Gender and Health: Technical Paper
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Small but committed groups of people in WHO have been working since the 1970s on the impact of discrimination and the low social and economic status on women’s health. More recently there has been a shift from an exclusive focus on women to a focus on gender, that is, the socially constructed differences and the power relations between women and men, as a determinant of health. This was clearly articulated in the contributions made by WHO to the Fourth World Conference on Women in Beijing in 1995. The Beijing Declaration and Platform for Action in 1995 and the more recent ECOSOC agreed conclusion on Mainstreaming a Gender Perspective into all Policies and Programmes of the United Nations System in 1997 have given further support to this approach.

The Women’s Health and Development programme in WHO (WHD) has worked to integrate gender into WHO programmes. WHD is doing this by playing a catalytic and coordinating role, working with WHO programmes and the WHD Focal Points in the Regional Offices.

In 1996 WHD convened an informal Gender Working Group (GWG), in order to develop a more strategic approach to the integration of gender issues in WHO programmes, and to strengthen those individuals working on gender and women’s issues in WHO.

The objectives of this group are:

- to raise awareness and understanding of the importance of gender analysis to public health programmes and;
- to promote, expand and guide the integration/application of gender in the work of WHO and in health research, policies and programmes.

The GWG undertook the production of this technical paper as a first step in what is recognised as a long-term process and a complex issue. The aim is to make accessible a review of the literature on gender and health that would introduce WHO staff, health policy-makers and planners to the concept of gender and to illustrate the role of gender in health and health policy and programme development.

This paper is not a ‘how to’ manual and should be followed by other technical documents that explore in greater depth gender in relation to specific diseases and policy and programme issues. There is also a need for a practical
user-friendly guide to making health-related programmes gender-sensitive along with the need to build up the knowledge base on the gender differentials of health problems and health care and on effective interventions. We envisage that this is the first in a series of publications and look forward to working with other technical programmes to develop the series.

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Introduction

The aim of this technical paper is to explore some of the implications of the shift from the 'women in development' (WID) to the 'gender and development' (GAD) approach for the analysis of health and health care issues in general and for the work of WHO in particular.

Health policies and programmes have focused on biological aspects of diagnosis, treatment and prevention. Likewise, when considering the differences between women and men, there is a tendency to emphasise biological or sex differences as explanatory factors of well-being and illness. A gender approach in health, while not excluding biological factors, considers the critical roles that social and cultural factors and power relations between women and men play in promoting and protecting or impeding health.

While gender interacts with other kinds of inequalities in health, such as social class, race and ethnicity, the focus of the paper is on gender and health.

There has been a tendency to equate gender analysis with the 'analysis of the situation of women.' The purpose of a gender analysis is, however, to identify, analyse and act upon inequalities that arise from belonging to one sex or the other, or from the unequal power relations between the sexes. These inequalities can create, maintain or exacerbate exposure to risk factors that endanger health. They can also affect the access to and control of resources, including decision-making and education, which protect and promote health, and the responsibilities and rewards in health work. Since these inequalities most often disadvantage women, a gender analysis has been used so far mainly to explain and address women's health problems.

However, the social construction of male roles may also disadvantage men and an attempt has been made in the paper to provide some examples of this.
From 'Women' to 'Gender'

Over the last two decades, women's issues have moved rapidly up the policy agenda of national governments and international organisations. In 1985 in Nairobi, participants at the Third World Conference on Women agreed to adopt a Forward Looking Strategy to improve the status of women, and in the years that followed, policies in line with this approach were devised across the globe. Although these initiatives have been diverse in their origins and implementation strategies, most have been loosely based on what is termed the 'Women in Development' or WID approach.

Central to this approach was the recognition that women are marginalised. They are excluded from the mainstream of economic and social life and as a result are likely to receive fewer benefits than men from whatever the development process has to offer. Post-Nairobi, the solution to these problems was seen to lie in improving the access of women to health and social services, to education, to credit facilities and to other resources that might enhance their own well-being, while at the same time maximising their contribution to the wider community.

Research projects using the WID framework have brought considerable benefits for women. Evidence collected from many parts of the world has demonstrated that now, far from being on the margins of their communities, many women are actually at the heart of them, carrying out much of the labour that makes the continuation of economic, cultural and social life possible (Boserup, 1970; Rogers, 1980). At the same time, a range of WID-policy initiatives were implemented and have achieved considerable success in bringing about practical improvements in women's lives. Across the world, women live longer than men, fertility rates have fallen by a third, maternal mortality rates have been halved and female literacy has increased from 54% of the male rate to 74% (UNDP, 1995).

There can be no doubt that these have been very positive developments, often making a major impact on women's daily lives. However, they have done little to alter women's basic position in society. Women's economic, social and political status has remained largely unchanged and in some communities has actually deteriorated. This has led a growing number of observers to question the appropriateness of the WID approach as a means for meeting women's long-term needs (United Nations/ INSTRAW
The main criticism of WID policies is that they continue to define women themselves as 'the problem', as passive victims who need welfare and special treatment if their circumstances are to be improved. As a result, the reasons for women's plight remain largely unexplored. No explanation is given for the systematic devaluation of their work or the continuing constraints on their access to resources. In an attempt to fill this gap in the analysis, the focus of many planners and policy-makers is now shifting from women themselves to the social divisions between the sexes - in other words gender relations.

It is now clear that most dimensions of economic and social life are characterised by a pattern of inequalities between women and men that routinely value what is 'male' over what is 'female'. Unless these divisions are taken seriously, policies designed to improve the situation for women are likely to offer only limited and often short-term solutions. In recognition of this reality, a growing number of developmental agencies and other organizations are now adopting the 'gender and development' or GAD approach as a more appropriate methodology for tackling the massive inequalities that continue to limit the potential of so many women around the world (MacDonald 1994; Moser 1993; Canadian Council for International Cooperation 1991; UNDP 1995).

At the Fourth World Conference on Women held in Beijing in 1995, the emphasis on gender provided a striking contrast with the much narrower 'women centredness' of Nairobi a decade earlier. Participants echoed the themes of the International Conference on Population and Development held in Cairo in 1994, where gender equity and the empowerment of women were accepted as cornerstones for the planning of effective health and population programmes (Germain and Kyte, 1995). This shift towards a gender analysis has now been widely endorsed and the contributions of WHO to both conferences reflected the changing focus (WHO, 1994a and 1995).
What Do We Mean By Gender?

In biological terms, what distinguishes women from men is the differences between their reproductive systems. These anatomical and hormonal variations are the basis upon which individuals are allocated to a particular sex. However, they represent only a part of the complex set of criteria by which we all learn to distinguish femaleness from maleness. Equally important are the socially defined characteristics that different cultures assign to those individuals defined as female and those defined as male i.e., gender. These apparent differences are sometimes justified with reference to biology. Women are given certain sorts of jobs for instance, because their biological capacity for motherhood is said to make them more 'caring'. In reality however, gender differences are social constructions that can be changed in ways that most biological characteristics cannot.

Despite their diversity, all societies are divided along what we can call the ‘fault line of gender’ (Moore, 1988; Papenek, 1990). This means that women and men are defined as different types of beings, each with their own opportunities, roles and responsibilities. The most obvious illustration of this is the split between the public world of employment and politics which is seen as ‘naturally’ male and the private arena of the family and the household which is seen as ‘naturally’ female. Thus women in most societies are expected to take the major responsibility for domestic tasks (if not for actually performing them), and care of children, the elderly and the sick. Men on the other hand, are allocated the primary responsibility for supporting the family (with women joining them increasingly in the labour market).

These gender divisions shape the lives of both women and men in fundamental ways. As individuals with particular identities and as actors in an infinite variety of social contexts, they are shaped and reshaped by their femaleness or their maleness. In one sense then, both women and men are constrained by their membership of a particular gender group. But these variations represent more than just difference. In most societies they are also used to justify major inequalities with those in the category of female having less access than those in the category of male to a wide variety of economic and social resources. This inequality is most obvious in the distribution of income and wealth. Around the world,
women now make up about 70% of those who are poor (UNDP, 1995). This 'feminization' of poverty is found in both rich and poor countries and reflects women's unequal situation in the labour market, their less favourable treatment in most social security systems and their low status within the household. Many have no access to independent income and those who do earn their own wage receive on average around three quarters of the comparable male salary (UNDP, 1995).

As well as material discrimination, women's lives are also affected by the cultural devaluation of femaleness that is a significant element of everyday thinking in so many societies (Martin, 1987; Ussher, 1989). Work which is done at home for instance, is deemed to be of less value than waged work and those who perform it are treated accordingly. The relatively low value placed on women and girls by individual

Gender
Refers to women's and men's roles and responsibilities that are socially determined. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organised, not because of our biological differences.

Sex
Genetic/physiological or biological characteristics of a person which indicates whether one is female or male.

Mainstreaming gender
Integration of gender concerns into the analyses, formulation and monitoring of policies, programmes and projects, with the objective of ensuring that these reduce inequalities between women and men.

Gender equality
Absence of discrimination on the basis of a person's sex in opportunities and the allocation of resources or benefits or in access to services.

Gender equity
Fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognises that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes.

(see also Glossary)
families and by society as a whole is evident in the global statistics on literacy. Although considerable strides have been made over the past two decades, women still outnumber men by two to one among the world’s illiterate people and girls constitute the majority of the 130 million children without access to primary school (UNDP, 1995).

Women’s access to political and economic power is not commensurate with their numbers, their needs or their contributions as citizens. Some do exercise considerable influence within their own families and communities but many do not and few have formal power in the arenas where important decisions are made. For instance, although women make up half the electorate, they hold only 14.2% of ministerial-level positions and only 6% of the seats in national cabinets (UNDP, 1997). In some countries these gender inequalities in power continue to be reflected in the discriminatory nature of the law. Many women, for instance, are denied the right to manage their own property, to travel abroad, or to control their own fertility.

These examples demonstrate the complex and multi-faceted pattern of inequalities that still characterise the relations between the sexes. Even though progress has been made in some areas, widespread discrimination against women continues and it is a recognition of this reality that lies behind the adoption of the gender approach to policy and planning. As many of the problems women face are closely related to their relationships with men, the lives of men must be also be considered. Gender inequalities in authority and power have to be identified and strategies sought for their amelioration.

It is not surprising that the development of gender analysis has been led by those concerned to remedy the manifest inequalities that currently disadvantage women. However, it is also important to identify the ways in which gender stereotyping may damage men. Where societies expect men to be the ‘breadwinner’ for example, some men will feel obliged to work extremely long hours with resulting damage to their physical and mental health. Similarly, the social expectation of what it means to be a ‘real’ man may make it difficult for men who are ill to admit weakness and seek medical help (Sabo and Gordon, 1993). In what follows we will be concerned primarily with the impact of gender inequalities on the health of women. We will also identify those areas where men’s health may be put at risk by the ways in which gender roles are currently constructed.
Sex, Gender and Health

Patterns of health and illness in women and men show marked differences. Most obviously, women as a group tend to have longer life expectancy than men in the same socio-economic circumstances as themselves. Yet despite their greater longevity women in most communities report more illness and distress than men (Blaxter, 1990; Rahman et al, 1994; Rodin and Ickovics, 1990; US National Institutes of Health, 1992). The precise details of this excess in female morbidity and the factors that lie behind it will vary in different social groups, but the broad picture is one where women’s lives seem to be less healthy than those of men (Macintyre, 1996). The explanation for this apparent paradox lies in the complex relationship between biological and social influences in the determination of human health and illness.

Part of women’s advantage in relation to life expectancy is biological in origin. Far from being the ‘weaker sex’ they seem to be more robust than men at all ages (Waldron, 1986). In all societies significantly more male foetuses are spontaneously aborted or stillborn and in most societies this pattern of excess male mortality continues to be marked during the first six months of life. The reasons for this greater ‘robustness’ of girl babies needs further investigation but they seem to include sex differences in chromosomal structures and possibly a slower maturing of boys’ lungs due to the effects of testosterone (Waldron, 1986). In adult life too, women may have a biological advantage at least until menopause as endogenous hormones protect them from ischaemic heart disease.

Sex differences in inherent susceptibilities and in immunities to particular pathogens are just beginning to be explored and a complex picture is already emerging. We know for instance that women are more likely to suffer (and die) from osteoporosis, diabetes, hypertension, arthritis and most immune disorders, and that biological factors are likely to play some part in this (US National Institutes of Health, 1992). But overall, their innate constitution appears to give women an advantage over men, at least in relation to life expectancy. When this female potential for greater longevity is not realised it is an indication of serious health hazards in their immediate environment.

Women have not always lived longer than men. In Europe and the United States of America the female advantage over males first became apparent in the latter part
of the nineteenth century as the life expectancy of both sexes increased (Hart, 1988). Ever since, this gap between the sexes has continued to widen, with the size of the female advantage being proportional to the life expectancy of the population as a whole. In Europe, Latin America and the Caribbean the gap is about 5 years, in Sub-Saharan Africa 3 years and in South-east Asia 4 years. Only in Southern Asia do women and men have equal life expectancy (UNDP, 1995).

European experience suggests that the gap between female and male life expectancy grew as economic development and social change removed some of the major risks to women’s health. At the same time the introduction of new birth control techniques alongside changing values gave women greater control over family size, while general improvements in living standards and the introduction of maternity services led to a significant reduction in maternal mortality rates. Thus a range of social factors combined to enhance women’s inherent biological advantage.

For men, changes in the gender division of labour meant that they were taking on new risks (Hart, 1988). The emergence of the male ‘breadwinner’ in industrial economies required men to take on life threatening jobs in much greater numbers than women. As a result, male deaths from occupational causes have historically been higher than those among females and that pattern continues today (Waldron, 1995). At the same time men’s increased access to resources and their growing freedom from religious and other constraints led many to take up potentially dangerous pursuits, including the consumption of a number of dangerous substances (Waldron, 1995). Increasingly, these new habits came to be defined as inherently ‘masculine’ pursuits that had to be adopted by those who wanted to be regarded by their peers as ‘real’ men (Kimmel and Messner, 1993).

While these defining characteristics of masculinity vary in different cultures, there are few societies in which risk taking of various kinds does not play a significant part (Canaan, 1996; Pleck and Sonenstein, 1991). In most parts of the world, young men now run a much greater risk than young women of dying from accidents and violence. This includes large numbers of deaths in motor vehicles, often with alcohol involved. Later in life the greater numbers of premature deaths among males from heart disease reflect not only their greater biological vulnerability but also what have traditionally been higher rates of smoking.
Smoking, along with men’s greater exposure to occupational carcinogens is also responsible for the much higher numbers of male deaths from lung cancer. According to one estimate, approximately half of the entire sex differential in life expectancy in the United States and Sweden can be attributed to (past) gender differences in smoking patterns (Waldron, 1986).

It would appear therefore, that as many societies have undergone economic and industrial development, a variety of social and cultural factors have combined to allow women’s inherent biological advantage to emerge. The hazards of infectious diseases and the perils of childbearing have been reduced in industrialised countries while certain risks associated with masculinity have increased, giving women longer, but not necessarily healthier, lives than men. These processes continue to be evident today but progress towards improved life expectancy for women differs markedly between societies. In some of the richest countries in the world the gap between female and male life expectancy is now extremely wide. Indeed, it may even be starting to narrow again as the consequences of increased female smoking rates become apparent. However, in other countries the picture is very different with gender discrimination continuing to prevent women from realising their potential for greater longevity.

In Bangladesh, for example, men outlive women, while in India and Pakistan the two sexes have almost equal life expectancy (United Nations, 1991). In these
societies there is an excess of female deaths both in childhood and in the childbearing years and most can be attributed to material and cultural discrimination against girls and women (UNICEF, 1990; WHO, 1992a). In some populations this has reached the point where the ratio between women and men has become unbalanced. In India for instance, the sex ratio fell from 972 women per thousand men in 1901 to 935 per thousand in 1981, while the ratio of women to men was increasing in most other parts of the world (Sen, 1988). These are societies in which the biological advantage of the majority of women is entirely cancelled out by their social disadvantage, offering a sharp reminder that economic development alone will not necessarily allow women greater opportunity to flourish.

But even when women's potential for greater longevity is realised, this rarely results in them being healthier than men during their lifetime. Again, the reasons for this are partly biological, but social influences play a major role. Most research on gender differences in health and illness has been carried out in developed countries and the pattern is a consistent one. Women's own assessment of their health is worse than that of men. In the United States for example, women are 25% more likely than men to report that their activities are restricted by health problems and they are bedridden for 35% more days than men because of acute conditions (US National Institutes of Health, 1992). In community surveys, women also report twice as much anxiety and depression as men (Paykel, 1991; Dejarlais, Eisenberg, Good and Kleinman, 1995). Although data on female morbidity in developing countries is extremely sparse a roughly similar pattern emerges (Rahman et al., 1994).

These very broad gender differences in self-reported illness are obviously difficult to interpret. The patterns themselves may vary slightly between age groups and across societies as may the different factors causing them. To some extent they may simply reflect gender differences in illness behaviour, with males less willing than females to admit weakness or distress. However, most commentators agree that, in a wide range of social groups, women experience higher levels of illness and disability than men. The reasons for this are elaborate but we can identify three contributory factors.

First, women's greater longevity is itself a cause of their higher rates of morbidity. As we have seen this has both social and biological dimensions. Deteriorating health is a frequent, though not an inevitable, part of the ageing process for both sexes and women make up the majority of elderly people in the world especially the 'old, old' (WHO, 1996a). Moreover the ageing process itself is a highly gendered
one and the experience differs for women and men in a number of ways. Older women are biologically more susceptible than men to certain disabling diseases including rheumatoid arthritis, osteoporosis and alzheimer’s disease (WHO, 1992b; WHO, 1994b; Murray and Lopez, 1996). Because of inequalities in income and wealth in earlier life, older women are also likely to have fewer material resources at their disposal and are less likely than men to receive assistance from relatives and friends (WHO, 1996a).

Second, women are more likely than men to suffer health problems connected with their reproductive systems. Throughout their lifetime, both women and men are at risk from sex-specific diseases. For example, only women need screening for cancer of the cervix and breast cancer is almost entirely a female problem, while only men can develop prostate or testicular cancer. Overall however, women bear a heavier burden than men of reproductive health problems and this vulnerability is exacerbated during their childbearing years.

Their capacity to conceive and bear children brings women into the arena of the health care system more often than men. Very often they are perfectly healthy and are either seeking access to fertility control or support during a normal pregnancy. However, these ‘natural’ processes will sometimes go wrong, causing problems that require expert care. Although these difficulties take the form of biological disorders, social factors often play a major part in causing them, with gender discrimination in nutrition, health care and social support all heightening women’s vulnerability during the reproductive process.

For some this will mean parenting that has not been actively chosen and possibly a dangerously high number of pregnancies. Others may be forced to take the risk of an unsafe termination of pregnancies. Close to 80,000 women die each year as a result of unsafe abortion (WHO, 1997a). If contraceptives are available women may have little choice about methods, forcing them to make complex trade-offs between the risks of the technologies themselves and the hazards of multiple pregnancies (Jacobson, 1991; Mintzes, 1992).

Whatever their circumstances the vast majority of the world’s women do embark at some point in their lives on the road to motherhood. Here too, an apparently biological process is profoundly affected by broader social and cultural factors, especially inequalities between the
sexes in the household. Some women face difficulties in carrying a pregnancy successfully to completion because of childhood discrimination (Royston and Armstrong, 1989). Failure to nourish girls can limit their capacity for healthy motherhood through, for example stunting and a small pelvis, while a reluctance to provide medical care may compound these problems. If a pregnancy goes wrong, lack of obstetric care may be fatal and millions of women continue to face such risks each year (Royston and Armstrong, 1989; Thaddeus and Maine, 1991; Royston, 1991). The result is an annual toll of over half a million deaths and eight million cases of disability from pregnancy-related causes. These deaths are an important indicator of the social and economic inequalities among women themselves. In developing countries maternal mortality is rare. In developing regions however, such as sub-Saharan Africa and South Asia, maternal mortality is high, with 686 and 444 deaths per 100,000 live births respectively (World Health Organization, 1991).

Women are also disproportionately affected by harmful traditional practices such as female genital mutilation (FGM). In parts of the world where FGM is practiced, there are serious health consequences for millions of women and girls. Short-term consequences include haemorrhage, shock, infection, urine retention and urinary tract infections. Long-term consequences include retention of menstrual blood, painful menstruation, risks during pregnancy and child birth, fistulae, incontinence and sometimes death (WHO, 1996b).
Third, studies from many parts of the world show that women are more likely than men to report symptoms of mental distress (Desjarlais et al., 1995). At most stages of life, women report higher levels of anxiety and depression than men, and in developed countries at least, they are more likely to receive treatment for these conditions. Men, on the other hand are more likely to suffer from schizophrenia and other serious psychoses and are more likely to commit suicide, although more women attempt it (Desjarlais et al., 1995).

Attempts to explain these differences in terms of biology have met with little success and answers are increasingly being sought in the daily lives of those who become mentally ill. For instance, the increasing rates of suicide among young men in many developed countries have been linked to rising rates of unemployment and a loss of identity and sense of self respect (Charlton et al., 1993). Similarly the higher rates of anxiety and depression found among women in so many parts of the world have been linked on the one hand to the stresses and strains of daily life, especially in conditions of poverty, and on the other to the gender socialisation that leads so many women to put little value on themselves and their potential (Desjarlais et al., 1995).
Gender and Risk: three case studies

We have seen that being 'male' or being 'female' has a major effect on an individual's health and well-being. The combination of their biological sex and the gendered nature of their cultural, economic and social lives will put individuals at risk of developing some health problems while protecting them from others. Furthermore, the subsequent effect of these problems on the individuals concerned will also be influenced by both their gender roles and their sex. The 'natural' course of a disease may be different in women and men; women and men themselves often respond differently to illness, while the wider society may respond differently to sick males and sick females. Women and men may also respond differently to treatment, have different access to health care and be treated differently by health providers. These are intricate processes that are not easy to disentangle but three case studies will be used here to illustrate them.

TROPICAL INFECTIOUS DISEASES

Worldwide, the so-called tropical diseases continue to be major causes of disability and death, causing between a half and a third of all deaths among young adults in sub-Saharan Africa (Howson, Harrison, Hotra and Law, 1996). Although they are closely linked with certain climatic conditions they are also diseases of poverty found almost entirely in the least developed countries. Malaria causes the most damage with around 300 to 500 million people infected worldwide and 10 million deaths annually (WHO, 1997b). Schistosomiasis is prevalent in more than 74 countries with 200 million individuals affected each year and around 100,000 deaths (WHO, 1997b). Leprosy, filariasis (onchocerciasis and elephantiasis), trypanosomiasis (African sleeping sickness and chagas disease), leishmaniasis and trachoma also cause extensive morbidity and mortality in tropical countries.

These differences are a function of the interaction between biological factors and gender roles and relations. Biological factors vary between the sexes and influence susceptibility and immunity to tropical diseases. Gender roles and relations influence the degree of exposure to the relevant vectors and also to access and control of the resources needed
to protect women and men from being infected (Rathberger and Vlassoff 1993; Manderson, Jenkins and Tanner, 1993).

Until recently, researchers had paid very little attention to either sex or gender issues in the field of tropical diseases. If differences between females and males were considered at all, the focus was clearly on women’s reproductive lives, assessing the effects of tropical diseases on fertility and pregnancy outcomes (Manderson et al., 1993). Few studies had explored either the impact of wider biological variations between the sexes or the influence of inequalities between women and men on the incidence or outcomes of infection. However, this gap is now beginning to be filled.

Differences between female and male prevalence and incidence rates are difficult to measure since cases in women are more likely to be undetected. The fact that services focus almost exclusively on women’s reproductive function means that opportunities are lost for detection of multiple conditions, including tropical diseases (Vlassoff and Bonilla, 1994; Hartigan, 1997). Moreover, when incidence rates in women and men are similar, there are still significant differences between the sexes in both the susceptibility and the impact of tropical diseases.

Even when tropical diseases are shared by both sexes, they may have different manifestations or natural histories in women and men, or differ in the severity of their consequences. For example, malaria is shared by women and men, with a tendency to be slightly higher in males (Howson et al.; 1996; Vlassoff and Bonilla, 1994). However, biologically, women’s immunity is compromised during pregnancy, making them more likely to become infected and implying differential severity of the consequences. Malaria during pregnancy is an important cause of maternal mortality, spontaneous abortion and stillbirths. Particularly during pregnancy, malaria contributes significantly to the development of chronic anemia (McGregor, 1984).

Malaria

The preponderance of male patients in malaria clinics in many countries has led to the assumption that males are more exposed to infection for occupational reasons. Research in a region of Thailand, established that rates of exposure, infection and illness among men, women and children were similar. Time, mobility and other social constraints discouraged women from attending clinics - Providing mobile services was found to be an effective way of taking treatment to the women. (Sims, 1994)
Likewise, schistosomiasis is shared by both sexes, but genital schistosomiasis in women has been associated with a wide range of pathological manifestations such as infertility, abortion, pre-term delivery and life threatening conditions such as extra-uterine pregnancy. However, these associations remain largely undocumented.

We still know little about how biological differences between the sexes can produce different health outcomes among women and men when exposed to the same environmental hazard. Further work is urgently needed to clarify the more general question of sex differences in susceptibility to a range of infectious diseases including measles and tuberculosis (Hudelson, 1996).

Turning to gender factors, the life spaces in which women and men carry out their activities will differentially expose women and men to disease vectors and hence to varying degrees of risk of contracting tropical diseases.

Gender factors may protect women or men from exposure to tropical diseases, or conversely, place either sex at greater risk. For example, women who remain in exclusion are less likely to be exposed to mosquitoes and therefore less likely to contract malaria (Reuben 1993). Women's more extensive clothing can also have protective effects. However, domestic labour itself may increase exposure to other vectors (Vassoff and Bonilla, 1994). A recent review of a study in Nigeria found that the highest prevalence of schistosomiasis was found in adolescent girls in the age group 5-15 years. The prevalence peaks at age 15, when they become fully involved in water-related domestic work such as agricultural tasks and clothes washing. The Nigerian study also noted that 71% of all water-related activities were carried out by women, and...
both studies attributed women's infection rates to their domestic responsibilities that involved continuous exposure to water (Sims 1994). While the rate in males drops after late adolescence, that of females remains stable, reflecting the fact that men grow out of playing around water but women's duties require continued exposure (Michelson, 1992). Care of dependants may also increase women's risk of contracting particular diseases. The excess of trachoma among females has been linked to their greater involvement with children who bring the disease home from school (Howson et al. 1996).

It is clear that not only do gender roles and relations affect exposure to tropical and other diseases, but also influence the degree to which either sex can access and control the resources needed to protect their health.

There is considerable evidence to show that women are often constrained in their use of the appropriate health services by lack of transport, by inadequate resources or even by their husband's refusal to grant permission (Parker, 1992). The social interpretation of particular diseases may also be important. In the case of disfiguring problems such as leprosy, for instance, women may be especially reluctant to expose themselves to health care providers, fearing subsequent stigmatisation. Also with leprosy, women may come later for care which leads to more disability and/or disfigurement (Ulrich, Zuyleta, Caceres-Dittmar, Sampson, Pinard, Rada and Nacard, 1993; Duncan 1993). Similarly, some cultures have a double standard equating schistosomiasis with immoral sexual behaviour in women but with virility in men (Sims, 1994). These gender differences in illness behaviour and in societal responses to female and male patients mean that the progress of tropical diseases can sometimes be accelerated in women, especially those with the least resources and the lowest levels of support.

HIV/AIDS AND OTHER SEXUALLY TRANSMITTED DISEASES

Around the world, sexually transmitted diseases (STDs) continue to be a major cause of distress, disability and sometimes death for both sexes (Dixon-Mueller and Wasserheit 1991; Germain, Holmes, Piot and Wasserheit 1992). HIV/AIDS in particular, is continuing to spread, killing millions of women and men in the prime of their lives. Current estimates suggest that over 30 million people are now living with HIV of which 1.1 million are children. By the year 2000 it is estimated that over 40 million women and men will have been infected with HIV. The pandemic is concentrated in the poorest parts of the world with 90% of
those who are HIV positive living in the developing world (UNAIDS, 1997).

Although the majority of current HIV infections are still among men, AIDS is becoming an increasingly female affair (Berer and Ray, 1993). In the initial stages, few women were among those directly affected but this pattern has changed dramatically. Heterosexual transmission is now dominant in most parts of the world and in Africa, south of the Sahara, there are already six women with HIV for every five men. Of the estimated 5.8 million HIV infections that occurred in 1997, nearly half were in women and about 590,000 occurred in children (UNAIDS/WHO, 1997). Women now account for 42% of the people living with HIV. In the United States HIV infection has now supplanted heart disease as the third major killer of women aged 25 to 44, following cancer and unintentional injuries (Zierler and Krieger, 1997).

This increase in the numbers of HIV positive women reflects their greater biological vulnerability to the disease. However, it is also a consequence of the social constructions of female and male sexuality as well as the profound inequalities that continue to characterise many heterosexual relationships (du Guerny and Sjoberg, 1993; Zierler and Krieger, 1997).

Biologically, the risk of HIV infection during unprotected vaginal intercourse is two to four times higher for women than men. This is because women have a bigger surface area of mucosa exposed to their partner’s sexual secretions during intercourse. Semen also contains a higher concentration of HIV than vaginal...
Many women find the heterosexual relationship a difficult one in which to negotiate a strategy for their own safety. In many societies, sex continues to be defined primarily in terms of male desire with women the relatively passive recipients of male passions (Richgels, 1992; Gavey, 1993). Under these circumstances women may find it difficult to articulate their own needs and desires and their own pleasure may be of little concern (Holland, Ramazanoglou, Scott, Sharpe and Thomson, 1990; Weeks, Singer, Grier and Schensul, 1996). They find it difficult to assert their wish for safer sex, for their partner’s fidelity or for no sex at all, and as a result their own health and that of others may be put at grave risk. This applies in particular to very young women who are often sought out by older men because of their presumed passivity and freedom from infection (Bassett and Mhloyi, 1991; de Bruyn, 1992).

Cultural pressures of this kind are reinforced by gender inequalities in income and wealth. For many women, their economic and social security - often their very survival - is dependent on the support of a male partner (Seidel, 1993; Worth, 1989). Sexual intercourse done in the way he desires may well be the price that has to be paid for that continuing support. In some instances this bargain will be explicit as social pressures in many parts of the world push women towards selling sex for...
subsistence (Jochelson, Mothibeli and Leger, 1991; Panos Institute 1992; Ford and Koetsawang, 1991). In other situations it may only be implicit, but the fear of abandonment can be a powerful force especially in those societies where few roles exist for a woman outside marriage and motherhood. In many societies, divorced or separated women and their children are even discriminated against and in some countries, women have no legal right to refuse sex with their husbands.

As well as economic and social insecurity, many women also have to face the threat of physical violence if they are not sufficiently responsive to a partner’s desires. Under these circumstances, many will prefer to risk unsafe sex in the face of more immediate threats to their well-being. It is the outcome of complex interpersonal negotiations in which the social constraints of gender inequality play a key role. It is often the poorest women who have the fewest choices, run the most risks and are most likely to become infected (Zierler and Krieger, 1997).

If a woman does become infected with HIV or with any other STD, gender inequalities may affect the progression of the illness and possibly her survival chances. In those parts of the world where AIDS is commonest, health care budgets are often so small that neither sex can expect sophisticated treatment. However, funds are still spent disproportionately on men (Seidel, 1993). Even in the United States where resources are more abundant, there appears to be a gender bias in their allocation (Kurth, 1993). Moreover women have often been excluded from clinical trials (Korvick, 1993; Denenberg, 1990).

This exclusion of women from many research studies on HIV/AIDS has had the additional effect of prolonging the male bias in research into the disease, so that key questions concerning biological differences in female and male experiences of AIDS remain unanswered (WHO, 1990; Kurth, 1990; Anastos and Vermund, 1993). Researchers are beginning to address this lack of information but it still affects some women’s ability to get an accurate prognosis and treatment and may exacerbate the uncertainties they face in making choices about their reproductive future. In the final analysis the combination of unequal access to care and the gender gap in medical knowledge contributes to a situation where women in both rich and poor countries have a shorter life expectancy than men after a diagnosis of AIDS (Anastos and Vermund, 1993; de Bruyn, 1992; Richie, 1990).

VIOLENCE AND INJURIES

Intentional and non-intentional injuries are among the major
causes of morbidity and mortality for both women and men at all ages and across all societies. Again, precise figures are difficult to obtain but we know that in developed countries they account for more deaths in people aged 15-44 than all infectious diseases combined. Even in developing countries they are usually among the top five causes of death at all ages (Howson et al., 1996). Both unintentional and intentional injuries are more common among men.

Starting with unintentional injuries, we know that men are more likely than women to die in car accidents or to suffer death or disability as a result of occupational hazards. The latter reflects their historical role as the main economic supporters of their households as well as their more frequent employment in the most dangerous industries. It also reflects the way occupational hazards have been defined. Although women have lower rates of

Health consequences of gender-based violence

Non-fatal Outcomes

- STDs
- Injury
- Unwanted pregnancy
- Miscarriage
- Chronic pelvic pain
- Headaches
- Gynaecological problems
- Alcohol/drug abuse
- Asthma
- Irritable bowel syndrome
- Injurious health behaviours (smoking, unprotected sex)

Mental health consequences

- Post-traumatic stress disorder
- Depression
- Anxiety
- Sexual dysfunction
- Eating disorders
- Multiple personality disorder
- Obsessive-compulsive disorder

Fatal Outcomes

- HIV/AIDS
- Suicide
- Homicide

(Heise, Pitanguy and Germain, 1994)

unintentional injuries overall, their domestic responsibilities mean that they are more likely than men to suffer injuries at home. These have so far received little attention but there is growing evidence that these occupational injuries may be as important as those in more conventional workplaces.

Intentional injuries too are more common among men, with much of existing violence being directly connected to what is defined as 'masculine' behaviour, risk-taking, aggression and the consumption of drugs and alcohol (Staples, 1995). In the inner cities in the United States for example, homicide is a major cause of death among young males.
However, it is not just themselves that men can damage through this type of behaviour. Male violence against women, particularly in the home, has many damaging consequences for women’s health, including intentional injury. Male violence against women lies at the heart of the debate about gender inequalities.

All acts of violence are ‘gendered’ irrespective of whether the victim is female or male. In general those who commit the violence are male (WHO, 1996c; Heise, Moore and Toubia, 1995). Both sexes can be the victims of violence but women and men are likely to experience the attack in distinct ways, they are likely to have a different relationship to the perpetrator and the type of harm inflicted is likely to reflect the sex of the person being attacked. When women are the victims of the attack, the perpetrator may well be motivated directly by the desire to demonstrate his own masculinity, to enforce his (male) power and to control the woman, as is usually the case in domestic violence. This has led many experts to adopt the term ‘gender-based violence’ to describe this kind of violence.

In most communities women appear to be at greatest risk from intimate male partners or other men that they know, and the violence girls and women experience occurs most frequently in the ‘haven’ of the family. The damaging effects on women’s physical and mental well-being can be extremely pervasive and go far beyond injury (see box on health consequences of gender-based violence). A physical battering may include pushing, clubbing, stabbing or shooting. The injuries inflicted may be severe and for some women will be fatal. 30% of suicides and 60% of homicides of women are associated with domestic violence. If the attack also includes rape then it may lead to unwanted pregnancy, gynaecological problems or sexually transmitted diseases (WHO, 1997c).

As well as causing physical damage, gender-based violence can lead to psychological distress and trauma with the resulting distress often lasting a lifetime. Those who are sexually abused as young girls may be especially damaged and some are never able to make a full recovery (Browne and Finkelhor, 1986; deChesney, 1989). Women who have been abused are often debilitated by anxiety about the next attack and many suffer post-traumatic stress disorder (Koss, 1990). They have increased rates of depression and substance abuse and some see suicide as the only way out (Andrews and Brown, 1988; Plichta, 1992). A recent study in the US found that between 30% and 40% of all battered women attempted to kill themselves at some point in their lives (Stark and Flitcraft, 1991).
Reliable, epidemiological data on the extent of domestic violence are sparse, particularly in developing countries. Not surprisingly, women are often extremely reluctant to report attacks for fear of not being believed or being revictimized. Information is often not recorded in a systematic or sympathetic way. However, some progress has been made in recent years in estimating the scope of the problem. A recent review of evidence from 40 well-designed population-based studies suggested that between 25% and 50% of women around the world report being victims of physical abuse by men at some point in their lives (Heise et al., 1994). Estimates from the World Bank suggest that rape and domestic violence together account for 5% of the total disease burden for women in developing countries and 19% in developed countries which is comparable to that posed by other risk factors and diseases, such as HIV and TB (World Bank, 1993; Heise et al., 1994).

Emerging evidence of the high rates of violence imposed on women has put it high on the agenda of women’s health advocates. However, successful prevention requires a much clearer understanding of the reasons behind this violence. Violence is an overwhelmingly male pursuit but it is unclear whether this is the result of biology, social conditioning or a combination of both. The answer to this question is still the subject of considerable debate, but there is now a growing consensus that male violence is neither an entirely biological phenomenon nor solely a product of culture (Heise et al., 1994). Hence, the greater propensity of some men to commit acts of violence may not
be immutable and is potentially reducible through community and/or individual interventions.

CONCLUSION

These case studies have explored the complex relationship between sex and gender in the patterning of health problems among women and men. They have identified both biological and social influences on well-being and identified some of the constraints imposed by gender stereotypes on each sex.

It has been evident throughout the analysis that despite their (usually) greater longevity, it is women who are most disadvantaged. They are less valued than men, have less access to a range of resources and less capacity to realise their potential for health. The remaining sections will therefore narrow the focus to concentrate on the implications of gender divisions of labour for women.
The Impact of Gender Roles on Women's Daily Lives

Every society around the world assigns gender roles which direct activities and govern behaviour for women and men, girls and boys. Mediated by factors such as socio-economic level and other status differences between women and men in a given society, these gender roles exert various degrees of constraints. In general, the more rigid the gender role in a society, the sharper the gender division of labour and the lower the status accorded to women. The roles are rooted in rational responses to a lifestyle no longer adapted to the forces of social change sweeping the world.

These forces, such as globalization and urbanization, are altering the pace and style of life in even the remotest corners of the world. This requires role changes and adaptations in home and working life which have differential gender impacts, particularly as the changes needed may be significant, and the pace of role adaptation is often slow. This disjunction has a tendency to leave resource-poor women caught between two worlds, the new and the old, with responsibilities in both. Any attempt to understand the social dimensions of health and illness must therefore include a systematic analysis of the impact of gender roles on daily life, both inside and outside the home.

For instance, looking at roles inside the home, the physical health consequences of heavy domestic work have not been adequately explored. This is particularly relevant in rural settings where the need for physical weight-bearing is greatest, and women may be required on a regular basis to carry loads that would not be permitted for either sex in countries with occupational health and safety legislation (Chatterjee, 1991; Rodda, 1991). Risks from domestic exposure to chemicals in cleaning agents may be poorly understood due to lack of information (Dowie, Foster, Marshall, Weir and King, 1982; Rosenberg, 1984) or illiteracy. Kitchens everywhere, but particularly in poor rural and urban dwellings, function as a major focus of activity for women, both in connection with domestic work and income-generating activities undertaken in the home. They pose a wide range of environmental and occupational hazards which are frequently
unrecognised or underestimated (Nystrom, 1994). Deficiencies in water, sanitation, energy supply, food handling and storage, equipment, design and layout have large affects on women. They mainly affect women in terms of workburden and inconvenience, cuts, burns, falls, exposure to indoor air pollution, and ergonomic problems, but the impact of inadequate kitchen facilities are felt by the whole family in terms of food safety, home hygiene and risk of accidents. Indoor air pollution, a risk linked entirely to kitchen activities, is a contributing factor to acute respiratory infection in infants under five years, and is also responsible for high levels of chronic respiratory and heart disease found in women in some of the world’s poorest countries (Chen, Hong and Pandey, 1990; Norboo, Yahya, Bruce, Heady and Ball, 1991; Behera, Dash and Yadav, 1991; Mishra, Malhotra and Gupta, 1990; Grobbelaar and Bateman, 1991; Sims, 1994).

Different gender roles also mean different priorities in daily life, and can be the cause of intra-household conflict. Development policy has been slow to recognise and respond to these differences, and until recently has tended to prioritise training and interventions aimed at men (Karl, 1995). This only increases the gender gaps in skills, knowledge, and income-generating power. At the household level, different priorities and decision-making power often operate to the detriment of women. For example, cash-cropping (see box). Trees themselves are gendered resources, and priorities may differ over which species are to be planted for what purpose. Agreement over the amount of land to be put under cultivation for cash crops, or the amount which should be sold, may differ, as men will largely control the resulting income although women’s labour.

Nutrition and cash cropping

In rural societies of developing countries, types of crops cultivated are frequently associated with either men or women, with the most lucrative crops usually being the men’s domain. Most women are obliged to invest a significant portion of their time assisting their husband’s cultivation of cash crops. This may leave insufficient time and good quality land for their own cultivation of food staples for family consumption. Coping mechanisms include growing less nutritious foods or buying ready-processed foods. These can have long-term negative impacts on health and nutrition.

(Sims, 1994)
will be a major input (Holmboe-Ottesen and Wandel, 1991).

As well as exposing women to chemical hazards, domestic work itself may be damaging to health. The labour can be extremely hard, requiring intense effort sometimes in extremely difficult conditions and often during pregnancy (Lado, 1992; Kishwar, 1984; Kabeer, 1991; Ferro-Luzzi, 1990; Cecelski, 1987). Women engaged in subsistence agriculture for example, may have to work very long hours in severe heat with little food or water to sustain them while further domestic labours await their return.

The nature of women’s domestic lives may also be dangerous for their mental health. A considerable body of evidence from developed countries indicates that depression is an occupational hazard among women who stay home alone to look after small children (Brown and Harris, 1978). In community surveys many full-time ‘housewives’ and carers report feelings of emptiness, sadness and worthlessness. Although research is sparse, it is increasingly evident that in other cultures too, women’s domestic lives are often the cause of considerable anxiety and depression (Desjarlais et al., 1995; Chakraborty, 1990; Malik, Bukhtiari, and Good, 1992; Davis and Guarnaccia, 1989). The reasons for this are complex but include the low status awarded to domestic work, as well as isolation and lack of economic and social support (Belle, 1993; Dennerstein, Astbury and Morse, 1993; Desjarlais et al., 1995; Reichenheim and Harpham, 1991).

Different valuation for different roles means that women and men
everywhere do not have equal access to the material and emotional resources needed to sustain health. There is considerable evidence to show that in some parts of the world, food, income and medical care may not be distributed according to need (Sen, 1988; Dwyer and Bruce, 1988; Ravindran, 1986; Sims, 1994; Kurz and Prather, 1995). In many societies, cultural norms dictate that males in the household have the principal share of income and wealth as well as higher status and greater decision-making power, with women exerting influence on their decisions to a greater or lesser degree. The ‘caring’ role carries through to formal employment, where jobs in which women predominate, such as office work, the service industry and nursing, often have a strong caring or service component. This can require ‘emotional labour’ through the obligation to present positive feelings not being experienced, or to repress negative emotions, which can lead to ‘burnout’ and feelings of ‘loss-of-self’ as emotions are denied (Garcia-Moreno, 1994).

These inequalities in influence and power within the household can also affect women’s reproductive lives, constraining their ability to make fully informed choices about sexual practices or about fertility control. All societies operate with a set of moral beliefs about the nature of women and men, the purposes of sexual activity and the meaning of parenthood and family life (Segal, 1987; Snitow, Stansell and Thompson, 1984; Vance, 1984; Caplan, 1982). As a result, many women find themselves locked into complex webs of duties and obligations which may severely limit their ability to make autonomous decisions that are central to their future lives.

On top of their domestic and reproductive responsibilities, millions of women are also engaged in economic activities. Official statistics suggest that 40% of women around the world are now in the labour force but this is clearly an underestimate since so much of their work is unrecorded, especially in the informal sector which is predominantly female (United Nations, 1991; United Nations, 1995). For some, this labour means an improvement in their general well-being through easier access to basic necessities, enhanced self esteem and wider social networks (Repetti, Matthews and Waldron, 1989; Waldron and Jacobs, 1989; Rosenfield, 1992; Bartley, Popay and Plewis, 1992). However, the circumstances of many women’s employment places limits on these potential benefits, especially for those who are living in poverty with few sources of economic and social support.

Continuing gender divisions in the labour market, and increasing numbers of unskilled women entering the labour force, tend to
concentrate more women than men in poorly-paid jobs, many of which combine high levels of responsibility with low levels of control (United Nations, 1991; Haynes, 1991; Haynes et al., 1987). For those in the informal sector there are few controls over hours or conditions of work. Domestic workers in particular are often severely exploited or even enslaved. Even more importantly, women's entry into paid work rarely frees them from responsibility for their own domestic labour. Many are engaged simultaneously in childbearing, care of dependants and a range of economic activities. As a result, their lives in general, particularly their leisure time, are more fragmented than those of men, with the pressures of their multiple roles representing an often greater drain on their mental and physical health, strength and vitality (Frankenhaeuser, Lundberg and Chesney, 1991; Desjarlais, 1995).

This section has examined how gender roles, which are present in every society, create different impacts on women and men in a changing world. The content and balance of activities varies markedly between cultures and societies, between women and men, and across the life span of all individuals. It is the co-existence and co-mingling of numerous tasks which usually fall to the shoulders of women which mainly differentiate their lives from those of men. In holding together the 'double burden' of productive and reproductive activities, frequently without adequate state or family support, the consequences for women can be damaging.
Gender Inequalities in Health Care

So far, we have been concerned mainly with gender influences on health itself. However, we have also identified differences in the ways in which women and men are treated by the health care system. In this section we look at these issues in more depth, exploring the various factors that can lead to inequality between the sexes, both in access to health care and also in outcomes. This will serve as a prelude to the next section, which outlines some of the ways in which health policies can be reconfigured to promote gender equity.

Gender bias in medical research

There is now a growing body of evidence to indicate that medical research has been a profoundly gendered activity (United States National Institutes of Health, 1992). The topics chosen, the methods used and the subsequent data analysis all reflect a male perspective in a number of important ways (Rosser, 1994). Common problems that cause considerable distress for women have received little attention if they are not central to their reproductive roles. Incontinence, dysmenorrhea and osteoporosis are frequently cited as examples of such neglect (US National Institutes of Health, 1992). In developed countries the failure to reduce the very high mortality rates from breast cancer has also led to accusations that research into the disease is not adequately funded (Freedman and Maine, 1993; Brady, 1991). This, however, has been changing thanks to organised advocacy efforts by women’s organisations.

Gender bias is evident not only in the selection of research topics but also in the design of a wide range of studies. Where the same diseases affect both women and men, many researchers have ignored possible differences between the sexes in diagnostic indicators, in symptoms, in prognosis and in the relative effectiveness of different treatments (American Medical Association, Council on Ethical and Judicial Affairs, 1991; Kirchstein, 1991). This problem was identified in earlier sections in the context of tropical diseases and HIV/AIDS research. Coronary heart disease (CHD) also continues to be seen as a 'male' disease and this is reflected in a number of ways in research design.

Most of the major studies carried out on CHD in the UK and the
US have used samples that are totally or predominantly male (Freedman and Maine, 1995; Gurwitz, Nananda and Auorn, 1992). This is usually justified by reference to the fact that more men than women in these countries die prematurely from CHD. However, it is also the single most important cause of death for post-menopausal women. There are clearly sex differences in the physiology of heart disease but because of the bias in research design, not enough is known about their implications to ensure gender sensitivity either in clinical treatment or in strategies for prevention.

The exclusion of women from research studies has also been justified on the grounds that their cyclical hormonal changes make the results difficult to interpret and/or that female subjects may become pregnant and put the resulting foetus at risk. These problems certainly pose both ethical and methodological challenges but they are not in themselves arguments for the exclusion of women from either epidemiological studies or clinical trials (Hamilton, 1996; Oberman, 1996). They merely provide rationalisations for the continuation of practices that significantly limit the capacity of medicine to deal effectively with the health problems of women. So long as researchers treat men as the norm, the medical care of women continues to be compromised. The results obtained from research on predominantly male subjects is applied with little questioning to (potentially pregnant) female patients (DeBruin, 1994). Yet their exclusion from the original studies was grounded both in their reproductive potential and in a presumption of significant physiological differences between the sexes. The end result is that women continue to be treated on the basis of information gathered from research in which drugs may not have been tested on female bodies, in which the precise manifestation of the disease in women may not have been studied and in which women’s experiences of both illness and treatment may not have been adequately explored.

GENDER DIFFERENCES IN ACCESS TO HEALTH CARE

There is now considerable evidence of gender differences in access to health care although the picture varies considerably around the world. In the developed countries a wide range of studies show that most women (apart from the very poorest) use medical services more than men. This has clearly offered them considerable benefits denied to women in many developing countries. However, it has also led in some instances to the criticism that doctors may be taking over aspects of women’s lives in inappropriate ways (Riesman, 1983; Miles, 1991; Martin, 1987).
Feminist writers in a number of countries have argued that the normal processes of pregnancy and childbearing for instance have been turned into medical events with control taken away from women themselves (Graham and Oakley, 1981; Rothman, 1989). Similarly, they have shown that too often doctors treat depressed women with a pill rather than identifying underlying causes such as domestic violence or examining their living and working conditions. (Gabe and Lipshitz-Phillips, 1986; Ashton, 1991). Hence, there are serious questions concerning appropriate levels of medical intervention in women’s lives. When does a problem become a ‘medical’ one and who should decide? Do doctors sometimes ‘take over’ in situations where other solutions would be more appropriate?

Viewed on a global scale however, the most pressing concern is not too much medical attention for those who can afford it but lack of attention for those who are poor. Even in rich countries like the United States, poor women find themselves without access to health care more often than men from the same social group (Zierler and Krieger, 1997; Krieger and Zierler, 1995).

However, it is in the poorest parts of the world that women’s lack of access to health care is at its most acute (Jacobson 1993; Timyan, Brechin, Measham and Ogunleye, 1993). In part this reflects the very low levels of expenditure on health care overall, which in many societies has been exacerbated by structural adjustment policies. While annual per capita expenditure on health care in the UK is about $1039, in Bangladesh the comparable figure is only $7 and in Mozambique $5 (WHO, 1995). These severe constraints on public sector spending obviously affect both sexes, but in conditions of poverty it is usually women who face the greatest problems in acquiring adequate health care.

We know that many households, in certain regions of the world, spend less on health care for women and girls (das Gupta, 1987; Papanek, 1990; Sen, 1988 and 1990; UNICEF, 1990). This reflects both their lower social status and their lack of decision-making power. Often men control the cash, making it difficult for women to pay for health care or for transportation costs if facilities are far away. Women are also more likely than men to spend what little cash they have on their children. The relationship between the cost of services and their rate of uptake is often complex, but in most cases increased costs lead to a decline in use and this trend is especially evident among women (Timyan et al., 1993).

These financial constraints are reinforced in settings where
customs and values deny women the right to travel alone or to be in the company of men outside their immediate family. In circumstances where female health workers are not available, treatment by a man may dishonour a woman and her family and she may need to go without care in order to avoid this. The opportunity costs of medical treatment may also be greater for a woman. If she becomes ill at harvest time for example, there may be no-one who will take her place either in the fields or at home so that the visit to a health worker might impose unacceptable burdens on the household as a whole.

As well as these economic, social and cultural obstacles, the emotional and cognitive capacities of women themselves may limit their access to health care. In many cultures women learn to believe that suffering is their lot (Papanek, 1990). Problems such as backache or vaginal discharge may be so widespread that they are accepted as normal with no expectation that things could be any different (Bang and Bang, 1992). Low self esteem limits women’s ability to make demands, and this may be reinforced by embarrassment if the problem is one that the community disapproves of. Lack of education contributes to this lack of self worth while also denying women the opportunity to understand their own bodies or to make an accurate assessment of their need for health care.

Traditionally, women’s health services have focused on their reproductive needs, especially contraception and safe childbearing. This has an obvious logic in the face of the huge toll of reproductive ill health that continues to affect some of the world’s poorest women. However, it has also had serious limitations. First and most importantly, it has meant that millions of young women and those who are post-menopausal have been denied access to any health care at all during periods of great need in their lives. Second, women of childbearing age have not found it easy to obtain health care for non-reproductive problems. This gap is especially evident in the context of mental health. Very few services are available for women in developing countries yet there is growing evidence that their needs are very great (Desjarlais et al., 1995; Paitel, 1987).
Quality of care in Argentina and Peru

A study of 8 primary health care posts in Argentina and Peru looked at the issue of gender and quality of public sector ambulatory care for patients with diabetes type II and hypertension. The research sought to respond to the following questions: i) how do women and men who have the same health condition perceive their condition, their possibility of improvement, their needs and expectations in regard to the health care they receive; ii) how do health workers' views on these same range of issues compare to those offered by male clients on the one hand, and female clients on the other?

Several major areas emerged where gender was a critical component, including:

- why women and men value their health; women value their health so as to be able to care for others, men so as to be able to work;
- possible alternative actions, such as self-help groups: women see self-help groups as essential to their sense of improvement and well-being, whereas men see groups as a means to strategize to access influential power-holders;
- obstacles in carrying out medically prescribed diets: women do not comply because they see taking care of themselves as selfish, particularly in economically difficult situations where special diets mean additional food expenditures; in addition, they consider they have no control over their health situation. Men do not comply because they doubt the doctor's recommendations and/or they feel better. Men express that they decide whether or not to follow medical recommendations;
- expressed needs in the interaction with physicians: women want to be taken into account as a person, want to be listened to, want to be cared for, and want to be told what to do; men want the doctor to solve the problem;
- the impact of messages or actions emitted by health workers: women adhere to the doctor's word and seldom question, even when not fully understanding the doctor as to their health situation. They view referral to a specialist as a rejection of them as a person, and view prescription to lose weight as an impossibility because they have no control over what is happening to them. Men talk about discussing their diagnosis with the doctor, see referral to a specialist as an indication that the doctor is taking his condition seriously and therefore is technically competent, and question weight loss;
- the use of gender stereotypes by physicians to maximize compliance: physicians express that they alternate 'being nice' and 'being mean' as a way of generating compliance. They scold women for non-compliance, refer to the danger of them becoming "fat as a cow", of having her male partner abandon her because of it, of having her become dependent on her children. In addition, physicians threaten non-compliant women with rejection if they do not follow recommendations. Physicians threaten men by referring to chances of death from the condition;
- client reactions to ill treatment from health providers: neither men nor women return to the service. Women are reluctant to complain about treatment unless it is their children that have been mistreated.

The study concludes that even treatment for such 'genderless' conditions such as diabetes and hypertension is heavily influenced by gender biases which can reinforce traditional gender roles and relations, and deter women and men from becoming full partners in their own health protection and promotion.

(Pan American Health Organization, 1997)
GENDER INEQUITIES IN QUALITY OF CARE

We have seen that women have additional needs for reproductive health care and that many face serious obstacles in their attempts to meet those needs. In this section we explore the quality of the treatment they do receive. Are the health services women receive comparable to that of men or are there inequalities here too? This question is difficult to answer because of the relative paucity of studies directly concerned with quality of care. Moreover, it is difficult to separate gender differences in quality of care from questions of class or race. However, there are consistent indications that gender divisions can be a causal factor in limiting the quality of care women receive (Gijsbers van Wijk et al., 1996; Mensch, 1993).

Women's health advocates have paid particular attention to the subjective dimensions of medical encounters, arguing that the sexism of some doctors combined with the biases inherent in the institution of medicine itself often make them demeaning experiences (Doyal, 1985; Fisher, 1986; Healthsharing Women, 1990; O’ Sullivan, 1987). Medical knowledge is usually presented as superior, giving women little opportunity to speak for themselves or to participate actively in decision-making about their own bodies. This has been especially evident in the experiences of many black and ethnic minority women who may be given little respect and little opportunity to exercise their own autonomy.

Much of this criticism has focused on reproductive health services where providers are too often concerned only with controlling women's fertility. This has been reflected in failure to communicate information, lack of cultural sensitivity and dehumanising treatment which itself has affected women’s willingness to use services (Gerber Fried, 1990; Hartmann, 1987; Jacobson, 1991; Timyan et al., 1992; Bruce, 1987; Sen, Germain and Chen, 1994).

Until recently, concern about poor quality services for women focused mostly on the personal relations involved in health care. However, this critique is now broadening. In developed countries in particular, it is now clear that women and men are sometimes offered different levels of treatment for what appear to be the same clinical conditions (Giacomini, 1996). In both the UK and the US there is considerable evidence to show that women are less likely than men to be offered certain diagnostic procedures or treatments for heart disease (Kudenchuk, Maynard, Martin, Wirkus and Weaver, 1996; Tobin, Wassertheil-Smoller and Wexler, 1987; Fiebach, Viscoli and Horwitz, 1990; Petticrew, McKee and Jones, 1993). Studies have
also shown that women on kidney dialysis are less likely than men of the same age to be offered transplants (Held, Pauly, Bovberg, 1988; Kjellstrand, 1988). It would appear therefore that there are significant gender differences not only in the quality of caring relationships but also in the effectiveness of the clinical care offered.
Reconfiguring Research

Research provides the knowledge base and the technology upon which health policies and health services are founded. Inequalities between women and men in the wider society are also reflected in research priorities, in the methods used and in strategies for design and analysis. If this is to change, women need to be more visible and their voices need to be heard. This is now beginning to happen, but a number of changes will be required if this involvement is to be successful.

MEASURING WOMEN’S HEALTH

First and most importantly, it is essential that the situation of women is more accurately reflected in routinely collected health statistics. It has been a frequent complaint of policymakers that most statistics are not disaggregated by sex (Jacobson, 1993). This makes it difficult to understand the specific situation of women (or men) and to plan in ways that take these differences into account (i.e. making projects gender sensitive). If this is to be remedied, special care is needed both in the collection of data and in its analysis and presentation.

If the diversity of women’s needs is to be acknowledged it is particularly important to have data that is disaggregated by sex and age as well as social class. A clearer focus on the health and social status of young girls for instance, could highlight the problems they face in nutrition or in access to health care (Tinker, Daly, Green, Saxeman, Lakshminarayanan and Gill, 1994). At the other end of the life cycle the changing circumstances of older women also need to be accurately monitored. This will require the development of appropriate indicators for measuring both their health and their quality of life (WHO, 1996a).

Failure to provide a complete picture of women’s health status stems in part from the fact that many developing countries lack a complete and accurate vital registration system. However, this is often compounded either by an official reluctance to recognise the importance of gender issues or by the complex social issues that surround so many women’s health problems. Maternal mortality for instance is often under-reported due to a variety of social, religious, emotional and practical factors such as the stigma of abortion, the desire to avoid an official enquiry and the failure to indicate pregnancy as a precipitating factor (Tinker et al., 1994: WHO, 1991). New methods have been developed for identifying these
deaths but high level commitment will be required to ensure that the problem is taken seriously (WHO, 1992).

Gaps in the availability of information on women’s lives are now beginning to be filled, with the United Nations in particular leading the way (United Nations 1991; United Nations, 1995; WHO, 1992a; UNDP, 1995 and 1997). However, much remains to be done if the database for health-related policy making is to be improved. In particular there is a need for the development of appropriate indicators combining biomedical, epidemiological and socio-economic data to monitor the changing state of women’s and men’s health around the world. The most recent United Nations Human Development Report combines a number of indicators, such as life expectancy, educational attainment and income, adjusted for gender inequality, to provide a gender-related development index (GDI) and a gender-related empowerment measure (GEM) (UNDP, 1997). These provide important tools for understanding the broader issues influencing women’s health.

Domestic violence in particular represents a huge public health problem that has not yet been accurately documented. At a recent WHO consultation, participants stressed the need for international reporting criteria with culturally sensitive definitions and standards (WHO, 1996c). They highlighted the difficulties of collecting information on gender-based violence and called for the dissemination of ethical and methodological guidelines for those working in the field (WHO, 1996a; Heise et al., 1995). The concluding report requested a revision of relevant categories in the International Classification of Diseases (ICD) in order to provide a clearer picture of the diversity of violence against women. It also called for the creation of a global database to be co-ordinated by WHO (WHO, 1996a). This has since been created.

PUTTING WOMEN INTO THE RESEARCH PROCESS

As well as making sure both sexes are equally visible in the collection of routine statistics, it is also important to scrutinise the design of individual studies. As we have seen, there is a growing recognition that the topics funded in epidemiological and clinical research are not equally relevant to both sexes and that women are not always included in appropriate numbers among the subjects (Rosser, 1994). In response to these concerns the United States government has created an Office of Women’s Health (OWH) with responsibility for ensuring that the health needs of women are adequately represented on the medical research agenda (Hamilton, 1996; Pinn and LaRosa, 1992).
The task of the OWH is to ensure that enough high quality research is undertaken into "diseases, disorders and conditions that are unique to, more prevalent among or far more serious in women, or for which there are different risk factors or interventions for women or for men" (Pinn et al., 1992). A number of strategies have been adopted to achieve this, including positive action to increase the number of female medical researchers. Legislation has also been passed requiring that all federally funded projects include in their sample both women and men (and those from different racial and ethnic groups) in numbers appropriate to the problem under investigation. This has not been easy to implement but the resulting ethical and methodological debates have shed important light on the complex issue of how to ensure gender equity in the generation of biomedical knowledge (Mastroianni, Faden and Federman, 1994).

Securing the appropriate number of female research subjects is important but continuing dialogue between researchers, women's health advocates, users of medical technology and other relevant stakeholders is also essential. One model for achieving this was a meeting held in 1991 where scientists from a range of disciplines working on contraceptive development met with groups of women's health advocates under the auspices of WHO (WHO and the International Women's Health Coalition, 1991). Topics discussed included the determination of priority areas for development and the selection and introduction of fertility regulation methods. A growing number of NGOs have now been involved in consultations of this kind and organisations such as the Women's Health Action Foundation have played an important role in developing criteria for women-centred technology assessment (Hordon, 1992).

CREATIVE METHODS

The inclusion of more women in the process of scientific research will go some way to extending our knowledge of the differences between the sexes. However, in order to achieve a full understanding of gender issues, there is a need for quantitative methods in documenting some of the more structural aspects of gender inequalities in health and well being. Qualitative methods are also needed so that the full range of influences on human health are properly understood.
Researchers trained in the biomedical tradition have usually attached little value to qualitative techniques, preferring instead the experimental methods of the natural sciences. But if the needs of women and men are to be incorporated more effectively into the knowledge base of health care, appropriate methods are needed to identify them. This is difficult to achieve with the insights and methods of only one discipline. To broaden their understanding, epidemiologists and clinical scientists need to work more collaboratively with sociologists and anthropologists, using a range of methods to illuminate the broader dimensions of women's and men's lives. These will include a variety of observational techniques and informal or semi-formal interviews as well as more collective methods such as focus groups (Brems and Griffiths, 1993).

Some of the most innovative work of this kind is to be found in the area of sexual and reproductive health where considerable effort has been expended either in developing new techniques or applying old ones in more creative ways. Researchers in this field have faced particular difficulties since they are often attempting to explore the intimate concerns of women who have little or no experience of putting either themselves or their ideas in the public arena. However, the last five years have been marked by a significant growth in the number of well executed studies in this field, many of them carried out by women’s advocacy groups (Weiss, Whelan and Das Gupta, 1996 Zeidenstein and Moore 1996).
GETTING THE WHOLE PICTURE

Research which takes account of gender has to consider the differences between women's and men's roles and responsibilities, their knowledge base, their position in society, their access to and use of resources and the social codes governing female and male behaviour. Strategies to improve women's health need to be grounded in a rigorous analysis of the whole range of their productive and reproductive activities and of the way these change across the life span. Femailness can no longer be equated with motherhood and the scope of health research needs to shift accordingly. We need to know much more, for example, about the risks women face through their work, both in the home and in the workplace.

Until recently, few researchers had examined the risks of domestic work. As interest in the issue grows, new techniques are now being devised to get inside the 'black box' of the family (Dwyer and Bruce, 1988; Kabeer, 1991). Time-budget studies for instance have used a variety of strategies to estimate who does what in the home and to assess the impact of this on gender differences in well-being (Khander, 1988; Leslie, 1989). Related work has explored the relationship between women's patterns of energy consumption and the volume of their household work (Ferguson, 1996; ICRW 1989). Studies are also needed to assess the labour intensity of specific tasks and the need for development of methods to ascertain these, which would allow a more accurate estimate of the health risks involved for both women and men. More research is urgently needed to explore the health implications of household labour in a variety of different settings.

Women's work outside the home has also received little attention from researchers. This has set up a vicious circle in which women's work is assumed to be safe, few studies are done to investigate possible hazards and the myth of safety is perpetuated (Messing, Neis and Dumaris, 1995). Male workers die more often than female workers from work-related causes but in many parts of the world women suffer more work-related disease and disability. Yet few researchers have explored the reasons for this.

There is now evidence to show the hazards of what are seen as traditionally female jobs. Nursing and clerical work have come under particular scrutiny as have certain types of factory work (Rodgers and Salvage, 1988; Coleman and Dickinson, 1984; Haynes, 1991). These areas of work frequently pose psychological as well as physical risks, with these risks being directly related both to the gendered definitions of the jobs themselves and to the gendered identities that
women bring to their work (Hochschild, 1988). Women are expected to care for others and about others. When they are unable to achieve this, female workers are especially likely to blame themselves and may suffer a range of psychological symptoms as a consequence (Barnett and Marshall, 1991).

Differences between female and male biology also require further attention if the impact of waged work on women’s health is to be properly understood. Differences in physique or muscle strength may affect their capacity to perform particular tasks, while their different weight, fat distribution, metabolism or hormonal systems may affect their response to a range of potentially toxic substances. Women often do different jobs from men under different physical conditions. They are also more likely to be responsible for physical housework which puts additional strain on their bodies.

If these differences are to be taken seriously, occupational health researchers need to develop greater gender sensitivity in their methods of investigation (Messing, 1996). For instance, ergonomic standards usually relate to the type of lifting done by men with discrete, heavy loads lifted all at once. Women on the other hand are more likely to be carrying out repetitive gestures which often involve the use of force such as carrying children for long periods of time and fetching water. This may cause significant musculo-skeletal damage but it will not be recognised without appropriate indicators of strain that properly reflect women’s (various) jobs as well as the specificity of female bodies (Messing, 1996). Similarly, equipment and workstations in many factories are often developed either around male norms or are standardised and not adjustable to different types of female bodies.

**CONCLUSION**

There are a number of factors that need to be considered in order for health policies and programmes to adequately address the inequalities between women in men in relation to their health. All data collected should be disaggregated by sex, age and social class, and women as well as men should be included in design and implementation of
epidemiological and clinical research both as researchers and as those being researched. Innovative quantitative and qualitative methods should be used to document gender inequalities and research should analyse productive and reproductive activities across life spans to provide more concrete evidence of the risks for women and men in the home and in the workplace. Each of these factors contribute to reconfiguring research to be more gender-sensitive.
Conclusions

We have explored the multiplicity of ways in which gender influences both health status and health care. In the final section of this document we begin to assess the implications of this analysis for health policy and planning. If gender is to be placed alongside race and class as a key determinant of health and health care, we need to see how this can be translated into concrete strategies for identifying and addressing the health needs of both women and men, including the planning of services. This will require an understanding of some of the key concepts that have emerged from the wider literature on gender and development (United Nations, INSTRAW, 1996; Moser, 1993).

Lack of awareness by researchers, policy-makers and planners, has frequently resulted in gender bias which often results in prioritization of men in the allocation of resources. This is often unconscious, with 'gender blindness' leading both individuals and organisations to ignore the realities of gender as a key determinant of social inequality. This problem can only be resolved through the development of 'gender-sensitive' policies that acknowledge both the reality and also the undesirability of the inequalities between women and men, including the unequal division of labour and power.

The aim of highlighting gender in this way is to move towards a position of equality between women and men. This does not, of course, mean that both sexes should be treated in exactly the same way since biological and social differences mean that each will have particular sets of needs. Instead it requires adherence to the principle of equity to ensure that women and men have their different interests recognised and their varying needs met with equality as the desired outcome. Nor does it mean that all women should receive the same treatment. A range of strategies will be needed to achieve equality for different groups and this diversity needs to be built into all policies designed to promote equality both between women and men and among women themselves.

In developing the principles of planning from a gender perspective, an important distinction has been made between 'practical needs' and 'strategic interests' (Moser, 1993). Women's practical needs are usually derived directly from their existing gender roles and reflect their responsibility for the well-being of their families - easy access
to clean water and a regular source of income for example. Most health or development initiatives are designed to meet practical needs of this kind and are often greatly valued as a result.

However, policies that reflect women’s strategic interests go a step further. As well as changing their basic conditions these policies also challenge existing gender roles and stereotypes, transforming women’s situation with respect to men. To take a simple example, a reproductive health service that simply gave women the technical means to control their fertility would meet their practical needs. In order to meet their strategic needs the service would also need to enable women to choose between a range of contraceptive methods, to understand the functioning of their own bodies, to make them aware of their rights and the risks related to childbearing, and to identify the various strategies needed to promote their own well-being as well as for men to take responsibility. Ideally the service would also facilitate women’s attempts to work together to put those strategies in place.

It is still important that women’s practical needs are met but this alone will not transform their situation. Making it easier for a woman to get a job, for instance, may simply increase her overall burden of work if there is no associated change in who does the domestic labour. Thus policies designed to meet women’s practical needs must also take their strategic interests into account if they are to be of lasting benefit. And for this to happen, women themselves and men need to be actively involved in their development and implementation. These principles have emerged as the foundation for the ‘gender and development’ approach. As we shall see they also need to be applied in the planning of health services.

IDENTIFYING GENDER CONCERNS IN THE POLICY ENVIRONMENT

If the goal of developing gender-sensitive policies and programmes is to be achieved, this needs to be built explicitly into the original objectives. This will require a preliminary analysis of the context in which the policy will be operating and a clear understanding of the gender issues involved. This may be a relatively simple operation, comparing the numbers of males and females in the target population and assessing gender patterns in current service use. The data may be local, regional or even international but whatever the scope of the exercise, sex-specific information of this kind needs to be collected and analysed in a way that can usefully be incorporated into subsequent monitoring and evaluation.

Preliminary data of this kind is
essential in any planning process, but the analysis will usually need to go a stage further to make sense of the gender relations between the individuals being counted. The questions to be asked will vary depending on the nature of the policy to be implemented but they are likely to include some or all of the following:

- Do differences in the division of labour expose women and men to different kinds of health risks?
- How are any differences between women and men in the use of existing services explained?
- Are there apparent differences in the way women and men are treated or in the quality of care they receive?
- Who controls access to health-related resources and do the criteria for allocation take into account the different roles and needs of women and men?

Unless these broader contextual issues are carefully elaborated and woven into the implementation process at all stages the resulting policies will not be sensitive to the different circumstances and needs of women and men in their approach or equitable in their effects. The importance of these issues is evident from a preliminary perusal of the process of health service reform.

GENDER INEQUALITIES IN HEALTH SECTOR REFORM

In most developing countries where health sector reform is being implemented, issues related to financing, resource allocation and management are of the utmost importance. This impetus to reform the health sectors of developing countries has raised many questions about the impact of such reforms on the poorest sections of their populations (Standing, 1997). Of particular concern has been the implications of cost recovery for the poor but unfortunately, this concern has not been extended to other dimensions of vulnerability such as gender, even though gender is an important indicator of inequality in developing countries.

In this context gender is significant for two reasons. Firstly, women are found disproportionately among the most vulnerable population groups. Secondly, access to and utilisation of health services are influenced by cultural and ideological factors such as low valuation of the health of girls and women as compared to that of boys and men. By highlighting some of the gender issues in health sector reform, the implications for vulnerable groups and the severe lack of information and understanding on the impact of health sector reform becomes evident. The types of gender issues requiring attention have been noted by Standing and can be seen in relation to the six main
Gender Issues in Health Sector Reform

1. Improving the performance of the civil service (i.e. reducing staff, changing pay, appraisal systems).
   What would the impact on the gender balance and composition of staffing at different levels be? What effects would human resources policies have on relations between predominantly male health service professions, such as doctors, and those of predominantly females, such as nursing?

2. Decentralization (i.e. management systems/health care provision devolved to local government).
   Does decentralization improve access to health care or further marginalize vulnerable groups?

3. Improving the functioning of national ministries of health (i.e. organisational restructuring to improve human and financial resource management, performance monitoring, prioritising and defining cost-effective interventions).
   What effects would human resources policies have as described in no. 1. above? In setting priorities, what criteria are used to determine health needs and cost-effectiveness?

4. Broadening health financing options (i.e. introduction of user fees and community financing mechanisms).
   What are the implications of different modes of payment? Are poor women affected differently than poor men? How does cost recovery affect access to services for both sexes?

5. Introducing managed competition (i.e. promoting competition between health service providers).
   How does managed competition affect equity and access for the most vulnerable?

6. Working with the private sector (i.e. establishing mechanisms for regulation, contracting with, or franchising providers in the private sector).
   Are vulnerable groups more or less likely to be appropriately served by different parts of the private sector? Are women's health needs more or less likely to be met in a mixed economy of health care?

(from Standing, 1997)

components of health sector reform programmes (Cassels, 1995) (see box on gender inequalities in health sector reform).

To fully appreciate the complexities involved under each component, the gender issues should be further broken down. For example, examining the effects of decentralization - it is likely to have adverse affects for women if steps are not taken to develop
measures of equity in resource allocation and systems to measure social vulnerability. For example, inter-regional inequalities may arise if wealthier districts are able to raise more funds than poorer districts. Following on from this, hospitals in wealthier areas would be able to lure good staff away from the less wealthy areas. This is likely to hit women hard, especially if they live in regions with large numbers of female-supported households (Standing, 1997).

Although their gender implications have yet to be properly analysed, these reforms are clearly having a major impact on women both as users of services and as health workers. More empirical research and carefully focused data collection is needed (Standing, 1997).

PLANNING, CAPACITY BUILDING, MONITORING AND EVALUATION

If gender inequities in health are to be clearly identified, women themselves will need to be involved in some way in the design, implementation and evaluation of health policies and programmes. Because of the relative invisibility of women in public life and their absence from many of the most important arenas of decision-making, special care has to be taken to ensure their views are heard. The form of this consultation will vary depending on the nature and the context of the policy being devised. In some settings it may necessitate discussion with the appropriate interest groups who can speak on behalf of potential users. In other contexts direct consultation with potential users themselves may be more appropriate. In either case, care is needed to determine how the consultation should be organised to ensure that a diversity of views is represented.

If gender-sensitive health plans are to be put into effective operation, the importance of educating health workers and policy-makers to understand better the importance of gender in their work cannot be underestimated. Capacity-building programmes must be designed for both female and male workers and they need to focus not just on ‘women’s issues’ but on the wider question of gender itself (Moser, 1993). They may include broadly-based ‘gender awareness’ courses and also more detailed briefings on gender-related topics not generally included in the medical or nursing curriculum (Williams, 1994).

Several training manuals/tools have been developed in this area, but not many focus specifically on health. However there are some examples. For instance, ‘Health Workers for Change’ was designed as a practical tool to help health workers relate in more positive ways to their female clients (UNDP/World...
how to mainstream gender in the health sector (SIDA Sweden, 1997).

MAINTSTREAMING GENDER EQUITY AND EQUALITY IN WHO

Many of the individual programmes within WHO are now aware of the importance of addressing gender equity and equality issues in health. Some programmes have been making progress in this area and materials are being produced looking at the differences of specific conditions and diseases between women and men. However, this progress has been due more to the efforts of committed individuals rather than to any institutional mechanism, which means that most programmes are not looking at their activities from a gender perspective.

In 1996, a Gender Working Group (GWG) was convened by the Women’s Health and Development Programme (WHD) to develop a more strategic approach to mainstreaming gender issues in WHO by raising awareness and understanding of the issues. As a result of the efforts of WHD and the GWG a plan has been devised with a goal that by the year 2002, gender equality and equity concerns will be mainstreamed into all WHO research, policies, programmes and projects. This goal will be met by undertaking activities in three broad areas over
a four year period:

1. Development of a gender policy for WHO
2. Development and implementation of a long-term strategy for competence building on gender and health among staff
3. Development of the technical bases on gender and health

Gender-sensitive WHO policies, programmes and projects will:

- ensure that these programmes and projects do not unknowingly create, maintain or reinforce those gender roles and relations that may be damaging to health.

This will improve health in a more equitable manner for both women and men.
Glossary

 Gender

Refers to women’s and men’s roles and responsibilities that are socially determined. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organised, not because of our biological differences.

 Sex

Genetic/physiological or biological characteristics of a person which indicate whether one is female or male.

 Mainstreaming gender

Integration of gender concerns into the analyses, formulation and monitoring of policies, programmes and projects, with the objective of ensuring that these reduce inequalities between women and men.

 Gender equality

Absence of discrimination on the basis of a person’s sex in opportunities and the allocation of resources or benefits or in access to services.

 Gender equity

Fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognises that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes.

 Gender roles

The particular economic and social roles which a society considers appropriate for women and men. Men are mainly identified with productive roles which tend to be sequential, while women have a triple role: domestic responsibilities, productive work and community activities which often have to be carried out simultaneously. Gender roles and responsibilities vary between cultures and can change over time. In almost all societies women’s roles tend to be undervalued.
Gender blindness

Failure to recognise that gender is an essential determinant of social outcomes including health.

Gender awareness

Understanding that there are socially determined differences between women and men based on learned behaviour, which affect their ability to access and control resources.

Gender sensitivity

Ability to perceive existing gender differences, issues and inequalities and incorporate these into strategies and actions.

Practical gender needs

Immediate in nature and often concerned with inadequacies in living conditions, health care and employment (such as improving primary health centres, ensuring a clean water supply and providing family planning advice). Addressing these needs does not change the position of either women or men in society.

Strategic gender needs

Related to gender divisions of labour, power and control and may include such issues as legal rights, domestic violence, access to resources, equal wages and women's control over their bodies. Addressing these needs helps women to achieve greater equality and challenges their subordinate positions. (Some programmes address strategic needs by attempting to change practices that perpetuate women's subordination. For example, helping women to participate in elections, taking measures to stop male violence and improving women's access to land ownership).

Gender analysis

This examines the differences and disparities in the roles that women and men play, the power imbalances in their relations, their needs, constraints and opportunities and the impact of these differences on their lives. In health, a gender analysis examines how these differences determine differential exposure to risk, access to the benefits of technology, information, resources and health care, and the realisation of rights. A
gender analysis must be done at all stages of an intervention, from priority-setting and data collection, to the design, implementation and evaluation of policies or programmes.

★ GAD (gender and development strategy)

Focuses on the social, economic, political and cultural forces that determine how women and men benefit from and control resources, and participate in activities differently. The situation of women is not considered independently of, but in relation to that of men.

★ WID (women in development strategy)

A development framework or approach which gives recognition to the distinct needs and capacities of women with considerable focus on developing strategies and action programmes that will facilitate their participation in the productive sector.
Bibliography


Duncan, M. (1993) A historical and clinical review of the interaction of leprosy and pregnancy: a cycle to be broken, Social Science and Medicine, vol 37 no. 4, pp 457-63


Held, P., Pauly, M., Bovberg, R. et al. (1988) Access to kidney transplantation: has the United States eliminated income and racial differences?, Archives of Internal Medicine, vol 148, pp 2594-600


McDonald, M. (1994) Gender, Drink and Drugs, Oxford: Berg


Michelson, E. (1992), Adam's rib awry? women and schistosomiasis, Social Science and Medicine, vol 37 no. 4, pp 493-9


Papenek, H. (1990) To each less than she needs, from each more than she can do: allocations, entitlements and value in I. Tinker (ed) *Persistent Inequalities: women and world development*, Oxford: Oxford University Press


Hilldale, NJ: Lawrence Erlbaum

Plichta, S. (1992) The effects of woman abuse on health care utilisation and
health status, Women's Health, Jacobs Institute, vol 2, no 3, pp 154-62

World Health Statistics Quarterly, vol 40, pp 233-66

Rahman, O., Strauss, J., Geurtier, P., Ashley, D., and Fox, K. (1994) Gender
differences in adult health: an international comparison, The Gerontological
Society of America vol 34 no. 4 pp 463-469

Rathgeber, E. and Vlassoff, C. (1993), Gender and tropical disease: a new
research focus, Social Science and Medicine, vol. 37 no. 4 pp 513-520

Sundari Ravindran, T. (1998) Health Implications of Sex Discrimination in
Childhood: a review paper and annotated bibliography prepared for

squatter settlement in Rio de Janeiro, British Journal of Psychiatry vol. 159,
pp 683-690

health: effects of paid employment on women’s mental and physical health,
American Psychologist, vol 44, no 11, pp 1394-401

control strategy, Social Science and Medicine, vol 37 no. 4 pp 473-480

feminist analysis, Women and Therapy, vol 12, nos 1/2, pp 123-35


Policy: Summer, pp 8-13

Righeim, K. (1993) Factors that determine the prevalence of use of
contraceptive methods for men, Studies in Family Planning, vol. 24 no. 2
pp 87-99


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Other Relevant WHO Literature
