Gender-sensitive health services

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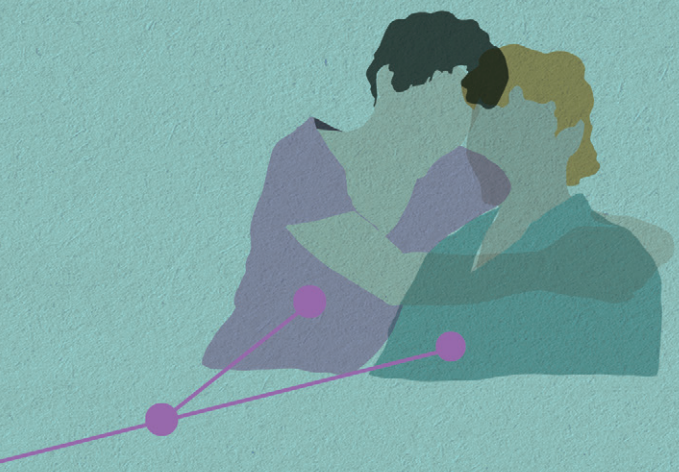

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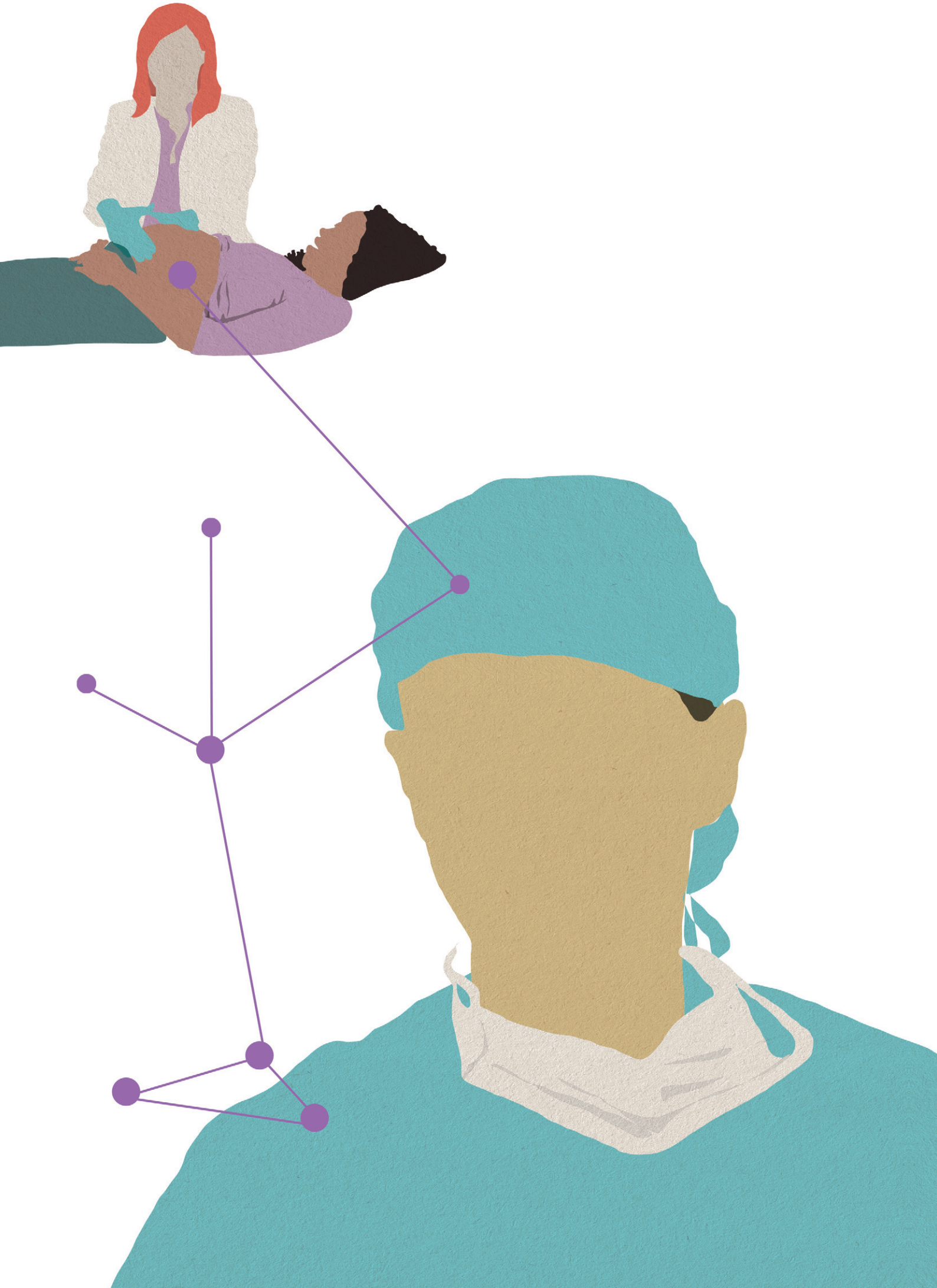


1. Introduction: Why do we need to look at gender and healthcare services?

This report draws on the work done by the European Federation of Public Service Unions (EPSU) and its affiliates on gender and health. More specifically, it aims at responding to the need for gender-sensitive health services. Healthcare services do not always adequately meet women's health needs in relation to, for example, **reproductive and sexual health, violence against women**, **endometriosis, chronic pain, vulvodynia or eating disorders**, which affect more women than men, as well as **women's mental health, menstruation, amenorrhea and menopause**. This report identifies intersecting power imbalances based on gender, class and racial divisions as major barriers to health service planning and provision and it provides policy recommendations. It aims to be a political tool in the hands of trade unions, and civil society towards the advancement of gender equality and high-quality healthcare for all, regardless of legal and economic status.

This introduction outlines the **rationale** behind the report, the context of the COVID-19 pandemic and the structure of the report. The following six sections explore different aspects of the relation between gender and health services: section two delves into gender biases in the sciences and in particular in medicine; section three spells out what a gender-sensitive approach to health services entails; section four describes gender health needs across the life cycle; section five looks at the importance of education in combating gender inequality and identifies trade unions as focal actors in educating young people and adults; section six deals with the most significant barriers to accessing universal high quality health services including under-resourcing and privatisation; section seven goes into the structural understaffing and the need for appropriate training for health workers. Finally, in the conclusions, the most important findings of the report are synthetised.

EPSU represents eight million public services workers across Europe. The majority of them are women, specifically in social and health services. As a union striving for equality, EPSU puts gender equality at the centre of its work across different sectors and through a variety of actions which range from research projects, such as the 2021 report on the gender pay gap[1],

[1] https://www.epsu.org/sites/default/files/article/files/GPGreport.pdf

to international campaigns to end violence against women[2]. This report follows a decision by the EPSU Women's and Gender Equality Committee (WGEC) to explore what gender-sensitive healthcare services are, why they are important and what should be done in order to deliver them. It builds on EPSU's earlier work concerning gender equality and health, and it draws on academic literature and international policy papers. The report relies on qualitative research, including a discussion with the EPSU Gender Committee, 13 interviews and 1 focus group.

The rationale behind the report is consistent with **EPSU's work in addressing power imbalances based on gender and in contributing to the improvement of health for all**.

In fact, high quality health services are essential to achieve better health outcomes for all, identified by the UN 2030 agenda for sustainable development, goal 3, as essential to build prosperous societies[3]. Moreover, health services may play a significant role in either reinforcing or defying discrimination and inequality whether it is based on gender, class, race, migrant status or on a combination of intersecting inequalities. This is why addressing new and old shortcomings in health services is so central for the broader struggle for transformation towards social justice. Gender-responsive public services could enable us to tackle not only the consequences but also the systemic causes of inequality – the uneven power imbalances at play in society[4].

Gender is widely recognised as an important determinant of health. Gender roles, norms and behaviour have an influence on how women, men, girls and boys access health services and how health services address their different needs. The World Health Organization (WHO) recognises that gender is an important determinant of health in two dimensions: 1) gender inequality leads to health risks for women and girls globally; and 2) addressing gender norms and roles leads to a better understanding of how the unbalanced power relations between men and women affect health outcomes of men and women in different age and social groups[5]. According to the 2018 World Economic Forum *Global Gender Gap Report*, no member state in the WHO European Region has achieved gender equality. Iceland, the best performer in 2018, still exhibited a gap of more than 33% between men and women. By contrast, the poorest performing country in the region, Hungary, exhibited a gap of 95.5%, with no women in ministerial positions. Due to widespread sexism and to the historical gender bias characterising medicine, health service provision is unequal. A report of the European Commission[6] points to the fact that the average across the 28 EU Member States is 3.2 % of

[2] https://www.epsu.org/article/our-non-gender-equal-world-covid19-hits-women-harder-international-day-elimination-violence

[3] United Nations General Assembly, 2015, *Transforming our World: the 2030 Agenda for Sustainable Development*. New York: UN Publishing

[4] "From gender-responsive to gender-transformative public services", GI-ESCR Brief on Women and Public Services, 8 March 2021 https://www.gi-escr.org/publications/from-gender-responsive-to-gender-transformative-public-services-gi-escr-brief-on-women-and-public-services

[5] World Health Organization (2010) *Gender, women and primary health care renewal: a discussion paper*. Geneva: World Health Organization.

[6] European Commission, DG for Justice and Consumers, Franklin, P., Bambra, C., Albani, V., 2021, *Gender equality and health in the EU*, Publications Office, https://data.europa.eu/doi/10.2838/956001

women and 2.1 % of men reporting unmet medical examination need which corresponds to a gender gap of 1.1 percentage points.

In 2020 EPSU's WGEC has conducted an internal survey on women's health[7]; the survey identified cuts to health services that were implemented in previous years as a response to the economic crisis. Cuts have often affected women's health through an impoverishment of sexual and reproductive health services. Amongst the reasons for poorer services, EPSU's affiliates have pointed to understaffing, long waiting lists and closing down of family clinics. Beyond reproductive health, the survey points to the need to strengthen services for breast cancer prevention and to work towards a gender-sensitive approach to occupational health and safety (including issues of menstruation and menopause in the workplace). Other major issues that exacerbate gender and health inequality identified by a WHO-Europe study are gender-based violence (around 25% of women in the WHO European Region will experience violence on the basis of gender at one point in their lives, ranging from 23.2% to 25.4% in the region)[8]and the overarching gender imbalance in paid and unpaid care work.

The impact of COVID-19 on gender and health

The situation of women's health and access to health services before COVID-19 was far from rosy. Nevertheless, the pandemic has brought to the surface systemic, intersecting crises that have been brewing for decades and which affect people's health and gender equity; ultimately the pandemic has made the need for gender-responsive health services more urgent than ever from the point of view of both health workers and patients.

More specifically, the pandemic has shed light, firstly, on the crisis of social reproduction[9]; secondly, on the crisis of inequality at a global and local level; and, thirdly, on the importance of public response.

The pandemic, which exploded as a health crisis, soon transformed also into a **crisis of social reproduction**. In fact, where the economy has been forced to slow down, reproduction work has intensified dramatically and it has proved necessary to the functioning of the economy and of society. Historically, reproduction work has been borne primarily by women, and specifically women of colour and migrant women, both within families and in those occupations where social reproduction and regeneration takes place such as nursing, cleaning or teaching.

[7] EPSU's WGEC, 2020, *Report: EPSU's Snapshot Survey on Women's Health 2019/2020, internal survey.* Unpublished.
[8] World Health Organization, 2021, Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women: executive summary
[9] Mezzadri, A., 2020, *A crisis like no other: Social reproduction and the regeneration of capitalist life during the COVID-19 pandemic. Developing Economics*. Available at: https://developingeconomics.org/2020/04/20/a-crisis-like-no-other-social-reproduction-and-the-regeneration-of-capitalist-life-during-the-COVID-19-pandemic/

The over-representation of women in social reproduction work has **negative consequences on women's health and well-being.** In recent times, women have been drawn *en masse* into the labour market while austerity programs have entailed cuts in social spending and public services. Due to the unequal burden of reproduction work[10], women have been further marginalised inside the labour market during the pandemic, as is shown by jobs losses disproportionally affecting women across the globe. Social reproduction work is the foundation of our societies as it spans from healthcare services to nurturing and feeding children, caring for elders, and everything that is needed for life to go on[11]. Yet it is mostly **concealed work** that the pandemic shed a light on. According to a study by Eurofound on work during COVID-19, women within the European Union were spending an average of 62 hours per week caring for children and 23 hours per week on housework, compared to 36 hours and 15 hours for men.[12] The crisis of reproduction has laid bare the unequal distribution of care labour in families and in society; this is visible in the amount of time women spend in unpaid care work as well as in the over-representation of women in under-valued jobs which entail care, including in the health and social care sector.

A gender-sensitive approach to health must start from the recognition of the social and economic value of care work, both paid and unpaid, its unequal distribution between gender identities and along racial and economic cleavages, and of the right to healthcare for all[13].

Secondly, with the pandemic, the crisis of global and in-country inequality has become ever more apparent. Although anybody can potentially get infected with COVID-19, the virus affects us differently based on our gender and our race and class positions, due to deep **intersecting structural inequalities**. According to the 2022 Oxfam report on inequality, the wealth of the 10 richest men of the world has doubled while the income of 99% of humanity has decreased, because of the pandemic[14]. Data from the United Nations Human Rights Agency show that one in five people in the EU population, 92.4 million people, were at risk of poverty in 2019. Women experience higher poverty rates than men. The pandemic has impacted most severely the poorest and most vulnerable, thus inflating poverty numbers and the inequality gap[15].

Inequality is a major determinant of disease patterns and access to healthcare services. During the pandemic this became evident because, for instance, remote work is only possible for certain categories of the workforce while others have to go to work, catch crowded public transport, and risk their lives to ensure essential services. When it comes to lockdowns,

[10] UN Women, 2020, UN Women surveys reveal that women are bearing the brunt of the COVID-19 pandemic.
[11] Jaffe, S (2020) *Social reproduction and the pandemic, with Tithi Bhattacharya.* Dissent Magazine, 2 April. Available at: www.dissentmagazine.org/online_articles/social-reproduction-and-the-pandemic-with-tithi-bhattacharya
[12] Eurofound (2020) *Living, working and COVID-19*, COVID-19 series, Publications Office of the European Union, Luxembourg.
[13] PSI, 2021, The social organisation of care: A global snapshot of the main challenges and potential alternatives for a feminist trade union agenda.
[14] Ahmed, N., 2022, *Inequality kills. The unparalleled action needed to combat unprecedented inequality in the wake of covid19*, Oxford: Oxfam GB. Available at: https://policy-practice.oxfam.org/resources/inequality-kills-the-unparalleled-action-needed-to-combat-unprecedented-inequal-621341/
[15] The Lancet Regional Health Europe, June 2021, *Addressing Poverty Post COVID-19 Pandemic* Vol 5 https://www.sciencedirect.com/science/article/pii/S2666776221001332?via%3Dihub

inequality affects our experiences: women find themselves confined with abusers, with dramatic consequences on the levels of patriarchal violence. Providing gender-sensitive health services means acknowledging and addressing intersectional inequalities. For example, certain population groups might encounter specific barriers (lack of resources or discrimination) which have to be overcome. At the same time, different population groups may have different needs, and therefore health services should be tailored to specific needs. In this sense, health services, together with other social services, may represent a means to transform social relations towards equality.

Finally, the pandemic has unveiled the importance of **public goods**, as related to the right to care, to be cared for and to the principle that the State has to be responsible for attaining this right. Only public provision of care and health services can guarantee gender-sensitive policies and services as well as a more balanced distribution of care work between men and women. On the contrary, the privatisation and commodification of care and health services are associated with unequal access to healthcare and increased unpaid care work performed by women. The risk of care being treated as a financial asset has emerged in dramatic ways during the pandemic, including in relation to the production and distribution of COVID-19 vaccines[16]. European trade unions could play a significant role in building collective action for healthcare advocacy and for lobbying public authorities to put health before profit – the interest of society before the interest of corporations. Health care provision should be removed from the domain of the market and placed in the sphere of human rights.

Governments must be obliged to develop coordinated and multisectoral responses, and trade unions could be leading these demands. Different public services (such as education, health, water and social security) must have coordinated and integrated agendas to simultaneously tackle different dimensions of health provision. The different aspects of reproduction of workers or social costs of production (nurturing children, feeding workers and their families, caring for elders, commuting to and from work) and the various forms reproduction may take (collective, commodified, unpaid) depend on **civil society and trade unions' advocacy and campaigning**[17].

Public health is about universal access to high quality health care as a human right. Public health neither starts nor ends in hospitals but is also about the way people live, work and age. Gender, race and class inequalities underlie patterns of diseases. What the pandemic has shown us is that a broader vision of health services is necessary today to overcome longstanding crises that predate the pandemic. In order to be effective and fully inclusive, **healthcare services have to be universal, high quality and gender-sensitive**.

[16] See EPSU's statement on the TRIPS waiver: https://www.epsu.org/article/eu-s-commitment-urgently-needed-vaccine-scale-and-trips-waiver

[17] O'Laughlin, B., 2017, Capital, labour and the politics of inequality in global public health. *Global Labour Column*. https://global-labour-university.org/fileadmin/GLU_Column/papers/no_268_Laughlin.pdf

2. Gender neutral health services in a sexist world?

Globally, gender inequality drives differentials in mortality and morbidity. Gender health risks are associated with discriminatory values, norms, beliefs, and practices; differential exposures to disease, disability, and injuries; biases in health services; and biases in health research[18]. Gender discrimination at any of these levels reinforces discrimination at other levels. For example, gender-based violence against women and LGBTQIA+ people is influenced by sexist gender norms, sexist language and broader systems of oppression[19]. This section discusses gender bias in the sciences generally and within medicine. It argues that **gender services are not neutral when their planning and the sciences underpinning them reflect gender biases that are dominant in society.** Acknowledging that health services are delivered mostly by women and led by men is pivotal to recognise and tackle the social division of labour when planning gender-sensitive health services.

Overlooked in science and research

Historically, women have been overlooked in sciences and knowledge production. Feminist authors have studied how gender prejudices and gender inequality have marginalised women's contributions and excluded women from professions. Moreover, the consequent male domination has informed the study of women's bodies, experiences and lives, giving rise to incoherent and slow data gathering and knowledge production on topics relevant to women[20]. As a result, the sciences have served women inadequately, both as agents of research and as subjects of scientific investigation.

Medical sexism

Medicine is not an exception amongst the sciences. Consequently, it is not surprising that health services do not fully meet women needs when the science underpinning their planning

[18] Shannon, G. Jansen, M. Williams, Cáceres,C. Motta, A. Odhiambo, A. Eleveld, A. Mannell J. (2019) Gender equality in science, medicine, and global health: where are we at and why does it matter? *The Lancet* Vol 393 Issue 10171

[19] Sen, G and Ostlin, P., 2007, *Unequal, unfair, ineffective and inefficient gender inequity in health: why it exists and how we can change it.* Final report of the Women and Gender Equity Knowledge Network (WGEKN), World Health Organization, Geneva

[20] Crasnow, S., "Feminist perspectives on Sciences", *The Stanford Encyclopedia of Philosophy* (Winter 2020 Edition), Edward N. Zalta (ed.), <https://plato.stanford.edu/archives/win2020/entries/feminist-science/>

reflects a male perspective. The history of medicine is in every way social and cultural as much as it is scientific; it has absorbed and enforced socially constructed gender divisions and ascribed power and dominance to men[21]. Patriarchy has influenced medicine since the work of ancient Greek physicians who laid the foundations of modern Western medicine; the male body was seen as *the* body to be studied and treated when necessary, while the female body was seen as different, inherently weak and overall medically faulty. What defined the female body was the uterus and women's ability to bear children. Consequently, women's functions and illnesses were often related back to their reproductive organs, which in turn defined women's inferior nature compared to the male being. Therefore, since its onset, Western medicine has conflated biological sex with gender identity.

In the twentieth century, modern medicine has progressively become evidence-based and many medical assumptions about women's bodies and health have been proved wrong. Nevertheless, the former stereotypes proved hard to eradicate, and today sexist biases continue to impact the care, treatment and diagnosis of all people who identify as women. Biases and discrimination start in the early stages of research on animals, which does not consider sex differences, and continue in clinical trials where not enough women are included. Men continue to be overrepresented in leadership positions in research teams. As a result, research continues to reinforce a male point of view while healthcare services continue failing women in treating their illnesses and pain, especially chronic pain. Illnesses such as **endometriosis, vulvodynia or eating disorders**, which affect more women than men, do not receive enough attention, and this also happens with **women's mental health, menstruation and menopause**.

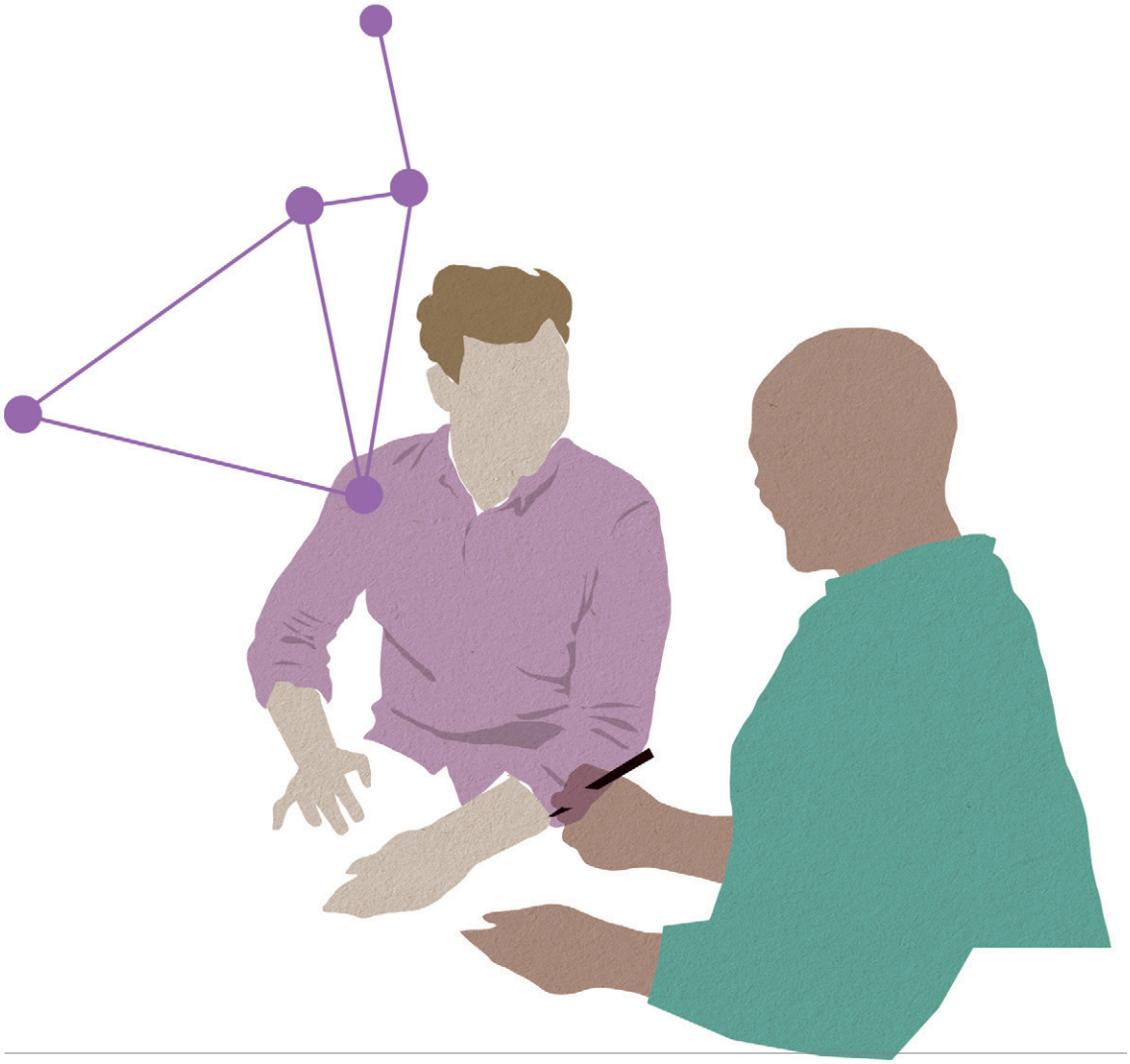
At the same time, women are expected to carry the medical burdens associated with birth control such as **hormonal contraception, intrauterine devices (IUDs)** or sterilisation, and to invest in the prevention of sexually transmitted diseases – for example by getting a Human Papillomavirus (HPV) vaccination – even though there is no medical justification not to share these tasks with men. Since the 1960s, when the first contraceptive pills became available, women have to deal with unwanted effects such as irregular bleeding, bloating and headaches. The risk associated with contraceptives can be serious, and may include high blood pressure, blood clots and stroke. Research has also found a link between the pill and an increased risk of depression, as well as decreased sexual desire and libido. These problems land on women's shoulders because research on male contraceptives lag behind. There is no scientific reason for this delay – it is simply a cultural sexist bias.

As put by Silvia Espinosa Lopez, the LGBTQ officer for the FSS health and social services federation of CCOO in Spain: "Women have a different biology, and also different social circumstances that condition our health, taking them into account in medical treatment and in research needs a gender perspective, to equalize health. At present, much remains to be done, since only a third of the research results are processed taking sex and gender into account. As a result, women and our health circumstances continue to be invisible. In universities there is still no compulsory or core syllabus in Spain that includes sections corresponding to women's health beyond reproductive health, despite the fact that at this point there is already plenty

[21] Cleghorn, E., 2021, *Unwell Women. A Journey Through Medicine and Myth in a Men-Made World*. Orion Publishing Group

of scientific evidence regarding different manifestations and diagnosis of pathologies or pharmacological effectiveness"[22].

To conclude, gender-sensitive health services should acknowledge the history of medical discrimination against women and aim to redress it. Medical research considering women, led by women and looking at women's bodies and health should be sought in order to plan and provide healthcare services that effectively respond to women needs. At the same time, research and services should aim to shift burdens between genders in relation to medical responsibility, for example in relation to birth control or sexually transmitted diseases.



[22] Espinosa Lopez, S. Women and LGBTQ Policy Officer Federación de Sanidad y Sectores Sociosanitarios de CCOO. 08/10/2021 Interview.

3. A gender sensitive approach to health services

A gender sensitive approach to health services entails: tackling the roots of gender inequality in relation to health in relation to the gender division of labour, acknowledging unpaid care work performed by women and LGBTQIA+ people within the household, sharing the burden of care in the household and in society, including fighting gender professional segregation, rewarding healthcare workers fairly.

Hence, as pointed by social scientists investigating the roots of gender power imbalances[23], the worlds of social reproduction have to come out of concealment. Reproduction work has to be integrated into trade union demands, where trade unions have a major role to play in advancing gender equality and strengthening health provision. Razvan Gae, vice-president of the health trade union federation SANITAS in Romania, made an important point about the link between gender discrimination in the healthcare sector and the lack of gender equality within trade unions; his point refers to the situation in Romania but it reflects the reality of many other countries: "In the healthcare sector there is a very high prevalence of women working as nurses, assistants and hospital administrators. High positions are occupied by men, there is seldom any woman doctor or hospital manager. Women at work suffer from bullying and sexual harassment but are often scared to report it. Trade unionists are mostly male, hence in the last Congress we established a Women's Department specifically to address the problem of women representation in the union and encourage women to take up leadership positions"[24].

At the global level, the *Care Manifesto*[25], promoted, amongst others, by the global union federation Public Services International (PSI), is gaining momentum; it is organised around the importance of care work, including health care, and the five Rs:

- Recognise the economic and social value of care work and the right to care.
- Reward and fairly remunerate care work.

[23] Federici, S., 2019, *Social Reproduction Theory. History, issues and present challenges*. Radical Philosophy, Issue 2.4 Available at: https://www.radicalphilosophy.com/article/social-reproduction-theory-2

[24] Gae, R. Sanitas, Vice-President, 05/10/2021, Interview.

[25] https://peopleoverprof.it/campaigns/care-manifesto-rebuilding-the-social-organisation-of-care?id=11655&lang=en

- Reduce the burden of unpaid care work on women.
- Redistribute tasks within families and between communities and the state, to tackle the division of labour.
- Reclaim the public nature of healthcare services.

The first R identified by the global Care Manifesto means **recognise** reproduction work, including its social and economic value and the right to high quality care for all. Reproduction work was discussed from a theoretical perspective in the previous sections as understanding it is the first and the most essential step to be taken in the struggle towards gender-sensitive health services. From a **policy** perspective there are several points to be developed at the national or European level. In particular:

- Conduct research on time use by women and men with specific attention to care work;
- Carry out studies on the economic value of care work, both paid and unpaid, and its contribution to economic output (GDP);
- Raise awareness on the link between women's care work and health outcomes as well as on the link between cuts to public care services and the increase in women's unpaid care work (see section 5 on education);
- Fairly value the professions related to healthcare provision (see section 7).

In relation to women's rights' protection at the point of provision of health services, human rights bodies and experts have established three broad criteria:

▶ **Non-discrimination and equality.** Health services should be accessible to all women in their full diversity. Specific groups of women who tend to be especially stigmatised and marginalised should be guaranteed access without discrimination. Specific groups may include, but are not limited to, migrant women, women with disabilities, women of colour, women and LGBTQIA+ people.

▶ **Safe, non-violent environment.** Prejudices and dominant attitudes that perceive women as subordinate to men allow widespread symbolic and physical violence, harassment or abuse, which is often reproduced in public spaces, including in health facilities or while women are traveling to or returning from these facilities. Security and safety must be guaranteed in healthcare facilities and when health workers commute. States need to adopt laws and policies specifically tailored for redress in cases of gender-based violence, including in workplaces, and invest in quality public infrastructure and adequate training for public sector workers to avoid any form of violence on the basis of gender. Trade unions can lead campaigns in relation to workplaces and public facilities free from gender-based violence. Education on symbolic and physical violence is advised.

▶ **Responsive to women's specific needs.** Health needs have to be tailored with consideration for sex and gender-specific needs in order to remove barriers that restrict access to health and

to deliver services that are appropriate to women in all their diversity and to where they are in their life cycles (see section 4). For instance, as will be explored in the next section, a person may require specialised health services owing to their reproductive capacities, particularly in the areas of family planning, pregnancy, gender-affirming treatments, and before and after giving birth.

The level of ambition of public services, including health, must be raised to actively address power imbalances and discrimination if we aim to advance towards gender equal societies: this is a gender-sensitive approach to health services.

4. Gender health needs across the life cycle

As argued in section 2, medical sexism continues to characterise health, from the research stage to the planning, budgeting and delivery of services. As a result, women's needs are not always met, especially in relation to sexual reproductive health and rights (SRHR), obstetric violence, gender-based violence and issues related to menstruation, dysmenorrhea and menopause, but also chronic pain, endometriosis, vulvodynia and eating disorders, which affect more women than men, as well as women's mental health. Research on women's unmet health needs is currently ongoing and further investigation is necessary in order to overcome the biases that have historically affected medicine and health services. Therefore, the list of women's health needs provided in this report should be not considered exhaustive. Moreover, each and every health need that is overlooked or not sufficiently addressed in health services deserves in-depth investigation, which is beyond the scope of this report. What is offered here is a snapshot of certain relevant women's health issues which do not receive enough attention in health services and which could be identified by civil society and trade unions as possible avenues for political action to advance gender equality in health.

Sexual reproductive health and rights

The European Union considers women's rights as human rights, and on 24 June 2021, the European Parliament voted in favour of a comprehensive report on "the situation of sexual and reproductive health and rights in the EU". The report, known as the Matic Report, points to widespread attacks on the full realisation of women's rights, gender equality and sexual reproductive health and rights (SRHR) across Europe. The report highlights the importance of access to all essential sexual reproductive health services (including comprehensive sexuality education, contraception, abortion, maternal health and fertility services) and of preventing and addressing sexual and gender-based violence.

The Matic report comes at a time when SRHR are in peril globally and in Europe. In October 2020, Poland's Constitutional Tribunal ruled that abortion procedures should be illegal even in cases involving severe and irreversible foetal defects, basically putting a ban on abortion and putting the lives of women at risk. As pointed out by EPSU[26], in certain countries or regions the

[26] https://www.epsu.org/sites/default/files/article/files/Statement%20Safe%20Abortion%20Day%202020.pdf

pandemic has been used as an excuse to regress to outdated patriarchal social structures and discriminate against women, LGBTQAI+ and migrants, for instance, in relation to abortions.

A 2018 study on SRHR in Europe[27] examined six member states (Croatia, Czech Republic, Italy, Poland, Portugal and Sweden) in detail, with respect to their legislation and practices relating to the protection of SRHR and the provision of related goods and services. The study pointed to major inequities throughout Europe in relation to access to reproductive services as an example, only Portugal and Croatia, out of the six, directly recognise a general right to sexual and reproductive health. In 22 countries within the EU, barriers are posed by religious factors which underpin practitioners' exercise of conscientious objection. According to the European Convention on Human Rights, conscientious objection is not an absolute right and it cannot overrule women's access to the health services they are entitled to. The Italian trade union CGIL is supporting a local government initiative in the Region of Lazio, to promote employment policies favouring gynaecologists who are not "conscientious objectors" to abortion.

In certain European countries, for instance in Italy, SRHR have been threatened by the dismantling of local family centres where multiple services used to be provided, including counselling, sexuality education, prevention of sexually transmitted diseases, contraception and abortion and pregnancy and maternity related services, as well as support for victims of violence. The role of these centres is essential, specifically for women and girls. Defunding them and leaving them understaffed are often techniques to mask anti-choice politics and attacks on women's control over their bodies. As put by Lara Verbigrazia from the FP-CGIL public service federation: "One of our main concerns at the moment relates to the family clinics (Consultorio familiare) which, on paper offer a variety of services spanning from youth helpdesk, pregnancy support, abortions, contraception, gynaecologist, paediatrician, vaccinations. The reality is that in the past two decades the number of these clinics has been decreasing and the services offered have been shrinking dramatically. As FP, we launched a campaign to demand the strengthening of family clinics; additionally, in October 2021, we have formally requested the Government to pay special attention to primary health institutions"[28].

Recommendations:

- Redistribute: demand policies that extend and strengthen paid maternity, paternity and parental leave, in order to guarantee a work-life balance for both women and men.
- Develop campaigns that encourage male parents to exercise their right to parental leave.
- Raise awareness about the essential services provided by primary health facilities in relation to SRHR and campaign for the state to support their expansion through targeted employment policies and gender-sensitive investment.

[27] https://eurogender.eige.europa.eu/system/files/post-files/eige_icf_sexual-and-reproductive-health-rights.pdf
[28] Verbigrazia, L. Funzione Publica CGIL (Italy), National Women's Officer, 19/05/2021, Interview.

- Campaign against barriers to abortion including administrative and language barriers for nationals and migrants. Demand access to medical abortion (through medically prescribed drugs as opposed to surgery).

- Protect the right to self-determination. No human being should be forced into any form of birth control or sterilisation or unwanted medical procedure in relation to their gender.

Violence and discrimination against women and LGBTQIA+

According to the United Nations Women agency, globally, 30% of women aged 15 or more have been subjected to intimate-partner violence, non-partner sexual violence or both at least once in their lifetime. The COVID-19 pandemic has increased the risk factor for violence dramatically, owing to restricted movement, social isolation, and economic insecurity. Although only 40% of women who experience violence seek help, the calls to helplines have increased five-fold during the pandemic.

Commenting about violence against women and LGBTQIA+ people in Turkey, and the country's withdrawal from the Istanbul Convention announced in March 2021, Can Kaya argued: "Since 2008 President Erdogan's discourse in relation to women and LGBTQIA+ people has started to change towards the conservation of traditional values; this year (2021) Turkey withdrew from the Istanbul Convention. There has been a steady cultural change taking place in the past decade. Men perpetrating or considering perpetrating violence, started feeling that they would not be punished by law or socially judged. Violence and rape have increased dramatically in the past 10 years and human rights organisations calculate that during the pandemic there might have been a 30% rise in domestic violence. Another thing that receives little attention is violence against children as well as child marriage, which are also on the rise"[29].

Public health services, in articulation with social services, can play a major role in addressing violence against women; actions could range from education and prevention programmes addressing boys and men to a variety of services for women. The latter should include first line support (help lines, empathic counselling, referrals), safety planning, shelters for victims of violence, and social and economic reintegration.

Violence and harassment may take place in the world of work and women are disproportionately affected. In 2019 the ILO established new global standards to ensure workplaces are safe from violence. In June 2019, the International Labour Conference of the ILO adopted Convention N190 (C190) and Recommendation N206. Governments that ratify C190 will be required to adopt the laws and policy measures necessary to prevent and address violence and harassment in the world of work. Trade unions may lead awareness-raising campaigns on issues of violence in the

[29] Kaya, C. Disk (Turkey) Union Officer, 12/10/2021, Interview.

workplaces and build alliances with civil society organisations for advocating the ratification of ILO Convention 190.

LGBTQIA+ people continue to face violence, exclusion and discrimination on a daily basis, because of their sexual orientation and gender identity or sex characteristics.

Narrow parameters for the definition of sex have public health consequences for the transgender population and individuals born with differences in sexual differentiation, also known as intersex traits[30]. According to the LGBTQIA+ equality organisation, ILGA-Europe, LGBTQIA+ people often experience discrimination when accessing health settings and may be discouraged from seeking medical help due to the barriers they expect to find. Discrimination includes inappropriate curiosity; exclusion of the patient's same-sex partner from medical information or refusing them visitation rights; discrimination against lesbian and bisexual women during fertility treatments and pregnancies; and double stigma when HIV-positive. Additionally, transgender and intersex people may experience what is called pathologisation of their identity, and in extreme cases they may face forced sterilisation. Pathologisation may entail psychiatric "conversion therapy" and hormonal or surgical procedures to "treat" their sexual orientation.

A gender-sensitive healthcare service should cater for everyone without discrimination. It should recognise the individual's right to access health services they need. Moreover, it should create a space where everybody feels respected, safe and empowered.

The right to health for gender-variant children should be fully respected while no treatment (surgeries, sterilisation, hormones) should be made compulsory by law. Free, full and informed consent and patient-centred care should be the core principles of healthcare provided to intersex people. Research should be conducted on the impact of medical treatments on the health of trans and intersex people. Finally, treatments that are deemed necessary by trans and intersex patients should be, as much as possible, accessible, affordable and included in the national basket of benefits[31].

Recommendations

- Raise awareness on the reality and the brutality of violence against women and LGBTQIA+ people.
- Build alliances with civil society organisations, especially women's rights groups for the ratification of ILO Convention 190 and for each state to adopt the necessary measures to prevent violence at work.
- Demand governments to invest in addressing violence as a public health issue, from

[30] American Medical Association (2018) New policies: https://www.ama-assn.org/press-center/press-releases/ama-adopts-new-policies-2018-interim-meeting

[31] ILGA-Europe, "Key demands for ensuring the enjoyment of the right to health and access to health without discrimination" https://www.ilga-europe.org/sites/default/files/Attachments/key_demands_health.pdf

the planning of services, recruitment of health and social workers, opening helplines and shelters and providing accompanying programmes for women's socio-economic re-integration.

- Raise awareness on the dangers of "conversion therapies" for transgender and intersex people, including children.

- Support the right to sex and gender self-determination.

Menstruation and menopause

Women's health needs are diverse and linked to where they are in their life cycles. Although menstruation has, historically, been under-researched, there is growing recognition of the importance of tackling the health issues related to menstruation in achieving gender equality, because the vast majority of women, as well as some trans men, experience menstruation for a large part of their adolescence and maturity, up to the time when menopause kicks in (or hormones or surgery in the case of some trans men). Menstrual health has been defined as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, in relation to the menstrual cycle"[32]. While or before they menstruate, women and some transgender men can experience pain, headaches, fatigue and other disorders.

Gender inequality, socio-economic conditions and traditional norms can turn menstruation into a time of deprivation and stigma, which can affect fundamental human rights. This is true for women and girls as well as for transgender men and nonbinary persons who menstruate. Menstruation is a taboo and many girls find out about it only during puberty when they experience the first menstruation. Education of young girls and boys is needed to strengthen their knowledge about and preparation for menstruation (see section 5).

During menstruation people need:

- safe access to clean material to absorb or collect menstrual blood, and these items must be acceptable to the individuals who need them and affordable;

- safe access to sanitation facilities to change these materials in privacy and to wash with soap and water if they want to;

- basic education about the menstrual cycle and how to manage menstruation without discomfort or fear.

Menopause may also determine health conditions that need specific attention both by health services and in workplaces. As explained by Josie Irwin, national women's officer at the Unison public services union in the UK: "Women's health should come to the fore, especially in work

[32] Hennegan, J., Winkler, I.T., Bobel, C., Keiser, D., Hampton, J., Larsson, G. (2021) Menstrual health: a definition for policy, practice, and research. *Sexual and Reproductive Health Matter* 29(1):1911618. pmid:33910492 (p. 2)

settings. I'm referring to issues like heavy bleeding, period pain or menopause. Everything to do with blood is embarrassing so problems go undetected. We need education to combat the stigma related to blood. Women at work need to have access to safe sanitary facilities at any time; the employers should make allowances for menopause. As Unison, we recently negotiated a policy with employers in the public sector to address the needs of women with menopause in the workplace. We hope to extend this agreement to other sectors"[33]. Many women may miss out on promotions and benefits or may be driven out of the labour market because of challenges related with menopause; undetected women's challenges may increase the pay gap between women and men. Trade unions are in the position to support members struggling with menopausal symptoms in the workplace. The starting point is to consider **menopause as a workplace health concern** and to develop a workplace policy which includes information and training for managers on how to best discuss and support colleagues experiencing menopause, sickness absence, flexible working hours, adequate ventilation and sanitation facilities, appropriate uniforms or personal protective equipment.

Recommendations

- Awareness-raising campaigning on health issues related to menstruation and menopause.
- Lobbying schools and employers to provide safe and clean sanitation facilities, including sanitary pads.
- Consulting trade union members on issues related to menopause and develop a workplace policy on menopause (flexible working hours, sanitation facilities, appropriate uniforms).

Women's mental health

Gender contributes to determining the power people have over the socio-economic determinants of mental health, their social position and the way they are treated by society. As a result, gender is an important determinant of mental health and women experience higher rates of mental illness than men, specifically in the common mental disorders of depression and anxiety[34].

The COVID-19 pandemic has led to a sharp increase in depressive and anxiety disorders globally as pointed by a study by The Lancet[35] medical journal; the increase was associated with COVID-19 infection rates and decreasing human mobility. Those whose mental health was most

[33] Irwin, J. Unison (UK) National Women's Officer, 26/07/2021 Interview

[34] WHO-Europe, Gender and mental health. Available at: https://www.euro.who.int/en/health-topics/health-determinants/gender/activities/gender-and-non-communicable-diseases/gender-and-mental-health

[35] COVID-19 Mental Disorders Collaborators. 2021. "Estimating the global prevalence and burden of depressive and anxiety disorders in 2020 due to the COVID-19 pandemic", *The Lancet,* 8 October 2021. doi: 10.016/S0140-6736(21)02143-7.

affected by the study indicators are women and children. Among women, there were almost 52 million additional cases of anxiety disorders and more than 35 million additional depression disorder cases present in 2020, compared to 2019. It was expected that mental disorders would have a greater impact on women as they are more likely impacted by the social and economic consequences of the pandemic; in particular, school closures and illness disproportionately require women to fill the role of care giver as it is expected by social norms and reinforced by women's financial vulnerable position. As put by Zita Holbourne, vice-president of the UK public services union PCS: "What has strongly emerged during COVID-19 is the huge race pay gap which intersects with gender. Black women, migrant women are employed under precarious conditions and many of the jobs where they are employed were shed during the pandemic. Moreover, retrenchments coupled with increased care work in families resulted in widespread mental health problems which are still mostly undetected because health services that were not strictly related to COVID-19 have been put on hold for a long time"[36].

There are no marked gender differences in the rates of severe mental disorders such as schizophrenia and bipolar disorder, which affect less than 2% of the population. But gender differences have been reported in age of onset of symptoms, frequency of symptoms, the course of these disorders and the long-term outcome[37].

More research is needed on the gender aspects of mental health. Part of the reason women experience higher rates of mental illness, at least in relation to common disorders, may be the oppression they face on a regular basis, something the feminist movement has been fighting against for decades. Hence, gender-sensitive health services should take into consideration widespread misogyny and patriarchal rule that may affect women's lives and health outcomes in different ways and with specific attention to consequences on mental health.

[36] Holbourne, Z. Public and Commercial Services Union (UK) Vice-President, 26/07/2021, Interview.
[37] https://www.who.int/teams/mental-health-and-substance-use/gender-and-women-s-mental-health

5. Education and stigma

Sexist stereotypes can create discrimination and unequal treatment, especially when people are perceived as non-conforming to social expectations attached to their assigned sex. Moreover, gender stereotypes limit educational and professional choices for both girls and boys. All young people should have access to sex and relationships education. It should be available to all, independently of their sexual orientation, health status, disability, ethnic origin or faith. Education addressing primarily girls and boys should:

- Combat sexist stereotypes associated with care and encourage boys to take up domestic and caring responsibilities from a young age.
- Support education programmes against violence and discrimination targeting boys and men from a young age.
- Systematically and continuously promote an approach of social co-responsibility for care work.
- Support education for gender equality in schools, from pre-school up to high school.
- Promote sexual health education for both boys and girls, including in relation to menstruation in order to eradicate associated stigma.
- Adolescents should be made aware of the various types of contraceptives. Boys should be encouraged to take responsibility for prevention and contraception as much as girls.

Trade unions could also play an important role in tackling the roots of patriarchy and gender discrimination in society as well as on symbolic violence. For instance, in November 2019 the Italian union Funzione Pubblica (FP-CGIL) has launched an initiative to raise awareness about the link between sexist language and violence against women[38]. On structural issues of gendered division of labour unions could organise awareness-raising campaigns against the femininisation of certain occupations which involve care and the subsequent gender professional segregation. For instance, the French union CGT is currently striving to push the Government to adopt employment policies towards "professional mixing" in order to challenge professional segregation. In the words of Francoise Geng, general secretary of the

[38] Grieco, N. Funzione Publica CGIL (Italy), International Officer, 06/10/2021, Focus group

confederation's health section: "The problem is that jobs where women are over-represented are always paid less, independently from the level of qualification required. We are fighting for the Government to have specific criteria for employment in order to have more men employed as child-minders, nurses and caretakers and more women employed as IT specialists or engineers"[39].

Recommendations

- Develop campaigns to highlight the role of men as caregivers in families and support men who take up care professions, including in the health sector.
- Raise awareness on the link between women's care work and health outcomes as well as on the link between cuts to public care services and the increase of women's unpaid care work.
- Raise awareness on health-related challenges affecting women and LGBTQIA+.
- Create a "Care Front" of women working in the care sector, including health services, and women performing unpaid care work in families and communities.
- Mobilise against symbolic violence and sexist language.
- Work on educational content and social factors to transform gender roles in care work in households and communities.
- Challenge the femininisation of certain jobs (involving care) and the exclusion of girls and women from other educational and professional paths (for instance in sciences, technology, engineering and mathematics).

[39] Geng, F. Fédération Santé Action sociale CGT, 11/10/2021, Interview

6. Challenges to universality and accessibility

In 1946 the Constitution of the World Health Organization was adopted. Its basic principles included:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition[40].

Since then, the right to health, including access to health services, has been recognised as a universal human right through the adoption of several international agreements. International human rights law requires that states ensure that services essential for the realisation of economic, social and cultural rights, such as health care, education, and water and sanitation, be provided in a democratic and non-commercial way, with public control, for the public good[41].

Nevertheless, the enjoyment of this universal right has been denied to many people owing to a variety of barriers, including socio-economic status, legal status and gender. Global public under-resourcing of health services is a major driver of unequal access, discrimination, and poor health outcomes. The UN Committee on Economic, Social and Cultural Rights has noted that "reductions in the levels of public services [...] have a disproportionate impact on women, and thus may amount to a step backwards in terms of gender inequality". The Committee on the Elimination of Discrimination Against Women has also highlighted that cuts to public services have a "detrimental and disproportionate impact on women in all spheres of life"[20] and that the privatisation of services such as healthcare and education has specific negative consequences for women and girls[42].

Gender may intersect with racial and class inequalities, exacerbating exclusion from health services. In this context, migrant women, and more specifically undocumented women, may be the most vulnerable to exclusion while their health needs may be particularly acute due to

[40] WHO (1946) Constitution of the World Health Organization, *American Journal of Public Health* (36)11 (November 1): pp. 1315-1323.

[41] ILO Policy Brief (2020) *The COVID-19 response: getting gender equality right for a better future for women at work*. May. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---gender/documents/publication/wcms_744685.pdf

[42] UN Committee on Economic, Social and Cultural Rights (CESCR) (2016) Public debt, austerity measures and the International Covenant on Economic, Social and Cultural Rights, 22 July, E/C.12/2016.

socio-economic determinants of health, precarious living conditions and legal and practical barriers to preventative care[43]. Moreover, global migration of health and care workers is an important factor in the provision of health services due to the widespread understaffing and precarious working conditions. In the context of under-resourcing of health and care services, global migration is part of the racialized and global sexual division of labour.

For several decades, international institutions (the International Monetary Fund, the World Bank, and the World Trade Organization, as well as European institutions) have encouraged governments to cut public budgets on healthcare and to allow liberalisation, privatisation and deregulation in many sectors, including health and care. A recent project[44] by the European Network of Corporate Observatories is mapping out the extent of privatisation of health services, in particular the growing role of profit-driven enterprises in the hospital sector. Some of its findings regarding extent of for-profit privatisation of hospitals and care homes are presented below (from the EPSU website):

In Spain: 19 % of the hospital beds/53% of the nursing home beds

In Italy: 29.5 % of the hospital beds/22% of the nursing home beds

In Portugal: 11 % of the hospital beds/25% of the nursing home beds

In Austria: 32.5 % of the hospital beds/48% of the nursing home beds

In Poland: 18 % of the hospital beds/5% of the nursing home beds

In the Czech Republic: 14.9% of the hospital beds/3% of the nursing home beds

in Austria: 13.9 % of the hospital beds/21 % of the nursing home beds

In Ireland: 8.5 % of the hospital beds/65 % of the nursing home beds

Widespread privatisation of health services takes place in different forms, including private-public partnerships. **Corporatisation, marketisation and outsourcing** have characterised changes in the provision of healthcare in Europe with massive consequences on universality of provision. Outsourcing is the transfer of the management and operation of non-clinical and clinical services from the public sector to external providers. Corporatisation can be defined as the adoption of business models by the public sector, where strategies, targets, regulation respond to the profit-motive rather than to the public interest. Marketisation in the public health sector entails the creation of markets for social and health services thus turning them into commodities[45].

[43] https://www.euro.who.int/__data/assets/pdf_file/0017/330092/6-Migrant-womens-health-issues-irregular-status.pdf

[44] https://corpwatchers.eu/en/investigations/caring-for-profit-en

[45] EPSU, 2021, Privatising our future: an overview of privatisation, marketisation and commercialisation of social services in Europe https://www.epsu.org/sites/default/files/article/files/Social%20services%20privatisation%20

While these changes have been portrayed as efficiency-driven "cost-cutting" measures, they have primarily served to create business opportunities for private entities, therefore putting the profit motive before people's health. The impact of these changes on intersecting inequalities has been enormous: healthcare workers' rights and the universal value of the right to health have been eroded.

The consequences of privatisation on the number and quality of health services provided has been dramatic, as well as its impact on the health workforce (see section 7); moreover, it resulted in poorer coordination with social and employment services.

As the COVID-19 pandemic has shown us, public planning and delivery is essential in healthcare. Today, in the midst of a pandemic, the need to find alternatives and to reverse privatisation in its various forms is greater than ever, especially in view of a gender-sensitive future for health services. A move to re-insource health services should be promoted, as well as the investigation of public-public partnerships (PuPs), which have been used in several parts of Latin America, Africa and Asia to reverse privatisation[46] and which involve the collaboration of two or more public entities, for instance local and national governments, civil society organisations, workers' cooperatives and other public institutions, to plan and provide public services. Collective and democratic ownership and control could allow for the pursuit of ambitious goals in the public interest, such as the transformation of power imbalances between genders, and, at the same time, could be responsive to the specific traits that shape gender relations in each community.

A different approach to ownership, management and delivery of public health services could ignite a shift in current paradigms and allow us to reclaim public health services for a gender-equal post-COVID-19 future.

Recommendations

- Reclaim healthcare as a public good which is free from exclusion and from the profit motive.
- Contest corporate capture of governance.
- Support community healthcare services at local levels or primary healthcare facilities
- Reclaim sufficient resources to be allocated by the state for providing health services that serve the wide diversity of people's needs.
- Campaign for fair and progressive taxation, including international tax cooperation.

Europe%20FINAL.pdf

[46] Transnational Institute (2020) The future is public, https://www.tni.org/en/futureispublic

7. Staffing and training

In health and care professions women are globally overrepresented and their work has been grossly undervalued historically. As a result of the outbreak of the virus and the crisis of reproduction[47] that has followed, health and care work has come into the spotlight and workers are called heroes. Nevertheless, global structural problems have not been addressed – understaffing, remuneration and occupational health.

At a global level, healthcare services are characterised by structural under-resourcing and **understaffing** in the public sector, with increasing **casualisation**. This needs to be understood in the context of a sector which has major recruitment and retention problems and an ageing workforce[48]. A trade union official from the Kommunal municipal services union in Sweden, commenting on the impact of the pandemic on the healthcare sector argues: "Welfare has been underfunded for so long - the pandemic has shown how important it is to have a strong welfare sector - where the staff is large enough, has safe conditions, where there are functioning security systems and where you can stay at home when you are sick. Work environment problems in health care have definitely worsened during the pandemic. It's both about the spread of infection at work, workloads and long-term stress. The main issues result from pre-existing factors such chronic understaffing of health services. Understaffing in itself is an important women's issue, especially because it happens in a sector where many women are involved and where care services are offered. It seems as if employers imply that you can demand anything from women and keep the services understaffed. Employers do not take care and employees are seen almost as disposable"[49].

The sector is highly labour-intensive and it generally employs more women than men, and thus it constitutes an important source of employment for many women. While acknowledging the unequal burden of care on women is essential, further work must be done to fight the femininisation of certain occupations (see section 5) and to improve working conditions.

Decent work is not always the norm in the sector although it is essential to ensure acceptable working conditions and quality services. The PSI Care Manifesto identifies a number of **fundamental ILO Conventions** to be implemented in order to assure **decent work** in the care sector, including health services. In particular, Convention 187 (on occupational safety and health) and Convention 156 (on workers with care responsibilities) should be ratified.

[47] Mezzadri (2020) A Crisis like no other. https://developingeconomics.org/2020/04/20/a-crisis-like-no-other-social-reproduction-and-the-regeneration-of-capitalist-life-during-the-COVID-19-pandemic/

[48] Lethbridge, J. (2021) Privatising our Future. An overview of privatisation, marketisation and commercialisation of social services in Europe, Bruxelles: EPSU

[49] Westerberg, S. (Sweden) Kommunal Union Official 07/09/2021 Interview.

Other general prerequisites are the ratification and implementation of the Fundamental Conventions referred to in the *Fundamental Principles and Rights at Work*:

(1) freedom of association and the effective recognition of the right to collective bargaining;
(2) the elimination of all forms of forced or compulsory labour;
(3) the effective abolition of child labour;
(4) the elimination of discrimination with respect to employment and occupation.

The PSI document also points to the importance of Convention 100 (on equal remuneration) and Convention 111 (on discrimination, employment and occupation), Convention 151 on labour relations in public services and Convention 154 on collective bargaining, as particularly important in relation to the public sector.

The training of health workers is essential, particularly in relation to gender-sensitive services. Professional and life-long training of practitioners operating at different levels in health settings should comprise information and knowledge on the specific health needs of women and LGBTQIA+ people.

Knowledge about specific health inequalities affecting patients, based on gender, class, race and nationality, would facilitate building a **relation of trust** between patients and their health practitioners. Communication skills should also be included in training packages. In particular, this should stress the importance of respectful communication with women and LGBTQIA+ people that encourages them to be involved in their own healthcare. In terms of **language**, it is important to raise the awareness of practitioners on the importance of using gender-sensitive language, avoiding assumptions, providing information in a transparent manner, and respecting the principles of confidentiality and privacy.

Research has shown that when understaffing in the care sectors (education, health, long-term care) is reversed, and public provision is higher, decent work is more likely. On the contrary, when the level of employment in the care sectors is low (that is, when most care relies on privatised or unpaid care work), public provision is weak, the incidence of privatised healthcare and domestic work is high then decent work is yet to be achieved. When public provision is limited workers, particularly migrant workers, face longer hours and worse conditions[50].

Care workers in gender health and SRHR services deserve better working conditions. Understaffing and low public provision have to be tackled simultaneously in order to achieve decent work for healthcare workers and high-quality gender-sensitive services. A gender-just adaptation of health services must start by fighting the existing deficits in care jobs, including in the health services sector[51].

[50] Rodriguez Enriquez, C. and Fraga, C., 2021 *The Social Organization of Care. A global snapshot of the main challenges and potential alternatives for a feminist trade union agenda*. Public Services International, Ferney-Voltaire France.
[51] EPSU, 28 September 2020, International Safe Abortion Day 2020 Statement https://www.epsu.org/article/international-safe-abortion-day-2020

Recommendations

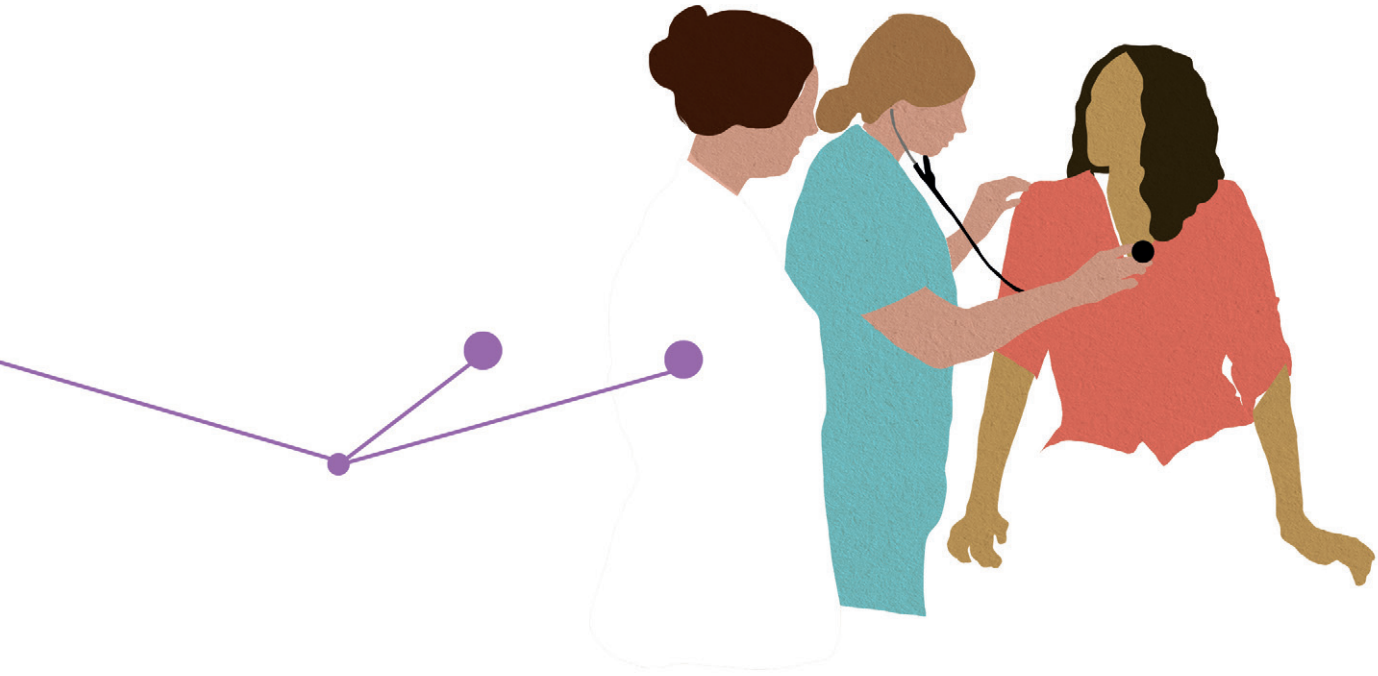
- Raise awareness on the challenges of healthcare workers and the importance of ILO Conventions concerning decent work in the sector.
- Reclaim resources to increase capacity in public services, reverse understaffing and casualisation.
- Advocacy for gender-sensitive adaptation training for health care workers.

8. Conclusions

Gender, race and class inequalities determine significant differentials in access to health across social groups. In order to cater for all, health services have to acknowledge power imbalances dominant in society and aim to contribute to redress them.

This report locates health services provision in the history of medicine and in relation to the COVID-19 pandemic. It highlights the need for further research on gender health as well as the urgency of action to bring down the barriers to accessing health services. It brings together theoretical analysis and a policy-oriented approach thus attempting at providing a contribution to current debates and ongoing, or future, campaigns.

Women and LGBTQIA+ people have historically seen their health needs overlooked in medicine and health services. Time is ripe for society to advance gender equality in health for the benefit of all because a healthier and more equal society is a freer society. Trade unions organising women and men who work across sectors to keep everyone healthy, cared for, fed, educated and safe are at the forefront of this struggle. This report is meant for them.



Key terms and definitions[1]

Gender is a social construct which places social and cultural expectations on people based on their assigned sex. Gender norms determine roles, relationships, power and positions in the overall social division of labour.

Gender identity refers to a person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. This includes the personal sense of the body which may include, if freely chosen, modifications by medical, surgical or other means.

Gender equality in health refers to all people's right to realise their full potential to lead healthy lives, contribute to health development and benefit from this development.

Gender equity in health is achieved through fairness in meeting different people's health needs according to their gender. Fairness means recognizing that there are different health needs and social disparities based on gender and therefore resources must be allocated differently to address disparities.

Sex is assigned at birth and it classifies a person as female or male based on their external anatomy. It draws on a binary vision of sex which excludes intersex people.

Sex characteristics are each person's physical characteristics relating to sex, including genitalia and other reproductive anatomy, chromosomes and hormones, and secondary physical characteristics emerging at puberty.

Intersex people have sex characteristics that are neither wholly male nor wholly female. There is no single static intersex; many forms of intersex exist. Gender activists prefer to use the term sex characteristics to talk broadly about grounds for protection against discrimination.

Social reproduction refers to the activities that nurture future people, regenerate the current workforce, and maintain those who cannot work. It consists, broadly speaking, of caring directly for oneself and others (childcare, elder care, healthcare), maintaining physical spaces and organizing resources (cleaning, shopping, repairing), and species reproduction (bearing children). These tasks involve staying alive and helping others stay alive and have traditionally been performed by women for low or no wages.

[1] The list of definitions is compiled by the author, it draws from the UN Free & Equal Campaign, Ilga-Europe and Oxfam International.

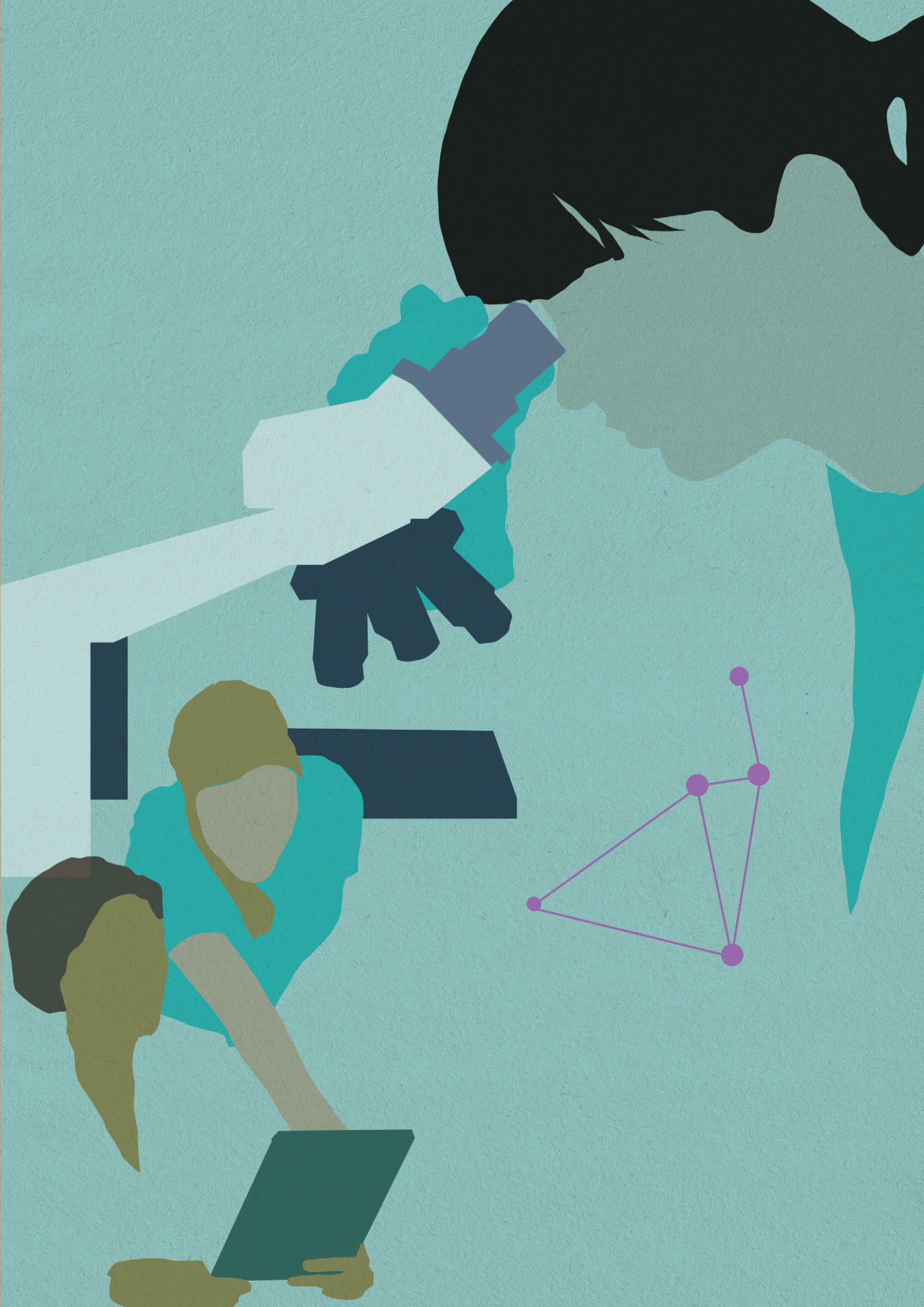
Reproductive rights refer to human rights recognised in national laws and international human rights documents which constitute basic right of all people to decide freely and responsibly the number, spacing, and timing of their children, and to have the right to the highest standard of sexual and reproductive health. They also include people's right to make decisions concerning reproduction free from discrimination, coercion and violence, as expressed in human rights documents. Moreover, they include the means to raise children.

Patriarchy refers to a systemic bias against women. The term comes from the ancient Greek *patriarchs* (fathers) and historically defines a social order where men hold positions of power and have privileges. Patriarchy is based on the assumption that oppression of women is justified by "natural" differences between women and men unfolding from their reproductive organs and subsequently from their psychology (biological determinism). Feminist thinkers believe that patriarchy is instead a social construct under which both men and women are unfree. In particular, capitalism compounds patriarchy and uses it to discipline the entire workforce and extract more profit through unpaid labour in households and workplaces.

Sexism rationalizes patriarchal norms ideologically. It legitimates gender inequality, stereotypes and discrimination through alleged "natural differences" in the way people think, feel and choose, based on their reproductive organs.

Symbolic violence includes discourses and practices that are based on sexist assumptions and are dominant in a given society, thus difficult to tackle. For instance, normative femininity, derogatory irony against certain groups, presumed desirability of maternity for all women, tolerance towards aggressive masculinity are widespread forms of symbolic violence. Social media, cultural industries and advertising can be terrains of amplification of symbolic violence thus exacerbate gender inequality.

Misogyny enforces patriarchal norms by defining a men's world. It is the system that polices women to maintain their subordination and to uphold male dominance.



EPSU

EUROPEAN PUBLIC SERVICE UNION

EPSU is the **European Federation of Public Service Unions**. It is the largest federation of the ETUC and comprises 8 million public service workers from over 250 trade unions across Europe. EPSU organises workers in the energy, water and waste sectors, health and social services and local, regional and central government, in all European countries including the EU's Eastern Neighbourhood. It is the recognised regional organisation of Public Services International (PSI).

www.epsu.org