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A preliminary conceptual framework

Sex, Gender and Health

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The term 'gender' is now widely used in health planning and also in medical research. However its precise meaning and its implications are not always clear. Two particular misapprehensions or confusions need to be addressed if the relationship between gender, health and development is to be properly understood.

First we need to be clear that 'gender ' is not just a more modern or more politically correct term for 'sex'. Rather it is a term used to distinguish those differences between men and women that are socially constructed from those that are biologically given. Second, it is important to recognise that gender issues are not only of concern to women. It is increasingly clear that men's health too is affected by gender divisions in both positive and negative ways. These are complex issues and we will be exploring them from a variety of perspectives, beginning with a brief overview of differences in male and female patterns of health and illness around the world.

One of the most obvious differences is that women as a group tend to live longer than men of the same social status as themselves. The extent of their greater longevity varies between countries and in some societies gender discrimination eliminates it altogether. Broadly speaking however, women appear to be biologically the stronger sex, when strength is measured in terms of life expectancy. Yet at the same time, women report more sickness and distress than men do. There are also marked variations in the rates of particular diseases between men and women. Men are more likely to die prematurely from heart disease for example, while women are more likely to suffer from autoimmune diseases or musculoskeletal disorders and also from anxiety and depression. How are we to explain these differences ?

In order to understand the impact of 'maleness' and 'femaleness' on human health, we need to use the expertise available across a number of disciplines. Traditionally, biological or sex differences have been explored within the framework of biomedicine while social or 'gender' differences have been the territory of the social scientists. Most researchers have explored

either one arena of difference or the other but both are important if we are to develop an integrated explanatory framework which can be applied to tuberculosis specifically but also to a wide range of other health problems.

Understanding sex differences in health and illness

Looking first at the biological influences on the health of men and women, the differences in the nature of male and female reproductive systems have dominated both common-sense and also biomedical thinking. The particular nature of their reproductive systems clearly do generate specific health problems for each sex. Only women can get cancer of the cervix for example, while only men need to fear cancer of the prostate. However, women's capacity to become pregnant and give birth means that they have additional needs for care both in sickness and in health. Unless she is able to control her fertility and give birth safely, a woman can determine little else about her life. (Sen et al 1994) This is only too evident from the continuing high rates of material morbidity and mortality borne by the world's poorest women (Koblinsky, 1992)

These differences in reproductive health needs are important but they do not exhaust the biological differences between the sexes. There is now a growing volume of evidence to suggest that a much wider range of variations may be clinically relevant but as yet these are little understood (La Rosa and Pinn , 1993). It seems likely for example that the differences between male and female hormonal systems affect both the onset and the progression of coronary artery disease but there have been few studies designed to investigate this possibility (Sharp, 1994). Similar concerns have been expressed in relation to HIV/AIDS. (Kurth, 1993). Thus the confinement of 'female problems' to the reproductive specialty of obstetrics and gynaecology leaves important sex differences in biological functioning unexplored. Many of these will be relevant to a broad range of both preventive and curative services and our understanding of them needs to be increased.

The social construction of gender differences in well being

But even if we learn more about these biological variations , this will still give us only a partial picture of the impact of maleness and femaleness on health. Gender or social differences are also important. In daily life men and women are systematically exposed to a range of different factors which can profoundly affect their well-being both positively and negatively. Thus far however, the nature of these influences and their broader relationship to gender divisions have received little attention from those working within the biomedical tradition.

In order to understand the significance of gender divisions we need to start by recognising that all societies are divided in two along a male/female axis. This means that those falling on either side of the divide are seen as fundamentally different types of creatures with different duties and responsibilities. Most importantly, those who are defined as female are usually allocated

primary responsibility for household and domestic labour - for the care of others in their family. Conversely males are much more closely identified with the public world- with the activities of waged work and the rights and duties of citizenship.

In most societies there are not just differences but inequalities inherent in these social definitions of maleness and femaleness. Those things defined as 'male' are usually valued more highly than those defined as 'female' and men and women are rewarded accordingly. The work women do at home for instance, is unpaid and usually of low status compared with waged work. These differences have a significant impact on the health of both men and women but so far it is only their impact on women that has been systematically investigated.

Economic inequalities mean that many women will have difficulty in acquiring the basic necessities for a healthy life. Of course the degree of their deprivation will vary depending on the society in which they live but around the world the 'feminisation of poverty ' remains a consistent theme. What we can call 'cultural devaluation' is more difficult to define but it too is important. Because they belong to a group that is seen to be less worthwhile, women may find it difficult to develop positive mental health. This process begins in childhood with girls in many cultures being less valued than boys and continues into later life as 'caring work' is given low status and few rewards. These gender inequalities are maintained and reinforced by women 's lack of power and influence which makes change difficult to achieve.

At the same time, the particular nature of female labour may affect health. (Doyal, 1995) Household work can be exhausting and debilitating especially if it is done with inadequate resources and combined with pregnancy and subsistence agriculture. It can involve exposure to toxic substances (Chen et al, 1990) and may also damage mental health when it is given little social recognition and carried out in isolation. (Desjarlais et al, 1995) For some women, domestic life may involve the fear or the reality of violence and the rewards they receive may bear little relation to the intensity of their labours.

But what about men? What can we say about the impact of gender divisions on male patterns of health and illness? Thus far it is women and their advocates who have explored the impact of gender divisions in the greatest detail. This is not , of course surprising since as we have seen it is clear that these inequalities often have damaging (and preventable) effects on their health. However new questions are now being raised about the possible health hazards of being a man and these need to be addressed if we are to take the issue of gender and well-being seriously.

On the face of it, 'maleness' can only be an advantage in the context of health, since it is likely to give the individual man greater power, wealth and status than a woman in a similar social situation. However certain disadvantages are also becoming apparent. One of the most obvious of these is to be found in the area of waged work. The emergence of the idea of the male 'breadwinner ' in the nineteenth century forced many men to work in dangerous conditions. As a result, male rates of industrial accidents and diseases have historically been higher than female rates with deaths from occupational causes more common among men than among women (Waldron, 1995).

During the same period men in many parts of the world have increasingly adopted unhealthy lifestyles- smoking and heavy drinking for example, as well as dangerous driving. All of these have contributed to their higher rates of premature mortality, reinforcing their greater biological vulnerability so that in most societies their life expectancy is lower than that of women in the same social groups as themselves (Waldron, 1995). These patterns are linked in most cultures to ideas about masculinity, with young men in particular often feeling pressure to indulge in 'risk taking ' behaviour in order to show they are a 'real man'.

Similar concepts are important in explaining the high rates of male on male violence found in many societies. In the inner cities of the United States for instance young black males are said to be an 'endangered species' because their life expectancy is declining as they fight to live up to particular notions of 'masculinity' (Gibbs, 1988). In the area of mental health too, some men are now beginning to make a link between their individual problems and the wider gender divisions in society. They are pointing out that gender stereotyping narrows the range of emotions men are allowed to express making it difficult for them to show weakness for example as well as other characteristics thought of as predominantly female (Harrison et al, 1992; Sabo and Gordon, 1995).

We have seen that the health of both men and women is influenced by their biological or 'sex' characteristics on the one hand and by the impact of their gender identity on their social, cultural and economic circumstances. Hence 'males ' and 'females' do have certain health needs in common. Moreover, gender differences may also affect the ability of individuals to meet those needs. As we shall see there is growing evidence of unacceptable variations between men and women both in access to medical care and in the quality of care received. Such inequalities are of course preventable and currently operate mostly to the disadvantage of women. We can explore the implications of this in more depth through looking first at the production of medical knowledge and then at aspects of the organisation of health care itself.

Sex and gender bias in medical practice

Gender bias in funding priorities and in the methods of medical research have received a great deal of attention in recent years especially in the United States (US National Institutes of Health, 1992). There have been campaigns for increased funding on topics such as breast cancer which have special relevance for women alongside demands for medical researchers to pay more attention to sex and gender issues in all their areas of work (Auerbach and Figert,1995).

Most epidemiological studies and clinical research continue to be based on the unstated assumption that men and women are physiologically similar in all respects apart from their reproductive systems (Mastroianni et al, 1994). Thus men are treated as the norm and women as the 'other'. As a result some studies leave out women altogether while other do not treat sex and gender as important variables in the analysis.

This bias can limit the effectiveness of both curative and preventive services. In the case of coronary artery disease for example, many of the major epidemiological studies in both Britain and the US were based on all-male samples, reflecting the perception of CHD as a predominantly 'male' problem (Sharp, 1994). As a result we know very little about the extent to which the most common prevention strategies in the field are equally applicable to men and women. Doubts have been raised for instance about the relative effectiveness of cholesterol lowering drugs in women .

Turning now to research into infectious diseases, women are rarely excluded from the samples to be investigated but relatively little attention has been paid to either sex or gender issues in analysing the results. If differences between males and females are considered at all , the focus has generally been on women's reproductive lives, assessing the impact of disease on fertility and pregnancy outcomes (Manderson, Jenkins & Tanner, 1993). Yet there is growing evidence that sex-related biological factors can affect both susceptibility and immunity to infectious diseases. (Hudelson, 1995) At the same time it is clear that gender differences in patterns of behaviour and in access to resources will influence both the degree of exposure to infection and also the options available to those who become infected (Vlassoff & Bonilla, 1994).

In the case of malaria for instance, men appear to be biologically more vulnerable to the disease than women. However women's greater immunity appears to be somehow compromised during pregnancy, for reasons that are not yet clear. There is also evidence that differences in the daily lives of men and women can affect their exposure to particular disease vectors. Research thus far has concentrated mainly on the higher risk faced by men because of their greater participation in activities out side the home. However the nature of women's labours may also be important.

Those women who remain in seclusion and keep their bodies covered, may well be less exposed to mosquitoes and therefore to malaria. However the greater involvement of so many women in water-related work may pose an alternative threat. In the case of schistosomiasis for instance, the rate in males drops after adolescence when they no longer play in water while that of females peaks at around the age of 15 when they become fully involved in agricultural and domestic tasks (Michelson, 1993). These early findings suggest that further work is urgently needed to clarify both sex and gender influences on a range of infectious diseases including tuberculosis (Hudelson, 1995).

Similar concerns have been raised about gender inequalities in access to medical treatment and about the quality of care received. In the poorest parts of the world in particular, there is massive evidence to show that women are often constrained in their use of health care by inadequate resources, by the lack of culturally appropriate care, by lack of transport, and sometimes by their husband's refusal to give permission (Timyan et al, 1993).

Of course limited public expenditure on health care will affect men as well as women, but we know that in conditions of scarcity it is usually women and young girls who are given lower priority especially if their needs are not directly connected to reproduction (Sen, 1988;

UNICEF, 1990). Many women also have to face additional obstacles if their disease is a stigmatising one, either because of its effect on appearance or its assumed relationship to sexuality.

If they do gain access to healthcare, there is evidence that the quality of care they receive is often inferior to that of men (Mensch 1993). Too many women report that their experiences of health care are distressing and demeaning. Medical knowledge is presented as inevitably superior, giving women little opportunity to speak for themselves or to participate actively in decision making about their own bodies. This is reflected particularly in the context of reproductive health services where providers are often concerned more with the prevention of fertility than with the well-being of individual women. As a result, the treatment women receive can be insensitive and dehumanising and often affects their willingness to use the services (Jacobson,1991; Timyan et al., 1992; Sen, Germain and Chen, 1994).

Concern about inequalities in health care has traditionally focused mainly on qualitative issues - on the unequal relationships between women and those who have the responsibility to care for them. In recent years however this critique has broadened . In the US and the UK in particular it is now clear that women and men are sometimes offered different levels of treatment for the same clinical conditions. They are less likely to be offered certain diagnostic procedures or treatments for heart disease for instance (Kudenchuk et al., 1996; Petticrew et al., 1993). Similarly women on kidney dialysis are less likely than men of the same age to be offered transplants (Kjellstrand, 1988). Again further research is needed to determine the extent of this discrimination in different parts of the world, and in different medical specialties.

Conclusion: putting sex and gender on the agenda

We have seen that the concepts of sex and gender need to be a central part of the framework we use for understanding both the determinants of health and illness and also the utilisation and effectiveness of health services. At present , we know most about the impact of gender divisions on women's health and more research is needed to identify both the advantages and disadvantages they offer to men. However we need to end on a note of caution

This paper has concentrated on the differences between men and women. It has explored the similarities between men and between women and has identified the interests that they have in common. Yet this does not mean that women (or men) can be treated as a homogeneous group. Class , race and age are also major determinants of health and these need to be integrated with sex and gender in any attempt to develop an integrated explanation of the complex reality of changing patterns of health and disease around the world. Insights from a range of both biological and social sciences will be required if an effective strategy is to be developed that respects both the biological reality of the disease itself and also the wider social and economic context in which it is embedded.

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