

How is Gender Relevant to Global Health?

The integration of gender into research projects can feel like a new challenge for researchers in Higher Education (HE). The international development sector has, however, been learning about the ways that gender is relevant, in all aspects of poverty alleviation and development, for several decades.

As part of the University of Edinburgh [genderED](#) project '[Integrating Gender into GCRF Bids: Getting to Sufficiency](#)' we have produced several thematic summaries describing how gender is relevant to different development themes.. These briefings are intended to support HE researchers who are tackling these challenges for the first time. This document provides a simplified and abridged summary of over four decades of learning that has taken place within social science approaches to health as well as the development sector, about the **relevance of gender in global health**. It aims to provide a starting point for **researchers, such as biomedical scientists**, who are unused to including **gender issues in their own work or unfamiliar with social science approaches to gender**. In addition to providing a simplified introduction, it provides some links to more detailed resources.

This briefing outlines how gender relates to the field of global health in relation to four key dimensions: 1) Non-communicable and infectious diseases, 2) structural aspects of healthcare, 3) research priorities, and 4) women's health.

Social Determinants, Gender and Global Health

Gender is a core factor to consider in the social determinants of health. The social determinants of health are the non-medical factors that influence health outcomes. The WHO defines social determinants as 'the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels' (WHO 2011). Recent approaches within global health aim to take account of the social determinants of health because they are mostly responsible for 'the unfair and avoidable differences in health status seen within and between countries' (WHO 2011). The social determinants of health thus include wider socio-political and economic contexts, as well as the social position of individuals, such as: education, ethnicity, age or gender.

Gender is an analytical term used in the social sciences to describe shared social ideals of femininity and masculinity, and associated behavioural expectations and relations between the sexes. These shared ideas vary across time and place, and between cultures.¹ **Gender is a social determinant that has a significant impact on health across all societies, resulting in a large literature linking gender**

¹ As such, **gender** (women/men) is different from **biological sex** (male/female), which is an anatomical classification based on body parts. Gender sensitive research is therefore distinct from a biomedical imperative to take account of sex differences in research or treatment. Biological sex differences should also be taken into account in gender-sensitive research where appropriate, see section on Medical Research below.

inequity to poor health (1, 2). Gender is **intrinsically linked to the distribution of power, status, wealth and security** and the subordination of women in relation to men can be seen across many domains of life. Women, for instance, are often expected to perform unpaid care or housework and have less access to and control over resources (3). This in turn has an impact on their education and finances, which impacts their health. For example, they can have lower health literacy, low income and fewer resources to attain health promoting assets or treatments, such as: good quality housing, healthy food, healthcare appointments or medication (4).

In the Global North, traditional cultures have assumed two genders exist – men and women – and have understood them as complementary and opposite (5). This view is increasingly being challenged in the Global North with rising acknowledgement of transgender² identities (6). Cultures in Global South nations, by contrast, have long acknowledged multiple genders beyond the traditional Western binary of men/women. Hijras, for example, are officially recognized as a third gender in the Indian subcontinent and have a recorded history in the region from 2nd/3rd century CE(7). The inappropriate imposition of gender binaries is a particularly important colonial legacy to bear in mind in the context of global health, and conducting gender-sensitive research can thus assist with current efforts to decolonise the field of global health itself (8). **This highlights the need for Global North researchers to avoid imposing their own assumptions regarding the relevance of gender and to instead investigate how gender is relevant in each context** (9).

Gender sensitive approaches to global health require researchers to take account of how social ideals of femininity and masculinity shape divisions of labour, power, status, wealth and security and how this is relevant in their own research. **Doing so provides more accurately designed interventions and helps to deliver better health outcomes** and help to ensure that global health activities are aligned with global frameworks, such as the Sustainable Development Goals, that aim to achieve healthy lives for *all* people, whilst also achieving gender equality (SDG3 and SDG5)(10). This briefing provides an introductory overview of how gender is relevant across four domains of global health research: 1) Non-communicable and infectious diseases, 2) structural aspects of healthcare, 3) research priorities, and 4) women's health. **It is helpful to think of people's different roles for example patients, carers, physicians, policymakers across each of these domains.**

Non-Communicable and Infectious Diseases

Although women outlive men in most countries, research shows marked **gender differentiated patterns in morbidity and mortality that vary over time and location**. Overall, women consistently have lower rates of *healthy* life expectancy(11).

Non-communicable diseases, such as diabetes, respiratory illness and cancer, are the leading cause of death worldwide (12) and are highly influenced by social determinants such as gender (13-16). Cardiovascular disease, the top cause of death worldwide, is marked by clear gender differences in both acute and chronic presentations of coronary heart disease³ (17-19). Mental health is also increasingly recognised as a major determinant of overall health (20). Compared to the general population, people with mental illness experience a greater burden of physical health conditions (21).

² **Transgender** is an umbrella term that describes people whose gender identity is not the same as the gender assigned to them at birth. In contrast, **cisgender** is a way to refer to someone who is not transgender.

³ These studies focus on both gender and sex factors in CHD, with the latter two studies equating one category for the other.

Globally, mental illnesses such as depression and anxiety, are more prevalent among women than men (22). Furthermore, direct health outcomes, as well as the broader impacts of infectious diseases, are also shaped by gender, as the cases of tuberculosis, HIV/AIDS and Ebola have demonstrated. For example, due to their role as care-givers, contact with bodily fluids of family members sick with Ebola emerged as a significant factor in infections reported by women (23).

Gender specific cultural norms shape people's experiences of and capacity to respond to illness. For example, restrictions on women leaving the home, or lack of socialisation into physical activity, can impact on women's ability to adhere to medical advice or respond to health interventions (14). Masculine ideals of 'stoicism' significantly influence men's lower rates of seeking medical help in many societies, as can be seen in the case of coronary heart disease (24-27). Feminine ideals of motherhood on the other hand can drive women to prioritise their identity as a mother over their own health, preventing them from following medical advice (28, 29).

Gender inequality in resources also deeply affect women's experiences of health. Women's lower access to material resources affects their health, where for example poor housing is linked to respiratory disease (30), and women's varying abilities to purchase and access health promoting assets and treatments (31-33).

Interventions and research that do not take account of the ways in which gender shapes morbidity, mortality, health outcomes and access to health care run the risk of being ineffective. Thus, awareness of gender and its relevance should be included in the first stages of project inception, literature review and needs assessment of the target population.

Structural Aspects of Healthcare and Health Systems

Health policies and laws are often shaped by, and reinforce, male social control over women and other gender minorities. For example, women's access to sterilisation in Brazil is contingent on spousal approval (34, 35). Furthermore, policies based on the assumption that transgender people do not exist, or that stigmatise them, can lead to violence against them. For instance, Peru passed gender-based Covid-19 mobility restrictions, which allowed women and men to access essential services only on alternating days. Due to these regulations, transgender people experienced increased gender policing, physical violence and verbal abuse (36).

Research also shows that **healthcare administration and delivery often fail to take the relevance of gender into account, resulting in poorer outcomes, especially for women from poorer or minoritized backgrounds** (37-40). For example research shows that African American women are often marginalized by institutional practices within public hospitals in the U.S. (41), and poorer women consistently report fewer positive health care experiences and more attempts by providers to limit their childbearing (42). In addition, assumptions in healthcare delivery regarding breast cancer as 'women's cancer' have a negative effect on transgender people's experience of cancer treatment (43). Gender bias has also been well documented in diagnosis, leading to worse health outcomes for women and transgender people (17, 44, 45).

Gender hierarchies⁴ also structure the healthcare work force and the distribution of unpaid care work. Women are overrepresented in low paid healthcare roles, such as nursing and midwifery (46), even though women now make up 70% of health and social workers (47). The social expectation that women serve as the **unpaid caretakers** of families also contributes enormously to the disproportionate impact that illness has upon women. For example, women comprise the majority of caregivers for those sick with Covid-19, HIV and Ebola in Africa (48, 49). Women's role in caring and healing, makes them important stakeholders and potential community leaders/communicators in community health interventions, in ODA contexts. However, these responsibilities also expose women to greater health risks and restrict their participation in education or paid work opportunities (50). As a result, interventions and policies that cut back on healthcare services disproportionately perpetuate poverty amongst women (51). These gendered distributions of low paid and unpaid work within the healthcare workforce are a significant concern for all ODA research ultimately aimed at reducing global poverty.

A gender-sensitive approach in global health research takes these gender inequalities into account from the start and aims to understand and tackle them. Relevant research practices include, consultation with specialist NGOs focused on gender equality and health, data collection methods designed to ensure participation of women or minoritized genders; identifying and avoiding gender biases in health care delivery, employment practices and policy making, and designing health communication strategies that reach women and include them as patients, professionals, carers, experts and policy makers.

Priorities in Medical Research

Priorities in medical research are also shaped by gender. Research shows a clear sex bias in medical research, as women have historically been excluded from biomedical clinical trials (52, 53). Studies show that different treatments, drug types and dosages all have differing effectiveness depending on whether the subjects are biologically male or female (54, 55). For example influenza vaccine research suggests that females can produce the same immunological response to half-dose vaccine as males do to full dose (56). Yet women are still less likely to be enrolled in trials, particularly minority women (55, 57). In contraception research, for example, lay perspectives of men on emotional and sexual wellbeing and the risk of side effects, are taken more seriously by reproductive scientists and policymakers than those of women (58). A gender-sensitive approach to medical research issues can, for instance: take women's perspectives seriously regarding side-effects, ensure clinical trials are accessible for women to join, or disaggregate trial outcome data by sex (59).

Women's Health

As a result of the above gendered patterns in morbidity, mortality and health priorities, women's health has long been a longstanding priority within global health. Maternal health is particularly relevant here. Global estimates for the year 2017 indicate that there were 295,000 preventable maternal deaths, 94% of which occurred in low and middle income countries (60). **Sexual health** and access to contraceptives are also a significant concern. Each year worldwide, 25 million unsafe abortions take place, and over 200 million women who want to avoid pregnancy have no access to modern contraception (61). Additionally, when menstruating women cannot access suitable period

⁴ The term '**gender hierarchy**' refers to this unequal power dynamic between genders, where men are valued more highly than women or other gender minorities, and have more social control over them.

products, this ‘**period poverty**’ can force women out of the workforce or education due to the need to stay confined to the home (62).

Physical or sexual violence against women is also a significant focus, affecting one in three women worldwide, mostly at the hands of an intimate partner (63). This has serious impacts on health, up to and including death (64, 65) and recent research shows violence against women and girls has increased during Covid19 pandemic lockdowns, by up to 30% in some countries (47). Gender-based violence disproportionately affects gender minorities within both global north and global south contexts (66-68).

These areas specific to women’s health are essential global health priorities because of their links to: gender equality and women’s wellbeing, their impact on maternal, new born, child, and adolescent health, and their roles in shaping future economic development and environmental sustainability (Starrs et al. 2018).

Incorporating Gendered Analysis in ODA Projects: Best Practice and Tools

Gender has a significant impact on the risk factors and consequences of most health conditions. It influences how particular groups will respond to health interventions, how healthcare is delivered and what medical research is undertaken. Organisations like the WHO, UNICEF and UN Women are excellent sources for toolkits and insights. These kinds of resources show how gender inequalities can be taken into account when conducting initial needs assessments for health promotion programmes, literature review, research design and monitoring and evaluation of programmes, to ensure that global health interventions are successful(69).

Useful Links: Gender Public Health

Useful Overviews

1. World Health Organisation [Gender Equality: making a difference: vision, goals and strategy](#)
2. UN Women (2020) [Universal health coverage, gender equality and social protection: A health systems approach](#)
3. Humsafar Trust (India) (2014) [The Hijra Health Manual for Healthcare Professionals](#)

Gender Sensitive Participatory Health Research Design

4. Special Programme for Research and Training in Tropical Diseases (2020) [Incorporating intersectional gender analysis into research on infectious diseases of poverty: a toolkit for health researchers](#)
5. Gendered Innovations, Stanford University. *Participatory Research and Design*. **Brief overview of participatory research with case studies from health & medicine**. Available at: [Participatory Research and Design | Gendered Innovations \(stanford.edu\)](#)
6. World Health Organization (2020) [Violence Against Women and Girls – Data Collection during COVID-19](#)
7. Jhpiego, John Hopkins University Affiliate (2020). Gender Analysis Toolkit for Health Systems <https://gender.jhpiego.org/analysistoolkit/>

Gender Sensitive Monitoring

8. GIZ (2014). [Guidelines on designing a gender-sensitive results-based monitoring \(RBM\) system \(oecd.org\)](#)

Gender Sensitive Health Communication

9. UNICEF (2018) [*Gender Responsive Communication for Development: Mapping and Assessment of UNICEF Initiatives in Afghanistan, Bangladesh, Nepal and Pakistan*](#). Detailed report with case studies on disasters, health and nutrition, menstrual health, mother & child immunization.

These publications and websites are examples of the kinds of health specific tools available on the web. **However, they are not geared to the specific gender equality requirements of most UK funded ODA research.** The University of Edinburgh's Toolkit 'Developing your GCRF Gender Equality Statement', available on our [website](#), draws on this best practice approaches from the international development sector and **provides a simplified structure and a four step process specifically tailored to the requirements of UKRI's Gender Equality Statement.** It helps PIs identify relevant gender differences in divisions of labour, access to resources, and access to decision-making, and applies these insights directly to the UKRI Gender Equality Statement.

Attributions

This briefing note was produced as part of a multi-phase genderED project for the University of Edinburgh. The project was funded through the University of Edinburgh's Scottish Funding Council GCRF allocation. The Principal Investigator was Prof Fiona Mackay (Director of genderED, University of Edinburgh). The project was managed by Dr Rosalind Cavaghan (Independent Consultant and Visiting Researcher, University of Edinburgh). The project team also included Dr Aoife McKenna (Usher Institute University of Edinburgh) and Dr Sarah Ssali (Makerere University Uganda).

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