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Module 1: Women's Health – A Gender Perspective

1A. Personal Details

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2B. Description of the Module

Item	Description of the Module
Subject Name	Women's Studies
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Module Name/Title	Women's health - a gender perspective
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Objectives	To make the reader understand the need for a gender perspective in women's health
Keywords	Gender, health

The Need for Gender Perspective

In many of our societies evidence suggests that men and women perform segregated roles and responsibilities both within the household, the private and in the public sphere. This creates a situation of experiencing different social realities and makes for unequal access to and control over resources. Thus one can observe gender differences percolating to different sections of society determined by class, caste, race, ethnicity and religious groups to name a few. In many societies, girls and women are denied education. For example when analysing the education outcomes, always more boys than girls are sent out to school, thus privileging them with more job opportunities in the labour market and better prospects in life. While the division of labour is ósexedô by segregation of jobs for men and women distinctly, mostly women are offered less honoured jobs than men. Although the situation is changing in some

sections of the society (a meagre proportion of the population), the vulnerable section of the population always has and continues to have restricted access to resources, particularly the women. This social indifference itself provides a higher authority and power to those privileged by the society, ignoring the needs of the marginalised.

A gender approach to 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 biological determinants of health are important, the social roles and responsibilities held by women themselves put women to greater risks of certain illness and diseases. For example, the social desirability for sons and neglect of daughters has put enormous pressure on women to undergo unsafe abortions and have caused potential health consequences. The undesirability of girls has socially impacted the investments in girl childrenôs feeding and healthcare. Patriarchal norms, deny women the right to make decisions regarding their sexuality and reproduction. The desirable male sexual behaviour determined by the established gender norms, puts the women at risk for various infections and mortality due to lack of health care, mainly due to practice of unsafe sex by men. Thus reproductive health of women becomes an important component of womenôs health, but is not the only aspect of womenôs health.

Essentially, the biologically determined differences between men and women while interacting with the socially constructed norms, work as a disadvantage to women. Further, to supplement the disadvantage, many policies are ógender blindô and implicitly male biased. The national and state policies fail to consider the social norms, the nature of gender relations, the social inequalities that exist in respective societies. The policies and programmes treat the entire population as homogenous groups failing to recognise that men and women are disposed to different health risks and the gender norms affects access to health care services, and other determinants of health. These indifferences underscore the need to examine womenôs health from a gender perspective.

Feminist movement that influenced policies and perspectives

The womenôs suffrage movement in western society took place during the nineteenth and early twentieth centuries working for womanôs rights. The turning point came with second

wave feminism, referred to as the Womenôs Liberation Movement, where many things happened between the 1960ôs and the 1980ôs period. It began with the women's liberation movement in the 1960s, which campaigned for legal and social rights for women. The movement was largely concerned with other issues of equality, such as ending discrimination and recognised that womenôs cultural and political inequalities were largely linked to their personal lives reflecting the sexist power structures. It extended the enquiry of feminism to wider issues such as sexuality, the work place, family, reproductive rights including abortion and contraception, violence against women insisting on marital rape laws, battered womenôs shelters and changes in custody and divorce laws.

Second-wave feminists moved beyond reproduction since they realised that the inequalities lay in the social structures and aimed at changing social attitudes towards gender roles, repealing oppressive laws that were based on sex. For example, medicine has considered the male physiology as the role model for medical care consequently, women were differentiated from men only by reproductive characteristics. In the eighteenth century, Thomas Laquer identified a transition from the one-sex view of the body to the two-sexed view. In the earlier view physical differences between the sexes are viewed as differences of degree. For instance, the female sexual organs were viewed as less developed versions of male organs, the female body a lesser version of the male body. However, later views of the body gradually changed. While this transition in understanding bodies evolved, medicine progressed through a science dominated by biological revelation of laboratory sciences, medical engineering and technology. This led to a situation where doctors completely isolated themselves from the social realities of their patients, both men and women. In her essay ñSisterhood is Global, "Planetary Feminism: The Politics of the 21st Centuryò, Robin Morgan explicitly showed how womanôs lives varied across, race, culture, nationality and so on. This emphasised two things. Firstly, the male model of medicine, that posits male superiority over females naturally did not deal with the problems of women in the same way as men, including the health problems. Secondly, the differences brought about by the predominantly patriarchal culture in the roles, responsibilities and the status of women and men in society that interact with biology made the experiences and realities of women quite different from men.

Definition of Women's Health

The terms ósexôand ógenderôare often used as synonyms in medicine and public health, but in gender research the two concepts have fundamentally different meanings. In the late twentieth century, followed by womenôs movement, ósexô referred to the biological differences between men and women (such as chromosomes, internal and external sex organs, hormonal makeup and secondary sex characteristics etc.,), while ñgenderò was employed to separate biological sex from the social, cultural and historical construction of femininities and masculinities (Rubin, 1975). For some feminists like Rubin, through this conception, sex remained an important aspect, where the psychological self, remained as a material ñgivenò, whereas the socialisation component which is superimposed on it (body), provided scope to postulate commonalities and differences among women.

While sex and gender are important precepts in gaining a gender perspective, analysing how sex and gender interacts with other aspects or variables is yet another factor. They interact both with the biological and social variables that create between or within group differences. Some of the factors that it interacts with but not limited to are: Genetics, age, sex hormones, reproductive status, body composition, co morbidities, disabilities, ethnicity, nationality, geographic location, socioeconomic status, educational background, sexual orientation, religion, lifestyle, language, family configuration, environment and more.

Further the difference is not just about interaction with other factors but also the different roles women engage in their daily lives displaying different identities. For instance, while exploring the abortion decision of a woman, she is not just a woman seeking abortion, but she is a mother of few children already, a daughter-in-law who has to fulfil her social norm that assigns her certain roles and responsibilities, a wife to a husband to whom she has to fulfil her assigned duties and more as prescribed by the gender roles and cultural norms of that space. Thus there exist multiple identities beyond a ósingleô woman in her. The self here is not a universal self rather a relational-self that is influenced by the local surroundings. Thus there is a need to factor in these influences that are beyond sex and gender as concepts independent of other factors. Thus, womenôs health as said above is not something that is pertinent to the health conditions faced by women because of their biological givens-ósexôbut containing the a broader understanding of the critical roles that women play and how social, cultural, political and other factors influence to promote and protect or impede health of women.

Gender perspective on women's health

The International Conference on Population and Development (ICPD) in Cairo created a landmark shift in the national population policies and donor strategies worldwide. The Programme of Action emphasised the need for improving the reproductive health and promoting gender equity. It referred to strategies that integrate gender norms into account and compensate for gender-based inequalities in the household and community. Similarly, goal -3 of the Millennium Development Goals (MDGs)ð aims to achieve gender equality and empower women, through rectifying those disadvantages through policies and programmes that builds womenôs capabilities, improve their access to economic and political opportunity, and guarantee their safety. These efforts are aimed at improving and sustaining womenôs health in the long-term by integrating them through the direct health interventions.

New approach to focus women's health: There are many illness and diseases that have been classified and identified based on male norms, for example the myocardial infarction, related to coronary heart disease. The medical male norms have been problematized and questions have been raised taking into consideration women's situation as the point of departure to identify the risk factors, diagnosis, symptoms and treatment as well as prognosis. Further, many health problems earlier neglected and associated as psychological such as fibromyalgia, infection of the urinary tract, musculoskeletal disorders and chronic pain that hit mostly women, have gained more research interest, although still with small resources. Another important aspect of research raised in the recent years is how medicine medicalizes women, where women's normal physiological functions have been diagnosed as illness. For example, the low levels of oestrogen treated as illness through hormone replacement therapies for menopausal women.

By asking questions such as:

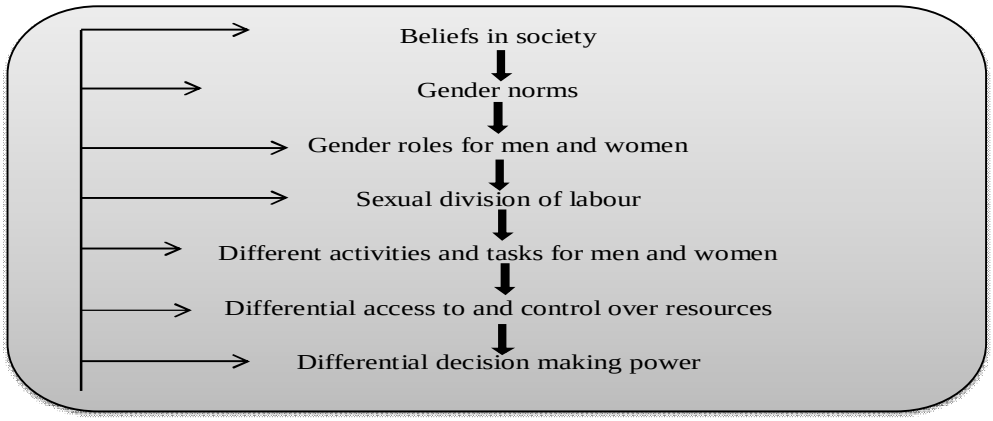
- Who does what?
- Who has what?
- Who decides?
- Who needs what?
- Who wins? Who loses?

These questions help us to address the engendering health inequalities. We would see how certain specific aspects of gender and gender relations that could affect womenôs health that are intricately woven in different cultures.

Gender concepts

Gender is the social meaning given to being male or female in a particular place and time. Gender is an acquired identity that is shaped through social norms, changes over time, and varies widely within and across cultures. Gender describes the array of different roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that a particular society assigns to men or women. We recognise that in every society there is a differential value ascribed to what men and women ópreôby the society. These beliefs about what men and women are determine the gender norms in that particular society. For example beliefs such as men are strong and rational and women are emotional and weak exist in many societies. These beliefs have translated to ***gender norms*** that govern the societies functioning. For instance men are rational, therefore they must be articulate; whereas women are emotional therefore they should not articulate or express themselves limits their expression. The differences in these gender norms have led to define the roles and responsibilities of men and women. The gender norm that men belong to the public because they are rational and strong has transformed to men should be breadwinners and women being weak and emotional has been transformed to the private to take care of the household and rear children. These gender norms in turn have permeated to define the ***gendered division of labour and sexual division of labour***. The gender based division of labour implies that men are meant to produce productive labour that involves wages, and women are to involve in reproductive labour and household manual labour that is unpaid and less valued. While the sexual division of labour, that employs both men and womenôs physical labour in the market classifies what men would do and what women would do. For instance in agriculture women are offered work like weeding, transplanting, threshing etc which are low paid as well involves hard labour; while men may have more responsibility for cash crops, operating equipment and overseeing the work of women which are well paid. Similarly in the community, men could be leaders like the Sarpanch, the community leader, highly valued; but women can only be wise women or *dai*, much less valued and mostly unpaid. This differential role leads to differential ***access to and control over resources***. Because of the different roles and differences in the position of men and women, the access to and control over resources also vary. Men have more access to control over the financial resources, credit, knowledge, self-esteem and more. This differential access to resources gives more power and decision-making authority to influence decisions. Only those people in position and have power have the ability to influence the beliefs, norms, sexual division of labour and control over access to resources.

Gender concepts and its substratum indicators



Source: Renu Khanna

The above diagram explains how the gender system feeds on its substratum to perpetuate the gender norms stronger day by day. Thus one need to recognise that gender operates at different levels, in all kinds of institutions such as family, health system, legal frameworks, and all kinds of formal and informal institutions including the market. There also exist ***gendered power relations***, that refer to a unique power relation that is reinforced by the family, kinship systems, communities and in the public sphere through various economic and political institutions both at the national and international levels.

How gender constructs affect health of the women

Through certain illustration it is possible to gain insight on how the above gender constructs built upon the gender norms affect womenôs access to health knowledge, self-perceptions of health needs and the ability to access services.

Exposure to health risks: The very belief that woman is to take care of household puts them to different risks. For example the extensive indoor pollution caused by biomass cooking fuels put women to greater risk of pulmonary diseases. Similarly the unpaid and less valued nature of womenôs reproductive roles actually affects access to health care since they lack time, money and resources for accessing these services. Further, social norms such as early marriage for women and the women looked at only for their reproductive roles, the exposure to health risks such as Vesico Vaginal Fistulaôs are higher. The nature of labour women take at the public sphere generally exposes them to different risks and health problems. It has been

studied that women engaged in agricultural fields are prone to chronic back pain and leg problems due the nature of the work they engage.

Health seeking behaviour: Since many women are denied education and they are not allowed to work or go out alone, their health seeking behaviour has been severely affected. For example women fail to recognise many health problems during pregnancy due to lack of knowledge. Even if recognised many women ignore for reasons such as they are over-burdened with household work, or lack support from family both physically and financially to visit a healthcare provider. This is partly due to the gender norms that govern womenôs behaviour. Many women do not perceive themselves entitled to seek or invest in their health and wellbeing.

Access to health services: Women have very limited access to resources and power to make decisions. In India, many women express the need to seek permission to access health care. With limited access to resources and power to decide many women have limited or no access to health care. The power to decide is not just about seeking care. Womenôs power to control sexuality and use of contraception is also limited. The gender norms that asserts normalcy to menôs behaviour of having sex with other women puts wives at greater risk for STD/HIV infections. Women are discouraged to seek treatment in such cases due to stigma attached to visiting an STD clinic accompanied by other constraints such as money, lack of time and decision-making power.

These examples above explain how and why gender is an important component in exploring the social determinant of health.

What is gender analysis?

Gender analysis is a tool that could enable to show us the gendered realities of the day-to-day life and highlight how these realities can affect health status, health decisions and access to health care. By answering the questions such as: Who does what? Who has what? Who decides? Who needs what? Who wins? Who loses; we actually perform a gender analysis. An intersectionality approach that considers simultaneous interactions between different aspects of social identity (e.g., race, ethnicity, indigeneity, gender, class, sexuality, geography, age, ability, immigration status, religion) as well as the impact of systems and processes of oppression and domination (e.g., racism, classism, sexism, etc) is one of the best ways to explore realities that envisions social justice. However, while gender is an important pointer,

it is important to recognise that while taking an ‘intersectionality’ approach where gender is stratified by caste, class and other relevant stratifiers, these may vary according to the health condition being considered. For example in HIV, sexual orientation would be an important stratifier; for access to health services, marginalised status such as being a migrant, living in remote areas and belonging to socially excluded groups may be more relevant. Thus a gender analysis helps us to understand,

1. The underlying causes of illness or disease to plan interventions or treat diseases.

2. To explain how biological and social differences between men and women interact to produce differential health outcomes.

3. To explores how social beliefs about gender have a direct effect on health and.

4. How gender is constructed across cultures.

Thus in order to promote wellbeing and contribute to human rights, gender analysis in health has to go beyond effectiveness and efficiency to promote social justice and empowerment for women, in present day’s agenda.

Approaches to address gender-based disadvantages affecting women’s health

While we so far we focussed on how the social norms in a society affect women’s health, it is important to recognise that gender integrated national policies and programmes are lacking in many countries and there is lack of sex disaggregated data to understand the gender differentials in health risks, health information and access to health services. It is in this context ‘gender mainstreaming’ as a concept emerged following the (ICPD) in 1994, and the Fourth World Conference on Women in Beijing in 1995. The aim is to exclusively focus on women to ‘mainstreaming’, or integrating, gender into the mainstream in all sectors. This approach is expected to increase coverage, effectiveness, and efficiency of all interventions. Further, it aims to promote equity and equality between women and men throughout the life course and, at the least, ensure that interventions do not promote or perpetuate inequitable gender roles and relations (WHO 2002).

This approach is envisioned through two dimensions of gender mainstreaming namely;

Operational mainstreaming, which refers to the integration of equality concerns into the content of policies, programme interventions, and projects to ensure that these have a positive

impact on women and reduce gender inequalities. This comprises mainstreaming within the government departments where in-house gender-sensitization workshops are implemented apart from other activities. It also implies incorporating gender sensitisation into the curricula of health professionals in medical education. Further, mainstreaming in health research is also part of mainstreaming wherein gender at all stages of the research process from defining the research till dissemination of results is considered. For operational gender mainstreaming to become successful it needs structures, mechanisms, and processes that will catalyse, initiate, and sustain gender-mainstreaming efforts.

Institutional mainstreaming, involves addressing the internal dynamics of formal (and informal) institutions, such as their goals, agenda setting, governance structures, and procedures related to day-to-day functioning, so that these support and promote gender equality (UN 2000). One aspect of this mainstreaming is to identify and address gender considerations in health, and within the organisations responsible for managing and delivering health care services. This aims at elimination of gender-based discrimination in human resource procedures, changing institutional rules and culture to create an environment supportive of gender equity and equality and enhancing the capacity of staff and senior management for mainstreaming gender concerns within health policies, programmes, research, and training. At the international mainstreaming level efforts were made to integrate gender considerationsô into all research, policies, programmes, projects, and initiatives. The aim is to evidence base on gender and health, and develop and refining tools and guidelines for gender mainstreaming in research.

Through these two approaches it makes it possible to address gender-based differences and inequalities across all health initiatives. And further it accentuates initiatives to address womenôs specific health needs that are result of either biological difference between women and men or gender-based discrimination in society. However, the challenges in mainstreaming remain. One of the challenges has been, top-down approaches that lack scope for democratic participation, both within international organizations and national government institutions. Further the within operational mainstreaming, community-based service-delivery and training interventions tend to focus on womenôs specific needs without challenging gender roles and norms. As regards the attempts at integrating gender issues in the training of health personnel have remained, largely, small-scale attempts. It is cited that the major reason for these challenges is lack of consideration of gender as part of human rights and social justice agendas.

However, mainstreaming gender remains a big challenge in the health sector due to certain reasons. Firstly due to attributing all male and female differences to biology and failing to examine gender issues in all health problem and delivery of health services. Secondly, the policy makers and programme managers are not convinced of any gender-based inequalities in health, and of the need for gender mainstreaming. This arises due to the reality of women who outlive men in most countries of the world, and, for many health conditions, male mortality exceeds female mortality. Lastly, the the health sector informed by biomedical approach, fails to see the relevance of understanding the social dimensions and determinants of health.

While there are many challenges spoken, one of the important is de-politicization of gender mainstreaming. In the words of Ravindran and Khambete,

"Gender mainstreaming is not just about identifying gender-gaps through gender analysis and 'including' women where they were previously excluded. It is also about asking why women were excluded in the first place, identifying the forces that perpetuated such exclusion, and challenging these forces. It is about taking on patriarchy, misogyny, and discrimination, and the structures that uphold them".

To conclude, this module has given insights on the importance of gender perspective to womenôs health. Although limited examples are given to express how gender aspects affect womenôs health, in the forthcoming modules, a similar gender perspective to different health problems gives a larger understanding of the implication of gender on health. And to gain more insights on the gender mainstreaming efforts across the world and the challenges, the paper by Ravindran and Kambete would prove to be more useful reading.

Summary Points:

- Gender differences are percolated at different sections of the society determined by class, caste, race, and ethnicity.
- The social roles and responsibilities held by women put women to greater risks of certain illness and diseases.
- A gender approach in health, while not excluding biological factors, considers the critical roles that social and cultural factors and power relations that play between women and men in promoting and protecting or impeding health.

- Second wave feminism, (1960ôsï 80ôs) campaigned for legal and social rights of women extended to wider issues such as sexuality, the work place, family, reproductive rights including abortion and contraception, violence against women.

- Sexô refers to the biological differences between men and women (such as chromosomes, internal and external sex organs, hormonal makeup and secondary sex characteristics etc,)

- ñGenderò refers to the social, cultural and historical construction of femininities and masculinities. It is the social meaning given to being male or female in a particular place and time.

- Sex and gender interact both with the biological and social variables that creates between or within group differences.

- Gender norms refer to the beliefs about what men and women are and determine the gender norms in that particular society.

- The gender system feeds on its substratum to perpetuate the gender norms stronger day by day.

- Gender operates at different levels, in all kinds of institutions such as family, health system, legal frameworks, and all kinds of formal and informal institutions including the market.

- Gender constructs affects womenôs health in terms of exposure to health risks, health knowledge, health seeking behaviour, access to health services.

- Gender analysis is a tool that could enable to show us the gendered realities of the day-to-day life and highlight how these realities can affect health status, health decisions and access to health care.

- Intersectionality approach ï considers simultaneous interactions between different aspects of social identity as well as the impact of systems and processes of oppression and domination.

- Gender Mainstreaming aims is to exclusively focus on women to ómainstreamingô, or integrating, gender into the mainstream in all sectors. The two types of mainstreaming are operational and institutional mainstreaming.