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Performance-based health financing programme in Jimma, Ethiopia: Sutume (left) and Mitke (right) explain the process of vaccinating baby Anisa.

GENDER & HEALTH

WHY TAKING GENDER INTO ACCOUNT IS ESSENTIAL FOR EFFECTIVE HEALTH SYSTEMS

WHY GENDER MATTERS IN HEALTH

Health is shaped by multiple factors, including social, economic, political, and biological conditions. Gender is one of these key determinants. It influences people's health-seeking behaviours, their access to affordable and quality healthcare, and ultimately health outcomes.

When we adopt a gender-transformative approach, we make sure health programmes work better for everyone, making communities healthier and stronger.

GENDER-RELATED BARRIERS IN ACCESSING HEALTHCARE

STRUCTURAL (COMMUNITY/SOCIETAL)

- Social norms restricting, for example, women's movement, or men's involvement in sexual and reproductive health.
- Harmful cultural practices (e.g. female genital mutilation, child- and forced marriage) affecting mainly women's health outcomes.
- Gender stereotypes shape health-seeking behaviour in different ways. Men are often socialised to value toughness and self-reliance, which can lead them to underreport or normalise symptoms and engage in riskier health behaviours [3]. Women, meanwhile, may normalise pain or ill-health and delay care-seeking due to stigma, caregiving responsibilities, or expectations to prioritise others' needs over their own health [13].

INTERPERSONAL (FAMILY)

- Family control over health decisions. Adolescents, especially girls, often have limited health autonomy due to family oversight, especially for reproductive and sexual health services.
- Exposure to sexual and gender-based violence (SGBV) limits healthcare access through direct control by perpetrators (e.g., restricting movement, withholding money, forbidding clinic visits), trauma, and violence itself.
- Cultural silence and stigma further prevent survivors from seeking help or even acknowledging the need.
- Early and forced marriage reduces autonomy and leads to poor health outcomes, including early pregnancy (with higher risks of maternal mortality, obstetric complications such as fistula, and anaemia), low birthweight and preterm babies, increased exposure to STIs, higher rates of intimate partner violence, and long-term mental health challenges such as depression and anxiety [15].

DEMOGRAPHIC (AGE/EDUCATION/URBAN VS RURAL/ETHNICITY)

- Younger women are disproportionately impacted. Lower literacy or education correlates with reduced awareness of health needs and available services, and preventive behaviours. Evidence shows that women and girls with limited schooling are less likely to understand health information, recognise danger signs in pregnancy, or navigate health systems - leading to delayed care-seeking, lower uptake of SRHR services, and higher risks of preventable illness and maternal complications.
- Early school dropout or shortened schooling for girls is also linked to earlier and more frequent pregnancies, including teenage pregnancies, which carry increased health risks such as complications during childbirth due to incomplete physical development.

WHAT GENDER BARRIERS LOOK LIKE IN PRACTICE

Gender-related barriers to healthcare access span a variety of scenarios. Here are some examples:

ACCESSIBILITY OF HEALTH CARE



- Many women and gender-diverse people (e.g. transgender and intersex people) face unfair treatment, stigma (e.g. unmarried young women asking for contraceptives), and financial issues stopping them from visiting a health care facility.
- Survivors of SGBV face additional barriers: perpetrators may restrict their movement or finances, while fear of stigma, retaliation, or being publicly identified discourages them from seeking even urgent medical care.
- Many men face social pressure to appear strong, self-reliant, and unemotional. Harmful masculine norms, stigma, and lack of male-friendly services lead to lower healthcare-seeking behaviour compared to women (e.g. health data show that suicide disproportionately affects men [2]).

What we do that works:

Under Cordaid's Results-Based Financing **HEROES programme in Uganda**, additional funding is tied to the health facilities' performance in terms of quality, accessibility, and affordability. For example, now, at Brim Health Centre, staff travel on foot and by donkey to reach 17 villages, ensuring that remote communities receive essential health services. At Kebula village, free vouchers are provided to survivors of sexual and gender-based violence for access to a comprehensive package of services.

Recommendation:

Strengthen and fund gender-sensitive healthcare services, including male-friendly (mental) health clinics and safe transport incentives for women in rural areas.



HEROES programme peer educators with Cordaid staff

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS



- Harmful gender norms and violence undermine women's ability to negotiate safer sex, make autonomous reproductive decisions, or seek timely care.
- Limited access to SRHR services - including contraception, gynaecological care - restricts women's and girls' ability to manage their health. Separately, lack of access to affordable menstrual hygiene products and adequate sanitation facilities - often due to cost - means many girls in rural areas miss school during menstruation.
- Stigma, discrimination, and in some contexts restrictive laws further limit access to respectful, rights-based care and deter women from disclosing sensitive health information or seeking the services they need. [16]
- Harmful masculine norms also limit men's access to contraception and discourage their involvement in family planning, while cultural expectations to father many children increase pressure and reduce autonomy in reproductive decision-making. As a result, men face significant risks of STIs and HIV, yet are less likely to use condoms, take an STI/HIV test, or adhere to treatment.

What we do that works:

Tubakarorero project, Burundi, a joint effort of 3 international (incl. Cordaid) and 3 Burundian agencies: household sensitisation, credit-group outreach and youth ambassadors created new demand for family-planning across six provinces. Young people are also trained in entrepreneurship, and some become youth ambassadors and volunteers to reach even more youngsters.

Jigiya project, Mali, Implemented since 2019 by the consortium of CAEB (a Malian NGO) and Cordaid, supported by the Dutch government: comprehensive sexuality education plus peer activities reached 1.3 million adolescents; 17,000 youth-led ventures reduce girls' economic vulnerability to early pregnancy.

Under the **S3G programme** in **DRC** (North and South Kivu), 73 awareness-raising sessions on SGBV and SRHR were held with members of the communities, on average involving 120 participants, 65 men and 55 women. Some 19,195 people were reached by the broader awareness messages (7,013 men, 10,423 women, 863 boys and 896 girls).

Recommendation:

Invest in youth-led, community-based SRHR initiatives that combine comprehensive sexuality education and economic empowerment.



Youth group participating in comprehensive sexuality education training under the Jigiya Project, Mali.

VIOLENCE AND HEALTH



- SGBV and harmful gender norms have severe physical and mental health impacts; even before the pandemic, around one in three women worldwide experienced physical or sexual violence, which increased by 25–60% during COVID-19 lockdowns (the “shadow pandemic” per [UN Women](#)), leading to long-term mental health issues such as anxiety and depression.
- (Armed) conflicts act as a multiplier of SGBV and mental health issues, while hindering access to healthcare and treatments. They indirectly affect the survival chances of women and children through malnutrition, physical injuries, infectious diseases, poor mental health, and poor sexual and reproductive health [10]. Due to increased tensions in society, there is also more (S)GBV.
- Male survivors of intimate partner violence, torture, or sexual violence frequently face stigma and shame, and asking for help is seen as weakness. Legal, medical, and psychosocial support systems are rarely equipped to meet these needs [11, 12]. In conflict-affected settings, masculinities often become more rigid and militarised. Armed groups and military structures pressure men and boys into violent roles, rewarding displays of aggression while ridiculing those who refuse as “cowards” or “not real men” [17].
- LGBTQIA+ individuals face higher risks of violence and discrimination, which significantly harm their physical and mental health, increase vulnerability to chronic stress and depression, and contribute to disproportionately high suicide rates.

What we do that works:

Comprehensive community-based mental health and psychosocial support (MHPSS), Cordaid Afghanistan:

Network of community counsellors in four provinces focuses on survivors of SGBV, youth, and persons with disabilities, reaching 50,000 people otherwise cut off by conflict or restricted mobility.

The S3G project in DRC (Cordaid and HEAL-Africa): One-stop centres provide holistic medical, legal & psychosocial care. Moreover, by engaging young men in income-generating activities, such as construction, chicken farming, and water purification, the programme offers nonviolent pathways to self-worth and status. S3G builds on the evidence and [SRHR materials](#) generated by the [JeuneS3 programme](#) (2016–2020).

Recommendation:

Institutionalise one-stop centres for survivors of gender-based violence, offering integrated medical, legal, psychosocial and income-generating support, with tailored services for all genders. Discreet referral pathways, mobile or community-based options, and strong confidentiality measures are essential to ensure survivors can access support without fear of judgment or exposure.



PHOTO CORDAID

Jeune S3 youth ambassadors in action. The lessons and materials developed for JeuneS3 underpin the S3G programme’s continued work on adolescent SRHR and gender equality.

WHO MAKES HEALTH DECISIONS?



- Global, national, and local health leadership structures remain largely non-inclusive, lacking diversity of voices at the decision-making level in terms of gender, ethnicity, and geographic representation [9]. Women – who make up most frontline and community health workers – hold only 25% of senior roles. Three-quarters of top global health bodies are led by nationals from high-income countries, and women from low- and middle-income countries occupy just 9% of board seats.
- In the meantime, countries with more women leaders often have better-funded and more inclusive healthcare systems. Hospitals and health boards with diverse leadership tend to provide more accessible, sensitive and effective care.
- Data on LGBTQIA+ representation in health leadership are largely absent, reflecting a broader failure to systematically recognise, measure, and include LGBTQIA+ voices in health governance.

What works:

A [2025 BMJ Global Health review](#) found overwhelmingly positive outcomes associated with female leadership in health. 87% of the analysed studies reported significant improvements in key areas, including:

- Financial performance, innovation, and organisational resilience
- Ethical engagement and sustainability initiatives
- Health outcomes and narrowing of health inequalities
- Health workforce culture, team cohesion, and patient care quality
- Inspiration and career advancement for other women

Recommendation:

Prioritise funding and mentorship for women, youth and LGBTQIA+ leaders, especially from low- and middle-income countries, across global, national, and local health governance structures, ensuring they can meaningfully participate in and influence decision-making bodies (with specific safeguards for LGBTQIA+ leaders in contexts where visibility may pose safety risks)



Female health workers at a health care centre in Jimma Zone, Ethiopia, supported through Cordaid's Performance-Based Financing (PBF) programme.

MONEY AND EDUCATION MATTERS



● Economic hardships impact the health of individuals and families. In particular, women are disproportionately affected in the following way: women's lower income often means less money for healthcare and nutritious food.

- Women's lack of control and decision-making power over finances in the household might prevent them and their children from accessing certain health services.
- Economic inequalities (lack of property rights and restricted access to formal employment) create heightened vulnerability to transactional sex and dependence on partners.
- Single mothers frequently struggle financially, affecting their children's and their own healthcare access.
- When girls are forced out of school due to financial pressures, it reduces their future earning potential and undermines long-term health for themselves and future generations.

What we do that works:

Jigiya, Mali: 17,000 youth-run ventures finance school fees, health costs, and contraceptives, helping to prevent adolescent pregnancy.

Tubakarorero, Burundi: entrepreneurship training equips young women to earn their own income and pay for transport and sexual and reproductive health services.

HEROES Project, Uganda: The project provides free vouchers to ensure access to a comprehensive package of sexual and gender-based violence (SGBV) services. Across 36 supported public facilities, health workers proactively screen and identify women and girls experiencing violence and ensure they receive the care and support they need.

Recommendation:

Integrate economic empowerment programs (e.g. vocational training, microfinance, savings groups, study scholarships) with reproductive health services to reduce financial barriers to care for girls, women and single mothers.



PHOTO MICHAEL FRANCI, CORDAID

Participants of the Tubakarorero entrepreneurship programme in Burundi.

GENDER-SENSITIVE HEALTH RESEARCH

PHOTO: MARINA T



- Health research often overlooks women (especially women of colour), leading to treatments that don't work equally well for everyone.
- Heart disease research has historically focused more on men, leading to ignorance and unawareness of specific women's symptoms, leading to delaying proper treatments for women.
- Women have historically been poorly represented in clinical trials for several reasons, including concerns about the influence of hormonal fluctuations or the influence of a possible pregnancy on the results, as well as a long-standing assumption in medicine that the male body represents the "standard" human model. Because biomedical research and leadership have been predominantly male, research questions, study designs, and clinical norms have often been shaped around male bodies and experiences - an assumption that has also been widely internalised within the medical field more broadly, including by women researchers - resulting in the systematic exclusion of female-specific evidence [14].
- The COVID-19 pandemic highlighted this bias clearly: although research showed that men and women differed in infection rates, treatment responses, and mortality risks, just 4% of clinical trials made a deliberate effort to include women [14].

Recommendation:

Mandate gender-disaggregated data and inclusion of women and gender-diverse people in clinical research, with ethics protocols adapted accordingly.



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CONCLUSION

Integrating gender equality into global health is not merely a matter of fairness – it is a strategic necessity for building resilient, inclusive, affordable and accessible and effective health systems. Evidence from a range of settings demonstrates that gender-transformative health interventions lead to markedly improved health outcomes. Addressing gender-related barriers also strengthens economic stability, increases service uptake, and promotes more representative leadership and research. To realise global health goals, governments, donors, NGOs, and academic institutions must embed gender equality at the core of both policy and practice.

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ABOUT CORDAID

Cordaid is a value-based international development and emergency relief organisation, based in the Netherlands with offices in 14 countries. We work in and on fragility and support communities in their efforts to improve health care, education, food security, and justice. Where disaster strikes, we offer humanitarian assistance.

Cordaid is deeply rooted in the Dutch society with more than 260,000 private donors. The Christian values of human dignity, justice, compassion and care for the planet guide us in our work. Cordaid is a founding member of Caritas and CIDSE, and member of the ACT Alliance.

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