1. Gender and health: an introduction

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This volume brings together the contributions of 56 leading writers on gender and health from a wide range of countries spanning Africa, the Americas, Asia, Europe and the Middle East. The chapters included in the Handbook offer a wealth of knowledge, theoretical reflection and empirical evidence on a diversity of topics that I selected as essential elements of a discussion around gender and health.

The importance of gender inequality as a critical determinant of health has been widely acknowledged (Marmot et al., 2008) and there has been a widespread acceptance of the need to mainstream gender into its analysis. Nevertheless, significant gaps remain between policy and practice, and addressing gender issues in health requires more than merely ensuring women gain better access to services and resources within the health sector (Gideon, 2012; Hawkes and Buse, 2013; Payne, 2014). The discussion within the book emphasizes the need to move beyond the ‘add women and stir’ approach that is still frequently found in practice, despite all we now know about the complexities of seeking to achieve gender equality (Chant and Sweetman, 2012; Razavi, 2012).

Much of the existing debate around gender and health has been primarily concerned with health outcomes; in contrast the discussion presented in this edited collection seeks to capture the multi-determinants of health and well-being as well as the organizational and institutional structure of the design and delivery of health care. In the context of economic and social change, the collection considers how these factors are altered and how far processes of change are gendered, as well as how far gender relations impact on these shifting dynamics. A significant and distinctive feature of this Handbook is that many of the chapters explore these challenges through empirical case studies from a variety of geographical settings in both the Global North and the Global South and illustrate that ‘gender’ remains central to any analysis of health, regardless of the level of development within the health system or wider economy. Moreover, the chapters offer a wealth of disciplinary perspectives, presenting critical insights and a diversity of approaches to the study of gender and health.

Four overarching themes are broadly explored in the book and all constitute what might be considered as distinct but overlapping elements of a broader gendered political economy of health (Gideon, 2014). The first theme is the tension between ideas of gender equity and gender equality and how these translate in practice when applied to the health sector. In practice gender equity approaches often boil down to a very reductionist focus on ‘women’ and fail to take into account other axes of inequality including race, caste, class, age and ethnicity, while at the same time failing to unpack the category of ‘men’ and looking more critically at the social relations between them and their female counterparts. In contrast, as discussed in more detail below, a gender equality approach can potentially enable a more transformative suite of measures likely to bring about gains in gender justice. The United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) (2010) argues that gender justice entails ending the inequalities
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between women and men that are produced and reproduced in the family, the community, the market and the state. However, at the same time it requires that mainstream institutions are more accountable and transparent, and this points to the second theme discussed in the book. Several of the chapters reflect on the need to uncover the gendered nature of the health system itself and shed light on the diverse ways in which women’s interests are frequently marginalized or health policies work to reinforce women’s gendered roles and responsibilities. The third theme that is examined is the importance of incorporating the voices of excluded groups in policy processes, as several chapters highlight the health costs of failing to engage with marginalized sectors of society. Finally, the fourth theme that emerges from a number of the chapters is the importance of appropriate policy responses and a move away from the ‘one size fits all’ approach, often espoused by international donors and global health discourses. While success at the local level often poses the challenge of how to scale up effective policy responses, extreme caution must also be exercised when successful policy initiatives are imposed on a variety of different settings with little thought given to the local complexities that may impact on the implementation process, often with disastrous results. As all of the chapters convincingly show, gender is a central element and there is clearly a need for more nuanced and reflective debate and discussion if the gender dimensions of health and health care are to be fully understood and incorporated into practice.

Overall the Handbook seeks to address the reasons why a palpable fissure between discourse and practice continues to occur. An important starting point for any gendered analysis is to critically reflect on mainstream understandings of health as merely the absence of disease. In the main the definition of health offered by the World Health Organization (WHO) has been widely used and accepted across the world. According to the WHO, ‘health’ refers to ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO, 1948). Nevertheless, it is important to consider some of the limitations of the definition, particularly the ways in which it has been seen to reinforce particular biomedical, Western approaches to health (Hoedeman, 2011; Larson, 1999; Pannenborg, 1979). Yet these tensions between overly medicalized understandings of health, and broader approaches which take into account the ways in which the wider social context, including political and economic conditions, shape individual’s health and well-being, remain unresolved. Moreover, the anthropologist Marcia Inhorn (2006) argues that the dominant medical focus of the definition of health is highly gendered and limits the boundaries within which people, and women in particular, can identify health problems and define their own health needs. Indeed the need for incorporating the voices of the excluded in health policy and planning is also a recurring theme in many of the chapters, and several chapters reflect on the limitations of overly medicalized approaches to health issues.

As stated earlier, an important issue considered throughout the Handbook is the use of the term ‘gender’ itself. As critics have argued, even where ‘gender’ is taken on board, considerable confusion exists around the meaning and usage of the relevant terminology. Most notably the terms ‘gender equity’ and ‘gender equality’ can generate considerable misinterpretation (Payne and Doyal, 2010). This is important because the terms represent very different approaches and encompass very different political projects. In part the confusion around the terms stems from the intense debate over their usage and meaning amongst participants at the 1994 United Nations Cairo Conference on Population and
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Development, to accept the promotion of both terms, along with the empowerment of women (Payne and Doyal, 2010; Petchesky, 2003).

Within the health field, policy documents frequently use ‘gender’ as a shorthand for ‘women and men’ and both are seen as fixed and unproblematic categories. ‘The evidence that there is a gender problem is a statistical difference between these categories, for instance, lower rates among men of general practitioner consultation, or higher rates among women of victimization in domestic violence’ (Connell, 2012: 1675). Yet this fails to recognize important inequalities within each category of ‘women’ and ‘men’. The work of scholars such as Kimberlé W. Crenshaw (1991) has highlighted the importance of ‘intersectionality’ and of looking at the importance of other forms of difference – notably race, caste, class, ethnicity and age – which interact with gender difference.

The work of Joan Anderson (2006) has focused attention on the ways in which racialized assumptions about the behaviours of particular ethnic groups raise concerns for health and well-being. As she suggests, these assumptions can apply equally to populations of any ethnic or racial background; for example, assuming that white middle-class people do not need support from social services on leaving hospital because they have resources of their own to pay for services, or presuming that people from ‘ethnic’ backgrounds will have an extended family available to care for them on leaving hospital, so likewise additional support is not required. Nevertheless, Anderson suggests that using the concept of racialization as process, as opposed to race as a category, can offer more analytical scope. She suggests that rather than ‘categorizing people by race, we would be examining how racial categories are constructed and how the constructions are used in everyday social encounters to categorise people in order to interpret what they do and say’ (2006: 10).

Yet, as she notes, these processes of racialization ‘Are most detrimental in situations of unequal power relations, when people from some racialized categories are constructed as inferior, therefore lacking in authority and unable to fulfil some roles, or when people from some groups are constructed as needy or as expecting too much from the “system”’ (2006: 11).

Even so, policy processes have tended to retain simple categorical approaches that frequently target women as a group not only distinct from, but effectively separate from, men. ‘Men and boys appear mainly as the statistical norm, or the privileged category. Categorical thinking thus underlies a very widespread problem in the health literature, where gender is named, but actually women are spoken about’ (Connell, 2012: 1676). Moreover, as Cornwall et al. assert, where women do appear in policy narratives they frequently do so as ‘both heroines and victims: heroic in their capacities for struggle, in the steadfastness with which they carry the burdens of gender disadvantage and in their exercise of autonomy; victims as those with curtailed choices, a triple work burden and on the receiving end of male oppression and violence’ (Cornwall et al., 2007: 3).

Within the health sector this frequently translates as constructing women as a single universal ‘risk group’ and as the problem to be addressed. This implicitly reinforces the significance of biological difference, and women’s biological essentialism as reproducers is overly emphasized. In effect this means that their health needs are thought of solely in terms of their ability to become pregnant, give birth and nurture their children (Inhorn and Whittle, 2001; Payne, 2014). Within the health field this type of approach is often referred to as the ‘women’s health needs’ approach and is often encompassed within a
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broader gender equity category. This is concerned with the implications for women of differences in the epidemiological profile between the sexes (Standing, 1997). Gender equity applies the general concept of equity in provision of health services to men and women, asking, for example, whether health systems respond equally to men and women in equal need. Such approaches attempt to address gender inequalities in health status by strengthening services to women and by drawing attention to the need for greater participation of women at all stages of health planning.

Within gender equity approaches to health women are seen as a special case of beneficiaries: attention is generally given to the special needs of women as mothers, but the ways in which gender inequalities affect morbidity throughout a woman's life are ignored. Men's needs are not adequately addressed, for example, by ignoring their role in reproductive health and men are frequently absent as actors in gender change, or 'remain a shadowy background' (Connell, 2012: 1676). The importance of 'bringing men in' to gender work, particularly within the health sector, is discussed in several chapters of this book and has also been taken up by the WHO (Barker et al., 2007). Indeed as Smith and Inhorn (Chapter 25 in this Handbook) note, men in fact generally experience worse health outcomes than women across the world, yet few projects which systematically address the needs of men and boys alongside those of women and girls have moved beyond the pilot phase (Barker et al., 2007).

Over the past couple of decades a growing body of ethnographic research has made important contributions to understandings of 'what men say and do to be men' (Gutmann, 1996: 17, cited in Smith and Inhorn, Chapter 25 in this Handbook: p. 437). This has led to new insights and challenges to earlier thinking around masculinities and health, and much of this work draws on Inhorn's notion of 'emergent masculinities', which entail 'change over the male life course as men age; change over generations as male youth grow to adulthood; and changes in social history that involve men in transformative social processes; [and the] new forms of masculine practice that accompany these social trends' (Inhorn, 2012: 60, cited in Smith and Inhorn, Chapter 25 in this Handbook: p. 444).

These ideas are more fully developed in several chapters of the book which draw on examples from both the Global North and the Global South to demonstrate the diverse ways in which men are actively challenging common stereotypes around health and masculinities.

ENGENDERING THE SOCIAL DETERMINANTS OF HEALTH

A gendered analysis of health is not just about focusing on health outcomes, and indeed one of the most significant shortcomings of much 'gender and health' work is that the social relations between women and men, which are themselves bearers of gender, frequently remain unexamined and taken for granted. In 1995 Lesley Doyal's ground-breaking work, What Makes Women Sick? Gender and the Political Economy of Health, highlighted the relationship between biomedical approaches and the gendered socio-economic determinants of health. She explored the gendered dimensions of women's health, including looking at issues around work (both paid and unpaid), pregnancy, childbearing, and the impact of substances ranging from tranquillizers to alcohol. This
analysis provided an important foundation for subsequent analyses which have built on her work to illustrate the centrality of unpaid care – frequently performed by women within households – to health, and the diverse ways in which it underpins the health sector (Doyal, 2005; Gideon, 2014; Mackintosh and Tibandebage, 2006). Research has also focused on the role of gender relations in the production of vulnerability to ill-health or disadvantage within health care systems and the conditions that promote inequality between the sexes in relation to access and utilization of services.

Gender differentials in exposure and vulnerability to health risk can arise for two main reasons: the interplay of biological sex with the social construction of gender, and the direct impacts of structural gender inequalities (Sen and Östlin, 2009: 18). Indeed as Sen and Östlin (2009) observe, vulnerability is also socially rather than biologically determined and reflects an individual’s capacity to avoid, respond to, cope, and/or recover from health risks. This vulnerability can be constructed in numerous ways; for example, as a result of gender norms around women and men’s work, which may mean women are more at risk of occupational health hazards. It may also be that gender gaps in wages mean women are less able to pay for costly treatments than men.

Within the health sector this type of relational approach to gender is often referred to as a ‘gender equality approach’. Such an approach is centrally concerned with power relations, and considers that health may also be a site of gender conflict. These questions are central to a number of the chapters presented in this collection and several of the authors explore a range of different dimensions of the gendered vulnerabilities to health risks, highlighting how these vulnerabilities are also shaped by class, racial and age differences.

Nevertheless, one ongoing challenge faced by those working on these issues is the lack of primary data available in numerous fields related to gender and health and, even where gender-disaggregated data is available, it is rarely aggregated by further variables such as socio-economic position or ethnicity. Despite sustained calls for data from the international community, there still remain large gaps where evidence is not available, or is of low or anecdotal quality. This in part may reflect gendered bias in research priorities (Kuhlmann and Annandale, 2010; MacPherson et al., 2012) and is certainly an area that requires further work and investigation.

GENDER, HEALTH AND PUBLIC POLICY

The chapters in Part II of the book examine some of the ways in which gender has been incorporated into public policy and considers the implications of this for health. One clear theme that emerges from the chapters is the simplistic assumptions about gender roles, responsibilities and forms of behaviour that are deeply embedded within many health policies. Yet as the chapters illustrate there is an urgent need to challenge these to ensure that policies are better able to respond to the health needs of individuals and households and to move away from a ‘one size fits all’ approach.

In Chapter 2 Ramya Kumar, Anne- Emanuelle Birn and Peggy McDonough reflect on the successive reframing of the women’s health agenda within international and global health policy. Taking a historical perspective, they consider the shifts that have occurred over the past 25 years, and point to the ways in which larger political and economic agendas have shaped international health policies, with direct consequences for women’s
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health. While at certain periods the clear contribution of women’s health activism to policy framing can be seen, the authors argue that with the growing influence of the corporate sector in the global health sphere, the language of women's rights has been co-opted to focus narrowly on reproductive and maternal health. Nevertheless, the authors believe that current debates about a sustainable development agenda that recognize the necessity of addressing the broad socio-economic determinants of health, and forging links across multiple progressive constituencies, offer potential new opportunities for transnational activism to reshape the debate in more effective ways that really do place women’s health needs at the forefront of health policy processes.

Moreover, as illustrated in Chapter 3 by Sarah Payne, processes of global change bring new policy challenges that point to the need for urgent responses from the health sector. Her chapter reflects on the gendered dimensions of climate change in relation to health and considers appropriate policy responses. The impact of climate change on the global system and on the way of life and health of individuals and the planet has been acknowledged in wider debates around health. Indeed the Commission on the Social Determinants of Health (2008) called for the need to address climate change alongside the need to address health inequalities. Yet as Payne highlights, while there has been a response to this call for action, much of the work has been gender blind. The impact of climate change on health and the global burden of disease is wide-ranging and includes greater risks of premature mortality and higher morbidity, through increasing rates of a number of communicable and non-communicable diseases and greater risks of injury. However, as Payne’s chapter clearly demonstrates these risks are also shaped by gendered norms and gendered forms of behaviour.

Several chapters highlight the potential for change when there is a convergence of interest around a particular topic at a global level. This can follow what retrospectively becomes seen as a landmark international conference, such as the 1994 International Conference on Population and Development in Cairo which represents a critical moment for women’s sexual and reproductive health and rights, or the Second World Congress on Men’s Health in Vienna, Austria held in 2002. This event in Vienna marked a turning point for men’s health organizations as they subsequently became increasingly engaged in awareness building and fundraising activities to bring men’s health issues into the global health spotlight. Likewise the Millennium Development Goals focused global attention on a number of health issues, most notably HIV/AIDS and maternal and child health, with both positive and negative consequences (Greco et al., 2008; Hsu et al., 2013; Pitt et al., 2010). Moreover, the existence of normative frameworks at global and regional levels can offer important entry points to build political support and mandate governments to formulate and implement strategies that specifically address the needs of marginalized groups. This is explored in more depth by Anna Coates and Sandra Del Pino in Chapter 4, which argues that the post-2015 development agenda has offered critical entry points for advancing the rights of indigenous communities in Latin America. Furthermore the existence of both global and regional normative frameworks has focused attention on the need to address the widespread gendered inequalities that exist within many of these communities, particularly in relation to health. Within Latin America indigenous populations tend to be disproportionately represented in rural, often remote, locations across the region, as well as amongst those living in situations of poverty and indigence. These factors are central in shaping their access to health care.
services, particularly where marked urban–rural inequalities continue to exist across the region in terms of health care provision. Moreover, many indigenous communities experience racism in their encounters with health care providers, while the continued expansion of regressive out-of-pocket payments can further limit access to services.

Global discourses can potentially produce many positive results for neglected health issues and marginalized groups, yet as Rochelle Ann Burgess warns in Chapter 5, there are also potential limitations. Her analysis examines the ways in which global discourses around health can work against the interests of the very groups they claim to support. There have been growing calls to address the mental health needs of women in the Global South, as it has been recognized that they face a series of gender-driven risk factors including a greater likelihood to be living in conditions of poverty compared to men, exposure to violence and conflict, as well as the ‘care burden’ which has been shown to have implications for mental well-being. The Movement for Global Mental Health was initiated in 2001 and has sought to push the issue of mental health to the centre stage through a variety of means including advocacy work and scholarly publications. A central question in Burgess’s chapter is how far the ‘voice’ of women has been incorporated into current global mental health discourses, or whether the ‘uncomfortable history of the field of psychiatry’s engagement with women’ is merely replicated in the current discourse and practice that is being extended to the Global South. She draws on the case of South Africa, where mental health care services have been developed in line with global mental health recommendations.

In Chapter 6, Deborah Johnston shows how recent social policy initiatives have been informed by specific aspects of neoliberal economic thinking which fail to recognize the complexities in intra-household decision-making processes around health and what this might mean for health outcomes. Instead, she argues, current neoliberal thinking has reshaped the definitions of health rights, with health seen as co-produced by the state, the private sector and the individual. Moreover, health is increasingly understood as the outcome of individual choice and people’s ‘preference’ for poor health-seeking behaviour. This has led to a plethora of social protection initiatives, predominantly in Africa and Latin America where recipients receive cash benefits if they practice good health-seeking behaviour. A central feature of many of these programmes is their orientation towards improving the intra-generational transfer of poor health and thus many programmes seek to reward mothers with cash benefits if, for example, they take their children to be vaccinated. The inherent maternalism in these programmes, which reinforces women’s caring role, has been widely critiqued (Molyneux, 2006). Nevertheless, while as Johnston documents, many of these programmes have produced better health outcomes in some contexts, the evidence remains mixed and requires further investigation, particularly from a gender perspective. Although dominant neoliberal thinking suggests that individuals are at fault for failing to respond to health messages, it completely fails to take into account the wider set of factors leading to poor health and how these processes may be gendered. Moreover as Johnston contends, under neoliberal reform programmes health sectors in a wide variety of countries have been restructured, reducing the role of the state in health care provision while at the same time increasing the role of the private sector and households. As she and other critics have shown, this has had significant implications for the levels of unpaid care work that is predominantly performed by women. This can then constrain women’s ability to earn higher levels of income, which in turn
can further constrain their access to health care services which have become increasingly commercialized and thus access is determined by ability to pay. At the same time, neoliberal economic reforms have had significant gendered implications for the nature of employment, with a growing number of female-intensive forms of work in particular offering jobs that come with little or no forms of social protection attached. For those individuals and households that have been most negatively impacted by these economic and social reforms and live precarious lives, ‘choosing’ healthy behaviours is therefore sometimes not an option at all.

Chapters 7 and 8 reflect on the ways in which men are frequently presented as a public health problem and consider the development of a number of policy initiatives designed to overcome this. According to James Smith, Noel Richardson and Steve Robertson in Chapter 7, the nature of ‘being a man’, one’s masculinity (whether seen as biologically driven or socially derived) means that men create a public health problem for themselves and for others. Men’s greater tendency to engage in unhealthy lifestyle practices such as drinking and smoking has led some within the public health field to identify men as ‘their own worst enemy’. At the same time, masculine norms are seen as limiting or delaying men’s take-up of health services and therefore their health suffers further as a consequence. Moreover, male roles also drive men to engage in lifestyle practices which have the inevitable negative consequences on health outcomes. Yet when men fail to perform these gendered roles it can create ‘gender role strain’, which also has public health consequences. The authors reflect on some of the policy responses that have emerged in Ireland and Australia and offer a potential roadmap for men’s health policy development in other countries.

In Chapter 8, Brendan Gough, Steve Robertson and Mark Robinson focus on the assumptions that are frequently made around men, masculinities and mental health. Their analysis highlights the need to unpack ideas around men and masculinity in order to bring new insights into men’s health-seeking behaviour around mental health and the ways in which men’s mental health problems are understood. The chapter points to the need for an intersectional approach and emphasizes the ways in which masculinities intersect with other systems of difference and inequality related to, for example, social class, race, ethnicity, age, sexuality and disability in shaping men’s vulnerability to poor mental health as well as their coping strategies. In response to these more nuanced understandings of the role of masculinity in influencing health-seeking behaviour, a number of ‘male-friendly’ mental health interventions have been developed in the UK.

Chapter 9 by Penny Vera-Sanso also challenges problematic policy assumptions but her focus is on older people, particularly assumptions that position people over age 60 as vulnerable, dependent and a burden on society. Comparing the discourses on dementia in the UK and failing family support in India, she shows how problematic these assumptions are and how they mask the reality that many older people continue to play an active role in the economy through both paid and unpaid work, which is essential for not only their own health and well-being (for example through their sense of being a contributor, rather than a ‘burden’, and through their ability to pay for services) but also contributes to the well-being of their families and of society. Vera-Sanso argues that widespread negative stereotypes and prejudicial discourses about older people’s needs, wants and capacities drive the overlooking of their social and economic contributions and the marginalization of their rights, and leave these factors out of the equation in investigating
older people’s health and well-being. Failing to address the structural obstacles to participation can only deepen inequalities between older people, and these inequalities reflect a lifetime of inequalities based on gender and class.

GENDER, WORK AND HEALTH

The chapters in Part III reflect on the linkages between gender, work and health and highlight how the role of gender is frequently overlooked in discussions around occupational health. Yet all three chapters clearly demonstrate that work is a highly gendered – and racialized – social determinant of health. The authors reflect on the gendered nature of the labour market and consider how gendered norms can not only constrain women’s access to the labour market as a consequence of their unpaid caring responsibilities, but also shape the types of job opportunities that are available to women, and indeed men. Moreover, the nature of work is critical in shaping gendered vulnerabilities to poor health as a consequence of occupational health risks, while also determining women and men’s differential access to services; for example through the availability of employment-related social protection benefits such as sick pay, or through wage levels which determine the ability to pay for services or make out-of-pocket payments. While gender norms have historically located men in work such as heavy manual labour, thus exposing them to greater occupational health risks, today many women are located in the informal economy where they lack social protection, generally earn lower wages than men and are frequently exposed to new occupational health risks. Nevertheless as Lucía Artazcoz, Imma Cortés-Franch and Vicenta Escribá-Agüir argue in Chapter 10, little is known about the role of gender in occupational health risks as women’s health risks are frequently excluded or overlooked in research. Yet gender differences in work have important implications for occupational health risks: while for example musculoskeletal problems among men are very much related to heavy loads, among women they are more likely to be associated with the type of repetitive work women often perform, for example in sewing garments or fruit picking. Gender is also cross-cut by social class and race in shaping exposure to occupational health risks, and the role of masculinities must also be considered.

In Chapter 11, Rima Habib, Kareem Elzein and Nadia Younes reflect on the question of incorporating intersectionality into occupational health research. One ongoing challenge, they assert, is that many occupational health researchers are unfamiliar with and lack training in useful qualitative methodologies that might provide instrumental insights, and tend to be more versed in quantitative approaches. Yet as the authors maintain, some of the assumptions around conducting intersectional quantitative research include access to large databases, as well as access to funds or resources that do not exist in poorer countries. Researchers from the Global South can also become marginalized in processes around the production of knowledge, and an approach that takes intersectionality into account can also offer new entry points for health researchers in less privileged positions.

Chapter 12 focuses on the growing concern of psychosocial hazards and mental health issues in the workplace. Elisa Ansoleaga Moreno, Ximena Díaz Berr and Amalia Mauro Cardarelli reflect on the ways in which workplace violence and psychological harassment, widely acknowledged as major working life stressors, are becoming increasingly
recognized as a serious public health issue. Despite evidence that shows a high prevalence of mental health and workplace violence issues among women workers, research into the links between mental health, work and gender are relatively under-researched. Their chapter draws on empirical findings from Chile and shows how the gendered nature of labour markets has meant that women are more likely to occupy low-paid, low-status forms of work. Despite widespread evidence to the contrary, women's paid work is often viewed as of secondary importance to the household and men continue to be considered the primary breadwinners. At the same time the gender division of labour within the household continues to place prime responsibility for unpaid care work onto women. These processes continue to limit women's participation in the labour market and often mean that few opportunities are available to them, sometimes giving them little choice regarding the type of work they do and locating them in precarious forms of employment where they are often more exposed to psychosocial hazards than their male counterparts. As a consequence women are at a greater risk of workplace violence and experience a higher prevalence of mental health issues than men. Nevertheless, the chapter also shows how men are also affected, and particularly those men located in more precarious forms of work.

GENDER, MIGRATION AND HEALTH

Acknowledging the voices of the excluded is particularly pertinent when exploring the relationship between gender, health and migration, another widely recognized social determinant of health. In Part IV, chapters by Lorena Núñez Carrasco (Chapter 13), Jasmine Gideon (Chapter 14) and Denise Spitzer (Chapter 15) examine these linkages and show how central gender roles and norms are in relation to shaping the health and well-being of migrants. The chapters draw on a range of disciplinary perspectives and all three locate their analysis across different empirical settings in both the Global North and the Global South, but the evidence in all three cases demonstrates the importance of the gender division of labour to migration, in terms of both household decision-making about who migrates, but also the centrality of women's unpaid care work in shaping employment opportunities available to many migrant women and how such processes are also cross cut by racial, class and income inequalities. Núñez Carrasco’s chapter conceptualizes migration as a gendered and embodied experience, and hence the centrality to look at health which represents the cumulative effects of the social forces on migrants’ bodies. Her analysis illustrates the importance of considering the gender-related health risks associated with different stages of migration. These include health-related decision-making at the pre-migration stage, the risks and vulnerabilities migrants may face during the migratory process, adaptation into the host society and finally, return migration. She presents the concepts of vulnerability and structural violence and discusses their suitability to understand the different positions men and women migrants occupy through the various phases of migration and the differential impact of migration on their health status. In Chapter 14, Gideon focuses on the case of internal migration within China and shows the importance of considering the linkages between home and migrant communities which are often ignored in health policy, yet are also highly gendered. In Chapter 15, Spitzer reflects on the ways in which the health impacts of migration are often invisible.
under a biomedical lens, yet for many migrants the precarious nature of their lives has a significant effect on their well-being but their health issues remain unresolved. All three chapters reflect on the gendered nature of these processes and illustrate the implications for health policies and outcomes.

In Chapter 16, Marlise Richter and Jo Vearey explore the complex intersection of gender and health through the cases of male, female and transgendered migrant sex workers. The analysis draws on experiences within South Africa, a country associated with high levels of population mobility – both within the country and across borders – and where sex work is illegal and sex workers are frequently denied the right to health. The chapter reviews a range of structural and gendered vulnerabilities experienced by migrant sex workers that are associated with increasingly restrictive immigration legislation, the criminalization of sex work, a strong anti-trafficking agenda, conservative international donor restrictions and negative public opinion. In particular it highlights the absence of voice of migrant sex workers themselves in terms of defining their health needs and appropriate services, and reflects on the ways in which restrictive donor policies around sex work have further limited the possibility of developing partnerships with sex worker organizations. Nevertheless, the discussion within the chapter draws together evidence which stresses the potential for health care services to play a transformative role in the material conditions of sex workers and to develop clear directives which can offer sensitive and effective responses to the health needs of sex workers.

GENDER AND HEALTH SYSTEMS

The need to recognize health systems as social institutions has been widely acknowledged, and as Gilson (2003: 1453) suggests, ‘Health systems are inherently relational and so many of the most critical challenges for health systems are relationship problems’. Yet a growing body of work has emerged that reveals how these relationships are also shaped by historically embedded gendered and racialized norms which in turn produce outcomes that reflect these biased norms (Ewig, 2010; Gideon, 2014; Goetz, 1997). In Chapter 17, in Part V, Christina Ewig draws on the case of Peru in the 1990s and explores how these historically embedded norms – or policy legacies – become reproduced over time through health reform processes. She focuses on the power relations between interest groups as well as institutions within health systems and identifies the mechanisms which, during periods of policy reform, privilege certain interest groups and institutions over others.

Ewig’s chapter shows how the complexity of health systems with multiple layers of providers and extensive workforces creates a wide range of potential interest groups each seeking to uphold an entrenched set of policies, while also upholding an entrenched set of privileges that frequently reinforce gender, race and class distinctions. Her chapter also looks at how reform processes can create specific entry points for the influence of epistemic communities or ‘expert’ groups, and how competing communities fight for influence over the nature of the reform process. However, as Ewig further demonstrates, in the Peruvian case, despite the presence of a gender-conscious rights-based epistemic community this lacked a strong anchor within the bureaucracy or ties to key decision-makers and so was limited in its efforts to influence policy outcomes.
The pervading influence of neoliberal epistemic communities on health systems is further explored in chapters by Meri Koivusalo and Sarah Sexton (Chapter 18) as well as Susan Murray (Chapter 19). Lynn Freedman et al. have asserted that ‘Health systems can be a vehicle for fulfilling rights, for active citizenship, and for true democratic development – poverty reduction in its fullest sense’ (Freedman et al., 2005: 997).

Nevertheless, as Koivusalo and Sexton as well as Murray warn, the potential of health systems to ensure the rights of women and men in equal measure has been challenged by the ongoing shift towards commercialization within the health sector. Koivusalo and Sexton maintain that it is important to distinguish between privatization and commercialization. As they point out, across the world many health care systems are funded through private insurance or through a combination of public financing and private provision of health care. However, as they argue, the crucial issue with respect to commercialization is not just about ownership, but also about the purpose of health systems and how far these are profit-oriented. It is this shift to commercialization that raises some important concerns that have to date been relatively under-researched in the health field. As Murray states it is sometimes assumed that certain areas, such as maternal and child health care services, stand outside the reach of commercial activities in developing countries; but as these two chapters show, this is not the case and these processes raise some specifically gendered concerns.

Koivusalo and Sexton suggest that there are three ways in which the links between commercialization, health care and the impacts on women can be analysed. The first is uncovering the ways in which more commercialized health systems operate and their gender implications. One example of this discussed in their chapter is the ways in which the commercial aspects of a service tend to be prioritized above the concerns and interests of either workers or patients. This is reflected in a variety of pressures on those working within the health care sector, ranging from workplace terms and conditions to the quality of care. In the UK, zero hours contracts are prevalent in care work, as is work that pays less than the minimum wage. Given that the workforce in the health and caring services is predominantly female, at least in Organisation for Economic Co-operation and Development (OECD) countries, this points to highly gendered inequalities that can occur as a direct result of commercialization. The second issue that the authors suggest requires further exploration is by focusing on specific areas where commercialization of services has become more prominent within publicly or privately financed parts of health care systems, and how these relate to women. Discussion within the chapter particularly highlights the rise of cosmetic surgery, most notably among women. Finally there is a need to look at how demand and supply for services is created, including new areas and ‘needs’ for medical and health care beyond what is currently provided. One example of this considered within the chapter is the rise of caesarean sections among women in a large number of geographical settings. This is a concern also taken up by Murray, who considers a range of explanatory factors for this growth.

Murray’s chapter also reflects on other areas for concern, including the continuing expansion of ‘partnerships’ between the public sector and corporate actors which has taken a number of different forms in the area of maternal and child health. While links with the private sector are not necessarily new in themselves, one aspect that is particularly troubling, according to Murray, is the unquestioning acceptance of these relationships without due consideration to the potentially problematic elements of these
‘partnerships’ and what they really mean for advancing the health needs of women and children – rather than the commercial interests of corporate actors.

Focusing on a rather different context in Chapter 20, Sarah Ssali, Sally Theobald, Justine Namakula and Sophie Witter reflect on how far gender equity is considered and realized in the reconstruction of the health sector in post-conflict settings. Their analysis considers the case of Northern Uganda, which has experienced multiple conflicts and a reconstruction process that has been in place since 2007. As the authors suggest, the post-conflict trajectory presents an opportunity to rebuild health systems to better meet the needs of all citizens, yet in reality little gender analysis has occurred. Instead their analysis found that reconstruction efforts were dominated by attention to maternal and child health (MCH) in health service provision and health system reconstruction and strengthening, regardless of whether such actors were government or non-government. This focus informed the nature of facilities constructed, the services provided and the indicators on which performance was measured. Yet as their chapter shows, while MCH is clearly important this type of approach fails to acknowledge that women’s – and indeed men’s – health needs go beyond the MCH agenda, and in a post-conflict setting it is particularly important to consider how these needs are shaped by other factors, especially poverty, age and life course. The chapter also highlights the importance of using a ‘gender lens’ to understand the needs of health workers. As the authors argue, health workers’ experiences and expectations are mediated by gender, as are experiences of conflict, and need consideration to support health care workers and enable them to deliver in their vital roles.

In Chapter 21, Johanna Gonçalves Martín examines the promotion of intercultural approaches to health where efforts have been made to integrate the needs of indigenous communities into health systems. Her work draws on her experiences of working as both a doctor and an anthropologist with the Yanomami people in Venezuela. Her analysis points to the inherent tensions between hegemonic biomedical models of ‘safe motherhood’, which even in remote, rural areas advocate the need for women to be close to a health post where some form of medical intervention can occur if required, and the birthing and childrearing practices advocated by indigenous groups such as the Yanomami people. As Gonçalves Martín explains, within these communities women prefer to give birth on their own and will only invite an older woman to attend the birth if some kind of problem is anticipated. Where there is a real risk to the child or mother a shaman rather than a midwife or doctor will be called upon to intervene, and doctors will only be brought in on rare occasions. In some instances women have had to give birth in hospital, and Gonçalves Martín shows how language and cultural barriers can mean that women’s immediate needs are rarely met. Yet, as she argues, these experiences point to the shortcomings of the Venezuelan health system to fully acknowledge an alternative ontology of well-being and reproduction, in spite of recent changes in both reproductive health care policies and policies for indigenous peoples’ health, including those advocated within the global health discourse such as that put forward in Cairo in 1994.

**HOUSEHOLDS, HEALTH AND HEALTHCARE**

One area of concern that has emerged from the feminist economics and gender and development literature that has gradually been incorporated into health debates is the need to
look more closely at the role of households in both the production and the consumption of health care. Yet despite insights from feminist research into intra-household decision-making processes and the allocation of resources, health policies, most notably financing strategies, often contain implicit assumptions about the unitary nature of households, and that resources are equally allocated among all members of the household. Attention is rarely given to the complexities of intra-household relations and family structures in the design and implementation of health policies. However, research for example on the gendered impacts of out-of-pocket payments and user fees suggests that they tend to impact more negatively on women than men (Ewig and Bello, 2009; Tibandebage and Mackintosh 2010) and points to the need for more nuanced understandings of how decision-making processes operate within households and what this might mean for health and well-being.

The intergenerational transfer of poor health-related behaviours is considered in Part VI, Chapter 22 where Karen Devries, Heidi Grundlingh and Louise Knight examine the question of children’s exposure to violence in gendered social contexts. One of the main risk factors for experience of violence as an adult is prior experience of violence as a child, and therefore their chapter reviews the debates that have sought to explain these cycles of violence and reflect on the physical and mental health implications of these processes. As the authors argue, individual pathways into violence need to be considered within a broader context and it is important to acknowledge the ways in which this is shaped by gender. Different attitudes and behaviours are seen as acceptable and normative for men versus women; for example, hegemonic masculinities which ‘allow’ adolescent men to have poor emotional regulation and behave aggressively, while young women are frequently expected to be more passive and are often ‘blamed’ for men’s aggressive behaviour where they have transgressed feminine norms. Their chapter also considers some intervention strategies which in certain settings have produced positive results for change.

In Chapter 23 Rachel Tolhurst, Esther Richards, Eleanor MacPherson, Dorcas Kamuya, Flavia Zalwango and Sally Theobald take up the issue of intra-household decision-making and use a small number of case studies to explore the complexities of households. Their analysis points to the fact that household structures are many and varied and that there is a need to understand how gender and generation shape decision-making capacities within and beyond households. The case studies also illustrate the ways in which bargaining positions are dynamic and constantly (re)constructed through cumulative effects of decisions made over time, and how they are also underpinned by a number of variables including access to material resources and social networks. Their work particularly highlights the importance of taking a longer-term view since their study clearly illustrates how constrained capacities at one point in the life course contributed to shaping the conditions for weaker breakdown positions at later stages.

GENDER, SOCIAL ACTIVISM AND HEALTH

A large body of literature has explored the potential for change offered by grassroots activism in the health sector, and a significant body of authors have considered the gender dimensions of these debates (Doyal and Pennell, 1979; Gideon, 2014; Petchesky,
Some discussion has centred around the nature of the spaces that exist for people’s activism and the extent to which they are top-down ‘invited spaces’, or ‘popular spaces’ where people come together at their own instigation (Cornwall, 2004; Cornwall and Coelho, 2007). While women have played an important role in health activism it is also important to recognize that not all women’s health activism has a feminist agenda (Molyneux, 2001). This is certainly the case among the multitude of women’s organizations mobilizing around diverse dimensions of health, although many ultimately have a shared agenda of getting their voices and needs recognized in policy debates (Doyal, 1996). The two chapters in Part VII provide contrasting examples of attempts to incorporate citizens’ voices into policy debates and discussions around health issues, at the national level in the case of Chapter 24, and at the global level as discussed in Chapter 25. Significantly, while activism around health has often been seen as part of women’s traditional ‘community role’, Sara Smith and Marcia Inhorn in Chapter 25 show how men are also actively engaging with health-related concerns and seeking new ways of pushing for better health outcomes for men.

In Chapter 24, Jeannie Samuel examines a rights-based participatory governance initiative in the southern Andean region of Puno, Peru which uses citizen monitors to ensure the effective functioning of public sector reproductive health services. The citizen monitors are mainly indigenous, Quechua-speaking women who have long experienced discrimination and exclusion in Peruvian society. The initiative draws on ideas around active citizenship, human rights advocacy, participatory democracy and vigilancia ciudadana, a national reform movement for citizen monitoring in Peru. While the programme does offer some cause for optimism, given the positive results it has produced, Samuel also expresses caution since the ability of monitors to address the wider systemic issues that they identify remains highly limited, particularly in the context of neoliberal models of health reforms.

A more global example of citizen activism is offered in Chapter 25 by Smith and Inhorn, who examine the ways in which men are enacting emergent masculinities – or new ways of being a man that run counter to forms of hegemonic manhood – through their participation in the Movember Movement. The Movember Movement is a global organization that encourages men to grow and stylize a moustache every November, with the aim of raising awareness and funding around men’s health issues, notably prostate cancer, testicular cancer and mental health. As the authors argue, a moustache is something that is frequently seen as a symbol of hegemonic masculinity, but by encouraging men to playfully stylize their moustache, the Movember Movement hopes to also challenge the ways in which men think about their own health. The chapter reflects on the ways in which the Movement has been able to achieve its objectives and what this can contribute to work and understandings around health and masculinity.

GENDER, HEALTH, SEXUALITY AND RIGHTS

Finally, Part VIII of the book brings together a set of chapters that engage with debates and discussions around gender, health, sexuality and rights. As Matthew Gutmann reflects in Chapter 26, men have been notably absent from debates around gender and health, particularly discussion around male heterosexuality and reproduction.
As he reflects, the lack of cross-cultural analysis around men’s sexuality ‘can lead us blithely to assume that . . . we know what most men are like with respect to sexuality and reproduction’. Nevertheless, as he suggests, the challenge is how to incorporate men into these debates without losing sight of the politics of reproduction. Indeed, as he notes, many feminist theories of gender inequality as well as insights from queer theory have been critical in developing analysis around men, sexuality, reproduction and masculinity. His chapter challenges many of the widespread assumptions that have become embedded in much health discourse and which contribute to prevalent ideas around men’s oppressive forms of behaviour. These include men’s apparent lack of responsibility for birth control, yet as Gutmann’s work in Mexico clearly demonstrates these kinds of beliefs fail to acknowledge the active participation and empathy of any men in contraception. Gutmann argues that the involvement of men in contraception is not just a matter of individual choice or a question of how far macho cultures affect the take-up of male forms of contraception. As he suggests, in order to challenge what has been termed the ‘female contraceptive culture’, in which women worldwide are overwhelmingly responsible for birth control, we also must look at the role of a wide range of global and state-level actors including governments, donor agencies, the Catholic Church and pharmaceutical companies in the promotion of population control, family planning, and reproductive health and sexuality campaigns.

However, as chapters by Lynn Morgan and Gabriela Alvarez Minte clearly demonstrate, women’s rights within this female contraceptive culture are frequently challenged and under threat from many of these global and state-level actors. In Chapter 27, Lynn Morgan documents the appropriation of human rights discourses by conservative Catholics in Latin America. The starting point for her investigation was the awarding of a human rights prize – the Rosa Parks Prize for Citizenship in Defence of Human Rights – to an Argentine pro-life, conservative Senator, Liliana Negre de Alonso. Indeed as Morgan comments, Rosa Parks and Negre de Alonso are ‘unlikely bedfellows’. Yet as Morgan shows in her chapter, the award is part of a widespread effort by conservative Roman Catholic activists to appropriate the liberal language of human and civil rights and use it to advance pro-family, pro-life agendas across Latin America. To date little attention has been given to the ways in which conservative Catholics are co-opting the conceptual framework of human rights to promote their political agendas, and her chapter addresses this critical knowledge gap.

Morgan’s chapter shows how efforts by conservative Catholics have gained ground across the region. Nevertheless, as Morgan argues, their approach seeks to ‘essentialize Latin America’ and fails to engage with much of the reality of the region, including that for many ‘human rights derive not from liberal legal traditions or abstract moral standards, but from the tension between repressive regimes and social justice movements’. Moreover, despite the strong influence of Catholicism across the region, social trends are changing and Latin America has some of the highest contraceptive prevalence and abortion rates in the world; as Morgan argues, ‘there are reasons to doubt the correspondence between doctrine and behaviour’.

The backlash against women’s sexual and reproductive rights is also examined in Gabriela Alvarez Minte’s analysis of Chile in Chapter 28. Her work focuses on three key areas relating to sexual and reproductive health and rights: abortion, sexual education in
schools and access to emergency contraception. The Committee on the Elimination of
Discrimination against Women (CEDAW) has expressed concern since the mid-1990s
about the lack of access to contraception in Chile; the high rates of teenage pregnancies –
allegedly closely linked to the quality of sexual education; and particular concern about
the illegality of abortion regardless of the circumstances. In order to understand the
backlash and resistance to rights in these areas Alvarez Minte examines developments
in the legislative arena, focusing on the ways in which specific policies and laws have
been negotiated, and then considers how far they are – or are not – implemented and
transformed into access to services and women’s and men’s choices in matters of repro-
duction. Her analysis shows how pervasive the power of the Catholic Church can be
in Chile as she maps out the ways in which different sets of actors, including from the
Church, have attempted to promote and constrain rights in the three areas over the past
few decades. Even once women’s reproductive rights have been guaranteed in law, such as
the passing of legislation in 2010 guaranteeing the provision of emergency contraception
in public health centres to any woman over 14 years of age requesting it, the influence
of the Church has remained apparent. In this instance strong links between sectors of
the business elite and elements of the Catholic Church became very clear as three of the
most significant national chains of pharmacies refused to stock emergency contraception
despite previously selling it.

Yet as Chapter 29 by Marianna Leite demonstrates, even where governments adopt
human rights language and appear to promote rights-based approaches, gaps between
rhetoric and reality remain. Her analysis of the Brazilian case shows how feminist
groups were able to push for a particular understanding of women’s health during the
transition to democracy, and this was integrated into the women’s health programmes
of the new democratic government. Nevertheless while subsequent administrations
co-opted the discourse, they failed to deliver on more equitable outcomes in relation
to women’s health; this is particularly evident in high maternal mortality rates,
especially among low-income black women. In Chapter 30, Jorge Lyra and Benedito
Medrado also focus on the case of Brazil and reflect on how men have been excluded
from the conceptualization of reproductive rights as well as the accompanying policy
process in Brazil. Through a series of interviews and analysis of policy documents
they look at men’s absence from these processes and consider some future pathways
for change.

In a very different geographical context Benjamin Eveslage’s Chapter 31 reflects on
the practical and theoretical tensions that can arise when global development actors
seek to introduce rights-based frameworks, particularly around sexual and reproductive
health and rights. Many international development donors have avoided working on
sexual rights, given the difficulties of ‘operationalizing’ them and because these rights
are often not fully understood by policy actors. Moreover, donors seek to promote their
own understandings of sexual rights which can fail to acknowledge locally defined ideas
around sexual rights and sexuality, thus leading to tensions. Since 2011 a growing number
of Western governments have supported lesbian, gay, bisexual, transgender (LGBT)
rights as a foreign policy objective, and the United Nations began advocating for the
human rights of people discriminated against based on their sexual orientation or gender
identity. Drawing on empirical data from Ghana, Eveslage’s chapter highlights a number
of complex tensions that have arisen as a consequence of donor interventions around
sexual health and sexual rights. His analysis shows how donors opted to work with local Ghanaian non-governmental organizations (NGOs) with access to sexual minority groups, given their history of advocacy work, yet donor funds prioritized work around HIV/AIDS awareness and prevention. These NGOs were then limited in the work they could do to promote human rights. Thus, as a consequence of their engagement with donors funding HIV interventions, the mandates of these NGOs shifted from one promoting sexual rights to an emphasis on sexual health that better fitted donor priorities. Eveslage argues that this shift has set back efforts to advance sexual rights in Ghana in a number of ways.

The Handbook closes with Chapter 32 by Lesley Doyal which examines the ways in which HIV positive women struggle (with varying degrees of support) both to survive and to live up to their own and other people’s expectations of motherhood. As her chapter demonstrates, while knowledge around the ‘prevention of mother to child transmission’ (PMTCT) has expanded considerably and the needs of children are frequently the primary focus of policy interventions, the needs of positive mothers are often overlooked, particularly in the early post-partum period. Doyal examines the experiences of HIV positive women in the Global South, who have to negotiate the reality of pregnancy (whether intended or unintended) with or without anti-retroviral therapy. Her analysis highlights the complex social, economic and cultural constraints on their lives as they face the twin challenges of HIV and pregnancy with few resources at their disposal. As she argues, despite numerous challenges, some progress can be made by integrating and expanding HIV and sexual and reproductive health services that are designed with the particular needs of positive women in mind.

In conclusion, the chapters presented within this Handbook clearly point to the need to move beyond reluctant attempts to ‘mainstream’ gender, but instead engage with more nuanced and reflective means of understanding more thoroughly the gendered pathways into poor health and ways of promoting better health outcomes for all. The volume seeks to highlight different disciplinary approaches and perspectives for a gendered analysis of health and underlines the importance of additional empirical data to support work in this area. In sum, the book offers critical insights into developing a clear road map that will take us closer towards achieving gender justice in health.

REFERENCES


