



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

**Final Report to the
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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARROW	Asian-Pacific Resources and Research Centre for Women
ART	Anti-retroviral therapy
AWID	Association of Women's Rights in Development
CASSA	Campaign against Sex Selective Abortion
CHWs	Community health workers
CSDH	Commission on the Social Determinants of Health
DALY	Disability Adjusted Life Years
DHS	Demographic and Health Survey
EU	European Union
FGM	Female Genital Mutilation
GBV	Gender Based Violence
GDP	Gross Domestic Product
GHI	Global Health Initiative
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HSKN	Health Systems Knowledge Network
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population Development
IDP	Internally Displaced Person
IGWG	Inter-Agency Gender Working Group
IMR	Infant Mortality Rate
IPV	Inactivated Polio Vaccine
KN	Knowledge Network
LGBT	Lesbian, Gay, Bisexual and Transgender
LE	Life Expectancy
LMICs	Low and middle-income countries
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
NFHS	National Family Health Survey
NDS	National Development Strategy
NGO	Non-Governmental Organization
NORAD	Norwegian Agency for Development Cooperation
OECD	Organization for Economic Co-operation and Development
PAHO	Pan American Health Organisation
PHC	Primary Health Care
PRS	Poverty Reduction Strategy
SDH	Social determinants of health
SRH	Sexual and Reproductive Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TFR	Total Fertility Rate
TB	Tuberculosis
UDHR	Universal Declaration of Human Rights
UK	United Kingdom
UN	United Nations

UNAIDS	Joint United Nation Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USA	United States of America
WB	World Bank
WGE KN	Women and Gender Equity Knowledge Network
WHO	World Health Organization

POLICY BRIEFING

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

Report of the Women and Gender Equity Knowledge Network of the Commission on Social Determinants of Health

Gender inequality damages the physical and mental health of millions of girls and women across the globe, and also of boys and men despite the many tangible benefits it gives men through resources, power, authority and control. 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 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 and especially women themselves.

Seven approaches that can make a difference:

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/programmes 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 programmes to transform both male and female attitudes to caring work so that men begin to take an equal responsibility in 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 programmes 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 life-styles 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 life-styles 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 life-styles 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 stratifiers 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 analysed 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 organisations 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 organisations who are critical to ensuring that women have voice and agency, who are often at the forefront of identifying problems and experimenting with innovative solutions, who prioritise demands for accountability from all actors, both public and private, and whose access to resources has been declining in recent years.

These seven approaches encompass a set of priority actions that need to be taken both within and outside the health sector, and need the engagement and accountability from all actors – international and regional agencies, governments, the for-profit sector, civil society organisations and people's movements. While health ministries nationally and WHO and its regional organisations internationally, have a critical leadership role in mobilising political will and energising coalitions and alliances, no person or organisation can be exempt from action to challenge the barriers of gender inequity. Only thus can the continuing vicious circles of health inequality, injustice, ineffectiveness, and inefficiency be broken.

Executive Summary

Background

Gender inequality damages the health of millions of girls and women across the globe. It can also be harmful to men's health despite the many tangible benefits it gives men through resources, power, authority 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. 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 and especially women themselves.

Gender relations of power constitute the root causes 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 voice or a modicum of 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. In particular, inter-sectoral action to address gender inequality is critical to the realization of the Millennium Development Goals (MDGs).

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 that govern gender systems have basic commonalities and similarities across different societies, although how they manifest through beliefs, norms, organisations, behaviours and practices can vary. The report shows that gender inequality and equity in health are socially governed and therefore actionable. Sex and society interact to determine who is well or ill, who is treated or not, who is exposed or vulnerable to ill-health and how, whose behaviour is risk-prone or risk-averse, and whose health needs are acknowledged or dismissed.

However gender intersects with economic inequality, racial or ethnic hierarchy, caste domination, differences based on sexual orientation, and a number of other social markers. Only focusing on economic inequalities across 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 standard work on gradients and gaps tells us easily enough that the poor are worse off in terms of both health access and health outcomes than those who are economically better off. But it does not tell us whether the burden of this inequality is borne equally by different caste or racial groups

among the poor. Nor does it tell us how the burden of health inequity is shared among different members of poor households. Are women and men, widows and income-earning youths equally trapped by medical poverty? Are they treated alike in the event of catastrophic illness or injury? When health costs go up significantly, as they have in many countries in recent years, do households tighten the belt equally for women and men? And are these patterns similar across different income quintiles? This poses a challenge for policy to ensure not only equity across but also and simultaneously within households. The right to health is affirmed in the Universal Declaration of Human Rights and is part of the WHO's core principles. This report is grounded in the affirmation of equal and universal rights to health for all people, irrespective of economic class, gender, race, ethnicity, caste, sexual orientation, disability, age or location.

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 land, wealth and property in almost all societies; yet have higher burdens of work in the economy of 'care' - ensuring the survival, reproduction and security of people, including young and old. 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. Girls and women are often viewed as less capable or able, and in some regions seen as repositories of male or family honour and the self-respect of communities. Restrictions on their physical mobility, sexuality, and reproductive capacity are perceived to be natural; and in many instances, accepted codes of social conduct and legal systems condone and even reward violence against them.

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 and second class citizens. Even in places where extreme gender inequality may not exist, women often have less access to political power and lower participation in political institutions from the local municipal council or village to the national parliament and the international arena. While the above is true for women as a whole vis a vis men, there can be significant differences among women themselves based on age or lifecycle status, as well as on the basis of economic class, caste, ethnicity etc. Much of the above also holds for transgender and intersex people who are often forced to live on the margins of mainstream society with few material assets, who face extreme labour market exclusion leaving them little other than sex-work as a means of survival, and who are often ostracised, discriminated against, and brutalised.

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 behalf, regulating and constraining their access to resources and personal agency, and sanctioning and policing their behaviour through socially condoned violence or the threat of violence. Again, not all men exercise power over all women; gender power relations are intersected by age and lifecycle as well as the other social stratifiers such as economic class, race or caste. The impact of gender power for physical and mental health – of girls, women and transgender /intersex people, and also of boys and men – can be profound. Furthermore, the extent to which the needs of young populations as well as older populations have to be met through the unpaid 'care' work of women is exacerbated by crumbling health services and vanishing paid health staff. Women become the shock-absorbers in the system, expected to act as such in both normal economic and health times, and during the bumps caused by health crises and emergencies.

Together, gender systems, structural processes and their interplay constitute the gendered structural determinants of health. What determines the pace or pattern of change in gender systems and how they affect people's health? The interplay between gender systems and structural processes such as rising literacy and education, demographic transitions in birth and death rates and in family structures, globalisation (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 instances, however, these changes also set off backlashes as those who wield gender power in families, communities and religious structures attempt to control and discipline (especially) young women. Trying to hold on to such power has led to attempts to roll back internationally agreed norms on 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 globalisation are of particular significance for our focus on gender relations. The first is how it has transformed the composition of workforces, and the implications for women's health. Feminisation of work-forces has gone hand in hand with increased casualisation, and continuing unequal burdens for unpaid work in the household, with serious implications for women's health, both their occupational health and the consequences of insufficient rest and leisure. A second gendered consequence of globalization is through its narrowing of national policy space that has resulted in reducing funds for health and education with negative impacts on girls' and women's access. A third aspect of globalisation of importance for health is the rise in violence linked to the changing political economy of nation states in the international order. Importantly, gendered violence does not only affect girls and women but includes violence against boys and men, as well as transgender and intersex persons and all those who do not meet heterosexual norms.

Some of the negative consequences of globalisation 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 women's hands and empowering them so that 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

Gendered norms in health manifest in households and communities on the basis of values and attitudes about the relative worth or importance of girls versus boys and men versus women; about who has responsibility for different household / community needs and roles; about masculinity and femininity; who has the right to make different decisions; who ensures that household /community order is maintained and deviance is appropriately sanctioned or punished; and who has final authority in relation to the inner world of the family /community and its outer relations with society. Norms around masculinity not only affect the health of girls and women but also of boys and men themselves.

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 therefore to provide a panacea 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 organisations; (C) working with boys and men to transform masculinist values and behaviour 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 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 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. 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. Two intertwined strategies to address social bias are: tackling the social context of individual behaviour, and empowering individuals and communities for positive change.** Strategies that aim at changing high risk life-styles would be more effective if combined with measures that could tackle the negative social and economic circumstances (e.g. unemployment, sudden income lost) in which the health damaging life-styles are embedded. 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 and communities to take action against the status quo.

The Gendered Politics of Health Care Systems

While the traditional approach to health care systems tends to be management oriented with focus on issues such as infrastructure, technology, logistics and financing, the WGEKN looked at the human component of health care systems and the social relationships that characterize service delivery. 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 role as health care providers, and building accountability for gender equality and equity into health systems, and especially in ongoing health reform programmes and mechanisms.**

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 women's access to and use of health services. 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). Health systems also tend to ignore women's crucial role as health providers, both within the formal health system (at its lower levels) and as informal providers and unpaid carers in the home. Absence 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.

Health sector reforms can have fundamental consequences for gender equality and for people's life and well-being, as patients in both formal and informal health care, paid and unpaid care providers, health care administrators and decision makers. 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 in general and particularly in health care have seldom been discussed or taken into consideration in planning. 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 differentials in health needs, health seeking behaviour, treatment, and outcomes, but also permeate the content and the process of health research. Gender imbalances in research content include the following dimensions: slow recognition of health problems that particularly affect women; misdirected or partial approaches to women's and men's health needs in different fields of health research; and lack of recognition of the interaction between gender and other social factors. Gender imbalances in research process include: non-collection of sex-disaggregated data in individual research projects or larger data systems; research methodologies are not sensitive to the different dimensions of disparity; methods used in medical research and clinical trials for new drugs that lack a gender perspective and exclude female subjects from study populations; gender imbalance in ethical committees, research funding and advisory bodies; and differential treatment of women scientists.

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.**

Removing Organisational Plaque

The WGEKN report complements its work on the substantive content of gender equitable approaches to health by looking into key organisational questions. Working towards gender equality challenges long-standing male dominated power structures, and patriarchal social capital (old boys' networks) within organisations. It 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 trivialisation, dilution, subversion or outright resistance, and can lead to the evaporation of gender equitable laws, policies or programmes. **Tackling this requires effective political leadership, well designed organisational mandates, structures, incentives and accountability mechanisms with teeth. It also requires actions to empower women and women's organisations so that they can collectively press for greater accountability for gender equality and equity.** The report provides a number of good practice examples from different countries.

The Way Forward

This report has shown that gender relations of power exist both within and outside the health sector, and exercise a pernicious influence on the health of people. It has drawn together the rapidly growing body of evidence that identifies and explains what gender inequality and inequity mean in terms of differential exposures and vulnerabilities for women versus men, and also how health care systems and health research reproduce these inequalities and inequities instead of resolving them. The consequences for people's health are not only unequal and unjust, but also ineffective and inefficient. It has also documented the growing numbers of actions by non-governmental and governmental actors and agencies to challenge these injustices and to transform beliefs and practices within and outside the health sector in order to generate sustained changes that can improve people's health and lives. In particular, it calls for support for women's organisations that are critical to ensuring that women have voice and agency, that are often at the forefront of identifying problems and experimenting with innovative solutions, that prioritise demands for accountability from all actors, both public and private, and whose access to resources has been declining in recent years.

I. Introduction

Gender inequality damages the health of millions of girls and women across the globe. It can also be damaging to men's health despite the many tangible benefits it gives men through resources, power, authority 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 and especially women themselves.

Gender relations of power constitute the root causes of gender inequality and are among 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 a modicum of 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. In particular, intersectoral action to address gender inequality is critical to the realization of the Millennium Development Goals (MDGs) as has been shown by the report of Taskforce 3 on Gender Equality of the UN Millennium Project (Grown et al., 2005). Each one of the MDGs² requires that strong efforts be made towards gender equality if the goal is to be achieved. Some of these efforts need to be within the health sector but many are outside. The health sector may take leadership but it must also act in collaboration with other sectors if these goals are to be achieved.

I.1 Basic Underpinnings

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

² The eight MDGs are eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, ensuring environmental sustainability, and developing a global partnership for development.

based on core structures that govern how power is embedded in social hierarchy. *The structures that govern gender systems have basic commonalities and similarities across different societies, although how they manifest in beliefs, norms, organisations, 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 malleable and subject to change as we show in this report. It is particularly necessary to recognise this at a time when policy makers are becoming increasingly concerned about the apparent difficulties of gender mainstreaming, their strategy of choice during the past decade (UNDP, 2006). We argue in this report that the problem is not with mainstreaming per se but with how it has been understood and implemented. For mainstreaming to work, it has to be done right. Moreover, 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 organisations. Political leadership is critical but it can be catalysed by the mobilisation and commitment of women organising 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 therefore difficult to change. The report shows that gender inequality and equity in health are socially governed and therefore actionable. It draws on a growing body of research and programme evidence that even in health (where the physical body has a central place), biology is not destiny. Sex and society, nature and nurture, chromosomes and environments interact in fascinating ways to determine, among other things, who is well or ill, who is treated or not, who is exposed or vulnerable to ill-health and how, whose behaviour is risk-prone or risk-averse, and whose health needs are acknowledged or dismissed. *The interactions between nature and nurture are probably more complex in the case of gender equity in health than in almost any other aspect of social hierarchy.*

However, it can be difficult to understand how gender power relations work to reproduce health inequity without also understanding how gender intersects with economic inequality, racial or ethnic hierarchy, caste domination, differences based on sexual orientation, or a number of other social markers. Not all of these will be relevant in all communities or societies, barring economic inequality or class differences that are pervasive everywhere. Our report draws on the analytical advances that have been made in recent years in understanding how different sets of social power relations interact to either exacerbate or mitigate the health effects of any one set of relationships taken by itself. *In particular, 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 stratifiers³ such as race or caste are added to the analysis.

³ The report uses the terms 'stratifiers' and 'stratification' to refer in a broad sense to the different dimensions along which societies are layered into hierarchies of power and control.

These findings challenge how many of those concerned about the social determinants of health understand the workings of social inequality. It calls for finer nuance in research and analysis, and greater sensitivity in policies and actions to the interactions among multiple sources of power and hierarchy.

They also challenge how one interprets human rights principles. The right to health is affirmed in the Universal Declaration of Human Rights (United Nations, 1948) and is part of the WHO's core principles. Yet the egregious violation of women's human rights through violence was only globally recognised at the World Conference on Human Rights in Vienna in 1993. Consequently, in 1993 the Pan American Health Organisation (PAHO) recognized violence against women as a public health problem and as a violation of human rights. As a result of this recognition, PAHO launched a 10-country initiative in 1994 to prevent and respond to the problem (Hartigan, 1997). However, it is only relatively recently that the WHO itself has begun to pay attention, albeit still in a limited way, to the health implications of violence against women (WHO, 2005a). *This report is grounded in the affirmation of equal and universal rights to health for all people, irrespective of economic class, gender, race, ethnicity, caste, sexual orientation, disability, age or location*, and it stresses the CSDH belief that "The function of a just society is to do more than simply open the way for individuals to make use of their opportunities, it is to organise in such a way that, where people are deprived of opportunity to lead meaningful lives, deprived of freedoms or empowerment, such effects can be detected and changed" (CSDH, 2007) p 3).

1.2 Beyond motherhood and apple pie⁴

The struggle to realise women's human rights and gender equality is somewhat surreal at the present moment in history. On the one hand, there are still forces in the world that oppose these core principles that derive from the Universal Declaration of Human Rights. Practices that are seriously harmful to women's health, and legal and political systems that condone or justify neglect of women's health needs, violence against women and other violations of their human rights, still exist in different countries and contexts. On the other hand, gender equality and equity have reached 'motherhood and apple pie' status in many governments and agencies. This means that genuflections in the direction of gender equity are made on most public occasions, and no one will speak against it. Only a few may publicly oppose it, and they are typically viewed as extreme or fringe elements. It is important to recognise this as a victory since both discourse and social norms have indeed changed in these contexts, but it is only a first victory. And it could become a pyrrhic victory if words are not followed by action. And that is the problem.

Because speeches are not followed by action, 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. A recent example

⁴ 'Motherhood and apple pie' is a metaphor that refers to something that is so well accepted as being good that it becomes politically incorrect to speak against it.

is from HIV policy where major agencies have agreed about its critical links to violence against women but action has been weak (Fried, 2007). Policy sensitivity to what has to be done *organisationally* is crucial to understanding whether and why policies to address women's health needs or gender inequity in health can misbehave or evaporate. Policy analysts have long recognised that in general the *how* of policies can be as important as or even more so than the *what*. Nowhere is this more applicable than for gender. This is true for a number of reasons as the report elaborates. *The heart of the problem is that gender discrimination, bias, and inequality permeate the organisational structures of governments and international organisations, and the mechanisms through which strategies and policies are designed and implemented.* People within these structures are themselves often deeply invested in the gender status quo. Men often benefit from gender inequality in organisations even if they may suffer from the emotional limitations of masculinist and heterosexist norms. Women internalise and acquiesce to unequal gender structures as a means to survive or get ahead in the organisation. Expecting that either men or women will easily give in to organisational change can be naïve. Focusing on how organisational changes happen has to be central to policy changes that hope to alter gender power relations (Ashcraft and Mumby, 2004).

This report argues that going beyond motherhood and apple pie requires attention to beliefs and values, incentive and disincentive structures, clear mechanisms to ensure action, strong organisational placement of gender equality champions within the system, and opening of spaces to civil society actors who are often the ones who can tell when the emperor has no clothes! The importance of organisational mechanisms means that it is not enough to focus on the broad characteristics of governments or agencies in order to tackle the structures of gender inequity. Whether for instance a state structure is neo-liberal or social democratic, or an agency's leadership has made a public commitment to gender equality is insufficient. While we believe firmly in and demonstrate the possibility of transforming unequal gender relations and their effects on health, this report offers no silver bullets or easy panaceas to cure the pervasive and persistent problems of gender inequality and inequity. The devil, so far as gender equity is concerned, is often in the details of governance structures and organisational processes.

This report has ten sections. Following the Introduction, **section II** describes the evidence base of the report. **Section III** focuses on a **diagnosis** of gender as a key social determinant of health. In addition to spelling out the features of gender power relations, it addresses the distinctions between equality and equity, and the analytical and policy implications of focusing on gender versus focusing on women's health. It also explores the intersections of different social hierarchies, in particular how gender intersects with economic class and ascriptive stratifiers like caste, race and ethnicity. It goes on to spell out the connections between gender as a social stratifier and key structural processes such as rising literacy and education, demographic transitions in birth and death rates and in family structures, and globalisation (including its effects on labour forces, health systems, and the media). It then outlines the analytical framework used to gather and organise the evidence base and to spell out the policy implications. **Sections IV-VIII** use the analytical framework to organise the **evidence** and the **key policy and action**

implications along five dimensions – (i) gendered structural determinants; (ii) norms, values and practices; (iii) differences in exposure and vulnerability; (iv) the gendered politics of health systems; and (v) health research. In **Section IX**, “Removing organisational plaque”, we discuss how to mainstream and catalyse gender equity effectively. **Section X** draws together the report’s evidence and recommendations to provide conclusions and ways forward.

II. The evidence base of the report

The evidence base of this report includes extensive and in-depth reviews of existing literature including scientific and research articles and books, policy reviews, evaluations, and ‘grey’ literature. The KN has developed a multi-component strategy for synthesizing and assessing the evidence:

Based on the WGEKN conceptual framework and discussions among KN members, nine review papers (Annex 1) and two case studies (Annex 2) were specifically commissioned by the KN, which provide useful in-depth analysis especially of frontier areas and difficult policy questions. The function of the review papers was mainly to fill in gaps in existing reviews and should not be seen as covering the full ground of the report. They are in that sense additional to already existing material of which the KN already had knowledge. The two case studies, one from Tunisia and one from South Africa, provide good examples for national governments and other actors (e.g. civil society) of how changes in laws, policies and health systems have in these countries positively affected women’s health and gender equality.

In addition, civil society organisations and the members and corresponding members of the WGEKN provided information including cases that can be more difficult to access. Both KN co-hubs have developed annotated bibliographies and gathered grey literature, country and sub-national case-studies, policy lessons, civil society initiatives, and new methodologies. Collaboration and sharing with other KNs, especially those on Globalisation and Health Systems has expanded the data base for all. Three 3-day workshops with KN members, specially invited commissioners, authors of commissioned papers and other guests were held, when discussions about the evidence base presented in the draft papers took place. Each paper has been reviewed by two reviewers and the KN coordinators. Drafts of the KN’s report have been submitted to both internal and external review. In the end, more than 70 people were involved in synthesizing and reviewing the evidence.

Most members of the KN and all lead authors of the commissioned papers have extensive research synthesis experience. They represent a variety of disciplines, such as medicine, biology, sociology, epidemiology,

anthropology, economics and political science, which enabled the report to draw on knowledge bases from a variety of research traditions and to identify intersectoral action for health based on experiences from different fields.

Consistent efforts were made to follow the “Guide for Knowledge Networks for the presentation of reports and evidence about the social determinants of health” (Kelly et al., 2006). Based on this, specific guidelines have been developed by the co-hubs for the commissioned papers. Regarding the evidence and data collection, authors were instructed to consult a broad range of evidence and access this evidence from a variety of sources. As the key task of the WGE KN was to identify a set of policies and actions that can effectively address gender inequalities and gender inequities in health, the KN-hubs have developed a simple check list for policies in the first instance that address the *what – how - when – who* questions:

- i. *What:* Is the policy well defined in terms of exactly what needs to be done and what are the pre- or co-requisites? What precisely will be the likely impacts over short- medium- and long-terms?
- ii. *How:* How will the policy be carried out? Is it easily doable? What will be the time-frame? What will be its requirements in terms of financial, human, managerial and other resources? How will the policy need to be communicated (advocated)?
- iii. *When:* What might be the best time for setting a policy in motion?
- iv. *Who:* Who will have to carry it out; monitor; review and evaluate? Who will have to support? Who will have to buy in or take ownership?
- v. *Likely challenges:* What are the likely challenges and how can they be pre-empted and/or addressed?

Throughout in the report there is a robust evidence base on the association between gender inequality and health. Where the evidence base is most tentative is in demonstrating the health effects of some of the policies and interventions among different segments of women and men. Although, many of the interventions presented in this report have been evaluated, there are some that are still waiting for a systematic assessment. However, these actions were assessed by the KN members as important and innovative with great potential for making a difference on the ground and holding promise for the future.

III. Diagnosis: So what’s the problem?

III.1 Gender, women, equity and equality

The last four decades have seen a gradual shift in both academic and policy circles from a focus on women to a focus on gender, followed by some confusion about the relative meanings and uses of each (Razavi and Miller, 1995, Wizemann and Pardue, 2001). In particular, gender has been conflated with biological sex in policy and programme

documents, and has sometimes been interpreted to mean a focus on the needs of men equally with women. Yet the confusion can be simply resolved by a look at the way in which both terms have entered current discourse. For the feminist academics who first began using the language of gender and gender systems, these implied social relations of power that govern hierarchies among people based on biological sex, age, life-cycle position, and family status (Lorber, 1996, Lorber, 1997, Rubin, 1975). Gender relations appeared to provide a richer and 'thicker' description for these hierarchies than simply recounting tales of women as victims⁵. However, complex academic concepts do not always translate easily into policy discourse. In this case, the confusion provoked by the shift to gender also provided comfort to those who were uncomfortable about its implicit critique of power structures by giving them room to divert attention from the very real abuse of women's human rights and inequality. This report navigates this terrain by using as appropriate the terminology of sex (referring to biology), gender (referring to social power relations and hierarchies, elaborated in more detail below), and women / men (in their common everyday usage).

Defining gender as power relations requires us to focus systematically on the forms that discrimination and bias take, and the resulting inequalities and injustice. 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. Absence of difference as such cannot therefore be the uniform foundation for gender justice or equity in health. Furthermore, equality of health outcomes can actually be an indicator of gender *injustice* because it may indicate that women's particular biology-dependent needs or abilities are not adequately recognised.

Thus gender equity in health cannot be based only on the principle of sameness but must stand directly on the foundation of absence of bias. Not being able to draw on a simple universal principle such as equality complicates our task in the health field, because it necessitates an even more careful interrogation of where bias is present and how it works. We have to ensure that gender discrimination and the resulting bias do not masquerade as 'natural' biological difference. 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* (Breen, 2002, Iyer et al., 2007a, Sen et al., 2002).

⁵ Gender is actually no more confusing or complex than the concept of economic class that refers to power relations while also being reduced, for some purposes, to simple comparisons among quintiles on the basis of income or consumption expenditure of households. In this report the term gender has been used in three ways: i) as an organizing principle, ii) as a source of inequality, and iii) as a description of power differentials and social fault lines.

These principles, based on the distinctions between women and men, and the gender analysis on which they are based, have been challenged more recently by work deriving from social movements for sexual rights, in particular the lesbian / gay / bi-sexual / transgender (LGBT) movement. These movements have challenged feminist movements to be more inclusive and to recognise sexual and gender orientation as an important source of discrimination, bias, violence and challenges to health. The challenge is not only to policy but to the very concept of gender itself. Biological sex has never only consisted of the simple binaries – women and men. The presence of transgender people has been rendered socially invisible in some societies; in others their presence is socially recognised but they are relegated to the margins of society through discrimination and violence. But the challenge to heterosexual norms by the LGBT movement goes beyond biology to the social and ideational realms where sexuality and gender are defined, negotiated and expressed. If the feminist movement has challenged masculinist norms, the LGBT movement challenges heterosexual norms that are also sources of discrimination and bias⁶. For the purposes of this report and the work of the Commission on Social Determinants of Health, the effects of sexuality-based discrimination on the health of people are vitally important (Parker and Aggleton, 2007, Currah et al., 2006, Misra and Chandiramani, 2005, Butler, 2005, Fausto-Sterling, 2000).

III.2 Intersecting social hierarchies

Examination of the intersections among different social hierarchies – intersectionality – has begun in recent years to yield new insights about the social determinants of health (Iyer et al., 2007b, Crenshaw, 1991, Iyer, 2007, Krieger et al., 1993, TK Ravindran, 1991). Unfortunately, this has not 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. Discussion of gradients, gaps and medical poverty traps typically focus on differences between rich and poor countries, households or people. Our trawling of the literature found that the bulk of the work on health equity in both high and lower income countries has this bias. Because income / wealth is only one source, however powerful, of social inequality, a proper understanding of its impact on health means that we must look into how it interacts with other sources of social inequality such as gender, race or caste. There has been a small but consistent literature that looks at the intersections between class and race and their implications for health in the USA. A much smaller subset of this looks at the intersections of both with gender (Breen, 2002, Schulz and Mullings, 2006, Geronimus and Thompson, 2004, Krieger et al., 1993, Geronimus, 1996).

The importance of such work cannot be overstated. The standard work on gradients and gaps tells us easily enough that the poor are worse off in terms of both health access and health outcomes than those who are economically

⁶ On February, the 11th, the Andalusian Parliament had the representatives of Identidad de Genero as guests for the discussion of a motion introduced by the PSOE (Socialist Party) about transsexual people's rights. The motion was passed with no votes against (Euro-Letter, No 68, March 1999).

better off. But it does not tell us whether the burden of this inequity is borne equally by different caste or racial groups among the poor. Nor does it tell us how the burden of health inequity is shared among different members of poor households. Are women and men, widows and income-earning youths equally trapped by medical poverty? Are they treated alike in the event of catastrophic illness or injury? When health costs go up significantly, as they have in many countries in recent years, do households tighten the belt equally for women and men? And are these patterns similar across different income quintiles? Even as we raise these questions, their potential implications become obvious. If the answers to such questions are in the negative, this poses a challenge for policy to ensure not only equity *across* but also and simultaneously *within* households.

However, seeking the answers to these questions has not been easy because of the multi-dimensional nature of the problem, and the complexity of the intersections. This has been a field waiting for an analytical breakthrough. In its absence, much of the analysis has been descriptive; there are few results that are quantitative or based on large data-sets. Some recent work holds promise for the development of simple techniques for quantifying and testing the intersections (Iyer, 2007, Iyer et al., 2007a)⁷. It suggests strongly that economic class should not be analysed by itself, and that apparent class differences can be misinterpreted without gender analysis. Important inferences for policy flow from this. For instance, the challenge of improving access to health care at a time of rising health care costs may best be met by a combination of universal systems (of provisioning or health insurance) across households coupled with forms of targeting or other mechanisms to ensure that they actually reach women and girls within households.

III.3 Social stratifiers and structural processes – how do they interact?

Many key social stratifiers including gender are ascriptive, i.e., they describe people not on the basis of what they do or acquired characteristics but on the basis of who they are along different dimensions which are not easy to change⁸. 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 lumped together in that class by and large, although the upward mobility of some of their peers may raise their own aspirations. Nonetheless, when compared to other stratifiers such as gender, race or caste, economic class tends to be more fluid even if it is

⁷ Using statistical methods to probe how economic class, caste and gender affect health-seeking by households in a poor rural area in south India where health services are sparse and of doubtful quality and health costs high and rising, this analysis found on the basis of a large sample that *how economic class works can only be grasped through an analysis of gender*. Not only were gender differences significant within each class group / quintile, but except for the poorest quintile there were no significant class differences among men. Almost all the apparent class differences in health-seeking were due to differences among women. Class itself appears to work *through* gender. While most poor men seek health care to the same extent as non-poor men, economic pressures on the household are visited on the women. It is poor women who are really trapped by medical poverty. It is only in the poorest quintile of households that class affects men, but even here they are better off than the women within the same households (Iyer 2007; Iyer et al 2007).

⁸ Social movements of oppressed people who are at the bottom of social hierarchies sometimes try to re-name or re-define themselves as a way of challenging their oppression, e.g., African-Americans in the US, or *dalits* in India. In fact *dalits* have also stepped out of the oppressive Hindu caste structure that declared them 'untouchable' by converting to other religions – Buddhism, Islam or Christianity. But these change are contested and difficult.

lumpy. Each of these stratifiers may have particularly implications for health operating through culture and economics. This is certainly true for gender. History and culture also play an important role in the way stratifiers evolve; change can sometimes be glacial, while at other times it may be more rapid.

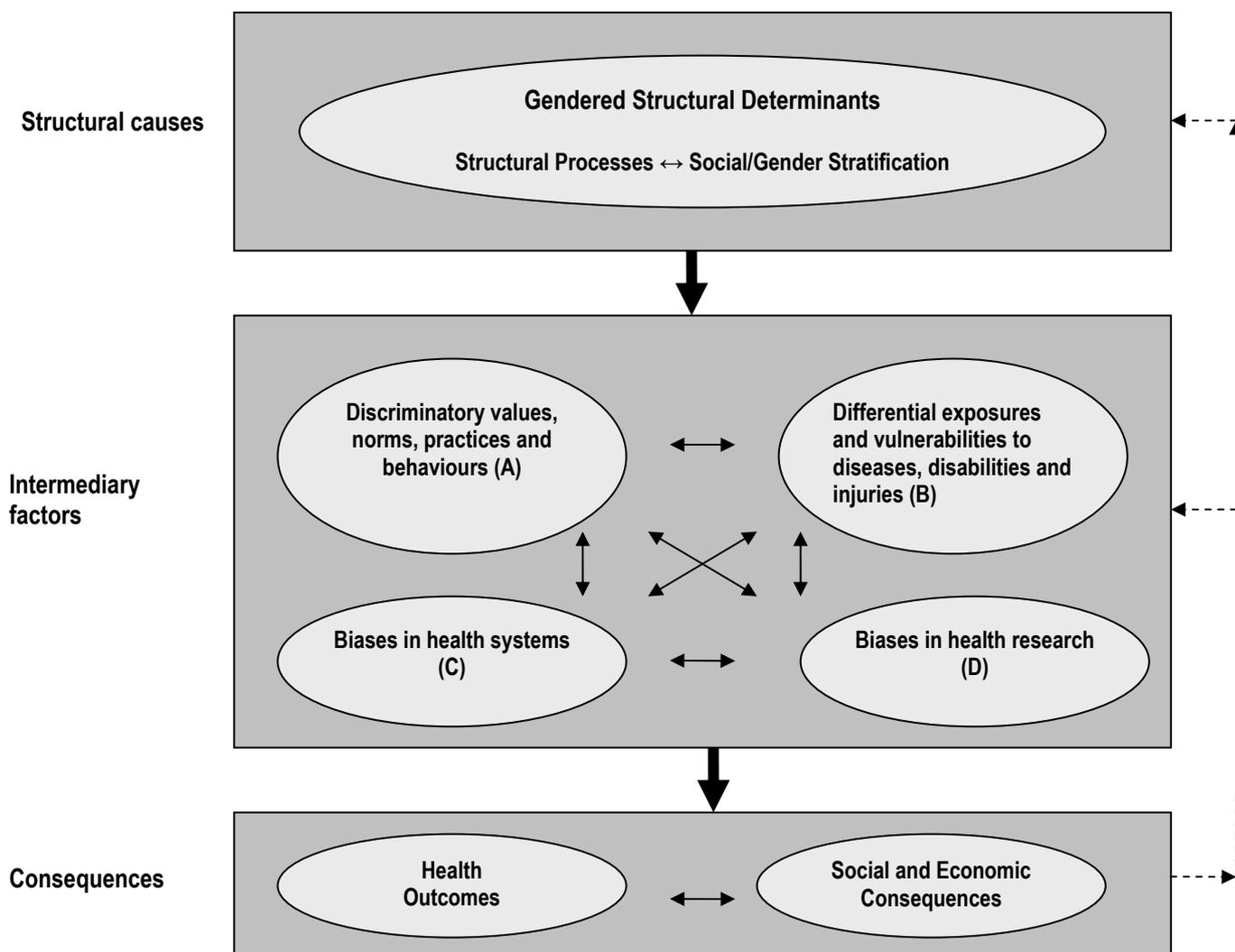
What determines the pace or pattern of change in gender systems and how they affect people's health? As with other stratifiers, this can depend on economic and social processes lying outside the health sector. In this report we have identified a few structural processes – rising literacy and education, demographic transitions in birth and death rates and in family structures, globalisation (including its effects on labour forces, policy space, health systems, and violence), and the strengthening of human rights discourse. While there are a number of other important structural processes at work, we have chosen these partly by way of illustration, and partly to complement the work being done by other Knowledge Networks of the CSDH. The choice has also been determined by their scope, speed, and importance at the present time, the depth of their implications for gender systems, and the availability of evidence regarding how they affect health.

The interplay between gender systems and these structural processes can be addressed by asking whether such processes weaken or strengthen gender hierarchies; whether they alter them in significant ways; and what this means for people's health. Gender systems may themselves alter the way in which these structural processes unfold. Together, gender systems, structural processes and their interplay constitute the *gendered structural determinants* of health delineated in the analytical framework outlined in the next sub-section.

III.4 Causal pathways and a framework

The pathways from the gendered structural determinants to the intermediary factors that determine inequitable health outcomes are multiple and can be complex. The intermediary factors are broadly four-fold: (A) discriminatory values, norms, practices and behaviours; (B) differential exposures and vulnerabilities to disease, disability and injuries; (C) biases in health systems; (D) biased health research. These intermediary factors in turn result in biased and inequitable health outcomes, which in turn can have serious economic and social consequences for girls and boys, women and men, for their families and communities, and for their countries. Feedback effects from outcomes and consequences to the structural determinants or to intermediary factors can also be important. Figure 1 summarizes these relationships.

Figure 1: Framework for the role of gender as a social determinant of health



Note: The dashed lines represent feedback effects

IV. Gendered Structural Determinants

IV.1 What do we know?

As mentioned previously, gender as a *social stratifier*, its intersections with other bases of discrimination and bias such as economic class, race, or caste for example, and its interactions with *structural processes* together constitute the *gendered structural determinants* of health. These are the upstream factors that shape people's health in important ways. For this report's analysis we have identified a few structural processes – rising literacy and

education, demographic transitions in birth and death rates and in family structures, and globalisation (including its effects on labour forces, health systems, and the media) – as crucial because of their current relevance, scope, rapidity, and interactions with gender. How these processes interact with gender systems of power and stratification, and to what extent and in what ways they weaken or strengthen gender inequalities and inequity, is central to the discussion of this section. We also examine the ways in which deepening the human rights agenda has altered the normative framework on which the case for gender equality rests. Where possible, given the limits of available evidence, the section also addresses the intersections between gender and other social stratifiers.

IV.1.1 Gender as a social stratifier

During the last half century, a great deal of evidence has accumulated based on work in almost all the social sciences and humanities as well as a number of the natural sciences about the presence, scope and depth of gender inequality and inequity throughout much of known history and in practically every part of the world. In connection with the tenth anniversary of the Fourth World Conference on Women (United Nations, 1995) a number of agencies had reviewed the evidence on gender and development and found gender inequality to be widely present (Sen, 2006). While its forms do vary across time and space and may be blatant or more subtle, the system of gender power that places women in subordinate social positions has been remarkably pervasive and persistent. The correlates of gender power can be felt by women and men in practically every field, and most certainly in health (Lorber, 1997).

While a number of concepts have evolved over the years to provide analytical bases for understanding and action⁹, central to most of them is the role of gender power in organising relations among people, creating and sustaining disequalising values, norms, behaviour and practices, and structuring organisations to reflect and consolidate those same beliefs and relationships. Gender affects people's functionings and capabilities (Sen, 1999). Gender relations operate through processes of *having, being, knowing* and *doing* that differentiate, stratify, subordinate, and hierarchise people, and particularly though not only in the case of transgender and intersex people, marginalise and exclude them¹⁰.

Women have less land, 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 (Elson 1993). 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. Girls and women are often viewed as less capable or able¹¹, and in some regions seen as repositories of male or family

⁹ Subordination, discrimination, bias, patriarchy, gender system, hegemonic masculinity to name a few.

¹⁰ Transgender and intersex people are not the only ones to face social exclusion; but the distinction between social exclusion and unequal inclusion is an important one. (For more on this, see the Social Exclusion Knowledge Network report)

¹¹ Witness the recent questioning of women's intrinsic scientific abilities by the former president of Harvard University.

honour and the self-respect of communities (Fazio, 2004). Restrictions on their physical mobility, sexuality, and reproductive capacity are perceived to be natural; and in many instances, accepted codes of social conduct and legal systems condone and even reward violence against them (Garcia-Moreno et al., 2006a).

They 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 and second class citizens¹². Even in places where extreme gender inequality may not exist, women often have less access to political power and lower participation in political institutions from the local municipal council or village to the national parliament and the international arena. While the above is true for women as a whole vis a vis men, there can be significant differences among women themselves based on age or lifecycle status, as well as on the basis of economic class, caste, ethnicity etc. Much of the above also holds for transgender and intersex people who are often forced to live on the margins of mainstream society with few material assets, who face extreme labour market exclusion leaving them little other than sex-work as a means of survival, and who are often ostracised, discriminated against, and brutalised (IDS Bridge Cutting Edge Pack on Gender and Sexuality).

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 behalf, regulating and constraining their access to resources and personal agency, and sanctioning and policing their behaviour through socially condoned violence or the threat of violence. Again, not all men exercise power over all women; gender power relations are intersected by age and lifecycle as well as the other social stratifiers such as economic class, race or caste. Poor women and those who belong to subordinated racial or caste groups for instance tend to be near the bottom of the social order, bearing multiple burdens of poverty, work burdens, discrimination and violence. At the same time, gender systems often allow possibilities for some women to exercise power and authority over other women – richer over poorer women, older over younger women, for example – and even along some dimensions, over poorer men.

The impact of gender power for physical and mental health – of girls, women and transgender /intersex people, and also of boys and men – can be profound. In later sections we see how it affects health norms and practices, exposures and vulnerabilities to health problems, and the ways in which health systems and research respond. But gender systems, while slow to change, are not immutable, and these changes can be for better or worse. They offer potential entry-points for advocacy, activism and policy.

¹² The concept of citizenship has been interrogated and expanded to include not only the public sphere but also politics within the home: see PITANGUY, J. (2002) Bridging the Local and the Global: Feminism in Brazil and the International Human Rights Agenda. *Social Research*, 69, 805-820.

IV.1.2 Gendered structural processes

While gender systems can be slow to change, they are often under pressure from other structural processes that challenge the foundations on which the edifice of gender power rests. Some of these processes may indeed shake those foundations, and this can lead to tension, resistance (especially from those who benefit from gender power), accommodation, or transformation. In this sub-section, we examine some of the key structural processes that have already changed and are continuing to change people's gendered lives.

Changes in literacy and education: Whenever one looks for positive factors affecting historically unequal gender systems, rising literacy and increases in the education of girls are usually at the top of the list. Nevertheless, a gender gap in literacy and education persists in many parts of the world as documented by Herz and Sperling (Herz and Sperling, 2004), and by the reports of Taskforce 3 on Education and Gender Equality of the UN Millennium Project (Grown et al., 2005, Birdsall et al., 2005). Significant numbers of women reach adulthood with no education, especially in South Asia where the literacy rate for women (equal to and over 15 years of age) in 2004 was as low as 48%, only two-thirds the rate for men (HDR, 2006).

The children of women who have never received an education are 50 per cent more likely to suffer from malnutrition or to die before the age of five (UNFPA, 2002). Children and especially girls with low levels of schooling assume the work burdens of adults prematurely and are deprived of the opportunity for learning in an institutional setting outside the family. In many countries millions of girls 'disappear' into early traditional marriages, hazardous labour or even combat roles (UNICEF, 2006).

Norms that create barriers to the education of girls include negative perceptions about women that devalue their capabilities, strong beliefs about the division of labour that places inequitable burdens on females, gender-biased beliefs about the value of educating girls, and curricula that are seen as inappropriate for girls (Abane, 2004). Such norms are exacerbated by structural barriers such as school fees or school-going costs, distance from schools and perceived or actual lack of safety for girls going to school, absence of female teachers, lack of gender sensitivity in schools including absence of decent toilet facilities for adolescent girls, and inflexibility of classroom programmes.

These barriers work especially strongly for education above the primary level. The gender gap in primary education has been narrowed significantly in almost all countries, but although the secondary education gap has been closed for most countries with a high or medium Human Development Index (HDI), there is a significant gap still in the net secondary enrolment ratio for many countries with a low HDI (HDR, 2006). Tertiary education in many high HDI countries appears to be tilted towards more women than men in terms of gross enrolment. This probably reflects a combination of lower returns to secondary education for girls in the job market (requiring them to stay longer in school), as well as higher drop-out rates for boys after high school.

The shift in some regions such as the Caribbean and parts of Latin America towards more girls than boys entering in and completing secondary and higher education needs to be examined more carefully. In part it is due to girls' higher interest in schooling and in part it is due to causes such as significant increases in youth unemployment and low returns to higher education for boys in the job market. Poorer school enrolment and higher drop-out rates among boys can also have consequences such as breeding aggression, destructive masculine norms, and violence against women as ways of compensating for poor self-esteem among young men (Osler et al., 2006).

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 especially reduction in traditional infectious disease mortality, and increases in immunization. The lowering of fertility has resulted from multiple factors including among them family planning programmes 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. Where the demographic transition towards lower fertility has been completed, it has certainly had its influence on gender relations by lowering the time women have to spend on bearing and raising children, and on culture by weakening the links between sexuality and child-bearing, and by transforming the size, composition, and relationships within families (Presser and Sen, 2000). But the pace and pattern of these changes is different in different regions of the world at present. Some countries have seen falls in death rates without as yet seeing corresponding declines in birth rates. The resulting increase in the absolute and relative numbers of young people in recent decades in these countries has gone hand in hand with the ageing of populations in other, usually high or middle income countries (UNFPA, 2003) In regions seriously affected by the HIV/AIDS pandemic, the age pyramid appears hollowed out in the middle ages due to the high infection rates among women and men in the reproductive ages. In regions with endemic son-preference, the availability of ultrasound technologies has significantly altered the sex-ratio in the population as a whole and particularly the child sex-ratio against girls and women (UNFPA, 2006).

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. A large young population typically means an increase in women's work in maternity and caring for children. In most countries, this work is unsupported and usually unpaid. When children fall ill, it is women who have to juggle the multiple responsibilities of double and triple burdens of work. When mothers work for an income (as most poor mothers do), girls are recruited to care for siblings at the expense of their own education (Herz and Sperling, 2004). When parents die due to HIV, it is often grandparents or children (often girls) who are left to care for young children and households (Monash and Buerma, 2004). Highly biased population sex-ratios result in larger

spousal age-difference and phenomena such as kidnapping of brides, or wife-sharing among brothers, all of which impact negatively on women's power within the home. (Hudson and den Boer, 2004)

Ironically the ageing of populations also increases women's care work burdens in supporting the elderly who usually also require more health care (WHO, 2003d). Ageing also hits women in another way, especially in countries that are experiencing greater longevity for women. Although there is evidence that widowers are less able to care for themselves and manage their lives than widows (Fry, 2001), the absolute numbers of widows tends to be greater. This is when the cumulative effect of women's lower economic position and dependency throughout their lives is felt. Widows tend to be poorer, and their rates of impoverishment and destitution higher than widowers and many other subsets of the population. In poor and middle income countries where it is acceptable for older men to marry much younger women, and remarriage for widows is frowned on, there are many more widows than widowers. Here widows may be at greater risk of poor health if they live alone (having outlived their older spouse and, for one reason or another, not living with one of their children). In Lebanon this is especially challenging for adult children who moved during the civil war to find work; 15% of elderly women live alone, compared to 1% of elderly men (Sibai et al., 2004). In the July-August 2006 war, the frail elderly who were forced to move from rural areas must have undergone considerable stress and danger. A study in Egypt and Tunisia found that older women, regardless of their residential status, appeared to experience more morbidity and disability than older men, and report using medication and visiting providers more often than men (Yount and Agree, 2005, Yount et al., 2004).

Few low and middle income countries provide adequate financial support or home health care for the elderly, whether with spouses or single. In countries where society frowns on institutional care for the elderly; most families cannot afford it and do not consider it adequate. But women cannot look after elderly relatives if they are not provided with extra support. As parents live longer and women work outside the home, caring for elderly parents can become stressful for family members. The dependent position of the frail elderly (a large proportion of whom are women) makes them vulnerable to abuse in the family, and in care. In low and middle income countries, where older people are still a relatively small proportion of the total population, and are mainly cared for in the home, elder abuse is not a topic which is discussed or researched.

The extent to which the needs of young populations as well as older populations have to be met through the unpaid 'care' work of women is exacerbated by crumbling health services and vanishing paid health staff (George, 2007a). Women become the shock-absorbers in the system, expected to act as such in both normal economic and health times, and during the bumps caused by health crises and emergencies. This is especially true for women who bear multiple intersecting burdens of poverty and, for example, race, ethnicity or caste. Indeed, the experiences of such women can contradict traditional biomedical norms, e.g. that early adulthood is the healthiest time for childbearing. Geronimus proposed the "weathering hypothesis" as a plausible explanation for racial differences in maternal age

patterns for births and birth outcomes in the US (Geronimus, 1992). The "weathering hypothesis" suggests that the health of African-American women may begin to deteriorate in early adulthood as a physical consequence of cumulative socioeconomic disadvantage. As a consequence, teenage might be a healthier time for them to become pregnant and bear children than early adulthood. This work has been taken forward both in terms of measurement and also its policy implications about the urgent need to reduce the socioeconomic stressors that women with multiple, intersecting oppressions face (Geronimus and Thompson, 2004, Geronimus et al., 2006). The weathering hypothesis has also been tested and found valid for US-born Mexican-American women with clear correlates in extraordinarily high levels of neonatal mortality and pregnancy related hypertension in early adulthood (Wildsmith, 2002).

However, reduction in family size and changes in family composition have also had major effects on relationships within families, reducing the time women have to spend in child-bearing and rearing, and diminishing the hold of patriarchal family structures on women and younger members (Hopkins, 2001). In some instances, however, these changes also set off backlashes as those who wield gender power in families, communities and religious structures attempt to control and discipline (especially) young women.

While some religious interpretations recognise women and men to be equal, others are deeply patriarchal and find the challenge posed by the demographic transition and gender equality to be extremely threatening to their own long-standing enjoyment of the fruits of masculinist power. Trying to hold on to such power has led to attempts to roll back internationally agreed norms on gender equality and sexual and reproductive health and rights in particular (Petchesky, 2003). Such attempts have had serious implications for the health and human rights of women and men and of young people. They include reduced availability of condoms even when they are the only known effective method to prevent HIV infection¹³, and limitations to safe abortions even where they are legal and women's health may be at risk¹⁴.

Globalisation: During the last four decades, the effects of demographic transitions and of such capability-enhancing processes as education have been crosscut by rapid changes in international and national political economies. While a variety of technological and other changes have tended to bring local, national and regional economies ever closer over at least five hundred years, recent decades have witnessed qualitative changes in their speed and scope. Countries and their economic systems have become more strongly inter-twined through large flows of money, goods

¹³ Under the ABC (Abstinence, Be Faithful, Condoms) programme funded by the Bush administration, the overwhelming emphasis has been on abstinence, while condom availability has dropped dramatically in highly HIV vulnerable populations. The reversal in recent years of the advances that had previously been made by Uganda in limiting HIV infection provide a sharp example of the very real dangers that gendered ideologies pose for people's health: see MURPHY, E. M., GREENE, M. E., MIHAIOVIC, A. & OLUPOT-OLUPOT, P. (2006) Was the "ABC" Approach (Abstinence, Being Faithful, Using Condoms) Responsible for Uganda's Decline in HIV? *PLoS Med*, 3, e379.

¹⁴ The conservative dominated US Supreme Court ruled in 2007 that a law banning certain second-trimester abortions was legal even though the law contained no exception when a women's health is at risk: see FEDERAL ABORTION BAN TRIALS (2007) U.S. Supreme Court Upholds Federal Abortion Ban: Law Threatens Women's Health: Criminalizes Safe, Early Abortions. Washington DC, April 18, 2007. http://www.federalabortionban.org/press_statements/070418-supreme_court.asp.

and people, through global assembly lines and commodity chains, greater information and knowledge, and stronger cross-national impacts of policies and actions. Fuelled by the revolution in information technology and its penetration to the core of economic and production systems, this globalisation has also given birth to social movements (environment, women, racism, and indigenous people) that are more global in scope. It has also been associated with (even if not always causally) with increased militarization and warfare, and a rise in wars over energy and mineral resources, leading to a rising number of internal refugees, displaced persons, and trafficking in women and children. A more detailed analysis of the effects of globalisation can be found in the Report of the CSDH Knowledge Network on Globalisation, while some of the implications for health systems are in the Report of the CSDH Knowledge Network on Health Systems.

Three implications of globalisation are of particular significance for our focus on gender relations. The *first* is how it has transformed the composition of workforces, and the implications for women's health. The 'feminisation' of labour forces (Joekes, 1995, Standing, 1997) has been the result of increased global competition for cheaper sources of labour made possible by technological changes and the emergence of global assembly lines for an ever widening range of goods. With such processes spreading also to services through business process outsourcing and the rise of the 24-hour global economy, women workers have been increasingly drawn into globally-linked markets, even as their work continues to be lower paid and often done under harsh conditions (Messing and Östlin, 2006, Mills, 2003). Feminisation of work-forces has gone hand in hand with increased casualisation – more insecure forms of work such as informal sector and home-based work – implying lack of social protection, and with potentially serious implications for the health of women and their families and resulting impoverishment. At the same time, women continue to bear unequal burdens for unpaid work in the household; for many women, child care responsibilities represent the single most important barrier to their ability to participate in formal (waged) labour markets (Barriento et al., 2004); Globalization Knowledge Network report). The burden of these multiple trade-offs is often experienced by women as a deepening of the double burden of earning an income outside the home while continuing to have primary responsibility for the domestic work of care (Mansdotter et al., 2006). These burdens have implications for women's health, both their occupational health and the consequences of insufficient rest and leisure. Despite this, women workers in such jobs are often loath to give up working if it means returning to the gender authority and patriarchal control of traditional family systems (Kabeer, 2002).

Migrant women workers and their children left behind are particularly at risk. In societies where men are not socialized to carry on the reproductive tasks at home, this results in the general neglect of children. Male partners left behind can also use the money sent home for vices and womanizing, exacerbating gender oppression (Pingol, 2001, Battistella and Asis, 1999).

In most Gulf Cooperative Council countries, immigrant workers have some health rights. However, female factory workers living in dormitory accommodation and domestic servants may not be aware of these entitlements. Domestic servants who were entitled to health care as a member of the family which employs them may not be aware of, or able to exercise such rights. These women are especially at risk from sexual harassment and social isolation. Immigrant housemaids in Kuwait have been found to suffer from a high rate of mental illness (Zahid et al., 2003). Needless to say, they often don't have a real option to leave if they are the sole financial support for their families. Without the skills that education provides and given the lack of options in formal labour markets for these women in their countries of origin, they are often trapped in immigrant housemaid employment.

A *second* gendered consequence of globalization is through its narrowing of national policy space that 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 (Rodrik, 1997, Stiglitz and Charlton, 2005). The structural adjustment loans given by the Bretton Woods institutions in the 1980s were an early manifestation of this phenomenon. Their impacts in terms of reducing funds for health and education and their negative impacts on girls' and women's access in particular were extensively criticized (Herz and Sperling, 2004).

In the 1990s, these policies springing from the so-called Washington Consensus were modified. Commitment to Poverty Reduction Strategies (PRS) or equivalent National Development Strategies (NDS) by countries were made the basis of foreign lending. Direct programme lending for health increased in a number of cases, but has often been associated with pressures for privatization, and increases in user fees. The modified approach has had mixed results in terms of actually being able to reverse negative trends in health systems¹⁵. Such policies have also been carried out in related spheres such as pension reforms with significant increases in inequality. Several Latin American countries have fully or partially privatized their public pensions since the 1980s. In 1995 Mexico privatized its public pension system, including a shift from a defined benefit to a defined contribution system based on privately administered individual accounts. The new system might provide incentives for women to increase their participation in formal work, yet the lack of support for working women will most probably lead to women in the future losing their rights to pension, and becoming dependent on their families for support in old age (Dion, 2006).

¹⁵ "... the growth of selective primary health care approaches, rooted in cost-effectiveness analysis, in the 1980s was also led by international agencies. Although some, such as immunization, had positive impacts on child mortality, their impacts on health systems' ability to respond to the wider range of health problems it faces on a daily basis have been hotly contested. Past debates about selective vs. comprehensive approaches to health system development (Rifkin and Walt 1986) are now again on the agenda with the rise of the Global Health Initiatives, some targeting specific health problems and some particular services, that have brought enormous new levels of funding to health systems within LMICs (US\$8.9 billion in 2006 for HIV/AIDS alone). An analysis of the policies, programmes and processes that govern the design and implementation of three Global Health Initiatives (PEPFAR, the Global Fund and World Bank MAP) suggests that they can have negative effects on health systems and, specifically, gender equity, unless a stronger equity focus guides their future activities" (Hanefeld et al 2007, cited in the Health Systems Knowledge Network Report). (See past debates in RIFKIN, S. B. & WALT, G. (1986) Why health improves: defining the issues concerning 'comprehensive primary health care' and 'selective primary health care'. *Social Science Medicine*, 23, 559-566.)

Another study shows that the new privately managed pension system in Chile has increased gender inequalities. Women are worse off than they were under the previous pay-as-you-go system of social security, in which the calculation of benefits for men and women did not differ and women could obtain pensions with fewer requirements than men. Currently, benefits are calculated according to individuals' contributions and levels of risk. Such factors as women's longer life expectancy, earlier retirement age, lower rates of formal labour-force participation, lower salaries and other disadvantages in the labour market are directly affecting their accumulation of funds in individual retirement accounts, leading to lower pensions, especially for poorer women. Lessons from the Chilean reform should encourage scholars, policy makers, and the general public to engage in debates that more adequately incorporate gender variables in designing and implementing policy changes (deMesa and Montecinos, 1999).

A *third* aspect of globalisation of importance for health is the rise in violence linked to the changing political economy of nation states in the international order. With the fall of the Soviet system (itself at least partially a consequence of its inability to withstand the growing power of the new global economics), there was an expectation that military expenditures would decline across the board, freeing up resources for human development and for more productive uses. The hope that swords would be beaten into ploughshares has, however, been sadly belied. The unipolar post-Soviet world still threatens to fall back into a renewed arms race¹⁶; there is increased competition by more powerful nations for the mineral resources of others; and there has been a rise in ethnic and communal conflicts as the governance capacities of poorer states have been eroded, and ethnic and other tensions have become mixed up with struggles for resources.

"According to recent estimates, in 2005 there were some 10-12 million refugees and asylum seekers worldwide and an additional 24-25 million International Displaced Persons (IDPs)¹⁷. Weiss and Korn (2006) point out the "dramatic reversal" in the "ratio of refugees to IDPs" in the past twenty-five years, from 1982, when the number of international refugees was ten times greater than that of IDPs, to the present, when the latter have become two and a half times more numerous. (2006:1)" (Petchesky and Laurie, 2007) Petchesky and Laurie argue that the central feature of the camps holding refugees and displaced persons is that they are sites where people are excluded from the rights granted to normal citizens, and are often neither counted nor remembered by major health systems or reports, despite being key transfer points for "viruses, violence, and damaged, discarded bodies".

¹⁶ Witness the criticism by Russia of US plans to expand its missile systems into parts of Eastern Europe.

¹⁷ Numbers vary depending on the method of counting and who is doing the counting; see UNHCR (2006) Global Refugee Trends. Geneva, UNHCR, USCRI (2006) World Refugee Survey 2006. U.S. Committee for Refugees and Immigrants (USCRI), NORWEGIAN REFUGEE COUNCIL (2006) Internal Displacement: Global Overview of Trends and Developments in 2005. Geneva, Internal Displacement Monitoring Center, WEISS, T. G. & KORN, D. A. (2006) Internal Displacement: Conceptualization and Its Consequences. Routledge: London and New York, 2006 drawing on the US Committee for Refugees' World Refugee Survey 2001, places the estimated number of people "displaced by complex humanitarian emergencies" at 35 million, but he is no doubt combining IDPs and refugees here.

Furthermore, they are major loci of gendered violence¹⁸. Importantly, gendered violence does not only affect girls and women but includes violence against boys and men, as well as transgender and intersex persons and all those who do not meet heterosexual norms.

The blurring of boundaries in public and private spaces is also one of the important gendered effects of the rapid expansion of communications media of various sorts, and the increasing centralisation of power over mass communication in a few hands. With increased global and national competition for control over media, they have tended to resort to lowest common denominator programming focusing on the depiction of violence and the display and commercialisation of (especially) women's bodies. As communication technology has grown and become more diverse, its content has become filled with violent and misogynistic images and messages¹⁹. The internet, video games as well as traditional media such as movies are filled with such content. The impact of gratuitous violence in de-sensitising young people has been argued by a large weight of psychological studies and evidence; yet this appears to have had little effect so far on media policies (Cantor, 2002). "The American Psychological Association says there are three major effects of watching violence in the media (i.e.: video games/television) children may become less sensitive to the pain and suffering of others, children may be more fearful of the world around them, and children may be more likely to behave in aggressive or hurtful ways toward others" (Tompkins, 2003).

IV.1.3 Women's movements and human rights

Some of the negative consequences of globalisation 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. While ascriptive social stratifiers such as gender, race, or caste generally tend to change slowly, they can sometimes be altered by sudden sharp bursts of social upheaval. In recent times, the social upheavals set off by the civil rights and women's movements of the 1960s and the intensified focus on a broad human rights agenda at the United Nations conferences of the 1990s²⁰ have challenged the narrower understanding of human rights that had prevailed until those times (Petchesky and

¹⁸ "Throughout much of the world, war is increasingly waged on the bodies of unarmed civilians [now 60-90 % of all conflict casualties]... rendering civilian women, men, and children its main casualties. The violence of such conflict cannot be isolated from other expressions of violence. In every militarized society, war zone, and refugee camp, violence against women and men is part of a broader continuum of violence that transcends the simple diplomatic dichotomy of war and peace. . . [and] resists any division between public and private domains. See GYLES, W. & HYNDMAN, J. (2004) Introduction: Gender and Conflict in a Global Context. IN GYLES, W. & HYNDMAN, J. (Eds.) *Sites of Violence: Gender and Conflict Zones*. University of California: Berkeley.

¹⁹ There is also an issue of media's presentation of how young women's bodies should look. Thin women in media become models for young girls, resulting in eating disorders. This phenomenon is increasingly affecting young boys as well – well-trained male bodies are glorified in the media, leading to unhealthy exercise patterns in young men, many of them even taking illegal drugs to increase capacity for training/performance.

²⁰ These include, among others, the UN Conference on Environment and Development (Rio de Janeiro, 1992), the UN Conference on Human Rights (The UN World Conference on Human Rights in Vienna, 1993), the International Conference on Population and Development (Cairo, 1994), the Social Summit (Copenhagen, 1995), the Fourth World Conference on Women (Beijing, 2005), and the International Conference against Racism (The UN World Conference against racism, racial discrimination, xenophobia and related intolerance in Durban, 2001).

Laurie, 2007). Through these processes, women's organisations and others have grown and matured as a result of their experiences with tackling gender inequality and inequity on the ground, at national policy levels, and in global negotiations and debates around normative frames and strategic directions. They have become important players in these debates even though there has been backlash and resistance from some quarters, mainly associated with conservative religious hierarchies (Faludi, 1992).

Women's movements have always been part of broad-based social movements (Antrobus and Sen, 2006). In the context of the UN conferences of the decade of the 1990s the international women's movement emerged as a powerful political constituency, and has increasingly become part of the global movement for social justice. The modern women's movement had its roots in the social and political ferment of the 1960s like so many other social movements of the latter 20th century. What was specific and unique to the women's movement was *its call for recognition of the personal as political*. The appearance of the international women's movement as part of an emerging transnational civil society was also conditioned by the processes generated by the United Nations Decade for Women (1975-1985).

The resulting deepening of the human rights framework took the global debate significantly beyond the existing approaches to human rights. Almost from the time of the Universal Declaration of Human Rights (United Nations, 1948), there had been a debate about the relative importance of civil and political rights versus economic, social and cultural rights. This debate was largely about the persistence of global economic inequality as against political openness and democracy. Other dimensions of inequality and injustice had been largely absent from this debate. With the rise of the social movements of the 1960s on, hitherto unrecognized dimensions of inequality and inequity – gender, sexual orientation, ethnicity, race, caste, and disability – began to be debated. All of these new elements drew their inspiration from the UDHR and referred to its various clauses and principles. But they also provided new interpretations to these same clauses, grounded in the realities of the lives of people who were subject to discrimination and inequality, or who were vulnerable for other reasons such as age.

IV.2 Promoting Human Rights and Strengthening Women's Hands

The discussion in the previous section points to the need for three distinct types of action to address the gendered structural determinants that operate 'upstream' from the intermediary determinants of health. Although there are a large number of potential actions, our choice of priorities is dictated by the way in which gender power relations are intertwined with roles, divisions of labour, resources and authority. These cause girls and women to bear disproportionate unpaid costs and burdens for the survival of households, the daily and generational reproduction of people, and the growth of economies. Women are the 'shock absorbers' of families and social systems in both regular and hard times. Furthermore, they bear these burdens with inadequate and unequal access to resources, to

opportunities and possibilities for developing their own capabilities, and often in the face of inequitable restrictions, social controls and violence. 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 women's hands and empowering them so that they can actually claim and realize their human rights. This points to the next two action priorities: cushioning the 'shock absorbers' through key structural reforms, and expanding women's opportunities and capabilities.

IV.2.1 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 explicit recognition of 'lived' realities – for example, of rape as a violation of women's human rights (United Nations, 1993), or racism as a violation of the human rights of specific racial or ethnic groups (United Nations, 2001) – was critical to their being acknowledged as needing legal and policy remedies. One important precursor at the global level was the adoption of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979. CEDAW provided a broad framework for women's rights that has been used in a number of countries to advance action at the national level. It also has an accountability mechanism built in whereby member states of the United Nations have to report on a regular basis on actions taken towards its implementation.

A further important way in which the human rights framework has been deepened is through interpreting the right to health to include reproductive and sexual health and reproductive rights (United Nations, 1994) and sexual rights (United Nations, 1995). The current UN Special Rapporteur on the Right to Health, Paul Hunt, has been paying special attention to sexual rights issues, as exemplified by his report to the UN Human Rights Committee in 2004. Most recently, a distinguished group of international human rights experts launched the Yogyakarta Principles on the application of international human rights law to sexual orientation and gender identity.²¹ Human rights violations targeted toward persons because of their actual or perceived sexual orientation or gender identity include extra-judicial killings, torture and ill-treatment, sexual assault and rape, invasions of privacy, arbitrary detention, denial of employment and education opportunities, and serious discrimination in relation to the enjoyment of other human rights. The Yogyakarta Principles affirm 29 key rights, many of which have implications for health, and affirm the primary obligation of states to guarantee these rights. Of particular note for this report are Principles 17 (the right to the highest attainable standard of health) and 18 (the right to protection from medical abuses).

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

²¹ http://www.yogyakartaprinciples.org/docs/File/Yogyakarta_Principles_EN.pdf

organizational mechanisms, funding for implementation, and accountability structures that create incentives for appropriate action. A number of later sections in this report provide detailed recommendations and examples of good practices.

As has been extensively discussed, economic and social rights are a fundamental part of human rights. The critique of structural adjustment programmes and neo-liberal economic reforms has clarified the need to 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.

IV.2.2 Cushioning the 'shock absorbers'

In a just world, responsibilities for domestic work and caring for people would be equally shared by women and men. Until then, providing women with the support that will minimize the health damaging consequences of their double burdens and especially their unpaid responsibilities for daily household needs such as gathering fuel, fetching water and fodder, cooking, washing and cleaning requires sustained public policy attention. In addition to these tasks women need support for their work of caring for the young, old and the ailing within families. Task Force 3 on Education and Gender Equality of the UN Millennium Project identified a set of strategic priorities in this regard (Grown et al., 2005).

The Task Force used an operational framework in three domains: capabilities, access to resources and opportunities, and security. To ensure that MDG 3 – promote gender equality and empower women - is met by 2015, the Task Force identified seven strategic priorities (Grown et al., 2005):

1. Strengthen opportunities for post primary education for girls while simultaneously meeting commitments to universal primary education.
2. Guarantee sexual and reproductive health and rights.
3. Invest in infrastructure to reduce women's and girls' time burdens.
4. Guarantee women's and girls' property and inheritance rights.
5. Eliminate gender inequality in employment by decreasing women's reliance on informal employment, closing gender gaps in earnings, and reducing occupational segregation.
6. Increase women's share of seats in national parliaments and local governmental bodies.
7. Combat violence against girls and women.

Among these strategic priorities, number 3 calls for investing in infrastructure that will save on time and drudgery for girls and women. The Women and Gender Equity Knowledge Network supports these strategic priorities, and strongly endorses this call as a way of providing support to women in their role as unwitting shock absorbers for

families and economies. We agree as well with the specification of efficient sources of energy, better transport systems, and clean water and sanitation as priorities. The health impacts of all three are significant. The substitution of biomass by cleaner and more efficient fuels will reduce both the time women spend and the problem of kitchen pollutants. Ensuring clean water and sanitation has well-known health implications for children and girls and women. However, the planning and implementation of such infrastructure can be most effective if girls and women are themselves involved.

Women's tasks, such as water treatment at the point of use (in the house), hand washing, covering of water storage jars, and safe disposal of children's feces, are recognized as effective behaviours that reduce the burden of diarrhoeal disease. Other preventive hygiene practices include face washing as a preventive against trachoma and, for schistosomiasis, providing alternatives to canals for domestic tasks. To improve hygiene behaviour requires an understanding of these behaviours, the choices women have, and the local constraints they experience – such as time constraints, poverty and lack of support from the health and social authorities. In this setting, expecting women to change their behaviour is unrealistic unless there are serious attempt to improve accessibility and reliability of water supplies, and the safe disposal of sewage and waste water (Watts, 2004, Zwane and Kremer, 2007). "A study of community water and sanitation projects in 88 communities in 15 countries finds strong evidence that projects designed and run with the full participation of women are more sustainable and effective than those that ignore women (Gross et al., 2001). This finding corroborates an earlier World Bank study that found that women's participation was strongly associated with water and sanitation project effectiveness (Fong et al., 1996, United Nations, 2005)

Also, health promotion policies and activities in general are most meaningful when target communities and groups are involved in all aspects of policy and programme development, implementation and evaluation. For example, "The Blue Nile Health Project" in Sudan with the objective to control water associated diseases was perceived as very successful, thanks to the particular emphasis in the programme on gender-related aspects that defined women's role and participation (Rahman et al., 1996). The study urges health planners to persuade women in many African countries, like Sudan, to play a more active role in such health programmes

A later section of the paper on health systems focuses specifically on how the work that women do as providers of health care within families can be better supported so as to reduce their burdens and promote their own health. In particular it will be important to invest in programmes to transform both male and female attitudes to caring work so that men begin to take an equal responsibility for such work.

IV.2.3 Expanding women's capabilities – focus on education

An earlier review of the links between education and economic well-being found that 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. It has been estimated that countries can expect per capita annual growth in GDP of between 1-3 percentage points higher with more gender-equal education levels, while each year of schooling lost means a 10-20% reduction in girls' future incomes (Herz and Sperling, 2004).

An in-depth review of the results of 44 scientific studies found that patients with low literacy had poorer health outcomes, including knowledge, intermediate disease markers, measures of morbidity, general health status, and use of health resources. Patients with low literacy were generally 1.5 to 3 times more likely to experience a given poor health outcome (Dewalt et al., 2004).

Educating women could be the key to breaking the cycles of infant and child mortality and poverty (UNFPA, 2002). However, primary education is insufficient to provide women with the knowledge and skills to improve and sustain their own health or economic independence. A study analysing the impact of female education on the use of maternal and child health services by women in Thailand during pregnancy found that secondary education was the most consistent predictor of health service use for three services - tetanus toxoid inoculations, prenatal care, and assistance by formal providers during delivery (Raghupathy, 1996). Higher levels of education can also give girls and women more ability to challenge gender norms provided their 'fallback' position in terms of control over economic assets or incomes also improves. Resistance and opposition to violence and genital mutilation is higher among women with at least some secondary education (Global Campaign for Education, 2005). Based on the report of the UN Millennium Project's Task Force 3 on Education and Gender Equality, it has been argued by Grown, Rao-Gupta and Pande (Grown et al., 2005) that secondary education for girls also influences later age at marriage, improved ability by women to manage their fertility, smaller and more sustainable families, improved material care for children including nourishment and success at school, and reduced vulnerability to HIV/AIDS.

What needs to be done to break the barriers to education for girls? Many of the actions 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" (Grown et al., 2005).

Example: Bangladesh's Female Secondary School Assistance Program

This program began in 1994 with the aim of increasing the secondary school enrolment and retention rates of rural girls. It is a government program which has built on the lessons learned from NGO programs over more than a decade. Over the years, it has provided full scholarships covering tuition and all other costs, increased the numbers

of female teachers, educated communities and parents about the value of girls' education, improved school infrastructure, and added occupational skills to the curricula. By 2002, the expanding program was supporting 5000 schools in the 118 poorest rural districts with around a million girls getting scholarships, and almost 40 % of the teachers being female. The enrolment and attendance rates for girls improved sharply and surpassed that for boys. Furthermore the proportions of married girls among ages 13-19 dropped significantly (Herz and Sperling, 2004).

Cultural norms about teen pregnancy vary widely. But even where there may be little stigma attached to it, as in many parts of sub-Saharan Africa, pregnancy and motherhood can make it very difficult for a girl to continue schooling. Systematic actions to break these barriers are therefore required.

Example: Botswana's Diphilana Initiative

This initiative shows how an integrated approach across social sectors – health, education and social welfare – can address the needs of pregnant schoolgirls. Unlike many other areas where pregnancy for a schoolgirl can lead to her dropping out because it is too difficult for her to combine multiple roles and because of legal restrictions, this initiative explicitly has worked to tackle such barriers. "Pregnant schoolgirls at Pekenene School are allowed to return to school after giving birth, for as long as they wish...During maternity leave, schoolwork and other resources are sent to girls' homes, and the school has developed a curriculum with some distance education modules that can be followed at this time. When girls are certified fit to return to school by a doctor, they return with their babies. The school has crèche facilities, which can take babies as young as four months, and nappies and milk are provided. At break and lunchtimes the young mothers breastfeed their children. The Diphilana project requires that the father, if he is at school, share the responsibility of looking after the baby at break and lunch times." (United Nations, 2005).

Although there are now a number of well-working initiatives, such as the above, that improve girls' enrolment and retention rates, this is often not enough to address the next level of constraints. *Where strong gendered norms persist, even those girls who do attend school may eventually take up gender-stereotyped roles (Lloyd and Grant, 2004). Breaking these barriers requires action also to remove labour market biases, to acknowledge the extent to which households, nations, and the global economy depends on the unrecognised and unpaid work of girls and women in the economy of 'care' and to be willing to take action to challenge this serious injustice.*

V. Norms, values and practices

V.1 What do we know?

V.1.1 How do norms work?

What is viewed as *normal* by a group, community or organisation is shaped by its values and practices. These in turn are governed by the structure of its social relations including importantly, relationships of power which evolve historically in response to many factors, some structural and others being the actions of people themselves through social movements and collective learning. In turn, social norms govern people's behaviour, although in every context there will be those who adhere to and others who rebel against accepted codes of behaviour.

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" (Tibandebage and Mackintosh, 2002). They form an essential part of how we organise 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" (Sen et al., 2006). They are not a monopoly of 'traditional', non-Western societies, nor do they operate only at the personal and subjective level. Modern medicine practises norms that sometimes over-medicalise women's health concerns (infertility, menopause and childbirth – 'Caesarean section epidemic') or naturalise them as inconsequential (labour pain becomes back pain for instance).

Norms are vital determinants of social stratification as they reflect and reproduce relations that empower some groups of people with material resources, authority, and entitlements while marginalizing and subordinating others by normalizing shame, inequality, indifference or invisibility. "It is important to note that these norms reflect and reproduce underlying gendered relations of power, and that is fundamentally what makes them difficult to alter or transform."²² (Sen et al., 2006).

They may be *formal* or *informal*. Formal norms are those where rules and sanctions are guaranteed through formal processes that are usually but not always official. They may be written and enforceable, possibly through legal recourse or arbitration. They can be associated therefore with organizations of the state, market, or civil society. They include economic and political institutions, legal systems, and cultural and social institutions with formal rules

²² An illustration for this point is the ease with which male dress codes change in most societies, while codes for 'proper' female attire continue to be enforced, and can be fought over bitterly. The former are simply a form of social behaviour, while the latter include sanctions that serve to define them as an informal institution. For further discussion of the distinction between informal institutions and informal behavioural regularities, see HELMKE, G. & LEVITSKY, S. (2004) Informal Institutions and Comparative Politics: A Research Agenda. *Perspectives on Politics*, 2, 725-740. p 727).

and procedures. Informal social norms, on the other hand, represent evolved practices with stable rules of behaviour that are outside the formal system. Acceptable behaviour may be governed through a set of known sanctions or through powerful processes of internalisation without recourse to sanctions. When considering norms referring to gender, such processes of internalisation may be as strong as actual sanctions, and can serve to recruit women themselves into norms of gender inequality (Sen et al., 2006).

Each person's experience, interpretation of, and attitude towards norms depends on her or his own social location. "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 (Worth, 1989, Amaro, 1995, Campbell, 1995, Cohen and Burger, 2000). In Costa Rica, men, whose economic entitlements and social status are disturbed by changing social norms that support women's entry into the formal labour market, express more concern about "family breakdowns" than women or younger men (Chant, 2002).

However, not only do those who stand to gain from norms defend them, but those who are marginalised 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, stigmatise and violate them, and subordinate them within power relations. Why does this happen? A number of factors may be at work. Women may simply give in if they have no choice because sanctions are too strong, and submission may buy peace or even survival. This is especially true in areas involving physical mobility, sexuality or reproduction. Women may support oppressive norms because this gives them status despite being painful or dangerous. Danger and even degradation may be in the eyes of the beholder, not women themselves. This has been discovered to be true for female genital mutilation where women's beliefs are around cleanliness and purity rather than mutilation and disfigurement. Women may tolerate loss of control and agency because they trade this off against economic support especially if their 'fallback position' (Sen, 1990) is weak. This is often the case when they confront disrespectful health service providers (George et al., 2005, Govender and Penn-Kekana, 2007). Women submit to negative norms because it assures their integration into social networks that may be crucial to their own survival and that of their children. Some practices such as segregation during menstruation or post-partum, may actually give them much needed rest, although they may be stigmatizing, and may carry risks to health. Women may themselves internalize, believe in, and enforce the norms that relegate them to secondary and subordinate status; especially if they hold a promise of improvement in status with age. Women may support norms as an expression of defiance against the larger society or in solidarity with the community, as in the case of the *hijab* or *niqab* in Europe today (Sen et al., 2006).

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. Because of the nature of power and dissent, norms are not homogenous or hegemonic. The lived realities of subordinated and oppressed people and those at the margins, whose lives are both enriched and complicated by the intersections of class, race, gender or sexual orientation, throws up challenges to the beliefs and practices that enshrine power. Structural and systemic changes such as globalization, migration, conflict and technological change, by altering those lived realities, can set off seismic tremors in beliefs and behaviours catalysing or reinforcing challenges and rebellion. When significant numbers of people begin to challenge a norm, the public discourse about it begins to change.²³ Sometimes this generates a backlash from within existing power structures, together with attempts to return to the status quo ante (Faludi, 1992).

V.1.2 Gendered norms affecting health

Gendered norms in health manifest in households and communities on the basis of values and attitudes about the relative worth or importance of girls versus boys and men versus women; about who has responsibility for different household / community needs and roles; about masculinity and femininity; who has the right to make different decisions; who ensures that household /community order is maintained and deviance is appropriately sanctioned or punished; and who has final authority in relation to the inner world of the family /community and its outer relations with society (Quisumbing and Maluccio, 1999).

Gender biased values translate into practices and behaviour that affect people's daily lives, as well as key determinants of wellness and equity such as nutrition, hygiene, acknowledgement of health problems, health-seeking behaviour, and access to health services to the extent that the latter are in the hands of communities. 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. Many of these practices are, as can be seen, in the area of sexuality, biological reproduction and the life cycle.

The problem of so-called 'missing women' and worsening sex-ratios especially in parts of East and South Asia due to son-preference has been well documented (Sen, 1992b)The pressure to bear sons has led to increasing use of ultrasound technologies followed by second trimester abortions that can carry significant risks for the pregnant woman. Drastic declines in sex-ratios have resulted in kidnapping, forced marriages, and trafficking in girls and women. In South Asia these practices have worsened in recent decades with rising aspirations for consumption

²³ One can see this for instance with regard to reproductive tract infections (RTIs) – while medically well known, they were hardly recognized as worthy of policy attention until the late 1980s and 1990s; this attention came largely as a result of action by women's health and rights organizations. Similar recent cases with drastic implications for women's health include female genital mutilation, and violence against women by intimate partners and family members – long known, widely prevalent, but shrouded for too long in policy silence.

(linked to economic globalization and growth), and growing prevalence and intensification of dowry as a means to meet those aspirations. These pressures are superimposed on traditional marriage practices favouring girls marrying outside their own villages, and customs that reinforce the cutting of links to her natal family (Hudson and den Boer, 2004). In many societies, ironically, practices surrounding notions of purity and hygiene are often harmful to the health of girls and women including the management of menstrual hygiene, ritual segregation after childbirth, and the different gradations of female genital mutilation.

Almost everywhere, adolescence is the time when masculine and feminine roles are strongly defined, with boys being groomed for independence, strength and authority, while girls are trained to suppress their capacities and abilities. This is also the time when sexual roles are defined and inculcated. "These social norms and identities are internalized by young women and girls and translated into cultural practices and individual actions of those who should protect girls and young women (for example, by parents who may encourage or ignore early coerced sex, allow their daughters to establish relationships with much older men, or allow their daughters to be sold into sex work). These social norms create the conditions in which some young and adult men (in the family or outside of it) sexually abuse girls or use physical violence against them, the preference by some adult men for younger female sexual partners, and the practice of sexual coercion by too many men and boys against girls" (Barker, 2006).

Girls' mobility and activities are curbed and they are expected to learn to become submissive and dependent. They are also expected to become self-sacrificing in relation to other family members, especially husbands and children. Men in some societies are expected not to show emotion, or acknowledge their own health needs. These traits can and do translate into women suppressing, and families not acknowledging their health needs, and men not seeking health care. "The social expectations of what men and boys *should* and *should not* do and be directly affect attitudes and behaviours related to HIV/AIDS, sexual and reproductive health, gender-based violence and men's participation in child and maternal health" (Barker et al., in press).

Practices around sexuality sometimes include ritual (and painful) 'deflowering' of brides, and sanctioned marital rape. They are also among the most punitive of deviance from the social norm by women, subordinate castes / races, or LGBT people. At least since the UN conference on Human Rights in Vienna in 1993, honour killings and other forms of violence on the basis of sexuality are increasingly being recognized in the global arena.

Childbirth practices that affect the survival of infants and mothers are among those that have been most extensively documented, yet the links between maternal nutrition and well-being and infant survival have not yet been effectively translated into policy. Maternal mortality itself has been on a policy roller-coaster that has been impervious to multiple policy initiatives due to the power of gender norms (Sen et al., 2007a).

Widowhood, in many societies, is a time of greater impoverishment and weaker financial capacity to address health needs, along with other practices that may demean, or subordinate women (Chen et al., 2005). For example research in Kenya revealed significant violations of widows' human rights especially in HIV affected households, including through property grabbing and "customary practices of wife inheritance and ritual cleansing, the latter involving a short-term or one-time sexual liaison with a man paid to have sex with the widow to cleanse her of evil spirits thought to be associated with her husband's death (Human Rights Watch, 2003). In the last two cases, women are granted conditional access to their homes and property in exchange for enduring these practices – which often are conducted without condoms, presenting new risks for further spread of HIV" (ICRW, 2004).

Many of the norms and practices cited above are in the area of sexuality and reproduction within families and communities, but gendered norms affect health in other ways as well. Norms governing the division of labour, work-roles and occupations of women versus men result in different and differential exposures and vulnerabilities (as we discuss in the next sub-section of this report). Gender discrimination and biases affect access to health services and treatment as has been extensively documented (George, 2007b, Iyer, 2007). "Gender, interacting with poverty and other factors, directly affects how health systems and services are structured and organized and how and which individuals are able to access them" (Barker et al., in press). They also affect how health providers view and therefore treat women and their illnesses and health needs as detailed in the sub-section below on health systems and in Govender and Penn-Kekana (Govender and Penn-Kekana, 2007).

Norms around masculinity not only affect the health of girls and women but also of boys and men themselves. "Research with men and boys in various settings worldwide has shown how inequitable and rigid gender norms influence the way men interact with their intimate partners on a wide range of issues, including HIV/STI prevention, contraceptive use, physical violence (both against women and between men), domestic chores, parenting and men's health-seeking behaviours (Barker and Ricardo, 2005, Kimmel, 2000, Barker, 2000, Rivers and Aggleton, 1998, Kaufman et al., 1993, Marsiglio, 1988). Sample survey research using standardized attitude scales has found that adult and younger men who adhere to more rigid views about masculinity (e.g. believing that men need sex more than women, that men should dominate women, that women are "responsible" for domestic tasks, among others) are more likely to report having used violence against a partner, to have had a sexually transmitted infection, to have been arrested and to use substances (Courtenay, 1997). Similarly, a recent global systematic review of factors shaping young people's sexual behaviour (involving 268 qualitative studies published between 1990 and 2004, and covering all regions of the world) confirmed that gender stereotypes and differential expectations about what is appropriate sexual behaviour for boys compared to girls were key factors influencing the sexual behaviour of young people (Marston and King, 2006).

These and other studies affirm that both men and women are placed at risk by specific norms related to masculinity. 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. Men in some predominantly male institutions, such as police forces, the military or in prisons also face specific risks due to institutional cultures that may encourage domination and violence. In sum, prevailing notions of manhood often increase men's own vulnerability to injuries and other health risks and create risks for women and girls" (Barker et al., in press)²⁴.

V.2 Challenging gender stereotypes and how they affect health

Gender stereotypes are among the most resistant to change. Cook (Cook, 2007) argues that women's moral agency is often denied by health services; women's bodies are used instrumentally by societies and governments, and the neglect of women's health is a form discrimination against women that governments must remedy. This follows from General Recommendation 24 that was adopted by the CEDAW Committee in 1999 in order to "elaborate the Committee's understanding of article 12 and to address measures to eliminate discrimination in order to realize the right of women to the highest attainable standard of health."²⁵
([http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/CEDAW+General+recom.+24.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CEDAW+General+recom.+24.En?OpenDocument)).

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 panacea 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 organisations; (C) working with boys and men to transform masculinist values and behaviour that harm women's health and their own.*

²⁴ We are grateful to Gary Barker for permission to quote extensively from this report

²⁵ Article 12 of CEDAW requires that "States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning."

V.2.1 Create formal agreements, codes and laws to change norms that violate women's human rights, and implement/enforce them

The first requirement is to create alternative norms through laws along with international and regional agreements that challenge gender inequality and violations of women's human rights. This may be easier said than done, especially if there is powerful organised opposition to gender equality. The cardinal rule is that there must be local groups of advocates, especially women's organisations or human rights groups who can play a strong role. Usually, reform will take a long period of preparation especially if there is an organised conservative opposition that can use the threat of change as a way to mobilise fears on cultural, religious or masculinist grounds. *Support should be provided to local organisations for the long haul. In the meantime, capacity building among government officials, judges and parliamentarians can be valuable against the day when change can happen (Sen et al., 2006). Once laws are there, they need to be enforced and this requires the appropriate institutions and budgets assigned for this.*

Example: Nepal - Supreme Court ruling against *chhaupadi*

A milestone judicial change that has potential to influence policy in many sectors, including health, is the ruling in September 2005 by Nepal's Supreme Court (in response to public interest litigation) against the age-old custom of *chhaupadi*. The ruling directed the government within a short period to pass a law to outlaw the practice. This custom requires girls and women to stay in animal sheds away from people during their menstruation and childbirth, times when they are deemed to be "ritually polluting" and "dangerous" to the normal social order. The practice involves secluding women away for days, virtually leaving them to fend for themselves at potentially vulnerable times with significant risks of rape and attacks by wild animals. This practice is still widespread across the western part of the country, and realistically it could still be many years before it disappears completely. But over the last few years the work of advocacy and human rights groups has influenced this far-reaching judicial change. Recently the government formulated a draft of the 'Chhaupadi Elimination Directives 2064' to do away with the practice of chhaupadi in the Far-Western and Mid-Western Development Regions of the country. (The Himalayan Times, 2007)

Example: Change in Tunisia's Personal Status law

Changes in the personal status law in Tunisia began with a 1956 Personal Status Code, outlawing repudiation and polygamy, establishing a minimum age for the marriage of girls, and providing for equal wages for men and women. Further reforms in 1993 concerned the marriage of minors, the mutual obligations of husband and wife, and domestic violence. This legislation has brought about a profound change in the norms concerned with women's position in society and within marriage, characterized as moving "from sexual submission to voluntary commitment" (Labidi, 2001).

Example: Change in Pakistan's *Hudood* Ordinance.

According to the Human Rights Commission of Pakistan, there is a rape every two hours and a gang rape every eight hours in the country. The promulgation of the *Hudood* Ordinance in 1979 has to be seen in this context, and is generally recognised as a political ploy by President Zia ul Huq to win the favour of the fast-growing conservative political parties. The small but articulate women's movement together with the human rights movement in Pakistan has been struggling for change in a political situation made increasingly complicated by the wars in Afghanistan and Iraq. Their efforts have recently borne fruit with the passing by the National Assembly and the Upper House of the 2006 Protection of Women Bill, which transfers the jurisdiction over rape cases from sharia to civil courts. It also makes it easier for a woman to prove a rape allegation without being charged for adultery. Although consideration of the Bill had to be postponed earlier because of Islamist opposition, spearheaded by the Muttahida Majlis-e-Amal (MMA), an alliance of six fundamentalist parties, it has been signed into law (gulfnews.com, 2006).

Example: Egypt's divorce law revision 2000

In Egypt formal written marriage contracts came into force under the law of 1979 (the so-called Jihan Al-Sadat law) which gave the woman the basis for demanding her rights in case of divorce. Although the initial version of the law allowed the woman to ask for a divorce in the case of her husband's polygamous marriage, this came under attack by religious circles and was done away with in the revision of 1985. However an additional revision in 2000 gave a woman much wider rights to ask for divorce, allowing her to obtain divorce unilaterally provided she is willing to renounce her financial rights. This formally gave women similar rights to divorce as men in Egypt which thereby joined Tunisia, the only other Arab country to do this (Fargues, 2001). A remarkable combination of coalition politics, legal activism and an intelligent reclaiming of Islam by women's rights advocates made this possible.

Example: India's Protection of Women from Domestic Violence Act 2005

An example of poor formulation was the early draft in 2002 of India's Domestic Violence Bill, which left many loopholes including lack of recourse for a woman who may be thrown out onto the streets by a violent husband if she dares to challenge him using the law. As a result of strong lobbying by women's groups, and effective re-drafting by feminist lawyers, the draft was changed, and a considerably improved Act has recently come into force as the Protection of Women from Domestic Violence Act 2005. Both physical and verbal abuse can lead to charges, and the rules also ban husbands from harassing their wives for larger dowry payments. The Act uses a broad definition of violence to include beating, slapping, punching, forced sex, insults or name-calling. Preventing wives from taking up a job or forcing them to leave are also covered.

The Act allows abused women to complain directly to judges instead of police, who usually side with men and rarely act on complaints. Now, when a woman files a complaint the onus is on the man to prove that he did not abuse his wife. The law also ensures the woman's right to stay in the family home, regardless of whether or not she has any

title in the household. The Act covers not only wives and live-in partners, but sisters, mothers, mothers-in-law or any other female relation living with a violent man. As such, it is one of the most progressive pieces of legislation on this subject to date (Agnes, 2005).

Example: South Africa's abortion law

In 1997 the Termination of Pregnancy Act, the most liberal abortion law in Africa, took effect in South Africa. This law followed on the UN International Conference on Population and Development (Cairo, 1994) which inspired it in some ways. The process by which the Act was passed included a remarkable of wide consultation spearheaded by women's organisations and covering poor, rural communities to discover their needs and concerns. Although the Act faced conservative opposition, it received considerable support as well in the climate of emancipation and rights that existed in the country at that time.

However, passing a law is only the beginning of a process in many cases. Implementing it, especially when it runs counter to conservative gender norms can face many hurdles, as has been the experience of many countries. This is especially true when the constituencies of women who might benefit from the law are poor and low on voice and agency. Studies on the implementation of the law shows that legalization alone cannot ensure implementation of abortion services (Harrison et al., 2000) and other changes. Because of this, attention must be paid to the complexities and incentive structures that will ensure effective implementation. This is discussed later in this report in section IX.

V.2.2 Adopting multi-level strategies to changes norms including support for women's organisations

Multilevel and multisectoral strategies are necessary to change inequitable gender norms. The former imply working at different levels within a given sector, while the latter means integrated interventions across sectors. As norms guide human interactions, they reflect the values, agency and social contexts of the individuals who are subject to them and practise them. *Hence interventions that address gender norms must address the multiple levels and interacting dimensions through which human life is organised (personal, public, sectoral, informal, formal; values, agency and context).* Kim & Motsei in South Africa found that norms and values of health personnel regarding violence against women must be addressed through sensitising workshops, before technical guidelines could be effectively taught, as health personnel have lived experiences that exemplify and replicate gender biases (Kim and Motsei, 2002). Nonetheless, once sensitising workshops that address values at the personal level succeed, they need to be matched with broader organisational and structural change in order for the new norms to be sustained. Technical guidelines or information alone will not change behaviour if the values and social context of individuals are not changed.

The effectiveness of programs to change gender norms at the level of household and community requires simultaneous multilevel (downstream-midstream-upstream) programs designed to influence the underlying determinants of the problem, and to reinforce the rights of women and girls. Changes in policies can trigger changes in attitudes and norms in indirect ways. This approach is also supported by the work of Seguino (Seguino, 2005) who analysed three successive rounds of the *World Values Survey*²⁶ to test whether economic policies that permit women to take on paid employment and to control assets such as land can provoke changes in gender attitudes and norms. She found that “women’s economic empowerment is one factor (in the shift in attitudes towards greater gender equality), helped along by economic growth. Thus, it would appear that as the economic pie expands, there is less male resistance to female economic empowerment, even though relative economic standing is shifting in favour of women” (Seguino 2005:17).

One of the most thorough attempts to date to delineate a multi-level, and multi-sectoral strategy for an important manifestation of unequal gender norms is in WHO’s 2005 report based on a multi-country study of violence against women.

Example: WHO Report on Violence against Women (WHO, 2005a)

The 15 recommendations of the report are detailed below, and provide an excellent example for multi-level, multisectoral action. They include the following: 1) Promote gender equality and women’s human rights, 2) Establish, implement and monitor multisectoral action plans to address violence against women, 3) Enlist social, political, religious, and other leaders in speaking out against violence against women, 4) Enhance capacity and establish systems for data collection to monitor violence against women, and the attitudes and beliefs that perpetuate it, 5) Develop, implement and evaluate programmes aimed at primary prevention of intimate-partner violence and sexual violence, 6) Prioritise the prevention of child sexual abuse, 7) Integrate responses to IPV in existing HIV/AIDS prevention/adolescent health promotion programmes, 8) Make physical environments safer for women, 9) Make schools safe for girls, 10) Develop a comprehensive health sector response to the various impacts of violence against women, 11) Use reproductive health services as an entry point for identifying and supporting women in abusive relationships, and for delivering referral or support services, 12) Strengthen formal and informal support systems for women living with violence, 13) Sensitise legal and justice systems to the particular needs of women victims of violence, 14) Support research on the causes, consequences, and costs of violence against women and on effective prevention measures, and 15) Increase support to programmes to reduce and respond to violence against women.

²⁶ The World Values Survey asks a series of gender questions that span 79 countries and 3 waves, conducted over the period 1981 to 1997.

These recommendations are the result of detailed country-level processes of investigation and consultation and provide a template that awaits implementation. While no country has adopted them in toto, many have included some as our examples show. Some norms may not respond well to legal changes but may require societal intervention.

Example: Female Genital Mutilation (FGM)

WHO estimates that about 130 million girls and women in some 28 countries have undergone some form of FGM with the highest incidence found in parts of Africa. FGM is banned in 14 African countries, including Ethiopia, Uganda, Ghana and Togo, but the practice is still carried out. Girls may undergo FGM from as young as three years old depending on local rituals and customs.

FGM is based on deeply held ideals of feminine purity and beauty accompanied by beliefs that it ensures that women remain faithful to their husbands. Some communities consider girls 'unclean' and unmarriageable if they have not been circumcised but overall, the practices are based on gendered norms about women's inferior social status, patriarchal family structures, honour, prestige, religious beliefs, and beliefs about men's ownership of women who should be economically dependent on men. Certainly, strong gender disparities within society lead to violations of women's rights but FGM appears to be part of a dense social and cultural fabric, from which the tradition can be extracted only with some difficulty and against tremendous resistance.

There is evidence that FGM may belong to a class of practices that respond more readily to social change in gender norms than to legislation and policing. Legislation can lead to unintended consequences for women and further entrench adherence to the practice among communities where poverty, economic uncertainty, and social isolation threaten those who challenge those norms. Change appears to respond better to the crafting of community consensus. Multi-pronged education approaches have succeeded in changing attitudes and community-held norms in some cases. Examples of success include the Senegal project (spearheaded by the NGO Tostan) that is now a regional model endorsed by UNICEF. Its success involves public declaration of intent to abandon the practice; and slow but steady human rights education program which encourages villagers to make up their own minds about. The model is being adopted in Guinea, Burkina Faso, Mali and Somalia. In Burkina Faso, education of community members has led to support for those who become spokespeople for the cause by organising village and inter-village meetings and discussions on women's health and FGM – a form of social mobilization – through to encouraging decision makers, donors and NGOs to advocate for the abandonment of FGM practices. Effective programmes typically have the following features:

- including men in interventions which attempt to change attitudes;
- careful selection of the 'right' group leaders/facilitators for projects, and agreement on criteria for selection of participants;

- reproductive health and rights education classes that lift the taboo on talking about health problems associated with FGM;
- collaboration with the community to design an alternative rite of passage; and
- ensuring the focus of education is much wider than FGM to include rights, health and development.

Simply affirming a stand against FGM is inadequate without close empirical scrutiny of the local, national and international politics that surrounds FGM and efforts to stop its practice. Tactics such as providing alternative employment for the circumcisers or introducing alternative rites of passage have failed to make an impact without a comprehensive and multi-level approach to education, social mobilization and diffusion strategies to spread ideas and changed attitudes. Gruenbaum (Gruenbaum, 2001) argues that human and economic development, particularly women's economic autonomy, are necessary for creating propitious conditions for the abandonment of FGM (Keleher and Franklin, 2007).

In Egypt, where the less severe type 1 circumcision is practiced, estimates of the proportion of women circumcised range from 65% to almost 80% in community studies, but much higher in DHS (El Geneidy et al 1991 cited in Watts and Siddiqi, 2006, Wassif et al 1994 cited in Watts and Siddiqi, 2006, Egypt DHS 2000, Egypt DHS 2003, Egypt DHS, 2005). The practice is most widespread in poor rural areas and among illiterate families. Because of the widespread popular support for the practice, successful activities to end FGM now focus on community activities to transform the social conventions that support it. FGM-Free Village programmes in Egypt and Sudan stress non-judgmental community discussion and debate, involving both women and men, which gradually bring a formerly hidden topic into the open (Abdel-Hady, 1998, UNICEF, 2005a, UNICEF, 2005b).

Particularly when attempting to change norms that violate human rights but are subject to significant conservative (including conservative religious) 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. On this breeds misinformation as well as callousness and lack of public attention. One way that has been particularly used by women's organizations in such situations is to hold public tribunals with judges who have credibility. This helps to raise public awareness, build solidarity and reduce misinformation.

Example: Polish Tribunal on Abortion

"FROM 1956 until 1993, abortion in Poland was widely accessible on therapeutic and socioeconomic grounds. Terminations were performed free of charge in public hospitals, or could be obtained in private clinics for a relatively low fee. The 1993 Act on Family Planning, Human Embryo Protection and Conditions for Legal Pregnancy Termination, commonly known as the Polish Anti- Abortion Act, was adopted by the Polish Parliament following a systematic anti-abortion campaign by the Roman Catholic Church, supported by conservative political forces in the

Solidarity movement and many in the medical profession. The majority of Polish society was (and still is) pro-choice (65%), although mostly Catholic (95%), and at that time was not in favour of a restrictive law. However, civil society proved incapable of standing up publicly to enormous and persistent pressure from the Church and its beloved head – John Paul II – which was exercised on a daily basis in religious services, school religious instruction and the media, and through regular visits by the Pope.

On 25 July 2001 the Polish Federation for Women and Family Planning organised a Tribunal on Abortion Rights in Warsaw, to publicise the negative consequences of the criminalisation of abortion in Poland. A panel of Polish and foreign experts heard the testimonials of seven Polish women's experiences under the 1993 "Anti-Abortion Act". Only two of the seven women were able to tell their stories in person. One died in 2001, at the age of 21, of an unsafe abortion. One is legally blind after having carried her last pregnancy to term. One is in prison for infanticide, which in all likelihood was committed by her boyfriend. National and foreign journalists were in attendance, as well as observers from all walks of life – writers, students, mothers, activists, feminists, and husbands. The evidence was clear and compelling. Restrictive abortion laws make abortion unsafe by pushing it underground, endanger women's health, create a climate where even those services that are allowed by law become unavailable, and contravene standards set by international human rights law. The restrictive abortion law in Poland has not increased the number of births; it has only caused women and their families suffering. The Tribunal brought the issue of abortion into the media prior to an election campaign and galvanised Polish and other Eastern European women's groups to become more active in defence of abortion rights" (Girard and Nowicka, 2002). The controversy goes on with the ruling in March 2007 by the European Court of Human Rights in favour of a woman who challenged the country's abortion law as a violation of her right to privacy. This was the woman who suffered irreversible retinal damage and went blind as a result of being forced to carry her pregnancy to term against the advice of more than one medical expert. (Rosen Molina, 2007)

V.2.3 Working with boys and men for male transformation

One of the major innovative ideas of the Cairo and Beijing conferences was the concept of male responsibility for the health of their partners as well as of themselves and their children. Since then, there has been a steady forward movement in understanding and experimentation with programmes on the ground, as well as rethinking the ideas themselves. "The critical perspective that has led to calls for greater male involvement in sexual and reproductive health has often described men in rather negative terms. This "deficit model" of male roles does not effectively motivate people to take action of any sort... Clarifying the negative effects of gender norms on *men's* health and well-being and not just women's could facilitate the development and implementation of more visionary policies and more innovative implementation." (Greene et al., 2006)

Barker (Barker, 2006) argues that there are always some boys and men in each situation of gender inequity who will oppose inequitable norms. He argues that "it is precisely these "cracks", inconsistencies or performances of resistances to traditional views about manhood that offer entry points for intervention". A closer look at these rather special boys and men revealed that typically they had observed and reflected about the injustice of gendered norms and had received positive reinforcement from family members or others. "This formative research has provided several program implications: (1) the need to offer young men opportunities to interact with gender-equitable role models in their own community setting; and (2) the need to promote more gender-equitable attitudes in small group settings and in the greater community. This research also confirmed the need to intervene: (1) at the level of individual attitude and behaviour change, by engaging young men in a critical reflection to identify the costs of traditional versions of masculinity; and (2) at the level of social or community norms, including among parents, service providers and others that influence these individual attitudes and behaviours (Barker, 2006).

A literature review of 57 interventions with men and boys in the areas of SRH, MNCH, GBV, fatherhood and HIV/AIDS prevention that applied gender analysis for male transformation found that 53% of the programs were assessed as either promising or effective. Programmes that tackled gender norms – within messages, staff training, educational sessions and campaigns with men and boys – were even more likely to show an impact in changing attitudes and behaviour (Barker et al., in press). *"Emerging lessons from such programs that have explicitly addressed gender with such a ecological perspective point to the importance of (i) promoting critical reflections of gender and socialisation in educational activities, (ii) the creation of environments in which individual and group-level changes are supported by changes in social norms and institutions and (iii) broader alliance-building across government, civil society and local communities to contribute to and reinforce positive changes in norms around gender and sexuality"*²⁷.

Example: Program H

An innovative educational programme that was pioneered by Latin American NGOs and has now spread to parts of Asia and Latin America, Program H attempts to create a safe space in which young men can question manhood

²⁷ Barker (2006) identifies the challenges that beset this work at present. "Nonetheless, there are a number of challenges that remain:

- Almost none of the programs were longer term, following men and boys for more than two years, and nearly all have been relatively small-scale.
- Only a few of the interventions ask women and girls directly about how men and boys changed.
- Few of the programs go beyond measuring individual attitude and behavior change to assess changes in social institutions and practices (in the health sector, the public school, and other public institutions).
- Few if any of the programs have included cost data, that is an analysis of what it costs to achieve large scale change in social constructions of gender.
- Only a few programs have engaged men, boys, girls and women in a comprehensive, integrated approach that understands gender as relational.

... There is evidence of positive impact of efforts to engage men and boys in gender-based health inequalities. More evidence is needed, to be sure, and such programs have been mostly small-scale and short-term. But the evidence confirms that slow change among men is not inevitable, but neither is quick, lasting change easy to achieve in terms of gender norms and structures".

norms, and learn alternatives through group activities and processes. A highly visible part of the programme is social marketing involving the young men, to create positive messages about gender-sensitive men using youth culture. The 'cool' or 'hip' young man is portrayed as non-violent and sensitive by popular and well-known youth icons.

Example: Stepping Stones in South Africa

Stepping Stones is a behavioural intervention which approaches HIV prevention and reduction in violence against women from perspectives of gender issues, relationship and skills and broader reproductive health concerns (Jewkes et al., 2007). It uses participatory learning approaches to build knowledge of sexual health, awareness of risks and the consequences of risk taking and communication skills, and provide opportunities for facilitated self-reflection on sexual behaviour. Over the last decade, the intervention has been used in over 40 countries, adapted for at least 17 settings, and translated into 13 languages (Wallace, 2006). Stepping Stones have been subject to rigorous evaluation in South Africa and provides evidence of success in reducing sexually transmitted infections in women, changing men's sexual risk taking behaviour and reducing their use of violence against women (Jewkes et al., 2007).

VI. Differences in Exposure and Vulnerability

VI.1. What do we know?

This section reviews how 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.

VI.1.1. Mapping male-female differences in health

In a wide range of countries male survival at all ages is inferior to that of females and this is reflected in lower life expectancy for men. However, there are also a number of countries such as Bangladesh, Tonga, Afghanistan, Nepal, Malawi, Benin, Botswana, Cameroon, Central African Republic, Kenya, Niger, Nigeria, Pakistan, Qatar, Tuvalu and Zambia where women's life expectancy is lower, or equal to that of men (WHO, 2006b). Even where men die earlier than women, most studies on morbidity from both high- and low income countries show higher rates of illness among women. Thus, women's potential for greater longevity rarely results in their being or feeling healthier than men during their lifetimes (Östlin et al., 2001). This so-called 'gender paradox' (Danielsson and Lindberg, 2001) and the ways in which biological and social determinants interact to produce it have not yet been fully understood, but 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 2002²⁸ indicate that 68 out of the 126 health conditions and health risk factors have at least a 20% difference between women and men (Annex 3). Setting aside potential methodological biases or data discrepancies, these numbers suggest that male-female differences in health are widespread. One area where difference exists is health conditions and risks directly related to reproduction. When taking into consideration, HIV, reproductive infections and cancers, the Disability Adjusted Life Years (DALYs) lost by women are 1.22 times those for men. In terms of reproductive cancers alone, women lose seven times more DALYs than men. If women's morbidity, disability and mortality related to maternity, accounting for 42,173,635 DALYs, are added to this calculation, women experience 2.19 times more DALYs than men²⁹.

Other areas where women lose more DALYs than men, as indicated by female: male ratios³⁰, include those related to eye sight (trachoma, cataract, age-related vision disorders, glaucoma), migraine, mental health (post-traumatic stress disorder, panic disorder, unipolar depressive disorder, insomnia, obsessive compulsive disorder), muscle and bone strength (rheumatoid arthritis, osteoarthritis, other musculoskeletal disorders, multiple sclerosis), ageing (Alzheimer and other dementias), nutrition (other nutritional disorders, iron-deficiency anaemia, vitamin A deficiency) and burns.

Areas where men lose more DALYs than women, as indicated by male: female ratios, include those related to excess consumption (gout, alcohol use disorder, drug use disorder, lung cancer, mouth and oropharynx cancers, liver cancer, oesophagus cancer, stomach cancer, cirrhosis of the liver, ischemic heart disease, peptic ulcer disease), infectious diseases (lymphatic filariasis, hepatitis B, trypanosomiasis (sleeping sickness), tuberculosis, shistosomiasis, leprosy, leishmaniasis, ochocerciasis) and deaths or injuries caused by drowning, falls and road traffic accidents). In addition there are extreme consequences from violent individual or collective practices and behaviours (war, violence, other intentional injuries, poisoning, and self-inflicted injury).

VI.1.2. Understanding male-female differences in health

Some health conditions are determined primarily by biological sex differences³¹. 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 men³². However, many health conditions reflect a combination of biological sex differences and gendered social

²⁸ Master table (Annex 3) provided by Rachel Snow (2007)

²⁹ This does not include DALYs accounted for by perinatal conditions which are 1.18 times for male relative to female babies, or co-morbidities increased by pregnancy like anaemia, malaria, etc.

³⁰ These comparisons build on Snow's (2007) analysis

³¹ For example, haemophilia is expressed in men who have the recessive gene in their X chromosome. Some women can be carriers, but as they have two X chromosomes, the recessive gene is not expressed.

³² Examples are gendered health outcomes like violence against women (by definition targeted at women), road traffic accidents (disproportionately affecting men) and drowning whether during natural disasters (disproportionately affecting women) or due to fishing (disproportionately affecting men).

determinants. For example, not all women get cervical cancer, even though biologically all women have cervixes. Their risk of getting cervical cancer is heightened by social factors like number of sexual partners, male sexual behaviour (Bosch et al., 1996), smoking (Trimble et al., 2005) and poor diet (Brock et al., 1988). In the case of blindness, biological differences combine with social factors such as women's lesser access to eye care services and their care of children infected with trachoma to heighten female risk³³. In countries where women's mortality rate is higher or equal to that of men, differential female deprivation of extraordinary proportions may exist that wipes out women's biological survival advantage (Sen, 1992a).

Before analysing male-female differences in health by sex and gender, we will clarify how this report uses these terms. The previous sections already explain how gender acts as a social determinant. With respect to biological sex, this report refers to the anatomical and physiological characteristics derived from the sex karyotypes 46, XX female and 46, XY male³⁴. All biological differences between women and men are based on these sex chromosome based differences. These inherited sex chromosomes cannot change, but other aspects of biological sex (sex hormones, reproductive organs, other secondary characteristics) can and do change through an individual's lifecycle (puberty, menopause), through their actions (sex change, hormone therapies, exercise) and the environment to which they are exposed (environmental toxins). As biological research advances, so does our understanding of how our sex chromosomes affect not only secondary sex characteristics or hormonal differences but go even deeper as we see below. This makes it more complex but no less critical to research such differences in order to understand how they interact with social gender bias.

Understanding the roles that biological difference and social bias play is important to understanding differential exposure and vulnerability. *While individuals can have different biological and social exposures to health risks and conditions depending on both their sex karyotype and their social position, their vulnerability to health risks and conditions is determined socially, not biologically.* For instance although one's exposure to haemophilia is determined biologically, one's vulnerability to it is determined by access to good care through functioning health systems. Like people suffering from other diseases, haemophiliacs from marginalised social backgrounds are more vulnerable, with worse complications and survival rates, than those from more privileged social backgrounds (Soucie et al., 2000).

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. Within the context of HIV, Gruskin and Tarantola (Gruskin and

³³ The result is a 10-15% higher incidence of cataract in women attributed to a hypothesized sex-linked difference (see ABOU-GAREEB, I., LEWALLEN, S., BASSETT, K. & COURTRIGHT, P. (2001) Gender and blindness: a meta-analysis of population-based prevalence surveys. *Ophthalmic Epidemiol*, 8, 39-56, SNOW, R. (2007) Sex, Gender and Vulnerability. Paper commissioned by the Women and Gender Equity Knowledge Network.) and a 2.3-3 times higher risk of adult trachoma in women (see COURTRIGHT, P. & LEWALLEN, S. (2002) Sex, gender and blindness: eye diseases and use of eye care services. World health organisation, LEWALLEN, S. & COURTRIGHT, P. (2002) Gender and use of cataract surgical services in developing countries. *Bull World Health Organ*, 80, 300-3.)

³⁴ Of the 46 chromosomes each human being has, only one (XX versus XY) differentiates females from males.

Tarantola, 2001) define vulnerability as resulting “ from social, cultural, economic, political and other factors that determine the degree of risk of being exposed to infection, or deprived of access to treatment, care, and support once infected”. 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.

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. Female newborns are known to be protected by characteristics of their sex karyotype. The poorer survival of male versus female newborns, to the extent of a male excess of 35-50% for a range of respiratory-related conditions (Stevenson et al., 2000), is increasingly theorized to reflect an X chromosome-linked recessive allele (Mage and Donner, 2004), contributing to the “newborn male disadvantage” in low birth weight as well (Snow, 2007). While deaths in the neonatal period (one month) are largely a sequel to events during intra-uterine life, in some social contexts, high level of son preference can lead to neglect of female newborns, which carries over into infancy and early childhood (Arnold, 1997).

VI.1.3. Exposure and vulnerability due to both sex and gender

As women's biological sex differences from men are derived from their karyotype, they go beyond reproductive organs and other visible secondary characteristics. For example, women's sensitivity to chemical exposure is greater than men's due to sex differentials in absorption, metabolism and excretion of fat-soluble chemicals (Sims and Butter, 2002). With respect to anti-retroviral treatments, women are more prone to experience adverse events associated with mitochondrial toxicity, higher incidence of skin rash and liver toxicity and different profiles of lipodystrophy compared to men (Forum for Collaborative HIV Research, 2002).

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, is too narrow and overly medicalises the problem. It 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 (Snow, 2002).

Another example is depression - women are two to three times more likely than men to be diagnosed with depression (Ustun et al., 2004, Bhugra and Mastrogrianni, 2004, Desjarlais et al., 1995). Depression is also more

likely to be medicalised in women than men (Russo, 1990). While some research has linked reproductive events, like menstruation, pregnancy and menopause to women's higher rates of depression, this association has been contested. Women's experiences of depression often predate pregnancy or the onset of menopause (Piccinelli and Wilkinson, 2000, Bebbington, 1998). Social factors, like partner and social support, life events such as abuse during childhood and other victimization, the social experience of motherhood and infant temperament may play a more important role than biological factors (Astbury, 2002). The focus on (biological) reproductive causes of women's depression has led to the neglect of how non-reproductive morbidities like cardiovascular disease affect women's depression (Astbury, 2002). It also denies attention to how men may also suffer from depression following the birth of a child (Bielawska-Batorowicz and Kossakowska-Petrycka, 2006), and how they may experience an increased risk of depression in later life related to decreasing levels of testosterone with ageing (Orengo et al., 2004, Seidman and Walsh, 1999) and also possibly associated with life-stage changes such as retirement and loss of authority and power in society. Similarly to the example of depression, women experience more reproductive health problems than men, but not all their reproductive health concerns and associated illnesses are biologically determined. Besides, men also have reproductive or other health problems that can be both biological and social.

The gendered nature of family life leads to starkly different vulnerabilities to mental illness for women and men. For women in low-income communities in Syria, mental illness is commonly associated with spousal violence, with having many children, with illiteracy, financial insecurity and lack of control over their own income (Ahmadi, 2007, Maziak, 2002). In Iran, up to 80% of those who committed suicide or who attempted suicide were women, mostly of reproductive age. Marital conflict and quarrels with relatives were found to be the major motivations for suicide attempts (Ahmadi, 2007, Groohi et al., 2006, Zarghami and Khalilian, 2002, Mohammadi et al., 2005).

The importance of differentiating between exposures (that can be both biological and social) and vulnerability that is socially determined is further underscored through the following examples referring to malaria, tuberculosis and HIV. These infectious diseases have been targeted by the Millennium Development Goals and have important gender components.

With malaria, pregnancy increases women's susceptibility by compromising their immunity (Rogerson et al., 2007, Shulman and Dorman, 2003), making them the main adult risk group in most malaria endemic areas (WHO/UNICEF, 2003). Despite this biological difference that increases their exposure, their vulnerability to malaria and its effects on pregnancy is predicated on a range of socially determined factors: access to malaria treatment during antenatal care; access to environments that protect against mosquitoes (bed nets, removal of stagnating water); good nutrition; and monitoring and treatment for anaemia, a complication of malaria during pregnancy. Because these social factors are not well addressed, even pregnant women residing in areas of low or unstable malaria transmission have two or

three times higher risk of developing severe disease as a result of malaria infection than other non-pregnant adults residents (WHO/UNICEF, 2003), with poor pregnant women being the most vulnerable.

For tuberculosis, *notification* rates are higher for males at all ages except in childhood, when they are higher in females. The reason why this is so is still poorly understood. Some male-female differences are explained partly by biological differences (women are less likely to present with a 'productive cough' or test positive through sputum microscopy than men), and also by gender differences in access to care (women may have less access to qualified health providers and TB treatment centres, or experience greater delays in seeking care), and gender differences in stigma influencing health seeking (women's marriage prospects and marriage security are threatened more than men's), while men's concerns are linked to loss of income and economic hardship (Thorson, 2002, WHO, 2002a).

In terms of disease progression, for women there are important biological factors. Similarly to malaria, tuberculosis increases poor health outcomes during pregnancy for both mother and child. Obstetric morbidity increases fourfold for pregnant women who have a late diagnosis of tuberculosis. Pulmonary tuberculosis increases the risk of premature and low birth weight in neonates twofold and the risk of perinatal deaths between three and sixfold. Genital tuberculosis in women commonly causes infertility, which is difficult to treat and persists even after TB is treated (WHO, 2002a). For men, however, it is gendered behaviour in the form of smoking that influences disease progression. The male: female ratio in disease progression in a study population in south India reduced from 2.7 to 1.2 after excluding the men who were smokers and alcoholics (WHO, 2002a). An ecological study estimates that one-third of the gender differential in tuberculosis may be explained by male smoking (Watkins and Plant, 2006).

According to the most recent statistics (UNAIDS, 2006), out of 34 million adults (15+) living with HIV/AIDS 17.3 million are women. The sex differences in adult HIV prevalence rates vary by region, reflecting different dominant modes of transmission and their social determinants. In sub-Saharan Africa, North Africa and the Middle East, and the Caribbean, the dominant mode of transmission is through heterosexual intercourse and there are more female than male HIV positive adults. In sub-Saharan Africa, 59 per cent of adults with HIV are women, and young women aged 15 to 24 are more than three times as likely to be infected as young men.

In unprotected heterosexual intercourse, females are about twice as likely as males to contract HIV from an infected partner³⁵. The biological factors involved include: the nature of vaginal mucous membranes and reproductive life cycles (Forrest, 1991); the infectiveness of semen (UNAIDS, 1999); and women's higher rates of sexually transmitted infections (STIs). Most significant, in the context of HIV, are the power relations that influence sexual behaviour and constrain health seeking behaviour and social support. Increasingly, men at risk of HIV have been initiating sex with younger and younger female partners, and this places young girls at increasing risk (Brown et al., 2001a).

³⁵ http://www.unaids.org/en/Issues/Affected_communities/women.asp
accessed 9 April 2007-04-09

Heterosexual norms often reflect double standards for men and women in terms of awareness and agency. Heterosexual women are often stigmatized as 'sluts' or 'loose women' for daring to be aware about safe sex or attempting to negotiate safe sex, with social norms condoning violence against them as a means to discipline deviance. Dominant sexual norms for men encourage promiscuity, neglect poor or non-existent condom use and sanction violence against women and non-conforming minority men (WHO, 2003c, UNAIDS/UNFPA/UNIFEM, 2004, Rao Gupta et al., 1996) .

At a policy level, women are also more vulnerable to HIV due to the conservative hierarchy of policy options that does not acknowledge women's realities or rights. An emphasis on abstinence and being faithful (the dominant emphasis of the ABC approach) fails to recognise that for many women being married and faithful, in monogamous and especially in polygamous marriages, is their biggest risk factor for HIV, especially when their male partners refuse to use condoms (Kelly, 2006). Developing female controlled methods of prevention has received limited support, in contrast to the recent enthusiasm with which male circumcision is being endorsed.

Ending maternal mortality and morbidity, and girls' and women's vulnerability to HIV/AIDS, require significant, sustained policy and program investment to address the social determinants common to both. These include work to end rape, sexual coercion, and violence against women (VAW inhibits women/girls from negotiating safe sex, or contraception, and can increase HIV transmission risk); multiple actions against child marriage; youth programs that help young people develop attitudes and skills for relationships based on gender equality, mutual respect, and human rights; and subsidies for female condoms and increased investment in R&D for safe and effective female-controlled microbicides.

These examples show that, although biological sex combined with gender contributes to differential health exposures for women and men, social determinants play a crucial role in determining their vulnerability at individual, community, programme and policy levels. The role of gender is further highlighted in the next section.

VI.1.4. Exposure and vulnerability due primarily to gender

This section reviews health risks and conditions that are determined primarily by gender biases. It starts with health outcomes closely identified with gendered identities, like violence against women, road traffic accidents, and smoking, and concludes with a discussion of broader areas like occupational health. *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* (Snow, 2007).

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. Males outnumber women for every category of road injury victim, whether

pedestrians, vehicle occupants, drivers and cyclists³⁶. Overall higher male risk is explained by greater exposure to driving, and in particular riskier forms of driving³⁷. Males are not only more likely than females to drive after they have been drinking (Stoduto, Adlaf et al. 1998), but when simulated driving was evaluated among 18-year-olds who had their blood alcohol raised experimentally, girls drove more cautiously as they got drunker, while boys became more reckless (Snow, 2007, Oei and Kerschbaumer, 1990).

Violence against women is another consequence of macho male behaviour and the epitome of unequal power relationships between women and men (Garcia-Moreno, 2002). It includes domestic violence, trafficking of women, and forms of violence linked to traditions that are specific to certain countries, such as sex selective abortion, female infanticide, the deliberate neglect of girls, rape in war, dowry-related deaths, female genital mutilation, and honour killings. While causes of violence are multiple and interlinked, gender inequality and norms of masculine behaviours that sanction violence poverty, low education, alcohol consumption and a history of witnessing abuse and prior victimization are among those most commonly documented (Jewkes, 2002). Risk of violence is greatest in societies with accepted codes of social conduct that condone and even reward violence against women.

The health consequences of violence against women are many: death and injuries ranging from cuts, bruises to permanent disabilities, STIs, HIV infection and AIDS, unwanted pregnancy, gynaecological problems, miscarriage, stillbirth, chronic pelvic pain and pelvic inflammatory disease, depression, post-traumatic disorder, just to mention a few (WHO, 2005b, ARROW, 2005, Campbell, 2002, Astbury, 2002, Gielen et al., 2000, Coker et al., 2000, Letourneau et al., 1999). Yet violence against women has only recently been recognized as a legitimate concern for societies³⁸. ARROW noted that only two out of eight countries in the Asian region (Cambodia and Malaysia) had ever had a national prevalence survey on domestic violence, let alone put prevention strategies in place (ARROW, 2005).

³⁶ Males in Pakistan were observed to be significantly more likely than females to jump off a moving buss (43% vs. 1.6%), get on a moving bus (49% vs. 12%) and run after a bus (45% vs. 8%) in the midst of heavy urban traffic WHO (2002c) WHO factsheet Gender and Road Traffic Accidents. Geneva, World Health Organisation

³⁷ In the USA, when higher male exposure to driving was controlled for, their higher involvement in crashes disappears, however this did not hold for male involvement in *fatal crashes*. The excess risk for fatal crashes among males is especially dramatic among the youngest drivers, and largely attributed to speed and alcohol (see ODERO, W. (1998) Alcohol-related road traffic injuries in Eldoret, Kenya. *East African Medical Journal*, 75, 708-711, MAIO, R., WALLER, F., BLOW, F., HILL, E. & SINGER, K. (1997) Alcohol abuse/dependence in motor vehicle crash victims presenting to the emergency department. *Academic Emergency Medicine* 4, 256-262, MMWR (1994) MMWR – Morbidity and Mortality Weekly Report. US Department of Health and Human Services, (June 1994) .

³⁸ Emerging evidence from all over the world suggests that its magnitude and severity of health consequences qualify for being recognized as one of the most important public health issues of our time (see WATTS, C. & ZIMMERMAN, C. (2002) Violence against women: global scope and magnitude. *Lancet*, 359, 1232-7. Recent findings from the WHO Multi-country Study on women's health and domestic violence, conducted in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and Tanzania, found that the reported lifetime prevalence of physical or sexual partner violence, or both, varied from 15%-71% with two sites having a prevalence of less than 25%, seven between 25%-50%, and six between 50%-75%. Between 4% and 54% of respondents reported physical or sexual partner violence, or both, in past year (see GARCIA-MORENO, C., JANSEN, H. A., ELLSBERG, M., HEISE, L. & WATTS, C. H. (2006b) Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *Lancet*, 368, 1260-9.

Globally 47% of men and 11% of women are currently smokers (Jha et al., 2002). Nonetheless, ill-health as a result of smoking is shifting away from men towards women³⁹. With considerable gendered marketing by the cigarette companies⁴⁰, smoking is seen as both an emancipatory and coping strategy for women and this gender shift is most notable among the young. Recent global survey findings found that despite site variations, among adolescents aged 13 to 15; young girls are smoking almost as much as young boys and use non cigarette tobacco products (spit tobacco, bidis, and water pipes) at similar rates. Future projections of tobacco-related deaths must consider these changing gender trends in smoking (Snow, 2007, WHO, 2003b).

The workplace is a critical arena determining gendered health differentials. The gendered division of labour, exemplified 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 regime⁴¹. These factors negatively affect women's social position relative to men's and the resulting inequalities contribute to gender inequalities in health (Messing and Östlin, 2006, Östlin, 2002a, Östlin, 2002b).

In terms of health hazards in the workplace, both in high and low income countries, work related fatalities are more common among men, due to the fact that men work in environments with greater risk for accidents, e.g. transportation, mining, fishing and fire fighting (Laflamme and Eilert-Petersson, 2001, Islam et al., 2001). In addition, men in high-income countries report more exposure than women to noise, vibrations, extreme temperatures, chemicals and lifting heavy weights (Paoli and Merlié, 2001). 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 (Messing, 2004, Östlin, 2002a, Östlin, 2002b). For example, women are the majority of those involved in lower levels of health care, which involves higher risks of infection (from biological agents in hospitals, needle injuries), violence, musculoskeletal injuries and burnout (WHO, 2002b, Mayhew, 2003, Aiken et al., 2002, Josephson et al., 1997).

The few studies that exist for developing countries show that, for example, in *maquiladoras*⁴² in Latin America, women are exposed to chemicals, ergonomic hazards, noise and stress (Cedillo Becerril et al., 1997). 17% of women had a cumulative trauma disorder diagnosed on physical examination (Meservy et al., 1997), with almost twice as

³⁹ There are differences in the biology of male and female lungs, such that an equivalent exposure to nicotine does greater damage to the female. This underlying sex difference in vulnerability may contribute to the convergence of lung cancer rates (i.e. more cancer for less smoke among women), but changes in smoking patterns account for the majority of the convergence (Snow 2007).

⁴⁰ For example, Virginia Slim's ad targeting the emancipated woman... *You've come a long way baby!*

⁴¹ Messing and Östlin found that women in general face unequal hiring standards, unequal opportunities for training, unequal pay for equal work, unequal access to productive resources, segregation and concentration in female sectors and occupations, different physical and mental working conditions, unequal participation in economic decisions-making, and unequal promotion prospects (see MESSING, K. & ÖSTLIN, P. (2006) Gender Equality, work and health: a review of the evidence. World Health Organisation.)

⁴² A maquiladora (or maquila) is a factory that imports materials and equipment on a duty-free and tariff-free basis for assembly or manufacturing and then re-exports the assembled product usually back to the originating country.

many women as men reporting such disorders. Where access to safe water and sanitation does not exist, women are at higher risk of water borne diseases when washing laundry and utensils in affected canals (Watts, 2004). Women cooking on open stoves not only are at risk of burns, but are at high risk of illness due to smoke pollution, as was found in India (Mishra et al., 1999) and Guatemala (Albalak et al., 2001). In developing countries, nearly 2 million poor women and children die annually from exposure to indoor air pollution caused by smoke from cooking fuels. Many more suffer from acute and chronic respiratory infection (Smith and Maeusezahl-Feuz, 2004).

VI.2. Reducing the health risks of being women and men

Conventional public health perspectives categorise health conditions by specific diseases⁴³, hazards⁴⁴ or functions⁴⁵. Other approaches (Goldman and Hatch, 2000, Sen et al., 2002) provide a gender analysis using this categorisation⁴⁶. In this report, rather than undertaking a gender analysis of each public health category, we directly focus on the biological and social risks of being female and male within the arena of health. Both approaches are complementary, but the latter enables us to highlight key messages about tackling differential exposures and vulnerabilities without having to specify actions for every health condition. This section of the report makes recommendations to reduce gendered vulnerability along three dimensions: meeting differential and specific health needs for both women and men; addressing social biases that heighten vulnerability to negative health outcomes; tackling the social causes of individual behaviours that may be risky or unhealthy; and empowering individuals and communities through positive messages and examples of effective actions.

VI.2.1 Meeting differential health needs

As mentioned in the previous section, gender differentials 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.*

One of the most visible differences between women's and men's health needs is in the sphere of reproduction. Donor commitments to the ICPD agenda have not been met consistently (UNFPA, 2004) The Millennium Development Goals did not originally include a general target for reproductive health (Campbell-White et al., 2006). Despite the obviousness of women's maternal health needs, and its positive linkages to neonatal health outcomes (Sen et al.,

⁴³ E.g. infectious diseases or chronic health conditions

⁴⁴ E.g. occupational or environmental

⁴⁵ E.g. mental or reproductive

⁴⁶ Chapters in Sen et al. 2002 include infectious diseases, reproductive health, mental health, violence against women, environmental health, occupational health, osteoporosis, along with a discussion of cross-cutting themes, like priority setting, social determinants, economic and health sector reforms.

2007a), this has not been matched by concomitant policy attention, financing, programmes or services. The consequences of not responding to women's reproductive health needs can be fatal, marked by thousands of women who die each year from the lack of safe abortion and emergency obstetric services.

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 (Razum et al., 1999). This was clearly a retrograde measure; it would have been far better for single German women if the west had followed the example of the east in this regard.

Providing basic maternal health care and reducing maternal deaths and morbidity is neither costly, nor very complex. The World Bank estimates that if all women had access to interventions that address complications of pregnancy and childbirth, especially emergency obstetric care, 74 percent of maternal deaths could be averted (Ramana, 2003). The interventions exist but they need political will and mobilisation that supports sustained policy attention, programme funding and service delivery expansion to ensure their implementation (Jahan, in press, van Lerberghe and de Brouwere, 2001).

Example: Reduction in maternal mortality in Bangladesh, Malaysia, Sri Lanka and China

In 1996-98, with sustained pressure and input from civil society, as well as donors, Bangladesh redesigned its national population policy to become a reproductive health policy and gave their first significant attention to building essential obstetric care capacity. Maternal mortality began to fall in the next five years (Jahan, in press, Jahan, 2003, Jahan and Germain, 2004). Similar rapid declines have been seen in Malaysia and Sri Lanka (UNFPA, 2005) A recent evaluation of the Health VIII project in China, shows a 40% overall reduction in maternal mortality (from 131.5 to 68.2 deaths per 100,000 live births) between 1998 and 2005 in the 71 counties where the project was implemented (LIU et al., 2007). This remarkable reduction in MMR was mainly attributable to the comprehensive measures undertaken in the project counties to transform health systems through increasing awareness and influencing attitudes about maternity care; improving services by investing in buildings and equipment; establishing rules and guidelines for strengthening obstetric services; investments in training health workers and strengthening supervision; cleaned and improved maternity wards, provision of free food to patients; provision of kitchens and

cooking utensils for family members; and establishing supervision and monitoring procedures to identify and correct problems. In addition, the counties reviewed all maternal deaths to identify failures to be corrected.

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. While important gains have been made in expanding services for breast cancer especially in higher income countries, more needs to be done in terms of research and interventions to address neglected issues like cervical cancer, obstetric fistula and technologies that address women's specific needs like improved abortion methods and female controlled HIV protection through female condoms as well as microbicides.

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. Treatment guidelines must be reviewed to ensure that they are sensitive to male-female differences in symptoms as demonstrated with tuberculosis (Thorson et al., 2007), HIV (Bates et al., 2004), and cardiovascular disease (Huxley, 2007). Further research is required to understand the extent and nature of such differences. For instance, women appear to progress at the same rate as men from HIV to AIDS, but they do so with lower viral load levels than men (Sterling et al., 2001). Although current guidelines about when to start treatment are primarily based on CD4 cell counts, if viral load is also considered, women's access to treatment would be delayed (Napravnik et al., 2002). There are also differences in the side effects experienced from antiretrovirals (Pernerstorfer-Schoen et al., 2001, Carr and Cooper, 2000). Taking into consideration these female-male differences is critical to ensure effective treatment even as efforts to expand access to medicines and roll out the services for anti-retroviral treatment are augmented.

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. Some examples include the following. Policies and actions need to ensure adequate rest and toilet breaks together with sufficient numbers of toilets with provisions to maintain hygiene during menstruation, resting and breastfeeding areas especially for pregnant and nursing mothers, and clean crèche facilities. Tools and equipment used in both paid and unpaid work need to be adapted ergonomically to suit male and female physiques if women are not to be excluded from heavier but better paying occupations. Legislation that restricts women's occupational opportunities by barring them from work that has toxic hazards must be reviewed. Rather than barring women, they must address the working conditions that make the environment unsafe for both women and men. Moreover, occupational health compensation schemes must ensure that they do not exclude women sex-specific health conditions (Messing and Östlin, 2006, Östlin, 2002a, Östlin, 2002b). Public health policies must address these sex-specific needs not only to improve health outcomes, but also

to advance social equality. For instance, legislation that discriminates against women due to maternity must be reviewed, and insurance schemes must include maternity coverage. Furthermore employment policies must provide measures that encourage more equitable sharing between men and women of child and elderly care leave (George, 2007b).

VI.2.2. Tackling social bias

This section gives some examples of the kinds of specific social biases that need to be tackled in addressing gaps in women's health and gender inequalities in health. We then discuss two intertwined strategies to address social bias: tackling the social context of individual behaviour, and empowering individuals and communities for positive change.

"Where there is no plausible biological reason for differential outcomes, social discrimination should be considered a prime suspect for causing unreasonable health outcomes" (Sen et al. 2002). 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. An example of discrimination cutting across race and economic class groups is from the state of Mississippi in the US. In 2004 the state elected a Governor who pledged to cut Medicaid (which pays health costs for the poor) and not to raise taxes on tax-payers. As a result, access by the poor to health services has declined in a variety of ways, including shorter hours when health centres are open, and longer distances to travel to reach services without easy public transport. Consequently, enrolment in Medicaid and children's health insurance has declined by 54,000 in 2005 and 2006⁴⁷ (Eckholm, 2007). One outcome is that the average infant mortality rate among African Americans in the state rose from an average of 14 to 17 per 1000 in 2005. However there is one county in the state – Sharkey county – where the IMR has held at 5 from 1991 to 2005 even though the county is quite poor. Although this has not been investigated closely, the low IMR in this county is believed to be due to an intensive home-visit system run by a non-governmental organization, the Cary Centre. This, coupled with special buses that enable women to attend pre and post-natal sessions, has made it possible for the IMR to remain much lower than the state average.

Apart from reinstating support services that enable poor women to 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 required. Domestic work needs to be acknowledged as work, even if not always remunerated. The occupational risks entailed and support required in carrying out family responsibilities and domestic work, including raising children, and caring for the sick, disabled or elderly need to be recognized and addressed. Family leave policies must mandate that men share these responsibilities with women. Social insurance

⁴⁷ Renewal of Medicaid coverage has been made much more difficult as it now requires face-to-face meetings, with fewer office timing and location and more stringent documentation required. Access to clinics has reduced due to the lack of transport for the poor and fewer clinic days offering less services.

systems must ensure that even those who may not have had formally recognized and remunerated occupations are also protected when not working or ill. These recommendations dovetail with ILO's efforts to promote 'decent work'⁴⁸.

At the same time, policy measures that encourage equal health outcomes must not compromise gender equality. For example, efforts to address skewed sex ratios in South Asia, must not infringe on women's rights to safe abortion. Policy interventions must tackle the gender discrimination that affirms son preference. Photo campaigns that highlight the consequences of son preference on women, marriage patterns and family structures is an important start in broadening the debate about the social determinants fuelling the skewed sex ratio in South Asia⁴⁹ (Nidadavolu and Bracken, 2006).

VI.2.2.1 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 programmes 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 (Osler et al., 2001, Bobak et al., 2000).

In the absence of 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 (Stronks et al., 1996, Kabeer, 1994). For example, working women may be offered help to reduce harmful stress by developing their own personal coping strategies to balance competing gender roles as mothers, wives, housekeepers and workers. To ensure that targeted women do not feel accused and ashamed for not being able to cope with their multiple responsibilities, *complementary measures to ease women's burden, such as the universal provision of accessible and affordable day-care centres for children, and the introduction of more flexible working hours, should also be introduced (Östlin et al., 2006). Moreover, measures should be taken for more equal sharing of family responsibilities between men and women, and ensuring that women do not have to add to their existing tasks even more responsibilities such as are involved in managing day care selection, schedules and "taxi services".*

Similarly, many men may experience extraordinary pressures from unemployment and material hardship, which constrain their ability to fulfil their assigned gender role as "breadwinners" (Moller-Leimkuhler, 2004). Those who try to cope with stresses through behaviours, such as smoking, drinking, aggressive driving or drug abuse, are accused

⁴⁸ By providing opportunities for work that is productive and delivers a fair income, security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns, organize and participate in the decisions that affect their lives and equality of opportunity and treatment for all women and men. (ILO Website on Decent Work <http://www.ilo.org/public/english/bureau/integration/decent/index.htm>)

⁴⁹ Photos by Ruhani Kaur http://www.voices-unabridged.org/liste_slideshow.php

of risking their health by their own personal choice. *Strategies that aim at changing the life-styles of these men would be more effective if combined with measures that could tackle the negative social and economic circumstances (e.g. unemployment, sudden income lost) in which the health damaging life-styles are embedded* (Östlin et al., 2006). Socially learned risk behaviours play a substantial role in explaining men's lower life expectancy. Men are more prone to smoking, drinking and violence and less likely to have positive social networks that enable them to cope with life changes in a positive manner. Nonetheless, men's vulnerability cannot be seen in isolation from their race and class relations with other men, their gender relations with women, their sexual relations with other individuals or their situation of relative privilege. *Appropriate policy responses must address men's vulnerability through interventions aimed at achieving more equitable power relations.*

With respect to HIV, various structural determinants linking poverty, gender and migration, affect the underlying vulnerability of individuals (Parker and Camargo, 2000). For example, there is ample evidence to suggest that suppressed immune systems that result from poverty and exposure to malaria and parasitic infections among populations in Africa help to explain much of the global disparity in HIV/AIDS prevalence. Yet prevention strategies do not focus sufficiently on these, preferring rather to address individual risk behaviours related to sexuality and drug use. In the case of women, such strategies focus on teaching women to refuse sex or initiate condom use. While there is a definite value to these individual-oriented strategies, it has also to be recognised that, within the context of unequal gender power relation, they may serve as triggers for violence against women, even as they operate as core pillars of HIV prevention efforts (Rao Gupta, 2002). Recognising these contradictions has led to some innovative efforts to address the structural roots of gender inequality that make women vulnerable to HIV.

Example: Combining women's access to micro-credit with empowering awareness sessions in South Africa

In South Africa, combining micro-credit with gender and HIV awareness sessions into an integrated packaged for women resulted in a 55% reduction in intimate partner violence over two years (Pronyk et al., 2006). Collaborative partners included the NGO sector (Small Enterprise Foundation and ADAPT), Northern and Southern academic institutions (the London School of Hygiene and Tropical Medicine and the University of the Witwatersrand) and the national government (South African National Department of Health). Important social mobilisation efforts were carried out, including setting up village rape and crime committees in association with the police; HIV education sessions in local schools, churches, burial societies, soccer clubs and taxi ranks; and protests to improve local health clinics and against local bars serving alcohol to young men. As a result, household communication between partners and children improved and traditional gender-biased norms were challenged among programme participants (Pronyk et al., 2005). Nonetheless, more time might be required for such changes to impact on sexual behaviour of other household members or a reduction in HIV incidence in the community, as little effect was found on these parameters during the short period under evaluation (Pronyk, Hargreaves et al. 2006).

Example: Addressing women's legal rights in Africa

In sub-Saharan Africa, women's legal rights, for example, in terms of property and inheritance are important in enabling them to manage the strains of being heads of households and primary caregivers for those living with HIV. Preliminary evidence also highlights legal rights as a protective measure reducing women's vulnerability to HIV risk factors by supporting their economic security and empowerment (ICRW, 2004). Legislative reform in terms of developing and implementing laws that protect women's land and property rights and in terms of reviewing and repealing discriminatory laws is imperative. In addition, efforts must address judicial capacity to favourably interpret and use such laws and awareness among women about their legal rights (ICRW, 2004).

The Women's Legal Aid Centre in Tanzania raises awareness among women about how to acquire, dispose of and mortgage land, to have title deeds of land owned and to participate in land-related decision-making, while providing legal aid services. In addition, the Centre provides training to police, magistrates and judges about women's rights to property (ICRW, 2004). More broadly, the International Commission of Jurists in Kenya, on the basis of an investigation revealing the extent of bias against women in family law, successfully lobbied for and established a Family Division within the High Court of Kenya to focus on arbitration of divorce, maintenance and family property, and to undertake training to correct gender bias within the judicial system. Subsequent efforts have focussed on using CEDAW as a guiding instrument in judicial practice as an effort to align national policy with international human rights standards (ICRW, 2004).

In summary, these examples indicate the need to look at individual behaviour 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. They must be involved in the training of health, social and legal aid workers so that the interventions they manage do not further victimise individuals most at risk. Information campaigns must address their world views, their concerns about side-effects and provide positive steps that empower them to change their lives, as discussed in the next section.

VI.2.2.2. 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.* Campaigns based on blaming individuals for risk behaviour or scaring individuals about the health risks have, in the case of HIV, led to increased stigma and discrimination, defiance against behaviour change efforts, and decreased access to health care (Brown et al., 2001b).

In Scotland, efforts to help low income women give up smoking included local conferences, women-centred support groups, peer education, assertiveness and other training programmes, breaks away and other 'fun' activities

(Crossan and Amos, 1994). In inner city Baltimore, USA, churches involved African American women aged 40 in the 'Heart, Body and Soul' programme targeting food preparation and exercise, along with health education information, singing and discussion. As a result, cardiovascular heart disease risk factors were reduced and overall well being improved (Yanek et al., 2000).

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. Labour legislation that is gender responsive needs to be formulated and extended to all groups, including those working in the informal sector, on a part-time basis or from their homes. If already existing, such legislation must be monitored and enforced to ensure gender equity outcomes.

In another example, although media images portray women as victims of natural disasters, they can be a vital part of disaster mitigation and response efforts (Enarson, 2000, Shrader and Delaney, 2000, Wiest et al., 1995). Following Hurricane Mitch in 1998, women in Guatemala and Honduras, were seen building houses, digging wells and ditches, changing social norms of what women could do. After the 1985 earthquake in Mexico City, women maquiladora workers organized into the '19 de Septiembre Garment Worker's Union' which was crucial in gaining back their employment. In response to increased gender based violence in Nicaragua following Hurricane Mitch, an NGO launched a campaign with the powerful and effective message, "Violence against women is one disaster that men can prevent."

With respect to maternal mortality, while documenting deaths and the missed opportunities that failed to save women's lives is important, disempowered communities respond to positive case studies that reflect their own efforts to change their realities (WHO, 2004). In Karnataka, south India, documenting maternal deaths highlighted the structural gaps at multiple levels that allowed such injustice to continue (George et al., 2005). Subsequent efforts through a systematic public campaign that mobilised village communities and local health personnel to begin taking responsibility for women's health and rights resulted in women surviving as 'near miss' cases rather than dying. Demonstrating how community engagement could yield positive results proved essential in overcoming fatalism about the inevitability of maternal deaths.

In order to translate alternative gender messages and policy efforts into action, they 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 perspective⁵⁰. They have also been used to challenge male norms on violence against women (e.g. Coaching Boys into Men – Family Violence Prevention

⁵⁰ <http://www.menshealth.com> and <http://www.emhf.org>, <http://www.mhfs.org.uk/mhfs/research.php>

Fund). 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'.

Example: The Soul city intervention in South Africa

The Soul City intervention in South Africa operated at multiple, mutually reinforcing levels (individual, community and socio-political) to address domestic violence by increasing knowledge about domestic violence and shifting perceptions of social norms on this issue. The evaluation showed that the Soul City intervention successfully reached 86%, 25% and 65% of audiences through television, booklets and radio, respectively. The evaluation suggests that the intervention played a role in enhancing women's and communities sense of efficacy, enabling women to make more effective decisions around their health. The evaluation concluded that the implementation of the Domestic Violence Act in South Africa can largely be attributed to the success of the intervention (Usdin et al., 2005, Goldstein et al., 2005).

Example: The LoveLife Campaign in South Africa

The LoveLife campaign of South Africa is another example of a positive campaign to support alternative behaviours different from current risk behaviour trends. LoveLife billboards challenge gender assumptions of male dominance in sexual and romantic relationships among youth, and provide young people an alternative gender vision of balanced, equitable, negotiated partnerships. LoveLife is not alone, but is perhaps more innovative in its messaging than others. Other social marketing firms such as New Start promote condom use, HIV testing and family planning, with efforts to incorporate images of a new responsible male. The impact of these messages is largely un-tested, and warrants closer evaluation, but it would be particularly worthwhile to examine how expanded messaging efforts may evoke behaviour change in non-reproductive and non-sexual domains (Snow, 2007). For example, boy's and men's risk taking behaviour with respect to road traffic accidents needs to change the current gendered norms about the supposed bravado of aggressive driving, jumping off and on buses, crowding onto already over-crowded vehicles, not wearing seat belts or helmets, drinking while driving etc.

Example: Mothers Against Drunk Driving in the USA

Efforts by Mothers Against Drunk Driving (MADD) in the USA have raised awareness about the contradictions that fuel rising road fatalities among young men. Their research highlights that in 2001, while the alcohol industry spent US\$ 23.2 million on 2,379 broad responsibility messages, it spent US\$ 812.2 million on 208,909 product messages that made alcohol sexy and glamorous. In 2002, young people aged 12-22 years in the USA were 128 times more likely to see an alcohol advertisement than a responsibility message (WHO, 2007). Although MADD has made serious efforts to lobby the US government for reform, their advocacy is still overshadowed by the political clout of the alcoholic beverage industry.

Apart from addressing the conflicting policies that prioritise alcohol and tobacco consumption over public health, more needs to be done to directly improve road safety. This includes improving road infrastructure to reduce congestion and improve visibility; enforce speed limits; deploy police to enforce discipline in busy intersections; provide graduated licensing programmes that award positive points for good driving records and subtract points for risky driving; develop and promote seat belts and helmets for all ages and improve emergency health service capacity (WHO, 2007).

VII. The Gendered Politics of Health Care Systems

VII.1. What do we know?

The WHO defines health systems as “all the activities whose primary purpose is to promote, restore, or maintain health” (WHO, 2001). Given the broad social, cultural and economic context in which health systems operate and the impact that factors external to the health system can have on health, health systems are not only “producers of health and health care”, but also “purveyors of a wider set of societal norms and values” (Gilson, 2003).

The Commission's *Health Systems Knowledge Network*, tasked with synthesising evidence to inform health system action against the root causes of health inequity, including gender inequities in health, mapped the terrain according to the broad, WHO definition of health systems. The work of the WGEKN in this area should be seen as complementary to the work by the *Health Systems Knowledge Network* and has been limited to focus on *health care systems* (including services and home-care) rather than health systems broadly.

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 differential needs of women and men in planning and providing health services. Another reason is that equitable utilization 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. Health services may also be unsuited to meeting the health needs of men: for example, reproductive health services are often not set up so as to encourage male involvement.

While the traditional approach to health care systems tends to be management oriented with focus on issues such as infrastructure, technology, logistics and financing (Govender and Penn-Kekana, 2007), the WGEKN looked at the human component of health care systems and the social relationships that characterize service delivery. More precisely, we have synthesized the evidence that 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.

As described in the next section, 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 (George 2007b). 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). The different supply-side dimensions of access to health care services include: a) availability (e.g. geographical location, transportation availability, opening hours and waiting time to appointment), b) affordability (e.g. costs for seeking care, including the opportunity costs of time spent on seeking services), and c) acceptability (e.g. the social and cultural distance between health care systems and their users that affect interpersonal interactions and quality of care especially for those who are poor, female or otherwise disadvantaged) (Health Systems Knowledge Network Report, 2007). 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 (Erdman and Cook, 2007). Accountability to citizens with regard to gender and health is defined here as the processes by which health policy makers and providers engage with, respond to, and answer to citizens, and enforce decisions in such a manner as to reduce gender inequities in health (Caseley, 2003, Goetz, 2006, Murthy, 2007).

In the following sections we will look at how the above factors mediate women's links to health care systems as consumers of health services. As gender relations also shape health systems through their effect on the occupational segregation among health providers, the conditions of work, and processes of regulation, supervision and management of health labour forces (George, 2007a) we also examine the working conditions of female health care providers. Finally, we look at different mechanisms by which governments have promoted accountability to citizens and the key gaps with regard to accountability on gender and health.

VII.1.1. 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 (Gijsbers van Wijk et al., 1996), but it can also be attributed to excess female health problems that are not caused by reproductive morbidity. Although, in low-income countries reproductive problems and other chronic diseases play a large role in explaining

gender differences in health, women may have less access to health care services than men (Puentes-Markides, 1992, Thaddeus and Maine, 1994, Vlassoff, 1994) due to a series of barriers at the individual, familial, and community levels that stand between women and their access to health care. For example, as mentioned in section IV.1.1, women are seen as objects rather than subjects (or agents) in their own homes and communities, which is reflected also within health systems in the philosophy with which reproductive health services were provided. Women were considered as means in the process of reproduction, and as targets in the process of fertility control. Services were not provided to women as ends in themselves. Although, women benefited from the process, they were not at its centre (Cook et al., 2003). These barriers are often the manifestations of women's low social status, lack of autonomy, and rights (Chatterjee, 1988).

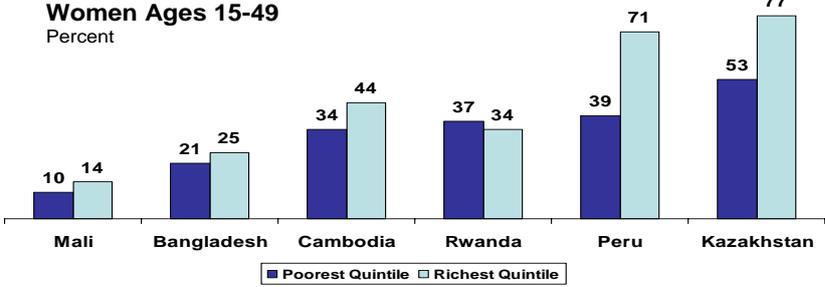
First, women themselves, their families and health care providers need to be *aware* of the existence of a health problem. They may look upon health problems as normal or natural aspects of women's biology or everyday activities. For example, certain types of health conditions, such as chronic pain, depression and reproductive tract infections, may be so widely prevalent that women and care providers treat them as normal states and ignore them (Iyer, 2005).

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. For example, adolescent girls in Koppal in India (Iyer, 2005) or young women with TB in Vietnam (Long et al., 2001, Johansson et al., 1999) do not publicly acknowledge their health problems, because it would lead to poorer chances for marriage. In some cultures, unmarried women with sexually transmitted infections may be highly stigmatised by the reaction from unsympathetic health care providers, preventing them from seeking care. Families may also turn a blind eye in some societies to women's health needs because of indifference, or low value attached to the lives or well-being of women. This can affect all women but especially women who are infertile (where fertility is valued and viewed as women's responsibility), have not borne sons (where son-preference is the social norm), or are past their reproductive years (especially if they are widows). Lack of acknowledgement may also affect the way in which health providers take action or not to promote health services for women, or deal with problems such as maternal risk or obstetric emergencies as well as other critical needs.

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 (Iyer, 2005). 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. In some places, girls are likely to receive less expensive and more home-based care than boys (Lane SD, 1987) and are also more likely to

suffer from outright neglect of their health needs than boys (Ahmed et al., 2000). Families may 'ration' scarce resources preferentially for boys and men relative to girls and women leading to higher rates of non-treatment or discontinuation of treatment (Iyer, 2007, Sen et al., 2007a, Sen et al., 2007b) Restrictions on physical mobility and the need for a husband's or other family member's permission to utilize health service outside the household are important gateways between women and their access to health care. Figure Y shows, that in the selected countries only a small percentage of girls and women in reproductive ages can decide by themselves to seek health care. This is the situation in both rich and poor households, although in some countries, such as Kazakhstan and Peru, women in rich households have more freedom to decide about health service utilization than women in poor households (Gwatkin, 2003).

Women Who Decide by Themselves to Seek Health Care



Note: Includes only those women who say that they alone have the final say in decisions to obtain their own health care.

Source: D.R. Gwatkin, S. Rutstein, K. Johnson, E.A. Suliman, and A. Wagstaff, *Initial Country-Level Information about Socioeconomic Differences in Health, Nutrition, and Population, Volumes I and II* (Washington, DC: The World Bank, November 2003).

Physical and economic barriers may also prevent women from accessing health services, due to long distances to health facilities and lack of transportation, user fees or lack of private/public insurance coverage. For example, out-of-pocket expenditures for public and private health care services drive many families into poverty, especially in developing countries (Krishna et al., 2004b, Krishna et al., 2004a, Hung et al., 2001, Gottlieb, 2000, Russell and Gilson, 1997, Pannarunothai and Mills, 1997) – the “medical poverty trap” (Whitehead et al., 2001). Women are disproportionately affected as they have less access to household resources and require more preventive reproductive health services (Hanson, 2002, Gijsbers van Wijk et al., 1995). Under the counter payments, referring patients from the public service to their own private clinic, making patients pay for drugs and supplies that should be provided free, recommending unnecessary interventions which they can charge for are examples of abusing users of services, sometimes contributing to maternal deaths (Parkhurst and Rahman, 2007, George et al., 2005).

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 (Bruce et al., 1998, George, 2007b, Govender and Penn-Kekana, 2007, Vlassoff, 1994). There is growing evidence on how women (and men) may be abused by care providers physically, verbally and economically (Govender and Penn-Kekana, 2007), as well as a large literature on the physical abuse by health care workers of women undergoing labour (Freedman, 2005, Jewkes et al., 1998). Verbal abuse of women seems often to be linked to health care workers presuming that women have transgressed gender norms and to health care workers taking out their own frustrations on patients (Kim et al. 2002).

In highly patriarchal societies, socio-cultural and/or religious norms and practices restrict social and physical contact between women patients and male care providers (Govender and Penn-Kekana, 2007, Holroyd et al., 2004, Rizk et al., 2005). In many cultures, women are reluctant to consult male doctors. For example, women seeking antenatal care in Saudi Arabia and Thailand highly preferred female doctors (Nigenda et al. 2003). The lack of female medical personnel – itself a reflection of gender bias in educational opportunity - is an important barrier to utilization of health services for many women (Zaidi, 1996). For this and other reasons, women may prefer to use traditional care providers even where other health care services are available. For example, a study in Columbia, demonstrated that men were more likely than women to comply with treatment provided through the health services. Health workers were not sufficiently trained to recognize and treat the symptoms, and women could not access the services as easily (Allotey and Gyapong, 2005, Velez et al., 1997).

VII.1.2. Women as health providers

Human resources both formal and informal are an integral part of health systems. The quality, commitment and dedication of health care providers are critical to health, and to equitable health systems. A majority of the health work force is female, and the contributions of women to formal and informal health care systems are significant (George, 2007a, Gupta et al., 2003, JLI, 2004, Ogden et al., 2006, Schindel J, 2006, WHO, 2006b), but undervalued and unrecognised, partly due to unavailability of sex disaggregated data on the care economy.

Female carers in the health system are less likely to occupy positions that involve decision making and more likely to become unemployed than male counterparts (De Koninck et al., 1997, Foster et al., 2000, Fox et al., 2006, Frenk et al., 1999, Kassak et al., 2006, Levinson et al., 1993, Magrane et al., 2005, Mayorova et al., 2005, Nigenda and Machado, 2000, UNIDO, 1989). Many studies have shown that women are often expected to conform to male work models that ignore their special needs, such as childcare or protection from violence. An American study revealed that more female doctors than male doctors are found in specializations where taking care of family responsibilities are more accepted (De Koninck et al., 1997). Women more often than men have to work part-time in order to be able to combine gainful employment with family responsibilities (Foster et al., 2000, Fox et al., 2006, George, 2007b,

Levinson et al., 1993, Mayorova et al., 2005). A meta-analysis of studies on physicians' suicides has revealed highly elevated suicide risk among female doctors (Schernhammer and Graham, 2004).

In some places, low wages and salaries coupled with lack of infrastructure and poor working conditions leads to migration of valuable and experienced human resources from low and medium income countries (LMICs) to high income countries. (WHO, 2006b, Socio-Economic Welfare, 2002, Buchan et al., 2006, Gerein et al., 2006). A study in the UK shows that 40% of the nurses emigrating from resource poor settings are 40 years of age or older (Buchan et al., 2006) which means that they are likely to be more skilled and experienced.

In other places *community health workers* may be subjected to violence (Mumtaz et al., 2003, George, 2007a). For example, in studies in Pakistan (Mumtaz et al., 2003) and in India (George, 2007b) female community health workers have reported that they are often harassed when they are on their way to work or performing work. The fear of being exposed to physical or sexual violence makes them hesitant to attend to obstetric needs of patients at night. Although supervisors informally acknowledge these problems, they do not see them as part of their official managerial remit (Mohan et al., 2003).

It is estimated that up to 80 percent of all health care and 90 percent of HIV/AIDS related illness care is provided in the home (Uys, 2003, WHO, 2000). In the context of the HIV/AIDS epidemic, it is generally recognized that women and girls are the principal caregivers and bear the greatest degree of responsibility for the psychosocial and physical care of family and community members (Ogden et al., 2006). However, home carers remain unsupported and unrecognized by the health sector and policy makers. The short-term and long-term impact of women's position as *informal caregivers* on themselves and on their households is not sufficiently documented. In the short term, household costs for health services outside the home is reduced, while in the long term, the opportunity cost to women in terms of education and participation in the labour market is significant (Steinberg et al., 2002). This is in addition to the direct health effects on these caregivers. Female home caregivers in Japan had higher scores for work burden and depression than their male counterparts (Sugiura et al., 2004) and in the USA they suffered from poorer emotional health than male caregivers (Navaie-Waliser et al., 2002). In Chile, home caregivers reported insomnia, stress, stomach ailments, over-sensitivity, anxiety, sadness, depression, loneliness, anguish and worry. Yet few consulted doctors about their needs and even fewer undertook treatment or therapy (Reca et al., 2002).

The short-term and long-term impact of women's position as informal caregivers is also felt in the reduction or elimination of social protection for women in those countries or segments of the population where direct access to social protection in health and social security is tied to employment status: beyond curtailing women's economic autonomy, the assignment of the caregiver role to women limits their opportunities to participate in paid labour, or pushes them into part-time or informal sector occupations that do not accrue short- and long-term social protection.

To address concerns of fairness in the distribution of unpaid care (between women and men, and between families and communities) is essential if the providers of unpaid health care are to get access to entitlements as citizens in their own right.

VII.1.3. Accountability mechanisms for improved health services

As mentioned previously, the lack of effective *accountability* mechanisms for high quality health services may seriously hinder the ability of women and their families to hold government and other actors accountable for violations of their human rights to health (Cook and Ngwena, 2006). Accountability to citizens with regard to gender and health can be understood as the processes by which health policy makers and providers engage with, respond to, and answer to citizens, and enforce decisions in such a manner as to reduce gender inequities in health (Caseley, 2003, Goetz, 2006). In order to address accountability, it is important for the health care managers, as a routine, to collect, analyse and interpret sex-disaggregated data and take action. This is discussed further in section VIII on health research.

Murthy (2007) identified the following mechanisms by which governments have promoted accountability to citizens:

1. Strategies which could be applied to the health sector (passing progressive legislation on rights of citizens to information and to participate in public policy and budgeting).

2. Strategies which can be extended to right of women and marginalized men to health (passing legislation on right to health; establishing of structures and processes for citizens input into health policy and health budgets; establishment of structures for citizen's participation in hospital management and health service delivery, and in quality assessments of provider clinics and providers; establishment of mechanisms for self regulation by health professionals like medical councils and nursing councils, and for protecting patient rights vis a vis providers like patient rights charters).

3. Strategies to promote gender and health accountability to citizens (passing of legislation banning practices that violate women's health rights, like banning of FGM, child marriage and domestic violence; Ombudsmen Centres on sexual and reproductive health and rights; national and state level committees involving citizens groups for inputs into and monitoring sexual and reproductive health programmes).

In Latin America, there are several instances of gendered accountability mechanisms in the form of Observatories. Some are run by civil society and some others by Ministries of Women's Affairs, for example in Colombia and in Chile (Matamala, 2007). There are also those which are run by a combination of both, as in the case of the Observatories of Gender Based Violence installed in several countries.

While analyzing the efficacy of the above measures, it is important to ask who is accountable, to whom with regard to what, how, and when (Goetz, 2006, Murthy et al., 2005, George, 2003). Such an analysis reveals key gaps:

- *There are few examples of accountability of public policy makers, private health sectors and donors to citizens:* Most accountability structures and processes focus on strengthening public health sector accountability, and not the private health sector, public-private partnerships, donors, or multilateral organisations. Within the public health sector, the focus is much more on strengthening lower level health provider accountability (in particular nurses and midwives), than on health policy makers and managers (Murthy et al., 2005).
- *There are few examples of accountability to women, marginalized men, sexual minorities and adolescents:* Citizens are often lumped into one category, and mechanisms for ensuring health accountability to women, marginalised men, sexual minorities, and adolescents are few (Elsay et al., 2005). Often NGOs in the good books of government are invited into accountability structures, and not the more rights-oriented organisations that might challenge the status quo.
- *There are few examples of accountability for controversial and low priority gender and health issues, as well as health policy making and budgeting:* Accountability in health service delivery has been much more emphasised by governments, than in policy making, planning, or budgeting (Murthy, 2007, Murthy et al., 2005). Further, accountability has been less emphasized for controversial issues (like provision of abortion services, contraceptives to adolescents).
- *There are few examples of gender sensitive accountability structures, tools and processes:* There are few accountability structures, tools, and processes, to ensure accountability to reduce gender inequities in health or promote the health rights of women and marginalised men. Several are in-fact gender blind (Murthy, 2007). For example, community health structures have little representation of women, and capacities of structures are not built on gender and health issues. As a result they do not promote accountability to reduce gender inequalities in health (ARROW, 2005).

VII.2 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 decentralisation, integration of services, financing, privatisation, organisation 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 (Östlin, 2005).

The reforms were championed by the World Bank, which provided a rationale for structural changes to the health sector based on their failure to improve health systems stemming from the lack of alignment between government actions and goals of economic development (Onyango, 2001). 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 (Eriksson, 2001, Berman and Bossert, 2000). For example, behind health sector

reform in sub-Saharan Africa, often influenced by donors, the main driving force has been the severe crisis in health sector budgets, weak capacity to manage and regulate the health sector in a sustainable and equitable ways, and limited civil society engagement (Standing, 2002). Reforms in Africa included the introduction of new financing mechanisms such as user fees, revolving drug funds, and other community-run financing schemes as well as the use of essential drugs lists to ensure cost-effective use of resources. In the Americas, health sector reform is strongly focused on institutional change through decentralization, privatization, reform of social security systems and the separation between financing and delivery of health services (Batthyany and Correa, 2007). In Brazil, these reforms were implemented with strong involvement of civil society organizations but this is not true for all countries (Batthyany and Correa, 2007, Tajer, 2003). Reforms in South East Asia have focused on decentralisation and improvement of financing mechanisms (Sharma, 2000). In most European countries, reforms were necessitated to accommodate rapidly increasing pharmaceutical costs and providing long-term and home care (Council of Europe, 2003, Saltman, 2002). Consequently, reforms emphasized cost containment and the use of managed competition to increase efficiency. There have also been some efforts made to increase accountability of health systems through international and national legislation, donor driven Sector Wide Approaches (SWAPs) and community monitoring tools. The quality of provider-client relationships has also received some attention in terms of its impact on service utilisation.

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 life and well-being, as patients in both formal and informal health care, paid and unpaid care providers, health care administrators and decision makers. 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 in general and particularly in health care have seldom been discussed or taken into consideration in planning (PAHO, 2001). The report of the *Knowledge Network on Health Systems*, points at the fact that, in the main evidence base in the health field, gender equity is not adequately addressed, and neither is information on the health equity impacts of interventions disaggregated by sex.

The few existing gender analyses of health sector reform programmes suggests 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 (Evers and Juárez, 2003, Ford Foundation, 2003, Mackintosh and Tibendebage, 2004, Neema, 2005, Onyango, 2001, Standing, 1997, Standing, 2000, Östlin, 2005). The evidence presented in section VII.1 pointing to the many problems women in many countries still have to face in their interaction with health systems, suggests that 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. There are a number of successful and promising policies, interventions and actions from all around the world that can serve as important policy lessons for future efforts to address gender biases in health systems. In the following, we review policies, strategies and interventions with bearing on 1) awareness and acknowledgement of women's health needs, 2) access to health care, and 3) accountability of health systems to citizens.

VII.2.1 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 institutionalised 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 (George et al., 2005). 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

An important requirement for addressing institutional indifference in health systems is mainstreaming gender consciousness and sensitization into the basic training and continuing education of health care providers (Govender and Penn-Kekana, 2007), including community volunteers (Nsabagasani et al., 2007, Kallander et al., 2006).

Example: *The Health Workers for Change (HWFC) project*

The HWFC project is a departure from conventional training on interpersonal communication which does not take gender into account. It uses a participatory research and learning approach for bringing about improvements in quality of care with emphasis on the need for gender sensitivity in health services (Fonn and Xaba, 2001). The intervention, developed by the Women's Health Project in South Africa, was also tested in five other African countries (Uganda, Zambia, Mozambique, Kenya and Senegal), Argentina (Onyango-Ouma et al., 2001) and more recently Pakistan (Shaikh, 2006). HWFC has a number of important contributions. Firstly, it provides a space for providers to examine how gender and how other social issues impact on their lives. Secondly, it can improve the relationship between providers and patients. Finally, it demonstrates the potential for improving health systems development by integrating gender considerations (Vlassoff and Fonn, 2001).

Example: Training programmes for PHC nurses in rural South Africa

In rural South Africa, training programmes for PHC nurses are provided to help them acknowledge women's health needs and problems related to domestic violence. With the help of an NGO working to combat domestic violence,

discussions were held on attitudes and beliefs regarding different forms of abuse (physical, sexual, psychological, and economic), nurses' perceptions of responding to gender-based violence and personal experiences of gender-based violence. Lessons from similar interventions may well inform the design and implementation of training programmes aimed at raising awareness and capacity within other sectors such as the welfare, police and judicial systems (Kim et al. 2002).

Transforming the medical curriculum is a key measure for building capacity of health care providers in gender analysis and responsiveness. It has been shown to be successful in evaluation studies (Verdonk et al., 2005). Historically, medicine and medical education has considered the male anatomy and physiology as the norm, with women continuing to be underrepresented in illustrations of non-reproductive anatomy (Lawrence and Bendixen, 1992) and in medical text books more generally. This has led to the neglect of the importance of sex and gender in explaining differences between men and women, and has contributed to gender-based inequities in medical treatment (Reichenbach and Brown, 2004, Garcia-Moreno, 2002). There have been efforts in several countries to transform the biomedical, male-centered medical curriculum.

Example: Incorporating gender into medical training in Kerala, Argentina and in Ontario

In Kerala state in India a three-year program on gender sensitization for medical college teachers which complements the traditional medical texts has been developed. This initiative has now been rolled out to other Indian states. Such efforts have as their ultimate goal the removal of gender biases in how providers deliver health services (Jesani and Madhiwalla, 2002). The medical school of the University of Rosario in Argentina has changed its curriculum in 2001, where gender is treated as a transversal axis of the academic training (WHO, 2006a). The Gender and Health Collaborative Curriculum Project includes faculty and students from the six medical schools of Ontario as well as members of the Undergraduate Education and the Gender Issues Committees of the Council of Ontario Faculties of Medicine (COFM) working together to produce a resource focused on the role of gender in medical education. The project aims to improve health care for both women and men through the development of a collaborative, web-enabled medical curriculum that integrates gender and health into all aspects of medical education. This integrated curriculum will be a common provincial resource for use by all Ontario medical schools (Ontario Women's Health Council, 2007).

2) Provide information about diseases and ensure confidentiality and respectful treatment by providers by integrating gender into treatment literacy programmes which intend to raise awareness, counteract stigma and empower patients in their interactions with providers.

Patient education and health literacy⁵¹ is increasingly being emphasised as an effective measure to empower patients at all ages to demand the necessary information to allow them to make informed decisions about treatment options (Govender and Penn-Kekana, 2007). The Convention on the Rights of the Child points at the obligations of health systems to treat adolescents and children according to their evolving capacity to understand the nature of health services and treatments.

Example: The “Smart Patient” Coaching initiative in Indonesia

The “*Smart Patient*” Coaching initiative in Indonesia was an intervention in which clients were trained to communicate more openly with family planning providers. The educator provided individual instruction on 3 basic skills: asking questions, expressing concerns, and seeking clarification. Smart Patient coaching narrowed differentials in active communication by client type, age, and assertiveness, but it widened differentials by client education and socioeconomic class. Coaching was associated with more tailored information-giving by providers. However, the intervention did not make a significant impact on contraceptive continuation rates (Kim et al., 2003).

VII.2.2 How to improve women’s access to health care

To build and strengthen 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. As mentioned in section VII. 1, many developing countries continue to suffer from weak or deteriorating health services, infrastructures, and unaffordable services, a situation that disproportionately affects women. The inadequacy and lack of affordability of health services are compounded by physical and psychological barriers to care. 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 realised and the goal of “Health for All by 2000” was not achieved, there are some lessons to be learnt from countries that achieved some successes under the PHC model (Allotey, 2005). For example, Indonesia and other parts of South East Asia succeeded in creating and maintaining a skilled workforce of community health workers and birth attendants through putting resources into the training of midwives. In addition there was a

⁵¹ Health literacy is the ability to obtain, process, and understand basic information and services needed to make appropriate decisions regarding health (see RATZAN, S. C. & PARKER, R. M. (2000) Introduction. IN C.R. SELDEN, M. Z., S.C. RATZAN, R.M. PARKER (Ed.) *National library of medicine current bibliographies in medicine: Health literacy.*, NLM Pub.No.CBM 2000-1. Bethesda, MD:National Institutes of Health, U.S.Department of Health and Human Services.)

formalised recognition of the importance of their contribution to the national health system through the creation of career structures (Allotey, 2005, Sherratt, 1999, Geefhuysen, 1999).

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 (Allotey, 2005). For example, in the area of maternal mortality and morbidity rate reduction, which is one of the Millennium Development Goals (MDG 5), the shift to emergency obstetric care provision will require the establishment of centres for such care at village, municipal and city levels. Such centres will require infrastructure and personnel investments. Because emergency obstetric care is a paradigm shift from old methods of preventing and treating pregnancy complications, the infrastructure and skilled personnel may be minimal or absent in many countries. This will require genuine increases in health care spending by government — something that would reverse a trend of decreasing expenditures.

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.

At the national level, there have been some attempts to tackle the cost and affordability barriers to health services for women. For example, both South Africa and Sri Lanka provide free maternal and infant health services. 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 (Borghi et al., 2006). Studies from African countries show that even though many poor women may be exempt from fees, there is little incentive for providers to apply exemptions, as they too are constrained by restrictive economic and health service conditions (Nanda, 2002).

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. Upgrading local (village-level) health centres, setting up systems for reliable emergency transport, and making it possible for women and their attendants to stay near a health facility can help to bridge this gap (WHO, 1998). Such measures have yielded good results in countries such as Cuba, Sri Lanka, Uganda, and, in the Matlab project, in Bangladesh. Many lives could be saved through preventing and effectively taking care of complications

during pregnancy and childbirth. This requires actions aiming at improving access to a skilled attendant at delivery and to emergency obstetric care, and by improving the referral system to ensure that women with complications can reach life saving emergency care in time.

Judgemental attitudes of providers, lack of privacy and confidentiality, and in some instances denial of care particularly in the context of sexual and reproductive health services were described earlier as important barriers to access especially for unmarried women, men and adolescents. This has contributed to the introduction of more gender- and adolescent friendly services which can take a range of forms: these may include youth-only and men-only clinics, women-only services within existing services, out-reach and community based services and different hours of services in already existing services (Govender and Penn-Kekana, 2007).

Initiatives towards '*women centred services*' have taken a number of forms:

Example: The Lady Health Workers in Pakistan and the Kumar Warmi project in Bolivia

The Lady Health Workers in Pakistan is the provision of door-to-door services for women whose mobility and hence access to services is constrained. The Lady Health Workers initiative in Pakistan is a response to meeting this need and has been effective in increasing the uptake of services, improved the adoption of contraceptives and improved community health (Douthwaite and Ward, 2005). The Kumar Warmi (Aymara for 'healthy woman') project in Bolivia illustrates how women-centred services through educational processes, shared decision making, and linking with women's groups, can help women overcome negative perceptions of the doctor-client relationship (Paulson et al., 1996).

Another instance is the integration of health services, which can take the form of multipurpose clinics, multipurpose staff, adding new services that serve a more diverse client population (e.g. expanding family planning services to include men and adolescents), and adding new reproductive health services (e.g. HIV/AIDS) to existing reproductive health services (e.g. MCH) (DePinho et al., 2005). Integration has been motivated from a patient perspective in terms of time convenience (one-stop-shop) which can potentially enable access to reproductive and other services and access for instance child care simultaneously in the same facility. Secondly, integrating STI prevention with reproductive health services instead of separate STI services can also help to ensure privacy and reduce stigma.

Male-friendly services can be promoted through separate waiting areas, male service providers, separate examination rooms and male only clinics.

Example: Profamilia's Clinica Para El Hombre in Colombia

Profamilia's Clinica Para El Hombre in Colombia represents one of the most successful attempts to increase men's access to comprehensive reproductive health services through the introduction of men-only clinics. Quality of care and gender-sensitive patient-provider interactions are central to the delivery of services. Staff are trained on personal and cultural beliefs about masculinity, and are encouraged to reflect on their personal attitudes regarding gender and how gender impacts on their interactions with patients. A quality of care evaluation of the clinics in 1997 found that doctors had less time to participate in training and a tendency to view clients exclusively in terms of the treatment of disease. An interesting observation has been the importance privacy and confidentiality from the patients' perspective (AVSC, 1997).

Leading international family planning and reproductive organisations including EngenderHealth's COPE (Client-Oriented, Provider-Efficient services), the Population Council's Client-Centred Approach to Reproductive Health, USAID's Maximizing Access and Quality (MAQ) Initiative and the more recent Decision-Making Tool for Family Planning Clients and Providers developed by WHO and the INFO Project at the Johns Hopkins Bloomberg School of Public Health have adopted the approach towards client-centred services (both men and women), away from government or provider-driven targets. These interventions incorporate gender through the involvement of men in family planning and reproductive health care, couple counselling and providing services specifically for men (RamaRao and Mir, 2004, Young et al., 2003, Kim et al., 2003, Ringheim, 2002).

The above examples indicate that universal health services provided to all individuals according to the same standards are not always appropriate or equitable when it comes to service provision to women and men, girls and boys. Health services need sometimes to pay extra attention to those most in need or those at high risk. Gender equity in health requires policy assurance that men and women will be treated equally where they share common needs, as well as recognition that where their needs are different, these needs will be addressed in an equitable manner.

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 programmes *recognise 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.

There is also a need to address concerns of fairness in the distribution of unpaid care between women and men, families and communities and the sex differentiated impacts of this distribution on health, well being and social protection of the individuals. Making women's unpaid care count means having it **counted** in statistics, **accounted for** in health economic representations of how the system works, and **taken into account** when policy is made.

Actions are needed to promote the *participation of women* in the health policy making process and decision making, which will increase the probability of gender sensitive planning and delivery.

Regularly track *women's equality issues within the health workforce* such as equal pay, decent working conditions, and representation in management and leadership.

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 programme on women and men, directly measure how a project or programme is effective for both sexes and take the necessary management decisions (Doyal, 1998).

A WHO review of 17 gender tools has identified eight practical tools that are applicable for monitoring and evaluating quality of health care from a gender perspective (Klugman, 2002). These are the following: *ARROW*: Women-centred and Gender-sensitive Experiences: Health Resource Kit; *AusAID* Guide to Gender and Development; *CIDA*: Guide to Gender Sensitive Indicators and The Why and How of Gender Sensitive Indicators – A Project Level Handbook; *DFID*: Gender Equality Mainstreaming (GEM) Information Resource; *Commonwealth Secretariat*: Gender and Health Curriculum Outlines; *Liverpool School of Tropical Medicine*: Guidelines for the Analysis of Gender and Health; *Sida*: Handbook for Mainstreaming a Gender Perspective in the Health Sector; *WHO*: Gender and Health – Technical Paper.

VII.2.3 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 (Cook and Ngwena, 2006). This requires transparency in terms of what is the extent of provisioning for needed services and who is responsible for it within the health care administration. Administrators and politicians need to be made accountable for not just sanctioning new facilities and services, but for actually making them function through the provision of inputs and responsive management. Budget analysis and service delivery assessments that detail actual

basic health service infrastructure, personnel, equipment and drugs on a regular basis are crucial measures that need to be undertaken and supported (George et al., 2005). Undertaking such assessments is not without costs. Implementing effective accountability mechanisms requires the removal of women's barriers to make claims – these should be designed in such a way that women's involvement will not burden them unfairly. Accountability processes are an important part of the legal framework to ensure women's access to health care (Cook and Ngwena, 2006).

The following section provides a number of examples of how accountability of health systems can be strengthened:

1) Enhancing accountability of health policy makers, and on controversial health issues

Citizens groups have used international instruments like CEDAW, ICESCR, and ICPD, to press for liberalising restrictive abortion laws (e.g. in Nepal), and protecting progressive legislation banning FGM (e.g. in Egypt). In South Africa citizens groups have used Clause 59.1 of the constitution which requires the parliament to facilitate public involvement in formulation of legislation and policies, to advocate liberal abortion laws and laws on violence against women. In India, citizens groups used public interest litigation in the late 1980s and 1990s to repeal the policy of conducting clinical trials of possibly harmful injectable hormonal contraceptives with poor women. Citizens groups have also used new aid infrastructure like Poverty Reduction Strategy Papers (PRSPs) (e.g. Rwanda) and Sector Wide approaches to health to press for addressing social determinants to women's health (like land rights of women, reduction of women's drudgery in Rwanda) and gender specific health needs of women and men (to name a few: services for management of RTI/STI, ante-natal care, basic Emergency Obstetric Care, contraceptive choice). The key factor for successfully influencing the restructuring of health systems in Bangladesh was clearly the participation of civil society, which enabled a large number of women, particularly poor women, to engage with the design of reforms (Jahan, 2003).

2) Strengthening accountability of private clinics and providers to gender and health

Women are major users of health services provided by the private sector in all its forms and for all kinds of conditions. There is a need for regulations and monitoring to ensure that initiatives such as contracting and franchising actually work for women.

Example: Campaign Against Sex Selective Abortion in India

In Tamil Nadu, India, the citizens' Campaign Against Sex Selective Abortion (CASSA) uses several innovative strategies to monitor private health clinics' and providers' adherence to the pre-natal testing and diagnostic Act. They use pregnant women who are part of the campaign to bring those private clinics and providers who disclose the sex of the child or conduct sex selective abortions to book, while protecting the right of women to abortion on other grounds. They also demand a list of private clinics registered with the district and state authorities under the Act, and

provide a list of unregistered clinics to the government to take appropriate action. Where their representatives sit on district committees, they are able to ensure that action is taken against unregistered clinics (Gupte, 2003).

3) Reducing hierarchies of power: gender and others

Example: Community based monitoring system in Uganda

The national civil society network, Uganda Debt Network, used a community based monitoring and evaluation system (with 40% participation of women) for monitoring health, education and other services in two sub-counties, and ensuring that they were in line with the norms on service provisioning under the PRSPs. As a result, the quality of care by providers improved, the number of beds in labour wards for women increased, and user fees were removed in one sub-county, which benefited women in particular given inequalities in access to income.

Example: Strengthening women's awareness and demands on services in Bangladesh, Argentina and Peru

In Bangladesh, the women's rights group, Naripokko, endeavours to strengthen poor women's awareness on services that should be available at Upazilla (sub-district) level and their ability to make demands on Upazilla health committees. They also seek to enhance gender sensitivity of the Upazilla health committees and providers, and sensitise local media on gender specific health concerns of women. As a result, the number of physicians (including a gynaecologist) in the clinics and their attendance increased and waiting times reduced leading to better access of women to maternal health services.

In Argentina, the women's groups involved in municipal council's participatory budgeting were able to negotiate better child care facilities and thereby reduce the work burden of women and enable them to engage in income enhancing work. In Peru, citizen's groups appealed to the Inter American Court of Justice, using ICESCR and CEDAW, for bringing a doctor who raped a woman patient in a public hospital to book, and also successfully challenged forced sterilization of poor women post delivery in public facilities.

4) Engendering accountability structures and tools, and ensuring that they are not hijacked

In Laba, China, the community structures for managing cooperative medical schemes (a prepayment scheme) were engendered and made more poor sensitive, following an evaluation by Yunnan Participatory Rural Appraisal Network, through bringing poor women and men into committees, enforcing user fee exemptions for poor, prioritizing provision of maternal health and services to diagnose and treat RTIs, and strengthening capacities of providers to provide these services (Wilkes, 2000). Moving to a regional level, ARROW is advocating with national governments and donors in South Asia for strengthening gender and health indicators within MDG targets adopted by the

government. This includes indicators on the sex ratio at birth, incidence of violence against women, reproductive cancers, infertility and availability for contraceptive services for unmarried adolescents (ARROW, 2005).

In the Philippines, the government embarked on devolution of health and social services after the passing of the Local Government Code of 1991. As part of the devolution in health services, 95 per cent of its facilities, 60 per cent of its personnel and 45 per cent of the budget was transferred from the Department of Health to local government units (LGUs) at provincial, city and, municipality levels (Tadiar, 2000). However, the implementation of gender aware health programmes has suffered because of decentralization. Provision of a wide range of contraceptives by local clinics depended on attitudes of members elected to LGUs at different levels. This in turn led to high rates of unsafe abortions. The key concern of women's rights groups is to ensure through local level lobbying that accountability structures, like local health boards attached to local governments, are not hijacked by conservative forces to prevent provision of modern contraception.

Key lessons are that to be effective in promoting gender and health accountability, accountability structures/tools/processes should (Murthy 2007):

- 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 (e.g. abortion law in South Africa), answerability (on injectable hormonal contraceptive trials in India), and enforcement (e.g. punishment for rape of a patient in Peru).
- 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 programmes; community and hospital health structures; professional councils, community audit, etc.
- Be engendered by increasing marginalised 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.

VIII. Health research

VIII.1 What do we know?

Gender not only affects differentials in health needs, health seeking behaviour, treatment, and outcomes, but also permeates both the content and the process of health research (Sen et al., 2002, Östlin et al., 2004, Eichler et al., 1992, Theobald et al., 2006). Gender biases in research sustain a vicious circle that serves to downgrade gender issues in health and perpetuate their neglect.

VIII.1.1 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 (Garcia-Moreno, 2002). The lack of research is obvious also in areas concerning menstruation and non-lethal chronic diseases that affect women disproportionately, such as rheumatism, fibromyalgia, and chronic fatigue syndrome (Doyal, 1995).
- 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 (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). 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 (Varga, 2001, Wang, 2000). Nonetheless, many chemicals, ionizing radiation, toxic contamination, high temperatures and sedentary work have been identified as hazardous to the male reproductive system (Bonde and Storgaard, 2002, Figá-Talamanca, 1998). Similarly, mental health research often ignores the role of reproduction in relation to men's mental health (Astbury, 2002).
- 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 stratifiers, such as socioeconomic class, race, ethnicity or sexual orientation. Like co-morbidity, these causal interactions make problems more complex and require more intensive research efforts. A positive example of such efforts is in the area of HIV/ AIDS where there was recognition relatively early on that women were especially vulnerable because of gender-power inequities, which are often related to the economic inequities between men and women (Smith, 2002, Turmen, 2003, Weiss

et al., 2000). While there has been research on this, particularly in Africa, much more attention needs to be paid to this issue in other parts of the world, such as south Asia for example.

VIII.1.2 Gender imbalances in the research process

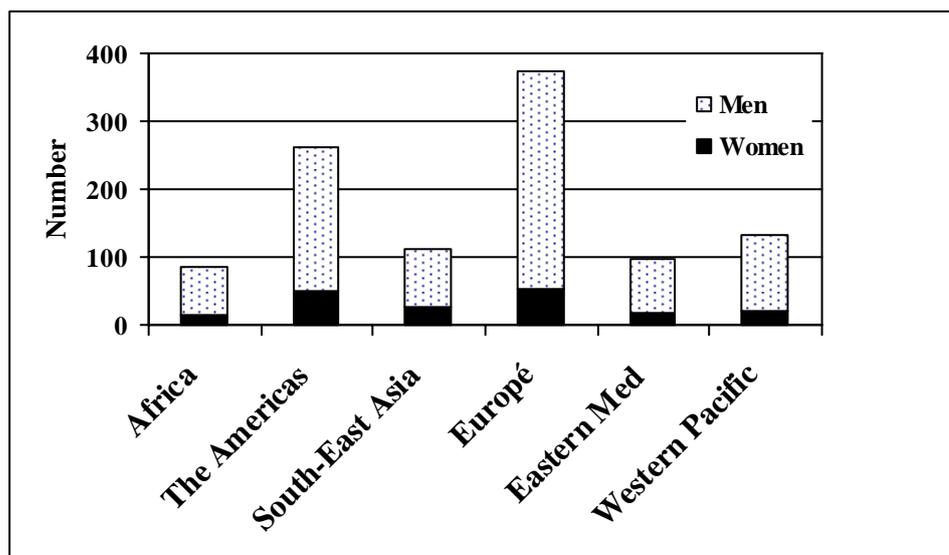
Gender imbalances in research process includes the following dimensions:

- 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. The reliability of data when collected in the home or community and through records of health service providers is sometimes questionable in societies where gender biases exists in health seeking behaviour or where social norms for women of suffering silently prevail. For instance, as discussed in section VI.1.3, several studies suggest that prevalence rates of tuberculosis in women may be under-estimated (Thorson and Johansson, 2004, Thorson et al., 2007, Thorson and Diwan, 2001, Begum et al., 2001, Thorson et al., 2000, Johansson et al., 2000, Liefoghe et al., 1997).
- b) *Gender-sensitive methodologies:* Research methodologies are not always sensitive enough to capture the different dimensions of disparity. For example, a study comparing the utility of active and passive case-finding methods for tuberculosis in Nepal found that females made up 28% of the 159 TB cases who came to the clinic, whereas with active case-finding the percentage of female TB cases detected rose to 46% of 111 cases identified (Cassels et al., 1982). Another study of individuals with long standing cough in rural Vietnam revealed reluctance among women to give sputum for diagnosis, which resulted in the under-estimation of TB in women when the sputum examination was the preferred method for diagnosing TB (Thorson et al., 2000). Moreover, because of biological reasons it is more difficult to diagnose TB in women compared to men when direct microscopy is used (Thorson and Diwan, 2001).
- 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. The rationale behind the exclusion of female subjects from research is that the menstrual cycle introduces a potentially confounding variable and the fear that experimental treatments or drugs may affect women's fertility and expose foetuses to unknown risk. Despite such concerns, research results based on studies of male subjects are seen as universally valid and applicable to women, which is not always the case. In response to critics, efforts have been made to include more women in clinical trials and pharmaceutical research. In 1993, the National Institutes of Health Revitalization Act in the USA required the inclusion of women in all human subject research (Mastroianni et al., 1994). Similar measures have been implemented in many other countries, including Sweden. The Swedish Medical Research Council has announced in 1998 that gender should be taken into account in the process of doing medical research (Caron, 2003). A policy document, issued at the same time (in 1998), authorized research ethics committees to require additional information concerning choice of study population. The Council adopted a policy in 1999 that one-sex-only research designs in principle would not be funded (ETAN, 2000).

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 also been acknowledged as a contributing factor to gender bias in research (Wenneras and Wold, 1997, Park, 2002). The under-representation and different treatment of scientists who are women reflects the pervasive gender hierarchy, which also exists in the field research. Although, through the World Health Assembly Resolution on the "Employment and Participation of Women in the Work of WHO", WHO is committed to advancing gender equality in its own workforce, as well as in scientific and technical advisory bodies, and among temporary advisers and consultants, the gender imbalance among advisers from all regions is still pervasive (Figure 2). There is also growing evidence of differential treatment of female scientists in terms of career opportunities, salary and as applicants for research funds and postdoctoral fellowships. It has been shown that female applicants for post doctoral fellowships in Sweden had to be 2.5 times more productive than their male colleagues to get the same peer review rating for scientific competence (Wenneras and Wold, 1997) .

Figure 2. Membership of WHO expert advisory committees, by sex and region, 2004 (Östlin et al., 2004)



VIII.2 Changing what we know

Health researchers need to focus more in future 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 differential health needs. Not doing so may have a negative impact on 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.

VIII.2.1 Prerequisites for conducting gendered health research

a) The *collection of sex-disaggregated data* that include also 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 (see also discussion on measurement and indicators in section VIII.2.2). Such data should be used for mapping and analysing the disease burden - incidence and prevalence of different health problems - among women and men and among girls and boys (epidemiological surveillance). Such data would also allow a cross-tabulation, classification and analysis of the intersections between sex and social stratifiers for a better understanding of mechanisms behind gender disparities in health. Without sex-disaggregated data gender analysis of health is not possible. One good example of recording sex disaggregated, gender sensitive and gender specific health data comes from Malaysia. In 2000, the Asian-Pacific Resource & Research Centre for Women (ARROW) published 'A Framework of Indicators for Action on Women's Health Needs & Rights after Beijing' (ARROW., 2000). This publication was developed as a tool for all government, non-government and international organisations to use in monitoring implementation of the Beijing Platform for Action. Health Canada's Women's Health Indicators project is a research initiative led by the Bureau of Women's Health and Gender Analysis (WHB) to develop, validate and evaluate a core set of indicators that takes gender and diversity into account. The aim is to improve the ways in which women's health is measured and to more accurately monitor changes in women's health status/outcomes. During the first stage of the project, gaps in women's health data and indicators were identified by reviewing and synthesizing data and information available on women's health indicators in Canada (Colman, 2003). Another good practice comes from Sweden, where every year, since 1994, the annual statement of the Government policy has declared that a gender equality perspective must permeate all aspects of government policy (Swedish Institute, 2004). At the national level, one of the main measures that have been taken to integrate a gender perspective into every policy area, including health research, is that all official statistics have been sex-disaggregated.

b) Recognition of women's health problems and gender equity concerns through *effective research methodologies* (see further discussion on this in section VIII.2.2). 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 differential exposure to health risks and vulnerability to diseases (e.g. due to differential health seeking behaviour and insensitivity of diagnostic methodologies). There are a number of evaluated tools available today for

counteracting such biases. For instance, the *BIAS FREE* Framework is an innovative tool designed to provide a unified approach to detect methodological and other types of biases that derive from *any and all* social hierarchies. *BIAS FREE* is an acronym for *B*uilding an *I*ntegrative *A*nalytical *S*ystem *F*or *R*ecognizing and *E*liminating *I*nEquities. The Framework identifies three major forms of bias – maintaining hierarchy, failing to recognize differences and using double standards – and employs a set of 20 analytical questions to alert users to their presence in research (Eichler and Burke, 2006).

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 analysed 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. Another study found that from 1994 to 1999, out of the 442 original articles including randomized, controlled trials published in *The New England Journal of Medicine*, only 120 met the inclusion criteria (enrolment of women with respect to disease state, funding source, site of trial performance, and use of gender-specific data analysis). On average, 24% women were enrolled and only 14% of the trials performed a gender specific data analysis (Ramasubbu and Gurum, 2001). Thus, efforts to include more women in research studies are not the solution to addressing gender bias in health research, just a weak and tentative beginning.

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 agenda on the linkages 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. A good practice is demonstrated by the Swedish Research Council, which has a committee for gender research, whose task is to coordinate efforts of all research councils with regard to equality, gender research and interdisciplinary approaches (The Swedish Research Council, 2003). The committee also is promoting gender research in its own right to continue to develop its own theoretical and knowledge base. At the same time, the committee strives for gender aspects to be mainstreamed in different academic areas and for making gender visible in different research areas. Health Canada is currently soliciting research proposals to fill identified gaps in women's health indicators and to link biomedical and social dimensions, through a request for letters of intent released September 19, 2003 by Health Canada's Health Policy Research Program (HPRP). The purpose of the proposed research is to develop and validate health indicators that reflect gender differences and diversity in the following areas: 1) Socio-cultural roles and responsibilities, and the physical and mental health of women; 2) Social exclusion and women's health; 3) The environment and women's health; and 4) Health services and women's health. The research projects are scheduled for completion by the end of 2006.

- f) *Women's role in research needs to be strengthened.* For example, the Swedish Council for Working Life and Social Research (FAS), which supports research into work, health and work organisation, welfare, public health, care-giving services and epidemiological research has in its Research Strategy document for 2005-2008, emphasized its intention to "*continue to work with gender and equality issues*" (FAS, 2003). Similarly to the Scientific Council for Medicine, FAS has taken several measures to promote gender equality through, for example, gender-based statistics on the distribution of research funding; monitoring the distribution of its research funding to women and men, ensuring equality in the composition of its Evaluation Committees and other groups with scientific tasks.
- g) *Ethical and other review boards, editors and editorial boards should include gender experts* to ensure that gender dimensions of research projects are not missed out.
- 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.*

VIII.2.2 What gets measured is what gets done – data and indicators

Progress towards developing gender-sensitive indicators to monitor gender equity in health presents a mixed picture. At the international level, the normative role of the UN system coupled with the work of the UN Statistical Division and small innovative units (with large impact) such as the Human Development Report office at UNDP has advanced the availability of data and indicators regarding population health status at national level. Some of this data, but not all, is disaggregated by sex; this reflects the quality of national data systems from which the UN system draws. Currently an inter-agency expert group has been discussing indicators to monitor progress towards targets and goals of the MDGs. These data will provide more possibility for inter-country comparisons and a consistent data set over a wider range of variables than are easily available at present. Recently, the World Bank (Global Monitoring Report, 2007) has proposed strengthening the indicators base for tracking progress towards the MDGs. "The shortcomings of the official indicators for monitoring progress in attaining MDG3 are widely recognized (see, for example, the report of the UN Millennium Project Task Force on Education and Gender Equality). In response, this chapter recommends that countries consider monitoring five additional indicators complementary to the official MDG indicators, to better measure gender equality (table 3.3). These indicators meet three criteria: data availability (wide country coverage), strong link to poverty reduction and growth, and amenability to policy intervention." (pp 120-1).

In some countries, decennial censuses are supplemented by regular sample surveys that provide more detail and with greater disaggregation on different aspects of health status, behaviour, access to services⁵². To the extent that such data are disaggregated by income /expenditure quintiles, sex, age, location or other socio-economic characteristics, it makes possible more careful and nuanced analysis of the way in which different social stratifiers interact to produce gendered health outcomes. Not many low income countries have such systems. In many of these

⁵² The National Sample Survey in India is a good example

the Demographic and Health Surveys (DHS) have generated useful data, especially on reproductive behaviour but also on less common issues such as domestic violence and women's empowerment (Kishor, 2000). A single survey of this kind can sometimes have a powerful impact. For example the information in India's second National Family Health Survey (NFHS) on the wide prevalence of domestic violence and attitudes towards it among both women and men catalysed action to deal with the problem, culminating in the landmark Domestic Violence Act 2005.

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, will operate in a vacuum. Surprisingly, in many situations data are not presented in a sex-disaggregated way even if they have been collected. Well-crafted gender-aware indicators can fulfil multiple functions, as "*signal*" to all actors involved in the intervention, as *constant reminder* during the life of the intervention, as *measure of performance* in the achievement of gender-aware goals and objectives, and as a *tool* for analysing shortfalls" (Kabeer and Subrahmanian, 1999)p 352).

But health status indicators alone are not enough. Data on health behaviour affecting different household members, including utilization 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 stratifiers are critical if work on health equity is to go beyond its historically narrow focus on economic differentials alone. When complemented by monitoring indicators that include women's own assessment of the impact on their well-being, this information can help foster better understanding of how women themselves view change processes.

A major requirement to track policies, programmes and projects is to have quantitative and qualitative data 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 be disaggregated by sex and age, and these data must be analysed from a gender perspective. The Women and Health Programme of WHO's Centre for Health Development (Kobe, Japan) has produced a detailed evaluation of indicators for Gender Equity and Health that is an important resource in this area (WHO, 2003a).

It is through research that 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 programmes.

IX. Removing organisational plaque⁵³

IX.1 Mainstreaming and catalysing gender equity in health

IX.1.1 Mainstreaming for gender equality and equity

Many of the organisational structures of government and other social and private institutions through which gender norms have to be challenged and practices altered have been in existence for decades, even centuries. Thickly encrusted with traditional (usually male dominated) values, relationships, and methods of work, it has been a serious challenge to expect these same structures to deliver gender equality and equity as has been attempted through gender mainstreaming. Two decades ago, a major policy challenge was posed by the narrow limits of existing women's programmes. It was in this context that gender mainstreaming came to the forefront of gender equity and equality policies after the Beijing conference on Women in 1995. The Beijing Platform for Action recommended making gender mainstreaming (complemented by actions to empower women) the main strategy guiding the actions of governments and donors together with support for specific programmes for women (Beijing, 1995).

Mainstreaming was clearly viewed at the time as a major advance, allowing forward movement beyond narrowly focused women's programmes or patchwork gender equality legislation. It was understood generally to mean systematic integration of gender perspective at all relevant levels. A common definition is a broad one from the UN Economic and Social Council: "*Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate aim is to achieve gender equality*" (TK Ravindran and Kelkar-Khambete, 2007). Another definition comes from the Commonwealth (The Commonwealth Secretariat, 1999): "*focusing less on providing equal treatment for men and women (since equal treatment does not necessarily result in equal outcomes), and more on taking whatever steps are necessary to ensure equal outcomes*" (TK Ravindran and Kelkar-Khambete, 2007).

The broadness of such definitions, the limited amount of in-depth analytical or technical work to back them up, and the lack of significant political debate to achieve a consensus about their meaning and implications have led to some weaknesses in implementation generally, and in the health field as well. A number of recent policy reviews have been critical of the progress made during the last decade in mainstreaming for gender equality (OECD/DAC, 2002,

⁵³ Plaque refers to a strong buildup and encrustation of material that is difficult but essential to remove. Removal of dental plaque is essential for oral hygiene for example.

NORAD, 2006, Moser and Moser, 2005, AWID, 2006, Eyben, 2006, Mehra and Gupta, 2006, Reisen and Ussar, 2005, Rao and Keller, 2005, EQUAPOL, 2005).

This is true, not only in developing countries but in countries in the European Union, many of which are global champions for women's human rights and gender equality and equity. Various, in different countries "...it is not uncommon to find ...that the term 'gender mainstreaming' mainly functions as a new name to refer to 'old' policy practices...Apart from this, there is also evidence...that 'gender mainstreaming' is exploited to serve diverse political needs....government officials conveniently use the term 'gender mainstreaming' to refer to a move from a focus on women to a more neutral focus on gender (which is simply understood as referring to both women and men)" (EQUAPOL, 2005) p 6). Insufficient resources, weak organisational mechanisms and poor political commitment have resulted in fragmented efforts, significant mismatches between stated gender policy and these efforts, and serious gaps between political rhetoric and actual practice. This holds true not only for efforts at gender mainstreaming but more generally for different attempts to change laws as well.

For instance, Himonga analysed the effect in recent years of changed legal provisions regarding family law favouring gender equality in South Africa, Namibia, Zimbabwe and Zambia (Himonga, 2000). The study found that while considerable advances had been made in the letter of the law, implementation had been less than satisfactory. This was mainly due to lack of political will, structural obstructions and plural legal systems that are contradictory and difficult to change.

Why this policy evaporation? An important reason is that working towards gender equality challenges long-standing male dominated power structures, and patriarchal social capital (old boys' networks) within organisations. 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 practices⁵⁴. Resistance to gender-equal policies may take the form of trivialisation, dilution, subversion or outright resistance.

"Gender-redistributive policies thus impinge directly on the personal beliefs and values, relationships and identities of those who formulate and implement policies ...When policies which seek to redress culturally-sanctioned inequalities have to be implemented by individuals who themselves have been beneficiaries of these inequalities, then implementers are critical stakeholders in the policy process along with members of the community that will be affected" (Kabeer and Subrahmanian, 1999). The EQUAPOL report states that two common reasons for the difficulty in sustaining the gender mainstreaming approach could be "the difficulty of achieving collaborative work across departments or agencies due to power struggles and competition, and the existence of a patriarchal culture within the

⁵⁴ Attempts to break traditional caste- or racial structures within organizations suffer from similar barriers.

Commission, whereby gender mainstreaming does not serve the interests of those in power" (EQUAPOL, 2005); p 15).

In addition, current trends towards harmonising the global development agenda via the Paris Agreement on Aid Effectiveness may serve to divert policy attention from cross-cutting themes such as gender equality, environmental sustainability and human rights (Gaynor, 2006, NORAD, 2006) By focusing largely on the cost-effectiveness of aid funds, the Paris Agenda to date has paid relatively little attention directly to these themes which are critical to development effectiveness. This seriously downgrades the importance of gender equality in the aid agenda that shapes development strategies and policies in low-income countries. In this unsupportive climate, funds for women's organisations have been shrinking as well (AWID 2006). Recognising the difficulty of transforming entrenched power structures within organisations or swimming against the stream of development assistance trends, some have suggested that the way forward is to show that gender equity can be instrumental for the effectiveness of these trends and structures (Bank, 2006, Mehra and Gupta, 2006).

Despite this less than cheerful situation, positive examples do exist of effective policies. Within Europe, Sweden stands out for its effective approach.

Example: Sweden's Gender Equality Strategy

The main goal of gender mainstreaming in Sweden is to tackle the structural roots of gender equality in society at large. This is telling because having such a goal is far from being the norm even within the European Union. In Sweden it involves taking gender relations into account in all activities by public, private and voluntary organisations through systematic gender analysis in the design and delivery of all policies and services. This has been made possible by the key role played by technical experts in defining objectives and methods, something that has, however been stronger at the central government level than at the municipal level. A second important condition that has been met in the Swedish case is effective coordination across sectors and different bodies. Coordination is provided by the Division of Gender Equality within the central administration. Interestingly, these two factors have generated a number of innovative methods for mainstreaming gender such as the 3-R method for analysing gender-based differences in Representation and Resources, and the Reasons for these differences (EQUAPOL, 2005) p 106). Most important, however, has been the forging of a broad social consensus across the political spectrum that insulates gender mainstreaming to some extent from the vagaries of democratic politics.

Sweden's internal policies have been translated into the importance given to gender equality in Swedish development cooperation. (SIDA, 2006) Sida's Policy on Promoting Gender Equality in Development Cooperation states that "Gender equality is at the centre of Sida's mission to promote and create conditions for poverty reduction in partner countries. Mainstreaming gender equality is a strategy for achieving sustainable development for all, by

supporting the right of choice, empowerment and provision of resources. To Sida gender equality involves ensuring that all human beings – women, men, girls and boys – are considered equal and treated equally in terms of dignity and rights. Gender discrimination is one of the main causes of poverty, and a major obstacle to equitable and sustainable global human development” (Sida 2005; p 4).

As can be seen from the case of Swedish policy, gender mainstreaming has to be understood properly, owned institutionally, and implemented effectively, and usually needs to be backstopped by a catalytic gender unit with strong institutional positioning and authority. Effective implementation entails intelligent use of organizational incentives and mechanisms.

Example: Management Improvement Program (Programa de mejoramiento de la Gestión PMG) of the Chilean government.

This program has already won an Inter-American Development Bank award as an example of successful gender mainstreaming in public policy. This Program works as a group incentive linked to institutional performance: all staff of a public institution receives a bonus of up to 4% of their salaries if the institution attains programme management targets which had been approved by the Ministry of Economics. The Management Improvement Program of each institution is prepared considering a group of common areas for all the institutions of the public sector, including those considered essential for effective and transparent management. These together constitute the Framework Program.

Since the year 2000, this mechanism has been applied on the basis of a matrix that identifies the following areas of management improvement in the institutions: human resources; quality of care; planning, control, and integrated territorial management; and financial management. In 2002 a fifth area was incorporated, namely gender planning. The PMG proposal is presented yearly, together with the budget proposal, to the Ministry of Economics. The incorporation of a gender planning component into the PMG implies the introduction of the gender approach in the budgetary cycle. This makes it possible to integrate gender considerations in the routine and habitual procedures of public administration, permanently introducing modifications into the daily dynamics of the institutions and their standardized procedures. Thus, public institutions have to incorporate this dimension into all their strategic products, making it possible to allocate the public budget in a way that responds better to men’s and women’s needs, and contributes to the reduction of gender inequalities .

The implementation of this incentive mechanism constitutes an important innovation, in view of the fact that for the first time a concept of **gender equity** is integrally associated with budgetary management in Chile. (This important innovation goes beyond previous examples of gender-responsive budgeting that have tended to be limited to budget diagnosis). Also, for the first time staff members must include in the analysis of each result produced by their service,

considerations about the usefulness of these products, the way to get to the people who need them, and how to improve them. Furthermore, it makes it possible to correct possible inequities in the delivery of the products of the Ministries and Services and to make public policies more efficient and effective. This is because this mechanism demands considering the needs of the beneficiaries and optimizing the attainment of the objectives proposed by the projects. Thus, to the extent that there is an increase in the number of programs with a gender approach, there is also a significant increase in the public budget assigned to women.

A different approach to the problem of adequacy of resources that is often a bottleneck to effective gender mainstreaming is to use instruments such as CEDAW to monitor government budgets. Elson (Elson, 2005) argues that "government budgets (like any other activity carried out by the state) should be constructed and implemented in ways that *respect, protect and fulfil* human rights. In turn, it is clear that government budgets are indispensable for the realisation of human rights, which cannot be realised without public expenditure and the revenue required to finance this. (p 2) ... Reference to human rights in general, and CEDAW in particular, will not change government budgets overnight. Ministers of Finance tend to give priority to financial obligations, especially to creditors, rather than to human rights obligations, which they tend to regard as the responsibility of other Ministers...Nevertheless, the discourse of human rights can make an important contribution to improving government budgets. Budgets are never the outcomes of a purely technical process based only on financial analysis... The discourse of human rights has a profound moral authority in contesting many current values which disadvantage women. (But) to have a stronger practical impact on budgets, human rights advocacy needs to be backed by detailed analysis of budgets, relating finance to human rights norms."(p 3)

IX.1.2 Gender mainstreaming in health

The discussion above points to the challenges and possibilities of mainstreaming gender in general. The Liverpool Gender and Health Group's *Guidelines for the analysis of Gender and Health* provide valuable tools for mainstreaming gender in health analysis including in research and to ensure quality of health care.⁵⁵ In focusing specifically on health, it is useful to distinguish between *operational* mainstreaming in policies, programmes 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 (TK Ravindran and Kelkar-Khambete, 2007) of gender mainstreaming in health concluded that the enabling conditions include the presence of international, national and regional mandates for the 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.

⁵⁵ http://www.liv.ac.uk/lstm/research/groups/gender_health/index.htm

Example: Sweden's Public Health Policy

Sweden's new public health policy, which came into force in 2003, is an excellent example of integrating gender within the framework of an existing equity-oriented public health policy. The guiding principle of the policy was "to raise the level of and reduce inequalities in people's capability and freedom to choose their lives and pursue their goals" (Östlin and Diderichsen, 2001).

This policy is unique in many ways. *First*, the policy was developed through a Commission consisting of experts as well as politicians from all seven political parties represented in the Swedish Parliament. An important point to note is that evidence was specifically gathered on socio-economic, ethnic, and regional as well as gender-based inequalities in health. The *second* unique feature is that unlike most public health policies, in which objectives are based on diseases or health problems, Sweden's public health policy addresses the broader social determinants of health. There are eleven objectives: participation and influence in society; economic and social security; secure and favourable conditions during childhood and adolescence; healthier working life; healthy and safe environment and products; health and medical care and more actively promotes good health; effective protection against communicable diseases; safe sexuality and good reproductive health; increased physical activity; good eating habits and safe food; reduced use of tobacco and alcohol, a society free from illicit drugs and doping and a reduction in the harmful effects of excessive gambling. The *third* unique feature is the integral way in which gender is woven into the public health strategy. The policy document specifically highlights its commitment to a gender perspective and to reducing gender-based inequalities in health, alongside reductions in inequalities by socio-economic groups, ethnic groups and geographic regions. Gender would thus be a crosscutting category within other dimensions of inequalities that the policy seeks to redress (Östlin and Diderichsen, 2001, Agren, 2003, TK Ravindran and Kelkar-Khambete, 2007).

The most comprehensive documentation of gender mainstreaming experiences in reproductive health is found in the "*So What Report*", commissioned by the Inter-Agency Gender Working Group (IGWG, 2004). This report seeks to find out whether integration of gender into health programmes makes a difference to the outcomes. All 22 interventions examined in the '*So What*' report pertain to improving reproductive health, although the entry points for some of the interventions have been through education or economic development. The interventions have been classified into four main areas: maternal mortality and morbidity, unintended pregnancies, quality of care initiatives and STIs and /HIV/AIDS. These case studies present very important evidence showing that the integration of gender consideration into programmes can lead to a positive impact on gender relations and reproductive health outcomes.

However, many questions remain. Unless we have a comparison group of interventions, which do not integrate gender considerations, it is not possible to claim that mainstreaming gender leads to improvement in reproductive health outcomes. Where there have been significant changes in health related behaviour, evaluation of gender

mainstreaming activities should be able to focus more on the processes or steps taken by women or the negotiation skills used by women with their partners or at the familial and community level to reach these positive reproductive health outcomes. In other words, were the positive outcomes a result of a change towards more equitable gender-power equations? Or were they simply the result of better access to services? (TK Ravindran and Kelkar-Khambete, 2007)

Access to mainstream budgetary resources is essential to successful implementation. A study by the International Center for Research on Women in 2002 compared budgetary allocations and spending to implement laws on domestic violence (DV) in a sample of Latin American and Caribbean countries (Luciano et al., 2005). "The research shows that there is clearly a difference between what is ratified in laws and/or outlined in sectoral policies, and the implementation of activities that follows those decisions. Funding for DV programs is typically insufficient for them to reach the entire target population and address the magnitude of the problem. Even after laws were passed and plans of action launched, major sources of funding for DV services have continued to be discretionary funds from the ministries' budgets and international donor funds. This means budgetary resource allocation is *not* being mainstreamed into ministerial budget line items as would be expected following the passage of law. Furthermore, there is no systematic and comprehensive information available on allocations made for implementing laws and plans of action, the distribution of those allocations, or their impact on gender equity. Also, there is no information about how public services on DV are meeting the victims' needs, especially women's, and if the financing laws and plans of action are in accord with women's needs and priorities. Budget allocations are a marker of political commitment and priority" (p 20).

IX.1.3 Empowering women for better health

The Beijing Platform for Action had identified clearly the need for a dual focus on women's empowerment and gender mainstreaming: "on the one hand, programmes aimed at meeting the basic as well as the specific needs of women for capacity building, organisational development and empowerment; and on the other, gender mainstreaming in all programme formulation and implementation activities". A detailed review of the links between empowerment and health improvements (Wallerstein, 2006) was done for WHO / EURO's Health Evidence Network. Based on evidence from interventions for youth empowerment, HIV/AIDS prevention, women's empowerment, and patient / family empowerment for health, the review concluded that "the most effective empowerment strategies are those that build on and reinforce authentic participation ensuring autonomy in decision-making, sense of community and local bonding, and psychological empowerment of the community members themselves" (p 5).

Women's empowerment has suffered from some of the same conceptual confusion as gender mainstreaming (though to a much less extent) and for some of the same reasons. Ultimately, empowerment is about changing power relations; hence the temptation for policy makers and programme and project managers to 'sanitise' the issue and play it safe is not surprising. While mainstreaming has been about policy structures, empowerment has typically

focused on households and communities. Wallerstein's review concludes that improved education (including adult literacy) for women has clear positive effects for children's health, while income in women's hands through micro-credit or other means has the potential for better family nutrition and health. However, what is really needed for this potential to be realized is simultaneous increases in women's autonomy, mobility, decision-making authority and power within the household. Without this, micro-credit may end up increasing women's work burdens without giving them greater authority or control. "A meta-analysis of 40 women's empowerment projects showed a wide range of quality of life improvements, including increases in women's advocacy demands and organizational strengths, enhanced services, and policy and government changes as a result of advocacy, with some organizations showing transformed economic conditions for the women" (Wallerstein 2006; p 13).

A different evaluation based on mobilization and organization by women sex-workers in Sonagachi showed successful reduction in HIV infection and increased condom use (Jana et al., 2004). Its success has been based on "the use of peer outreach workers, broad community concern as the starting point of the project, leadership development of the women, support by health professionals, and the eventual ceding of leadership to a new sex worker association" (Wallerstein 2006; p 13). Similar experiences have been found in other parts of India as well.

A third set of experiences draws from the experiences of women community health workers. Meta-analysis of studies on health impact has shown improvements in health care utilization, in patient completion of health education programmes, improved immunization coverage along with increased social support, leadership and advocacy capacity of the health workers themselves. Wallerstein (Wallerstein, 2006) concludes that "...interventions that have been most integrated with the economic, education, and /or political sectors have resulted in greater psychological empowerment, autonomy and authority, and have substantially affected a range of health outcomes" (p 14).

X. The Way Forward – Getting There From Here

This report has shown that gender relations of power exist both within and outside the health sector, and exercise a pernicious 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. Outside the health sector, traditional gender power is embedded in unequal access to and control over resources (both material and non-material), and unfair divisions of work, leisure and possibilities of improving one's life. It is expressed through normative frameworks that are internalised by people and used to socialise and discipline them to accept and reproduce gender inequities in their private lives and in society. Within the health sector, gender

power relations translate into differential access to and control over health resources within and outside families, unequal divisions of benefits and labour in formal, informal and home-based health care systems, and unfair attention (or lack of it) through health research, all justified and reinforced through potent gender norms of what actions are needed and appropriate. Both within and outside the health sector, gender relations mean reduced voice, agency, decision-making, authority and recognition for women relative to men.

This report has drawn together the rapidly growing body of evidence that identifies and explains what this implies in terms of differential exposures and vulnerabilities for women versus men, and also how health care systems and health research reproduce these inequalities and inequities instead of resolving them. 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.

It has also documented the growing numbers of actions by non-governmental and governmental actors and agencies to challenge these injustices and to transform beliefs and practices within and outside the health sector in order to generate sustained changes that can improve people's health and lives. While there are still only a few countries that have taken comprehensive multi-sectoral actions backed by policies and legislation and supported by civil society actions, there are many smaller cases and examples from which all actors can learn, and which can be the basis for moving forward. The report has highlighted a number of examples, some of which have been fully evaluated, and others of which are experimental and hold promise. These actions span a set of seven approaches that are essential for forward movement.

Seven approaches that can make a difference:

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/programmes 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 programmes 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 programmes 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 life-styles 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 life-styles 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 life-styles 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 stratifiers 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 analysed 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 organisations 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 organisations who are critical to ensuring that women have voice and agency, who are often at the forefront of identifying problems and experimenting with innovative solutions, who prioritise demands for accountability from all actors, both public and private, and whose access to resources has been declining in recent years.

These seven approaches encompass a set of priority actions that need to be taken both within and outside the health sector, and need the engagement and accountability from all actors – international and regional agencies, governments, the for-profit sector, civil society organisations and people's movements. While health ministries nationally and WHO and its regional organisations internationally, have a critical leadership role in mobilising political

will and energising coalitions and alliances, no person or organisation can be exempt from action to challenge the barriers of gender inequity. Only thus can the continuing vicious circles of health inequality, injustice, ineffectiveness, and inefficiency be broken.

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Annexes

Annex 1. List of background papers

1. Aditi Iyer, Gita Sen and Pirooska Östlin (2007) Intersectionality in Health and Health Care: A review of Research and Policy
2. Rosalind Petchesky and Melissa Laurie (2007) Gender, Health and Human Rights in Sites of Political Exclusion
3. Helen Keleher and Lucinda Franklin (2007) Strategies/interventions for Changing Gendered Norms at the Level of Household and Community
4. Rachel Snow (2007) Gender, Sex and Vulnerability
5. Asha George (2007) Human resources for Health: A Gender Analysis
6. Veloshnee Govander and Loveday Penn-Kekana (2007) Gender Biases and Discrimination: a review of health care interpersonal interactions
7. Ranjani K.Murthy (2007) Accountability to Citizens on Gender and Health
8. Karina Batthyany and Sonia Correa (2007) Health, Gender and Poverty in Latin America
9. TK Sundari Ravindran and Aarti-Kelkar Khambete (2007) Women's Health Policies and Programmes and Gender Mainstreaming in Health Policies, Programmes and within the Health Sector
10. Susan Watts (2007) Case study: The impact on women of changes in personal status law in Tunisia
11. Marion Stevens (2007) Case study: What was done in South Africa and what can be learnt from it

Annex 2: Case studies

1. The impact on women of changes in personal status law in Tunisia

Tunisia is a progressive, middle income country with a population of 10 million, which is now predominantly urban, changing from 33% urban in 1956, at the time of political independence, to 63% urban in 2002 (Bousslama 2004). It has achieved both the demographic and epidemiological transition. It enjoys a health status that is considered good for its economic position and expenditure on health, \$137 per capita in 2003 (EMRO 2007 A). The poverty rate has fallen from around one third in the mid-1960s to 4.1% in 2000 (Lahouel 2007). Maternal and infant health have been a prominent part of national health programs since the 1960s, with the infant mortality rate falling from 200 per 1000 in 1956 to 20.6; this most recent figure is the highest in EMR, except for countries of the Gulf Collaborative Council. Ninety-five per cent of the population lives within 5 km of a health facility (EMRO/WHO 2007 A; EMRO/WHO 2007 B). The improved health status of Tunisians is attributed to a number of factors, such as primary health care that is physically and financially accessible for the population (with social protection being unified and being extended to all under current reforms), and to changes in the personal status law which have affected the status of women over the last fifty years and are unique in EMR (EMRO 2007 B).

Changes in the personal status law in Tunisia began, soon after independence, with the 1956 Personal Status Code, outlawing repudiation and polygamy, establishing a minimum age for the marriage of girls, and providing for equal wages for men and women. Reforms in 1993 concerned the marriage of minors, the mutual obligations of husband and wife, and domestic violence. This legislation has brought about a profound change in the norms concerned with women's position in society and within marriage, characterized as moving "from sexual submission to voluntary commitment" (Labidi 2001; see also Adas 2007).

The position of women in family and society is reflected by women's responses in the Tunisian family health study in 2000. Almost 60% (58%) of women believed that it is possible to take care of the family and work at the same time; 47% believed they have a better status with their husbands than their mothers had, and 46% believed that working women have more say in their households than non-working women.

Two thirds of women believed that women who have no children have a lower social status, reflecting a continued strong belief in the proper role of women as mothers. Respondents still believed in social restrictions on single women and unmarried girls: 16% unconditionally agreed that single women can live alone; 10% unconditionally approve that girls can travel alone; and only 7.5% unconditionally approve that girls can go out with boys. Among never married youth (both males and females) aged 18-19 years, 93% declared that they chose/will choose their

future spouse; 70% declared it was unacceptable to use contraception before marriage (PAPFAM 2001). Most of these responses confound the critics in the Arab world who believe that "family breakdown" and "immorality" will follow from giving women more rights, and encouraging them to work and be educated.

Higher levels of education and employment are part of the overall change, and improvement in the status of women. In 2000, one quarter of urban women worked and 8% of rural women (PAPFAM 2001). These figures refer to formal employment, and reflect the expansion of urban manufacturing jobs, with official pro-poor policies fostering employment opportunities, especially in the textile industry. In 2000, women comprised three quarters of textile labor force. Most of these women came from poor households, and their work made a significant contribution to household income, helping lift families out of poverty. Employment in the formal sector, such as the garment industry, provided job security and other rights for women that were guaranteed by law (Lahoule 2006). However, the ratio of female to male earned income is around the mid-point for EM countries for which data is available, 0.28, compared to Egypt 0.23 and a high for the region in Iran of 0.38 (Egypt and Iran also have equal pay legislation for women). There is not enough data to compile the index of gender empowerment for Tunisia (UNDP 2006).

The growing proportion of women receiving education is reflected vividly in the 1988 figures for women with no schooling; in the age group 15-19 yrs 34.5% had no schooling, compared to 89% for the age group 45-49, their mother's generation. The proportion of young women who had completed at least secondary education was 10.8%, compared to 4.5% for their mothers' generation (et al. 1989). A generation later, almost all girls and boys were enrolled in school: the gross primary school enrolment ration was 97% for both girls and boys, and in secondary school 73% and 75% respectively (EMRO 2007 A).

Tunisia has succeeded in controlling its population growth with a family planning programme in place since the 1960s which has had a profound impact on women's lives. Tunisia had a total fertility rate of 2.0 in 2004, one of the lowest in EMR; it is equal to that of Iran (2.0 in 2000) and higher than Lebanon (1.7 in 2005) (EMRO 2007 A). The FHS 2000 found a total fertility rate for the three years prior to the survey of 2.1. The mean number of live children for women 45-49 years was 4.8, reflecting the considerable decline in fertility experienced by Tunisian women over the past 10-15 years (PAPFAM 2001).

Women in Tunisia received the right to vote and to stand for election in 1959, well before most other countries in EMR. In 2006; 22.8% of seats in the lower house were held by women (compared to 4 in 1990), and 13.4% of seats in the upper house were held by women. Women held 7.1% of ministerial appointments as of 2005; two EMR countries where women received the vote much more recently have achieved slightly higher levels (Oman 10%, Bahrain 8.7%) (UNDP 2006). Thus, in terms of political representation, the overall position of women in Tunisia is

good compared to other countries in EMR and demonstrates the concrete way in which women, with political as well as social power, can contribute to changes in Tunisia as a whole, and in their own lives.

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2. What was done in South Africa and what can be learnt from it

CURRENT STATISTICS (Sources: Ijumbaand Padarath 2006; Barron et al. 2006; UNDP 2007; Benjamin 2007)

Population: 47.4 million

Water access: 85% of households have access to piped water There is great variation in access to water across districts with 90% of metro (Cities) having access to piped water yet some rural areas particularly in the Eastern Cape only having 28% access to piped water.

Gini Coefficient: 0.722

Human Development Index: 0.653 **Gender-related Development Index** 0,646

Unemployment: 26%

Life expectancy: 47 years

Energy supply 40% experienced at least periodic shortages of fuel for cooking or home heating. 61.3% used electricity for cooking

Mortality: HIV (51%) is the leading cause of death of women aged 15-54 years

Connectivity: 28 million out of 47 million people have cellphones. 98% of public health clinics have a cellphone

Women's Health and Sexual and Reproductive Health and Rights (Sources: Ijumbaand Padarath 2006; Barron et al. 2006; Mosotho 2006)

Rapes reported: 55 1114 reported from April 2004 –March 2005.

Incidence: 143 per 100 000

PPTCT: 51% of HIV positive pregnant women accessed neviripine

Total Fertility rate: 2.7

Contraception rate: Use of 'family planning': 65%

Antenatal care attendance: 95%

Abortion: There have been **529 410** safe and legal pregnancy terminations during the ten year period (1997 to 2006) since the introduction of the Choice on Termination of Pregnancy (CTOP) Act in February, 1997. This has led to a 90% reduction in maternal mortality and morbidity in relation to abortion.

Abortion Facilities: 51% of designated facilities functioning

Maternal death: 150/100 000. The main reasons for primary obstetric death are non-direct causes of non-pregnancy related infections Maternal deaths (deaths during pregnancy and the puerperium) was made notifiable condition in 1997. The National Committee for Confidential Enquiries into Maternal Death (NCCEMD) secretariat is responsible for coordinating the process of notification and reporting and making recommendations

Caesarian Rate: 18.4%

HIV/AIDS and other STIs (Sources: Ijumbaand Padarath 2006; Barron et al. 2006; Xundu 2007; Moodley 2006)

Estimated number of people living with HIV: 5.5 million

Antenatal HIV prevalence 29%

Overall adult prevalence rate: 18.8%

Average STI incidence: 4.8% (This indicator measures the percentage of people 15 years and older who have been treated for a new episode of a sexually transmitted STI)

Incidence in terms of gender and age: Women are disproportionately affected: accounting for approximately 55% of HIV positive people. Women in the age group 25-29 are the worst affected with prevalence rates of up to 39.5%

HAART treatment: January 2007 250 000 on treatment in government public sector and 100 000 on treatment in private sector

AIDS Defining Illnesses: The incidence of cervical cancer is 30:100 000. There is presently an increase in pre-cancerous lesions in HIV positive women. Cervical Cancer is the leading cause of cancer mortality in South African women.

Children (Source: Barron et al. 2006)

Immunisation coverage measures the percentage of children under one year who have completed their primary course of immunisation. The national target of 90% was achieved during the year and this is one of the success stories of PHC in South Africa. Linked to this was the great achievement of South Africa being declared a polio free country in 2006.

Diarrhoea: 258 new cases of diarrhoeal disease per 1000 under five in 2005

Perinatal mortality 34 per 1000 births in 2005

THE CONTEXT OF WOMEN'S HEALTH IN SOUTH AFRICA

Following the change of government in 1994 rapid strides were taken to prioritize women's health. In the first 100 days of President Mandela's presidency, an announcement was made that primary health care was to be free to pregnant women and children under six. This was to ensure that poor women and their children had access to care. These broad strides were welcomed and heralded a period of significant policy and legal change orientated to the poorest of the poor. This took place when the health care system itself was transforming towards developing an integrated and decentralized health care system based on primary health care. Subsequently primary health care was made freely available to all citizens in the public sector. Health workers were not prepared for this and in retrospect have become overwhelmed with what is commonly termed 'change fatigue'. Efforts continued to increase access to health broadly and are clearly defined in the South African Constitution in section 27 in the clause 'Health care, food, water and social security'. It states: '(1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependents appropriate social assistance. (2) The state must take reasonable legislative and other measures within its available resources, to achieve progressive realization of these rights, (3) No one may be refused emergency care treatment' (Klugman 1998). While efforts have been made to implement this with over 4000 public health facilities employing some 235 000 personnel, care is sometimes sub-optimal, public facilities have long waiting times and primary care facilities have too few doctors (Barron et al. 2006). In relation to broader determinants of public health many people do not have access to clean water, sanitation, nutrition, electricity and safety which facilitates poor health. Poor people face the high costs of transport, buying medicines, and follow up visits to a doctor. Language barriers between patients and health workers mean that many people may not be able to fully understand their treatment. Many women experience domestic violence, sexual offences and other forms of violence against women. There are discriminatory attitudes amongst health care workers against people because of their race and gender. Because of the HIV/AIDS crisis, many hospitals and clinics face a huge increase in patients, but there has not been an increase in the doctors and nurses available to care for all the new patients. The health care system is better equipped and provides better services in provinces like Gauteng and the Western Cape, than in others such as the Eastern Cape and Limpopo.

It is perhaps important to underline the period of 'transformational flow' or 'soft boundaries' during the period of about 1994- 1998. This period was characterized by a flow and political ease in which policy change at addressing the apartheid past was welcomed. It was enabled by relationships which spun a network into various institutions including parliament, political parties, the media, government departments and NGOs. There was an element of trust and the need to work collaboratively to address the past imbalances that characterized South Africa. As Black women were known to have borne the brunt of apartheid's evils, women's rights were acknowledged as human rights and there was an understanding that laws and policies needed to be put in place to correct this.

LAWS AND POLICIES ADDRESSING WOMEN'S HEALTH

While there were broad reforms addressing issues of equity and women's health, there have also been very specific changes. These include: The Choice on Termination of Pregnancy Act 1996 and the Choice on Termination of Pregnancy Amendment Act, 2004, the Notification of and Confidential Enquiry into Maternal Deaths (NCCEMD), The Sterilization Act, 2000, Contraception policy guidelines and the Comprehensive plan for the management of HIV and AIDS and the HIV and AIDS National Strategic Plan 2007-2011. In highlighting a few of these areas:

1. While South Africa has liberal abortion law which has successfully reduced abortion related maternal mortality and morbidity, demand for services exceeds supply and health workers have not easily accepted the provision of this service. The law is constantly under attack from anti-choice activists. The media is not helpful and in 2006, services were suspended for two weeks in the Northern Cape as service providers thought the legislation had been repealed
2. The NCCEMD is a process designed to evaluate, indirectly, the quality of care that women receive during pregnancy and childbirth. It is evident that AIDS is proving to be the largest challenge to addressing maternal mortality in South Africa.
3. As part of the HIV/AIDS continuum of care, the programme for the prevention of mother to child transmission PMTCT was the first step in improving the health care of pregnancy women infected with HIV in that it helped to identify those pregnant women who were HIV positive. The South African PMTCT programme was largely introduced as a vertical programme to allow for central control and faster implementation; however the result is that it does not function integrally with broader maternal and child health services. The indicators suggest that many opportunities to prevent mother to child transmission are being missed. The orientation of the programme has also been to emphasize the child's health and not the mothers' health which has been problematic.

The period of policy has changed and is not as open and easy as in the late nineties. The Sexual Offences Bill was passed in Parliament in May 2007 and has been in the making for some ten years. While it has been welcomed as a positive change by activists, it still falls short in including clear regulations concerning integration of health, justice and safety and security which would make the law implementable.

HEALTH SYSTEMS CHALLENGES

As noted all of these developments have taken place in a transforming health system. There has been increased expenditure in primary health for capita from – R168 in 2001 to R232 in 2005. The average clinical workload of a nurse was 31.6 patients a day in 2005. And the primary health care utilization rate is the average number of visits a person per year to a public PHC facility which in 2005 was 2.1 (Barron et al. 2006). The challenges of South Africa are complex as it is a profoundly inequitable country as noted by the gini coefficient. There are consistent efforts to spread the resources and transform the health system. In developing systems to increase the supply of health workers in rural areas health graduates have a compulsory community service year and there is a rural allowance for certain health workers.

THE ROLE OF LEADERSHIP AND CIVIL SOCIETY

As noted in this case study, HIV/AIDS is the challenge that is affecting women health in their reproductive years. There have been enormous difficulties and complexities in delivering leadership around HIV/AIDS in South Africa led to a number of missed opportunities, confusion and what is know as 'denialism'. In the recent past there has been excellent leadership demonstrated by the Deputy President of South Africa (Mrs [Phumzile Mlambo Ngcuka](#)) and Deputy Minister of Health (Mrs Noziwe Madlala-Routledge) who have engaged and lead the processes of the South African National AIDS Council and the new National Strategic Plan for HIV/AIDS (Department of Health 2007). Prior to this there has been a re-emergence of strong social movements as in the Treatment Action Campaign (TAC), The Social Movements Indaba and the Anti-Privatization Forum (fighting the privatization of basic services of water and electricity). TAC has been successful in litigating for the access to HAART and for increasing treatment literacy amongst activists.

It is important to note that the recent past has been characterized by a lack of leadership and mistrust of politicians. As the country matures in findings its identity, so have activists who previously would have made things happen in across various institutions. There is a period of 'hard boundaries' where there appears to be tiredness and a sense of poor morale.

While the HIV/AIDS sector has embraced the concern of general equity issues, women's sexual and reproductive health and rights in relation to HIV/AIDS are not being explored and addressed with he same vigour and passion.

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Annex 3. Age adjusted and non-weighted 2002 DALYS by sex

CAUSE	MALES	FEMALES	M/F RATIO	F/M RATIO
Breast Cancer	44 483	11 733 351	0,00	263,77
Chlamydia	264 196	2 888 421	0,09	10,93
Trachoma	811 980	2 475 721	0,33	3,05
Migraine	3 146 812	8 802 838	0,36	2,80
PTSD	720 628	1 883 391	0,38	2,61
Rheumatoid arthritis	1 672 682	4 259 468	0,39	2,55
Panic disorder	1 844 713	3 594 381	0,51	1,95
Alzheimer and other dementias	7 213 869	12 818 790	0,56	1,78
Osteoarthritis	9 149 400	15 629 274	0,59	1,71
Other musculoskeletal disorders	2 093 852	3 518 880	0,60	1,68
Fires	8 223 566	12 768 433	0,64	1,55
Unipolar depressive disorders	21 133 650	32 507 673	0,65	1,54
Other nutritional disorders	830 738	1 256 324	0,66	1,51
Iron-deficiency anaemia	6 077 808	9 025 199	0,67	1,48
Other oral diseases	65 503	95 088	0,69	1,45
Insomnia (primary)	1 362 610	1 894 676	0,72	1,39
Multiple sclerosis	722 796	1 000 898	0,72	1,38
Obsessive compulsive disorder	1 705 743	2 330 821	0,73	1,37
Other intestinal diseases	65 128	88 928	0,73	1,37
Cataracts	15 729 865	21 454 199	0,73	1,36
Rheumatic heart disease	4 548 016	6 184 772	0,74	1,36
Vision disorders, age-related	9 413 331	12 714 330	0,74	1,35
Glaucoma	2 464 786	3 304 452	0,75	1,34
Gonorrhoea	1 468 966	1 951 707	0,75	1,33
Other genitourinary system diseases	2 842 889	3 668 296	0,77	1,29
Dengue	544 347	677 779	0,80	1,25
Japanese encephalitis	533 117	658 357	0,81	1,23
Other infectious diseases	36 796 917	45 068 486	0,82	1,22
Vit A deficiency	775 426	945 049	0,82	1,22

Edentulism	1 778 465	2 162 310	0,82	1,22
Diabetes mellitus	12 372 560	15 027 673	0,82	1,21
Hepatitis C	1 202 062	1 408 635	0,85	1,17
Other cardiovascular diseases	18 319 241	21 265 330	0,86	1,16
Syphilis	4 053 856	4 692 917	0,86	1,16
Anencephaly	683 447	775 349	0,88	1,13
Malaria	47 184 421	52 646 469	0,90	1,12
Upper respiratory infections	1 736 106	1 923 279	0,90	1,11
Other sense organ disorders	36 444	40 358	0,90	1,11
Endocrine disorders	8 226 732	9 109 567	0,90	1,11
Spina bifida	1 730 621	1 896 377	0,91	1,10
Parkinson's disease	1 439 561	1 559 615	0,92	1,08
Skin diseases	2 218 661	2 385 765	0,93	1,08
Hypertensive heart disease	7 303 915	7 807 575	0,94	1,07
Iodine deficiency	2 463 954	2 622 004	0,94	1,06
Meningitis	6 084 357	6 458 471	0,94	1,06
Measles	28 939 456	30 117 187	0,96	1,04
Pertussis	14 170 510	14 661 193	0,97	1,03
Ascariasis	1 405 192	1 451 820	0,97	1,03
Tetanus	10 074 844	10 404 369	0,97	1,03
Hearing loss, adult onset	21 165 370	21 849 494	0,97	1,03
Other digestive diseases	24 031 025	24 802 408	0,97	1,03
Oesophageal atresia	49 725	51 254	0,97	1,03
Poliomyelitis	119 581	123 148	0,97	1,03
Cerebrovascular disease	46 437 060	47 623 180	0,98	1,03
Congenital heart anomalies	15 605 506	15 766 841	0,99	1,01
Mental retardation, lead-caused	9 781 145	9 864 597	0,99	1,01
Periodontal disease	124 100	124 655	1,00	1,00
Bipolar disorder	6 758 278	6 741 688	1,00	1,00
Protein-energy malnutrition	16 303 497	16 171 434	1,01	0,99
Cleft palate	151 758	150 012	1,01	0,99
Lower respiratory infections	99 057 981	97 801 108	1,01	0,99

Schizophrenia	8 493 345	8 362 836	1,02	0,98
Dental caries	2 661 761	2 598 162	1,02	0,98
Other STDs	206 978	200 553	1,03	0,97
Other neoplasms	1 738 442	1 684 413	1,03	0,97
Trichuriasis	753 613	723 769	1,04	0,96
Asthma	9 470 074	9 084 234	1,04	0,96
Cleft lip	135 239	128 909	1,05	0,95
Chagas disease	433 079	412 078	1,05	0,95
Nephritis and nephrosis	8 092 123	7 649 053	1,06	0,95
HIV	78 020 596	73 516 955	1,06	0,94
Lymphomas, multiple myeloma	4 243 131	3 982 863	1,07	0,94
Diarrhoeal diseases	71 883 930	67 296 145	1,07	0,94
Other neuropsychiatric disorders	11 921 124	11 075 765	1,08	0,93
Colon and rectum cancers	5 840 667	5 399 893	1,08	0,92
Diphtheria	217 735	200 701	1,08	0,92
Other perinatal conditions	20 890 338	18 912 259	1,10	0,91
Hookworm disease	52 920	47 754	1,11	0,90
Otitis media	999 810	892 137	1,12	0,89
Low back pain*	1 283 741	1 141 412	1,12	0,89
Chronic obstructive pulmonary disease	27 105 051	24 060 627	1,13	0,89
Down Syndrome	3 586 625	3 183 535	1,13	0,89
Epilepsy	5 288 586	4 692 538	1,13	0,89
Low birth rate	58 925 647	51 321 438	1,15	0,87
Melanoma and other skin cancers	702 842	607 265	1,16	0,86
Abdominal wall defect	163 394	139 379	1,17	0,85
Other Congenital anomalies	6 533 135	5 532 364	1,18	0,85
Pancreas cancer	2 112 858	1 782 346	1,19	0,84
Other respiratory diseases	12 109 816	10 145 982	1,19	0,84
Leukemia	4 915 256	3 989 204	1,23	0,81
Birth asphyxia and birth trauma	44 068 687	34 940 346	1,26	0,79
Appendicitis	359 687	281 805	1,28	0,78
Inflammatory heart diseases	5 650 277	4 387 989	1,29	0,78

Ischaemic heart disease	64 504 498	50 082 860	1,29	0,78
Other malignant neoplasms	9 324 018	6 993 333	1,33	0,75
Onchocerciasis	355 411	264 327	1,34	0,74
Leishmaniasis	1 970 613	1 462 594	1,35	0,74
Leprosy	198 328	142 864	1,39	0,72
Self-inflicted injuries	21 665 217	15 201 138	1,43	0,70
Renal agenesis	104 192	69 973	1,49	0,67
Cirrhosis of the liver	14 613 849	9 734 719	1,50	0,67
Falls	14 429 845	9 532 961	1,51	0,66
Other unintentional injuries	49 236 025	32 020 194	1,54	0,65
Schistosomiasis	1 025 505	666 404	1,54	0,65
Stomach cancer	9 576 685	6 171 105	1,55	0,64
Peptic ulcer disease	4 574 045	2 939 246	1,56	0,64
TB	37 298 748	22 944 907	1,63	0,62
Trypanosomiasis	1 741 306	1 043 857	1,67	0,60
Oesophagus cancer	5 266 748	3 049 496	1,73	0,58
Poisonings	8 927 574	5 011 169	1,78	0,56
Hepatitis B	2 645 774	1 408 635	1,88	0,53
Anorectal atresia	49 504	25 843	1,92	0,52
Bladder cancer	1 913 556	964 949	1,98	0,50
Drownings	13 983 352	6 795 333	2,06	0,49
Liver cancer	9 409 480	4 208 880	2,24	0,45
Trachea, bronchus, lung cancers	15 232 399	6 687 840	2,28	0,44
Road traffic accidents	45 112 383	19 625 523	2,30	0,44
Mouth and oropharynx cancers	4 751 823	1 991 476	2,39	0,42
lymphatic filariasis	6 248 138	2 056 275	3,04	0,33
Drug use disorders	6 006 662	1 616 742	3,72	0,72
Other intentional injuries	496 974	126 953	3,91	0,26
Violence	27 470 156	6 810 306	4,03	0,25
Alcohol use disorders	14 810 111	2 662 637	5,56	0,18
Gout	4 246 359	572 741	7,41	0,13
War	9 306 296	1 131 676	8,22	0,12

Source: Table provided by Rachel Snow

