



National Collaborating Centre  
for Determinants of Health

Centre de collaboration nationale  
des déterminants de la santé

## **A Synthesis of the WHO Women and Gender Equity Knowledge Network Final Report**



### **Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it exists and how we can change it**

**Original Report Authors:  
Gita Sen, Piroska Östlin, Asha George**

## Table of Contents

Main Messages .....	1
Executive Summary.....	2
Gendered Structural Determinants of Health .....	2
Norms, Values and Practices .....	3
Differences in Exposure and Vulnerability.....	4
The Gendered Politics of Health Care Systems .....	4
Health Research .....	4
Changing Organizations.....	4
Introduction.....	6
Basic Underpinnings .....	6
Gender, Women, Equity and Equality .....	8
Intersecting Social Hierarchies .....	9
Social Groupings and Structural Processes – How Do They Interact?.....	9
Gendered Structural Determinants.....	9
Gender as a Social Grouping .....	9
Gendered Structural Processes .....	10
Women’s Movements and Human Rights .....	11
Promoting Human Rights and Strengthening Women’s Hands.....	11
Deepening the Normative Framework and Realizing Human Rights .....	12
Cushioning the ‘Shock Absorbers’ .....	12
Expanding Women’s Capabilities – Focus on Education .....	12
Norms, Values and Practices .....	13
Gendered Norms Affecting Health .....	13
Challenging Gender Stereotypes and How They Affect Health.....	14
Differences in Exposure and Vulnerability.....	14
Mapping Male-Female Differences in Health .....	15
Understanding Male-Female Differences in Health.....	15
Exposure and Vulnerability Due to Both Sex and Gender.....	15
Exposure and Vulnerability Due Primarily to Gender .....	16

Reducing the Health Risks of Being Women and Men .....	16
Meeting Differential Health Needs.....	16
Tackling Social Bias .....	17
Tackling the Structural Dimensions of Individual Risk Behaviour .....	17
Empowering Individuals and Communities for Positive Change.....	18
The Gendered Politics of Health Care Systems .....	19
Women as Consumers of Health Services.....	19
Accountability Mechanisms for Improved Health Services .....	20
Changing How We Care and Cure .....	20
How to Raise Awareness and Improve Acknowledgment of Women’s Health Problems .....	21
How to Improve Women’s Access to Health Care.....	21
How to Strengthen Accountability of Health Systems to Citizens? .....	23
Health Research.....	24
Gender Imbalances in Research Content .....	24
Gender Imbalances in the Research Process .....	25
Changing What We Know .....	25
Prerequisites for Conducting Gendered Health Research.....	26
What Gets Measured is What Gets Done – Data and Indicators .....	27
Mainstreaming for Gender Equality and Equity .....	27
Gender Mainstreaming in Health.....	28
The Way Forward – Getting There From Here .....	28
Endnotes .....	33

To download the original WHO report please visit [www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/).

## Main Messages

- This document is a summary version of a report that was prepared for an international audience by the Women and Gender Equity Knowledge Network established as part of the World Health Organization Commission on the Social Determinants of Health. This summary is intended to identify areas for discussion and application within public health in Canada.
- Gender inequality damages the health of millions of girls and women around the world. It can also be harmful to men's health, despite the tangible benefits it gives them through resources, power and control.
- Taking action to improve gender equity in health is one of the most direct ways to reduce health inequities and ensure effective use of health resources.
- This report identifies seven key actions which can help to bring about positive change when it comes to gender equity in health. They are:
  1. Address the essential structural dimensions of gender inequality
  2. Challenge gender stereotypes and adopt multilevel strategies to change the norms and practices that directly harm women's health
  3. Reduce the health risks of being women and men by tackling gendered exposures and vulnerabilities
  4. Transform the gendered politics of health systems by improving their awareness and handling of women's problems as both producers and consumers of health care, improving women's access to health care, and making health systems more accountable to women
  5. Take action to improve the evidence base for policies by changing gender imbalances in both the content and the processes of health research
  6. Take action to make organizations at all levels function more effectively to mainstream gender equality and equity and empower women for health by creating supportive structures, incentives, and accountability mechanisms
  7. Support women's organizations, which are critical to ensuring that women have voice and agency.

## Executive Summary

Gender inequality<sup>1</sup> damages the health of millions of girls and women around the world. It can also be harmful to men's health, despite the tangible benefits it gives them through resources, power and control. Taking action to improve gender equity in health is one of the most direct ways to reduce health inequities and ensure effective use of health resources. Deepening and consistently implementing human rights tools can be a powerful way to motivate and mobilize governments, people in general and, especially, women themselves.

Gender power relations are a root cause of gender inequality and are among the most influential of the social determinants of health. They determine whether people's health needs are acknowledged, whether they have control over their lives and health and whether they can realize their rights. Addressing the problem of gender inequality requires action both outside and within the health sector because gender power relations operate across such a wide spectrum of human life and in such inter-related ways.

The structures that govern gender systems have similarities across different societies, although how they manifest through beliefs, norms, organizations, behaviours and practices can vary. Gender inequality and equity in health are socially governed and, therefore, actionable.

Gender intersects with economic inequality, racial or ethnic hierarchy, caste domination, differences based on sexual orientation and a number of other social markers. Focusing just on economic inequalities across households can seriously distort our understanding of how inequality works and who actually bears its burdens. Health gradients can be significantly different for men and women; medical poverty (poverty caused by high payments for medical treatment) may not trap women and men to the same extent or in the same way. Studies tell us the poor are worse off in terms of both health access and health outcomes than those who are economically better off. But they don't tell us whether the burden of this inequity is borne equally by different caste or racial groups among the poor. Nor do they tell us how the burden of health inequity is shared among different members of poor households. This poses a challenge for policy to ensure equity both across and within households.

### Gendered Structural Determinants of Health

Gender systems have a variety of different features, not all of which are the same across different societies. Women may have less wealth and property in almost all societies, yet they carry higher burdens of work in the economy of 'care' - ensuring the survival, reproduction and security of people both young and old. Girls in some cases are fed less, educated less and are more physically restricted. Women are typically employed and segregated in lower-paid, less secure, more 'informal' occupations. Gender hierarchy governs how people live and what they believe and claim to know about what it means to be a girl or a boy, a woman or a man.

Women are sometimes seen as objects rather than subjects (or agents) in their own homes and communities, and this is reflected in norms of behaviour, codes of conduct and laws that perpetuate their

---

<sup>1</sup> In fields other than health, feminist analysts have used the concept of gender *equality* as the foundation for notions of gender justice or *equity*. This is based on the presumption that, to the extent that inequalities between women and men are the product of social power relations, they are likely to be inherently biased and unfair. Such a position is less easily held in the field of health because of the confounding influence of biology.

status as “lower beings”. Even in places where extreme gender inequality may not exist, women often have less access to political power and lower participation in political institutions.

The other side of the coin of women’s subordinate position is that men typically have greater wealth, better jobs, more education, greater political clout and fewer restrictions on behaviour. Moreover, men in many parts of the world exercise power over women, making decisions on their behalves, regulating and constraining their access to resources and sanctioning and policing their behaviour. Not all men exercise power over all women - gender power relations are intersected by age and lifecycle as well as by social groupings like economic class or race.

Together, gender systems, structural processes and their interplay make up the gendered structural determinants of health. The connections between gender systems and structural processes such as rising literacy and education, demographic transitions in birth and death rates and in family structures, globalization (including its effects on labour forces, policy space, health systems, and violence) and the strengthening of human rights discourse, work to weaken or strengthen gender hierarchies and their effects on people’s health.

In some cases, though, these changes also set off backlashes as those who wield gender power in families, communities and religious structures attempt to control and discipline women. Trying to hold on to such power has led to attempts to roll back internationally agreed norms of gender equality and sexual and reproductive health and rights in particular. Such attempts have had serious implications for the health and human rights of women and men and of young people.

Three implications of globalization are of particular significance for our focus on gender relations - how it has transformed the composition of workforces and the implications for women’s health; how its narrowing of national policy space has resulted in reducing funds for health and education with negative impacts on girls’ and women’s access; and the rise in violence linked to the changing political economy of nation states in the international order.

Some of the negative consequences of globalization contrast with the deepening during recent decades of the normative framework of human rights. This deepening has been important in altering values, beliefs and knowledge about gender systems and their implications for health and human rights. The first action priority is, therefore, to protect and promote women’s human rights that are key parts of the normative framework for health. But this in turn requires strengthening and empowering women so they can actually claim and realize their human rights. This points to the next two action priorities: cushioning women who act as the ‘shock absorbers’ through key structural reforms including gender-sensitive infrastructure and expanding women’s opportunities and capabilities.

### **Norms, Values and Practices**

Challenging gender norms, especially in the areas of sexuality and reproduction touch the most intimate personal relationships as well as one’s sense of self and identity. No single or simple action or policy intervention can be expected to provide a solution for the problem. Multi-level interventions are needed. We identify three sets of actions: (A) creating formal agreements, codes and laws to change norms that violate women’s human rights, and then implementing them; (B) adopting multi-level strategies to change norms including supporting women’s organizations; (C) working with boys and men to transform masculinist values and behaviours that harm women’s health and their own.

## **Differences in Exposure and Vulnerability**

Male-female differences in health vary in magnitude across different health conditions. Some health conditions are determined primarily by biological sex differences. Others are the result of how societies socialize women and men. However, many health conditions reflect a combination of biological sex differences and gendered social determinants. Understanding the roles biological difference and social bias play is important to understanding differential exposure and vulnerability.

Where biological sex differences interact with social determinants to define different needs for women and men in health, policy efforts must address these different needs. Not only must neglected sex-specific health conditions be addressed, but sex-specific needs in health conditions that affect both women and men must be considered so treatment can be accessed by both women and men without bias. Two intertwined strategies to address social bias are: tackling the social context of individual behaviour and empowering individuals and communities for positive change. For strategies to succeed they must provide positive alternatives that support individuals and communities to take action against the status quo.

## **The Gendered Politics of Health Care Systems**

Evidence shows the different ways in which the health care system may fail gender equity from the perspective of women as both consumers (users) and producers (carers) of health care services. Action priorities include supporting improvements in (especially poor) women's access to services, recognition of women's roles as health care providers and building accountability for gender equality and equity into health systems and especially in ongoing health reform programs and mechanisms.

Health sector reforms can have fundamental consequences for gender equality and for people's life and well-being. Health sector reform strategies, policies and interventions introduced during the last two decades have had limited success in achieving improved gender equity in health. Minimizing gender bias in health systems requires systematic approaches to building awareness and transforming values among service providers, steps to improve access to health services and developing mechanisms for accountability.

## **Health Research**

Gender discrimination and bias not only affect health needs, behaviour, treatment and outcomes, but also permeate the content and the process of health research. Mechanisms and policies need to be developed to ensure that gender imbalances in both the content and processes of health research are avoided and corrected.

The importance of having good quality data and indicators for health status disaggregated by sex and age from infancy through old age cannot be overstated. Gender-sensitive and human rights-sensitive, country level indicators are essential to guide policies, programs and service delivery; without them, interventions to change behaviours or increase participation rates, will operate in a vacuum.

## **Changing Organizations**

Working toward gender equality challenges people's comfort zones by threatening to shake up existing lines of control over material resources, authority and prestige. It requires people to learn new ways of doing things and unlearn old habits and practices. Resistance to gender-equal policies may take the form of trivialization, dilution, subversion or outright resistance, and can lead to the evaporation of gender

equitable laws, policies or programs. Tackling this requires effective political leadership, well-designed organizational mandates, structures, incentives and accountability mechanisms with teeth. It also requires actions to empower women and women's organizations so they can collectively press for greater accountability for gender equality and equity.

## **Introduction**

The original version of this report was prepared for an international audience by the Women and Gender Equity Knowledge Network established as part of the World Health Organization Commission on the Social Determinants of Health. This document is a summary version prepared in the '1:3:25' "reader-friendly" report-writing style recommended by the Canadian Health Services Research Foundation. This summary is intended to identify areas for discussion and application within public health in Canada. The full report can be accessed at:

[http://www.who.int/social\\_determinants/resources/csdh\\_media/wgekn\\_final\\_report\\_07.pdf](http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf).

Gender inequality damages the health of millions of girls and women around the world. It can also be harmful to men's health, despite the tangible benefits it gives them through resources, power and control. These benefits to men do not come without a cost to their own emotional and psychological health, often translated into risky and unhealthy behaviours, and reduced longevity. Because of the numbers of people involved and the magnitude of the problems, taking action to improve gender equity in health and to address women's rights to health is one of the most direct and potent ways to reduce health inequities overall and ensure effective use of health resources. Deepening and consistently implementing human rights instruments can be a powerful mechanism to motivate and mobilize governments, people in general and, especially, women themselves.

Gender power relations are among the root causes of gender inequality and the most influential of the social determinants of health. They operate across many dimensions of life affecting how people live, work, and relate to each other. They determine whether people's needs are acknowledged, whether they have voice or control over their lives and health, whether they can realize their rights. This report shows that addressing the problem of gender inequality requires actions both outside and within the health sector because gender power relations operate across such a wide spectrum of human life and in such inter-related ways. Taking such actions is good for the health of all people - girls and boys, women and men.

### ***Basic Underpinnings***

Gender inequality and inequity are among the key parts of social hierarchy that shape how people are born, grow, live, work, age and die. Gender power relations are complex, diverse, shaped by history and

by the politics of both place and time. But complexity and diversity do not mean that gender relations are infinitely varied to the point where generalizations are impossible or where solutions become entirely context-specific. Like other social relations, gender relations as experienced in daily life and in the everyday business of feeling well or ill are based on core structures that govern how power is embedded in social hierarchy. The structures governing gender systems have basic commonalities and similarities across different societies, although how they manifest in beliefs, norms, organizations, behaviours and practices can and does vary.

However, as products of social structures, no matter how complex, diverse or deeply entrenched, gender systems are also subject to change. Central to making change happen, as the experience of the last three decades and of earlier periods in history show us, is the passion, staying power and courage of women activists and their organizations. Political leadership is critical but it can be catalyzed by the mobilization and commitment of women organizing in and through civil society, especially where there is entrenched opposition.

Some might argue that gender inequalities in health are a natural consequence of biological difference and difficult to change. We show that gender inequality and equity in health are socially governed and therefore actionable.

Our report draws on analytical advances that have been made in recent years in understanding how different sets of social power relations interact to either worsen or lessen health effects. We argue that only focusing on economic inequalities among households can seriously distort our understanding of how inequality works and who actually bears much of its burdens. Health gradients can be significantly different for men and women; medical poverty may not trap women and men to the same extent or in the same way. The picture becomes more complex when factors like race or caste are added to the analysis.

These findings challenge how many of those concerned about the social determinants of health understand the workings of social inequality. They call for finer nuance in research and analysis and greater sensitivity in policies and actions. They also challenge how one interprets human rights principles. This report is grounded in the affirmation of equal and universal rights to health for all people, regardless of economic class, gender, race, ethnicity, caste, sexual orientation, disability, age or location.

Gender equality remains in a limbo where everyone agrees publicly about the need to act, but resources are not allocated and follow-up action is weak or non-existent. Policy sensitivity to what has to be done *organizationally* is crucial to understanding whether and why policies to address women's health needs or gender inequity in health are misused or become ineffective. Policy analysts have long recognized that the *how* of policies can be as important as the *what*.

This report argues that there must be attention to beliefs and values, incentive and disincentive structures, clear mechanisms to ensure action and strong organizational placement of gender equality champions within the system. The importance of organizational mechanisms means it is not enough to focus on the broad characteristics of governments or agencies in order to tackle gender inequity.

### ***Gender, Women, Equity and Equality***

Over the years, gender has been merged with biological sex in policy documents and has sometimes been interpreted to mean a focus on the needs of men equally with women. This report uses, as appropriate, the terminology of sex (referring to biology), gender (referring to social power relations and hierarchies) and women/men (in their common everyday usage).

In fields other than health, feminist analysts have used the concept of gender *equality* as the foundation for notions of gender justice or *equity*. This is based on the presumption that, to the extent that inequalities between women and men are the product of social power relations, they are likely to be inherently biased and unfair. Such a position is less easily held in the field of health because of the confounding influence of biology.

The approach of this report is based on the following principles: Where biological sex differences interact with social determinants to define different needs for women and men in health (the most obvious being maternity), gender equity will require different treatment of women and men that is sensitive to these needs. On the other hand, where no plausible biological reason exists for different health outcomes, social discrimination should be considered a prime suspect for different and inequitable health outcomes. Health equity in the latter case will require policies that encourage equal outcomes, including differential treatment to overcome historical discrimination<sup>i</sup>.

## **Intersecting Social Hierarchies**

Examining the intersections among different social hierarchies has recently started to yield new insights about the social determinants of health<sup>ii</sup>. Unfortunately, this hasn't yet permeated the health equity field generally. For many who work on or advocate health equity, the sources of inequity are primarily viewed as linked to gender-blind concepts of economic class differentials.

Research shows the poor are worse off in terms of both health access and health outcomes. But it does not tell us whether the burden of this inequity is borne equally by the poorer members of different caste or racial groups. Nor does it tell us how the burden of health inequity is shared among different members of poor households. Recent studies strongly suggest that economic class should not be analyzed by itself, and that apparent class differences can be misinterpreted without gender analysis.

### ***Social Groupings and Structural Processes – How Do They Interact?***

Many key social groupings including gender describe people not on the basis of what they do, but on the basis of who they are along different dimensions that aren't easy to change. The only exception to this may be economic class in situations that allow for considerable class mobility, but even this is uncommon. People born into a particular economic class tend to stay in that class.

The pace or pattern of change in gender systems and how this affects people's health can depend on economic and social processes outside the health sector, including rising literacy and education levels, demographic transitions in birth and death rates and in family structures, globalization (including its effects on labour forces, policy space, health systems, and violence) and the strengthening of human rights discourse.

### ***Gendered Structural Determinants***

Gender and its interactions with other bases of discrimination and bias like economic class, race or caste and with structural processes like education and literacy levels make up the *gendered structural determinants* of health. These are the upstream factors that shape people's health in important ways. This section looks at how these processes interact with gender power systems and to what extent and in what ways they weaken or strengthen gender inequity.

### ***Gender as a Social Grouping***

Gender power plays a role in shaping relations among people, creating and sustaining disequalizing

values, norms, behaviour and practices and structuring organizations to reflect and consolidate those same beliefs and relationships. Gender also affects people's functioning and capabilities<sup>iii</sup>.

Women have less wealth and property in almost all societies, yet they have higher burdens of work in the economy of 'care' – ensuring the survival, reproduction and security of people, including young and old<sup>iv</sup>. Girls in some contexts are fed less, educated less and more physically restricted; and women are typically employed and segregated in lower-paid, less secure, and 'informal' occupations. Gender hierarchy governs how people live and what they believe and claim to know about what it means to be a girl or a boy, a woman or a man.

Women are thus seen as objects rather than subjects (or agents) in their own homes and communities, and this is reflected in norms of behaviour, codes of conduct and laws that perpetuate their status as lower beings. However, there can be significant differences among women themselves based on age or lifecycle status as well as on the basis of economic class, caste and ethnicity.

The other side of the coin of women's subordinate position is that men typically have greater wealth, better jobs, more education, greater political clout, and fewer restrictions on behaviour. Again, not all men exercise power over all women - gender power relations are intersected by age and lifecycle as well as other social layers like economic class, race or caste.

The impact of gender power on the physical and mental health of girls, women and transgender/intersex people, and also of boys and men can be profound, affecting health norms and practices, exposures and vulnerabilities to health problems and the ways in which health systems and research respond.

### ***Gendered Structural Processes***

Some of the key structural processes that have already changed and are continuing to change people's gendered lives include:

- *Changes in literacy and education:* Whenever one looks for positive factors affecting historically unequal gender systems, rising literacy levels and increases in the education of girls are usually at the top of the list.
- *Demographic transition:* Changes in the demand for and supply of education have been fuelled in part by the demographic transition in birth and death rates in many parts of the world. Broadly speaking,

reduction in death rates has been linked to public health transitions such as reduction in traditional infectious disease mortality and increases in immunization. The lowering of fertility has resulted from multiple factors including family planning programs and changes in power relations between women and men which are strongly tied to women's gains in education, paid labour force participation and access to contraception. But the pace and pattern of these changes is different in different regions of the world at present. These processes have important implications not only for the kind of demands placed on health services, but specifically on girls and women as the first line providers of all forms of care, including health care within and outside the home. Women become the shock-absorbers in the system, expected to act as such in both normal economic and healthy times and during the bumps caused by health crises and emergencies.

- *Globalization*: Three implications of globalization are of particular significance for our focus on gender relations:
  - 1) How it has transformed the composition of workforces, and the implications for women's health.
  - 2) How its narrowing of national policy space has resulted in many countries (high, medium, and low income) having to subordinate health, education and other human development policies to the requirement of aligning national economics to the pressures of global financial and commodity markets<sup>v</sup>.
  - 3) The rise in violence linked to the changing political economy of nation states in the international order.

The blurring of boundaries in public and private spaces is also one of the important gendered effects of the rapid expansion of communications media and the increasing centralization of power over mass communication. As communication technology has grown and become more diverse, its content has become filled with violent and misogynistic images and messages.

### ***Women's Movements and Human Rights***

Some of the negative consequences of globalization contrast with the deepening during recent decades of the normative framework of human rights. This deepening has been important in altering values, beliefs and knowledge about gender systems and their implications for health and human rights.

### **Promoting Human Rights and Strengthening Women's Hands**

There are three distinct types of action needed to address the gendered structural determinants that

operate 'upstream' from the intermediary determinants of health:

- 1) Protect and promote the women's human rights that are key parts of the normative framework for health;
- 2) Cushion women in their roles as 'shock absorbers' through key structural reforms; and,
- 3) Expand women's opportunities and capabilities.

### **Deepening the Normative Framework and Realizing Human Rights**

The engagement of social movements has been crucial to clarifying and deepening the normative framework for key human rights affecting people's health. The human rights framework has also been deepened by interpreting the right to health to include reproductive and sexual health and reproductive rights<sup>vi</sup> and sexual rights<sup>vii</sup>. But deepening the recognition of human rights through such actions is only half the needed action. The other half is to turn such norms into reality through mechanisms for implementation and accountability. This requires creation of organizational mechanisms, funding for implementation, and accountability structures that create incentives for appropriate action.

### **Cushioning the 'Shock Absorbers'**

Providing women with support that minimizes the health damaging consequences of their unpaid responsibilities for daily household needs such as gathering fuel, fetching water, cooking, washing and cleaning requires sustained public policy attention. Women also need support for their work of caring for the young, old and the ailing within families. There is a strong need to provide women with efficient sources of energy, better transport systems and clean water and sanitation. It will also be important to invest in programs to transform both male and female attitudes to caring work so that men begin to take an equal responsibility for such work.

### **Expanding Women's Capabilities – Focus on Education**

Education enhances labour market productivity and income growth for all, and educating women also has beneficial effects on social well-being. For instance, it increases women's productivity in the home which in turn can increase family health, child survival and investment in children. Educating women could be the key to breaking the cycles of infant and child mortality and poverty<sup>viii</sup>.

Many actions are needed to break the barriers to education for girls may be the same for both primary and post-primary education. "These include making schooling more affordable by reducing costs and offering targeted scholarships, building secondary schools close to girls' homes, and making schools girl-

friendly. Additionally, the content, quality, and relevance of education must be improved through curriculum reform, teacher training, and other actions. Education must serve as the vehicle for transforming attitudes, beliefs, and entrenched social norms that perpetuate discrimination and inequality<sup>x</sup>.”

## **Norms, Values and Practices**

Norms can be understood as “patterns of behaviour that are widespread, are generally tolerated or accepted as proper, are reinforced by responses of others and are quite hard for individuals to resist even if they run against what is felt to be right.”<sup>x</sup> They form an essential part of how we organize our lives. Norms “cover the entire gamut of human interaction, from the most private sphere of sexuality to the public arenas of economic and political life. Consequently, they form a web of beliefs and practices whose different strands mutually reinforce each other<sup>xi</sup>.”

“There is increasing evidence that gender norms – social expectations of appropriate roles and behaviours for men (and boys) and women (and girls) -- as well as the social reproduction of these norms in institutions and cultural practices, are directly related to many of men’s health-related behaviours, with health implications for themselves, their partners and their children<sup>xii</sup>.”

However, not only do those who stand to gain from norms defend them, but those who are marginalized by them may also support them whether inadvertently or even at times strategically. Women may support norms that limit their mobility, reduce their life chances, stigmatize and violate them, and subordinate them within power relations.

Despite this, even powerful gender norms are not static. They need constant reinforcement because they are often contested and have to be re-negotiated and reformulated by the social actors who practice and are invested in them. Women and men play important roles in maintaining norms, but also in subverting and transforming them.

### ***Gendered Norms Affecting Health***

Gender-biased values translate into practices and behaviours that affect people’s daily lives, as well as key

determinants of wellness and equity. Health equity and wellness can be affected through the preferred sex of children, and practices surrounding coming of age and menarche, adolescence, sexuality and marriage, childbirth, widowhood and divorce.

Norms around masculinity not only affect the health of girls and women, but also of boys and men themselves.

In some settings, for example, being a man means being tough, brave, risk-taking, aggressive and not caring for one's body. Men's and boys' engagement in some risk-taking behaviours, including substance use, unsafe sex and unsafe driving may be seen as ways to affirm their manhood. Norms of men and boys as being invulnerable also influence men's health-seeking behaviour, contributing to an unwillingness to seek help or treatment when their physical or mental health is impaired.

### ***Challenging Gender Stereotypes and How They Affect Health***

Gender stereotypes are among the most resistant to change. Challenging gender norms, especially in the areas of sexuality and reproduction, hit people where they live, and touch the most intimate personal relationships as well as one's sense of self and identity. No single or simple action or policy intervention can be expected therefore to provide a solution. Multi-level interventions are needed. We identify three sets of actions: (A) creating formal agreements, codes and laws to change norms that violate women's human rights, and then implementing them; (B) adopting multi-level strategies to change norms including supporting women's organizations; (C) working with boys and men to transform masculinist values and behaviour that harm women's health and their own.

To be effective, programs intended to change gender norms at the household and community level must be multi-level and designed to influence the underlying determinants of the problem and reinforce the rights of women and girls. When attempting to change norms that violate human rights, but are subject to significant conservative support, many methods may be needed to bring the issue out into the open. Fear, stigma and shame prevent people, especially women, from speaking about the subject.

### ***Differences in Exposure and Vulnerability***

Women and men are differently exposed and vulnerable to specific health conditions. Understanding these differences requires distinguishing between sex and gender. Such an analysis is crucial to designing health policies that can address the health risks of being female or male in ways that affirm

well-being and gender equality.

### ***Mapping Male-Female Differences in Health***

There is a growing body of evidence about health differences between men and women. Male-female differences in health vary in magnitude across different health conditions. The Global Burden of Disease estimates for 2002 indicate that 68 out of the 126 health conditions and health risk factors have at least a 20 per cent difference between women and men<sup>xiii</sup>. Setting aside potential methodological biases or data discrepancies, these numbers suggest that male-female differences in health are widespread.

### ***Understanding Male-Female Differences in Health***

Some health conditions are determined primarily by biological sex differences. Others are the result of how societies socialize women and men into gender roles supported by norms about masculinity and femininity, and power relations that accord privileges to men, but which adversely affect the health of both women and men.

However, many health conditions reflect a combination of biological sex differences and gendered social determinants.

Understanding the roles that biological difference and social bias play is important to understanding differences in exposure and vulnerability. Vulnerability reflects an individual's capacity to avoid, respond to, cope and/or recover from exposures. As such, one's ability to deflect or absorb exposures with differing health effects and social consequences depends on a range of normative and structural social processes. Vulnerability increases with lack of awareness and acknowledgement of health problems or decision-making power to act on them, and inadequate access to treatment and social support throughout the health seeking experience. As well, while biological sex differences may decrease or increase the risk of certain health outcomes, this does not necessarily result in corresponding changes in gender-based vulnerability to a health condition.

### ***Exposure and Vulnerability Due to Both Sex and Gender***

Biological differences are important, but they do not always have sufficient power to determine health outcomes on their own. Yet women's health concerns are often understood as being mainly determined by biology. One example is osteoporosis, which in women appears to be partly linked to hormonal changes at the time of menopause. However, a response focused on marketing hormone replacement therapies, while useful, tends to divert attention from other potentially more important social factors

influencing women's vulnerability to osteoporosis and its complications, such as isolation among elderly women, poor public and private infrastructures and possibly some features of traditional diets. Worse still, it obscures the importance of preventive measures at the individual level through nutrition and exercise or protective measures at the societal level through better designed buildings and roads and pavements that reduce the risk of falling<sup>xiv</sup>.

### ***Exposure and Vulnerability Due Primarily to Gender***

Whether related to individual social behaviour or to how broader processes of social stratification, exposures and vulnerabilities attributable to gender are amenable to social change and thus they offer potential "best-buys" for health interventions<sup>xv</sup>. An outcome of male norms that are manifested through risk behaviour is that globally, 2.7 times as many men as women die from road traffic injuries.

The workplace is a critical arena determining gendered health differentials. The gendered division of labour shown by the allocation of specific tasks to men and women is extensive and pervasive in all countries, regardless of level of development, wealth, religious orientation or political regime. These factors negatively affect women's social position relative to men's and the resulting inequalities contribute to gender inequalities in health<sup>xvi</sup>.

In terms of health hazards in the workplace, both in high and low income countries, work related fatalities are more common among men, because men work in environments with greater risk for accidents, e.g. transportation, mining, fishing and fire fighting<sup>xvii</sup>. Nonetheless, women's occupational health hazards are not insignificant. Evidence mainly from high-income countries suggests that women more than men are engaged in work characterized by high demands and little control, with highly repetitive movements and awkward postures, often facing intense exposure to the public<sup>xviii</sup>.

## **Reducing the Health Risks of Being Women and Men**

### ***Meeting Differential Health Needs***

Gender differences in exposure and vulnerability to health risks can arise either through the combined influences of biological sex and gendered social bias or through gendered social bias alone. Where biological sex differences interact with social determinants to define different needs for women and men in health, policy efforts must address these different needs.

In some instances, larger social changes that appear to be beneficial overall in terms of either economic growth or democracy may be harmful to women's access to such services. For example, prior to reunification, maternal mortality rates were uniformly low for all women in East Germany. After reunification, maternal mortality patterns have come to resemble those in West Germany, with unmarried women in East Germany having 2.6 times the age-adjusted risk of maternal death of married women. The change is attributed to the removal of social support and protection measures that were previously constitutionally guaranteed to single mothers in East Germany. With reunification, cash incentives for prenatal care; follow-up for those who could not attend prenatal care, and guaranteed employment for single mothers was removed<sup>xix</sup>.

Significant advocacy is required to raise attention and sustain support for other services that address the specific health needs of poor women, and those in low income countries, thereby reducing their exposure and vulnerability to unfavourable health outcomes. Not only must neglected sex-specific health conditions be addressed, but sex-specific needs in health conditions that affect both women and men must be considered, so that treatment can be accessed by both women and men without bias.

Sex-specific differences that contribute to distinct needs in terms of the workplace must be addressed. These include a range of different actions addressing the nature of work facilities, tools and safety, as well as policies towards worker compensation and the coverage of benefit schemes.

### ***Tackling Social Bias***

Social discrimination can operate between women and men, across different race or ethnic groups, or across different groups of women themselves, and can make those at the bottom of the hierarchy vulnerable to adverse health outcome even while those at the top are faring well.

Apart from reinstating support services that let poor women overcome the structural barriers that challenge their lives, more comprehensive policies that balance working lives with family commitments in ways that do not further discriminate against women are needed. At the same time, policy measures that encourage equal health outcomes must not compromise gender equality.

### ***Tackling the Structural Dimensions of Individual Risk Behaviour***

Many health promoting interventions aim at reducing high-risk behaviours such as unhealthy eating,

alcohol and drug abuse and smoking. These programs often ignore the material, social and psychological conditions within which the targeted behaviours are embedded. For example, in many countries there is a strong association between material hardship, low social status, stressful work or life events and smoking prevalence<sup>xx</sup>.

Without attention to the structural forces in which they are embedded, a focus on gender roles and their influence on health-related behaviours can lead to an emphasis on behavioural change at the *individual* level rather than on policy change at the *societal* level<sup>xxi</sup>.

Individual behaviour must be considered in the social context in which that behaviour takes place. In order to design appropriate policies for these social contexts, individuals at the heart of preventive strategies must be involved in designing interventions that address their constraints.

### ***Empowering Individuals and Communities for Positive Change***

While broader structural factors, including legal rights; infrastructure, public services, employment and other wealth generating measures, are essential to positive change, individual empowerment linked to community level dynamics is also critical in fostering transformation of gendered vulnerabilities. For strategies to succeed they must provide positive alternatives that support individuals to take action against the current status quo, which might be either gender blind or gender biased.

With respect to the workplace, in order for women and men to be empowered to address gender inequalities, responsive mechanisms must exist to channel their concerns. Ombudsmen that monitor gender equality and sexual harassment must be appointed and empowered with resources and enforcement authority. Unions must have accountability mechanisms to ensure that their membership, leadership and decision-making processes are responsive to gender concerns.

In order to be translated into action, alternative gender messages and policy efforts must be delivered in settings that exemplify stereotypical gender behaviour. In the UK, football clubs, bars and other predominantly male spaces have been effective arenas in which to address men's needs from a gender perspective. Adolescent health messages similarly have more impact if they are not constrained to just health centres, but are also extended to schools and popular 'hang outs'.

### ***The Gendered Politics of Health Care Systems***

The Commission on the Social Determinants of Health sees health systems as a site for action to promote greater equity in health. However, health systems in many countries have been unable to deliver adequately on basic health or on health equity in general and gender equity in health in particular. One reason is that many health care systems pay insufficient attention to the different needs of women and men in planning and providing health services. Another reason is that equitable use of health care is strongly affected by gender inequalities in society that determine whether women's health needs and problems are properly acknowledged, and whether families are ready to invest equally in the health of girls and women. It is also affected by unequal restrictions on physical mobility, unequal control over financial resources, and unequal decision-making.

The lack of *awareness* (knowledge of women, their families and health care providers about the existence of a health problem) and *acknowledgement* (recognition that something should and can be done about the health problem) are important barriers to *access* to and use of health services<sup>xxii</sup>. Access depends therefore both on factors affecting the demand side (how families treat women who may be potential users and how women see themselves) and the supply side (including different aspects on the side of providers). Moreover, the lack of effective *accountability* mechanisms for available, affordable, acceptable and high quality health services and facilities may seriously hinder women and their families in holding government and other actors accountable for violations of their human rights to health<sup>xxiii</sup>.

### ***Women as Consumers of Health Services***

Women in most places need more health services than men. A large part of this can be attributed to women's use of preventive services for contraceptives, cervical screening, and other diagnostic tests<sup>xxiv</sup>, but it can also be attributed to excess female health problems that are not caused by reproductive morbidity.

First, women themselves, their families and health care providers need to be *aware* of the existence of a health problem. They may look upon health problems as normal or natural aspects of women's biology or everyday activities. For example, certain types of health conditions, such as chronic pain, depression and reproductive tract infections, may be so widely prevalent that women and care providers treat them as normal states and ignore them<sup>xxv</sup>.

Second, even though women are aware of their health problems, they may refuse to *acknowledge* the problem by choosing to remain silent if they fear adverse reactions from the family, community and health care providers.

Third, even when women and their families *acknowledge* the need for treatment, social and financial barriers may be encountered before health care can be utilized<sup>xxvi</sup>. These considerations may be influenced by gender-biased normative structures that govern households. Although health services may be available, women and girls may be unable to access them due to discrimination within the household, granting preferential allocation of resources to male health needs or requiring consent from partners or other family members.

Fourth, women in some cultures are reluctant to use health services because respect, privacy, confidentiality and information about treatment options are not ensured by the often overworked, underpaid and gender insensitive health care providers<sup>xxvii</sup>.

### ***Accountability Mechanisms for Improved Health Services***

Accountability to citizens with regard to gender and health can be understood as the processes by which health policy-makers and providers engage with and respond to citizens and enforce decisions in such a manner as to reduce gender inequities in health<sup>xxviii</sup>. In order to address accountability, it is important for health care managers, as a routine, to collect, analyze and interpret sex-disaggregated data and take action.

### ***Changing How We Care and Cure***

In the last two decades, powerful international trends in health sector reform have been observed all around the world, often associated with policy prescriptions focused on institutional and financial reforms. Although adopted reforms such as decentralization, integration of services, financing, privatization, organization and management, and priority setting vary considerably from country to country and region by region, the stated objective in most countries has been to improve efficiency, equity and effectiveness of the health sector<sup>xxix</sup>. The driving forces behind these reforms vary, but limited governmental resources, combined with rapid demographic and technological changes often serve as the rationale for the desired change<sup>xxx</sup>.

Regardless of the national and regional context in which health sector reforms are implemented, they have fundamental consequences for gender equality and for people's lives and well-being. However, health sector reforms that have been implemented in many countries have tended to focus on their implications for the poor, and their consequences for gender equity generally and specifically pertaining to health care have seldom been discussed or taken into consideration in planning<sup>xxx</sup>.

The few existing gender analyses of health sector reform programs suggest that many of the reforms may affect women differently than men because of women's greater need for health care due to their reproductive functions, their greater social, cultural and financial vulnerability and their greater enrolment as health care providers both within the formal health care sector and the informal care system<sup>xxx</sup>. Minimizing gender bias in health systems requires systematic approaches to building awareness and transforming values among service providers, steps to improve access to health services and developing mechanisms for accountability.

### ***How to Raise Awareness and Improve Acknowledgment of Women's Health Problems***

The lack of awareness and failures to recognize women's specific health needs are largely due to gender bias which leads to neglect and low priority. Bias of this kind can be institutionalized into indifference in health systems through the design of budget lines, supervision systems, staffing patterns, drug allocations, training curricula, etc. which do not take this into account<sup>xxx</sup>. The following actions are needed to raise awareness and make health systems acknowledge women's health:

- 1) *Develop skills, capacities and capabilities among health professionals at all levels of the health system to understand and apply gender perspectives in their work; and,*
- 2) *Provide information about diseases and ensure confidentiality and respectful treatment by providers by integrating gender into treatment literacy programs which intend to raise awareness, counteract stigma and empower patients in their interactions with providers.*

### ***How to Improve Women's Access to Health Care***

Building and strengthening equitable health care systems that meet the needs of women, both as users and care providers in formal and informal care, requires that policy-makers remove financial, physical and cultural barriers to access to good quality care for women. The following actions are important for to remove women's barriers to access to care:

- 1) *Provide comprehensive and essential health care, universally accessible to all in the community in an acceptable and affordable way and with the participation of women, envisioned under the principles of the Alma Ata Declaration on Primary Health Care (PHC).*

The Alma Ata Declaration of PHC in 1978 was based on a need for equity and the just distribution of resources according to need. Although, due to the lack of commitment, the potential for change promised by the comprehensive PHC has not been realized and the goal of “Health for All by 2000” was not achieved, there are some lessons to be learned from countries that achieved some successes under the PHC model<sup>xxxiv</sup>. The principles of the PHC framework should be used for pushing current boundaries towards the development of health systems that are accessible, acceptable and affordable to all and that could address sexual and reproductive health for women<sup>xxxv</sup>.

- 2) *Ensure that user fees are not collected at the point of access of the health service, and prevent women’s impoverishment by enforcing rules that adjust user fees to women’s ability to pay.*

Available evidence creates a strong case for removal of user fees and provision of universal coverage for pregnant women, particularly for delivery care. To be successful, governments must also replenish the income lost through the abolition of user fees. Where insurance schemes exist, maternal health care needs to be included in the benefits package, and careful design is needed to ensure uptake by the poorest people<sup>xxxvi</sup>.

- 3) *Offer care to women according to their needs, their time and other constraints taken into consideration*

Even though services are available or affordable to the poor in general, they may still be out of reach for girls and women. In some settings, this is a matter of distance or transport access, which may make it impossible for girls or women to visit health centres, particularly where gender taboos limit women’s mobility or their interaction with male care providers.

- 4) *Improve the quality and women’s access to health care by increasing gender equity in the health care workforce at all levels.*

Given the crucial role women play in providing health care, it is important that policies and

programs recognize women's contributions to the health sector, not just in the formal, but also through informal care.

5) *Incorporate gender into clinical audits and other efforts to monitor quality of care.*

All health systems need to develop a clear strategy for an assessment of the differential impact of health care on women and men. A gender-based monitoring and evaluation plan enables health professionals to clearly identify the effects of the project or program on women and men, directly measure how a project or program is effective for both sexes and take the necessary management decisions<sup>xxxvii</sup>.

### ***How to Strengthen Accountability of Health Systems to Citizens?***

Accountability mechanisms enable both providers and patients to establish which health policies and institutions are working and which are not, who has responsibility to do what, whether they have done it, and if not, why not<sup>xxxviii</sup>.

There are several ways that health system accountability can be strengthened:

- 1) Enhance accountability of health policy-makers, and on controversial health issues;
- 2) Strengthen accountability of private clinics and providers to gender and health;
- 3) Reduce hierarchies of power: gender and others; and,
- 4) Engender accountability structures and tools, and ensuring that they are not hijacked.

To be effective in promoting gender and health accountability, accountability structures/tools/processes should<sup>xxxix</sup>:

- Not be looked at in isolation, but be looked at along with accountability to development, health, and women's rights.
- Be at multiple levels (international to local) and multiple institutional sites (public/state, private/markets, community).
- Address accountability in its different facets, as engagement and responsiveness, answerability, and enforcement.
- Be multi pronged in approach - use gender and health sensitive international instruments, declarations, and goals; new aid infrastructure, progressive health and women's rights legislation, policies and programs; community and hospital health structures; professional councils, community

- audit, etc.
- Be engendered by increasing marginalized women's and men's direct participation, building pressure groups from outside, strengthening gender, health and accountability capacity of providers and elite groups, anticipating adverse consequences, and adding gender-specific health indicators.
  - Ensure accountability structures and processes are designed in such a way that it will not cost for women.
  - Not be added on, but be context specific, and be accompanied by adequate earmarking of resources.

## **Health Research**

Gender not only affects differences in health needs, health-seeking behaviour, treatment, and outcomes, but also permeates both the content and the process of health research<sup>xi</sup>. Gender biases in research sustain a vicious circle that serves to downgrade gender issues in health and perpetuate their neglect.

### ***Gender Imbalances in Research Content***

Gender imbalances in research content include the following dimensions:

- a) *Slow recognition of health problems that particularly affect women:* for example, it is only within the past decade or so that serious research into the prevalence of reproductive tract infections and the prevalence and health consequences of domestic violence has occurred<sup>xii</sup>.
  
- b) *Misdirected or partial approaches to women's and men's health needs in different fields of health research:*  
Occupational health research and safety regulations are mainly focused on health hazards in formal employment, where men predominate. Thus, research has long ignored the problems of indoor air pollution and smoke-filled kitchens, factors that are critical to the health of poor women in the developing world<sup>xiii</sup>. Misdirected or partial approaches may also affect men. Because of gender stereotyping, where reproduction is viewed as women's domain, male reproductive health related to occupational exposures has been neglected<sup>xiiii</sup>.
  
- c) *The lack of recognition of the interaction between gender and other social factors:* Little attention is being paid in health research to the interaction between gender and other social groupings, like socioeconomic class, race, ethnicity or sexual orientation. These causal interactions make

problems more complex and require more intensive research efforts.

### ***Gender Imbalances in the Research Process***

Gender imbalances in research process include the following dimensions:

- a) *Data*: Non-collection of sex-disaggregated data in individual research projects or larger data systems: health data in individual research projects and in national and regional data systems is still not systematically collected or disaggregated by sex.
- b) *Gender-sensitive methodologies*: Research methodologies are not always sensitive enough to capture the different dimensions of disparity.
- c) *Representation of women and men in clinical trials*: An equally important, but different kind of problem with methods used in medical research and clinical trials for new drugs has been the general lack of a gender perspective and the exclusion of female subjects from study populations.
- d) *Gender balance in research communities, ethical committees, and in research funding and advisory bodies*: The gender imbalance in ethical committees, research funding and advisory bodies, and the differential treatment of women scientists have been acknowledged as a contributing factor to gender bias in research<sup>xliv</sup>.

### ***Changing What We Know***

Health researchers need to focus more on the possibility that risk factors, biological mechanisms, clinical manifestation, causes, consequences and management of disease may differ in men and women. In such cases, prevention, treatment, rehabilitation and care-delivery need to be adapted according to women's and men's different health needs. Not doing so may have a negative impact on the health of both women and men and gender-based inequities in health might even increase.

Physiological differences between men and women are not confined to the reproductive system and the possibility of gender differences must be considered in all areas of health research. In addition, to physiological differences that may or may not be linked to the reproductive system, research must also investigate the different experiences that underpin health seeking behaviour, health status and access to both material and non-material resources. Mechanisms and policies need to be developed to ensure that gender imbalances in both the content and processes of health research, discussed in the previous sections, are avoided.

### ***Prerequisites for Conducting Gendered Health Research***

- a) The *collection of sex-disaggregated data* that include indicators of social position (e.g. education, income, occupation, and ownership of land or homes) by individual research projects or through routine data collection systems at regional and national levels. Such data should be used for mapping and analyzing the disease burden - incidence and prevalence of different health problems - among women and men and among girls and boys.
- b) Recognition of women's health problems and gender equity concerns through *effective research methodologies*. Attention needs to be paid to the possibility that data may reflect systematic gender biases due to inadequate methodologies that fail to capture women's and men's different exposures to health risks and vulnerability to diseases (e.g. because of different health seeking behaviour and insensitivity of diagnostic methodologies).
- c) *Data managers and systems need to be sensitized* to the need for basic disaggregation of data by sex and presentation of data that allow analysis of the intersections between gender and other social determinants of health. At the same time it is important to *build capacity of researchers* for gender-sensitive research analysis.
- d) *Women should be included in clinical trials and other health studies in appropriate numbers and the data generated from such research should be analyzed by gender*. Although, steps have been taken to this direction, a study by the US General Accounting Office reports that although women now are being adequately represented in clinical trials in the US, the data collected is not being analyzed by gender.
- e) *Research funding bodies should promote research that broadens the scope of health research and links biomedical and social dimensions, including gender considerations*. They should promote multi-disciplinary research agendas on the links between gender issues and health and promote gender sensitive health research and operations research to translate broad knowledge about gender and health into practical guidelines and to evaluate interventions from a gender perspective.
- f) *Women's roles in research need to be strengthened*.
- g) *Ethical and other review boards, editors and editorial boards should include gender experts* to ensure that gender dimensions of research projects aren't missed.
- h) *Medical and related journals should request that papers present data disaggregated by sex and explain observed differences adequately in terms of either biology (sex) or gender (social factors)*

*or both.*

### ***What Gets Measured is What Gets Done – Data and Indicators***

The importance of having good quality data and indicators for health status disaggregated by sex and age from infancy through old age cannot be overstated. Without gender-sensitive and human-rights-sensitive country level indicators to guide policies, programs and service delivery, interventions to change behaviours or increase participation rates, operate in a vacuum.

But health status indicators alone are not enough. Data on health behaviour affecting different household members, including use of services and expenditures for health needs are essential to understand how households allocate health resources and who benefits from them. These data, by gender, age and other groupings, are critical if work on health equity is to go beyond its historically narrow focus on economic differentials alone.

Tracking policies, programs and projects requires quantitative and qualitative data from at least three levels: 1) investments, policies and institutions; 2) service and program delivery; and 3) conceptual frameworks that foreground gender equality and equity and the human rights of women and girls. Furthermore, outcome indicators, input indicators regarding resources, and process indicators on implementation have to disaggregate by sex and age, and these data must be analyzed from a gender perspective.

Through research, we can understand and learn about the importance of sex and gender in health. Health policies informed by gender-biased health research will themselves be gender insensitive and gender-biased. Engendering health research is not without cost. However, the benefits of the efforts proposed above overshadow the cost in terms of better science and more effective and equitable health policies and programs.

### **Mainstreaming for Gender Equality and Equity**

Mainstreaming has previously been viewed as a major advance, allowing forward movement beyond narrowly focused women's programs or patchwork gender equality legislation. It was understood generally to mean systematic integration of gender perspective at all relevant levels. However, a number

of recent policy reviews have been critical of the progress made during the last decade in mainstreaming for gender equality<sup>xlv</sup>.

Why is this taking place? An important reason is that working toward gender equality challenges long-standing male-dominated power structures and old boys' networks within organizations. It therefore crosses the boundaries of people's comfort zones by threatening to shake up existing lines of control over material resources, authority, and prestige. It requires people to learn new ways of doing things about which they may not be very convinced and from which they see little benefit to themselves, and to unlearn old habits and practices. Resistance to gender-equal policies may take the form of trivialization, dilution, subversion or outright resistance.

### ***Gender Mainstreaming in Health***

In focusing specifically on health, it is useful to distinguish between *operational* mainstreaming in policies, programs and projects, versus *institutional* mainstreaming which addresses the internal dynamics of formal institutions - their goals, agenda setting, recruitment, staff advancement and promotion policies, governance structures and procedures related to day-to-day functioning. A review<sup>xlvi</sup> of gender mainstreaming in health concluded that enabling conditions include the presence of international, national and regional mandates for activities to be initiated; presence of political will; establishment of legal and constitutional frameworks that support gender equality; availability of resources; and the presence of a strong women's health movement and a culture of active civil society participation.

## **The Way Forward – Getting There From Here**

There are seven approaches that are essential for forward movement:

- 1) Address the essential structural dimensions of gender inequality.**
  - Transform and deepen the normative framework for women's human rights and achieve them through effective implementation of laws and policies along key dimensions.
  - Ensure that resources for and attention to access, affordability and availability of health services are not damaged during periods of economic reforms, and that women's entitlements, rights and health, and gender equality are protected and promoted, because of the close connections between women's rights to health and their economic situation.
  - Support through resources, infrastructure and effective policies/programs the women and girls who

function as the 'shock absorbers' for families, economies and societies through their responsibilities in 'caring' for people, and invest in programs to transform both male and female attitudes to caring work so that men begin to take an equal responsibility for such work.

- Expand women's capabilities particularly through education, so that their ability to challenge gender inequality individually and collectively is strengthened.
- Increase women's participation in political and other decision-making processes from household to national and international levels so as to increase their voice and agency.

## **2) Challenge gender stereotypes and adopt multilevel strategies to change the norms and practices that directly harm women's health.**

- Create, implement and enforce formal international and regional agreements, codes and laws to change norms that violate women's rights to health.
- Work with boys and men through innovative programs for the transformation of harmful masculinist norms, high risk behaviours, and violent practices.

## **3) Reduce the health risks of being women and men by tackling gendered exposures and vulnerabilities.**

- Meet women's and men's differential health needs. Where biological sex differences interact with social determinants to define different needs for women and men in health, policy efforts must address these different needs. Not only must neglected sex-specific health conditions be addressed, but sex-specific needs in health conditions that affect both women and men must be considered, so that treatment can be accessed by both women and men without bias.
- Tackle social biases that generate differentials in health related risks and outcomes. Where no plausible biological reason exists for different health outcomes, policies and actions should encourage equal outcomes. More comprehensive policies are required that balance working lives with family commitments. Domestic work, including care for other family members, needs to be acknowledged as work and work-related health risks need to be addressed regardless the location of the workplace. Family leave policies must mandate that men share these responsibilities with women. Social insurance systems must ensure that even those who may not have had formally recognized and remunerated occupations are also protected when not working or ill.
- Address the structural reasons for high-risk behaviour. Strategies that aim at changing health

damaging lifestyles of men (or women) at the level of the individual are important, but they can be much more effective if combined with measures to change the social environment in which these lifestyles and behaviours are embedded. These measures should tackle the negative social and economic circumstances (e.g. unemployment, sudden income lost) in which the health damaging lifestyles are embedded.

- Empower people and communities to take a central role in these actions. For strategies to succeed they must provide positive alternatives that support individuals to take action against the current status quo, which may be either gender blind or gender-biased.

**4) Transform the gendered politics of health systems by improving their awareness and handling of women's problems as both producers and consumers of health care, improving women's access to health care, and making health systems more accountable to women.**

- Provide comprehensive and essential health care, universally accessible to all in an acceptable and affordable way and with the participation of women: ensure that user fees are not collected at the point of access to the health service, and prevent women's impoverishment by enforcing rules that adjust user fees to women's ability to pay; offer care to women and men according to their needs, their time and other constraints.
- Develop skills, capacities and capabilities among health professionals at all levels of the health system to understand and apply gender perspectives in their work.
- Recognize women's contributions to the health sector, not just in the formal, but also through informal care. Women as health providers in auxiliary, volunteer and informal care need multiple linkages to formal and professional sectors: training, supervision, acknowledgement and support, functioning referral systems linking them to drugs, equipment and skilled expertise.
- Strengthen accountability of health policy-makers, health care providers in both private and non-private clinics to gender and health. Incorporate gender into clinical audits and other efforts to monitor quality of care.

**5) Take action to improve the evidence base for policies by changing gender imbalances in both the content and the processes of health research.**

- Ensure collection of data disaggregated by sex, socioeconomic status, and other social groupings by

individual research projects as well as through larger data systems at regional and national levels, and the classification and analysis of such data towards meaningful results and expansion of knowledge for policy.

- Women should be included in clinical trials and other health studies in appropriate numbers and the data generated from such research should be analyzed using gender-sensitive tools and methods.
- Research funding bodies should promote research that broadens the scope of health research and links biomedical and social dimensions, including gender considerations.
- Strengthen women's role in health research. Redress the gender imbalances in research committees, funding, publication and advisory bodies.

**6) Take action to make organizations at all levels function more effectively to mainstream gender equality and equity and empower women for health by creating supportive structures, incentives, and accountability mechanisms.**

- Gender mainstreaming in government and non-government organizations has to be owned institutionally, funded adequately, and implemented effectively. It needs to be supported by an action-oriented gender unit with strong positioning and authority, and civil society linkages to ensure effectiveness and accountability.
- Effective interventions for women's empowerment need to build on and reinforce authentic participation ensuring autonomy in decision-making, sense of community and local bonding. If these interventions are integrated with economic, education, and/or political sectors, they can result in greater psychological empowerment, autonomy and authority and they can substantially affect a range of health outcomes.

**7) Support women's organizations, which are critical to ensuring that women have voice and agency, are often at the forefront of identifying problems and experimenting with innovative solutions, prioritize demands for accountability from all actors, both public and private, and which have seen declining access to resources in recent years.**

- Gender power relations exist both within and outside the health sector, and have a harmful influence on the health of people. While it is the health of girls and women that is most affected, gender power relations also harm the health of boys and men even though they benefit in terms of resources, authority, and control. Both within and outside the health sector, gender relations mean reduced

voice, agency, decision-making, authority and recognition for women relative to men. The consequences for people's health are not only unequal and unjust, but also ineffective and inefficient. The results are vicious circles of ill-health that trap people in ways that are both unfair and unnecessary.

## Endnotes

---

- <sup>i</sup> Breen, 2002, Iyer et al., 2007a, Sen et al., 2002.
- <sup>ii</sup> Iyer et al., 2007b, Crenshaw, 1991, Iyer, 2007, Krieger et al., 1993, TK Ravindran, 1991.
- <sup>iii</sup> Sen, 1999.
- <sup>iv</sup> Elson 1993.
- <sup>v</sup> Rodrik, 1997, Stiglitz and Charlton, 2005.
- <sup>vi</sup> United Nations, 1994.
- <sup>vii</sup> United Nations, 1995.
- <sup>viii</sup> UNFPA, 2002.
- <sup>ix</sup> Grown et al., 2005.
- <sup>x</sup> Tibandebage and Mackintosh, 2002.
- <sup>xi</sup> Sen et al., 2006.
- <sup>xii</sup> Worth, 1989, Amaro, 1995, Campbell, 1995, Cohen and Burger, 2000.
- <sup>xiii</sup> Annex 3.
- <sup>xiv</sup> Snow, 2002.
- <sup>xv</sup> Snow, 2007.
- <sup>xvi</sup> Messing and Östlin, 2006, Östlin, 2002a, Östlin, 2002b.
- <sup>xvii</sup> Laflamme and Eilert-Petersson, 2001, Islam et al., 2001.
- <sup>xviii</sup> Messing, 2004, Östlin, 2002a, Östlin, 2002b.
- <sup>xix</sup> Razum et al., 1999.
- <sup>xx</sup> Osler et al., 2001, Bobak et al., 2000.
- <sup>xxi</sup> Stronks et al., 1996, Kabeer, 1994.
- <sup>xxii</sup> George 2007b.
- <sup>xxiii</sup> Erdman and Cook, 2007.
- <sup>xxiv</sup> Gijsbers van Wijk et al., 1996.
- <sup>xxv</sup> Iyer, 2005.
- <sup>xxvi</sup> Iyer, 2005.
- <sup>xxvii</sup> Bruce et al., 1998, George, 2007b, Govender and Penn-Kekana, 2007, Vlassoff, 1994.
- <sup>xxviii</sup> Caseley, 2003, Goetz, 2006.
- <sup>xxix</sup> Östlin, 2005.
- <sup>xxx</sup> Eriksson, 2001, Berman and Bossert, 2000.
- <sup>xxxi</sup> PAHO, 2001.
- <sup>xxxii</sup> Evers and Juárez, 2003, Ford Foundation, 2003, Mackintosh and Tibendebage, 2004, Neema, 2005, Onyango, 2001, Standing, 1997, Standing, 2000, Östlin, 2005.
- <sup>xxxiii</sup> George et al., 2005.
- <sup>xxxiv</sup> Allotey, 2005.

- 
- xxxv Allotey, 2005.
- xxxvi Borghi et al., 2006.
- xxxvii Doyal, 1998.
- xxxviii Cook and Ngwena, 2006.
- xxxix Murthy 2007.
- xl Sen et al., 2002, Östlin et al., 2004, Eichler et al., 1992, Theobald et al., 2006.
- xli Garcia-Moreno, 2002.
- xlii Smith and Maeusezahl-Feuz, 2004, Bruce et al., 2002, Ezzati et al., 2000, Mishra et al., 1999, Dennis et al., 1996, Behera et al., 1991.
- xliii Varga, 2001, Wang, 2000.
- xliv Wenneras and Wold, 1997, Park, 2002.
- xlv OECD/DAC, 2002, NORAD, 2006, Moser and Moser, 2005, AWID, 2006, Eyben, 2006, Mehra and Gupta, 2006, Reisen and Ussar, 2005, Rao and Keller, 2005, EQUAPOL, 2005.
- xlvi TK Ravindran and Kelkar-Khambete, 2007.