ISSN: 2643-4512

Kayode et al. Int Arch Public Health Community 2024, 8:100
DOI: 10.23937/2643-4512/1710100
Volume 8 | Issue 2
Open Access

International Archives of
Public Health and Community Medicine

REVIEW ARTICLE

Gender Inequality and Public Health: Exploring the Negative Impacts

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Abstract

Background: Gender inequality significantly impacts public health, including adolescent sexual and reproductive health. Despite extensive research, gaps remain in understanding the intersectionality of gender with other social determinants, the long-term impacts of inequality on public health, and the effectiveness of interventions. Therefore, this literature review aims to investigate the consequences of gender inequality on public health and identify key pathways. It will further explore and analyze key data sources that reflect on how gender inequality shapes public health.

Methods: The review synthesized findings from literature and provides evidence on the effect of gender inequality on public health. Relevant studies were sourced through a comprehensive literature search and Key data sources were analyzed.

Results: The study highlighted the pervasive influence of gender inequality on health outcomes, including higher rates of chronic diseases, maternal and child health, sexual and reproductive health and mental health issues, gender-based violence, disparity in healthcare access, high out-of-pocket payment for women, and significant economic and educational disparities. These impacts are compounded by intersecting factors such as race, ethnicity, and socioeconomic status.

Implications for policy practice: Addressing gender inequality is essential for improving public health outcomes. Policies and Programs must focus on providing access to healthcare, enhancing education, and economic opportunities for women, and implementing effective interventions to reduce gender disparities and other forms of discrimination.

Conclusion: Gender inequality has far-reaching negative effects on public health by perpetuating disparity in healthcare, education, health services, and economic opportunities. While some progress has been made, substantial disparities persist, highlighting the need for targeted interventions and policies to address these issues. Stakeholders must develop multidimensional and multisectoral evidence-based strategies that consider the complex interplay of social determinants and the cumulative impact of inequality over time.

Keywords

Gender inequality, Public health, Sexual and reproductive health, Health outcomes

Introduction

Gender plays an important role in influencing health throughout a person's life. It refers to the socially constructed relationships, attributes, behaviors, norms, roles, and opportunities accorded to boys, girls, women, and men which vary across societies and evolve. These constructs are often upheld by societal values, laws, education, religion, and media. Gender reflects the distribution of power within relationships, and it requires understanding the complex social processes

Citation: Kayode T, Singh M, Sidi-Ali M, Ottoho E, Rodrique R, et al. (2024) Gender Inequality and Public Health: Exploring the Negative Impacts. Int Arch Public Health Community 8:100. doi.org/10.23937/2643-4512/1710100

Accepted: October 26, 2024; **Published:** October 28, 2024

through which individuals are defined and linked, and how this progress [1]. It is hierarchical and often intersects with drivers of social and economic inequities, discrimination, and marginalization which have complex effects on health and wellbeing [2].

Gender inequality is a social phenomenon in which individuals receive unequal treatment or discrimination based on their gender. This concept remains a significant contributor to adverse health outcomes around the world, including the United States. The unequal distribution of power between genders contributes to female mortality across the lifespan, while detrimental gender norms affect the health-seeking behaviors of men and boys by promoting risk-taking behaviors [1]. Globally, gender inequality disproportionately affects women and girls resulting in lower social status and limited control over their bodies, relationships, families, and communities. It shapes how individuals experience crises, and predisposes them to various acts of violence, coercion, and health challenges such as unintended pregnancies, HIV, cervical cancer, other chronic diseases, malnutrition, and depression [2].

This discrimination influences adolescent sexual and reproductive health, resulting in disparities in access to contraception, education, and healthcare. Societal norms and gender-based biases predispose girls to risk of teen birth through limited access to sexual health education, and contraceptive resources. Socioeconomic factors, racial, and ethnicity intersect with gender to further complicate these outcomes, significantly affecting the prevalence and management of teen births [3].

Gender Inequality undermine the health of half of the world's population by adversely affecting women. The gender bias in healthcare puts women at considerable risk, and as long as gender inequality persists in public health, women will continue to face gaps even in research, treatment of maternal and child health, and in sexual and reproductive health. The CDC reports that four out of five pregnancy-related deaths are preventable, yet black women are three times more likely than white women to die following pregnancy-related causes [4].

The World Economic Forum (2024) report, "*Closing the gender health gap is a $1 trillion opportunity*" presents the gender health gap as a $1 trillion opportunity to improve lives and the economies, with a health benefit of 3.9 billion to women. Closing this gap could prevent premature deaths, and significantly reduce the number of life-years lost due to ill health, with an estimated 24 million life-years saved [5]. In assurance of the government's commitment, the Biden administration responded by announcing a $12 billion investment in women's health research.

Over the years, gender disparities within healthcare have continued to garner significant attention. As far back as 2016, the World Health Organization reported that women in the European Union live longer than men, yet they spend a greater part of their lives in poor health. Although these findings received attention at that time, they did not generate the impact required to prioritize gender equity and women's health [6].

Despite multiples of evidence on the impact of gender inequality on public health, there remain a lack of comprehensive evidence in understanding the pathway of how gender inequality negatively influences population's health, including adolescent reproductive, and sexual health outcomes. Additionally, it is imperative to understand the implications of intersectional factors including race, ethnicity, and socioeconomic status on gender and health.

Therefore, this study aims to review existing literature, analyze specific data, and explore the negative impact of gender inequality on public health.

Methods

The review synthesized findings from literature and provides evidence on the consequences of gender inequality on Public Health. Relevant studies were sourced by conducting a comprehensive literature search using databases of PubMed, PLoSONE, Scopus, Google Scholar etc., with search terms including "Gender Inequality AND Public Health", "Gender AND Health outcomes", "Gender Inequality AND Population Health", "Gender Inequality AND teen pregnancy", "Gender Inequality AND Reproductive Health AND Adolescent Health". We applied the snowball method to search for additional studies through the reference lists of retrieved articles. The Search was not restricted by publication date, but only studies in English Language were included.

Negative Consequences of Gender Inequality

Gender inequality considerably influences health outcomes, with notable disparities between females and males. The rates of disability adjusted life years (DALY) for the top 20 causes of disease burden for individuals over 10 years old at the global level and across seven regions were compared using data from Global Burden of Disease Study 2021 [7]. Findings revealed that females had conditions such as low back pain, depressive disorders, and headache. In contrast, males experienced COVID-19, road injuries, and ischemic heart disease.

Evidence from the analysis of males and females with fair or poor health status (Figure 1) with those with less than a high-school education across five U.S. States of California, Florida, Illinois, New York and Texas (Figure 2), using BRFSS Prevalence & Trends Data 2019 revealed the effects of gender inequality on health and educational attainment [8]. Females reported a higher

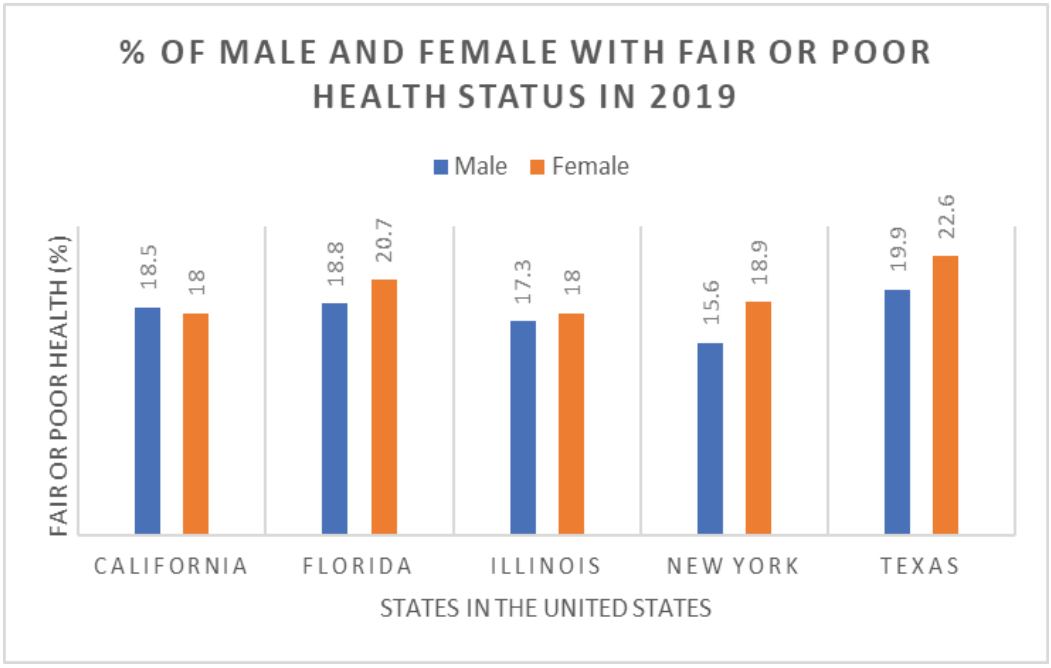

Figure 1: Bar chart showing % of Male and Female with Fair or Poor Health Status in 2019.

Source: BRFSS Prevalence and Trends Data: https://www.cdc.gov/brfss/brfssprevalence/index.html

Explanatory note: This chart highlights the variations in health status between males and females across five states of California, Florida, Illinois, New York and Texas. The chart shows that females generally report a higher percentage of fair or poor health status, especially in Texas. The extent of the disparity between genders varies by state. In New York, results show the largest gender gap (3.3%), while California and Illinois have the smallest gaps (0.5% and 0.7%, respectively). Texas stands out with the highest percentages of individuals reporting fair or poor health for both genders, indicating potential underlying health issues or socio-economic factors affecting the population.

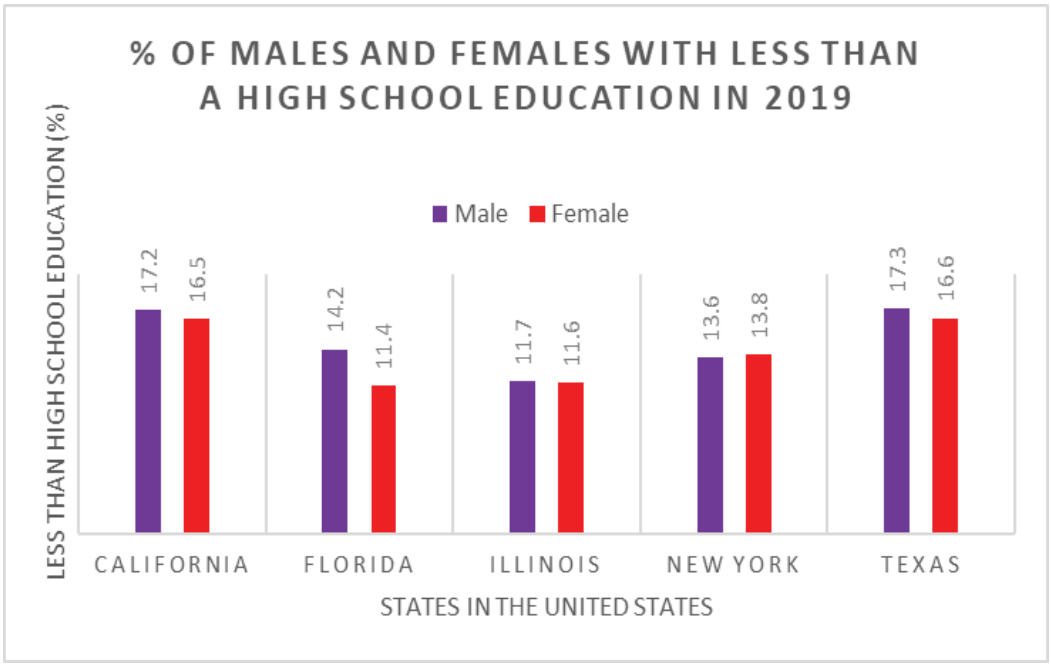

Figure 2: Bar chart showing % of Males and Females with Less than a High School Education in 2019.

Source: BRFSS Prevalence and Trends Data: https://www.cdc.gov/brfss/brfssprevalence/index.html

Explanatory Note: The bar chart highlights the percentages of males and females with less than a high school education across five U.S. states in 2019. While states like Florida show noticeable gender disparities, others like Illinois and New York have nearly identical percentages for both genders. However, California and Texas have higher overall percentages, indicating a potential need for targeted educational interventions. The data suggests that there is no significant gender disparity in most states, but with minor variations.

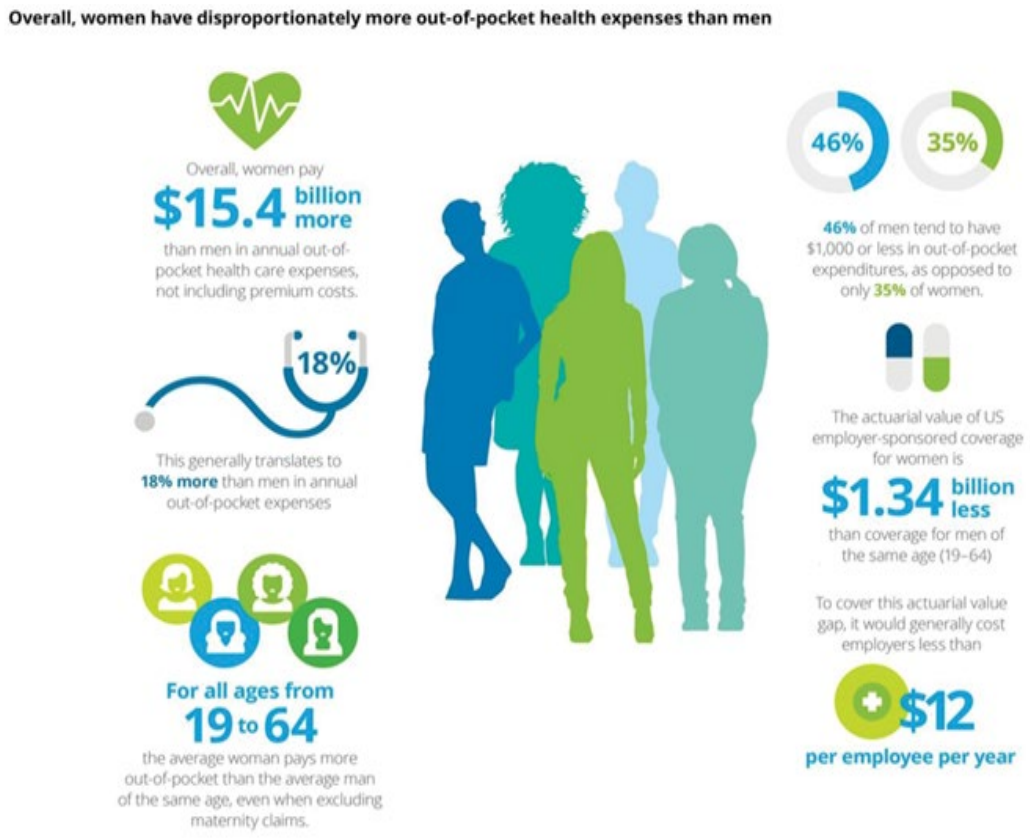

Figure 3: The gender-gap financial burden.
Source: Closing the Benefit Gap to Advance Women's Health Equity | Deloitte US
Explanatory Note: Women pay $15.4 billion more than men in annual out-of-pocket healthcare costs.

percentage of fair or poor health status compared to males. The extent of the disparity between genders varies by state. In New York, results showed the largest gender gap (3.3%), while California and Illinois have the smallest gaps (0.5% and 0.7%, respectively), and Texas has the highest percentage of poor health for both genders (Figure 1).

The percentages of males and females with less than a high school education is quite similar across the States (Figure 2), with the largest disparity seen in Florida, where males are significantly higher (2.8%). Nevertheless, California and Texas have the highest percentages of individuals with less than a high school education for both genders, indicating potential areas for educational improvement. Illinois has the lowest percentage for both genders, suggesting better educational attainment compared to other states [8]. Comparatively, females reported worse health outcomes across all the states, which can affect their educational outcomes (Figure 1 and Figure 2).

Although there was a relatively balanced level of educational attainment between males and females across the states. However, stakeholders can work towards reducing gender disparities and improving socio-economic outcomes for their populations by addressing both health and educational challenges. This analysis highlights that gender inequalities influence poor health and can adversely impact educational attainment. This indicates the intersection of other factors such as economic conditions, healthcare access, and state policies.

In the United States, **women pay more for healthcare than men every year**. They are more likely to receive healthcare services from health professionals more often than men, even exceeding the deductibles with a corresponding higher cost [9]. Women on employment in the United States pay about $15 billion more than men to access healthcare, with an average woman spending about 18% or $266 in excess yearly (Figure 3). These women consistently make out of pocket payments more than men for healthcare costs not covered under their insurance excluding maternity and pregnancy related services (Figure 4). The gender-gap financial burden continues to oppress most women, even affecting their overall well-being.

Although, employers in the U.S. are expected to provide equal healthcare insurance premiums costs to both men and women. However, this does not reflect the actual cost as premiums are just a fraction of the financial implication, therefore further exacerbating the gender-gap financial pressure [9]. Men in the U.S. wait more than two years following the last visit to access a

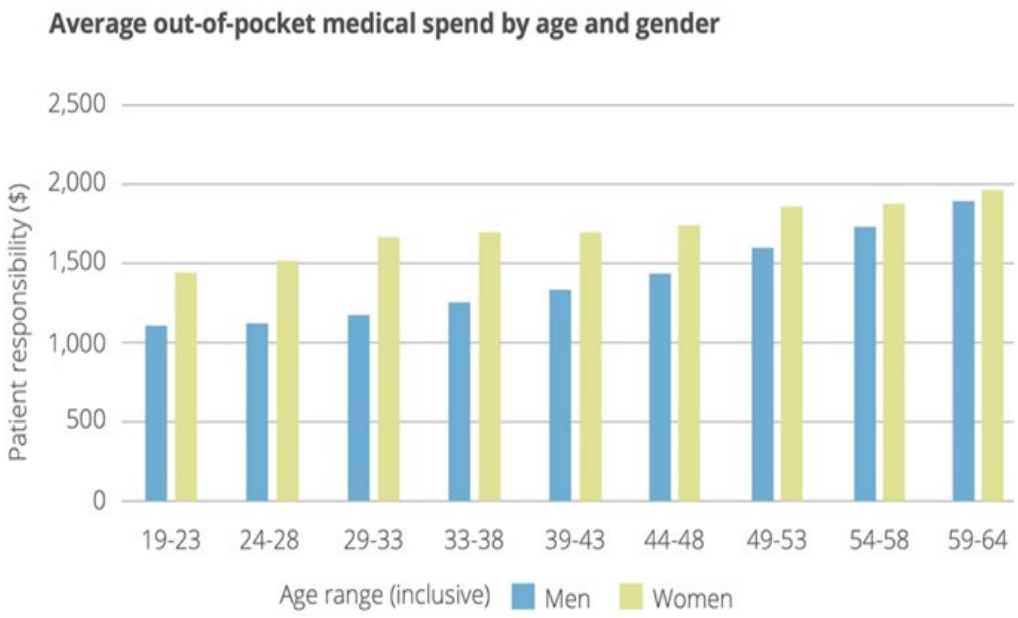

Figure 4: Employer Sponsored Coverage: Average out of pocket Medical Expenditures in 2021, excluding maternity claims.

Source: Closing the Cost gap: Strategies to advance women's health equity (2024). Closing the Benefit Gap to Advance Women's Health Equity | Deloitte US

Explanatory Note: Women consistently pay more out-of-pocket than men for healthcare costs not covered under their insurance across all age groups.

healthcare professional, and with a higher probability of having lesser services than women with about 46% of men having less than $1,000 in Out-of-payment (OOP) claims per year compared to 35% of women [9]. The evidence also highlighted that the actuarial value of coverage for women, which is the proportion of average costs that a plan covers is consistently lower than that provided to men. This indicates that women tend to receive less value from their insurance premiums compared to men.

This evidence justifies the affirmation of The WEF report which states that "The combination of higher health care expenditures and the gender wage gap can negatively impact the financial and health status for employed women, potentially creating a choice between the care women need and the care they can afford".

The relationship between gender inequality and various health indicators in Organization for Economic Cooperation and Development (OECD) countries from 1990 to 2017 revealed that greater gender inequality (GII) was associated with lower Life expectancy, increased premature mortality, and morbidity [10]. The findings highlights the impact of gender inequality on population health outcomes and underscore the importance of promoting gender equality in public policies to improve overall health at the population level.

Similarly, the COVID-19 pandemic worsened gender inequalities and presented new problems, including disrupted healthcare due to lockdowns, high COVID-19 cases, deaths among women, and a sharp rise in domestic violence [11]. Greater gender Inequality ranged from 0.13 to 0.83, within 37 Low Middle-Income Countries (LMICs) showing a double burden of disease. The adjusted odds ratio (OR) for the double burden was 1.05 per 0.01 increase in GII (95% CI 0.99 to 1.00, p = 0.10). However, there was a borderline significant association for women (OR 1.05, 95% CI 1.00 TO 1.11, p = 0.06), but none for men (OR 0.99, 95% to 1.04, p = 0.75). Overall, there appears to be a positive relationship between gender inequality and double burden of disease, especially among women [12].

An assessment of gender inequalities in health and wellbeing within the first 20 years of life in 40 low-income and middle-income countries across Asia and the Pacific was conducted. Evidence revealed higher-than-expected male-to-female sex ratios at birth in countries like India, Vietnam, and China, and excess mortality of girl children in South Asian and Pacific nations, which signifies that gender inequalities consistently manifest during early adolescence [13]. Adolescent girls encounter sexual and reproductive health issues including teen birth, high fertility rate, and intimate partner violence in Bangladesh, Nepal and Afghanistan. Additionally, Females aged 15-24 years are less likely than males to engage in education, employment, or training in some of these countries. These findings emphasize the need for gender-focused policies and interventions during later childhood and early adolescence to mitigate the negative impact of gender inequalities [13].

Gender discrimination is a significant barrier to women's access to quality healthcare, resulting in poor

Table 1: Showing rate of teen births and % of ninth graders graduating high school in four years for the top five and the bottom five counties in New York State in 2020.

Ranking	County	Teen Birth Rate	% of ninth graders graduating high school in four years
1	Nassau (NA)	7	91%
2	Saratoga (SA)	8	91%
3	Rockland (RO)	12	85%
4	Putnam (PU)	3	93%
5	Westchester (WE)	9	90%
58	Niagara (NI)	20	85%
59	Montgomery (MO)	31	76%
60	Sullivan (SV)	20	78%
61	Chautauqua (CH)	26	83%
62	Bronx (BR)	26	68%

Source: RWJ County Health Indicators and Roadmap: https://www.countyhealthrankings.org/

Explanatory Note: Teen birth rate is inversely proportional to % of ninth graders graduating high school in four years

health outcomes, especially in resource-poor areas [14]. Worldwide, Individuals exhibits unequal health outcomes across and within countries with women showing more vulnerability and inequity during their life course. Women experience obvious social and economic disparities including low representation in global health leadership position, low rates of schooling, and employment, less pay for similar jobs, psychological problem, and intimate partner violence [15].

Women exposed to domestic violence and abuse, were seven times more likely to develop post-traumatic stress disorder (PTSD), anxiety, depression and mood disorders [16]. During the COVID-19 pandemic, women reported an increase in deterioration of mental health and overall well-being with increased use of prescription medication for new mental health diagnosis [17].

Despite global commitments, gender inequality continues to have negative impacts on mental health [18]. Some individuals with mental disorders experienced a disproportionate rate of anxiety and depression based on their gender and socioeconomic status (SES), with low-SES males showing the highest rates and females of medium-to-high SES having the lowest overall, except for anxiety and depression [19]. This highlights the necessity of developing policies to assist women in managing mental health challenges arising from the pandemic or any other public health crisis.

Although adolescence should be a phase of growth and excitement, most adolescents are exposed to an array of gender inequalities during this period of opportunities. Adolescent girls are mostly affected, boys also experience some gender norms that predispose them to harm and danger. In comparison to men, adolescent girls and women have higher prevalence of psychosocial issues, including maniac, eating disorders, and anxiety, while men and adolescent boys are more susceptible to high-risk behaviors including substance use abuse, anger issues, antisocial behaviors and tendency to commit suicide [20].

Analysis of the 2020 County Health Rankings Key Findings Report, compared the rate of teen births and percentage of ninth graders graduating high school in four years for the top five (ranked 1-5) and the bottom five (ranked 58-62) health ranking counties in New York, United State for the year 2020 (Table 1) [21]. The top five (1-5) counties with top health ranking have low teen birth rates, which ranges between 3-12 per 1000 females aged 15-19 years, with a corresponding higher percentage (93-85%) of ninth graders graduating high school in four years (Figure 5). While the bottom five (58-62), with lower health ranking have teen birth rates ranging from 20-31 per 1000 females, aged 15-19 years, with a corresponding (85-76%) % of ninth graders graduating high school in four years [21].

The evidence highlights an inverse relationship between teen birth rates and high school graduation rates. It revealed that top counties with high health rankings and probably with higher socio-economic status have lesser teen birth rates than bottom counties with higher teen rates. Similarly, Hispanic or Latino teens in El paso had the highest teen birth rates at 31.6 births per 1,000 females aged 15-19, while White teens in Phoenix and Tucson had the lowest teen birth rate at around 8 births per 1,000 females aged 15-19 [22].

More evidence suggests that less educated adolescent girls are more vulnerable to the consequences of poor economic status including teen pregnancy. Therefore, with education inequality, teen mothers' education is estimated to be 2 years shorter compared to other women who bear children at a later age [23]. Globally, only about 50% of adolescent girls and young women aged 15-19 have access to contraceptives by modern methods, leaving behind another huge percentage of

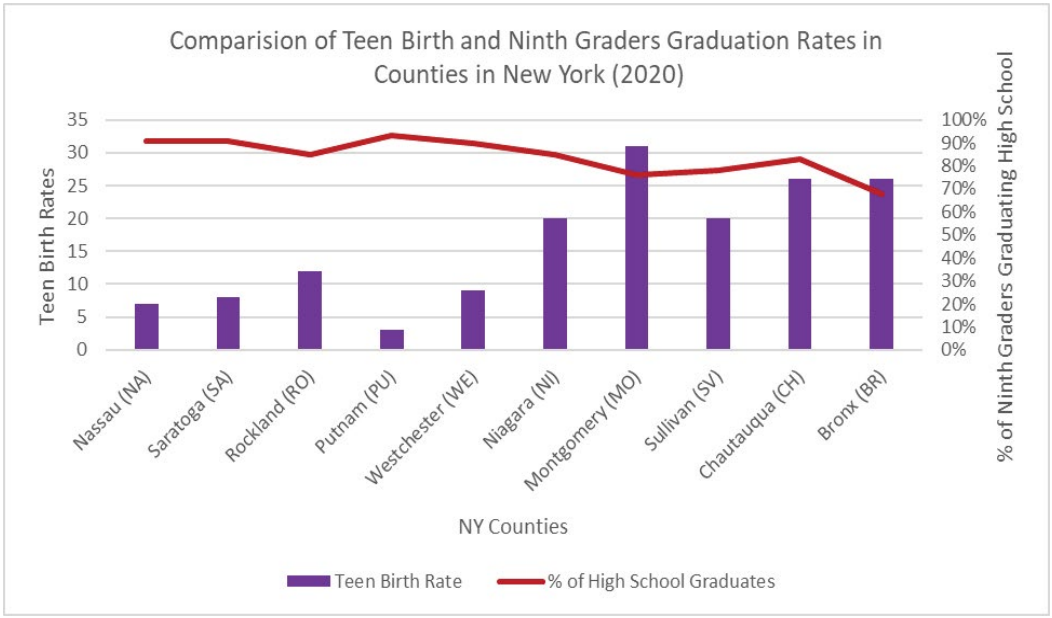

Figure 5: Bar chart showing rate of teen births and % of ninth graders graduating high school in four years for the top five and the bottom five counties in New York State in 2020.

Source: RWJ County Health Indicators and Roadmap: https://www.countyhealthrankings.org/

Explanatory Note: The comparative analysis of the teen birth rates and ninth graders graduating high school in four years across the top five (1-5) and bottom five (58-62) counties in New York State in 2020, reveals an inverse relationship between teen birth rates and high school graduation rates. Counties with lower teen birth rates, and top ranking such as Putnam and Nassau, exhibit higher graduation rates, while counties with higher teen birth rates, and bottom ranking such as Montgomery and Bronx, show lower graduation rates. This trend suggests that lower teen birth rates are associated with better educational outcomes, highlighting the need for targeted interventions in counties with higher teen birth rates to support educational attainment and improve socio-economic conditions.

young girls with unmet needs at a similar percentage of almost 50%. Policies should focus on girl education, healthcare services, and access to socioeconomic opportunities [24].

Gender Inequality was higher in Africa, lower in Europe, and is negatively correlated with life expectancy, education, and smoking rates. However, it was reported to be positively correlated with the rate of death in noncommunicable disease [25]. The relationship between GII, prevalence of low birth weight (LBW), child malnutrition (stunting and wasting), and under-5 mortality across 96 countries were evaluated [26]. Findings revealed that GII accounted for 10% of the variance in wasting and stunting, and 41% in child mortality. It affirms that reducing GII could lead to substantial reductions in LBW, child malnutrition, and mortality in low- and middle-income countries. Women empowerment may play a vital role in improving birth weight and promoting child nutritional status and survival.

A community based cross-sectional study in West Bengal assessed the differences in nutritional status of under-five males and females and the related biological and social determinants. Evidence suggests that 55.9%, 51.4% and 42.3% of the girls were underweight, stunted and wasted respectively compared to 46.6%, 40.5% and 35.3% of the boys. These results were found among female children of families with higher birth order and low per capita income compared to males [27]. This further highlights the implications of paucity of reproductive and sex education, access to contraception, and economic status in deciding the health outcomes of women.

The association between child mortality rates and gender inequality indices of 138 countries were assessed using multivariate non-parametric regression models. Findings revealed that women in low- and middle-income countries (LMICs) suffer significantly more gender inequality ($p < 0.001$). Gender Inequality Index was positively associated with neonatal ($\beta = 53.85$; 95% CI 41.61-64.09), infant ($\beta = 70.28$; 95% CI 51.93-88.64) and under five mortality rates ($\beta = 68.14$; 95% CI 49.71-86.58), after adjusting for the effects of potential confounders ($p < 0.001$) [28]. The study affirms statistically significant positive associations between GII and child mortality rates.

Furthermore, there was a statistically significant association (P-value < 0.001) between GII and under-five children's health as 33% of variations in immunization rate were related to the rate of inequality between genders. Similarly, 76% of the variation in the prevalence of anemia in children is related to the disparity between genders, and 75% and 80% of crude birth rate and neonatal mortality rate respectively were traced to gender inequality [29].

Gender-based violence (GBV) contribute to a range of physical, mental, and social health issues. Victims often experience chronic health conditions, including injuries, reproductive health problems, and mental health disorders. GBV exacerbates health disparities, particularly in marginalized populations, leading to increased healthcare costs and resource allocation challenges. It disrupts public health initiatives by perpetuating cycles of violence, restricting access to healthcare, and undermining social stability [15]. Addressing GBV is therefore crucial for improving population health outcomes and achieving broader public health goals.

Gender inequality in aging often results in older women experiencing greater economic insecurity and limited access to healthcare, compared to men, worsening disparities in quality of life. This inequality also affects their social support networks and overall well-being, as they engage more in caregiving responsibilities. Although women generally live longer, however, they face more health challenges and lower retirement benefits [30]. In addition, this aging population is more susceptible to abuse because of the structurally embedded ageist beliefs, and societal norms. Moreso, older women experience higher rates of mental health issues, elder abuse, and a lower quality of sexual life [30].

Analysis of 2011/2012 Canadian Community Health Survey data using logistics regression analyses to investigate whether gender impacts perceived unmet needs in British Columbia adults revealed that women still had significantly higher odds of unmet healthcare needs despite adjusting for confounders [31]. This evidence suggests that regardless of various individual and contextual factors, being female is independently associated with an increased likelihood of perceived unmet healthcare needs. The findings further highlight the role of gender in healthcare access within Canada's universal system, underscoring the need for comprehensive interventions to ensure equitable access for all British Columbia residents.

Discussion

Overall, the study employed a descriptive analysis to identify, explore, and review literature about gender inequality and its implications on Public Health. This review investigates how gender inequality negatively impacts public health. The study highlights multiple evidence showing consequences of the pathways of how gender inequality and harmful gender norms impact health through differential exposures, and systems intersections, reinforcing and reproducing gender inequalities with serious implications for health across and within countries.

Gender intersects with other power dynamics, including socioeconomic determinants of health such as income, education, environment, class, and access to care. The negative consequences include chronic diseases, malnutrition, depression, anxiety, low education and literacy rate, teen birth, low birth weight, and child mortality. Addressing these prevailing challenges requires a collective commitment to valuing and prioritizing the well-being of girls, women, and boys. Policymakers and practitioners must design and conduct gender analysis and shape public health policies and programs to reflect gender mainstreaming to achieve the goals of gender equality in health.

Implications for Policy and Practice

The evidence from the literature review suggests that reducing gender inequality could improve health outcomes at the population level. Therefore, the review underscores the need to address socioeconomic factors affecting women's health, advance gender equality, and promote public health. Policy makers and implementers should design gender responsive public health policies and programs, aimed at closing gender equality gaps and achieving good health and well-being for all populations.

More so, achieving gender equality and empowerment of women and girls are crucial to the 2030 Agenda for Sustainable Development Goals (SDGs). The United Nations adopted the SDGs as a framework for global development. It emphasized the interdependence of Sustainable Development Goal 3 (SDG3)-ensuring healthy lives and well-being for all ages, with SDG 5 which aim to achieve gender equality and empower all women and girls.

Global Action Plans and Interventions to Advance Women's Health and Gender equality

Global action plans are developed as roadmaps to end all preventable deaths of women, children, and adolescents. This includes:

Every Woman, Every Child which was launched in 2010 and was delivered using a strategic plan of action of the-global-strategy-for-women-s-children-s-and-adolescents-health-2016-2030.

The Partnership for Maternal, Newborn and Child Health (The Partnership, MNCH), which harness the power of partnership to advocate for women, children, and adolescents' health through networking and engaging partners.

Beijing declaration and platform for action, a consensus adopted in 1995 and committed towards achieving gender equality, and to provide opportunities for women and girls. The Platform of action covers 12 critical areas including, women and poverty, human rights of women, and violence against women and the girl child.

Conclusion

The review on gender inequality and public health

reveals a multifaceted issue that significantly impacts health outcomes worldwide. Gender disparities influence healthcare access, quality, and outcomes, and are deeply rooted in socio-economic, cultural, and policy contexts. This review highlights the critical ways in which gender inequality manifests in public health, affecting areas including maternal and child health, adolescent sexual health, teen births, mental health, healthcare costs, chronic diseases, and overall life expectancy.

Key findings from the literature underscore that gender inequality leads to disproportionate health burdens on women and adolescent girls, exacerbating existing vulnerabilities and hindering progress towards equitable health systems. Evidence also emphasizes the role of social determinants, such as education, income, environment, and social support, in perpetuating gender-based health disparities. Furthermore, it identifies significant gaps in research, particularly in women focused healthcare where gender inequality is often most pronounced.

Addressing gender inequality in public health requires comprehensive and targeted policy interventions. Strategies must include improving healthcare access and quality for all genders, promoting gender-sensitive health policies, and addressing the socio-economic factors that contribute to health disparities. Additionally, public health programs must be designed to empower women and gender minorities, ensuring their active participation in health decision-making processes.

Future research should explore high impact studies and targeted interventions to address gender disparities more effectively and assess their impact on public health across diverse contexts. The limitation of this review varies as there is a potential for bias, as studies with significant or positive results are more likely to be published, potentially skewing the review's conclusions. The literature review was restricted to studies published only in English Language, which might have overlooked important research conducted in other languages.

Collaborative efforts between researchers, policymakers, and community stakeholders are essential to developing effective solutions and promoting gender equity in public health. Gender inequality is a critical public health issue that demands urgent attention and action. By addressing the root causes of gender disparities and implementing evidence-based interventions, stakeholders in public health can achieve a more equitable and healthy future for all.

Acknowledgements

This research work acknowledges the support of Mr. William Anyebe and Dr. Duro Dolapo for their guidance and advice in developing this article.

Funding

This study was not funded.

Authors Contributions

Conceptualization: TK; Original draft preparation: TK, MS & EO; Methodology, analysis, & writing: All authors; Review & editing: All authors; Final Review & editing of the manuscript: TK, EO & MS; Supervision: All authors reviewed and approved the submitted manuscript.

Ethics Declarations

No Ethical approval and Consent were obtained as there was no need for one.

Competing Interests

Authors declare no competing interests.

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