7 *SDG5, gender equality: co-benefits and challenges*

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7.1 Introduction

Universal healthcare coverage (UHC), "Health for all" and "Leaving no one behind" (WHO, 2021) need to include equity of and access for women, men and all other genders. The reverse is true as well: gender equality and human rights need health equity. Assessing policy co-benefits and improving intersectoral governance may help us achieve progress in these areas. This chapter explores the linkages between SDG3 Health and SDG5 "Achieve gender equality and empower all women and girls". We introduce selected sub-goals/targets of the two SDGs and briefly clarify the terms and concepts of gender equality. We argue that health equity and gender equality are "'twin forces" that are historically connected and cannot be separated, creating either strong co-benefits or a "double jeopardy" scenario for health and gender equality. Thus, developments at the crossroads of SDG3 and SDG5 are never "gender neutral" and need attention for two reasons: to strengthen the health policy co-benefits and to prevent and mitigate adverse effects if gender equality is ignored.

The chapter describes the pathways between health and gender equality, taking into account theoretical issues, governance and policy challenges. We introduce a conceptual model of researching co-benefits that expands the focus on macro-level co-benefits towards more complex governance processes and outcomes. Selected empirical case studies consider four major targets of SDG5 and related SDG3 sub-goals, illustrating different scenarios of implementation of health and gender co-benefits in a range of policy and governance contexts.

Our first case study highlights an optimum scenario of co-benefits driven by health policy action, using two mini-case studies as empirical examples: domestic violence against women (Amin, Kismödi & García-Moreno, 2015; WHO, 2002) and training midwives to improve access of migrant women to healthcare (Fair et al., 2021). Both examples are characterized through a global/European approach and a scenario of

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"high importance" and "low conflict" of SDG3 and SDG5 that supports intersectoral governance. Case study 2 sets the focus on the developments in the health workforce during the coronavirus (COVID-19) pandemic in Brazil (until December 2022, under the Presidency of Bolsonaro), one of the worst hit countries and regions in the world (Lancet, 2021). It illustrates a problematic scenario of political elites strongly contradicting epidemiological facts and public health relevance and ignoring both the population's health and gender equality. The Brazilian case study reflects a "low importance/high (public health) conflict" scenario on the side of the political actors and reveals the "double jeopardy" for gender equality and public health when health policy action co-benefits are lacking. Our final case focuses on the European Union (EU) and a more mixed scenario of "importance" and "conflict" where the results depend on the stakeholder groups. This case sheds light on academia and the science system, where evidence and "epidemiological facts" are produced and leadership is defined. This makes academia an important arena and a major switchboard of SDG co-benefits, including both the substance (research) and the institutions. The example of coronary heart disease reveals the capacity of co-benefits when health action is supported by intersectoral governance and the threats to health and equality if gender is ignored.

The selection of cases seeks to highlight how gender matters in different contexts and how systematic interlinks between the different SDGs may create co-benefits for health care and gender equality. The three scenarios and empirical cases illustrate that governance actions and intersectoral structures (institutional pathways) shape the "windows of opportunity" for co-benefits. Co-benefits remain fragile and contested and need thus to be re-assured, a lesson most recently learned from the COVID-19 pandemic (Kuhlmann et al., 2023; Lotta et al., 2021; Tomsick, Smith & Wenham, 2022; Wenham et al., 2020).

7.2 Background

Strong connections between SDG3 and SDG5 have created intersecting health and gender equality targets (United Nations, 1999). The targets are specified in the SDG sub-goals. We have selected four targets of SDG5 to explore major synergies and interlinks:

- SDG5.1: "End all forms of discrimination against all women and girls everywhere";

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- SDG5.2: "Eliminate all forms of violence against all women and girls in the public and private spheres";
- SDG5.5: "Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life"; and
- SDG5.6: "Ensure universal access to sexual and reproductive health and reproductive rights" (https://www.undp.org/sustainable-development-goals#gender-equality).

Some SDG3 targets are explicitly linked to gender equality (Gupta et al., 2019). These include SDG3.1 "Reduce maternal mortality", SDG3.7 "Universal access to sexual and reproductive health care services" (WHO Europe, 2017) and SDG3C "Support to health workforce" (WHO Europe, 2018). More recently, Target 16.1 "Reduce violence everywhere" has been added, arguing among others that "[G]endered social and cultural norms and concepts of masculinity increase the risk of violence" (WHO, 2020a). SDG3.8 "Achieve universal health coverage" highlights the need to "leave no one behind" and pays greater attention to the needs of vulnerable groups; this also provides a platform for including gender equality more explicitly and addressing intersecting social inequalities.

Some international declarations and commissions on gender equality are explicitly linked to health and the SDGs (Gupta et al., 2019; United Nations, 1999). The *Gender Equality, Norms and Health Steering Committee* provides a good example of how intersectoral governance may create co-benefits driven by health action. The Committee highlights that "[R]esearch, health systems, policies, and programmes can reduce gender inequalities, shift gender norms, and improve health" (Gupta et al., 2019). Similarly, the *Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health* has previously argued that "taking action to improve gender equity in health and to address women's health is one of the most direct and potent ways to reduce health inequities and ensure effective use of health resources" (Sen, Östlin & George, 2007). The *Spotlight Initiative* joined forces with the United Nations and the European Commission in a global partnership (supported by WHO) to "eliminate all forms of violence against women and girls", demonstrating how action can be taken to improve "Health for All" (Spotlight Initiative, 2021). More generally, the *European Pillar of*

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Social Rights Action Plan demonstrates the interlinks between gender, health and other sectors (European Commission, 2021a).

Health sector actions may support gender equality (see, for example, Abdool, García-Moreno & Amin, 2012; Amin, Kismödi & García-Moreno, 2015; Kuhlmann & Annandale, 2015; Morgan et al., 2021; Takemoto et al., 2021) and co-benefits are strongest "when they engage multiple stakeholders from different sectors" (Gupta et al., 2019). However, co-benefits are rarely considered in a more pro-active manner as an important policy concept and they are still poorly researched.

Some brief clarification regarding the terminology may be helpful (Annandale & Kuhlmann, 2012; Kuhlmann, 2009; Wenham, 2021). Historically, the distinction between sex (more related to biological dimensions) and gender (more related to social conditions and identity) has helped to explore how differences between women and men are socially constructed. However, since the 1990s feminists and scholars of postmodern theories have illuminated the connections (for example, Haraway, 1988) and questioned the sex/gender and culture/nature distinctions (Kuhlmann, 2009), also highlighting intersectionality of social inequalities (Lotta et al., 2021). Notwithstanding the important theoretical differences, the categories of sex and gender are increasingly perceived as fluid and interconnected, and this is especially relevant in relation to health. For the purpose of this chapter – and in line with SDG5 – we utilize "gender" as an umbrella term, which includes biological dimensions as well as women, men and other sexes/genders and their sexual orientations (often summarized as LGBTQ – lesbian, gay, bisexual, transsexual, queer – or non-binary people). We also follow the SDG5 targets by focusing on women's/girls' health, while acknowledging that a gender approach and attention to co-benefits are also relevant in the group of men/boys as well as in relation to sexual minority groups (Morgan et al., 2021; Rice et al., 2021).

We refer to a non-binary concept of sex-gender – including women, men and other genders – and to intersectionality as an approach:

> "wherein gender intersects with other social markers of power, such as race, age, and income, to create clustered relative advantage or disadvantage that gives rise to power dynamics and hierarchies among boys and men and girls and women, not just between them" (Gupta et al., 2019).

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The strong connections between SDG3 and SDG5 have created specific conditions of co-benefits. One key characteristic is the *embodied* nature of the sex–gender–health connections (Kuhlmann, 2009). Another important issue is the *intersectionality* of gender with other forms of social inequality (Gupta et al., 2019; Krieger & Davey Smith, 2004). Intersecting social inequalities may create marginalized groups and may thus have negative effects on the physical and mental health of the people affected, as well as on societal coherence and resilience of health systems and societies. A third characteristic is the *gender–power nexus*, pushing women more often to the bottom and men to the top of societies and marginalizing those who do not fit a binary gender order, such as LGBTQ people (European Network against Racism, 2021; Paine, 2018). In relation to policy and governance, the two SDGs draw on largely similar policy approaches of *mainstreaming* major targets into different policy areas. SDG3 is informed by Health in All Policies (Leppo et al., 2013) and SDG5 by "gender mainstreaming" (Council of Europe, 1998; Kuhlmann & Annandale, 2012). Also, UHC is still an "unfinished journey" (Rajan, Richiardi & McKee, 2020) and much the same applies to gender mainstreaming (Allotey & Denton, 2020). Thus, co-benefits should be considered as a process – bringing the role of actors and stakeholder groups into play – and a policy tool rather than an outcome.

7.3 Pathways between health action and co-benefits

The procedural nature of SDG3 and SDG5 co-benefits, together with the interconnectedness, embodiment and intersectionality of health and sex/gender, makes it difficult to identify linear relationships and causal pathways (Kuhlmann & Annandale, 2015). In some areas, health action and gender equality co-benefits may be amalgamated; this applies, for instance, to maternity care as a typical SDG3 and SDG5 co-benefit. In most other areas, things are more complicated and less positive.

Major challenges to the development of intersectoral governance and the creation of co-benefits are arising from the "embodied" connections between health and sex-gender. These conditions bear the risks of either reinforcing differences as "natural facts" and essentialist attitudes (for example, "hardiness" of men, "caring attitudes" of women) or hiding gendered power relations and inequalities behind seemingly "gender-neutral" approaches. A neutrality paradigm is based on a White,

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male, heterosexual person, thus creating disadvantages for all women and "double jeopardy" or even "triple jeopardy" for female members of ethnic minority groups and LGBTQ people. Neutrality may also threaten men who do not fit, or do not want to fit into the norms of "hegemonic masculinities" (Connell & Messerschmidt, 2005). Assuming neutrality inevitably excludes many people. It creates health risks, most often for women and girls, but in some areas (such as mental health) also for men (Kuhlmann & Annandale, 2015; Morgan et al., 2021; Ovseiko et al., 2017; Rice et al., 2021).

The "coronavirus politics" (Greer et al., 2021) have added new examples of gender-blindness and policy failures that impact women/girls and minority groups most, but may also create risks for men (European Parliament, 2021; Global Health 50/50, 2021; Morgan et al., 2021; Tomsick, Smith & Wenham, 2022; UNDP-UN Women, 2020). For instance, lockdown policies have increased the risks of sexual and domestic violence (WHO, 2020a), they have disrupted reproductive health care services (Bojovic, Stanisljevic & Giunti, 2021; Takemoto et al., 2021) and disadvantaged female health care workers (HCW) and female-dominated health care sectors in relation to pandemic protection and preparedness (Lotta et al., 2021; Shamseer et al., 2021; WHO, 2020b) (for an overview, see Kuhlmann et al., 2023).

New inequalities often emerged despite strong legal gender equality frameworks and anti-discrimination policies, a situation observed, for example, within the EU (Council of Europe, 1998; European Commission, 2020). For instance, women's jobs are more at risk during the pandemic and for those "who remain in employment, their greater care obligations are forcing them to cut down on paid working hours or to extend total working hours (paid and unpaid) to unsustainable levels" (ILO, 2020). The International Labour Market Organization calls upon policymakers to put "gender equality at the core of the emergency and recovery efforts to avoid long-term damage to women's job prospects and to build back better and fairer" (ILO, 2020; see also Gupta, 2019).

A WHO country briefing provides another illustrative example of how to create co-benefits and implement intersectoral governance in the health care system in times of COVID-19. The WHO advises Member States "to incorporate a focus on gender into their COVID-19 responses in order to ensure that public health policies and measures to curb the epidemic take account of gender and how it interacts with other areas

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of inequality" (WHO, 2020b). Although the briefing does not use the term, it clearly refers to co-benefits and reveals supportive conditions of intersectoral action.

7.3.1 Governance and implementation challenges

An intersectoral governance approach is important, but is no free ticket to co-benefits. Strong power and interest-driven politics and contradictory developments in the health care system and society shape the implementation processes at the crossroads of SDG3 and SDG5, thus challenging governance and policy outcomes. For instance, successful efforts on the macro-level of governance through equal opportunity laws and joint funding sources, for example, observed in the EU (European Commission, 2020), may be hampered by "organizational plaques" of "old-boys-networks" (Sen, Östlin & George, 2007) or by new performance management schemes that benefit men more than women, for example in academic health care settings (Kuhlmann et al., 2017).

Successful macro-level efforts may also be weakened or even blocked on the micro-level through cultural, ethnic or religious stereotypes and attitudes, for example, if women are prevented from developing leadership skills and men from developing caring skills, or if women's sexual and reproductive rights are denied and sexual violence justified as cultural practice (Zuccala & Horton, 2018). Governing the implementation of SDGs in ways that enhance co-benefits, therefore, needs a flexible intersectoral approach and knowledge of processes and actors at macro- and micro-levels and in different policy areas.

7.3.2 Policy challenges

The SDGs and mainstreaming policies have spotlighted gender relations and helped bring equity and equality to the policy agenda (Council of Europe, 1998; Kuhlmann & Annandale, 2012; United Nations, 1999). However, no country has achieved the goals (Allotey & Denton, 2020). Major challenges, such as preventing sexual violence, continue to persist (Amin, Kismödi & García-Moreno, 2015; WHO, 2020a) and the COVID-19 pandemic has caused a global backlash in all areas of gender equality (Global Health 50/50, 2021; Lotta et al., 2021; Morgan et al., 2021). Some of these problems are rooted in the SDGs and the gender blindness of health policymaking (Hawkes & Buse,

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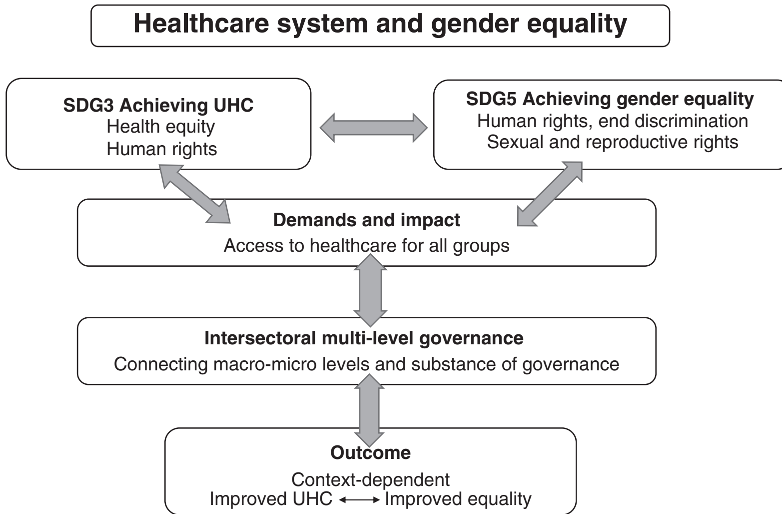

Fig. 7.1 Connected pathways of SDG3 and SDG5 co-benefits

2013; Kuhlmann & Annandale, 2015; Zuccala & Horton, 2018), while others are caused by a lack of attention to conflicting interests and diverse needs. Fig. 7.1 introduces a conceptual framework for assessing health and gender action co-benefits in context.

Intersectoral multi-level governance in health care can be operationalized through a number of tools and every tool can be, and should be, utilized to support the creation of SDG5 and SDG3 co-benefits, as defined by gender mainstreaming (Abdool, García-Moreno & Amin, 2012; Kuhlmann & Annandale, 2012). For instance, the "Strategy for integrating gender analysis and actions into the work of WHO", reproducing resolution WHA 60.25, calls for incorporating gender equality in health policies, programmes, research and planning processes in any area and at all levels. Mainstreaming must consider the entire process of design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres (WHO, 2009).

Table 7.1 below provides an overview of the tools for possible governance actions to support the creation of co-benefits, illustrating that co-benefits are embedded in gender mainstreaming and SDG5. However, the implementation of "possible" governance actions depends on contexts and may be constrained in many ways. As we put it in

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Table 7.1 *Possible governance actions to support co-benefits between SDG5 and SDG3*

			Possible governance actions with these tools								
			Goals and targets	Evidence support	Policy guidance	Implementation and management	Coordination	Advocacy	Monitoring and evaluation	Financial support	Legal mandate
Tools	Plan	Plan	X	X	X	X	X	X	X	X	X
	Indicators and targets	Indicators	X	X	X	X	X	X	X	X	X
		Targets	X	X	X	X	X	X	X	X	X
	Budgeting	Pooled budget	X	X	X	X	X	X	X	X	X
		Shared objectives	X	X	X	X	X	X	X	X	X
		Coordinated budgeting	X	X	X	X	X	X	X	X	X
	Organization	Ministerial linkages	X	X	X	X	X	X	X	X	X
		Specific ministers	X	X	X	X	X	X	X	X	X
		Organization	X	X	X	X	X	X	X	X	X
		Legislative committees	X	X	X	X	X	X	X	X	X
		Interdepartmental committees/units	X	X	X	X	X	X	X	X	X
		Departmental mergers	X	X	X	X	X	X	X	X	X
		Civic engagement	X	X	X	X	X	X	X	X	X
	Accountability	Transparent data	X	X	X	X	X	X	X	X	X
		Regular reporting	X	X	X	X	X	X	X	X	X
		Independent agency/evaluators	X	X	X	X	X	X	X	X	X
		Support for civil society	X	X	X	X	X	X	X	X	X
		Legal rights	X	X	X	X	X	X	X	X	X

Source: Authors' elaboration, based on McQueen et al., 2012

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our introduction, health equity and gender equality are "'twin forces" creating either strong co-benefits or a "double jeopardy" scenario for health and gender equality.

7.4 Case study 1: health action creating co-benefits to gender equality and women's health

We have selected two mini-case studies to illustrate an optimum scenario of health action creating gender equality co-benefits with a focus on women's health. The examples refer to large multi-country projects that implemented intersectoral governance elements aiming to improve women's health. In addition, evaluations of outcomes and transferability are available, which are lacking in most other cases.

The first case reflects the intersectionality of gender and race/ethnicity and the opportunities of creating co-benefits for socially disadvantaged and marginalized groups of women within the EU. The EU project *Operational Refugee and Migrant Maternal Approach* (Box 7.1) aimed to provide intercultural training for midwives and to establish partnerships between health professionals and service users (Fair et al., 2021; ORAMMA, 2020; Petelos et al., 2019; WHO, 2019). The project responds to the growing demand for better health care services and UHC for pregnant women of minority groups.

Box 7.1 Operational Refugee and Migrant Maternal Approach (ORAMMA)

"The project … has a vision to develop an operational and strategic approach in order to promote safe motherhood, to improve access and delivery of maternal health care for refugee and migrant women and to improve maternal health equality within the European Union. Moreover, the project will increase awareness, commitment and action towards improving maternal health of refugees in the EU. There is an increasing need for a prompt, coordinated, and effective response for all migrant and refugee pregnant and lactating women with newborn babies. Migrant and refugee women face specific health risks and challenges during perinatal period. … The ORAMMA project will develop, pilot, implement and evaluate by comparative analysis an integrated and cost-effective approach on safe motherhood provision for migrant and refugee women."

Source: ORAMMA, 2019

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This example shows an amalgamation of SDG3 targets captured in sub-goals 3.1 "Reduce maternal mortality" and 3.7 "Universal access to sexual and reproductive health care services"' and SDG5 target "Ensure universal access to sexual and reproductive health and reproductive rights". In addition, it considers inclusiveness and support for minority groups. A recent evaluation highlights that the "training improved midwives' knowledge and self-perceived cultural competence in three European countries with differing contexts and workforce provision", although the actual impact in the provision of care and the long-term effects remain to be seen (Fair et al., 2021; see also Petelos et al., 2019).

The second example takes a global approach and highlights policy pathways and strong co-benefits in the prevention of domestic violence against women. Box 7.2 refers to an international WHO project (Amin, Kismödi & García-Moreno, 2015; WHO, 2002), exploring how health action can enhance change in other areas of gender equality. This project makes the implementation pathways of co-benefits created through health policy action visible (although it does not explicitly refer to a co-benefit approach). It demonstrates the transferability across countries and regions of the world, with a focus on low- and middle-income countries.

Box 7.2 Women's health and domestic violence against women: the WHO multi-country study

"The WHO multi-country study brought together researchers, women's organizations working on violence against women, and policymakers from ten countries to develop policy and action-oriented research to measure the magnitude, risk and protective factors and consequences of violence against women. The study was designed to engage with local women's organizations, build capacity, generate dialogue among the different partners and generate new information that could lead to policy change. The implementation of the study led to an increased awareness about violence against women among researchers as well as among the women interviewed. It led to the inclusion of violence against women in national and educational policy agendas of several Ministries of Health. For example, in Brazil, domestic and sexual violence was incorporated as a new subject in the training programme for family physicians. In Peru violence against women was incorporated into a master's course on reproductive health. And in Thailand the institutions responsible for implementation of the study established networks and

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Box 7.2 (cont.)

became sources of information on the issue. The results of the study also contributed to dialogue with policymakers and the public and to legal and policy discussions. For example, in Thailand the data contributed to discussions on a domestic violence bill, which, based on the study results, included provisions for marital rape that were not considered earlier. In Namibia, the study contributed to discussions on the anti-rape bill. In Maldives, the results were used to launch a campaign to stop violence against women that included participation of the Prime Minister and other dignitaries. In short, the research itself became an intervention with important benefits for driving policy changes in addition to the production of data."

Source: Amin, Kismödi & García-Moreno, 2015:605–606, with reference to WHO, 2002

These two mini cases reflect a scenario of "high salience" and "low conflict" that supports intersectoral governance action and reinforces co-benefits. In both cases, the governance contexts are similar and characterized through a legal mandate, joint funding, strong advocacy and public engagement, among others (Table 7.1). Both projects apply a participatory governance approach, most strongly emphasized by the WHO project. ORAMMA aims to "establish partnerships" between midwives and the pregnant migrant refugee women, while the WHO project highlights engagement with "local women's organizations", "dialogue among the different partners", also including health professionals, policymakers and the public. Strong stakeholder involvement in all stages of the project appears to be an important factor of successful outcomes (Amin, Kismödi & García-Moreno, 2015). Especially, health professionals can be "change agents" and generally play an important role in policy implementation (Gofen & Lotta, 2021). Thus, the creation of co-benefits reflects key characteristics of "good governance" (Greer et al., 2019).

A number of specific conditions apply, however, which may challenge the co-benefits. In particular, sexual and reproductive rights are highly contested, as the attacks on the rights of LGBQT people in Hungary, or the new restriction of abortion rights in Poland, for instance, demonstrate. Both are EU countries and formally accountable to gender equality law and policy, yet national right-wing and populist politics, together

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with cultural and religious belief systems, are more powerful than EU laws. The implementation of intersectoral governance may therefore be more challenging and constrained (UNDP-UN Women, 2020) than a supportive policy scenario and close linkages between SDG3 and SDG5 suggest.

Furthermore, the COVID-19 pandemic has taught us that co-benefits are not a stable outcome (WHO, 2020c), but must be continuously confirmed and rearranged. Health care workers, especially women in the health workforce networks, play an important role as gender equality advocates in these processes, as co-benefits are contested and may easily be blocked by public health emergencies perceived to be more relevant than gender equality. This can be observed during the pandemic in different policy contexts and even in countries with institutional paths of intersectoral governance and established mainstreaming policies (Bojovic, Stanisljevic & Giunti, 2021; Takemoto et al., 2021). The major outcomes of these cases include strengthening awareness of the health needs of women and creating pathways towards intersectoral and participatory governance. Such pathways can also contribute more generally towards compliance to public health measures, trust in governments and institutions, and increased preparedness and resilience.

A policy scenario of high salience and low conflict of SDG5 targets increases the likelihood that available tools are used effectively and governance actions support the creation of co-benefits (Table 7.1).

7.5 Case study 2: health care workers during the COVID-19 pandemic in Brazil and gender (in)equality

The Brazilian case about health care workers during the COVID-19 pandemic is a good illustration of a problematic situation, considering the lack of focus on gender inequalities. During the pandemic and the period of the Bolsonara presidency, gender issues were made invisible and the Brazilian health workforce, mostly composed of women, was exposed to risky conditions.

Brazil is a middle-income country, which was until December 2022 governed by a right-wing populist president who denied the threats of the pandemic and refused to take action to protect the population. Consequently, Brazil is one of the countries with the highest incidence and death rates of COVID-19 globally (Lotta & Kuhlmann, 2021; Lotta et al., 2021; Rocha et al., 2021) and was ranked as the worst-case

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worldwide in facing the pandemic (Lowy Institute, 2021). This was far from expected, as Brazil has one of the world's biggest public health systems and high expertise in dealing with epidemics (WHO, 2020c).

However, the strong populism and lack of public health action have hampered the appropriate protection of health and care workers (HCWs). Four rounds of surveys conducted during 2020 and 2021 show this scenario: in April 2021, around 50% of the HCWs had not yet received personal protective equipment (PPE) during the pandemic; only 27% received training and 15% were tested. Consequently, 70% did not feel prepared to work during the pandemic, 88% feel afraid, and 80% have mental health issues due to the pandemic (Lotta et al., 2021). These numbers remained almost the same during the 14 months of the pandemic, evidencing the lack of government efforts.

These data confirm the widespread disregard for HCWs during the pandemic. However, if we disaggregate the data by gender, we see clear differences. As in other countries, more than 70% of the Brazilian health workforce is composed of women and the effects of the pandemic and the lack of policies surrounding HCWs disproportionately impact women. Data from April 2021 show, for example, that women receive less PPE, less training and fewer tests than men; the differences are even greater when including race issues. Black women are the most affected by the pandemic, while White men have the best conditions among the HCWs. For example, while 43% of White men received training, only 21% of Black women did. One of the consequences of these inequalities is that 58% of the HCWs who died during the pandemic were women (Lotta et al., 2021).

Gender inequalities do not only appear in the field of employment, but also in domestic work. Several researchers indicated that the pandemic overloaded women's work with domestic care. This also happened with HCWs. While 51% of the women said they were working more than 14 hours overtime in domestic work during the pandemic, 39% of men reported the same data.

These findings clearly suggest that the lack of attention towards gender issues surrounding HCWs has a higher and more negative impact on women than on men. However, it is important to place this in a broader discussion of gender issues in the Brazilian government that was in office until December 2022. The Brazilian president Jair Bolsonaro was misogynistic, as evidenced in several sexist and homophobic speeches that he was not ashamed to declare. Recently, an analysis of federal

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policies revealed an explicit misogynistic commonality (Ventura et al., 2021). For example, in April 2021, the health ministry started telling women not to get pregnant during the pandemic, considering the high death rates in Brazil – 80% of all pregnant women killed by COVID-19 worldwide were Brazilian. However, the government did not provide any tools for them to postpone pregnancy (Ventura et al., 2021) and primary health care policies were dismantled (Lotta et al., 2021; see also Kuhlmann et al., 2023). These data show how gender inequalities experienced by HCWs are not exclusive to this professional category. Gender inequalities were structural in this government.

Populism generally opposes gender equality and often attacks minority rights. Within a climate of political attacks and structural ignorance, gender and social inequalities were largely invisible. The Brazilian case evidences this process. This has caused a lack of protection, especially for women and minority groups, and reinforced vulnerabilities in the health workforce. Taking the appropriate action in the health sector would have greatly helped reduce the health risks for female HCWs and those belonging to minority groups, yet the government failed to do so.

The Brazilian case illustrates a scenario of low political salience and subsequently low conflict due to a lack of attention and visibility of inequalities. It also reveals that "salience" is value-based and highly context-dependent. Low political salience and low conflict, as perceived by the elites, strongly contradicts epidemiological conditions and health and societal salience. Consequently, conflict of interests and countervailing powers are embedded in this scenario and might enhance resistance. A climate of populist political attacks combined with an authoritarian government generally hampers intersectoral governance. If action is lacking in both health and gender equality, there is no opportunity for creating co-benefits and using the tools shown in Table 7.1.

However, the strong public health expertise of the Brazilian health care system has established pathways to implement co-benefits, which may be activated to some degree. Especially relevant are established systems of public statistics/research, monitoring and evaluation, as the empirical data confirm. These systems must also improve transparency in sharing data and global health implications, as well as infrastructures to generate them. There are also some formal connections between ministries (even if currently silenced) and most importantly, strong public and stakeholder engagement action might be mobilized if the

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conflicts increase (Lotta et al., 2022). These conditions might provide hypothetical pathways of co-benefits. However, currently the major outcome is a reinforcement of gender inequality through structural ignorance of population health and gender equality. This has left the HCWs without adequate protection, threatening women, most strongly migrant female HCWs, more than the male groups, the "double" and "triple" jeopardy.

7.6 Case study 3: gender equality in the health science system

The science system is a switchboard of health and gender equality. Medicine, in particular, is furnished with public trust and power to define sex, gender and health and its relationships. The science system produces both the elites that populate politics and the evidence to inform policymakers and practitioners. However, science has been deaf to the calls for gender equality and diversity (Ovseiko et al., 2016). The foundation of modern medicine tells a story of exclusion and "othering" of women, sexual minorities and non-White people, and public health and epidemiology have sadly contributed to the legitimization of inequalities (Krieger & Davey Smith, 2004; Kuhlmann, 2009). We consider global developments but explore the pathways with a focus on the EU and its equal opportunity policies. Key legal elements include, for instance, sexual and reproductive health and rights (SDG5.6; for details, see EUPHA Statement on sexual and reproductive health and rights, 2021) and "effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life" (SDG5.5).

Historically the "neutrality" paradigm of science created an invincible bastion, protecting White male elites and the global North against "unpleasant truths" of gender and race assessments and the needs of the global South (Hawkes & Buse, 2013; see also Haraway, 1988). The situation changed when women entered health professions in larger numbers and increased the power of their voice in health research, both as researchers and as users. Here, research into coronary heart disease was one of the milestones, opening new opportunities for gender-sensitive health care and for an emergent field of "gender medicine" (Wenger, 2012). Since the 1990s, large clinical trials show that seemingly gender-neutral diagnosis and treatment of coronary heart disease focus

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on men and threaten the health of women (for an overview, see for example, GENCAD, 2017; Hulley et al., 1998; Wenger, 2012).

> "In 2003, the Agency for Healthcare Research and Quality Report on the Diagnosis and Treatment of CHD in women, a systematic review of relevant research, concluded that most contemporary recommendations for prevention, diagnostic testing, and medical and surgical treatments of CHD in women were extrapolated from studies conducted predominantly in middle-aged men, with resultant fundamental knowledge gaps regarding the biology, clinical manifestations, and optimal management strategies for women … Despite their burden of CVD, women remain underrepresented in clinical trials (27% of patients in mixed-sex 1997–2006 National Institutes of Health trials); even when included, women are disadvantaged by absence of sex-specific analyses." (Wenger, 2012).

More recently, attention to the intersections of gender and the non-White and minority groups has increased. For instance, an Australian study revealed that,

> "[I]ndigenous status was associated with more than twice the risk of long-term mortality during a median of 5 years of follow-up, independent of age, comorbidities, presentation, socioeconomic status, and geographical remoteness … Indigenous patients were younger, more often women." (Dawson, Burchill & O'Brien, 2021).

Like case study 2, this research, too, reveals a "triple jeopardy" of gender and race/ethnicity.

Lessons learned from coronary heart disease research enhanced, for the first time, a chance in clinical guidelines to respond more adequately to women's health needs (GENCAD, 2017). The global nature of medicine helped accelerate and spread gender-sensitive research evidence around the globe, even in countries that lack equal opportunity rights. Next to global transferability, the co-benefits of health action in the field of coronary heart disease spilled over to other areas of health care and policy and even beyond, including those concerned with men's health (Ovseiko et al., 2016). For instance, sex-disaggregated data are now collected and strengthened in many areas of health care (for example, the OECD has significantly increased its data sources), many disciplines have introduced gender-sensitive clinical guidelines and some

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are monitoring and evaluating the implementation. So, health action co-benefits enhanced transformations towards gender equality, although gender and diversity are still not adequately and effectively addressed (Bambra, Albani & Franklin, 2021; Kuhlmann & Annandale, 2015; Morgan et al., 2021) and a gender leadership gap in academic medicine persists (Kuhlmann et al., 2017).

This case study reflects a scenario of middle-to-strong political salience supported by global research and policy frameworks and by legal action in the EU, in particular, equal opportunity laws implemented through the EU Treaties (Council of Europe, 1998; European Commission, 2020) and translated into Member States' law (albeit in different ways). Intersectoral governance pathways were created on different levels and by a range of diverse stakeholders including public, private and advocacy groups (Table 7.1). Key issues include, for instance, the establishment of "gender mainstreaming" as a global strategy (Allotey & Denton, 2020; United Nations, 1999), the implementation of specific EU and national research programmes and new funding models of "gender budgeting" which connected gender equality goals to financial incentives and shared budgets. Participatory governance and stakeholder engagement were strong elements in some areas (such as maternity care), but poorly developed in most areas of science (Ovseiko et al., 2016).

Macro-level and transnational support structures are helpful, but conflicts may persist at meso- and micro-levels of the health care and science systems as well as in the attitudes of people, outflanking equal opportunity laws and hampering co-benefits. This situation can currently be observed in Europe (and in other countries), where the COVID-19 pandemic has heightened the pressures on the health systems and caused a strong backlash in health equity and gender equality (European Parliament, 2021), also exacerbating intersecting social inequalities (Kuhlmann et al., 2023).

Lack of attention to gender equality in health action has an impact on various levels. It hampers the "production" of knowledge: for example, vaccines are not sufficiently tested for pregnant women. Vijayasingham and colleagues (2021) further highlight that:

> "of nearly 2500 COVID-19-related studies, less than 5% of investigators had pre-planned for sex-disaggregated data analysis in their studies, although there are important hints that women and men

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respond differently to vaccines: Previous influenza vaccine research suggests that women can produce the same immunological response to half-dose vaccine as men do to full dose." (Vijayasingham et al., 2021)

Missing gender sensitivity also affects the "'knowledge producers" themselves, the health professionals: the pandemic threatens the entire health workforce but female HCWs most strongly, as mentioned previously (Shamseer et al., 2021; see also, ILO, 2020) and addressed in more detail by the Brazilian case study.

In case study 3, major outcomes are legally defined gender equality frameworks and changing knowledge systems that support health action co-benefits, such as the implementation of gender-sensitive clinical guidelines. However, elites still dominate knowledge production, while women and minority groups are less well represented, thus facing higher conflicts especially during major public health emergencies like the COVID-19 pandemic.

The examples highlight that governance actions for gender equality must consider both institutions/structures and processes, including the production of data and scientific evidence. This makes the possibilities for creating co-benefits highly context-dependent, shaped to a large degree by stakeholder interests and established coordination across sectors and levels. Governance actions may integrate a wide range of available tools (Table 7.1), but they may also be constrained by policy contexts that ignore the goals of SDG5. The latter scenario is currently demonstrated by the COVID-19 pandemic policies.

7.7 Conclusions

The range of different scenarios (Table 7.2) displayed within this chapter highlight the importance of policy contexts. Our collection of cases provides further information as to *how* context shapes intersectoral governance and the implementation processes of co-benefits. Health policy interventions may create co-benefits especially if flanked by comprehensive intersectoral governance and institutional paths that connect action not only between sectors, but also across the levels and the substance of governance (for example, law and policy, health professional groups, micro-level cultural attitudes) (Fig. 7.1). Strong and diverse stakeholder involvement on all levels of governance appears to be a key condition for achieving positive outcomes. Scenarios 1 and 3

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Table 7.2 *The context of policy and implementation of health and gender co-benefits*

EU, migrant maternity care		Conflict	
		Low	High
Political importance	High	X	
	Low		

Brazil, health care workers		Conflict	
		Low	High
Political importance	High		(public health) X
	Low	(politics) X	

EU, gender and science		Conflict	
		Low	High
Political importance	High	X (those in power)	X (women, minority groups)
	Low		

Source: authors' own table, adapted from Page (2005).

explore the pathways between health and gender equality co-benefits mainly through positive examples (benefits) and scenario 2 does so through negative examples (jeopardy). However, all scenarios reveal that established pathways may collapse under pressure, making co-benefits a volatile outcome and a contested policy terrain, as demonstrated most recently by the COVID-19 pandemic (Kuhlmann et al., 2023; Lotta et al., 2021).

The COVID-19 pandemic and the "coronavirus politics" (Greer et al., 2021) have added a new chapter to the health and gender co-benefits. The *Pan-European Commission on Health and Sustainable Development* (2021) is just one of many examples demonstrating how gender equality was "'forgotten" during a major public health crisis (for example, see, for the WHO, Tomsick, Smith & Wenham, 2022). A backlash in gender equality during the COVID-19 pandemic is increasingly documented (Kuhlmann et al., 2023; Lotta et al., 2021; Wenham et al., 2020). As a report by the European Commission shows, the pandemic was "markedly slowing the reported average progress"

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and 2020 data showed "a clear deterioration for individual indicators" (European Commission, 2021b).

Bringing a gender lens to the debate over SDG co-benefits raises more general questions about universalist policy concepts, which assume "neutrality" and do not adequately respond to policy contexts and the diverse needs and interests of the actors. There is a need for fresh approaches to the SDGs that pay more attention to gender equality and intersectionality, and that better capture and address the importance of participatory governance. The "unfinished journey to universal health care" (Rajan, Richiardi & McKee, 2020) would greatly benefit from a gender-sensitive lens and mainstreaming approach, while co-benefits provide an important policy tool to speed up this journey.

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