Health degendered is health denied

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Let me thank the Institute for Gender and Development Studies for inviting me to give this lecture this evening. I am in the Caribbean and any time I speak here of health issues and with even the slightest relation to women; I refer to Dame Nita Barrow, as she was one of my heroines. I knew her well, counted her as a family friend and valued her advice on a range of health and other issues. I was on my way to Barbados to consult her on the way to involve the church more tangibly in matters of health in the Caribbean, but she died on the very day that I arrived. Many know her primarily as a champion of women's causes, and her stellar work as President of the YWCA and her leadership of the historic women's conference in Nairobi are well chronicled. The Nairobi conference with the participation of some 20,000 women was a triumph of diplomatic and managerial skill and a case study in leadership and conflict resolution. Her seminal activities in the field of health are equally stellar. She held many senior posts in the nursing profession, both nationally and internationally, but perhaps the one which has had the greatest impact globally was that of Director of the Christian Medical Commission. That Commission was formed by the World Council of Churches to give effect to the concern that health and healing should be a fundamental part of the Church's mission.

The evolution of that thinking into concern for the health of and by the people was one of the factors that influenced Halfdan Mahler, Director General of the World Health Organization, to articulate the concept of Primary Health Care. Indeed the term "primary health care" was first used by the Commission. Dame Nita saw health very much as a manifestation of social conditions and I have quoted before one of her many speeches on health and social injustice in which she said:

"In many parts of the world, the distribution of land, the inability of the rural sector to feed itself, the scarcity of employment opportunities, the lack of basic domestic and sanitary conveniences and other pressures arising from social injustice constitute the greatest threat to public health. The subject of the people's participation in the delivery of primary health is crucial to the justice and sustainability of the social system as it relates to health."

On several occasions when she discussed health and injustice with me she would refer to the particular plight of women and the extent to which they were disadvantaged.

I would also like to recognize the pioneering work in this field of persons like Peggy Antrobus, Jocelyn Massiah and Elsa Leo-Rhynie and the current group of

academics like Eudine Barriteau, Christine Barrow, Rhoda Reddock, Patricia Mohammed, Verene Shepherd and Barbara Bailey among others who stimulated me to give this lecture and have contributed to my own thinking in the area of health and gender.

Let me affirm at the outset that I have no intention of entering the lists over the topics of female or male marginalization as such. This is beyond my competence and the time I have been allotted. My more prosaic intention is to describe some of the evolution of my own thinking on gender and health, set out some of the health problems which have their foundation in gender and point out some of the pitfalls to be avoided and the steps to be taken to reduce some of the health inequities that arise from gendered discrimination. This must not distract attention from the many major health problems that affect men and women generally or because of their biological sex, but rather to pay attention to some of those which arise from gender considerations.

When I was a schoolboy and studied the classics, I thought of gender exclusively as a grammatical category. Perhaps my first introduction to thinking about gender in its social sense and its possible relation to health and medicine occurred when I was Professor of Medicine and a group of female medical students presented me with a copy of Germaine Greer's "The Female Eunuch." I have never been clear if this was a silent rebuke or a thank-you for my understanding of some of the issues they faced as they tried to come to grips with a profession which was at that time male dominated. I was fascinated and a bit taken aback by Greer's flaming rhetoric and what I considered then an almost revolutionary approach to a change in human relations. I marvelled that she dismissed almost nonchalantly the pioneering work of the early feminists as being insufficient and almost a barrier to acquiring the kind of justice and liberation that were necessary for women's advancement. On reading it now, I am less alarmed and am struck with the view that it was necessary to be specific and identify clearly the nature of the difference – the nature of the inequality before assigning a gender bias and trying to correct it.

My more intimate contact with women's organizations and gender was as Director of the Pan American Health Organization (PAHO) and I took great pride in our programme on Women, Health and Development. I insisted then that the name be such rather than calling it Gender, Health and Development and took the view that while I accepted that gender discrimination affected men as well, the impact on women was much greater. One of the challenges was to keep the programme fixed on the gender dimensions of health and less on the health of women that derived from their biology. It was critical to have health statistics disaggregated by sex as that was the first step towards establishing the difference and therefore those aspects that were gendered.

Through this programme and since, I have come to have some better understanding of the currents of feminist thought and have arrived at the rather

prosaic conclusion that in spite of the various forms of interpretation of the issues, and the various sociological constructs, what underpinned much feminist thought was the basic objective of acquiring political, social and economic equality for women and men. The biological differences should not enter judgment of individual strength or weakness. The recent World Bank report on "Gender Equality and Development" deals with gender equality as a core development objective. It bases the work on a definition of gender with which I am comfortable. "Gender refers to the social, behavioural and cultural attributes, expectations and norms associated with being a man or a woman". We are born male or female but we are acculturated into the different gender roles by societal custom and practice or as Simone de Beauvoir would say famously, "One is not born a woman, one becomes one."

But before entering into the relation between gender and health, I must relate a personal incident which demonstrated for me the pervasiveness of the gender dimensions of health. Gender discrimination is pervasive and powerful to the point where it enters into areas that might properly be designated as within the biological role of women and thus not subject to gender discrimination.

I visited a clinic in a rural area in which PAHO was supporting a project on maternal health. The head of the clinic related the story of a young woman who had started to haemorrhage towards the end of her pregnancy. Although the haemorrhage grew worse she did not go to the nearby hospital for attention, but stayed at home and bled to death. When I asked why, I was told that she could not go because she had to have her husband's permission to do so. By the time the husband arrived home she was dead. I commented on the case as one of inadequate services that have led throughout the world to maternal mortality. The head of the clinic with quivering voice replied that it was a most horrible manifestation of gender inequity. Such was the level of male dominance in that society that it overshadowed the basic dictates of self-preservation. This was a lesson that the construct of gender appears even in the discharge of roles that are eminently within the biological domain of women.

I am sympathetic to the view articulated by some feminists that focus on individual or particular aspects of gender inequality is simply playing at the margins and we need a radical transformation of the way the world addresses its major problem which is injustice in its many guises. We need a transformational movement led by women in which the value of solidarity, posed as a quintessential feminine characteristic will be the banner of the new army. My gaze is rather fixed on the less ambitious and perhaps reductionist target of addressing those health issues of which I have some knowledge and establishing how improvement in understanding and addressing them might come by viewing them through a gender lens. Of course, I must make the point as sharply as I can that gender considerations of health are not now exclusively a feminist issue, although history will show that it was feminist thinking in the 1970s which espoused the distinction between the biological and

sociological construction of gender and logically the focus was on the extent to which women were disadvantaged.

I chose the topic "health degendered is health denied" partly because I have been intrigued by the arguments in the feminist literature on the need for degendering society. One of the more elegant proponents of this, Judith Lorber makes the point that there is general acceptance of the proposition that gender inequality is unjust and unfair and as a most egregious form of inequity is a brake to human development. There are two approaches to addressing this. There can be equality of the genders or there can be complete abolition of gender as a social category thus eliminating the need for equalization. She comes down on the desirability of the latter and argues persuasively that the time has come to rebel against gender as a social categorization and thus dismantle the social institution of gender altogether by degendering society. The reality of the multiple perspectives and social statuses of humans makes the binary categorization irrelevant at best and damaging at worst. She writes:
"When we no longer ask 'boy or girl' in order to start gendering an infant, when the information about genitalia is as irrelevant as the color of the child's eyes (but not yet the color of skin), then and only then will women and men be socially interchangeable and really equal."

I found the argument entertaining, but I have my doubts whether we will reach this nirvana. As Barry Chevannes had stated bluntly, *"Every known society organizes many if not most or all human activities along lines of gender and orders the relations between males and females in a manner that places females in a position subordinate to males."* However, I believe that the world is filled with examples of gender inequality and gender discrimination that can indeed be corrected, even if the category of gender remains.

Tonight I wish to deal principally with health and my thesis is fundamentally different from that of Lorber. I contend that if one is to alter the inequity inherent in gender differences in health, one first has to start from the conviction that such differences have evolved and are not immutable. It can be asked whether gender discrimination arose as a result of biological differentiation. Difference in reproductive roles, differences in physical attributes as a result of the sex difference may be at the root of the social construct that is gender, and societal organization of roles over the millennia has done nothing more than adapt to these biological differences. Certain societal values have changed more rapidly than others, and in this sense, our concern for equity and gender justice has evolved more rapidly than those values which assigned an unfavourable role to females. The change may have been helped by the advent of technologies which diminished the importance of some of the biologically derived differences. Societal value systems are not universal, but western value systems are currently accepting, albeit slowly, that gender must not be a social determinant which impacts negatively on any aspect of human wellbeing. This thesis of course, relates predominantly to gender considerations as they affect female health, but there is also now universal acceptance that seeing gender as a social determinant

as related only to females is of limited value. Gender considerations enter into discussions of male health as well. If one denies the relevance of gender in addressing health issues, then one will not succeed in improving health individually or collectively for both females and males. Gender has to be seen as a structural determinant of health in that it produces differential exposures to risks and vulnerabilities.

Viewed only through the lens of social determination, the gender aspect of health is one of the more difficult to address. Other social determinants such as poverty and urbanization are relatively easy to identify and quantify and thus lend themselves to proposals for changes in policy. Gender is more subtle and in a sense more difficult as other social determinants are themselves gendered. Poverty is the obvious example.

An important first step in defining and removing inequity is establishing the inequalities – the differences. Not all inequalities or differences are unjust, unfair and beyond the agency of those involved and are therefore not manifestations of inequity. In that sense if one degenders health – if one fails to take account of gender, then one is doomed to deny many aspects of health to both men and women.

The World Bank Report on gender equality and development identifies three dimensions of gender equality. They are the *"accumulation of endowments, (such as education, health and physical assets); the use of those endowments to take up economic opportunities and generate incomes and the application of those endowments to take action or agency, affecting individual and household wellbeing."* These endowments are akin to the capabilities which Amartya Sen posits as the bedrock of the freedom necessary for genuine human development and although they are interconnected, I will deal exclusively with health not only because it is the area I know. I have long contended that health has both an intrinsic as well as an instrumental value and the latter has only recently been universally accepted. I subscribe to the view that health should be valued intrinsically more than other aspects of human development which have little intrinsic social value such as income.

I will begin with the best known of the differences in health between men and women. Women are sicker, but men die quicker. The current difference in life expectancies between men and women is an almost universal phenomenon and the evidence is strong that while there may be some slight biological input, it is a gendered phenomenon. There is no sound, major intrinsic biological difference present at birth which predisposes women to live longer than men. The gap is seen clearly in the Caribbean where the average life expectancy at birth is 70.0 years for men and 75.7 years for women. There is not much variation between the countries, but the largest gap is in Guyana where the life expectancy for both sexes is the lowest in the region. One of the consequences of this differential here is that women have a long period of widowhood and are often left without resources after having cared for a sick partner, thus creating the frequently observed problem of the poor, elderly widow. While there may be a minor input of biology, it is generally accepted that men die earlier because

they have been socialized into forms of behaviour that lead to early death: smoking, eating more unhealthy foods and indulging in more risky behaviour. The most risky of these behaviours is violence, and homicide is many times commoner in males than females. More men die from heart disease, cancer and stroke while diabetes kills more women in the Caribbean and the latter can possibly be related to the greater prevalence of obesity. The mortality from diabetes in the Caribbean is exceeded in the Americas only by Mexico.

Women take more careful notice of the symptoms of ill health and seek attention more frequently. Men, perhaps because of the false sense that complaining runs counter to the image of the brave and stoic male stereotype, complain less. This common perception or misperception of the complaining woman often leads to her being misdiagnosed when indeed there is serious illness. The social construction of masculinity and its hegemonic version may not only induce health damaging behaviour that leads to earlier death, but it will impact on health help-seeking behaviour. The denial of weakness, the need to appear strong and powerful and the idea that soliciting help is feminine all conspire to keep men away from the health services or to attend late. It has also been suggested that because health services are staffed predominantly by females, the need to seek help from them would be yet another denial of the hegemonic masculinity. This defect increases in importance in the management of the non-communicable diseases which require chronic rather than episodic care. If this perception of the health services as a feminine space really contributes to poor health help-seeking behaviour by males, the situation will only get worse as the medical profession becomes more feminized since females have consistently outnumbered males among medical graduates in our University for at least the past decade if not for longer.

There is no indication of this phenomenon in the Caribbean, but in Asia there is clear evidence of female infanticide as female children are valued less than males. With the growing availability of prenatal sex determination, parents have the possibility of early abortion of the female foetus. It is claimed that there are millions of "missing" women in Asia because of these practices. The reasons for this are complex, but it is estimated that "globally, excess female mortality after birth and 'missing' girls at birth account every year for an estimated 3.9 million women below the age of 60."

The high mortality from non-communicable diseases such as cardiovascular disease, cancer, diabetes and chronic respiratory disease (NCDs) has generated considerable concern in the Caribbean. This region has the distinction of having convened the first Summit of Heads of Government in Port of Spain to address them and the 15-point Declaration from that Summit forms the framework for Caribbean action in this area. So concerned were our Heads of Government with the problems of these diseases that they mobilized global attention and we saw the United Nations convene a High Level Meeting of the world's Heads of Government and State in

September [2011] to consider and decide what might be done globally to address them. This has been recognized universally as a major diplomatic success by CARICOM. The Political Declaration from that Meeting recognized that "*the economic, social, gender, political, behavioural and environmental determinants of health are among the contributing factors to the rising incidence and prevalence of non-communicable diseases.*"

One of the areas that has drawn more attention recently is the role of women in the genesis and treatment of these diseases. It has become clear that maternal nutrition bears close relation to the birth weight of the infant and the infant's birth weight and nutrition in the first two years of life have a clear and direct impact on the chances of that infant developing diabetes, becoming obese and dying from a heart attack. This is an example of biology being affected by gendered behaviour as it is almost universally accepted that the nurturing of the young is usually the responsibility of the mother. The exposure to the epigenetic factors which affect the development of the infant's predisposition to these diseases is likely gendered as well. While this knowledge of what is referred to as the developmental origins of health and disease has been hailed as a tremendous advance in our understanding of the genesis of these diseases and the possibility of preventing them, I have a concern that once again the burden of change will be placed on the woman. It is bad enough to have the responsibility for one's own health, but I view with concern the pointing of the finger at women as the agents responsible for the future development of diseases in their offspring and the charge will be even more grave if as is possible these changes are intergenerational. Unfortunately the percentage of infants with low birth weight in the Caribbean is higher than in any other part of the Americas.

It is not only the genesis of these diseases that may be gendered, but the care of them as well. There is a growing epidemic of childhood obesity in the world as well as high and increasing prevalence of diabetes. The Caribbean countries figure in the first seven positions among the Americas in terms of diabetes. There is the tendency to regard the increasing prevalence of childhood obesity and obesity in general as a function of domestic consumption, and this has been and continues to be the domain of the woman. One of the standard tenets of neo-liberalism is to urge individual responsibility and in that sense, place the blame squarely on the woman. However the better approach is the classical liberal one which takes account of the role of the state. Indeed it is the latter view that is gaining traction internationally and emphasis is being placed not solely on the individual and principally the woman, but on the state or rather the government to so change the environment as to facilitate the healthy choice. The common risk factors for these diseases are smoking an unhealthy diet, the harmful use of alcohol and physical inactivity. In all of these the better approach is to insist that the enabling environment be so changed by government action as to make the healthy choice the easy one.

But it is not only in the NCDs that gender is important. The feminization of the AIDS epidemic in the Caribbean is a major cause of concern and this region has

the lowest male to female ratio of AIDS cases in the Americas. This is the area of health that has perhaps stimulated more gender research than any other. There are several studies from The University of the West Indies on the female vulnerability to infection with HIV which is enhanced by the power relationships and the male domination in economic, social and often physical terms. An area which intrigues me relates to the attitudes and practices of young girls with relation to sexuality and the vulnerability to HIV. The incidence of HIV infection is rising rapidly in this group. Christine Barrow describes the phenomenon of *"bashment"* in which there is aggressive display of sexuality by a subset of young girls who have no truck with the societal norms and use their bodies according to their perception of their own agency. It is not that they do not possess information, but they choose what of it they wish. I have drawn an analogy here with the character in the famous song by Althea and Donna, "Uptown Top Ranking." Let me cite one verse:

"Shouda see me and the ranking dread
Check how we jamming and ting
Love is all I bring inna me khaki suit and ting
Nah pop no style, a strictly roots
Nah pop no style, ah strictly roots.

I take these as almost a rejection of the common submissive gender role assigned by society. Thus we have a double danger. The young female is the victim of male domination and frequently violence thus causing her to be vulnerable to infection. But when she kicks over the notion of domination and acts out her gender freedom, *"jamming and ti*ng," she may also be more vulnerable to infection.
In this area of HIV, it has become clearer that failure to understand and consider the role of gender in the epidemic will make it impossible to control it even in the face of the availability of information and treatment. Male circumcision has emerged as a highly effective measure for prevention of transmission of HIV. It will be interesting to see the level of uptake of this method, given the organization of much of masculinity around the penis and the perception of it by the young male as shown for example in the popular music.

I have outlined only a few of the gendered aspects of health which can lend themselves to change and I ask myself whether there can indeed be substantial and significant change. I believe the answer is yes. First, there is historical evidence of change. The gender difference in life expectancy was not present a century ago. My colleagues in PAHO point out that change will come when there is empowerment of both men and women through transformative programmes that acknowledge and value the different norms and roles for women and men and include ways to change harmful norms. The push for changes of norms and values that drive social movements has usually been fed with the notion or reality of there being a

disadvantaged class, as was the case with the civil rights and the feminine movements. In one sense, this is applicable to female health, but when the argument is put that gender considerations apply to both women and men, we will need a somewhat different approach to the problem. But I have no doubt that there will be change. But more importantly, I see change as a result of more profound social evolution. The highway of history may meander, but I believe it goes inexorably in the direction of equality. Although this has caused much debate, the political scientists such as Fukuyama aver that this finds its best expression in the universal adoption of liberal democracy as a form of political and social organization. The thrust for this lies in what Hegel would describe as the drive for recognition and for dignity as the forces behind the move towards justice and fairness. This drive and struggle originate in the thymos – the spirited part of the soul as described by Plato. Another facilitating factor is that the world is moving slowly to recognizing that soft power which is essentially in the feminine domain will replace hard power with its masculine visage as the means of influence.

But more prosaically and more to the point locally, I am cheered that our University and specifically the Institute is dedicating time and thought to these issues. The one small request I would make of you is that this concept of gender and how it affects health find a place in the training of all our health personnel.

The truth of Gladstone's "Justice delayed is justice denied" has been well validated. I trust that similar recognition will attend "Health degendered is health denied."

I thank you.

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