Gender Equity in Health: debates and dilemmas

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Abstract

Gender equity is increasingly cited as a goal of health policy but there is considerable confusion about what this could mean either in theory or in practice. If policies for the promotion of gender equity are to be realisable their goal must be the equitable distribution of health related resources. This requires careful identification of the similarities and differences in the health needs of men and women. It also necessitates an analysis of the gendered obstacles that currently prevent men and women from realising their potential for health. This article explores the impact of gender divisions on the health and the health care of both women and men and draws out some of the policy implications of this analysis. It outlines a three point agenda for change. This includes policies to ensure universal access to reproductive health care, to reduce gender inequalities in access to resources and to relax the constraints of rigidly defined gender roles. The article concludes with a brief overview of the practical and political dilemmas that the implementation of such policies would impose.

Key words

Gender equity, sex differences in potential for health, gender differences in health risks, gender inequalities in access to resources, strategies for gender equity in health

Introduction

Gender equity is increasingly identified as one of the goals of health policy at both national and international levels. However the precise meaning of the term is not always clear. Are there any examples of it in the real world? Would we recognize them if we saw them? In attempting to answer these and other questions this paper will address some key policy concerns. It will also identify some of the underlying theoretical and conceptual issues that need resolution if anything resembling gender equity in health is to be realised.

In recent years there has been a shift away from talking about 'women' to talking about 'gender'. Instead of focussing on women as an underprivileged group, the emphasis is now on the social construction of gender identities and on the nature of the relationships between women and men. This shift is evident in academic discourse where 'gender studies' is increasingly replacing 'women's studies' as the framework for generating new knowledge. It is also apparent in many policy settings where the language of gender equity is increasingly heard. However closer examination reveals a distinct lack of clarity about how such a goal should be defined or about how it might be achieved.

Gender equity: the politics of confusion

The essential contestability of the term 'gender equity' can be illustrated through an examination of debates at the recent UN conferences in Cairo and Beijing. Participants in these debates could be loosely categorised into three major groups. Each would claim to represent the interests of women but all perceive gender equity in very different ways (Baden and Goetz, 1998).

First, there is a loose grouping of individuals who could be called traditionalists, many but not all of whom would ground their views on gender in fundamentalist beliefs of a nationalist and/or a religious kind. Members of this group find the notion of ‘gender’ itself unhelpful on the grounds that it overpoliticises what they see as the ‘natural’ differences between men and women. These differences they regard as unavoidable and indeed desirable. Hence they argue that public policies should be 'equitable' in meeting what they see as the very different developmental needs of the two sexes in their separate spheres. However they reject the idea of attempting to achieve some kind of spurious equality.

Members of the second grouping could be called feminist radicals. They would certainly welcome much greater equality between the sexes but do not believe that this can be achieved through the adoption of 'gender equity' as a political goal. Citing a range of examples they argue that policies such as gender mainstreaming are too often used as a technological fix. Once a gender policy has been introduced, they say, it is all too easy for those in power to claim that they have ’done gender’ and now it is time to move on to something else. So for these feminist radical sceptics, the best strategy is to retain a single focus and to pursue an agenda based not so much on equality between the sexes but on the rights of women.

The third group could be called the gender radicals. This group holds to the belief that despite the obvious difficulties, the pursuit of greater gender equity in health is still a worthwhile goal. At a conceptual level they argue that the emphasis on gender relations offers considerable potential for a critical understanding of inequalities in health between men and women. At a more practical level the pursuit of gender equity as a policy goal is seen to offer opportunities for collaborative action between a range of different groups (including both women and men) concerned with wider campaigns for equality and social justice.

It is clear then, that the definition of gender equity itself, judgements about its desirability and strategies for its achievement are all open to question. Within this context of continuing political and theoretical debate it is the third or 'gender radical' position which provides the underlying rationale for this paper. That is to say, the arguments presented here are based on the assumption that the pursuit of gender equity in health is a legitimate goal of public policy and that the health of women (and maybe men) could be improved as a result. However the task will not be an easy one.

Defining the problem

Any attempt to promote gender equity in health must begin with a clear definition of what is being sought. The most obvious goal might seem to be equality in health outcomes between men and women. However this is clearly unachievable. Because individuals (and groups) begin with very different biological constitutions, any attempt to equalize male and female life expectancy or morbidity rates is doomed to failure. Instead, policies in pursuit of gender equity must focus not on health outcomes themselves but on the inputs that provide the basis for human flourishing. The only practicable strategy for reducing unfair and avoidable inequalities in health outcomes between men and women is to ensure that the two groups have equal access to those resources which they need to realize their potential for health (Doyal and Gough, 1991; Nussbaum and Glover, 1995).

However this still leaves questions about how such a strategy should be carried out. It is clear that the implementation of equal opportunities in the allocation of resources for health cannot mean treating men and women identically. Both sexes have a range of needs that have to be met if they are to achieve their potential for a healthy life. Most of these will be basic requirements such as food, water, shelter and physical and psychological security. These are the same for both groups and should be equally available to all. However there are also significant differences in the health needs of men and women, which stem primarily (but not entirely) from biological differences between male and female reproductive systems. These differences need to be clearly identified so that they can be reflected in equitable strategies for resource allocation.

But in order to ensure that such policies are effective, we need to identify not just the needs themselves but also the ways in which current modes of social organisation place differential constraints on the meeting of those needs for men and women. Of course many of the constraints will again be the same for the two groups. To take an obvious example, poverty can prevent both men and women from realizing their potential for health. But poverty itself is a gendered phenomenon in its causes and in its effects (Jackson, 1998). The next section will therefore take the argument one stage further through identifying both the differences in the health needs of men and women and the variety of obstacles that currently prevent them from meeting those needs.

Nature or nurture?

This investigation will require an examination of both the biological (sex) and the social (gender) dimensions of difference as well as the relations between them. There are, of course, a variety of philosophical problems awaiting the unwary who talk in any simple way about separating these two domains. Indeed much recent work in gender studies has been concerned in one way or another to demonstrate their intrinsic interconnectedness (Butler, 1995). Some of this has been extremely valuable in drawing attention to the social construction of much that had previously been taken as purely biological in character. However there is also a danger that our understanding of the material dimension of human health will be undermined by the spread of radical deconstructionism.

Paradoxically perhaps, some of the new writing on the body is especially problematic on this score. Far from 'bringing the body back' into social science, too much of this work has conceptualised fundamental bodily processes in an overly theoreticised and abstract way which adds little to the conceptual armoury needed to improve human wellbeing (Davis, 1997; Morgan and Scott, 1993). In order to avoid the paralysis that sometimes results from these approaches, this paper will explore the biological and the social domains in turn in order to identify those issues central to gender equity strategies. The importance of (re)integrating the two perspectives will be addressed later.

The biology of risk

In biomedical theory and practice the analysis of maleness and femaleness starts (and usually ends) with sex differences in reproductive systems. This is also a useful starting point for thinking about equity in public policy since it is an area in which women start off at a considerable disadvantage by comparison with men. If they are to realize their potential for health, most women require access to the resources necessary to control their fertility and also, intermittently, to those which will ensure healthy pregnancy and childbirth. They therefore have what could be called 'special' biological needs and these need to be taken into account in any strategy for gender equity **(**Sen and Snow, 1994; Sen, Germain and Chen, 1994).

Men do not need reproductive health care in the same way that women do. Of course, every act of intercourse puts them at risk of contracting a sexually transmitted disease (though the biological risk is lower for a man than it is for a woman). But once the initial conception has happened, men need to take no further risks to achieve fatherhood. Hence, they can, in theory, have as many children as they like without damaging their health. But despite what could be seen as a biological advantage, there are now very few societies in which men have a longer life expectancy than women.

This appears to be due at least in part to the fact that men are innately the weaker sex and this is reflected in higher numbers of male deaths both in utero and around the time of birth (Waldron, 1995; Hart, 1988). So men could also claim to have 'special needs' in any debate about gender equity in health. However the situation of men is not like that of women in that modern medicine does not currently have the technology to compensate for their particular disadvantage. While it is theoretically possible for all women to have their need for high quality reproductive health care met; the technology is not (yet) available to prevent what is seen as 'premature' death among men. Hence, even if we could guarantee both sexes equivalent access to health-related resources, women would still be likely to live longer lives on average than men in the same groups as themselves.

This sex difference in potential longevity alerts us to the fact that biological differences between women and men go beyond the obvious ones related to reproductive systems, to include genetic, hormonal, metabolic and other variations. Sex differences in the causes, the incidence and the prognosis of a number of health problems including HIV/AIDS, tropical infectious diseases, tuberculosis and coronary heart disease are just beginning to emerge (Doyal, 1998; Garenne & Lafon, 1998; Hudelson, 1996; Vlassoff and Bonilla, 1994). They reveal complex biological differences in patterns of risk and susceptibility which need to be taken seriously if equity is to be achieved in service delivery.

However these biological influences can tell only part of the story. Socially constructed inequalities or gender differences between males and females are also important in determining whether individuals are able to realize their potential for a long and a healthy

life. And as we shall see, it is generally males who have a significant advantage over females in access to health- related resources.

The hazards of female gender

All societies are divided in two along a male/female axis. This means that those falling on opposite sides of the divide are seen as fundamentally different types of creatures with different duties and responsibilities as well as different entitlements (Charles, 1993; Moore, 1988). Though the precise formulation of these definitions varies between societies, there is also a surprising degree of consistency wit those who are defined as female having primary responsibility for household and domestic labour. Conversely males have generally been more closely identified with the public world, with the arena of waged work and the rights and duties of citizenship.

Of course in most societies there are not just differences but inequalities inherent in the social definitions of femaleness and maleness. Those things defined as male are usually valued more highly than those things defined as female and men and women are rewarded accordingly (Charles, 1993; Moore, 1988; Papanek, 1990). Not surprisingly these inequalities have a significant effect on the health of both men and women though so far it is only their impact on women that has been explored in any detail.

In recent years women and their advocates have built up a large body of work demonstrating the intimate interrelationship between gender inequalities and both mental and physical health (Annandale & Hunt, 2000; Doyal, 1995; Doyal, 1998; Stein, 1997). Most importantly they have looked not just at life expectancy but at more qualitative dimensions of well being. They have shown that many of the health problems women face are not related in any direct way to their specific biological characteristics. Rather they reflect the discrimination and disadvantage that so many continue to experience as they carry out the gendered activities making up their daily lives (Belle, 1990; Kitts and Roberts, 1996). Anxiety and depression for instance, are more common among females than among males in most parts of the world (Desjarlais et al., 1995). Yet there is no evidence that women are constitutionally more susceptible to these problems than men (Busfield, 1996)

Gender inequalities in income and wealth make women especially vulnerable to poverty. Though levels of discrimination vary significantly between societies, millions still find it difficult to acquire the basic necessities for a healthy life (UNDP, 1995). Poverty can affect both males and females but women and girls often suffer additional disadvantage as a result of discrimination (Jackson, 1998; Dwyer and Bruce, 1988; Kabeer, 1994, ch5). Lack of adequate nourishment and unequal access to health care mean that sometimes their most basic needs are not met (Tinker et.al. 1994). The gender division of work means that women are often denied the opportunity to meet other basic needs such as time for rest and recuperation (Charles, 1993; Moore, 1988).

Within the household women often have little support and too many end up being abused by others (Doyal, 1995 ch.2; Heise, Moore and Toubia, 1995, WHO, 1996). Hence their need for physical and psychological security may also be denied. The process of 'growing up female' influences the type of identity girls are able to develop. Being raised as members of the less valuable group can make it more difficult for them to develop the positive sense of themselves that is usually associated with good mental health (Papanek, 1990). In many societies this means that women's identities are shaped in ways that encourage them to put the wellbeing of others before their own (Kandiyoti, 1998).

So we can see that gender inequalities in access to a wide range of resources have a

significant impact on the health of women. Though they have a longer average life expectancy than men, they do not necessarily lead healthier lives. And most importantly, a considerable amount of the illness they experience can be traced back in one way or another to the nature of their daily lives and should therefore be preventable through public policy. Since gender relations affect as men as well as women we need to ask whether they face similar risks. Are the health problems experienced by men preventable in the same way?

Male gender: a mixed blessing?

Thus far, relatively little attention has been paid to the impact of gender on the health of men. Indeed this is part of a much broader pattern whereby men's lives have not usually been seen as gendered at all. This has now begun to change with the creation (mostly in the developed countries) of the sociology of masculinities, men's studies and associated men's movements (Brod and Kaufman, 1994; Connell, 1995; Hearn & Morgan, 1990; Mac an Ghaill, 1996). A major focus of many of those working in these new paradigms has been the exploration of male (homo)sexualities and their implications for health promotion in the context of the HIV/AIDS epidemic (Kimmel and Levine, 1993). Other aspects of men's health have received less attention but important links are now beginning to emerge between gender, heterosexuality and the wellbeing (Huggins and Lumb, 1998; Sabo and Gordon, 1993).

First it is evident that in some societies the stereotyped role of provider ' puts men at greater risk of dying prematurely from occupational accidents. Just as women face hazards in carrying out their domestic tasks, so many men may also be at risk from doing the duties that are socially expected of them (Waldron, 1987; Hart, 1988). However the other risks associated with maleness are of a rather different order from those linked to femaleness. Gender inequalities themselves rarely deprive men of the resources to meet their needs. If anything they operate in the other direction. However it does appear that constructing and maintaining a male identity often requires the taking of risks that can be seriously hazardous to health

Many men feel compelled to engage in risky behaviour in order to 'prove' their masculinity and to 'do' gender in the socially approved way (Kimmel and Messner, 1993). Their behaviour has been shaped by what t Connell calls the 'hegemonic' version of masculinity and as a result men are more likely than women to be murdered, to die in a car accident or in dangerous sporting activities (Canaan, 1996; Pleck and Sonenstein, 1991). In most societies they are also more likely than women to drink to excess and to smoke which in turn increases their biological predisposition to early heart disease and other health problems (Waldron, 1995). They also seem to be more likely than women to desire unsafe sex (Zeidenstein and Moore, 1996)

The significance of a male identity in the arena of mental health has also received attention, especially from participants in the new men's movements. It has been argued that growing up male renders many men unable to realize what might be their emotional potential. The desire to be seen as a 'hard' man for instance may prevent them from exploring the 'caring' side of their nature while a refusal to admit weakness may prevent them from consulting a doctor when they are ill (though the evidence here is rather inconclusive) (Harrison et.al., 1992; Kristiansen, 1989) Indeed illness itself may be especially feared because of its capacity to reduce men to what has been called 'marginalised masculinity' (Cameron and Bernardes, 1998).

The implications of male gender for health have been highlighted by recent debates about mortality and morbidity in central and eastern Europe (Chenet, 2000). In many countries, the

health of both men and women has been deteriorating since the 1960's and this trend has accelerated over the past decade. However the impact has been much greater on men with premature deaths from circulatory diseases and some cancers rising dramatically. Between 1989 and 1994 life expectancy in Russia declined by more than 6.7 years in men and by 3.4 years in women (Bobak et al., 1998). As a result there is now a fourteen year gap in life expectancy between the two groups (Chenet, 2000). Some of this difference can be explained by gender differences in accidents and in smoking and alcohol consumption (Leon et al., 1997; Peto et al., 1992) However more qualitative variations in the lives of men and women may also be involved (Bobak et al., 1998; Chenet, 2000; Watson, 1995 & 1998)

Both men and women have been affected by the disruption of civil society which can result in feelings of hopelessness and lack of control (Bobak et.al. 1998). However there may be significant gender differences in these experiences. The collapse of state socialism highlighted the importance of the family as a locus for 'getting by'. In this context, women's social support networks and their capacity to generate survival strategies have come to the fore. This has meant that unmarried men may be materially and socially disadvantaged by lack of a family and this is reflected in their higher mortality rates. At the same time, there are now fewer opportunities for men to carry out the economic activities traditionally associated with masculinity. This has generated feelings of helplessness and frustration which have been linked both directly and indirectly to the greater decline in male health (Bobak et al 1998; Watson, 1995).

Thus far we have explored the complex ways in which both sex and gender need to be taken into account in thinking about strategies for equity in health. Developing an integrated perspective is not easy but important insights are emerging into how this interdisciplinary work can best be done. In the context of HIV/AIDS for instance, many biomedical scientists have come to recognise the importance of social and cultural factors in explaining the epidemic. At the same time an increasing number of social scientists have begun to explore the nature of 'material embodiment' and its differential implications for the health of women and men (Davis 1997; Shilling, 1993; Scott and Morgan, 1993). Further work of this kind is needed if the interrelations between sex and gender in the shaping of human health are to be properly understood.

Sex, gender and diversity

We have now explored the biological and the social commonalities that identify men and women as separate groups. But of course this does not imply homogeneity within each group. Hence socio-economic, cultural and age differences among women and among men also need careful exploration in order to assess their implications for the promotion of gender equity in health.

Despite the fact that they share the same biology, it is clear that women's reproductive health status is profoundly affected by who they are and where they live. The technical means to ensure safe contraception, abortion and childbearing do exist but they are not equally available to all. Half a million women still die each year as a result of pregnancy and virtually all of these avoidable deaths occur in poor countries where there is insufficient access to trained health workers (WHO,1991; Rooney, 1992; Royston and Armstrong, 1989). It is therefore impossible to understand the impact of sex on health without also taking factors such as class, race and geopolitical status into account.

Shifting to the gender differences between men and women, again we have to take seriously the issue of diversity. The reality of 'maleness' and 'femaleness' varies significantly between

cultures and communities. Hence the impact of gender on wellbeing will vary too. The implications for health of being a woman will be very different depending on whether the 'femaleness ' in question is mediated through poverty or wealth, through an urban cosmopolitan existence or life in a traditional village. To be a single female lawyer in an affluent London suburb may well be considerably healthier than being a working class mother of two in a run down tower block in the same city. However both will face many fewer social and economic constraints on their health than a landless woman with seven children in a village in Bangladesh.

Age too is crucial. It is increasingly clear that the health needs of men and women and the resources available to meet these needs vary significantly across the life cycle. However these differences are again complex. On the one hand the 'special needs ' of women for reproductive care are at their most acute during the childbearing years when they are most dependent on men. In mid-life, levels of need may be reduced only to rise again in old age. Yet in many societies older women lose what little status they had with the disappearance of childbearing potential and the sexual allure of youth (Owen, 1996). This mix of social and biological influences has profound effects on the nature of gender relations at different ages and these need to be included in any planning for gender equity.

It is clear from this analysis that the pursuit of gender equity is likely to be more challenging than is often assumed. A complex matrix of variables still require clarification both conceptually and also in terms of policy implications. However some preliminary conclusions can be drawn both about the way forward and also about the questions that remain to be resolved.

Policies for gender equity: a preliminary agenda

It can be argued that universal access to high quality reproductive health care is the single most important element that must be included in any global strategy for gender equity. In the richer parts of the world this has largely been achieved and its impact on women's capacity to realize their potential for long and healthy lives is very obvious. In the UK the gap between male and female life expectancy is now around 7 years but in India it is less than two years while in Bangladesh men live around one year longer than women (UNDP, 1995). Access to reproductive health care is an essential component in explaining these differences.

However this can only be part of the strategy. As we have seen, gender relations themselves also create obstacles to the realization of health. On the one hand they sustain inequalities in the allocation of resources and on the other they shape male and female identities in ways that can have a significant effect on wellbeing. These dimensions of gender also need to be addressed but the resolutions are likely to be complex and highly political as we can see from a brief exploration of current debates on gender, masculinity and health.

Health and the politics of gender

Concerns about health and masculinity have recently come to the fore both in academic and policy arenas and also in the popular press. While these debates are taking place mainly within the developed countries they do have a broader significance for the gender equity debate. A number of different positions can be identified and these will be examined in turn.

The first argument could be characterised as 'back to the future'. The supporters of this position claim that in many societies, changes have challenged men's sense of identity, causing a significant decline in wellbeing. The rise of male unemployment for example, the entry of more women into the labour market and the increase in one parent families are all

said to be the cause of significant mental health problems. In the UK the rise in suicides among young men has been linked to these trends (Charlton et.al. 1993). These are important concerns as the example of central and eastern Europe demonstrated, but the policy implications are by no means clear. According to some observers, these trends demonstrate the need for a return to traditional models of masculinity which they claim would benefit women as well as men. However it is unlikely that such an approach would be either practicable or justifiable as part of a strategy for achieving gender equity.

The second position has also been developed predominantly by men but it is very different from the one above. Indeed it has been referred to as a 'women centred ' approach to men's health by some of its main proponents (Sabo and Gordon, 1993). This approach is based on a recognition that unreconstructed masculinity can be dangerous to the health of both women and men. Thus men who are oppressed or even beaten by other men or feel constrained by social expectations may respond by turning on women. Similarly the failure of some men to realize their emotional potential will also be damaging to the women (or of course the men) with whom they live since it will limit the quality of the relationships of which they are capable.

It follows for the proponents of this view that the road to gender equity in health lies in the reconstruction of masculinity to make it healthier for both men and women. The main aim would be to enable men to change first their sense of themselves and then their behaviour so that they were less self-destructive and also less aggressive towards others (Lloyd and Wood, 1996). Paradoxically perhaps, what this strategy requires is that men behave more like women. That is to say that they model their behaviour not on what is usually perceived as 'masculinity ' but rather on what has stereotypically been regarded as 'femininity'.

This approach also contains a great deal of value. At a conceptual level it reminds us of the importance of not assuming that 'masculine ' or 'feminine' behaviour is inextricably linked to either biological sex or female gender (Annandale and Hunt, 1990). At a practical level it would help men to achieve their potential for health if it reduced the risk taking that currently constitutes one of the main hazards of maleness. It would also benefit women since these ‘new men’ would be less likely to be irresponsible or abusive. However it still leaves a number of important issues unresolved. In particular it places a great deal of emphasis on changes in male identity and masculine subjectivity while leaving largely untouched the material and institutional inequalities between men and women that constitute such major obstacles to gender equity.

This limitation is recognised in the third position on gender equity and health which could be called a broadly feminist approach. While it is not always clearly spelled out, this position does provide the underpinning philosophy for much of the women’s health advocacy taking place around the world. A large part of the burden of preventable morbidity and mortality experienced by women is related directly or indirectly to the patterning of gender divisions. If this harm is to be avoided there will need to be significant changes in related aspects of social and economic organisation. In particular, strategies will be required to deal with the damage done to women’s health by men, masculinities and male institutions.

While men may be exposed to risks because of the need to constantly affirm their gender identities they also derive major benefits from the gender system as a whole. In fact for most men the social gains of masculinity probably far outweigh the losses. Yet if gender equity is our goal many of these advantages might have to be given up. Hence men and women cannot be assumed to have an automatic identity of interests in the reform of gender relations. Policies will need to be developed to ensure that women receive an equal share of social and economic resources. Some men will certainly cooperate in working for these and other

changes in the nature of gender relations. However many others will be opposed to the removal of privileges which they have come to see as an inalienable right.

We are left then with a schematic policy for gender equity in health that places the greatest emphasis on universal access to reproductive health care followed by the removal of gender inequalities in access to resources. However there is also a need for policies to free up individuals from the constraints of rigidly defined gender roles. Since it is now accepted that gender identities are essentially negotiated, policies are needed which will enable individuals to shape their own identities and actions in healthier ways. These could include a range of educational strategies as well as more flexible employment policies and changes in the structure of state benefits. By this means both women and men would have opportunities to open up their lives in ways that could be beneficial to both physical and mental health.

It is important to acknowledge that the implementation of a strategy of this kind would be of most benefit to women. Indeed it could even be described as a recipe for reducing gender equity since in some parts of the world at least; it would increase the gap between male and female life expectancy still further. However the justification for this approach should be self evident. Since women have the potential for longer life expectancy and also suffer more severe social constraints on that potential then these conclusions should logically follow. Yet the implementation of a strategy along these lines would not solve all problems related to gender equity in health and might raise new ones in the process. These outstanding concerns are briefly examined in the conclusion.

The way forward: dilemmas and constraints

The first dilemma is whether we can improve the health of women without men losing out. And if we cannot, what implications does this have for the equity debate? If improvements in women's health necessitate them receiving a fairer share of available social resources, then men may have to get less and this will sometimes have a negative impact on their health. Men on the edge of poverty for example, might be dragged down below subsistence if their income had to be shared equally with their wives. Similarly, the mental health of men whose self-esteem was dependent on feeling superior to female kin might be damaged if the status of women improved. Will trade offs of this kind be necessary and if so how do we conceptualise them within an equity framework?

The second concern is primarily an empirical one and relates to how the transformations necessary to achieve gender equity are actually to be achieved. Many aspects of gender are deeply embedded in individual psyches (both male and female) making them difficult to change. This resistance will be reinforced by the location of many of these inequalities within the private space of the household. This creates problems about how best to balance equity issues with what may be legitimate concerns about privacy. But mostly it raise questions about how successful public policy can ever be in changing some of the more fundamental aspects of human behavior. This will clearly be especially problematic in the case of those men (and some women) who would be required to make sacrifices without any obvious short term gain.

Finally, it is important to conclude with what must be a continuing debate about the priority to be given to gender equity in the face of the many different injustices that continue to confront us. Health outcomes for both individuals and populations are profoundly influenced not just by gender but by factors such as race, class, ethnicity and geopolitical status. Indeed in particular circumstances these may be more powerful than either sex or gender in determining health status. However it is clear that many women (and some men) will

continue to experience avoidable constraints on their wellbeing until gender issues are taken seriously by all those seeking to achieve equity in health and health care.

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