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GENDER MATTERS: STRENGTHENING PANDEMIC PREPAREDNESS AND RESPONSE POLICYMAKING

An analysis of the Dutch Global Health Strategy

INTRODUCTION

Gender and pandemic preparedness are intricately connected. Gender is a fundamental factor that shapes health systems and their capacity to face pandemics. It also shapes people's vulnerability to health risks and the way they are treated within health systems. Health policies that are gender transformative have the potential to ensure health systems reach those most left behind, even in times of pandemics.

In response to the sweeping impacts of COVID-19, the Netherlands accelerated the development of a [Dutch Global Health Strategy](#) (DGHS), with pandemic preparedness and response (PPR) at the forefront. Yet, it is lacking a strong focus on gender. Omitting gender within the DGHS leaves untapped potential for a comprehensive and transformative approach to PPR. It is essential for the DGHS to implement an intersectional and gender transformative approach to PPR in order to improve its response to future pandemics.

In this policy brief, we provide pragmatic recommendations to strengthen the DGHS's approach to gender. Evidence that gender inequalities adversely affect health outcomes and systems is extensive. Our recommendations are based on a review of the literature as well as interviews with experts in this field. The policy brief focusses on **six key areas** where gender plays a large role in PPR: access to healthcare, sexual and gender-based violence (SGBV), frontline health workers, economic impacts, leadership and governance, and research.

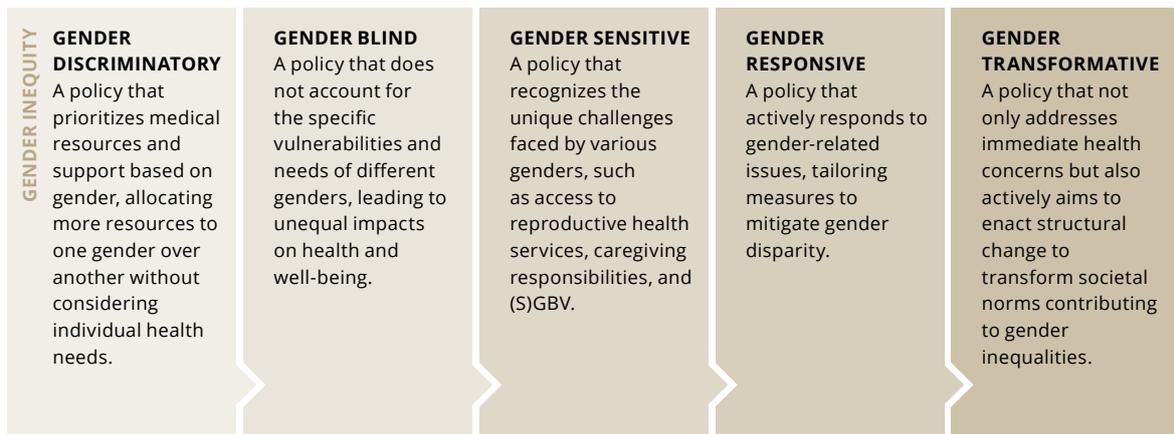
Based on our analysis of other European global health strategies (including Norway, Switzerland, France, the United Kingdom, Sweden and Germany), gender remains a major blind spot across strategies. By taking up equity as the basis to its PPR approach, the DGHS could set an example for mitigating the gendered impacts of pandemics.



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A GENDER FREQUENTLY ASKED QUESTIONS

What is gender & why does it matter for global health?	<p>Distinct from biological sex, gender is socially constructed and influenced by laws, politics, policies and individuals. It shapes how people behave, act and feel based on societal expectations of femininity and masculinity. Gender influences the health risks we are exposed to, whether or not we seek care, and how we are treated by health systems.</p> <p>It is important to note that the binary distinction between men and women is a European construct spread globally through colonisation. It hinders our ability to perceive and describe gender in more inclusive terms, limiting the capacity of policies to address the diverse needs of people in a nuanced way.</p>
What is intersectionality?	<p>Intersectionality is a lens through which we understand that people's experiences are shaped by a combination of factors, like gender, race, (dis)ability, religion, and many more. It is the recognition that people face unique challenges and opportunities due to the interplay of these factors. By considering these intersections, policies can be more inclusive and therefore more effective.</p>
What do we mean by "gender transformative"?	<p>A gender transformative approach explicitly seeks to transform unequal gender relations by promoting shared power, control of resources, decision making, and by supporting empowerment.</p>
What are the benefits of integrating gender in global health policymaking?	<p>Health systems that provide care to those most left behind lead to more resilient societies. Integrating gender in global health and pandemic preparedness and response policymaking can help policies achieve more equitable outcomes, resulting in greater effectiveness. This can help boost public trust in governments, reinforce democratic institutions and combat gender inequalities.</p>



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1. ACCESS TO HEALTHCARE

Effective PPR policies ensure vaccines reach everyone and safeguard that primary healthcare needs are still being met in times of crisis. In this context, policymaking should address gender barriers as they represent obstacles to accessing healthcare in an outbreak.

Evidence has shown that COVID-19 has [exacerbated pre-existing gender disparities](#), including in terms of access to primary healthcare. Sexual and reproductive health (SRHR) services were [disproportionately affected during COVID-19](#), amplifying existing challenges related to contraception and maternal healthcare for women and girls. Transgender people in particular experienced [decreased access to specific healthcare services and gender-affirming care](#).

WHO ARE 'KEY POPULATIONS'?

Key populations are population groups who experience both increased impact from HIV and tuberculosis and decreased access to services. Widespread stigma and discrimination, violence and harassment, restrictive laws and policies, and criminalisation of behaviours or practices put key populations at heightened risks and undermine their access to services. This includes sex workers, transgender people, men who have sex with men, people who use injectable-drugs, and people in prisons and closed settings.

For people living with HIV, both research and expert interviews pointed to the impact of the pandemic on HIV care. This is particularly the case for the so-called key populations whose access to life saving treatment was heavily compromised due to fear of stigma, discrimination and violence. The pandemic [reversed decades of progress towards eradicating the HIV pandemic](#). HIV prevention, such as community education projects and medication to reduce the risk of infection (pre-exposure prophylaxis), was also negatively affected. In terms of immunisation, [access to and uptake of vaccines is also highly variable and gendered](#). [Evidence](#) shows that, compared to women, men are significantly under-vaccinated in the USA, while in South Sudan they are more likely to be able to access immunisation, compared to women.



“COVID-19 lockdowns were implemented as a blueprint across the world. In reality each context is unique. PPR policies should be context-specific, adapting to cultural health seeking behaviours. In rural South Sudan, men access vaccination clinics when travelling to work to urban areas. If you impose a lockdown, cultural norms will not encourage men to visit clinics for vaccination as it’s not related to their daily economic activities. For women, while they seek healthcare sooner than men, they experience more restriction of movement due to socioeconomic reasons. Lockdowns made it worse. PPR policies need to adapt if they are to be effective.”

> **Andrew Nguigi, Health Programme Manager** > Cordaid South Sudan

Recommendations

While the DGHS contains language on vulnerabilities and is sensitive to gender inequalities, it does not articulate how it plans on addressing the interplay between gender and access to health. The DGHS lists “improved access to primary healthcare and SRHR” and “global access to medicines and health products” as part of their main priorities. The strategy acknowledges that vulnerabilities are “being caused by a multitude of factors”, explicitly underscoring the need to “consider intersectionality in order to reach the most vulnerable groups”. Yet, it remains unclear how the DGHS operationalise vulnerabilities and intersectionality, including which factors it considers within its definitions. The DGHS aims to improve access to healthcare by engaging groups that are marginalised, civil society and the private sector. Specifically for PPR, the DGHS also emphasises the necessity of global collaboration, local capacity-strengthening, and strategic autonomy. Based on this, we put forward the following recommendations:

- a. Develop a comprehensive plan on how to systematically assess and address vulnerabilities and gender inequalities.** The Global Health Hub, as the implementing arm of the DGHS, should include a clear definition of vulnerability and intersectionality, and how gender is a key factor. This comprehensive workplan should then be part of the Global Health Hub’s Communities of Practice workplans.
- b. Commit to the meaningful engagement of groups that are marginalised.** The Global Health Hub and the Dutch ministries involved in the DGHS should explicitly identify groups that are marginalised and ensure their participation to strategy development, implementation, monitoring and governance of the DGHS. This enables more comprehensive consideration of gender-related issues and can generate more appropriate programming, which can be used as a best-practice example for other strategies within the ministries and in the implementation of Dutch-funded programmes.
- c. Advocate for context-specific programming.** Advocates should call for increasing cultural awareness of issues related to access to prevention, diagnostics, treatments and vaccination and ensure programmes are context-specific. This should be the driving principle when approaching primary health care, with an understanding of the particular needs and barriers for the specific context. Primary health care is an area where the Dutch government can support and advocate for context-specific programming as a key element for Universal Health Coverage.
- d. Maintain policy coherence across ministries,** engaging the Feminist Foreign Policy, and implementing the core principles in the implementation of strategies such as DGHS. Access to healthcare in pandemics is also a domestic issue that requires collaboration and engagement across ministries.
- e. Allocate a specific budget for gender within the implementation of the DGHS.** Gender budgeting is essential to enable a gender transformative approach in all areas of the DGHS, making sure that the gendered impacts of each action are explored and addressed.

2. SEXUAL AND GENDER-BASED VIOLENCE

Early on in the pandemic, [studies](#) showed an increase in sexual and gender-based violence (SGBV), particularly against women and girls. The World Health Organization (WHO) pleaded that “governments and policy makers must include essential services to address violence against women in preparedness and response plans for COVID-19, fund them, and identify ways to make them accessible in the context of physical distancing measures”.

Pre-pandemic, [one in three women](#) (but [up to 50% in some contexts](#)) experienced violence from an intimate partner. Sharp increases in (S)GBV were reported around the world during the COVID-19 outbreak, a trend that was named the “*shadow pandemic*” by [UN women](#). Based on a [Frontiers research review](#), the third most-cited open science platform, the rise in (S)GBV during COVID-19 is linked to lockdown and social distancing policies. They promote psychological, social and financial stress within households, which may in turn exacerbate gender inequalities. Lockdowns also promote isolation of people in abusive contexts, particularly youth. Especially women and people of the LGBTQI+ community face heightened risks to become trapped in violent households with abusive partners or family members. This is illustrated by the surge in calls to domestic violence hotlines during lockdowns worldwide: Colombia reported an increase up to 130%.

We must consider how a health crisis interplays with SGBV. People living with HIV, women in particular, can face violence from intimate partners when disclosing their HIV status. The risk of SGBV discourages people to seek treatment. Without tackling HIV-related stigma and SGBV risks, we won't be able to ensure healthcare is accessible to those most in need. COVID-19 exacerbated this, underscoring the need invest in SGBV-care, community prevention and response systems.

> Sarah Auma, HIV and TB Programme Coordinator > Cordaid South Sudan

The increase in (S)GBV was flagged by many governments and approached, for example, with awareness campaigns. However, (S)GBV is a prevalent issue worldwide for which resource allocation is scarce, even in non-pandemic contexts. The large increase during the COVID-19 outbreak only highlighted the inadequacy of the services available to (S)GBV survivors pre-pandemic. While women make up [90% of reported cases of \(S\)GBV](#), people of all genders can experience violence based on their gender and/or sexual orientation. Policies must diversify their approach based on the understanding of how people's vulnerability to (S)GBV interacts with marginalised identities markers (e.g. race, (dis)ability, sexual orientation, HIV status).

Recommendations

The DGHS explicitly refers to the rise in (S)GBV during the COVID-19 pandemic. Yet, similar to other global health strategies, the connection between (S)GBV and PPR is not specifically addressed. Any PPR action taken should include measures to prevent and respond to (S)GBV, in particular in relation to lockdown measures, if we are to avoid repeating past mistakes. The Government of the Netherlands acknowledged the connection between COVID-19 and (S)GBV in a 2021 [news item](#), where they identified the government's role in upholding the priorities set in the [Istanbul convention](#): prevention, protection, prosecution, and coordinated policies. As such, we put forward the following recommendations to strengthen the DGHS's integrated approach on PPR and (S)GBV:

- a. Commit to the meaningful participation of civil society organisations and survivors of (S)GBV.** The Global Health Hub, specifically its Community of Practice on PPR, should consult with these groups to include their perspectives in the development of the Communities of Practice workplan and approach.

- b. **Include (S)GBV responders and services as essential during PPR.** The Global Health Hub Communities of Practice should plan to ensure (S)GBV-related services are included and prioritised in any policy or implementation plan on PPR. These key asks should consider how to ensure these services remain operational, and even upscaled, during a public health crisis. This could be a case study for policy coherence, as this element should be prioritised in both domestic and international PPR responses.
- c. **Invest in community SGBV awareness raising and response services and make it an aspect of PPR.**

3. FRONTLINE, SOCIAL AND COMMUNITY HEALTHCARE WORKERS

According to the [WHO](#), women represent the overwhelming majority (70%) of healthcare personnel, primarily frontline workers (e.g. doctors, nurses and midwives) and 90% of social care workers. As a result, [women are at higher risk of exposure during an outbreak as seen during COVID-19](#). Additionally, community health workers, also overwhelmingly women, are often [afforded less protective gear](#) (e.g. face masks, gloves, gowns etc.) despite a high risk of exposure. When equipped with ongoing training, remuneration and protective equipment, [community health workers can strengthen prevention and response to pandemics](#) as they access hard-to-reach communities and carry out diverse tasks such as infection control, sample collection, medication rollout and counselling.

These frontline health workers are also at higher risk of experiencing secondary effects of pandemics, such as [psychological distress and burnout](#). This impacts the wellbeing of healthcare workers as individuals and as essential pillars of a functioning health system. An example of the unintended consequences of gender-blind health systems and PPR was seen during the COVID-19 pandemic: [most protective gears are developed around male bodies](#). This leaves the majority of women frontline health workers with ill-fitting equipment that does not protect them appropriately.

Recommendations

None of the global health strategies analysed, including the Dutch one, mention frontline, social or community healthcare workers in relation to PPR. This underscores a major blind spot in global health and PPR policymaking. We encourage the integration of these considerations in the future, reflecting another key ask from the WHO: “*All front-line health and social workers and caregivers have equitable access to training, PPE [protective personal equipment] and other essential products, psychosocial support and social protection, taking into account the specific needs of women who constitute the majority of such workers*”. Based on best-practices, we put forward the following recommendations:

- a. **Ensure personal protective equipment is available and adequate for all frontline health workers.** The Global Health Hub and Ministry of Health should engage with the Dutch industry that designs, produces and distributes protective gear to present evidence for the need of protective gear that responds to the needs of the health workforce, which should include protective gear adequate for female bodies.
- b. **Recognise and include the importance of adequate, sustainable and predictable investments in health workers as a priority for the Dutch Government.** This should include particular focus on Community Health Workers.

4. LEADERSHIP & GOVERNANCE

Global health leadership and governance is widely not inclusive of a various forms of diversity, including gender, race, geography and many others, found a [Global Health 50/50 2022 report](#). Despite being a majority of frontline, social and community healthcare workers, [women only hold 25% of senior roles in healthcare](#). Stark disparities also exist geographically, [with 75% of the most influential global health governing bodies held by nationals of high-income countries](#). Women from low- and middle-income countries represent a mere [9% of all board seats](#). Not being inclusive deprives global health leadership from the diverse perspectives and expertise of people who tackle past limitations of PPR in terms of equity and justice.

In order to evolve and improve, leadership in health must intentionally address gender barriers as the basis of strong PPR and health systems. This highlights the importance of [gender transformative leadership](#): women, gender minorities, and other groups that are marginalised and underheard must be better represented in senior and management roles in policymaking, international and civil society organisations, and healthcare governance. This means being in the position of having decision-making power, allowing the voices and needs of underrepresented gender minorities to be heard and acted upon. Only this way can real structural change take place. Diversifying health leadership and governance has the potential to improve health systems and outcomes by addressing the gendered legal, cultural, and social barriers, particularly in times of crisis. The HIV/AIDS pandemic is a good example of how diversifying leadership and governance can strengthen PPR.

“HIV is itself a pandemic that disproportionately affects people belonging to stigmatised groups and relates to taboo areas of life like sex and sexuality. However, the response has evolved, with affected communities gaining representation in decision-making bodies like The Global Fund and UNAIDS. This stands in contrast to the COVID-19 response, which lacked diverse leadership and failed to amplify the voices of the most vulnerable. The lesson from the HIV pandemic underscores the importance of inclusive representation for effective crisis management.”

> **Lyle Muns** > Health Advocate at Aidsfonds

Recommendations

The area of inclusive and diverse global health leadership is left out of the global health strategies analysed, including the Dutch one. While the DGHS recognises gender inequalities and how it hindered the COVID-19 response, it does not address inequalities at governance level. The Global Health Hub Communities of Practice and the Dutch government should include the following elements in its planning, engagement and funding:

- a. Promote gender equity and diversity in leadership at a national level to bolster diverse representation into global health leadership.
- b. Support civil society, grassroots movements and collective actions that advocate for gender transformative leadership to strengthen locally led-development.
- c. Advocate for gender equity and equitable representation in global health boards, leadership and governance structures.
- d. Mobilise men as allies to advocate for gender transformative leadership.
- e. Implement global commitments to gender equality in leadership.

5. ECONOMIC IMPACTS

Economic stability is an important social determinant of health. Numerous studies, including from the WHO, have demonstrated the correlation between worsening financial hardship and poor health outcomes. The economic impacts of pandemics are heavily gendered and vary with the interplay of other factors such as ethnicity, (dis)ability and sexual orientation. From the onset of the COVID-19 pandemic, a [study](#) from the Lancet showed that the economic downturn caused by the crisis was affecting women more severely. It warned that this was partially reversing progress towards gender equality in a way that would persist long after the pandemic was over. During a sanitary crisis, women are also at [increased risk of losing their jobs and not returning to work or school](#). The latter is also correlated to an increase in [forced marriages](#).

Women are overrepresented in sectors such as hospitality and tourism, which were for instance greatly affected by the restrictions of the COVID-19 pandemic. To compound this, women are mostly responsible for the [often-unrecognised and unpaid caregiving work](#) such as looking after children and assisting elderly family members, while also managing the household. These factors go on to worsen the impact of the economic recession both on women who work and those who take care of their families.

[Women and people of the LGBTIQ+ community](#) are overrepresented in the service industry and in jobs deemed “non-essential” (e.g. hospitality and entertainment sectors), as well as in occupations made riskier by physical distancing protocols (e.g. sex work). Not only does this make them already more financially insecure to begin with, but they are also more likely to suffer the financial consequences of pandemics and lockdowns, while being forced to continue working in often unsafe conditions.

In most societies, there is an expectation on men to financially provide for their families. Not being able to fulfil this role during a pandemic can negatively impact their mental health, with rising rates of suicide and alcoholism. The increase in tension due to financial stress within households has been found to correlate with an increase in (S)GBV.



Recommendations

The DGHS recognises the disproportionate impact of COVID-19 on people living in vulnerable circumstances, particularly women and children, in areas such as education, economic stability and food security among others. The DGHS also mentions the effect that mass school closures have had on educational disadvantage. Other global health strategies analysed mention the increase in social inequalities and financial instability. However, most framed it as issues of social welfare or universal health coverage (UHC), without mentioning the specific gendered aspect of it. As such, we put forward the following recommendation:

- a. Integrate a more nuanced gender transformative and intersectional approach to the DGHS.** This should consider the intersectional aspect of economic impact, the pre-existing financial insecurity of women and the LGBTQI+ community, and the impact on men's mental health. These elements should be integrated into the analysis of the priorities of the implementation of the DGHS, and translate this into actionable elements within its planning and implementation.
- b. Include mitigating policies for the economic impacts as part of PPR plans.** This will require policy coherence and collaboration across ministries. Meaningful engagement of key stakeholders in the development and evaluation of these should be systematically included and funded.

6. RESEARCH

Our ability to gain insight into the effects of pandemics on different groups hinges on the availability of reliable and comprehensive data. This data should always be sex-disaggregated to be able to show sex differences in the various aspects of PPR research. Without it, preparedness and response cannot be adjusted to appropriately address the effects of pandemics.

During the COVID-19 pandemic there was a significant lack of sex-disaggregated data from many countries. This has been flagged by [the WHO](#), who has made it a key ask for its Member States, and should be a valuable lesson for future global health and PPR strategies. Additionally, research attempting to quantify the effects of the COVID-19 pandemic on gender equality on health, social, and economic indicators exposed severe inequalities, but struggled to fully explain their nature. This shows that sex-disaggregated data is only the start. Early clinical trials often exclude [women](#) and [transgender](#) people, leading to unclear treatment protocols and substandard care for these groups. This occurred, for example, with [COVID-19 vaccine research](#).

Recommendations

Among global health strategies of various European countries, none set research approaches as a theme of interest or gave recommendations on sex-disaggregated data. In the DGHS, the Netherlands positions itself as an innovator and a valuable player in terms of action against cross-border health threats such as antimicrobial resistance (AMR) and zoonotic diseases, in addition to engaging in monitoring, surveillance and evaluation in collaboration with the WHO. Besides the DGHS, the Dutch Research Council (NWO) strategy for 2023-2026 aims to consciously enhance the position of underrepresented researchers and take into account inclusiveness in research consortia and designs. Considering the Netherlands' ambition as an innovator, we put forward the following recommendations:

- a. Implement the WHO's recommendation to collect, report and analyse sex-disaggregated data in PPR within their Global Health Strategy.** In addition, this element should be integrated within the Netherlands' domestic PPR strategy.
- b. Include other social markers in data disaggregation.** Recognise ethnicity, age, urban/rural living status, socio-economic status, ability and sexuality as dimensions that might affect the impact of a pandemic on different groups, both biologically and socially. Integrate the previous recommendation with disaggregation by these elements. This should be integrated into demographic research. In addition, the Netherlands should provide funding for academic institutions that are implementing innovative approaches on disaggregation, aiming to learn from them.
- c. Include a gender transformative requirement to research and development calls of drugs and vaccines.** Advocate for R&D that is geared towards analysing and adjusting for gender and sex differences.

CONCLUSION

Gender is a fundamental factor shaping everyone's health, especially in times of crisis. It is a matter of equity, justice and human rights, principles that lie at the heart of global health. Yet, the majority of COVID-19 programming did not address gender inequalities, leaving devastating consequences particularly for women and people of the LBGTQI+ community. This policy brief highlighted the repercussions of gender blind policymaking on people and our capacity to address pandemics. The DGHS is sensitive to gender, recognising the importance of an intersectional approach. Yet, much progress can be made to concretise the DGHS' actions to ensure it is truly gender transformative.

ABOUT THIS POLICY BRIEF

This policy brief is an initiative of the Cordaid's Global Health, Global Access programme. It is based on an extensive literature review covering publications (academic journals, publications and reports from international organisations such as the WHO, UN, World Economic Forum, the Dutch government, the Dutch Research Council (NWO) and CSOs. This research was complemented with interviews with internal and external experts.

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