acquire knowledge, make decisions on and take responsibility for their own health, health promotion interventions that project a positive and strong self-image for all girls and women, and educate men regarding the importance of women's health and well-being.
- Prepare and disseminate accessible information, through public health campaigns, the media, reliable counselling and the education system, designed to ensure that women (and men) can acquire knowledge about their health; an example of a policy of this kind has been the "plain language" initiative (CDC, 2016), set out to improve communication between health providers and the public through enhancing the readability of medicine instructions and health promotion material.
- Use a transformative gender approach in designing adult health and literacy programs in order to make sure that they move beyond the stereotypes of women as mothers and carers and of men as breadwinners.
- Develop policies that reduce the disproportionate and increasing burden on women who have multiple roles within the family and the community by providing them with adequate support from health and social services.
- Adopt regulations to ensure that the working conditions, including remuneration and promotion, of women at all levels of the health system, are non-discriminatory and meet fair and professional standards to enable them to work effectively.
- Ensure that women's work is not only valued but valued equally to that of men and that women's paid and unpaid contributions as care providers are recognized, valued and compensated.
- Devise and implement comprehensive and coherent programs and services for the prevention, diagnosis and treatment of conditions that affect predominantly women, such as osteoporosis and cancers of the reproductive system.
- Ensure that medical school curricula and other health-care training include gender-sensitive, comprehensive and mandatory courses on women's health.
- Encourage all sectors of society, as well as international organizations, to develop informative, compassionate and supportive, non-discriminatory HIV/AIDS and other sexually transmitted diseases policies.
- Promote gender-sensitive and women-centered health research, treatment and technology by also increasing financial support to them.
- Improve financing to address women's health priorities and integrate gender budgeting across health policies and programs.

- Establish ministerial and inter-ministerial mechanisms for monitoring the implementation of women's health policy and program reforms at the national, subnational and local levels.

Thus, improving women's health requires changes in governance for health that integrate women's lifelong needs into health policies, health-in-all-policies approaches and intersectoral action. Engagement of women to ensure that they are at the centre of these changes is a defining factor for success. Applying a rights-based approach requires urgent political commitment and investment in intervention and programs and the removal of structural, political and social barriers that prevent the realization of women's full health and well-being potential.

2.2 Global efforts to reach gender equality in health

Notwithstanding the currently evolving landscape of global gender data, even more complicated nowadays due to the COVID-19 pandemic, the overall pattern of gender equality for women in medicine and global health is, and has been for decades, one of mixed gains and persistent challenges.

After more than a century of feminist advocacy, 40 years of international discourses on gender in development, and a mounting body of evidence, gender has finally been recognized as one of the most important determinants of health and economic development. Despite this recognition and many international and national efforts, gender equality in health is a goal far from being achieved.

2.2.1 International Organizations, NGOs and National Governments

The women's health movement of the 1970s and early 1980s is generally considered to have had significant influence on the direction taken by feminist theorizing. Verbrugge and Wingard's 1987 work on gender-based health disparities helped inaugurate the women's health movement, which in turn helped launch the more recent men's health movement. This focus on women's health was aimed at contrasting the underrepresentation of women in clinical research, and the "female disadvantage" in the availability and access to health information, especially relating to women's desire to gain control over their fertility. The advocacy movement had an impact also on the medical community, who began to recognize the deficit of data on gender differences for many diseases, especially cardiovascular ones (CVDs). As a result of pressure from both the lay and clinical communities, the *Women's Health Initiative* (WHI), a 10-year study to examine the major causes of death and disability among 163,000 postmenopausal women, was launched in 1991 in the United States. The WHI was designed to address the lack of women in clinical trial research in general and specifically the shortage of scientific data about how to prevent and treat the most common causes of death, disability, and poor quality of life in postmenopausal women: cardiovascular disease, cancer, and osteoporosis. Although the WHI represented a huge step forward in gathering scientific evidence regarding women's health, it was not able to shed light on a broader array of potential risk factors and social determinants of differences and similarities in men's and women's health, missing comparable data on both

women and men. In 1983, the International Council on Women's Health Issues (ICOWHI), an international nonprofit association based in the United States, was founded. Its goal is to promote health, health care, and well-being of women throughout the world through participation, empowerment, advocacy, education and research. Another important event was the establishment in 1993 by the U.S. Food and Drug Administration of an Office of Women's Health and the correlated publication of *"Guidelines for the Study and Evaluation of Gender differences in the Clinical Evaluation of Drugs"* which ended the policy of exclusion, recommending that women be appropriately represented in clinical studies and that their findings be analyzed from a gender perspective.

During the United Nations Decade for Women (1976-1995), many other institutions specifically devoted to the advancement of women were established at the national, regional and international levels. At the international level, the International research and Training Institute for the Advancement of Women (INSTRAW), the United Nations Development Fund for Women (UNIFEM), and the Committee to monitor the *Convention on the Elimination of All Forms of Discrimination against Women* were established. These entities, along with the Commission on the Status of Women and its secretariat, the Division for the Advancement of Women, became the main institutions in the United Nations specifically devoted to women's advancement globally. The Commission has been responsible for organizing and following up the world conferences on women in Mexico (1975), Copenhagen (1980), Nairobi (1985), and Beijing (1995), where the *Beijing Declaration and Platform for Action,* with a focus on women and health as one of the 12 critical areas of concern, was adopted unanimously by 189 countries. At the national level, a number of countries established or strengthened national mechanisms to plan, advocate for and monitor progress in the advancement of women. In 1997, the United Nations Economic and Social Council (ECOSOC) adopted a resolution calling on all specialized agencies of the UN to mainstream a gender perspective into all their policies and programs. In 1998, the United Nations Division for the Advancement of Women (UN DAW), together with WHO and UNFPA, issued a report on "*Women and Health – Mainstreaming the Gender Perspective into the Health Sector"*[12], as a result of an expert group meeting held in Tunisia.

The World Health Organization (WHO) has identified gender as an issue cutting across all of its programs and activities: in 2002, its Director-General issued a policy statement[13] highlighting a strong and visible political commitment to promoting gender equity in health. Building on this gender policy of 2002, the WHO Strategy for integrating gender analysis and actions in its work was endorsed in resolution WHA60.25 at the Sixtieth World Health Assembly in 2007.[14]

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[12] UN DAW, 1998. *Women and Health: Mainstreaming the Gender Perspective into the Health Sector*. [online] Un.org. Available at: https://www.un.org/womenwatch/daw/csw/healthr.htm [Accessed 20 April 2021].

[13] WHO, 2002. *Integrating Gender Perspectives in the work of WHO - WHO Gender Policy*. [online] Apps.who.int. Available at: http://apps.who.int/iris/bitstream/handle/10665/67649/a78322.pdf?sequence=1 [Accessed 23 May 2021].

[14] WHO, 2007. *Strategy for integrating gender analysis and actions into the work of WHO*. [online] Apps.who.int. Available at: http://apps.who.int/iris/bitstream/handle/10665/44044/9789241597708_eng_Text.pdf?sequence=1 [Accessed 24 May 2021].

In 2011, WHO issued "*Gender mainstreaming for health managers: a practical approach*"[15], a guide aimed to raise awareness and develop skills on gender analysis and gender responsive planning in health sector activities.

In 2012, the Director-General of WHO established the Gender, Equity and Human Rights (GER) team in the Family, Women's and Children's Health (FWC) Cluster, with the purpose of catalyzing, supporting and coordinating institutional mainstreaming of equity, gender and human rights at all levels of WHO. In 2016, WHO issued a *"Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children"*[16], guided by resolution WHA67.15 on "*Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children*"[17], adopted by the Sixty-seventh World Health assembly in 2014. It offers a set of practical actions that Member States can take to strengthen their health system in response to violence against women.

In recent years WHO has then conducted extensive research on women and men's health through a gender-based approach in research papers, such as "*Women's health and well-being in Europe: beyond the mortality advantage*" (2015), "*The health and well-being of men in the WHO European Region: better health through a gender approach*" (2018) and "*Breaking barriers: Gender and equity to reach universal health coverage*" (2019). WHO has also developed the Health Equity Monitor, with its Health Equity Assessment Toolkit (HEAT), which provides evidence, tools and resources to support countries in health inequality monitoring.

There have been several other international endeavors to integrate sex and gender dimensions in health research, such as GENDRO, a non-profit NGO based in Switzerland, the Gendered Innovations project, the Medical Women's International Association, Global Health 50/50, and the International Society of Gender Medicine, and also to protect women's maternal and reproductive health, such as the White Ribbon Alliance, the Partnership for Maternal Newborn and Child Health (PMNCH) and Merck for Mothers.

Global efforts to advance women's health have been endorsed by countries in 2015 through the adoption of the *2030 Agenda for Sustainable Development*, with its *Sustainable Development Goals* (SDGs). The

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[15] WHO, 2011. *Gender mainstreaming for health managers: a practical approach*. Geneva, Switzerland: World Health Organization.

[16] WHO, 2016. *Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children.* [online] Apps.who.int. Available at: http://apps.who.int/iris/bitstream/handle/10665/252276/9789241511537-eng.pdf?sequence=1 [Accessed 23 May 2021].

[17] World Health Assembly, 2014. *Resolution WHA67.15 - Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children*. [online] Apps.who.int. Available at: https://apps.who.int/iris/bitstream/handle/10665/162855/A67_R15-en.pdf?sequence=1&isAllowed=y [Accessed 23 May 2021].

SDGs provide a normative global vision for worldwide social improvements and progress. Central to achieving these goals is promoting healthy lives and wellbeing for all people (goal 3), eliminating all kinds of inequalities. In particular, SDGs also provide specific guidelines on global efforts to improve gender equality (goal 5), by ending gender-based discrimination and resource allocation, recognizing and supporting women in leadership positions, addressing the issue of unpaid care, stopping harmful and unhealthy practices, and improving sexual and reproductive health. These commitments build on and reaffirm progress made towards achieving the *Millennium Development Goals* (2000)[18], the *Beijing Platform for Action* (1995)[19], the *Programme of Action from the International Conference for Population Development* (1994)[20], and the *Convention on the Elimination of All Forms of Discrimination against Women* (1979)[21], usually described as an international bill of rights for women.

Some of the challenges and opportunities for women's health posed by the 2030 Agenda are addressed through the *WHO Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)*[22] and its operational framework, which has been developed by Every Woman Every Child (EWEC) movement, launched in 2010 by the former UN Secretary-General Ban Ki-moon. Every Woman Every Child is an "unprecedented global movement that mobilizes and intensifies international and national action by governments, multi-laterals, the private sector and civil society to address the major health challenges facing women, children and adolescents around the world."[23]

The *Global Strategy for Women's, Children's and Adolescent's Health (2016-2030)* presents an expanded vision, moving from the earlier narrow focus on Maternal Child Health to a broader framework of sexual and reproductive health, analyzed at all life stages. Its aim is to end all preventable maternal, newborn and child deaths, including stillbirths, by 2030, and improving their overall health and well-being. This Global Strategy includes a monitoring framework with 60 indicators to help counties and their partners promote accountability in ending preventable deaths ("Survive"), ensuring health and well-being ("Thrive"), and expanding enabling environments, so that all women, children and adolescents can reach their potential ("Transform"), and no one is left behind.

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[18] United Nations, 2000. *United Nations Millennium Declaration*. [online] Ohchr.org. Available at: https://www.ohchr.org/EN/ProfessionalInterest/Pages/Millennium.aspx [Accessed 23 March 2021].

[19] United Nations, 1995. *Beijing Declaration and Platform for Action*. UN Women

[20] United Nations, 1995. *Report of the World Summit for Social Development*. [online] Undocs.org. Available at: https://undocs.org/pdf?symbol=en/A/CONF.166/9 [Accessed 23 March 2021].

[21] United Nations, 1981. *Convention on the Elimination of All Forms of Discrimination against Women*. [online] Ohchr.org. Available at: https://www.ohchr.org/documents/professionalinterest/cedaw.pdf [Accessed 23 March 2021].

[22] EWEC, 2015. *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)*. [online] Everywomaneverychild.org. Available at: https://www.everywomaneverychild.org/wp-content/uploads/2017/10/EWEC_GSUpdate_Full_EN_2017_web-1.pdf [Accessed 26 March 2021].

[23] EWEC, 2016. *What is Every Woman Every Child?* [online] Every Woman Every Child. Available at: https://www.everywomaneverychild.org/about/#sect1 [Accessed 26 March 2021].

In 2014, a WHO statement on the prevention and elimination of disrespect and abuse during facility-based childbirth called for greater research, advocacy and dialogue on this important public health issue, in order to ensure safe, timely, respectful care during childbirth for all women. Recognizing the need for action, in February 2017, 10 countries, led by WHO, in collaboration with UNFPA, UNICEF, implementation partners and other stakeholders, have established the Network for Improving Quality of Care for Maternal Newborn and Child Health, with the aim to halve maternal and newborn deaths and stillbirths within five years of implementation, so by 2022, and improve experience of care in participating health facilities, by developing and implementing national quality strategy and policies.

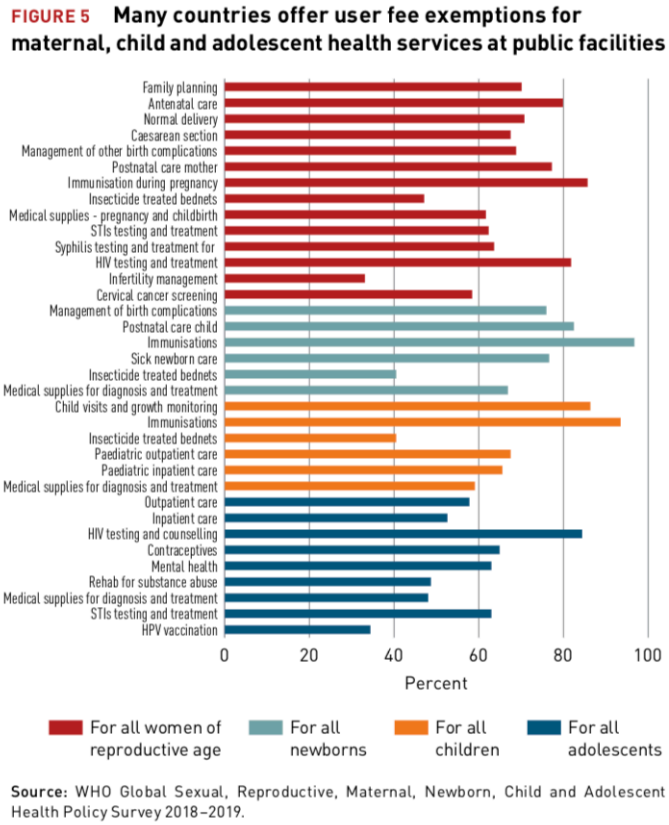

Figure 10: WHO, 2019. *Breaking barriers: Towards more gender-responsive and equitable health systems*.

In 2019, the United Nations Special Rapporteur on violence against women, its causes and consequences, established a global enquiry on *"Mistreatment and violence against women during reproductive healthcare with a focus on childbirth"*[24].

Also focusing on women's reproductive health, national and international family planning programs began in the mid-20th century, as soon as modern contraceptive methods became available. Some of these early programs viewed family planning as a question of top-down population control. It took decades of

[24] UN Special Rapporteur on Violence against Women, 2019. *On mistreatment and violence against women during reproductive healthcare with a focus on childbirth*. [online] Available at: https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/White%20Ribbon%20Alliance.docx. [Accessed 24 May 2021].

activism and a global change in sensibility to reach the Cairo consensus in 1994, when the right of women and girls to use family planning was recognized as central to health and development, and the Beijing agreements in 1995, acknowledging that the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality and reproductive health, free of coercion, discrimination and violence. It was another 20 years before the Sustainable Development Agenda put the right to family planning at the center of the UN's global goals, essential to both human health (goal 3) and gender equality (goal 5). Family Planning 2020 is a global partnership launched in 2012 to empower women and girls by investing in rights-based family planning. By making a commitment to FP2020, partners join the global community of leaders, advocates and implementers who are working together to address the most challenging barriers to expanding access to contraceptives. In 8 years, the total number of users of modern contraception in the 69 FP2020 countries has risen from 260 million to 320 million. The partnership has now evolved into Family Planning 2030; the severe impact of the COVID-19 pandemic on family planning services has created an especially urgent need for bold, new family planning commitments to ensure that women and girls have access to the high-quality reproductive health service they need and deserve. As part of its *Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)* and under Family Planning 2020, WHO committed itself to expand contraceptive access, choice and method mic through research and development, to assess the safety and efficacy of new and existing methods, and to scale up the availability of high-quality contraceptive commodities through product prequalification and Expert Review Panel fast-track mechanisms. WHO also works to synthesize and make available evidence on effective family planning delivery models and actions including return to fertility, so as to inform policies, reduce barriers and strengthen programs.

Furthermore, in collaboration with the United Nations Department of Economic and Social Affairs, the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) has launched the open-access *Global Abortion Policies Database*[25], containing abortion laws, policies, health standards and guideline for all WHO and UN Member States. In addition to providing data on specific abortion policies, country profiles include sexual and reproductive health indicators, the list of human rights ratifies by the country in question, and links to the concluding observation of United Nations treaty bodies with selected extracts relating to abortion.

Many significant changes also in HIV-related policies research and practice have occurred in the 10 years since WHO published "*Sexual and reproductive health of women living with HIV/AIDS*"[26] in 2006.

[25] HRP, 2021. *GAPD - The Global Abortion Policies Database - The Global Abortion Policies Database is designed to strengthen global efforts to eliminate unsafe abortion*. [online] GAPD - The Global Abortion Policies Database. Available at: https://abortion-policies.srhr.org [Accessed 7 April 2021].

[26] WHO, 2006. *Sexual and reproductive health of women living with HIV/AIDS*. Geneva: World Health Organization.

These changes include the rapid expansion of antiretroviral therapy (ART) and the release in 2015 of WHO recommendations to offer immediate ART to all individuals living with HIV and to offer pre-exposure prophylaxis (PrEP) to individuals at substantial risk of HIV infection as an additional prevention choice.

Likewise, in 2016, seven United Nations Entities (IAEA, IARC, UNAIDS, UNFPA, UNICEF, UN Women and WHO), under the United Nations Inter-Agency Task Force on the Prevention and Control of Noncommunicable Diseases (UNIATF), established the United Nations' *Joint Global Programme on Cervical Cancer: Prevention and Control*[27], which brings together the major players involved in cervical cancer prevention and, focusing on one country from each of the six WHO regions, provides global leadership and technical assistance to support governments and their partners to build high-quality national programs to prevent and control cervical cancer, ensuring that all women and girls can access services equitably. Cervical cancer can be eliminated, and no woman should die from it. The political will to prevent the disease is stronger than ever, and cost-effective tools exist (HPV and DNA testing, screening and treatment). Funded by Belgium, the program started in October 2018 and will run through April 2021. HPV vaccine for girls had been introduced into 71 national immunization programs by March 2017.

For what concerns women workers in the healthcare and social sectors, UN Women regularly conducts research and collects data to measure progress in the status of women in the UN systems, including health-related entities. Many make an effort to feature women and/or gender balance in the images and in their outreach materials and create material specifically targeted at women. Such approaches are aimed at improving the numbers of female applicants and enhancing the UN's image as an attractive workplace for women. For example, UNAIDS regularly releases an internal publication titled "Spotlight on UNAIDS Women" highlighting female staff and their roles. Another example is WHO, which requires supervisors with recruitment responsibilities to set targets for gender equality in staffing and to report on this at the end of the Performance Evaluation Cycle. In addition, the WHO Accountability Compact for Assistant Director Generals in Headquarters incudes an indicator on gender equality in staffing.

The UNAIDS Secretariat Gender Action Plan focuses on staff development through its two flagship programs – the UNAIDS Mentoring Programme for Women and the UNAIDS Leadership Programme for Women – which were both launched in 2014. More than 23 per cent of UNAIDS women professionals have benefitted from participation in a dedicate program, which help mentees to strengthen competencies, address workplace challenges and build confidence.[28]

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[27] WHO/NMH/NMA, 2016. *UN Joint Global Programme on Cervical Cancer Prevention and Control*. [online] Who.int. Available at: https://www.who.int/ncds/un-task-force/un-joint-action-cervical-cancer-leaflet.pdf [Accessed 7 April 2021].

[28] UN Women, 2016. *Status of Women in the United Nations System*. [online] Unwomen.org. Available at: https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2016/status-of-women-in-the-united-nations-system-2016-en.pdf?la=en&vs=2511 [Accessed 1 April 2021].

In 2015, Women in Global Health, an organization built on a global movement to challenge power and privilege for gender equity in health, together with the Global Health Council (GHC), launched the Women Leaders in Global Health Initiative (WLGHI), to address the individual, institutional and political challenges that impede women's positioning as leaders in global health through strategic advocacy, networking, mentorship and capacity building.

In 2016, WHO adopted the *Global Strategy on Human Resources for Health: Workforce 2030*[29] and the recommendations of the High-Level Commission on Health Employment and Economic Growth. It also established the Global Health Workforce Network, which includes a Data and Evidence Hub and a Gender Equity Hub, which both bring together key stakeholders for strengthening data and evidence and supporting gender transformative actions, investments, policy guidance and implementation capacity for overcoming gender biases and inequalities in global health and social workforce.

In 2017, WHO, together with the International Labour Organization (ILO) and Organization for Economic Co-operation and Development (OECD), adopted the *"Working for Health: Five-Year Action Plan for Health Employment and Inclusive Economic Growth (2017-2021)"*[30]. According to the plan, gender equality will be mainstreamed as a cross-cutting goal in gender-transformative investments and actions for the health and social workforce. Some of the provision envisioned are:

- Analyzing and redressing gender inequalities, as, for example, women's provision of unpaid care in the absence of social protection and skilled care workers
- Ensuring women are appropriately represented in social dialogue mechanisms
- Strengthening and using sex-disaggregated data
- Undertaking gender analysis as an integral part of labour market analysis
- Developing and strengthening national health workforce strategies, policies and investments that address identified gender biases and inequalities, including gender-sensitive considerations regarding women's security, working conditions and mobility.[31]

In March 2019, WHO published the report "*Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health Workforce*"[32], produced by the Gender Equity Hub (GEH), which is a

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[29] WHO, 2016. *Global strategy on human resources for health: workforce 2030*. Geneva: World Health Organization.

[30] ILO, OECD and WHO, 2018. *Working for health: Five-year action plan for health employment and inclusive economic growth (2017–2021)*. [online] Apps.who.int. Available at: http://apps.who.int/iris/bitstream/handle/10665/272941/9789241514149-eng.pdf?ua=1 [Accessed 24 May 2021].

[31] WHO, 2018. *Five-year action plan for health employment and inclusive economic growth (2017–2021)*. [online] Apps.who.int. Available at: https://apps.who.int/iris/bitstream/handle/10665/272941/9789241514149-eng.pdf?ua=1 [Accessed 8 April 2021].

[32] WHO, 2019. *Delivered by women, led by men: A gender and equity analysis of the global health and social workforce. (Human Resources for Health Observer Series No. 24)*. [online] Apps.who.int. Available at: https://apps.who.int/iris/rest/bitstreams/1211297/retrieve [Accessed 6 April 2021].

thematic hub in the Global Health Workforce Network, co-chaired by WHO and Women in Global Health. This report examines the paradox of why relatively few women lead in a profession where 70 per cent of the workforce is female. In 2018, the GEH had identified and reviewed over 170 studies in a literature review of gender and equity in the global health workforce, with a focus on four themes: occupational segregation; decent work free from bias, discrimination and harassment, including sexual harassment; gender pay gap; and gender parity in leadership.

Celebrating 25 years since the Beijing Declaration and Platform for Action, the Gender Equal Health and Care Workforce Initiative, a partnership launched in February 2021 between WHO, the Government of France and Women in Global Health. The aim of the initiative is to strengthen investment in and protection of health and care workers. 2021 has been designated as the International Year of Health and Care Workers (YHCW) in appreciation and gratitude for the unwavering dedication in the response to the COVID-19 pandemic that health and care workers have shown. The Gender Equal Health and Care Workforce Initiative sees the International Year of Health and Care Workers as an opportunity for the health and care sectors to drive policy action to achieve the visionary agenda for women's rights and empowerment outlined in Beijing Declaration and Platform for Action.

Most recently, a series of dialogues between civil society organizations and WHO DG have been organized by GENDRO and Women in Global Health on different topics of interest for civil society to achieve a global gender transformative COVID-19 response.

2.2.2 European Union

Organizing and delivering healthcare is the responsibility of EU Member States' national governments. The European Union's role is to complement national policies by helping them achieve shared objectives, pooling resources, and helping countries tackle common challenges, such as eliminate gender inequalities in health, being gender equality one of EU's core values. Over the years, the different organs of the EU have worked in order to achieve this goal through various means.

In 2006, the Council of the European Union adopted a statement on common values and principles in EU healthcare systems, listing the overarching values of universality, access to good-quality care, equity and solidarity. In its *Council Conclusions on women's health*[33], the Council invited the European Commission to integrate gender aspects in health research, support gender-sensitive health promotion and prevention, and assist Member States in developing effective strategies to reduce gendered health inequalities.

[33] Council of the European Union, 2006. *Council Conclusions on Women's health*. [online] Ec.europa.eu. Available at: https://ec.europa.eu/health/ph_information/dissemination/documents/women_council_en.pdf [Accessed 18 May 2021].

The European Commission's "*Communication on Solidarity in Health: Reducing Health Inequalities in the EU"*[34] (2009) sets out actions for the Commission to take to help address health inequalities. This was later followed by a "Report on Health Inequalities in the European Union" in 2013 to describe the main actions the Commission had taken to implement its 2009 Communication.
In 2010 the European Commission approved the "*Strategy for equality between women and men 2010-2015"*[35]*,* which comes from the recognition of gender equality as a core value for the European Union, a principle affirmed in the EU Charter of Fundamental Rights. In March 2010 the Commission adopted the *Women's Charter*[36], in order to renew its commitment to gender equality and to strengthen the gender perspective in all its policies.

In the same year, the EU adopted its first Action Plan on *Gender Equality and Women Empowerment in Development (2010-2015),* which was followed by the Gender Action Plan II (GAP II), "*Gender Equality and Women's Empowerment: Transforming the Lives of Girls and Women through EU External Relations 2016-2020*", adopted in 2015 and by the Gender Action Plan III (GAP III), "*Gender Equality and Women's Empowerment in External Action 2021-2025*, adopted in 2020 and based on the Commission's "Gender Equality Strategy 2020-2025", which recognizes the gender-specific health risks and among others foresees the facilitation of regular exchanges of good practices between Member States and stakeholders on the gender aspect of health, including on sexual and reproductive health and rights.

In 2011, the European Parliament voted a "*Resolution on Reducing health inequalities in the EU*"[37]. In 2012, an *Action plan for the EU health workforce*[38] was drawn up by the European Commission, and it recognized gender inequalities in the gender pay gap, in overall wage levels being lower in the healthcare sector, in work-life balance, and in the provision of supportive and safe working environment. In the same year, the European Commission committed 28.3 million € to family planning services for 2013. Building upon this previous commitment to increase access to family planning and to promote sexual and

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[34] European Commission, 2009. *Commission Communication - Solidarity in Health: Reducing Health Inequalities in the EU*. [online] Eur-lex.europa.eu. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:52009DC0567 [Accessed 18 May 2021].

[35] European Commission, 2010. *Strategy for equality between women and men 2010-2015*. [online] Eur-lex.europa.eu. Available at: https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0491:FIN:EN:PDF [Accessed 24 May 2021].

[36] European Commission, 2010. *Strengthening the commitment to equality between women and men: a women's charter*. [online] Eur-lex.europa.eu. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=LEGISSUM%3Aem0033 [Accessed 26 May 2021].

[37] European Parliament, 2011. *Resolution on Reducing health inequalities in the EU*. [online] Europarl.europa.eu. Available at: https://www.europarl.europa.eu/doceo/document/TA-7-2011-0081_EN.html [Accessed 25 May 2021].

[38] European Commission, 2012. *Action Plan for the EU Health Workforce*. [online] Ec.europa.eu. Available at: https://ec.europa.eu/health/sites/default/files/workforce/docs/staff_working_doc_healthcare_workforce_en.pdf [Accessed 18 May 2021].

reproductive health rights (SRHR), the European Commission allocated 20 million € to UNFPA Supplies in 2017.

The recent changes to the Common European Asylum System (CEAS) place a greater emphasis on gender-sensitive asylum procedures, so that women and girls making asylum claims on the grounds, for example, of female genital mutilation (FGM) feel safe. However, the degree to which these provisions are implemented in practice differs among Member States and depends on the resources available to deal with the pressure of ongoing migratory flows. The EU has funded the development of training packages to healthcare professionals on FGM as a specific topic, as well as part of the wider aim of improving the quality of and access to health services for migrant and ethnic minorities, and in particular women.
The EU also funds projects on the organization of support services to victims of gender-based and domestic violence, including the provision of health services, under its Rights, Citizenship and Equality (REC) program. As part of the *Gender Equality Strategy 2020-2025*, the EU will table a Recommendation on the prevention of harmful practices, including the need for effective preemptive measures and acknowledging the importance of education. The recommendation will also address the strengthening of public services, prevention and support measures, capacity-building of professionals and victim-centered access to justice.

The EU Clinical Trials Regulation[39], adopted in 2014, requires the consideration of gender in clinical trials and addresses concerns about drugs being mainly tested on men, and thus possibly ignoring side effects that are more common among or exclusive to women. The regulation is yet to enter into application.

The European Commission Directorate General for Health and Food Safety (DG SANTE) has published reports on men's and women's health in the EU (2006 and 2011), and the European Institute for Gender Equality (EIGE), an autonomous body of the EU, has also distributed many reports on gender inequalities in health, such as the publication on "*Gender in health*"[40] (2017), which constitutes the integral part of its Gender Mainstreaming Platform, and has reviewed the Beijing Platform for Action (BPfA) Area C, Women and Health, in 2020.

The European Commission has also funded projects such as the European Gender Medicine Network (2013-2015), which was started in order to introduce sex and gender aspects into medicine to improve biomedical and health research, by identifying focal areas of work where sex and gender play a major role. During the project, six meetings with key stakeholders were organized in order to produce recommendations, guidelines and teaching materials, which will be disseminated through a European

[39] European Union, 2014. *Regulation (EU) No 536/2014 of the European Parliament and of the Council of 16 April 2014 on clinical trials on medicinal products for human use, and repealing Directive 2001/20/EC*. [online] Ec.europa.eu. Available at: https://ec.europa.eu/health/sites/default/files/files/eudralex/vol-1/reg_2014_536/reg_2014_536_en.pdf [Accessed 26 May 2021].

[40] EIGE, 2017. *Gender in health*. [online] European Institute for Gender Equality. Available at: https://eige.europa.eu/publications/gender-health [Accessed 21 February 2021].

Gender Health portal. Another example of EU-funded research that explores and develops gendered diagnosis is the GenCAD project (2015-2017) on coronary artery disease (CAD), which aimed to improve the knowledge and awareness of sex and gender differences in chronic diseases, using coronary artery disease as an example to highlight differences between women and men in prevention and treatment of CAD in European countries.

The umbrella policy framework for health and well-being in the WHO European Region, *Health 2020*[41], adopted by the 53 Member States in 2012, acknowledges gender as a determinant of health alongside other social and environmental determinants, and includes gender mainstreaming as a mechanism to achieve gender equity. Its values underpin the *WHO European Region's Strategy on Women's Health and Well-Being*[42], which advises Member States to adopt a multisectoral approach to eliminate discriminatory values, norms and practices that affect the health and well-being of girls and women and to tackle the impact of gender and social, economic, cultural and environmental determinant on women's health and well-being. The Strategy sets priority areas for action and provides guidance to optimize investment in girls' and women's health, including by refining existing national policies and strategies to make them more consistent with current evidence and more responsive to women's health and well-being, which requires action by ministries of health, both alone and in collaboration with other sectors, including departments for women's issues, social protection, social affairs, education, labour and employment. It also calls for a whole-of-society approach that acknowledges the extraordinary contributions of women to society, family and work, and empowers women by strengthening their participation in key decision-making on their health and well-being. The Strategy invites countries to build on existing actions, specifically increasing women's access to equal opportunities to education, employment and power; appropriate, affordable and quality health care, information and related services; strengthening preventive programs that promote women's health; undertaking gender-responsive initiatives that address sexually transmitted infections, HIV/AIDS, and sexual and reproductive health issues; promoting research and disseminating information on women's health; and increasing resources and monitoring follow-up for women's health.
In 2018, the WHO Regional Office for Europe published the *Health Equity Status Report*[43] (HESR), which is a comprehensive review of the status and trends in health inequities and of the essential conditions needed for all to be able to live a healthy life in the WHO European Region. The report is part of the HESR

[41] WHO/Europe, 2013. *Health 2020: A European policy framework and strategy for the 21st century*. [online] Euro.who.int. Available at: https://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf [Accessed 23 March 2021].

[42] WHO/Europe, 2016. *Strategy on women's health and well-being in the WHO European Region*. [online] Euro.who.int. Available at: https://www.euro.who.int/__data/assets/pdf_file/0003/333912/strategy-womens-health-en.pdf [Accessed 23 March 2021].

[43] WHO/Europe, 2019. *Healthy, prosperous lives for all: the European Health Equity Status Report*. [online] Euro.who.int. Available at: https://www.euro.who.int/en/health-topics/health-determinants/social-determinants/health-equity-status-report-initiative/health-equity-status-report-2019 [Accessed 26 May 2021].

initiative (HESRi), which includes new evidence and tools for Member States to use to accelerate progress in reducing health inequities.

Many other international organizations and NGOs operating in the European region have been working in the past years to achieve gender equality in health, including the Council of Europe.

In 2008, the Council of Europe adopted a *"Recommendation on the inclusion of gender differences in health policy",* which required member states to "make gender one of the priority areas of action in health through policies and strategies which address specific health needs of men and women and incorporate gender mainstreaming"[44]. After the "*Council of Europe Convention on Action against Trafficking in Human Beings"*[45] (2005) and the "*Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence"*[46] (2011, Istanbul Convention, from which worryingly Turkey has recently withdrawn), the Council of Europe formulated a *Gender Equality Strategy 2014-2017*[47], with the intention to achieve the advancement and empowerment of women and the effective realization of gender equality in the Council of Europe member states, through different action: combating gender stereotypes and sexism, preventing and combating violence against women, guaranteeing equal access of women to justice, achieving balanced participation of women and men in political and public decision-making, and achieving gender mainstreaming in all policies and measures. In 2012, the Council of Europe Transversal Programme on Gender Equality was launched, and the Gender Equality Commission was established to help ensure the mainstreaming of gender equality into all Council of Europe policies. Relevant committees of the Council of Europe's Directorate for the Quality of Medicines and Healthcare (EDQM) are indeed starting to consider gender equality aspects in their work, including the European Committee on Organ Transplantation (CD-P-TO) and the European Committee on Pharmaceuticals and Pharmaceutical Care (CD-P-PH).

The Council of Europe has also analyzed sexual and reproductive health and rights (SRHR) in their paper *"Women's sexual and reproductive health and rights in Europe"*[48] (2017) and noted that failures to collect and analyze data and evidence on women's sexual and reproductive health, and in particular

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[44] Council of Europe, 2008. *Recommendation CM/Rec(2008)1 of the Committee of Ministers to member states on the inclusion of gender differences in health policy*. [online] Search.coe.int. Available at: https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805d4212 [Accessed 18 May 2021].

[45] Council of Europe, 2005. *Council of Europe Convention on Action against Trafficking in Human Beings*. [online] Rm.coe.int. Available at: https://rm.coe.int/168008371d [Accessed 25 May 2021].

[46] Council of Europe, 2011. *Council of Europe Convention on preventing and combating violence against women and domestic violence*. [online] Rm.coe.int. Available at: https://rm.coe.int/168008482e [Accessed 25 May 2021].

[47] Council of Europe, 2014. *Council of Europe Gender Equality Strategy 2014-2017*. [online] Rm.coe.int. Available at: https://rm.coe.int/1680590174 [Accessed 25 May 2021].

[48] Council of Europe, 2017. *Women's sexual and reproductive health and rights in Europe*. [online] Rm.coe.int. Available at: https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead [Accessed 25 May 2021].

disaggregated data, remain a concern in a number of European countries. Nonetheless, the "*Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind*"[49] (2016) has been designed, reflecting the objectives and main policy directions of *Health 2020*. Over the past 15 years, Member States in the European region have made substantial progress in improving several key sexual and reproductive health indicators, such as maternal mortality ratio, contraceptive prevalence rate, abortion ratio, and the incidence of syphilis and gonococcal infections.

Always in the field of reproductive health, the European Contraception Atlas is an original research project led by the European Parliamentary Forum for Sexual and Reproductive Rights (EPF), a network of MPs throughout Europe committed to protecting women's SRHR, with a group of renowned experts in the field of contraception, which investigates how European public authorities perform in the three categories of access to contraceptive supplies, family planning counselling and online information on contraception. In 2020, the level of population access to modern forms of contraception ranged from 96.4 percent in Belgium and 90.1 percent in France to just 35.1 percent in Poland, which reflect also the culturally traditional stance of the country, which has also recently outlawed abortion, except in cases when the woman's life or health is endangered by the continuation of pregnancy or when the pregnancy is a result of a criminal act.

Figure 19. Access to modern contraception

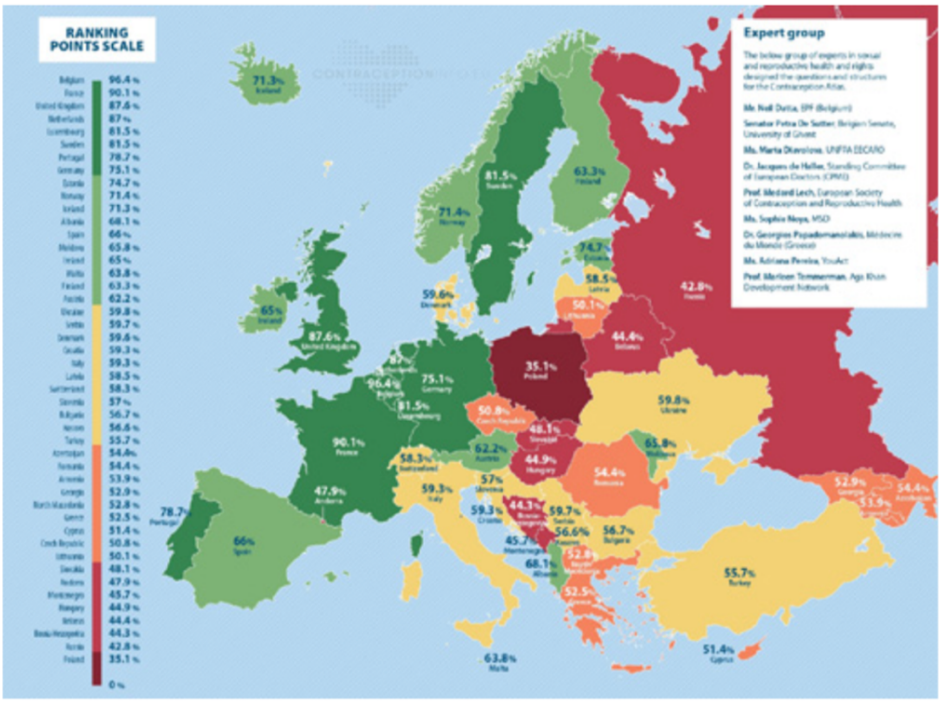

Figure 11: European Parliamentary Forum on Population & Development, 2020. *European Contraception Atlas*

[49] WHO/Europe, 2016. *Action Plan for Sexual and Reproductive Health Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind*. [online] Euro.who.int. Available at: https://www.euro.who.int/__data/assets/pdf_file/0003/322275/Action-plan-sexual-reproductive-health.pdf [Accessed 23 March 2021].

In 2016, in association with the International Planned Parenthood Federation (IPPF) European Network and Countdown 2030 Europe, Euro NGOs brought together 22 participants from member organizations to enhance the knowledge and capacity on the SRHR, especially in humanitarian responses to crisis, and exchange concrete ideas on how to use this is advocacy and policy work in Europe and beyond.

The European Women's Lobby is the largest European umbrella network of women's associations representing a total of more than 2000 organizations across Europe. Among its several working areas, it developed actions to push for gender equality principles to be fully embedded into European health policies in order to ensure and reach an improvement of women's health status.

One of the NGOs working to promote gender equity in public health, research and social policies across Europe is the European Institute of Women's Health (EIWH), whose efforts in the past years have focused on reducing the burden of chronic diseases for women by investing in prevention, encouraging healthy lifestyles and promoting the implementation of sex and gender in all researches and policies.

Finally, another non-profit partnership of organizations, agencies and statutory bodies working on public health, disease prevention, promoting health, and reducing inequalities, is EuroHealthNet, which has launched a Health Inequalities portal in 2021 for international exchange including information, policies, research, and initiatives on all kinds of health inequalities, including gender-based ones.

Chapter III

"Women's Health in the European region: a comparison between country-level policies"

3.1 Differences between gender policy regimes in European countries

National policies and regulations can directly or indirectly affect individual health either by differentially limiting or broadening men's and women's options or by affecting other aspects of their lives in ways that shape perceptions of their expectations, priorities and needs. Not only can policy decisions directly affect health by providing universal access to health care, but they also indirectly affect health in part by altering or reinforcing gender-based social roles and men's and women's opportunities to engage in health-related behaviors. Taken together, a country's social policies establish an opportunity structure that creates both a minimum level of socioeconomic status (SES) and the range of socioeconomic circumstances within which most of its citizens live, perceive options, and make choices influencing their health, however constrained. In European countries, in particular, there are five essential conditions, influenced by countries' policies, contributing to health inequities.

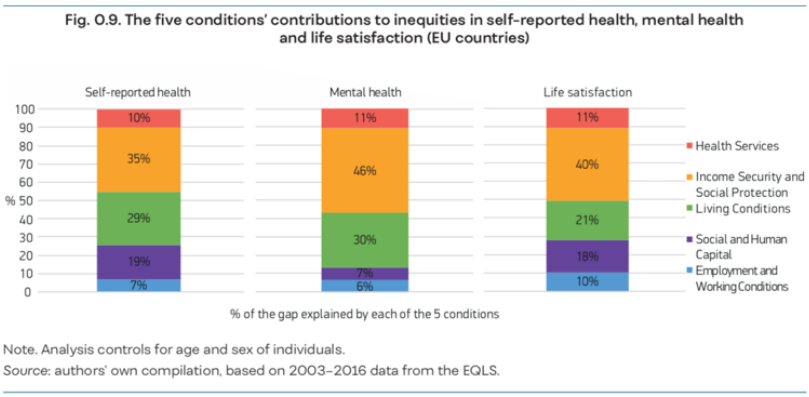

Figure 12: Eurofund, 2016. *European Quality of Life Survey*

The term "policy regime" refers to the range of national policies and regulations enacted over time within a particular country that collectively reflect a broader philosophical orientation that transcends any individual administration. A country's policy regime creates priorities and establishes the guidelines for what rights and entitlements are to be covered through general social provisions, as well as the basic protections that serve as a safety net for its citizens. If policymakers want to create the opportunity to pursue health and to remove obstacles to making health a priority, they will need to consider gender roles and biological differences that affect how men's and women's lives are organized. Such a perspective would be effective both in the formulation of new policies and in the evaluation of existing ones.

A gender policy regime entails a set of rules, norms, and institutions about gender relations that influence the construction of policies. In 2010, Korpi tried to develop a country regime typology for Europe that was relevant for both gender and class inequalities.[50] He classified European countries in terms of characteristics of their family policies that affect the situation of men and women with respect to paid and unpaid work, which in turn affects their health. He identified three main regimes:

- Dual-earner/dual-carer countries, which are mainly characterized by dual-earner and dual-carer policies, relying to a great extent on the provision of public services for care and this promoting women's employment and men's engagement in care activities; the Nordic countries are exemplar for this type.
- Tradition-central countries, where policies tend to be supportive of the traditional family model, with men as breadwinners and women as caregivers, resulting in more public support to the caregiving role of families, predominantly adopted by women; examples of such policies are child allowances for minor children, part-time day-care services, home care allowances, and marriage subsidies; this categorization includes most Continental, northwestern European countries.

[50] Korpi, W., Ferrarini, T. and Englund, S., 2013. Women's Opportunities under Different Family Policy Constellations: Gender, Class, and Inequality Tradeoffs in Western Countries Re-examined. *Social Politics: International Studies in Gender, State & Society*, 20(1), pp.1-40.

- Market-oriented countries, characterized by the absence of strong action to support households, with the market being therefore the principal institution governing individuals' and families' access to resources; they are mainly Anglo-Saxon countries.

Several other authors have amplified this classification to include also most southern and eastern European countries. In particular, two types of regime were added:

- Traditional-southern countries, characterized by a strong sense of family, with a family solidarity model based on an asymmetrical gender division of work and a low female participation in the labor market; these countries, predominantly situated in the south of Europe, have residual family policies with lack of support to families, making them rely quiet exclusively on unpaid work.
- Contradictory countries, those countries simultaneously attempting to preserve both a highly gendered division of domestic labor and support to dual-earner family; this group consists of former socialist countries where family policies have changed after the transition (before, they were more supporting of women's labor force participation)

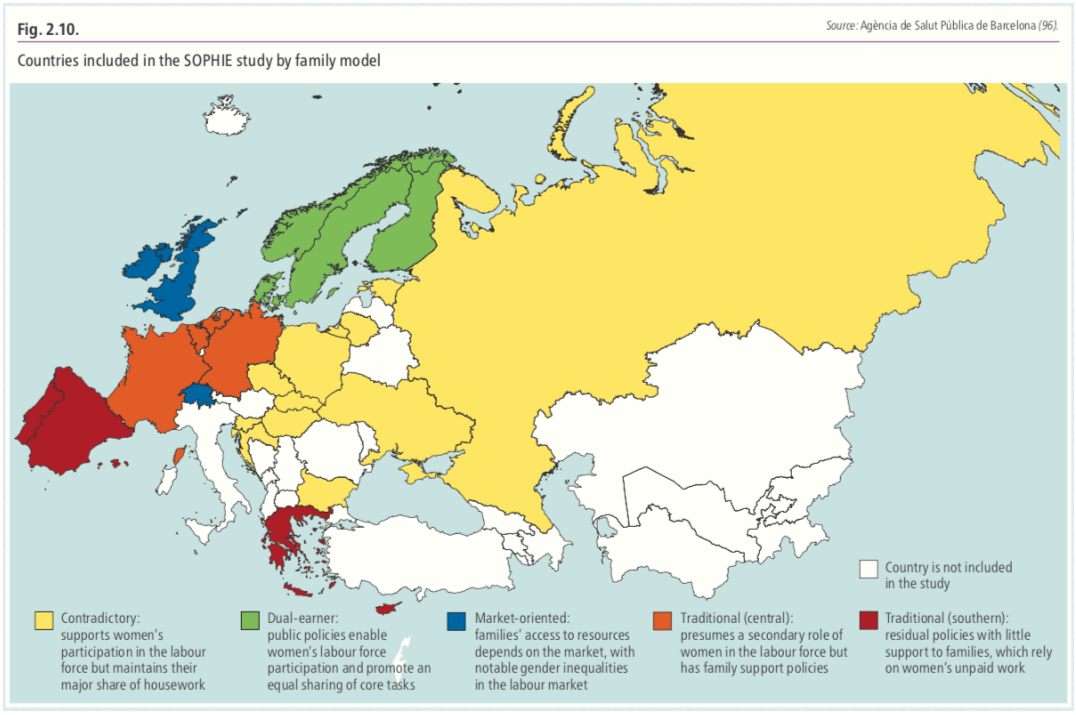

Figure 13: WHO/Europe, 2016. *Women's health and well-being in Europe: beyond the mortality advantage.*

Thanks to the European Social Survey of 2010, researchers found that self-assessed health status was poorer in women than in men in the traditional (both continental and southern countries) and contradictory welfare models, but not in the dual-earner or market-oriented models. This is due to the fact that traditional countries have traditional family support where women are responsible for domestic and family work and enter the labor market mostly as secondary earners, which reinforces the hypothesis that women's poorer health could be related to their lack of power, status and financial resources. Instead, the federal family

policies of Scandinavian countries (e.g., universal childcare and extensive paid maternity leave) have led to a higher proportion of women being employed full-time than for instance in the United Kingdom or Switzerland, where more women tend to work part-time. Moreover, family-friendly policies contribute to men's and women's work and family expectations, choices and behaviors in ways that affect the gender distribution across occupations and professions.

In traditional-southern countries, women are entitled to a relatively short paid period of child-related leave and there is relatively low provision of child-care services, while fathers' specific entitlement to paternity leave is very limited. Studies have consistently associated longer maternal leave with lesser depressive symptoms and better mental health for the mothers. In general, self-reported health seemed to improve with longer maternity leave. The positive effects were more pronounced among mothers who returned to full-time work. In addition, longer maternity leave was consistently associated with duration of breastfeeding, which is known to be associated with better maternal and infant outcomes. Interestingly, father's leave also impacted maternal health.

Across all gender regimes, it was found out that employed men report better mental well-being than employed women, which reinforces the idea that women are victims of higher pressures and stress in the workplace, being usually relegated to inferior positions and being victims of abuses and molestation. In counties with few or no benefit and services for families, it can also be assumed that women's mental well-being is more vulnerable than that of men due to the difficult reconciliation of work and household responsibilities. Family economic needs may push women into the labor market in a situation of economic vulnerability that may lead to exploitation. Furthermore, when family policies provide limited childcare and/or care for older people, women are more likely to be in part-time or low-paid position and less likely to hold management and leadership positions, because lack of public and private support may mean that opportunities providing sufficient flexibility for women to combine paid economic activity with unpaid household responsibilities are offered only by the informal economy.

These considerations suggest the importance of generous work-family balance policy measures for the reduction of gender inequalities among European employees. Social transfers, such as family allowances, social pensions and other cash transfers, are tools for gender empowerment by preventing deprivation throughout the life-course and supporting women in their role as carers.

3.2 Impact of European countries' gender policies on women's health

In general, women in Europe are living longer and healthier lives, because important progress has been made in relation to gender equality and other social, economic and environmental determinants of women's health and well-being. Health systems are slowly adapting to address women's health issued beyond reproduction. Still, large health inequities among women remain within and between countries in

Europe, and the causes of these inequities include the range of determinants of women's health and well-being and health system responses to women's needs. Even if from a global perspective, according to the World Economic Forum Global Gender Gap Index, which benchmarks national gender gaps using four subindices – economic, political, education and health – to provide country rankings, European countries generally rank high, no country has achieved gender equality in health, and progress has been quite slow since the late 2000s. Across the entire region, there is still a higher proportion of women (19.9 percent) than men (16.3 percent) reporting "bad or very bad health", and this is true in particular in Eastern European countries (Source: European Statistics on Income and Living Conditions Survey, 2019). Some studies have shown that countries with higher social spending have smaller inequalities in self-rated health among men and women, higher levels of female labour force participation and more women-friendly employment conditions.

Figure 14: WHO/Europe, 2016. *Women's health and well-being in Europe: beyond the mortality advantage.*

Governments and organizations in many European countries have made several kinds of efforts to introduce the dimension of gender in their policies to reach equality and improve the situation of women. For example, the Swedish Association of Local Authorities and regions has published a guide to inform on the legal possibilities of imposing gender equality requirements on public procurements. The guide reports on the best practice of the Stockholm Country Council (SCC) that states they should guarantee provision of good healthcare on equal terms regardless of gender.

In Ireland, the Health Service Executive (HSE) and National Women's Council of Ireland (NWCI) have developed a training handbook for gender mainstreaming in health. A specific focus is given in the training to how policymakers, service planners, managers and front-line staff can build their knowledge and understanding of gender-related health issues and how they impact on the health and wellbeing of women and men.

With the Action Plan for Women's Health, the Austrian Ministry of Health and the Federal Ministry of Education and Women launched a joint project in 2015, focusing on women's health promotion and prevention as well as gender-sensitive healthcare.

In Denmark, the Strategy for development cooperation and humanitarian action, adopted by the Danish Parliament in 2017, focuses on attaining gender equality and ensuring the respect of sexual and reproductive health and rights of women.

Finally, in Italy, with the approval of Law 3/2018 "Application and dissemination of Gender Medicine in the National Health Service", commonly known as “Law Lorenzin”, a plan for the application and diffusion of Gender Medicine[51] has been published by the Italian Ministry of Health, in collaboration with Reference Center for Gender Medicine of the National Institute of Health, which has also recently established an Observatory dedicated to Gender Medicine. It represents an important step toward the complete implementation of the concept of gender in the national medical research and health system.

SOPHIE (2011-2015)[52] was a research project funded by the European Community’s Seventh Framework Programme, aimed to generate new evidence on the impact of structural policies on health inequalities and to develop innovative methodologies for the evaluation of these policies in Europe.

One of these policies was the Dependency Law in Spain: in 2006 Spain passed the Law 39/2006, of Promotion of Personal Autonomy and Care of Persons in Situations of Dependency, known as the “Dependency Law”, which contemplated social benefits in the form of services and economic compensation when a person is cared for at home. Although the implementations of LAPAD has been facing difficulties as a consequence of budget constraints, especially after austerity cuts in July 2012, it was one of the few welfare policy reforms in a context of little public support for people in situations of dependency and it proved quite effective in reducing health inequalities due to the burden of care on women. This example highlights the importance in investing in solutions that could promote a fairer social distribution of care.

Morris et al. (2018)[53] explored effects of family and employment policies on cardiovascular diseases (CVD) in Europe, which continue to comprise a major part of the overall disease burden for women, especially for those living in countries towards the east, rather than for those in Nordic countries. Indeed, the study highlighted a correlation between government spending on early childhood education and childcare and lower CVD mortality rates for both men and women equally, and government spending on paid parental leave was found out to be more strongly associated with lower CVD mortality rates for women. Additionally, government spending on public employment services was associated with lower CVD mortality for men but was not significant for women (since more employment means more strain), while

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[51] Italian Ministry of Health, 2019. *Piano per l’applicazione e la diffusione della Medicina di Genere*. [online] Iss.it. Available at: https://www.iss.it/documents/20126/0/Piano-Medicina-di-Genere.pdf/aac479dc-f2ae-09be-5d1d-0d052e7f3a6f?t=1576061528911 [Accessed 30 May 2021].

[52] Palència, L., De Moortel, D., Artazcoz, L., Salvador-Piedrafita, M., Puig-Barrachina, V., Hagqvist, E., Pérez, G., Ruiz, M., Trujillo-Alemán, S., Vanroelen, C., Malmusi, D. and Borrell, C., 2016. Gender Policies and Gender Inequalities in Health in Europe. *International Journal of Health Services*, 47(1), pp.61-82.

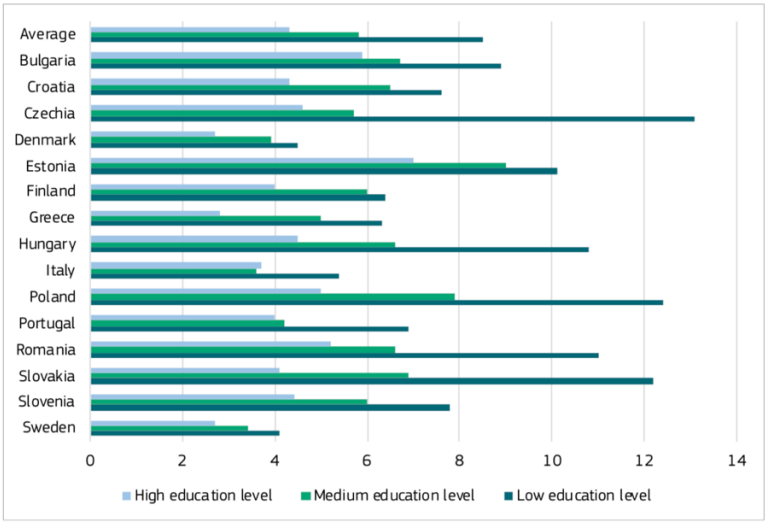
[53] Morris, K., Beckfield, J. and Bambra, C., 2019. Who benefits from social investment? The gendered effects of family and employment policies on cardiovascular disease in Europe. *Journal of Epidemiology and Community Health*, 73(3), pp.206-213.

government spending on employment training was associated with lower CVD mortality rates for women but was not significant for men.

The design of parental leave policies is indeed very important for gender equality, because it can either promote women to return to paid labor as mothers or force women to choose between work and family life. Policies that give both parents paid leave with universal coverage, non-transferable quotas for each parent, and scheduled flexibility at the workplace give signals of equal value of both paid and unpaid work and show that both forms of work should be equally shared between men and women. Policies that support women's participation in the labor force and decrease their burden of care, such as increasing public services and economic support for families and entitlements for fathers, are related to lower levels of gender inequality in terms of health. Some countries, including Norway and Portugal, even use financial incentives to encourage fathers to take paid parental leaved from their jobs. By using Multinational Time Use Study data from Sweden and Spain, a Nordic and a Southern country, which are part of two completely different policy regimes, taken in 1990, 2000 and 2010, it was observed that changes in leave policies involving the introduction of or increases in exclusive paternal leave were followed by reduction in time use inequality between mothers and fathers, which has substantial effects on the well-being of women.

Education policies are also very important, since the gender life expectancy gap generally decreases in correlation to them being applied in most European countries, and instead it is particularly large in the lowest educated groups in all countries. Even if, with a few exceptions, girls and boys in Europe generally have equal access to pre-primary, primary and secondary education, and women outnumber men in tertiary education in several countries, there are still some gaps in access to education for specific groups of girls and gender stereotypes continue to limit girls' education and training choices.

Figure 2. Gap in life expectancy at birth (years) between women and men by level of education in 15 EU Member States, 2016



Source: European Core Health Indicators. European Commission. (2016). Life expectancy by educational attainment. Retrieved from https://ec.europa.eu/health/indicators_data/indicators_en.

Notes: Bars indicate the difference between excess of women's life expectancy at birth compared to men in years.

Figure 15: European Commission, 2016. *Life expectancy by educational attainment.*

Another important aspect to which policymakers should pay attention is reproductive rights and healthcare for women. Many European countries have made substantial progress in improving key sexual and reproductive health indicators over the past 20 years. Finland, for example, has a high level of sexual and reproductive health rights, and, consequently, the level of infant mortality is among the lowest in the world. This can be explained by Finland's universal and comprehensive primary health care services. NGOs are important service providers, especially for vulnerable groups. Effective education and family services are also beneficial. Finland offers health services in schools; sexuality education is highly prioritized and is a mandatory part of the school curriculum. Furthermore, there are many benefits for families with children in Finland: maternity clinics, a maternity grant and a parental leave also for fathers. Importantly, men are increasingly considered when addressing sexual and reproductive health and uptake of services in this field.

Since 2007, European regulations have allowed Member States to reduce the so-called "tampon tax" to the minimum for essential goods. Most European countries have therefore decided in recent years to lower VAT on these goods: Spain, Greece and Austria are among them, with a rate of 10 percent or slightly higher. Also on this list are France with 5.5 percent and Ireland with 0 percent. Notably, Ireland is an exception: the tax deduction for tampons was in fact decided before the European directive on VAT reduction and exemption came into force, and therefore Ireland is not required to apply the minimum rate of 5 percent. Since 2018, in Belgium the rate has decreased from 21 percent to 6 percent and in Germany, since 2020, from 19 percent to 7 percent. England in particular, which has always been in the forefront of this battle, had already lowered the rate on sanitary towels to the minimum allowed by the Union in 2000, and now, with the final exit from the EU, it is planning for 2021 the total abolition of VAT on sanitary products. However, in many other countries, including Italy, the rate still exceeds 20%.

In the end, although national social provision policies certainly impact on the population's health and can provide benefits to men and women that alleviate some of their exposure to health risks, it is important to remember that they do not completely govern personal agency, the choices that individuals make regarding their health, usually influenced and constrained by gender roles, or the gendered division of labour in families and organizations.

Chapter IV
"Gender and COVID-19"

4.1 The particular importance of sex-disaggregated data in relation to COVID-19

Already in 2002, WHO published an information sheet on *"Gender and health in disasters"*[54], recognizing the general lack of research on sex and gender differences in vulnerability to and impact of

[54] WHO, 2002. *Gender and Health in Disasters*. [online] Who.int. Available at: https://www.who.int/gender/other_health/genderdisasters.pdf [Accessed 23 May 2021].

disasters, while there is evidence showing that women and men suffer different negative health consequences following a disaster, due to an interaction of social and biological factors.

The situation is not different for the latest disaster that has hit the world in 2020, the COVID-19 global pandemic. A higher vulnerability to COVID-19 has been found in male patients, which can be explained by gender disparities in lifestyles (e.g., smoking tendencies) as well as by genetic factors. Although the severity and mortality of COVID-19 infection is twice as high for men as for women, women and girls have still been disproportionately affected by the multi-dimensional impacts of the recent COVID-19 pandemic: the virus has taken a toll on the everyday psychological and physical health of women. The pandemic has proved again the fact that health is not driven just by biology, but also by the social environment in which people find themselves and gender is a major part of it.

Furthermore, the COVID-19 pandemic has put a halt to progress toward gender equality and, instead, exacerbated existing gender inequalities across domains – from gendered division of labour to economic stability. Due to the COVID-19 pandemic, almost half of the nongovernmental commitment makers anticipate a decrease in their financial commitments in the coming years or a degree of uncertainty on their ability to deliver on pledges to contribute to the EWEC Global Strategy. In general, all post-crisis policies cause a downgrading of gender equality, which is likely to produce an increase of the prevalence of health problems among women due to the worsening of their living and working conditions.

Composing 70 percent of global health workers, at the front line of the pandemic there are more women than men, and therefore women are the ones who are mostly suffering acute psychological stress and possible posttraumatic stress disorder after the pandemic, as well as having a higher possibility of getting infected. In some countries, COVID-19 infections among female health workers are twice that of their male counterparts.

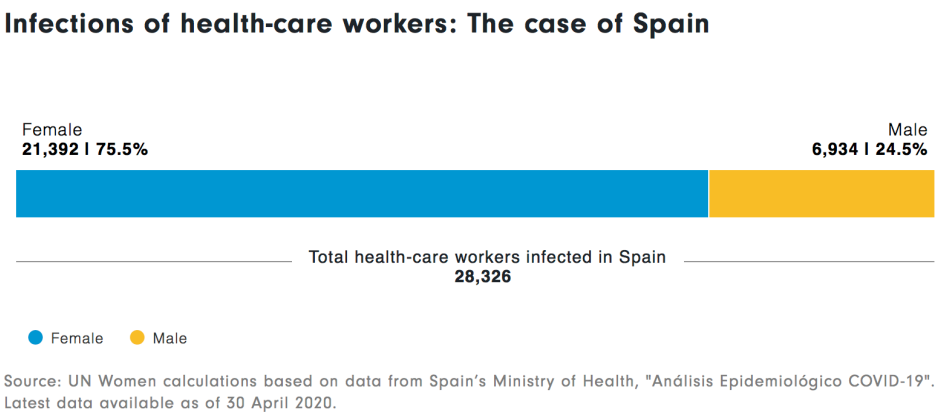


Figure 16: UN Women, 2020. *Women Count Data Hub*

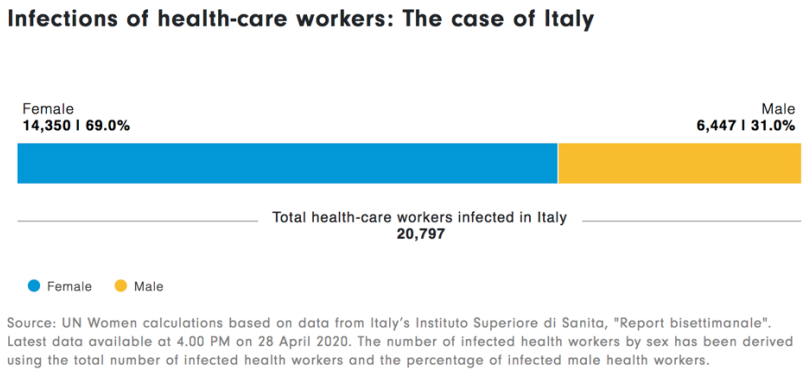


Figure 17: UN Women, 2020. *Women Count Data Hub*

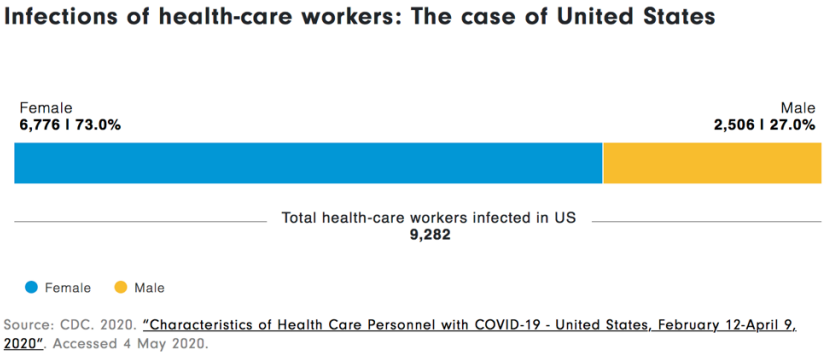


Figure 18: UN Women, 2020. *Women Count Data Hub*

Sex-disaggregated data along the clinical pathway, from testing through to hospitalization and intensive care unit (ICU) admissions, is essential to help understand who is being impacted by the epidemic and who has access to testing and health services. The COVID-19 Sex-Disaggregated Data Tracker[55] is the world's largest database of sex-disaggregated data on COVID-19 vaccinations, testing, confirmed cases (including among health workers), hospitalizations, ICU admissions and deaths.

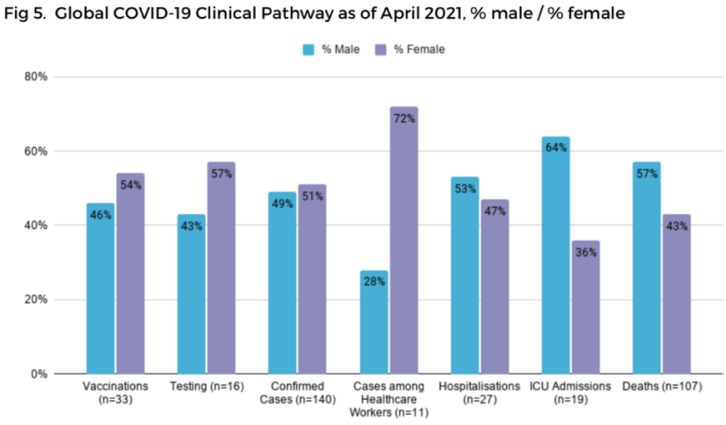


Figure 20: Global Health 50/50, 2021. *The COVID-19 Sex-Disaggregated Data Tracker.* The Sex, Gender and COVID-19 Project

[55] Global Health 50/50, 2021. *The COVID-19 Sex-Disaggregated Data Tracker | Global Health 50/50.* [online] Globalhealth5050.org. Available at: https://globalhealth5050.org/the-sex-gender-and-covid-19-project/the-data-tracker/ [Accessed 12 May 2021].

The Tracker is part of the Sex, Gender and COVID-19 Project, a partnership of Global Health 50/50 (an independent initiative housed at the UCL Centre for Gender and Global Health), the International Center for Research on Women and the African Population and Health Research Center, aimed at investigating the roles sex and gender are playing in the outbreak, building the evidence base of what works to tackle gender disparities in COVID-19 health outcomes, and advocating for effective gender-responsive approaches to COVID-19. Data is collected directly from official national sources, including ministry of health websites, national statistics sites, death registers and government social media accounts, with a new update every two weeks. As of mid-April 2021, 51 percent of the 197 countries tracked provided some sex-disaggregated data in the past month.

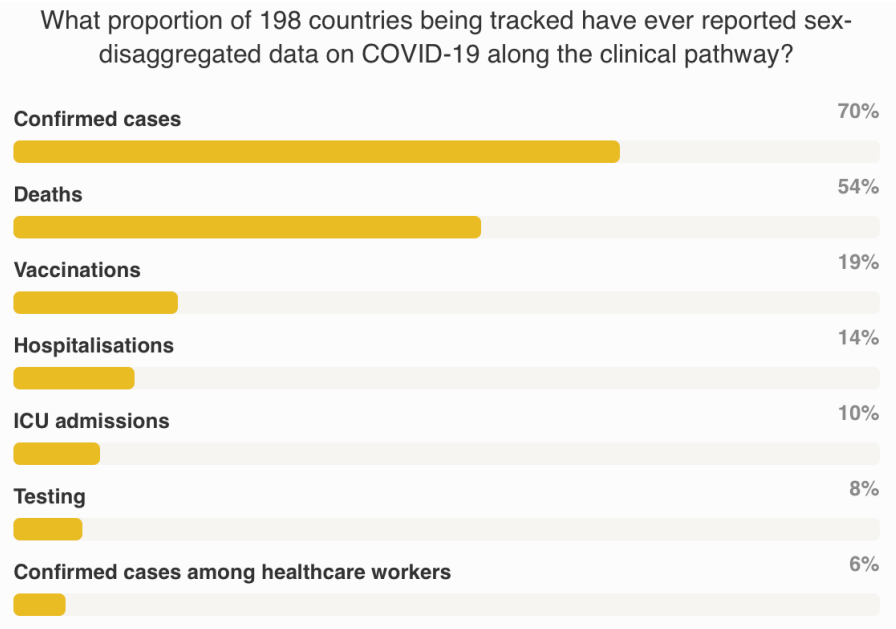


Figure 20: Global Health 50/50, 2021. *The COVID-19 Sex-Disaggregated Data Tracker.* The Sex, Gender and COVID-19 Project

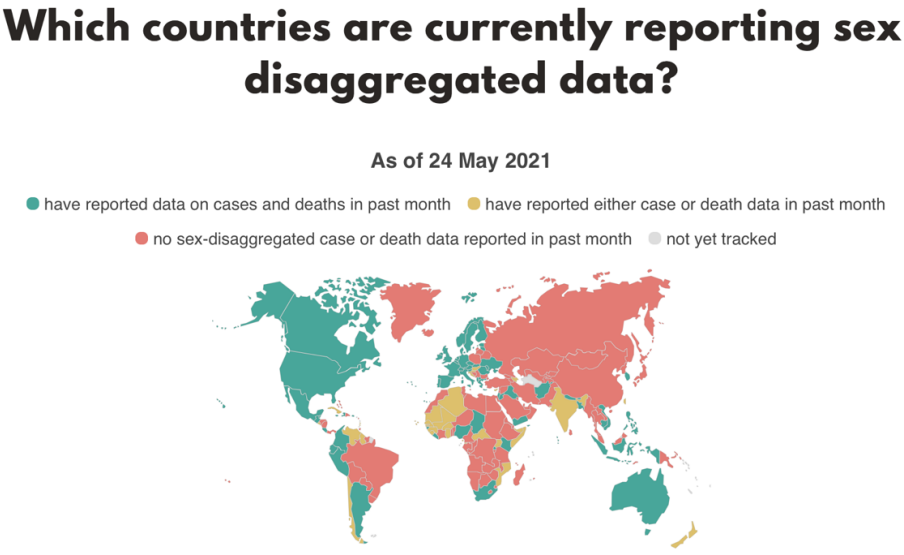


Figure 21: Global Health 50/50, 2021. *The COVID-19 Sex-Disaggregated Data Tracker.* The Sex, Gender and COVID-19 Project

This means that there has been a decline in reporting sex-disaggregated data since August.

Table 1. Percent of 119 Countries Tracked Regularly since August 2020 Reporting Sex-Disaggregated Data

Variable	Aug 2020	Oct 2020	Jan 2021	Apr 2021
Case Data by Sex in Past Month	84%	70%	71%	69%
Death Data by Sex in Past Month	60%	57%	57%	55%
Both Data by Sex in Past Month	55%	48%	55%	53%
Either Data by Sex in Past Month	89%	79%	73%	70%

Figure 22: Global Health 50/50, 2021. *The COVID-19 Sex-Disaggregated Data Tracker.* The Sex, Gender and COVID-19 Project

Across the 10 countries, with the highest number of confirmed cases globally, there are four countries that account for 60 percent of cases with unknown sex and 88 percent of deaths with unknown sex.

Table 2. Availability of Sex-Disaggregated Data within the Past Month amongst Countries with the Highest COVID-19 Caseload as of this Update

Date indicates the last month where sex-disaggregated data was located for that country.

Country	Cases	Deaths
USA	Reporting	Reporting
India	Sept 2020	May 2020
Brazil	Dec 2020	Feb 2021
France	Reporting	Reporting
Russia	Never	Never
Turkey	Oct 2020	Oct 2020
United Kingdom [2]	Reporting	Reporting
Italy	Reporting	Reporting
Spain	Reporting	Reporting
Germany	Reporting	Reporting

Figure 23: Global Health 50/50, 2021. *The COVID-19 Sex-Disaggregated Data Tracker.* The Sex, Gender and COVID-19 Project

The tracker has recently begun to include sex-disaggregated data on vaccination from 33 countries, mostly European (17 out of 33, 51 percent) and high-income countries (22 out of 33, 69 per cent), which reflects patterns in global vaccine distribution being concentrated in Europe and North America and among high income countries. As vaccines against COVID-19 continue to be rolled out, it is important to collect more sex-disaggregated data on the different responses of women and men and clinical trials for new vaccines must include a gender-balanced representation of women and men to see how the vaccine might affect them differently.

4.2 An increase of risks and inequities for women as a result of the pandemic

The fact that many countries still do not collect sex-disaggregated data shows the lack of consideration of gender and its intersections as critical moderators of health and well-being. Some experts, policymakers and medical professionals underscore the disproportionate risks that women face during

pandemics not only as a majority of healthcare workers, but also as those responsible for intimate care which includes longer periods of exposure and heightened risk of transmission. In addition to working as nurses and midwives, women are spearheading the fight against COVID-19 on multiple levels: as doctors, medical researchers, epidemiologists, schoolteachers, Parliamentarians and Ministers, all while facing disproportionate social, economic and health risks.

Nonetheless, a study found out that men greatly outnumbered women in the bodies created to respond to the pandemic. Of 115 national dedicated COVID-19 task forces in 87 countries, including 17 EU Member States, 85.2 percent were made up mainly of men, 11.4 percent comprised mainly women, and only 3.5 percent had gender parity. Women make up only 20 percent of the WHO Emergency Committee on COVID-19.

Figure 24: Women in Global Health, 2021. *Operation 50/50: Women's perspectives save lives*

In partnership with Women of Color Advancing Peace and Security, Women in Global Health is working to change this disconnect between vulnerability and representation in health security, which has been highlighted by the COVID-19 pandemic, by compiling the Operation 50/50[56] list of expert women who are working to strengthen global, regional, national and local capacities to prevent, detect and respond to outbreaks.

Another study of COVID-19 leadership showed that countries with female leaders fared better in the early stages of the pandemic than countries with male leaders. This has been explained thanks to perceived gender differences in leaders' appraisal of the costs and benefits of national lockdown. For instance, female

[56] WGH and WCAPS, 2020. *Operation 50/50: Women's perspectives save lives - 100 women experts working in health security*. [online] C8fbe10e-fb87-47e7-844b-4e700959d2d4.filesusr.com. Available at: https://c8fbe10e-fb87-47e7-844b-4e700959d2d4.filesusr.com/ugd/ffa4bc_aa83e933b1294558a11df9172afd926a.pdf?index=true [Accessed 24 May 2021].

leaders' initiation of national lockdowns at a lower number of fatalities may be due to their perceptions that the loss of human life may be more costly than the economic consequences. In contrast, male leaders, for whom financial risk and reward are key to their performance of masculinity, may have prioritized economic tolls over human life. This is just one of the consequences of gender roles and stereotypes.

Another one is the fact that women are overrepresented in sectors that have been worst affected by the crisis (retail, hospitality, residential care, clothing manufacturing and domestic work), because these jobs cannot be done remotely. Gender segregation in the labour market leads to different levels of risks and consequences for women and men. Emerging from the crisis, women's poverty rate is expected to increase by almost 10 percent globally and 47 million more women have been pushed into living on less than $1.90 per day. Furthermore, women's unpaid care has risen dramatically owing to factors such as stay-at-home orders and lockdown policies, the closure of schools and childcare facilities, and an increased need for elder care. Mothers are more than three times as likely as fathers to be responsible for most of the housework and caregiving during the pandemic, and to scale back or consider leaving their job as a consequence of this. During the pandemic, women at work are reporting higher levels of exhaustion and burnout than men, which is likely due to a greater stress at both ends of the work-life balance as a consequence of the pandemic.

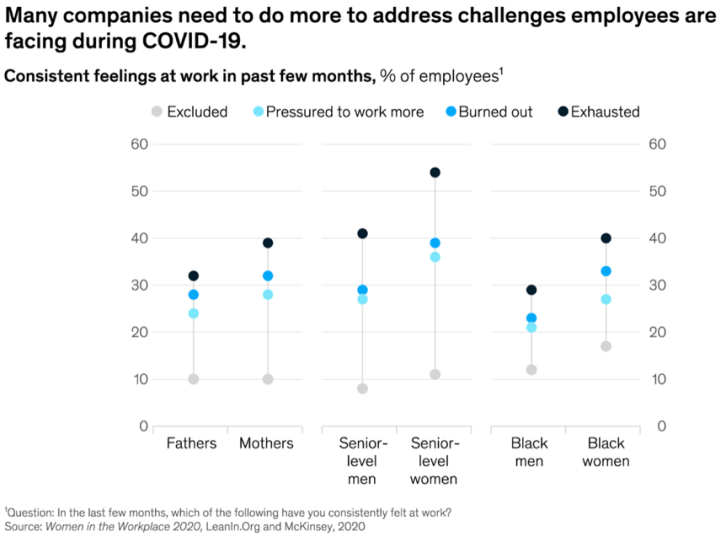


Figure 25: McKinsey & Company, 2020. *Women in the Workplace 2020*

In general, women report greater stress and anxiety because the pandemic has both increased the role strain and expectations put on women to be the primary caregivers and reduced external support. The emotional repercussions of the new stressors of isolation and the possibility of infection will be higher in those women whose duties include taking care of old relatives and children at home. It is also true that gender roles are responsible in discouraging women from displaying coldness or stoicism, and men from displaying anxiety or distress. They are also the cause of precarious masculinity, which may explain the increase in partner violence against women: because of economic and environmental instability, men may have greater propensity to enact violence against women to regain a sense of masculinity, control or power

in their relationships. Stay-at-home orders worsen the situation, because they force women to remain in close proximity to their abusers, while also reducing access to external support. Moreover, out of fear of COVID-19, victims may feel less inclined to seek support or go to the hospital. All of this shows how conventional gender roles and divisions of labour are not only unsustainable, but also harmful.

The COVID-19 pandemic has also put women's physical and reproductive health in jeopardy: indirectly, COVID is causing more women than men to suffer and die, in large part because the pandemic has disrupted health care services for women, especially the ones before, during and immediately after childbirth. Access to preventative care such as breast cancer and cervical cancer screening has been restricted in many countries as a result of healthcare system pressures and the need for social distancing. Many countries, such as Brazil, India and Nepal, have relocated their already scarce resources to the care of COVID-19 patients. Many health care workers, including experience nurse-midwives, who used to manage pregnancy emergencies which can cause maternal deaths, are being diverted to COVID wards. This is particularly concerning for those countries where unsafe abortions are a leading cause of maternal death.

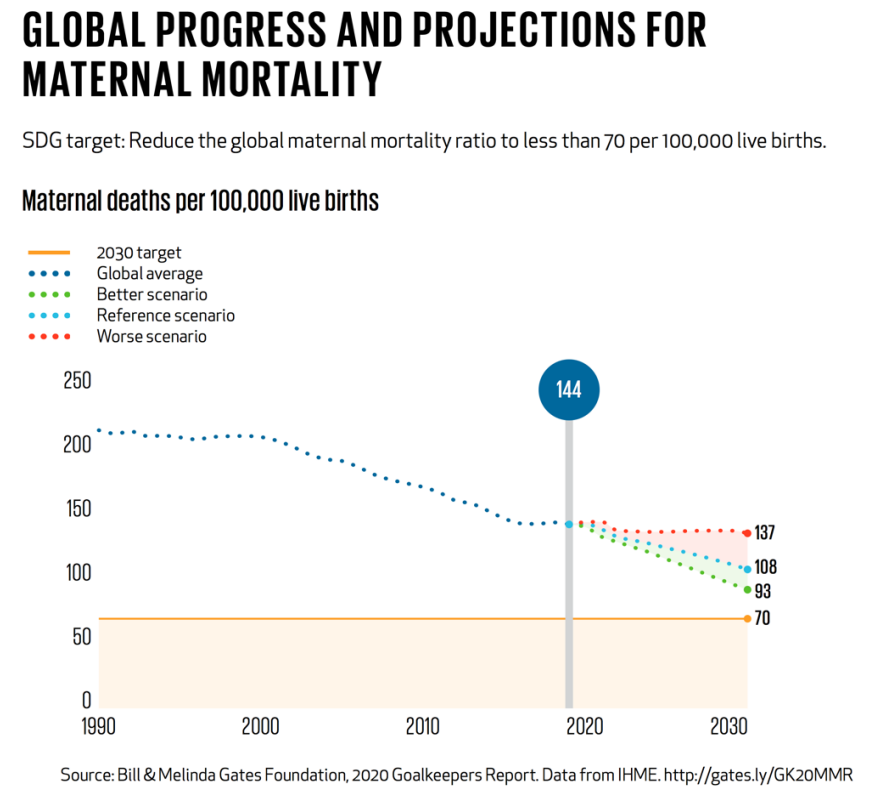


Figure 26: Bill & Melinda Gates Foundation, 2020. *2020 Goalkeepers Report*

Lockdown and travel restrictions complicate access to essential sexual and reproductive health information, services and goods for women and girls. Meanwhile, pregnant women and new mothers must weigh the benefits of visiting a clinic against the risk of exposure to COVID. Some are deciding to deliver at home and/or skip newborn care visits as a result.

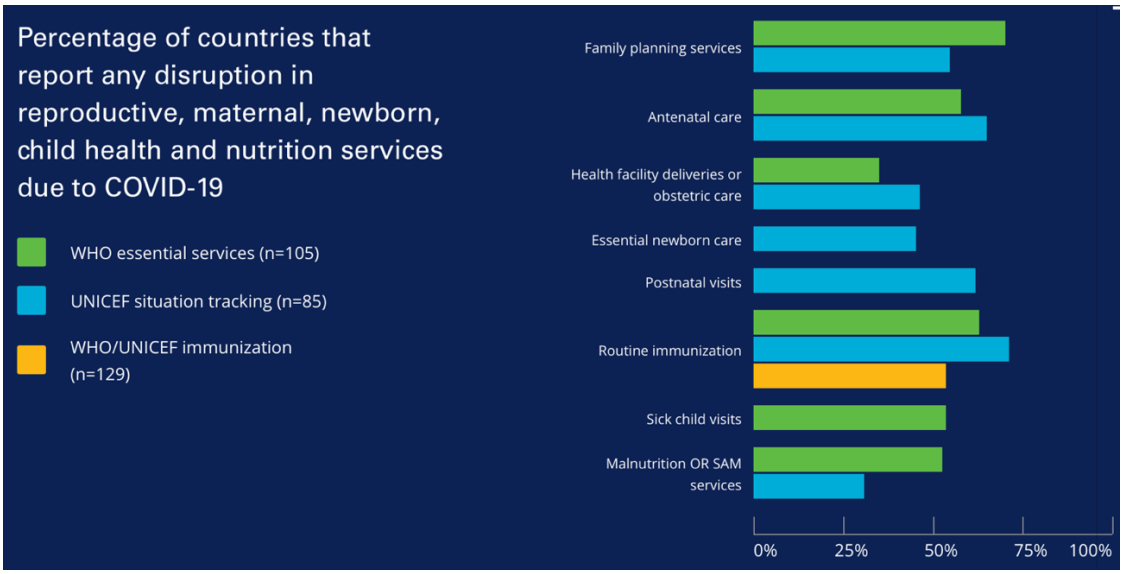


Figure 27: Every Woman Every Child, 2021. *Protect the Progress*

The continuity of essential services and funding for reproductive, maternal, newborn, child and adolescent health must not only be protected from cuts and reallocation as part of national COVID-19 response and recovery efforts, but also prioritized and increased to respond to the immediate and long-term repercussions of the pandemic. “We must not let mothers and children become collateral damage in the fight against the virus. And we must not let decades of progress on reducing preventable child and maternal deaths be lost.”, stated Henrietta F. Fore, Executive Director of UNICEF.

What has been the international response to prevent backsliding and protect women’s rights and health? Around the world, women’s organizations have stepped up in response to the pandemic, providing frontline services and support to the marginalized, advocating for gender-responsive policy agendas and demanding government accountability for human rights. As the pandemic strains public services and creates significant economic hardship, women’s rights organizations are stepping up to fill gaps in state service provision, often with little recognition and at significant cost. From providing food ais and personal protective equipment (PPE), to organizing collective childcare, disseminating reproductive health and hygiene kits, creating reporting mechanisms and providing psychosocial support for survivors of violence, women-led NGOs, associations and mutual-aid groups around the world have pivoted to address the needs of women and their families at the community level. The Women’s Peace and Humanitarian Fund established a COVID-19 Emergency Response Window that has already financially supported 42 grassroots women’s civil-society organizations across 18 countries to remain operational and respond to the gendered impacts of the pandemic.

UN Women and UNDP compiled over 2,500 policy measures across 206 countries and territories in the COVID-19 Global Gender Response Tracker – a new and unique database that monitors policy responses taken by governments worldwide to tackle the pandemic and focuses on measures that address three key challenges: the surge in violence against women, the unprecedented increase in unpaid care work,

and the large-scale loss of jobs, incomes and livelihoods. It is also useful to provide guidance for policymakers and evidence for advocates to ensure a gender-sensitive COVID-19 policy response. Decisions that are informed by accurate data and include a gender perspective are more likely to be effective. That is why UN Women is cooperating with decision-makers to ensure gender is integrated in national and sub-national COVID-19 response plans, not only to achieve better outcomes for women and girls, but to achieve better outcomes for everyone.

The tracker identifies 992 measures across 164 countries that are "gender-sensitive", which means that they address the three dimensions of violence, unpaid care and economic security. Only 12 percent of countries analyzed have a holistic response, while 20 per cent of countries analyzed seem to have no gender-sensitive measures in response to COVID-19 at all.

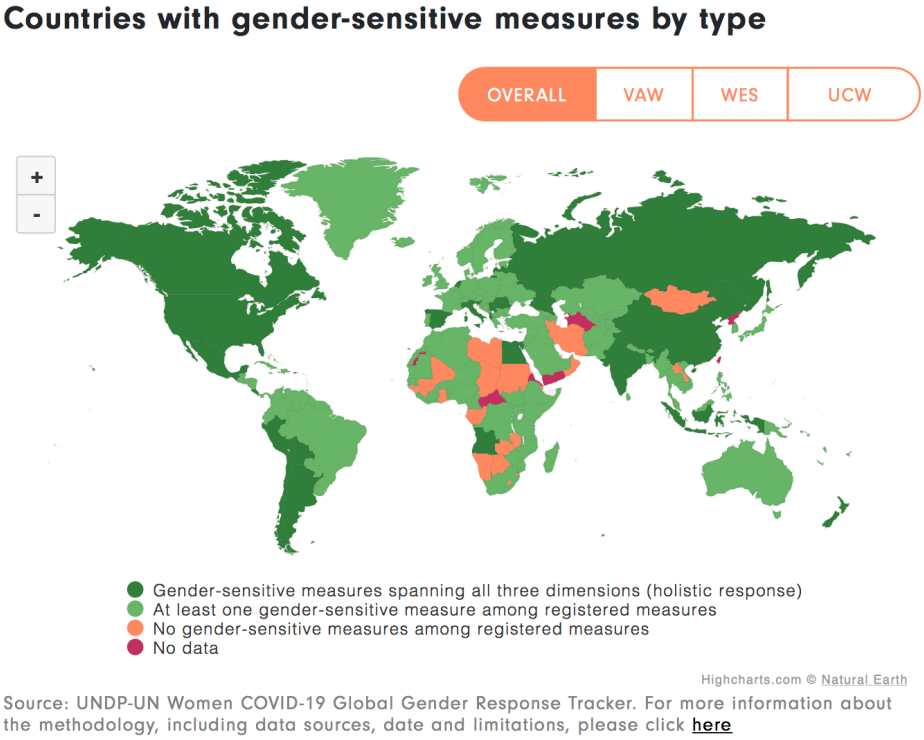


Figure 28: UNDP, UN Women, 2021. *Global Gender Response Tracker*

Which types of gender-sensitive measures have been implemented in response to COVID-19? Equitable access to relevant training on infection prevention and control measures, personal protective equipment (PPE), essential products for hygiene and sanitation, and psychosocial support have been provided to healthcare and social workers. The strengthening and adaptation of services for survivors, including shelters, hotlines, health, police and justice services, make up almost two-thirds of measures taken to respond to violence against women in the context of COVID-19. Cash transfers, food and other in-kind support that target women or prioritize them among recipients have been the most common responses to the income and food insecurity triggered by the pandemic. New or expanded family leave provisions have enables working parents to take time off paid work to care for children or sick family members; however, such leave provisions often do not cover informal workers.

Also commissioned by UN Women, through its global gender data program Women Count, in partnership with UNFPA, a new 28-country study on the *Impact of COVID-19 on Gender Equality and Women's Empowerment in East and Southern Africa*[57] has revealed the opportunities and constraints for gender equality in post-COVID-19 recovery, by making concrete recommendations for advancing gender equality and influencing policies and programs in the COVID-19 and post-pandemic times.

Ahead of International Women's Day, the European Commission published its 2021 report on gender equality in the EU, that showed the negative impact of the COVID-19 pandemic on women, with a surge in domestic violence and an unprecedented rise in workload, health risk and challenges to work-life balance. In order to track progress on tackling these issues, the Commission has launched the Gender Equality Strategy Monitoring Portal, a joint project developed by the Commission's Joint Research Centre and the European Institute for Gender Equality (EIGE), which will allow to monitor individual EU Member States' performance and compare the performance among the 27 Member States.

In general, public interventions should always take into account the gender perspective, especially in times of crisis like the one we are living right now with the COVID-19 pandemic. Analyzing social policies in order to predict or determine actual effects on men and women usually proves to be a particularly important practice for sustaining gender equality, particularly in times of economic retrenchment and the resulting increase in competition for existing resources. The impacts of the COVID-19 economic fallout will be gendered, impacting mostly women. However, research into previous global financial crisis has shown that health inequalities were less negatively impacted in countries that maintained a strong social security safety net compared with those such as Greece, Spain and the UK, which pursued austerity. National gender equality bodies should work with the national structures responsible for COVID-19 recovery efforts to ensure gender-mainstreaming tools, such as gender impact assessments and gender budgeting, are used throughout the recovery. National governments should also work together in order to launch a study on gendered differences in the long-term impacts of the virus and the policy measures taken. It is fundamental to apply a gender lens to all COVID-19 pandemic response and recovery efforts, by protecting and supporting the specific needs of women.

[57] UNFPA and UN Women, 2021. *Impact of COVID-19 on Gender Equality and Women's Empowerment in East and Southern Africa*. [online] Reliefweb.int. Available at: https://reliefweb.int/sites/reliefweb.int/files/resources/Impact%20of%20COVID-19%20on%20Gender%20Equality%20and%20Women's%20Empowerment%20in%20East%20and%20Southern%20Africa.pdf [Accessed 30 May 2021].

Conclusion

The aim of this dissertation has been to show the complex influence that gender has on health, and in particular on women's health, focusing on how national social policies differently impact people's lives and health based on their gender, and on how the situation has evolved in relation to the recent COVID-19 global pandemic. The first chapter has highlighted how women have been, and still are, disadvantaged both as healthcare recipients and as healthcare providers. Several examples have been provided of how diseases differently affect women because of biological, psychosocial, cultural and economic reasons. It has been shown that historically, if they did consider women at all, research and the design of health programs and policies have considered quite exclusively the male body and have placed much more emphasis on the biological differences between the sexes than on the complex interaction between sex, gender and health, with the result of considering women only in the reproductive function. Throughout this entire dissertation, evidence has been brought up to show that the different ways in which men and women fall ill cannot only, or even often, explained by genetic differences with a biological foundation and traditionally attributable to sexual differences. Therefore, it has been necessary to introduce the concept of gender to explain some health differences that depend on people's way of life, their expectations, and other social and cultural aspects: there seem to be certain "healthgenic" and other "pathogenic" norms, both for men and women, with regard to their health behaviors, and this reinforces the idea that research on the relationship between gender and health requires a multidimensional approach, which would deepen our understanding of the costs and benefits of gender roles in relation to health and how they intersect with other social determinants of health. Furthermore, the intent of this dissertation has been to show that to achieve full gender equity in health would not necessarily translate into equal rates of mortality and morbidity in women and men, but into the elimination of avoidable differences in opportunities to enjoy health and not to fall ill, suffer disabilities, or die from preventable causes. Likewise, gender equity in healthcare does not necessarily imply equal quotas of resources and services for men and women; equity implies a differential allocation and reception of resources, according to the particular needs of each person and in each specific socioeconomic context. Another important aspect that has been considered is that in health systems everywhere issues of occupational segregation, wage and working conditions, and leadership disparities are still pronounced. The WHO Global Health Workforce Network Gender Equity Hub has officially recognized that, across the health and social care workforce, despite the so-called "feminization" of the workforce, women are substantially under-represented in management, leadership and governance. Gender discrimination is linked to low morale, low self-esteem, and lower productivity, and thus to worse healthcare for everyone. Therefore, unless gender – and its intersections with other social factors – is explicitly recognized and addressed, progress towards universal health coverage might not solve, or might even exacerbate, gender inequality.

In the second chapter, a list of resolutions and best practices that governments should implement has been provided: policymakers should design health systems to meet the challenges imposed by gender norms, roles and relations on the development and implementation of policies, programs and services, incorporating gender as part of the design, and throughout the entire process of implementation and evaluation. Besides the unethical component of excluding sex and gender from health research, policies and programs, the available data support the belief that the effective management of inequalities based on sex and gender may represent an important economy to health care and contribute to improving those services and the overall health of individuals and groups. International research has shown associations between gender inequality and patterns of morbidity and mortality, and there is accumulating evidence that lack of gender sensitivity can negatively impact the health care provided for women, but also for men. Specific strategies exist to promote women in health and research, and many international organizations and associations, comprising the World Health Organization and the European Union as pioneers, have catalogued and recommended them to national governments worldwide. Furthermore, many reports on different topic concerning different aspects of women's health and the impact of gender on global health have been published since the 1980s, when for the first time the women's health movement started to advocate for a greater inclusion of women in medical research. These serve to inform both policymakers and health providers, and the civil society in general, which has to develop a greater awareness to problems affecting women's lives. Nonetheless, it is important to remember that neither men nor women on their own, no matter how extensive a health consciousness they may possess, can gain control over all of the health-damaging environmental and social risks and exposures without policies and regulations at a variety of levels which make the health of people a priority. However, at the same time, even if national social provision policies provide benefits to men and women that alleviate some of their exposure to health risks, as it has been shown in the third chapter bringing as examples the different gender policy regimes in European countries, they do not completely govern personal agency, the choices that individuals make regarding their health, usually influenced and constrained by gender roles, or the gendered division of labour in families and organizations. Therefore, to achieve gender equality in health is fundamental to combine both the individual and the national and international levels, working on both the structural and cultural factors that influence health.

Finally, the fourth chapter focuses on the recent COVID-19 global pandemic, which has hit men and women differently, and the disruptive effect it had on many health and social services, which impacted women in particular, being the greatest part of the health and care workforce. In short, understanding the relationship between sex, gender and COVID-19, also by collecting sex-disaggregated data, means recognizing the role that both biology and social factors play a role in the risk of infection and disease, clinical presentation and severity of outcomes both at the individual and population levels, which is what policymakers and civil society should do to reach gender equality in health in general.

Throughout this entire dissertation, what has emerged clearly is that the evidence that women are being let down by the medical establishment is overwhelming. The bodies, symptoms and diseases that affect half the world's population are often being dismissed and ignored. And it's all a result of the data gap combined with the still prevalent belief that men are the default humans, and women are just "the other". In addition, many countries, despite international recommendations, are still far behind in the mainstreaming of gender in all policies, and especially health-related ones, and in the realization of social policies who could help women's lives and well-being. The current gender reckoning in research, medicine and global health highlights both missed and future opportunities, and the need to situate gender analyses in the context of political influences and structural inequalities. Beyond quantitative gender equality, we must strive as a global society for a cultural transformation, for a revolution in the research, in the practice of medicine and in policymaking. Until now, we have seen only the beginning of it, and the COVID-19 pandemic is putting at risk even the only progress that has been made. Now, more than ever, it is finally time to stop dismissing women and start saving them.

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Riassunto in italiano

“Genere e Salute: un'analisi dell'influenza del genere sull'assistenza sanitaria e delle politiche sociali sulla salute delle donne”

A partire dagli anni Ottanta, per la prima volta, grazie al movimento per la salute delle donne, si è riconosciuta la necessità di integrare il genere nella ricerca e nella medicina e di prestare più attenzione alla salute delle donne. Molte di loro ancora oggi in tutto il mondo hanno poco o nessun accesso a servizi sanitari ed educativi essenziali e di buona qualità, all'aria e all'acqua pulita, a servizi igienici adeguati e a una buona alimentazione. In più, affrontano violenza e discriminazione, non sono in grado di partecipare pienamente alla società e incontrano altre barriere alla piena realizzazione dei loro diritti umani. Le donne, e altre persone, che affrontano la discriminazione a causa della loro identità di genere, o dell'orientamento sessuale, hanno spesso un accesso ineguale ai servizi sanitari di base e alle risorse e la loro fruizione. Norme di genere diseguali e stereotipi di genere creano anche pregiudizi nelle politiche, nelle istituzioni e nella pianificazione, con gravi conseguenze sull'efficacia dei servizi.

Nonostante in media a livello globale le donne abbiano un’aspettativa di vita più alta rispetto agli uomini, questo non equivale a una vita più sana, in quanto gli anni di vantaggio delle donne sono spesso gravati da disabilità, principalmente correlata alle conseguenze determinate da malattie croniche e scarsa qualità della vita. Alcuni parametri fisiologici sono differenti nell’uomo e nella donna e condizionano il meccanismo d’azione delle varie terapie. Nonostante queste variabili, gli effetti della maggior parte dei farmaci sono stati studiati prevalentemente su soggetti di sesso maschile. La medicina, fin dalle sue origini, ha avuto un’impostazione androcentrica, relegando gli interessi per la salute femminile ai soli aspetti specifici correlati alla riproduzione. La salute delle donne è perciò molto influenzata da pregiudizi di genere nei sistemi sanitari e dalla fornitura di servizi medici inadeguati e inappropriati alle donne. La qualità dell'assistenza sanitaria per le donne è spesso carente: le donne non sono trattate con rispetto, né sono garantite loro la privacy e la riservatezza, né ricevono sempre informazioni complete sulle opzioni e i servizi disponibili. Gli stereotipi di genere da parte degli operatori sanitari e le differenze di genere nella presentazione delle malattie possono influenzare i percorsi diagnostici e terapeutici, come, per esempio, è spesso il caso delle malattie cardiovascolari, riconosciute per molto tempo come un problema che riguardava esclusivamente gli uomini, ignorando la diversa sintomatologia che queste malattie avevano nelle donne. Ciò che manca alla maggior parte dei sistemi sanitari è la sensibilità di genere, il che significa che gli operatori sanitari non sono competenti a percepire le differenze di genere esistenti e a incorporarle nelle loro decisioni e azioni.

Dagli anni Ottanta è diventato sempre più evidente come lo studio della medicina si fosse concentrato quasi esclusivamente su soggetti maschili, nell’errata convinzione che, eccetto per i diversi apparati sessuali e

riproduttivi, uomini e donne fossero equivalenti. Dagli anni Novanta in poi, in seguito a questa presa di coscienza e alla maggiore attenzione data alla salute delle donne a livello internazionale, la medicina tradizionale ha subito una profonda evoluzione attraverso un approccio innovativo che mira a studiare l'impatto delle variabili biologiche, ambientali, culturali, psicologiche e socioeconomiche determinate dal genere sulla fisiologia, sulla patologia e sulle caratteristiche cliniche delle malattie. Da qui l'inclusione delle differenze di genere in buona parte della sperimentazione farmacologica e della ricerca scientifica. La medicina di genere (MdG), o meglio la medicina genere-specifica, consiste nello studio dell'influenza del sesso e del genere, termine che comprende anche aspetti socioculturali e psicologici, sulla fisiologia e sulle malattie che colpiscono sia gli uomini sia le donne. Differenze tra i sessi, infatti si osservano nella frequenza, nella sintomatologia e gravità di numerose malattie, nella risposta alle terapie e nelle reazioni avverse ai farmaci, nelle esigenze nutrizionali e nelle risposte ai nutrienti e ai contaminanti ambientali, nonché negli stili di vita, nell'esposizione a prodotti tossici e nell'accesso alle cure. Secondo una visione globale di salute, l'erogazione di cure appropriate presuppone la presa in carico della "persona" malata, valutata oltre che sulle caratteristiche biologiche e cliniche della malattia, anche sulla base di tutti i fattori personali, culturali e sociali che ne influenzano la salute. Un approccio di genere nella pratica clinica può contribuire notevolmente alla promozione della salute tramite un miglioramento dell'appropriatezza e della personalizzazione delle cure in base alle diverse esigenze di uomini e donne e nel rispetto delle differenze di genere rese evidenti dalla ricerca scientifica fino a oggi.

Le disuguaglianze di genere nella salute hanno origini sia biologiche che sociali. Le cause di morte e malattia prevenibili per le donne includono malattie trasmissibili e non trasmissibili, malattie mentali, lesioni e violenza, malnutrizione, complicazioni della gravidanza e del parto, gravidanze indesiderate e la mancanza di accesso o uso di servizi sanitari di qualità e di prodotti salvavita. Le cause strutturali sottostanti includono la povertà, la disuguaglianza di genere (che si manifesta nella discriminazione nelle leggi, nelle politiche e nelle pratiche) e l'emarginazione (basata su età, etnia, razza, casta, origine nazionale, stato di immigrazione, disabilità, orientamento sessuale e altri motivi) che sono tutte violazioni dei diritti umani. Altri fattori che influenzano significativamente la salute e il benessere delle donne in particolare includono: la genetica; le famiglie, le comunità e le istituzioni; le norme di genere disuguali nei vari ambienti sociali; i livelli di reddito e di istruzione; i contesti sociali e politici; il luogo di lavoro; e l'ambiente. Per esempio, l'esposizione maggiore delle donne a certi eventi e situazioni di vita fortemente stressanti contribuisce in maniera molto significativa al maggior rischio femminile di ammalarsi di determinati disturbi della psiche. Inoltre, le donne sono maggiormente suscettibili all'infezione da HIV rispetto agli uomini e tale suscettibilità è sicuramente dovuta a una serie di fattori insieme anatomici, biologici e sociali.

All'interno dei sistemi sanitari, si assiste a una discriminazione e segregazione del personale sanitario, composto globalmente al 70 per cento da donne, le quali però sono solitamente relegate a lavori meno

qualificati, con una minore retribuzione e all'estremità inferiore delle gerarchie professionali. Anche se le donne costituiscono la stragrande maggioranza di coloro che lavorano nel campo della salute globale, sono sottorappresentate all'interno delle istituzioni più importanti, nei forum di politica globale e di governance, nei panel di leadership, e nelle strutture decisionali del settore pubblico e privato. Oltre agli stereotipi di genere, le operatrici sanitarie affrontano anche il peso delle molestie sessuali da parte di colleghi maschi, pazienti maschi e membri della comunità. In più, le donne si occupano della quasi totalità del lavoro di assistenza, che molto spesso non viene considerato e retribuito in modo adeguato. Poiché l'assistenza e la cura delle persone comportano compiti che le donne hanno tradizionalmente svolto senza retribuzione, le competenze richieste per la fornitura di assistenza sono sottovalutate o trascurate nelle misure nazionali dell'economia. Un sistema sanitario ottimale dovrebbe, come minimo, adottare una buona pratica dei diritti umani per evitare di replicare o amplificare le dinamiche di potere locali, spesso altamente discriminatorie nei confronti delle donne e di altri gruppi di persone. Le donne costituiscono la base della piramide su cui poggia la salute globale e dovrebbero essere valorizzate come agenti di cambiamento della salute, non come vittime.

Come affermato in precedenza, l'attenzione per una medicina che tenga conto delle differenze di genere comincia a sorgere negli anni Ottanta del secolo scorso, con la stipula da parte delle Nazioni Unite di una convenzione volta all'eliminazione di tutte le forme di discriminazione contro le donne, comprese quelle nel campo delle cure sanitarie. Nei decenni successivi altri organismi internazionali, primo fra tutti l'Organizzazione Mondiale per la Sanità (OMS), sono intervenuti con azioni specifiche volte in particolare a riconoscere il genere come determinante fondamentale della salute e a integrarlo in tutte le politiche, che fossero strettamente legate al sistema sanitario e alla salute o meno, per arrivare a eliminare completamente le disuguaglianze di genere in campo sanitario e migliorare la salute delle donne. Nonostante l'attuale panorama globale in evoluzione dei dati di genere, ancora più complicato al giorno d'oggi a causa della pandemia COVID-19, il modello generale di uguaglianza di genere per le donne nella medicina e nella salute globale è caratterizzato da guadagni discontinui e disomogenei e da sfide persistenti. Dopo più di un secolo di campagne femministe, 40 anni di discorsi internazionali sul genere, e un crescente numero di dati, prove e testimonianze, il genere è stato finalmente riconosciuto come uno dei più importanti determinanti della salute e dello sviluppo economico. Malgrado questo riconoscimento e i molti sforzi internazionali e nazionali, l'uguaglianza di genere nella salute è un obiettivo ancora lontano dall'essere raggiunto.

Rimuovere la discriminazione nei contesti sanitari e garantire che le donne e le ragazze adolescenti siano consapevoli dei loro diritti e siano in grado di richiedere, e ottenere, servizi sensibili al genere e privi di stigma e discriminazione, è fondamentale. Inoltre, la raccolta di dati disaggregati per sesso e di indicatori sensibili al genere è essenziale per monitorare e valutare i risultati delle politiche e dei programmi sanitari. Le politiche e gli interventi sanitari sensibili al genere richiedono un'analisi approfondita delle barriere al

perseguimento della salute delle donne, comprese altre disuguaglianze basate su etnia, classe, posizione geografica e orientamento sessuale o identità di genere. È necessario che gli ambienti, domestici, sociali e lavorativi, siano favorevoli all'uguaglianza di genere, in quanto essi sono inestricabilmente legati a una migliore salute della popolazione femminile e a risultati sociali più ampi per l'intera popolazione. Solo un approccio globale basato sui diritti umani potrà superare le varie e complesse sfide che riguardano la salute delle donne. Per avere successo, i paesi e i loro partner dovranno agire simultaneamente in nove aree interconnesse e interdipendenti: leadership nazionale; finanziamento della salute, compreso il bilancio di genere; resilienza dei sistemi sanitari; potenziale individuale; impegno comunitario; azione multisettoriale; ricerca e innovazione; responsabilità. Le politiche e gli interventi multisettoriali sono essenziali per raggiungere la parità di genere nella salute e devono quindi far parte delle strategie nazionali sulla salute delle donne. Dovrebbero essere monitorati allo stesso modo degli interventi del settore sanitario, collegati ai corrispondenti Obiettivi di Sviluppo Sostenibile, parte dell'Agenda 2030 delle Nazioni Unite.

In merito a questo, anche la strategia dell'Unione Europea per l'uguaglianza di genere 2020-2025 riconosce i rischi per la salute specifici al genere e, tra le altre cose, prevede l'agevolazione di scambi regolari di buone pratiche tra gli Stati membri e le parti interessate sugli aspetti di genere e salute, inclusi i diritti sessuali e riproduttivi delle donne in particolare. In Europa, esistono diversi tipi di regimi politici, i quali formulano politiche e regolamenti che influenzano direttamente e indirettamente le differenze di genere nella salute. I ruoli e le responsabilità di genere interagiscono con le risorse e le barriere come le opportunità di lavoro, la fornitura di assistenza ai bambini e agli anziani e la sicurezza pubblica. I paesi europei sono stati leader nelle politiche per la famiglia e hanno messo in atto vari investimenti sociali incentrati sull'assistenza all'infanzia, sul congedo parentale, sui programmi attivi del mercato del lavoro e sulle politiche di assistenza a lungo termine. Questi sono in parte attuati per rafforzare l'equità di genere e ridurre l'onere del lavoro di cura familiare, che ha un enorme impatto sulla salute psicofisica delle donne. Un punto critico qui riguarda il grado in cui lo stato si assume la responsabilità delle norme di protezione della salute pubblica e specialmente del benessere familiare e della cura dei bambini, e quanto rimane di esclusiva responsabilità degli individui e delle famiglie, e specialmente delle donne. Per esempio, nei regimi di welfare socialdemocratico come nei paesi nordici, dove lo stato ha tradizionalmente avuto più responsabilità, la salute della popolazione sembra essere nel complesso migliore che nei paesi tradizionali dell'Europa meridionale, dell'Est o orientati al libero mercato. Il motivo economico e sociale per investire nelle donne è chiaro e basato su dati concreti. Investire in azioni per la salute e il benessere delle donne ha molti benefici: prima di tutto, le mantiene in vita e in salute. Inoltre, riduce la povertà, stimola la produttività e la crescita economica, crea posti di lavoro ed è efficace dal punto di vista dei costi. Oltre a questi motivi economici, l'imperativo giuridico di sostenere i loro diritti umani al più alto standard di salute raggiungibile, come protetto dal diritto internazionale, è indiscutibile.

La recente pandemia globale di COVID-19 ha provocato allarmanti rallentamenti e inversioni di tendenza nell'uguaglianza di genere. La pandemia sta portando alla luce vulnerabilità e carenze nei sistemi sanitari, sociali, politici ed economici che dovrebbero salvaguardare la salute delle donne, le quali stanno sopportando il peso sproporzionato delle conseguenze economiche e sociali del COVID-19. Chiusura delle scuole, il crescente onere sui sistemi sanitari locali per la fornitura di cure primarie, l'aumento del rischio di violenza di genere e di sfruttamento sessuale tra l'intensificarsi delle misure di contenimento e le crescenti pressioni economiche stanno minacciando i mezzi di sostentamento ed esacerbando la disuguaglianza di genere. La continuità dei servizi essenziali e dei finanziamenti per la salute riproduttiva e neonatale non solo deve essere protetta da tagli o riallocazioni come parte degli sforzi nazionali di risposta e recupero al COVID-19, ma deve essere data loro priorità per rispondere alle ripercussioni immediate e a lungo termine della pandemia. In generale, gli interventi pubblici dovrebbero sempre prendere in considerazione la prospettiva di genere, soprattutto in tempi di crisi come quello che stiamo vivendo ora con la pandemia COVID-19. Analizzare le politiche sociali per prevedere o determinare gli effetti reali su uomini e donne si rivela di solito una pratica particolarmente importante per sostenere l'uguaglianza di genere, specialmente in tempi di ristrettezze economiche, con il conseguente aumento della competizione per le risorse esistenti. L’impatto della ricaduta economica dovuta al COVID-19 sarà inevitabilmente influenzato dal genere, e colpirà soprattutto le donne. Tuttavia, la ricerca sulle precedenti crisi finanziarie globali ha dimostrato che le disuguaglianze di salute hanno avuto un impatto meno negativo nei paesi che hanno mantenuto una forte rete di sicurezza sociale rispetto a quelli che hanno perseguito l'austerità. Gli organismi nazionali per l'uguaglianza di genere dovrebbero collaborare con le strutture nazionali responsabili degli sforzi di recupero per garantire che gli strumenti d’integrazione della dimensione di genere siano utilizzati durante tutta la ripresa. I governi nazionali dovrebbero anche collaborare per lanciare uno studio sulle differenze di genere nell'impatto a lungo termine del virus e sulle misure politiche adottate, utilizzando in modo estensivo dati disaggregati per sesso e genere. È fondamentale applicare una lente di genere a tutti gli sforzi di risposta e recupero della pandemia COVID-19, proteggendo e sostenendo i bisogni specifici delle donne.

Alla fine, comprendere la relazione tra sesso, genere e COVID-19 significa riconoscere il ruolo evidente che sia la biologia sia i fattori sociali giocano nel rischio di infezione e malattia, nella presentazione clinica e nella gravità degli esiti sia a livello individuale sia di popolazione, che è ciò che i politici, il personale sanitario, i ricercatori in campo medico e la società civile tutta dovrebbero fare per raggiungere la parità di genere nella salute in generale. La nuova sfida per la comunicazione istituzionale è quella di coinvolgere ed ottenere la collaborazione attiva del singolo nel processo di costruzione della salute intervenendo sulle variabili individuali, e in particolare su quelle influenzate dal genere. È comunque importante ricordare che né gli uomini né le donne da soli, per quanto ampia possa essere la consapevolezza sul loro stato di salute, possono avere il controllo su tutti i rischi ed esposizioni ambientali e sociali dannosi per la salute se non

esistono politiche e regolamenti a vari livelli che facciano della salute delle persone una priorità. Tuttavia, allo stesso tempo, anche se le politiche nazionali di previdenza sociale forniscono benefici a uomini e donne che alleviano parte della loro esposizione ai rischi per la salute, come è stato dimostrato dai diversi regimi politici di genere nei paesi europei, esse non governano completamente le scelte che gli individui fanno riguardo alla loro salute, di solito influenzate e vincolate dai ruoli di genere, o dalla divisione di genere del lavoro nelle famiglie e nelle organizzazioni. Pertanto, per raggiungere la parità di genere nella salute è fondamentale combinare sia il livello individuale che quello nazionale e internazionale, lavorando sia sui fattori strutturali che culturali che influenzano la salute.