A Feminist Global Health Policy

A Centre for Feminist Foreign Policy Briefing

*"Health is a state of complete physical, mental and social well-being
and not merely the absence of disease or infirmity.
The enjoyment of the highest attainable standard of health is one of
the fundamental rights of every human being without distinction
of race, religion, political belief, economic or social condition."*

Constitution of the World Health Organisation (WHO)[1]

The Issue

While an increasing number of countries, like Sweden, Mexico, Canada, or Spain, are either implementing or considering implementing Feminist Foreign Policies, they have yet to include feminist health policies into their approaches and frameworks beyond a focus on on Sexual and Reproductive Health and Rights (SRHR).[2] Moreover, in many cases, SRHR are framed and focused on heterosexual and cis-gender women and girls only, neglecting the experiences of LGBTQI* and BIPoC individuals and their lack of access to equitable healthcare. Additionally, they also often fail to address sexual and reproductive health issues on the domestic level. Moreover, feminist health policy is about much more than SRHR, but about ensuring everyone has equal access to all aspects of health care. It is about centering the needs of the most marginalised and actively contributing to overcome structural disccrimination in all its forms.

The ongoing COVID-19 pandemic has yet again illuminated the discriminatory structures in our health system as e.g. Black and Hispanic people made up almost fifty per cent of the hospitalisations in the United States and Indigenous People were almost twice as likely to die from the disease than white people.[3] Thus, the pandemic has also illustrated the interlinkages and interdependency of health, foreign, and domestic policy, emphasising the need for a holistic approach to health policies. It is time to bring feminist approaches to global health policy and define a Feminist Global Health Policy.

This briefing aims to contribute to the Feminist Global Health debate, which is slowly gaining ground. It builds on the growing work of civil society and is targeted at states and governments, especially those located in the Global North. Firstly, it outlines the interconnection of health policy, peace, and development and provides an overview of existing inequalities in global health, the lasting effects of colonialism and imperialism, and the persisting influence of gender stereotypes on health outcomes. Secondly, it outlines concrete policy recommendations for those states.

Why it matters: The interlinkages of health policy, peace, and development

Access to healthcare is a human right, which is central to and dependent on the achievement of other human rights, such as education, food, and political freedom.[7] The participation of women and other politically marginalised groups in society is restricted by their access to resources, privileges, and opportunities.

Research has repeatedly demonstrated states with a high level of gender equality are less likely to experience internal and external violent conflict. In particular, the lack of bodily integrity and physical security, inequality in family law, and the lack of parity in councils of human decision-making contribute to gender inequality. The lack of good health and well-being is deeply intertwined with all of these aspects.

Sexual and Reproductive Health and Rights (SRHR) are a prominent example for exemplifying the interlinkages between health and political participation. The term SRHR refers to concept of human rights being applied to sexual and reproductive health, which includes access to legal and safe abortion, contraception, sexual healthcare, menstrual hygiene products, and further related issues recognised as central to women's and LGBTQI*-persons' human right to health.[8] The rate of maternal mortality, one indicator of reproductive health and rights, is widely seen as an indicator of a country's general health capacities and its economic development because it is influenced by a vast amount of economic, infrastructural, and political factors, such as the number of hospitals in a country or the availability of sanitary living conditions.[9] When access to contraception and family planning options increases, women's literacy and women's economic status increases as well.[10] The improvement of women's health, in general, is also tied to a long-term productivity increase, an improvement of a nation's economic performance (as indicated by the GDP), and the literacy rate among children.[11] The increase in women's access to health is also directly linked to a decrease in child mortality and an increase in male life expectancy.[12]

Full enjoyment of SRHR remains a contested issue, and many actors – such as the Catholic Church but also governments and civil society groups – across the world are working to actively limit the access to sexual and reproductive health rights for these groups, highlighting the ongoing struggle and crucial need for strong continuous efforts in these areas. Many of these efforts center on the right to safe and legal abortion, but also on the availability of contraception, the ability for gender recognition or sexuality education in school.[13]

Access to health for all genders has to be prioritised in its own right. Moreover, the interlinkages between health and the level of security and development within a society underlines the importance of universal access to health.

Patriarchy is everywhere: Inequalities within Healthcare Systems and the Global Health Landscape

Health and access to health services are distributed extremely unevenly on a global scale, but also within countries and already discriminated and marginalised people, such as people living in the so-called "Global South"[14] as well as women, Black, Indigenous, and People of Colour (BIPoC) and LGBTIQ* individuals, but also migrants in the Global North are most affected by those health inequalities.

Global Disparities in Health and Power

Global health inequalities start with differences in life expectancy that vary between an average of roughly eighty-two years in countries like Germany, Sweden, and Canada and an average of only about fifty-two years in Lesotho, the country with the lowest life expectancy globally.[15] The highest burden of disease, the highest maternal mortality rate, and the lowest number of healthcare workers per person is found in countries of the so-called "Global South". Unequal distribution of resources, health services, and access to essential medicines among different parts of the world mirror to a large extent the lasting effects of colonialism. Today, it is still former colonial powers in the Global North who hold power over the access to pharmaceuticals and essential medicines, as well as the access to knowledge, decision making, and financing in global health. The current struggle of low and middle-income countries (LMICs) to secure sufficient COVID-19 vaccine doses serves as a crucial example. Despite commitments of high-income countries (HIC) to share the vaccine globally and in an equitable fashion, they pre-ordered and reserved a large number of vaccines, leaving LMICs without the opportunity to receive sufficient amounts. So far, the United States has already bought twice as many vaccines dosages as its actual number of inhabitants,[16] while Europe has pre-ordered up to 3.5 dosages per person.[17] The promise to share "left-over" doses is not equivalent to a truly equal sharing of access and privilege. The unwillingness of HICs to address power imbalances in global health is prolonging the pandemic and potentially costing the lives of thousands of people.[18] A Feminist Global Health Policy must ensure equal and fair access to health services for all people everywhere.

> **"To decolonise global health is to remove all forms of supremacy within all spaces of global health practice, within countries, between countries, and at the global level."** [19]

Actively addressing colonial legacies within international global health policies is also a fundamental aspect of a Feminist Global Health Policy. The mainly student-led *Decolonise Global Health* movement, for example,[20] is emphasising the need for diverse voices and perspectives in the global health landscape. By integrating critical, anti-colonial reflections into mainstream global health discourse, the movement advocates for a shift in global health paradigms, leadership, and knowledge.[21] Powerful global health actors need to amplify diverse voices and perspectives towards better health for all people, and governments in particular need to decolonise their internal and external policies. This includes actively diversifying global health institutions, enabling especially young people from Global South countries to work, publish, and shape these institutions and integrate the knowledge and lived experience of local communities into global health approaches.

With its historical roots in tropical medicine and imperialism, the current global health landscape is shaped by power imbalances reflecting sexist and racist dimensions. The majority of global health decision-makers are white men from and working from within the Global North.[22] Recent numbers from the *Global Health 50/50* collective have demonstrated that a glass ceiling still exists for women and people from the Global South working in global health. In 2020, seventy per cent of global health organisation's leaders were men, eighty-four per cent were born in a high-income country, and ninety-four per cent of them also attained their education in a high-income country.

Private Money in Global Health

Over the last twenty years, we have witnessed an increase of private investment in the field of global health – often from large foundations such as the Bill and Melinda Gates or the Rockefeller Foundation, which are financing large amounts of global health research and implementation.[23] This development is perceived critically by many civil society organisations as these private organisations, which are not accountable to anyone, can exercise enormous power over international global health decisions. They can influence which diseases are researched and which are not, which medications are trialled and which are not.[24] At the same time, they address many research and financial gaps that governments and UN bodies are either unwilling or incapable of addressing. A critical rethinking of global health power dimensions must also include questioning corporate influence and strengthening public investment in global health.

Inequalities Within Countries

Health inequalities do, however, not only exist among different nations but also *within* countries. For example, in the United Kingdom, the maternal mortality among Black women is about four times higher than among white women.[25] In Australia, the indigenous Aboriginal population's life expectancy is eleven years shorter than the average white population.[26] In Germany, children from households with low socioeconomic status are more likely to develop psychological problems of any kind, ADHD and depression being the most prevalent examples in this sample.[27]

This is due to various reasons, which can be summarised by the concept of social determinants of health. This refers to non-medical factors, for example, gender, race, income, and education level, influencing health outcomes.[28] Additionally, some of the injustices can be attributed to healthcare professionals exhibiting so-called implicit biases, which are described as unconscious and involuntary associations affecting someone's judgement. In the context of racialised discrimination in healthcare, this often means that healthcare professionals do not believe BIPoC's description of pain or treat their symptoms as less severe.[29] For example, Black women with symptoms of cardiothoracic pain are less likely to be diagnosed with the use of an electrocardiogram, which would be the appropriate diagnostic measure, as their white male counterparts, likely due to an underestimation of the severity of their pain.[30]

As of today, we are not only witnessing racialised discrimination in healthcare. We are also witnessing further reinforcement of racism globally. Historically, the white majority of people has seen non-white people as a threat of infection, blamed and treated them as scapegoats for virus outbreaks. Even though BIPoC and especially LGBTQI* individuals of colour were more vulnerable to and affected by the HIV/AIDS epidemics in the 1980s and 1990s, the white majority still blamed these groups for the outbreaks. The same dynamic can be witnessed with the ongoing COVID-19 pandemic, especially with violence and hate against Asian communities increasing.[31]

Another group who suffers tremendous discrimination and inequality within the healthcare systems are LGBTQI* individuals. In the United States, three out of ten LGBTQI* individuals report difficulties accessing necessary medical treatment; and at least thirty per cent, despite having access to these treatments, report previous experience of discrimination within a medical facility.[32] For transgender people, the access to gender-affirming healthcare and mental health services remains challenging all over the world, and there many places without any treatment facilities at all.[33] The discrimination experienced from different healthcare providers and institutions also leads to hesitation among LGBTQI* individuals to seek out healthcare in the first place. Avoiding or postponing necessary medical interventions and treatments due to fear of discrimination is fairly common among LGBTQI* individuals, with transgender people being the most affected group.[34] The perception of 'transgenderism' as a mental disorder still exists in many countries and is accepted by many physicians worldwide, even though WHO has recently recognised it as harmful and incorrect.[35] This treatment and a mandatory medical treatment before any legal gender affirmation processes required in many countries further perpetuate the stigma and deny these individuals a healthy life with human dignity.

In most instances, the discrimination against LGBTQI* individuals is the result of political decisions. The unwillingness of governments to acknowledge 'gender' as a social construct and laws that require trans persons to undergo sterilisation before they can legally transition contribute to health systems unable to cater to the need of trans persons. It should come as no surprise that Global Health 50/50, a global health research collective, has found that only thirty-nine per cent of global health organisations have a definition of gender that acknowledges that it is socially constructed. Many organisations also still use the term 'gender' to refer only to cis-gender women and girls, neglecting non-binary gender identities. Furthermore, the experiences of transgender people are only explicitly mentioned by ten per cent of these organisations.[36]

Science is not neutral: The gendered bias within health research and education

Health research and education are historically primarily focused on male bodies. For decades, the male body has been taught as the default type in medical schools globally. Symptoms, which are experienced by women but not men, are described as 'atypical' and sometimes not taught at all. Heart attacks are a prominent example: hundreds of women are misdiagnosed every year because their symptoms do not match the textbook versions, which only focus on male patients.[37] Women's symptoms are not only overlooked, but there is also far less inclusion of women than men in clinical research trials. Across thirty-one landmark trials for congestive heart failure between 1987 and 2012, women made up only twenty-five per cent of the participants.[38] Even in animal trials there are significantly fewer female animals included. In addition, in some of the studies, which do include male as well as female animals, the outcomes are not disaggregated by sex.[39] Furthermore, there is far less research on diseases that predominantly affect women. There have been five times as much research on erectile dysfunction (affecting nineteen per cent of men) as on premenstrual syndrome (affecting ninety per cent of women).[40] Looking at these shortcomings at a global scale, the collective Global Health 50/50 found that only thirty-nine per cent of global health organisations are reporting fully sex-disaggregated data.[41] During the COVID-19 pandemic, only thirty nine percent of data tracking was sex-disaggregated.[42] The neglect of female participants and lack of research on women and other genders leaves these individuals with significantly worse health outcomes. Drugs and treatments do not work, side effects are overlooked, and many diseases are left undiagnosed.[43]

Patriarchy affects men too

Our entire societies, including our health systems, are shaped and influenced by gender stereotypes and norms on what is expected to feminine and masculine behaviour. These gendered stereotypes also affect the health of men. For example, men have a significantly shorter life expectancy than women (by about five years), a higher lifetime prevalence of cardiovascular risk factors and diseases. Moreover, the suicide rate is much higher among men.[44] One explanation is that behavioural risk factors such as smoking tobacco, alcohol use, and dietary risks are more prevalent in men,[45] whilst gendered stereotypes make it difficult for men to seek healthcare treatment and take preventive health measures. They are also less likely to admit to mental health issues and seek help in these areas.[46]

Men's unhealthy behaviour also reinforces the belief that men's bodies are "stronger" and more resilient than women's bodies, and therefore better equipped to lead and hold power.[47] This behaviour and the implications of toxic masculinity also have tremendous negative effects on women's and LGBTQI* individuals' health and well-being. In terms of mental health, women tend to take on the emotional and mental workload in the family, which men are placing on them by, for example, refusing to go to therapy. Caring for one's own and the families health and well-being continues to be coded as a feminine characteristic, placing the responsibility of maintaining the family's health on women.[48] Men who suppress their feelings and do not seek mental healthcare are also more likely to develop external coping strategies, such as intimate partner violence, aggression, and substance abuse.[49] Male violence against women and LGBTQI* individuals is also a major health risk to their physical, mental, sexual, and reproductive health.[50]

As not all men meet the ideals of hegemonic masculinity and are able to conform to those standards, it is especially the men not conforming who also suffer in the patriarchy. It can be seen that some gay and bisexual men or boys, in particular, are endangering themselves by trying to adopt physically dominant behaviours in order to pass as masculine.[51]

Ways forward and policy recommendations:

To address these inequalities, we need a holistic Feminist Global Health Policy. A Feminist Global Health Policy is grounded in a people-centred and human rights-based approach. It places the needs of the most marginalised at its centre and recognises the human right to health as its core value. It strives to question and reshape power dynamics in governments, global health institutions, and medical facilities. It applies a thorough understanding of gender as a social construct in all levels of global health decision making and actively deconstructs toxic masculinities and harmful gender stereotypes. A Feminist Global Health Policy strives to achieve Universal Health Coverage for all people, regardless of gender, race, sexual orientation, or socioeconomic status.

We, therefore, propose the following policy recommendations to states looking to make their health and foreign policy more feminist and gender-transformative:

Implementing Feminist Health Policies on a National Level:

Work Towards a More Just and Equal Health System:
- Ensure sufficient and sustainable funding of initiatives and facilities addressing the specific health needs of LGBTQI* and BIPoC individuals and other marginalised groups.
- Ensure access for LGBTQI* individuals to all necessary health facilities and treatments without discrimination and stigmatisation.
- Ensure access to SRHR facilities, including free and legal access to abortion, for all individuals anytime, within their own country.
- Ensure and finance research on specific health needs of all marginalised groups and invest in research on health issues, which mainly affect women or LGBTQI* people, including the vast range of gynaecological and maternal diseases.

Deconstruct and Reform Discriminatory Structures in Healthcare and Health Politics:
- Ensure gender parity as well as representation of diverse perspectives in decision-making bodies and structures.
- Install a task-force assasing all health policy decisions and structures from an intersectional feminist perspective, creating a knowledge foundation of all discriminatory practices in the country's domestic and global healthcare polices.
- Include anti-bias and anti-racist training and awareness workshops in the education of all healthcare professionals and political decision-makers focused on health.
- Strengthen the voices and influence of civil society within all these efforts.

Ensure All Health Data to be Disaggregated with regards to all forms of discrimination:
- Ensure disaggregation of all health data on all possible forms of discrimination.
- Enforce research guidelines, which ensure the gender-disaggregation of all health research and the inclusion of sufficient numbers of participants of all genders in health research.
- Invest in health data tracking and research participation that reflects the composition of the population in its diversity.

Challenge Hegemonic Masculinities and Harmful Norms in the Context of Health:
- Promote gender-transformative approaches to public health campaigns by addressing harmful stereotypes of destructive masculinities in prevention and awareness campaigns.
- Ensuring easy and affordable access to mental health services for all people.
- Actively encourage men to access mental health as well as preventive health services.
- Prioritise prevention of male violence against women and LGBTQI* individuals.

Ensure the Inclusion of A Health Perspective in All Foreign Policy Decisions:
- Integrate and prioritise a health perspective in all foreign policy decisions, analysing all foreign policy decisions with a focus on their impact on the health and well-being of the human beings affected by those decisions.

Ensure Sustainable Financing of Multilateral Global Health Organisations and Research Institutions:

- Advocate for and invest in the achievement of Universal Health Coverage in all countries by 2030 in line with the Sustainable Development Goals (SDGs).
- Support UN bodies working to improve health, such as WHO and UNAIDS, with sufficient amounts of flexible funding, decision-making capacity, and;
- Increase public investments in global health research and implementation to diminish the influence of private foundations and corporate money.

Prioritise Access to Sexual and Reproductive Health Rights (SRHR) for All Individuals:

- Ensure access to SRHR, including free and legal access to abortion, for all individuals anytime, everywhere, including in conflict and post-conflict settings.
- Extend the scope of current policies beyond the inclusion of women and girls to all genders.
- Protect and advance legislation and international human rights standards on the issue of SRHR.

Ensure an Equal and Just Global Health Landscape:

- Advocate for gender parity and diverse perspectives in multilateral global health institutions and UN bodies.
- Advocate for an intersectional feminist perspective in all global health projects with a focus on their impact on the health and well-being of the human beings affected by those decisions.
- Centre the needs of the people most affected by certain global health interventions and enable their equal and meaningful participation in decision-making processes.

Invest in The Decolonisation of all Global Health Institutions and Organisations.

- Examine their colonial pasts and roots and actively discontinue the colonial continuities by acknowledging how colonialism and racism are continuous threats to global health equity.
- Ensure the inclusion of diverse perspectives, especially from people from the Global South, in decision-making processes and leadership positions.
- Bridge geopolitical imbalances in global health education by offering people from marginalised and Global South backgrounds learning opportunities in global health facilities.

End Notes

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2. Find out more on Feminist Foreign Policy: Sweden; Canada; Mexico, and Spain.

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