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Gender and health inequities: A comment on the Final Report of the WHO Commission on the Social Determinants of Health

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ABSTRACT

The Final Report of the World Health Organization (WHO) Commission on the Social Determinants of Health is a substantial and important contribution to understanding the social factors that shape global health inequities. Although gender is highlighted as a key social determinant of health, the report's conceptual approach inappropriately equates gender and health with women's health. This essay discusses the analytic and policy implications of this shortcoming.

The World Health Organization (WHO) Commission on the Social Determinants of Health (CSDH) was an unprecedented global effort to understand the extent and nature of social inequities in health worldwide and what is needed to ameliorate them. Begun in 2005, and under the leadership of twenty expert Commissioners, the CSDH elicited and synthesized evidence from scientists and practitioners from a large and disparate range of countries and disciplines. Much of that input was formally channeled through nine "Knowledge Networks" covering an array of topics and charged collectively with providing a concrete evidence base for developing strategies to address social inequities in health. The Final Report of the CSDH (CSDH, 2008a), released in August 2008, is a landmark document with profound implications for shaping discourse and guiding action on the social determinants of health. The work behind this report is commendable, and the background literature commissioned by the CSDH is an important contribution to the diagnostic and policy knowledge base that should not be overlooked (CSDH, 2008b). The Final Report includes a dedicated chapter entitled Gender Equity which highlights the importance of gender as a social determinant of health (CSDH, 2008c). Much of the chapter's treatment of gender is quite strong. For example, there is an emphasis on gender as a structural phenomenon, rooted in social relations of power, which appropriately moves beyond conceiving of gender as merely a set of socially prescribed norms, values, roles, and behaviors. As a result, the text highlights important ways in which gendered social inequities – between men and women – translate into damaging health consequences for women and girls. However, in other respects, the conceptual approach in the Gender Equity Chapter does not adequately reflect contemporary gender theory. In effect, the chapter perpetuates the perception of gender as primarily affecting women and, accordingly, the equation of "gender and health" with "women's health." In this essay, we discuss three specific limitations stemming from this approach to gender that have important analytic and/or policy implications: inadequate attention to how gender interacts with other axes of social stratification; neglect of gender as it pertains to men and men's health; and insufficient problematizing of gender mainstreaming as a policy response.

Gender and its intersections

The Gender Equity Chapter's treatment of gender is inconsistent with growing recognition of the limitations of treating individual categories of identity or oppression (e.g., social class, gender, race/ethnicity, sexual orientation) in isolation. An alternative paradigm – intersectionality – focuses on the interactions between social hierarchies and how individuals' dynamic location in multiple categories shapes experience in ways that are more than simply additive (Crenshaw, Gotanda, Peller, & Thomas, 1995; Hankivsky & Christoffersen, 2008). The intersectionality perspective brings to the fore the complexity and contingency of social inequities. With respect to gender, this implies necessary attention to how it is

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embedded in and interactive with multiple axes of power relations; the specific meaning, salience, and expression of gender, and therefore its impact on health and health inequities, depends on the context and other dimensions of social stratification.

Health research directly examining the intersection of gender with other social hierarchies, while relatively scant, confirms the validity and utility of the intersectionality paradigm (Breen, 2002; Drever, Doran, & Whitehead, 2004; Geronimus, 1996; Krieger, Rowley, Herman, Avery, & Phillips, 1993; Schulz & Mullings, 2006). For example, studies show that gender differentials in health in high income countries vary by race and social class (Drever et al., 2004; National Center for Health Statistics, 1998). A focus on only the gendered status of women, or on differences between "men" and "women," without attention to concurrent intersecting statuses can therefore obscure important heterogeneity. It can also mask the workings of gender in the production of health patterns, with important implications for policy response. For example, research on the intersection of gender, socioeconomic status (SES) and women's health in Bangladesh highlights the role of SES in shaping both gender norms and the consequences of transgressing them. Poor families perpetuate early marriage, perceiving that they, unlike those with resources, cannot afford the social and economic risks associated with delaying a daughter's marriage (Schuler, Bates, Islam, & Islam, 2006). However, physical mobility and autonomy on the part of extremely poor or deserted women have often been regarded as socially legitimate due to economic necessity (Schuler, Rottach, Islam, & Bates, 2008), and this relaxing of gender constraints may help offset the damaging health consequences of poverty. In its approach to gender, the Gender Equity Chapter in effect marginalizes these and other intersections, which are critical to achieving a better understanding of the complex role of gender in health inequities.

Men, masculinities, and health

The absence of men and masculinities is another problematic result of the narrow framing of gender in the Gender Equity Chapter. Gender theory underscores the fact that men's health risks are shaped, in part, by social norms and cultural expectations of masculinity (Courtenay, 2000). Decreased health care seeking and higher engagement in risk behaviors are two crucial health-damaging manifestations of masculinity ideals (Connell & Messerschmidt, 2005; O'Brien, Hunt, & Hart, 2005; Springer & Mouzon, 2008). Normative masculinity often dictates that men should be confident, powerful, and impervious to health problems. Enacting these ideals entails denying pain, ignoring health problems, and not asking for help. Understood in this context, health care seeking is akin to voluntary emasculation.

Contemporary gender theory also highlights the multiplicity of masculinities and how gender contributes to an accounting of health differentials *among* men as well as between men and women. Men, like women, are not a monolithic category and the ways in which gender shapes men's health depend as well on its intersections with other social and structural locations. For example, in the US, high status men are more likely than lower status men to incur health costs when they fail to achieve the masculine ideal of "male breadwinner" (Springer, 2008). Men may engage in injurious activities such as excessive alcohol and tobacco consumption, unsafe sex, reckless behavior and violence both to conform to masculine norms and to actively negotiate social status and power vis-à-vis women and other men (Barker, 2005; Courtenay, 2000). Gender is therefore implicated in the high burden of disease and disability related to substance use (e.g., many cancers, liver disease, heart diseases) and intentional and unintentional injuries among men (WHO, 2008). Importantly, gender is also for men, like women, a structural phenomenon; normative masculinity can, for example, function in the interests of the state and elites by fostering tolerance among men (predominantly of lower SES) for harmful exposures in the service of war or dangerous work. By equating "gender and health" with women's health, the Gender Equity Chapter neglects the importance of a gendered understanding of men's health.

Gender mainstreaming

A key policy recommendation of the Commission (13.2) for reducing gendered health inequities is gender mainstreaming (GM), that is, the development of administrative policies and procedures with the intention of "assessing the implications for women and men of any planned action so that women and men benefit equitably" (p. 148) The Gender Equity Chapter emphasizes that GM implementation requires substantial strengthening and thus analyzes the enabling conditions for achieving this goal. In so doing, however, the chapter fails to identify two fundamental critiques of GM in the context of health research and policy: first, that it has not adequately addressed the subject of men and men's health, and second, that GM is inherently limited in its ability to respond to the broad spectrum of health inequities in which gender is not necessarily and systematically *a priori* the most important axis of discrimination or oppression to consider.

In the background report produced by the Women and Gender Equity Knowledge Network, the authors note that "a number of recent policy reviews have been critical of the progress made during the last decade in mainstreaming for gender equality" (Sen, Östlin, & George, 2007, p. 86). One specific concern of the report is the potential for GM, in practice, to neutralize gender and to be used somewhat cynically to foster a false equivalence between the status and needs of men and women with respect to health. The solution to this problem, however, is not to reassert the primacy of women's health needs, but rather to recognize that an integrated, relational approach to gender and women's *and* men's health is a more comprehensive and appropriate way to understand health inequities. To date, GM has not been used in any meaningful way to explore men and masculinities in the context of health (Chant & Gutmann, 2000; Hankivsky, 2007).

Moreover, the Gender Equity Chapter does not sufficiently problematize GM's utility for understanding and addressing the complexity of health inequities. In response to GM's shortcoming in attending to differences both among and between men and women, alternative strategies, informed by an intersectionality perspective, have been proposed (Hankivsky, 2007; Hankivsky & Cormier, 2009; Squires, 2007). These frameworks do not privilege gender a priori, but instead seek to integrate and respond to the range of health determinants, including geography, SES, and race/ethnicity, recognized as critical to grappling with the diversity of women's and men's health needs. Given the inherent limitations of the present GM approach, it is not at all clear that the Commission's recommendation to governments and international institutions to implement GM systematically through the establishment and long term funding support of gender equality units worldwide will achieve the desired outcomes.

Conclusion

The Final Report of the CSDH (2008) brings much needed attention to the role of gender in producing and sustaining health inequities. However, the Gender Equity Chapter's treatment of gender is not only inconsistent with much of the content in the background materials submitted to the Commission by the Women and Gender Equity Knowledge Network (e.g., Sen et al., 2007), it is also at odds with current approaches to gender and emerging

understandings of how best to conceptualize, examine and address gendered health inequities. We suspect these limitations are due, at least in part, to the sacrifices in complexity and nuance that are inevitable when synthesizing material to produce a summary statement. However, given the visibility of the CSDH and the authoritative connotations of the Final Report, it is important to highlight these shortcomings so that they can be addressed as part of future global efforts to reduce health inequities.

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