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# **GENDER AND HEALTH**

## **The case for gender-sensitive health policy and health care delivery**

*Conference paper for 14 November 2003*

**Oonagh O'Brien and Dr Alan White**

## First UK Gender and Health Summit Promoting Health Equality for Men and Women

*14 November 2003*

The driving force behind the First UK Gender and Health Summit is the Gender and Health Partnership (GaHP), with representatives from the King's Fund, the Men's Health Forum, Women's Health, various university departments and charities, and observers from the Department of Health (DoH) and Equal Opportunities Commission (EOC). The GaHP has been in existence for two years.

The Summit is being funded by the DoH and EOC, and supported by the Men's Health Forum, Women's Health, the European Men's Health Development Foundation and the King's Fund. It is being hosted by the King's Fund.

The Summit is a way of widening the discussion on gender and health issues. The kinds of questions to be addressed by the speakers will include:

- What is 'gender-sensitive' policy and practice?
- What happens when policies are gender insensitive?
- What is the evidence base and where are the gaps?
- What practical changes are needed in order to develop gender-sensitive policy and practice?

This conference paper provides a background to gender and health issues in the UK. It has been developed for the Summit delegates but will also be of interest to other professionals and members of the public with an interest in gender and health.

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# Introduction

There is growing national and international recognition that gender is an important indicator of health differences. The United Kingdom is in danger of falling behind many other countries that are beginning to recognise the crucial importance of gender to the development of effective health policy and practice.

This briefing paper sets out some of the reasons why those involved in the gender and health partnership (GAHP) believe that it is time to place gender at the heart of the equalities agenda in health, and why it is important to ensure gender sensitivity in health policy, medical research and services. This briefing paper refers to the United Kingdom; however, Scotland is in the process of producing guidelines specifically on mainstreaming gender in health policy and service delivery.

*Neither men nor women are “minorities”, needing special treatment. All patients in the NHS are either male or female and if services are to be effective, efficient and evidence based, the recognition of this reality needs to be at the heart of the planning and delivery of care. Failure to pay attentions to differences between men and women will clearly reinforce existing gender differences.*

Doyal, Payne and Cameron 2003

## What is the difference between gender and sex?

The classification of people as men and women is based on biological differences, in particular those relating to reproductive functions. However, these biological differences take on very different social manifestations as a response to the conditions and expectations of different kinds of society.

**Sex** is the term generally given when differences between women and men appear to be primarily biological. **Gender** is the term given to the social construction of roles allocated to men and women. These roles vary geographically and change over time. There is now a much wider understanding that gender refers to both men and women, and the relations between them.

The term ‘gender’ was initially used during the 1960’s to challenge the prevailing belief that gender differences between women and men were fixed and immovable. It signalled a shift away from the biological genetic model, which perceived these differences as naturally occurring, to a growing awareness of the impact of social factors, which could be addressed and changed.

Recent proposals for the development of gender-sensitive perspectives have drawn attention to gender relations, arguing that we need to ‘move away from women and men as isolated categories to looking at the social relationships through which they are mutually constituted as unequal categories’ (Kabeer 1999). This might include examining in greater detail the impact of men on women’s health and women on men’s health, through the wide variety of personal, family and professional relationships that exist between the two.

### Isn't gender all about women?

The term gender was originally used to argue that the different roles of men and women were capable of sustained change. Interest in these issues came from feminists who argued that inequality lay at the heart of the differences between men and women. The focus was therefore on redressing the unequal power relations experienced by women. Feminist debate over recent years has shifted from a focus on women to a gender approach, with an interest in the dynamic of relations between men and women. This inevitably led to conclusions that men's health could also be disadvantaged by their sex and gendered identity, particularly when examining such health issues as cardiovascular disease and accidents.

It is still the case that in many settings, gender is used to imply 'women'. However, there is now a much wider understanding that gender refers to both men and women, and the relations between them. In the health arena, the recent growth of men's health organisations joining those led by women in drawing attention to the links between gender, health and health care has been a welcome sign of this shift in understanding and emphasis.

## Are sex and gender really so different?

The interaction of sex and gender can be complex when discussing health issues. Current debates have tended to use 'gender' as a generic term when identifying these two experiences in any way. Awareness is growing of the complex ways in which sex and gender interact in health issues; gender is 'rooted in biology and shaped by environment and experience' (Wizemann and Pardue 2001). Biology appears to be fixed and specific. However, we know that biological differences between men and women change over time in response to changing social norms. An example of this complexity is given in the box below.

### How sex and gender interact

A variety of factors, including behavioural habits, hormones, genetics, and environmental influences, affect the development of bone mass. Some of these are generally understood to be internal to the organism (genes and hormones) and some are generally understood to be external. In one sense, some might even be called 'sex related' and others might be called 'gender related.' Closer examination, however, shows that this distinction is less clear-cut. Exercise and body weight, for example both contribute to bone formation. In the United States, current conventions promote extreme thinness as an appropriate body image for young girls, whereas vigorous weight-bearing exercises are still less commonly performed by girls and young women than by boys. Both of these factors result in differences in weight-bearing impacts on bones and this contributes to differences in the development of bone mass. In other words culture and behaviour (gender) become contributing causes to differences in bone mass between males and females (sex).

(Wizemann and Pardue 2001)

## Why do sex and gender matter for health?

Women and men are biologically vulnerable to certain illnesses in differing degrees and severity. Women have been active in campaigning for improvements in the choice and quality of their health and health care. This has traditionally focused on reproductive health. Until recently there was little attention paid to the impact of gender on men's health. However, it is increasingly evident that the social and biological nature of being female and male carries certain risks.

For example, men are much more biologically vulnerable to cardiovascular disease (CVD) than women. However, older women are also susceptible to CVD. Nevertheless, there is a prevailing assumption among public and health professionals in the UK that this is primarily a male disease, and women appear to have experienced problems in obtaining correct diagnosis and treatment (Lockyer and Bury 2003).

Autoimmune illnesses such as diabetes and multiple sclerosis affect more women than men (although men have a higher death rate from these conditions). But the relapsing intermittent form of multiple sclerosis affects men more severely than women.

In almost every country in the world, except those few that have still not managed to reduce maternal mortality, women live longer than men. Men are more likely to die than women at almost all ages, including in the womb before birth (Kraemer 2000). Men are diagnosed with the majority of cancers and have a greater rate of premature death across nearly all disease states, except those of the musculo-skeletal system, skin and connective tissue, where women's death rate is higher across all age groups (White and Cash 2003).

Underpinning all of the explanations for these differences are both biological (sex) factors and social (gender) issues. Lifestyle is implicated in many disease states with biological outcomes resulting from social determinants: for example, CVD is related to changes in diet, physical activity and other issues. Diabetes is also linked to lifestyle factors, such as increasing levels of obesity, physical inactivity and poor diet (Tringham and Davies 2002).

Other health concerns appear to be predominantly linked to social gender issues, with very little information available about the possible importance of any biological factors. For example, gender violence is a major cause of death and injury for women around the world. In 1993, the World Bank estimated that 19 per cent of the health interventions of young women in the developed world is the result of domestic violence and rape (World Bank 1993). The World Report on Violence and Health (WHO 2002) also highlights the death toll among men worldwide and acknowledges the considerable problem of unreported violence and injury that men face and the lack of research in this area. Violence towards men is largely carried out by other men: violence is gender specific and imposes a huge health burden on women and men.

Although social gender roles vary between communities, the development of a heterosexual male identity appears to require risk taking (Lloyd and Forrest 2001). This may be through paid work or through men engaging in risky behaviour to 'prove' their masculinity. The need to constantly reinforce masculinity results in high death rates through car accidents, murder and dangerous sporting activities. An unwillingness to appear 'weak' may also explain why many men are unwilling to seek help for physical or mental health problems (Doyal 2001; Griffiths 1996). Baker (1996) has argued that

homophobia is the constraining value system that prevents men from breaking out of their traditional masculine identity.

Anxiety and depression are reported more often by women than by men in most parts of the world, yet there is no evidence of any biological basis for such differences. While masculinity imposes its own health hazards, women are subject to the hazards resulting from unequal power relations. Much has been done in many countries to alter this balance of power through equalities legislation. However, there are still no societies in which women are treated as equals with men and this inevitably affects women's health. Such inequalities make women particularly vulnerable to poverty, and in many cases a lack of support in the household. Interest in women's health has therefore focused on the health deficit resulting from women's poverty and heavy workloads through the need to carry out both unpaid domestic work and paid labour alongside pregnancy and childcare.

There have been exceptionally high increases in suicide rates among young men during the last 30 years, and it is now the major cause of death in men under 44 in the UK. Suicide is generally discussed in social terms, highlighting lack of support structures and high expectations placed on this sector of the population. There is evidence that young gay men form a significant proportion of these suicides, reflecting an increase in homophobia among young people, which can result in bullying and social exclusion (Douglas-Scott et al Forthcoming). The suicide level in older men in the UK is also of great concern.

Wizemann and Pardue have argued that the ability to look at sex and gender as part of a single system with both social and biological elements has important consequences for medical treatment, (Wizemann and Pardue 2001). Some of the differences between the sexes may be small, yet they result in important outcomes, which need to be reflected in all aspects of health, not least health promotion and the planning and delivery of services. Coote (2000) has argued that if public policy persists in assuming that gender roles are simple and fixed, both men and women will find their opportunities restricted and quality of life impaired. Much more research is needed in this area to inform appropriate policy and service delivery.

## **Does current health policy meet the needs of men and women?**

Currently most health policy is written in gender-neutral language, with targets set for the whole population. This approach is typified by the National Service Framework for Coronary Heart Disease. However, if we consider, for example, the vastly different experiences of men and women in relation to cardiovascular disease, this approach does not serve men or women very efficiently (White and Lockyer 2002).

Two recent government publications, however, make an important contribution to including gender in the inequalities literature and have relevance for health: *Women's Mental Health: Into the Mainstream* (2002), a consultation document on gender for the National Service Framework on mental health; and *Delivering on Gender Equality* (2003), documenting work by the Women and Equality Unit (WEU) on gender, and proposing ways in which gender could inform future policy initiatives in the UK.

The gender focus of both publications is welcome. There is a clear commitment from the Government, especially in *Delivering on Gender Equality*, to mainstream gender issues across all government policy, including health. However, limitations arise from the way in which the publication prioritises the needs of men and women as parents, with targets relating to childcare and appropriate service provision. Another problem is the focus on narrow statistical targets. Both childcare and the monitoring of targets are important, but they do not encourage the development of in-depth understanding of gender relations at local levels.

On a positive note, the targets in both publications have a gender focus, which is unusual. The majority of government health targets do not differentiate between men and women (Doyal *et al* 2003), and therefore disregard how gender differences affect patterns of risk. An example of this is evident in the screening programme proposed in the strategy for Chlamydia Trachomatis, one of the most common sexually transmitted diseases. While there is a clear gender differentiation in the proposals, these are not linked to an understanding of sex and gender differences in sexually transmitted infections, but rather to issues of practical implementation. Screening is recommended for men and women, but the focus is largely on women.

Doyal, Payne and Cameron (2003) list the reasons for focusing on women, including the fact that they are more likely to attend health care clinics, that the consequences of infection are more serious for them than for men and that computer modelling has indicated that this is a cost-effective approach. Fenton (2000) has written that screening men has not been pursued because of cost, invasiveness of screening procedures (recently less invasive procedures have become widely available) and the need to carry these out in a clinical setting (which is assumed unattractive to men).

Both Doyal *et al* and Fenton highlight that the screening programme is a lost opportunity to take control of the transmission of Chlamydia. In this case an inappropriate gender approach to health promotion is likely to result in poor health outcomes.

## **Gender and inequality**

For both men and women, belonging to a lower social class has a deleterious effect on their health. For example, the life expectancy of a man in Manchester is eight years less than for a man living in Chelsea in London (Department of Health 2002). But sex and gender differences across the social classes is much broader than just life expectancy, with issues relating to health service usage, uptake of health promotion and the greater likelihood of developing chronic debilitating illness. Poverty is a key cause of maternal and child ill-health.

Sexual identity is an important component of gender-sensitive health care. For example, lesbian women often find it difficult to explain why they might not require contraception to health care providers, and the specific health needs of lesbian and bisexual women are poorly researched and understood. The early development of health services for men focused almost solely on HIV prevention and care for gay men. This has resulted in a poor understanding of gay men's broader health needs and belated awareness of health issues for heterosexual men.



Differences between men and women's health exist irrespective of race and ethnicity, but they also interact closely. It is becoming clearer that certain ethnic groups have a biological vulnerability to specific forms of ill health and these can affect men and women differently (Doyal *et al* 2003). For example, data from the USA confirms a much higher incidence of prostate cancer in African-American men than their white counterparts. Standard mortality rates are much higher in second-generation Irish women than Irish men living in the UK (Raftery *et al* 1990). There are also issues when cultural factors affect either the potential to develop health problems or the use of health services in the UK. An extreme example of this is female genital mutilation, which is carried out on women originating from certain countries in Africa, frequently resulting in severe health problems (Forward 2003). In addition women from some ethnic and religious groups will only access health care if delivered by a woman. Careful targeting of resources is needed to ensure both men and women from different social classes, sexual identities and ethnic groups are able to access appropriate health care.

## What is 'gender mainstreaming'?

The term 'gender mainstreaming' came into widespread use as a result of the Beijing 'Platform for Action' at the 1995 UN International Conference for Women. Mainstreaming gender equality is a commitment to ensure that women's and men's concerns and experiences are integral to the work of an organisation, incorporating all aspects of its activities, from employment issues, through to organisational governance, delivery and outcomes (Derbyshire 2002).

Gender mainstreaming has been taken up more readily by international organisations than those based in the UK. Pressure from donors in national governments, as well as a genuine commitment to address gender issues, ensured that some of the cutting-edge work in this field has happened in non-governmental organisations (NGOs), as well as multilateral and bilateral agencies (see, for example, the work of Oxfam, the United Nations Development Programme, the UK Department for International Development, and many others).

The term is now being used widely within the health context, with countries increasingly recognising the need to target men and women specifically through policy development. The move is fully supported by the World Health Organization, which sponsored the inaugural Gender and Health Conference in September 2003; this was the first time women's and men's health groups had come together to debate these issues on an international stage.

Concerns have been raised about gender mainstreaming: these have centred around the fears that gains which women have made in unequal power relations with men will be lost. There are also fears that mainstreaming will result in the loss of any specific 'champions' for gender issues within organisations. Mainstreaming, however, should not override feminist arguments about where power lies. In order to achieve improved well-being for women and men, gender needs to be addressed as specific to both men and women.

## Why now?

Practitioners have long identified gender as a key variable within health care assessment and treatment. There is growing public concern that individual needs should be met. Both of these factors reinforce the importance of developing gender sensitive health policy and health care to respond to the differences in male and female experiences of health and health care. The modernisation and equality agendas of the Government offer an ideal opportunity to re-assess the way health policy is formulated.

## What needs to be done?

- Health policy should be formulated in a more gender-sensitive manner.
- Health targets need to be gender specific.
- The National Institute for Clinical Excellence (NICE) and the Commission for Healthcare Audit and Inspection (CHAI) must incorporate gender as a variable within their assessments of current practice.
- The current national service frameworks should be amended to incorporate a gendered approach.
- Training on developing an understanding of the impact of sex and gender on health should be widely available.
- The range of health data disaggregated by sex needs to be widened to help understand the impact of sex and gender on health issues.
- Health research should be more aware of gender as a key variable; sex should be routinely identified in sampling.
- More research needs to be carried out to develop understanding of the impact of sex and gender on specific health issues.
- Those involved in health promotion and health care delivery should recognise that 'one size' does not 'fit all': just as social class, ethnicity and race are key variables, so is gender.
- Gender is not solely a health service issue: the social and economic implications of men's and women's health makes gender a cross-cutting issue across all government departments.

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